www.tricitymhs.org

Tri-City Mental Health Authority
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Founded by Pomona, Claremont, and La Verne in 1960

Robin Carder (La Verne), Chair
Jed Leano (Claremont), Vice-Chair
Carolyn Cockrell (La Verne), Board Member
Paula Lantz (Pomona), Board Member
John Nolte (Pomona), Board Member
Elizabeth Ontiveros-Cole (Pomona), Board Member
Ronald T. Vera (Claremont), Board Member

GOVERNING BOARD AGENDA

WEDNESDAY, JUNE 16, 2021
5:00 P.M.

MEETING LOCATION

Pursuant to California Governor's Executive Order N-29-20 (Paragraph 3), adopted as a response to mitigating the spread of Coronavirus (COVID-19), the Governing Board is authorized to hold its public meetings via teleconference and the public seeking to observe and to address the Governing Board may participate telephonically or otherwise electronically. Therefore, this meeting will be held via teleconference. The locations from where the Board Members are participating are not listed on the agenda and are not accessible to the public.

To join the Governing Board meeting clink on the following link:

https://webinar.ringcentral.com/webinar/register/WN_8Y_GiMW9T3Ch39HP2L1E0w

Or you may call: 1 (213) 250-5700
Webinar ID: 149 122 1077

Public Participation. Section 54954.3 of the Brown Act provides an opportunity for members of the public to address the Governing Board on any item of interest to the public, before or during the consideration of the item, that is within the subject matter jurisdiction of the Governing Board. Therefore, members of the public are invited to speak on any matter on or off the agenda.

The public can make a comment during general public comments or on a specified agenda item by leaving a voice mail message at (909) 451-6421 or by writing an email to molmos@tricitymhs.org. All voice mail messages and emails received by 3:30 p.m. will be read into the record at the appropriate time. No action shall be taken on any item not appearing on the Agenda. The Chair reserves the right to place limits on duration of comments.

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by Tri-City Mental Health Authority to all or a majority of the Tri-City Governing Board less than 72 hours prior to this meeting are available for public inspection at ***http://www.tricitymhs.org***

CALL TO ORDER

Chair Carder calls the meeting to Order.

ROLL CALL

Board Member Cockrell, Board Member Lantz, Board Member Nolte, Board Member Ontiveros-Cole, and Board Member Vera; Vice-Chair Leano; and Chair Carder.

POSTING OF AGENDA

The Agenda is posted 72 hours prior to each meeting on the Tri-City's website: http://www.tricitymhs.org

CONSENT CALENDAR

1. **APPROVAL OF MINUTES FROM THE MAY 19, 2021 GOVERNING BOARD AND MENTAL HEALTH COMMISSION REGULAR JOINT MEETING**

   Recommendation: "A motion to approve the Minutes of the Governing Board and Mental Health Commission Regular Joint Meeting of May 19, 2021."

2. **CONSIDERATION OF RESOLUTION NO. 585 ESTABLISHING MENTAL HEALTH SERVICES ACT (MHSA) COMMUNITY PROGRAM PLANNING PROCESS (CPPP) POLICY AND PROCEDURE NO. IV.14, EFFECTIVE JUNE 16, 2021**

   Recommendation: "A motion to adopt Resolution No. 585 establishing Policy and Procedure No. IV.14 – MHSA Community Program Planning Process, effective February 16, 2021."

3. **CONSIDERATION OF RESOLUTION NO. 586 ESTABLISHING MENTAL HEALTH SERVICES ACT (MHSA) INNOVATION PLAN PROJECTS POLICY AND PROCEDURE NO. IV.15, EFFECTIVE JUNE 16, 2021**

   Recommendation: "A motion to adopt Resolution No. 586 establishing Policy and Procedure No. IV.15 – MHSA Innovation Plan Projects, effective June 16, 2021."

NEW BUSINESS

4. **CONSIDERATION OF RESOLUTION NO. 587 AWARDING CONTRACT TO CERNER CORPORATION FOR ELECTRONIC HEALTH RECORDS SOFTWARE PLATFORM SERVICES AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE ITS MASTER SERVICES AGREEMENT FOR THREE YEARS IN THE AMOUNT OF $867,816.00, WITH AN OPTION TO EXTEND AN ADDITIONAL TWO YEARS**

Recommendation: "A motion to adopt Resolution No. 587 approving a Master Services Agreement with Cerner for Electronic Health Records Software Platform services in the amount of $867,816.00; and authorizing the Executive Director to execute the Agreement."

5. CONSIDERATION OF AWARDING COMMUNITY WELLBEING GRANTS FOR FISCAL YEAR 2021-22 UNDER THE COMMUNITY CAPACITY BUILDING PROJECT OF THE PREVENTION AND EARLY INTERVENTION (PEI) PLAN

Recommendation: "A motion to award seventeen Community Wellbeing Grants totaling $85,300.00 to be funded under the PEI Plan in FY 2021-22"

6. CONSIDERATION OF RESOLUTION NO. 588 AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE A MEMORANDUM OF UNDERSTANDING WITH THE CLAREMONT UNIFIED SCHOOL DISTRICT (CUSD) FOR SPECIALTY MENTAL HEALTH SERVICES FOR THREE YEARS EFFECTIVE JULY 1, 2021

Recommendation: "Staff recommends that the Governing Board adopt Resolution No. 588 approving the MOU with the CUSD and authorizing the Executive Director to execute the MOU."

7. CONSIDERATION OF RESOLUTION NO. 589 AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE AN ADDENDUM TO THE SOFTWARE SERVICES AGREEMENT WITH WELLIGENT FOR ONE-YEAR IN THE AMOUNT OF $115,500 EFFECTIVE JULY 1, 2021

Recommendation: "A motion to adopt Resolution No. 589 approving an Addendum to the Software Services Agreement with Welligent in the amount of $115,500 for one year Effective July 1, 2021; and authorizing the Executive Director to execute it."

8. CONSIDERATION OF RESOLUTION NO. 590 AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE AN AGREEMENT WITH KAIROS PARTNERS, LLC FOR IT CONSULTING SERVICES IN AN AMOUNT NOT TO EXCEED $25,000 EFFECTIVE JUNE 17, 2021

Recommendation: "A motion to adopt Resolution No. 590 approving an Agreement with Kairos Partners, LLC for IT Consulting Services in the amount not to exceed $25,000 Effective June 17, 2021, and authorizing the Executive Director to execute it."

9. CONSIDERATION OF RESOLUTION NO. 591 ADOPTING THE MENTAL HEALTH SERVICES ACT (MHSA) ANNUAL UPDATE FOR FISCAL YEAR 2021-22 AS RECOMMENDED BY TCMHA MENTAL HEALTH COMMISSION

Recommendation: "A motion to adopt Resolution No. 591 approving the MHSA Annual Update For Fiscal Year 2021-22."

10. TCMHA GOVERNING BOARD WILL CONSIDER FORMING AN AD-HOC COMMITTEE TO INTERVIEW AND SELECT MENTAL HEALTH COMMISSION MEMBERSHIP APPLICANTS

Recommendation: "Staff recommends that the Governing Board select two of Board Members to participate in an Ad-Hoc Committee to interview and select potential MHC Membership Applicants."

MONTHLY STAFF REPORTS

11. TONI NAVARRO, EXECUTIVE DIRECTOR REPORT

12. DIANA ACOSTA, CHIEF FINANCIAL OFFICER REPORT

13. LIZ RENTERIA, CHIEF CLINICAL OFFICER REPORT

14. SEEYAM TEIMOORI, MEDICAL DIRECTOR REPORT

15. RIMMI HUNDAL, DIRECTOR OF MHSA AND ETHNIC SERVICES REPORT

16. NATALIE MAJORS-STEWART, CHIEF COMPLIANCE OFFICER REPORT

17. KEN RIOMALES, CHIEF INFORMATION OFFICER REPORT

Recommendation: "A motion to receive and file the month of June staff reports."

GOVERNING BOARD COMMENTS

Members of the Governing Board may make brief comments or request information about mental health needs, services, facilities, or special problems that may need to be placed on a future Governing Board Agenda.

PUBLIC COMMENT

The public can make a comment during general public comments or on a specified agenda item by leaving a voice mail message at (909) 451-6421 or by writing an email to molmos@tricitymhs.org. All voice mail messages and emails received by 3:30 p.m. will be read into the record at the appropriate time. No action shall be taken on any item not appearing on the Agenda. The Chair reserves the right to place limits on duration of comments.

ADJOURNMENT

The next Regular Meeting of the **Governing Board** will be held on **Wednesday, July 21, 2021 at 5:00 p.m.**, via teleconference due to the COVID-19 pandemic.

MICAELA P. OLMOS
JPA ADMINISTRATOR/CLERK

MINUTES

GOVERNING BOARD / MENTAL HEALTH COMMISSION REGULAR JOINT MEETING

MAY 19, 2021 – 5:00 P.M.

The Governing Board and the Mental Health Commission held on Wednesday, May 19, 2021 at 5:03 p.m. its Regular Joint Meeting Via Teleconference pursuant to California Governor Newson Executive Order N-25-20 wherein he suspended certain provisions of the Brown Act to allow the continuation to hold meetings without gathering in a room in an effort to minimize the spread and mitigate the effects of COVID-19 (Corona Virus Disease of 2019).

CALL TO ORDER Chair Carder called the meeting to order at 5:03 p.m.

ROLL CALL Roll call was taken by JPA Administrator/Clerk Olmos.

GOVERNING BOARD

PRESENT: Robin Carder, City of La Verne, Chair
Jed Leano, City of Claremont, Vice-Chair
Carolyn Cockrell, City of La Verne, Board Member
Paula Lantz, City of Pomona, Board Member
John Nolte, City of Pomona, Board Member
Elizabeth Ontiveros-Cole, City of Pomona, Board Member
Ronald T. Vera, City of Claremont, Board Member

ABSENT: None.

MENTAL HEALTH COMMISSION

PRESENT: Anne Henderson, Chair
Wray Ryback, Vice-Chair (joined at 5:36 pm)
Carolyn Cockrell, GB Member Liaison
Joan M. Reyes, Commissioner
Twila L. Stephens, Commissioner
Alfonso “Al” Villanueva, Commissioner
Toni L. Watson, Commissioner
David J. Weldon, Commissioner

ABSENT: Ethel Gardner, Commissioner
Davetta Williams, Commissioner

STAFF: Toni Navarro, Executive Director
Darold Pieper, General Counsel
Diana Acosta, Chief Financial Officer

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AGENDA ITEM NO. 1

Elizabeth Renteria, Chief Clinical Officer
Seeyam Teimoori, Medical Director
Rimmi Hundal, Director of MHSA & Ethnic Services
Ken Riomales, Chief Information Officer
Mica Olmos, JPA Administrator/Clerk

NEW BUSINESS – GOVERNING BOARD

1. CONSIDERATION OF RESOLUTION NO. 579 AUTHORIZING THE EXECUTIVE DIRECTOR TO SUBMIT ON BEHALF OF TRI-CITY MENTAL HEALTH AUTHORITY THE FINAL BANKRUPTCY PAYMENT TO THE DEPARTMENT OF HEALTH CARE SERVICES IN THE SUM OF $200,512 AND TO THE LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH IN THE SUM OF $130,551

There being no discussion, Board Member Lantz moved, and Board Member Vera seconded, to adopt Resolution No. 579 authorizing the Executive Director to Submit on behalf of Tri-City Mental Health Authority the final bankruptcy payment to the Department of Health Care Services in the amount of $200,512 and to the Los Angeles County Department of Mental Health in the amount of $130,551. The motion was carried by the following vote: AYES: Board Members Cockrell, Lantz, Nolte, Ontiveros-Cole, and Vera; Vice-Chair Leano; and Chair Carder. NOES: None. ABSTAIN: None. ABSENT: None.

Chief Financial Officer Acosta expressed proudness and excitement for being part of this celebration because Tri-City is a very special place, noting that all the hard work and dedication from all of the staff has contributed to this event. She then recognized Tri-City's former Chief Financial Officer Margaret Harris, who passed away in January of 2020, pointing out that she also would have been extremely proud of Tri-City and all that has been accomplished to date. She indicated that Ms. Harris came to Tri-City with a mindset of staying working on a 10-month project, and instead, she stayed for 10 years which shows how special is what we do here at Tri-City. She then reported that Tri-City owed $13.1 million and started paying this debt in back in 2009.

Congresswoman Grace Napolitano commended Tri-City for ending its bankruptcy; announced that the Secretary Xavier Becerra of the HHS (Department of Health and Human Services) had just announced $3 billion for mental health services and encouraged Tri-City to stay aware of the funding and to reach out to her and Congresswoman Norma Torres to provide more mental health services for a better community and a better society for everybody; wished Tri-City well and expressed gladness that it is thriving and is doing well; indicated that she has a monthly virtual Mental Health Consortium hosted by Dr. Irma Diaz, as well as a Mental Health Caucus in Washington with her cohort, John Katko from New Jersey, whose efforts is to elevate mental health to where it is taken more seriously; and also congratulated Tri-City for its 60th anniversary.

Executive Director Navarro thanked Congresswoman Napolitano for all her work in Congress on behalf of mental health needs, students and youth; expressed excitement about Secretary Becerra's announcement of funding allocation for mental health; noted that Tri-City staff and a Commission Member attends her monthly consortium meeting; and thank her for being here today.

Assembly Member Freddy Rodriguez, 52nd Assembly District, former Pomona City Council Member, and former Tri-City Board Member, was unable to attend today's meeting and sent a video congratulating Tri-City, which was shown during the meeting. He stated that services

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provided by Tri-City are central to our community; thanked staff for their hard work and dedication and for Tri-City's partnership in Pomona, especially around providing services to our homeless populations; and congratulated Tri-City.

Jessie Duff, former Tri-City Executive Director, expressed gratitude for being invited to be part of this celebration. He then reported that Congresswoman Grace Napolitano was a big supporter of Tri-City and she 'held our feet to the fire' which was very helpful in many ways to Tri-City; that he came to Tri-City in 2007 and the bankruptcy happened approximately the year before; he talked about the different persons who helped during the bankruptcy including Dean Rallis, Kathy Drummy, noting that Darold Pieper and the late Margaret Harris were very instrumental in Tri-City's success during the bankruptcy court proceedings; he also recognized former Board Members Paula Lantz, Freddie Rodriguez, and John Blickenstaff, and late Ellen Taylor who not only supported staff in all of their efforts, but were also nurturing during a very, very difficult period of time. He also stated that current Executive Director Toni Navarro came to Tri-City during a very critical time to handle the clinical operations and found many very creative ways to keep the clinic open, operating, and serving our residents of Pomona, Claremont and La Verne, which was a monumental task and she handled it admirably; that as she has become the executive director, she has continued to be creative, efficient, and effective and has gotten Tri-City to where it is today.

Kathy Drummy, Attorney, stated that it was great to hear all of this and the so well deserved tribute to Margaret Harris who was fabulous; and congratulated Tri-City.

Executive Director Navarro welcomed and introduced John Ott and Rose Bernard, who brought to Tri-City's door the community willingly, lovingly, and with full support and intention to cooperate with Tri-City; that they took Tri-City to the next five years and created 'A New Day' for Tri-City, a new pathway, and also help us get onboard with the Mental Health Services Act and create the wonderful system of care we have today.

John Ott, stated that he was delighted to be here; that it was their work with Tri-City that inspired him and Rose to know that collective wisdom is possible; that they have started an organization called the Center for Collective Wisdom; that they are teaching this way of working with communities and systems across the country and beyond; that they are regularly telling the story and singing the praises of Tri-City and what was possible of achieving from the depths, not just despair, but of fear; that this system from the beginning has been modeling what it means to be a community based mental and behavioral health system, and to really understand that mental health goes beyond immediate services to really embrace community wellbeing and community engagement; that it is a remarkable day; and expressed being grateful for the invitation to be present and celebrating this day with Tri-City.

Executive Director Navarro stated this Fiscal Year 2020-21 is Tri-City's 60th Anniversary; that there were still so many unknowns about COVID and things got even darker until the first of this year; that all celebration plans were cancelled; however, that now it is the right time and a perfect parallel to our country in that we are coming out of bankruptcy and we are ending our 60th birthday so strong just as our country is coming up out of COVID; that there is a lot of hope and renewed like the spring and people are once again smiling; that this makes this day even more special for all of us because it is our 60th year and we are ending our bankruptcy.

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Board Member Lantz stated that the old adage 'what doesn't kill you makes you stronger' is really appropriate for this day because we were on our knees and in desperate situations, and out of that it was created a much more community based and stronger system of care; that it is so wonderful to see what Tri-City is today, noting that she never envisioned it when she first came on the Board; that this is a direct result of what we were forced to do because of the bankruptcy; and thanked John Ott, Jesse Duff, Toni Navarro, and Margaret Harris.

Dr. Edina Martinez, former Tri-City Board Member, recognized the number of people that were in attendance; stated that it is a testament to the shared goal of wanting to see Tri-City succeed that everyone really did pull together to help it get to the place that it currently is; that she is aware of all the challenges along the way and noted, when attending the various meetings, it was amazing seeing staff representing Tri-City advocating for the various needs, particularly around stigma; that this is such a huge accomplishment, expressing gladness for being part of this process; and agreed that it is kind of beautiful that this is happening in May during mental health month and it is Tri-City's 60th Anniversary.

Executive Director Navarro welcomed Mr. Dick Bunce; stated that he was not only an ally, he was also at that time co-president of NAMI with Michael Fay; that they were determined to keep us to our word; that he was a true North; and thanked him for his continued partnership with Tri-City.

Dick Bunce, former NAMI Pomona President, thanked Tri-City for this invitation; stated that it is just amazing what Tri-City has accomplished while at the same time paying its way out of bankruptcy. He then said that his experience with Tri-City had been very dynamic and he always knew he was dealing with honest individuals and never worried about dealing with anybody who had a hidden agenda, nor manipulative, nor in any way dishonest; described the various ways that he has intersected with Tri-City and stated that Toni Navarro, and Tri-City's leadership, bring more than professionalism to this job, that they also bring a passion and they have a calling, which without it something would be missing; stated that this is only the beginning; that Tri-City has a golden future and he wants to be part of it; and congratulated everyone.

At 5:36 p.m. Mental Health Commission Vice-Chair Wray Ryback joined the meeting.

Executive Director Navarro announced that she would introduce a really special group of people, which she is calling Tri-City's legacy team because these staff members have been right here since before 2004, or between 2004 and 2008, and through the bankruptcy. Shen then introduced Patricia Recalde, Program Support Specialist III; Sunny Alino, Employment Services Outreach Supervisor; Rosie Olivos and Loane Truong, Accounting Managers; Griselda Marquez and Angel Emery, Program Assistants III; Joanne Duran and Gina Martinez, Finance Specialists; Laura Rodriguez, Licensed Psych Tech; Francis Avila, Mental Health Worker; Manny Ortega, Facilities Specialist; Ernie Avila, Community Navigator; Alexis Naranjo, she's always at 2008 to greet you with a smile; Kevin Armstrong, Transportation staff; Veronica Serret, Quality Assurance Specialist; Cindy Martinez, Electronic Health Record Specialist; Shawn Smith, Medication and Crisis Support Outreach Manager; Rimmi Hundal, Director of MHSA and Ethnic Services; and Rocio Bedoy, Manager of Best Practices; and stated that these staff members maintained hope and positivity for either the clients or their colleagues, embraced and promoted everybody to get on board with the many and sometimes really difficult changes we had to make to be able to sustain ourselves, stayed really focused on what a great opportunity it was for us to have all this reorganization instead of getting pulled down into the depths of the despair of the crisis; and thanked them for their dedication to Tri-City, noting that they are a big part of why we are here today.

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Board Chair Carder stated that this organization is just so well ran that staff makes their job easy; that it has been her honor to be the Chair of Tri-City Mental Health's Board, noting that she has seen such growth in the 12 years that she has been on the board and watching how the finances progressed through the years; that the Board looked forward to this day and she congratulated everyone. She then recognized Bill Aguirre, former City of La Verne employee, who had been also part of Tri-City, pointing out that he kept her abreast of everything; that even though he has retired, he still cares so much for this organization; and thanked him for the years of dedication.

Dr. Anne Turner, former Human Services Director for the City of Claremont, congratulated Tri-City noting that this was a long time coming; that as a more than 40 year Claremont resident, she had the opportunity to watch Tri-City from the point of view of a resident and of a Claremont City employee; gave kudos to the Tri-City team, stating that they are an extraordinary group of folks; that the programs that are in place now, and the integration of mental health into our public safety teams, and the work that has been done which has been groundbreaking and innovative by this very nimble mental health organization, has given them new hope of what is possible in partnership between municipalities and their mental health providers; that it has been an amazing honor to be involved with this organization; thanked former Claremont Council Member Joe Lyons and Jed Leano; and congratulated Toni Navarro, Jesse Duff, Rimmi Hundal, Diana Acosta, and the whole team.

Board Member Vera recognized Jesse Duff because he really did not have to come and take on the role when he did at the time; talked about when he met him to find out if Tri-City was going survive, and Jesse had a steady vision ahead; that John Ott worked a lot with community members to recognize that Tri-City should survive; that the credit is to all the people that were involved during that time and said that they needed Tri-City and that it can stand in its own; and thanked all of the people in the past that made this day possible.

Counsel Pieper stated that this has been an interesting journey for 17 years; thanked Paula Lantz, who found herself at the helm when all of this happened and who helped chair everything in the early days. He said that either of them will ever forget black Friday, February 3, 2004 when they filed the bankruptcy petition and had to invite all of the staff into a large auditorium, noting that it was an incredible and emotional experience to have to go through terminating at least a full third of the staff in one day, and then proceeding with the bankruptcy, which is now quite a thrill to see it finally concluded and paid off after all of these years.

JPA Administrator Olmos read comments from the chat room, Sonny Alino indicated he was very proud to be at Tri-City. Loane Truong wrote that she is very proud and honored to be with the Tri-City team. Dr. Pramila Agrawal said that she has known Tri-City for a long time; that the story and challenges to Tri-City are new to her, and how they were handled are amazing; and congratulated everyone.

Executive Director Navarro thanked everyone for their time and Tri-City's community partners who were able attend the meeting; gave kudos to the legacy team and thanked them for everything they bring every day to the residents of the three cities. She then thanked Jesse Duff for attending the meeting, noting that he was her mentor; that she is missing Margaret Harris very much today; that when Jesse hired her she was very excited because she really believed in what Tri-City was, what they stood for, and the collaboration with the residents which was amazing; and thanked everyone for allowing her to be here and to be the executive director.

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MENTAL HEALTH COMMISSION

2. APPROVAL OF MINUTES FROM THE APRIL 13, 2021 REGULAR MENTAL HEALTH COMMISSION MEETING

Chair Henderson, welcomed everyone on behalf of the mental health commission, and indicated that the Mental Health Commission is an advisory body to Tri-City Governing Board; that it meets monthly to help advise the governing board, the executive director, staff, and stakeholders of Tri-City Mental Health Authority, about how to ensure high quality mental health services in our area.

There being no further comment, Commissioner Reyes, and Vice-Chair Ryback seconded, to approve the Minutes of the April 13, 2021 Mental Health Commission Regular Meeting. The motion was carried by the following vote: AYES: Board Member Liaison Cockrell; Commissioners Reyes, Stephens, Villanueva; Vice-Chair Ryback; and Chair Henderson. NOES: None. ABSTAIN: None. ABSENT: Commissioners Gardner, Watson, Weldon, and Williams.

3. CONSIDERATION TO RECOMMEND TO TCMHA GOVERNING BOARD TO APPROVE THE EXPENDITURE OF $300,436.00 FROM ITS CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN) PLAN FUNDS TO IMPLEMENT A NEW ELECTRONIC HEALTH RECORD (EHR) SYSTEM AND A NEW CLIENT REFERRAL MANAGEMENT PLATFORM

There being no comment, Commissioner Stephens, and Commissioner Reyes seconded, to recommend to the Governing Board to approve the expenditure of $300,436.00 from its CFTN Plan Funds to implement a new Electronic Health Record (EHR) system, and a new client referral management platform. The motion was carried by the following vote: AYES: Board Member Liaison Cockrell; Commissioners Reyes, Stephens, Villanueva; Vice-Chair Ryback; and Chair Henderson. NOES: None. ABSTAIN: None. ABSENT: Commissioners Gardner, Watson, Weldon, and Williams.

4. PUBLIC HEARING FOR THE MENTAL HEALTH SERVICES ACT (MHSA) INNOVATION PLAN UPDATE EFFECTIVE JULY 1, 2021 THROUGH JUNE 30, 2024

Chair Henderson reported that under state law, this public hearing occurs as part of a Regular Mental Health Commission Meeting; that MHSA Innovation plan had emerged from almost a year of extensive work and conversations with individuals and organizations throughout our three cities; that tonight an overview of the plan would be presented and ask for feedback; and that Tri-City's MHSA Projects Manager Dana Barford would facilitate the Public Hearing.

A. Open the Public Hearing

At 5:58 p.m., Chair Henderson officially declared the public hearing open.

MHSA Project Manager Barford stated that we are here today to talk about a brand new innovation project; explained that Innovation is one of the five plans that we have under MHSA; that this plan provides an opportunity for counties to engage with community members, not only to identify the needs of the community, but also to come together to develop a learning project that is time limited and also fund limited, which hopefully will inform both current and future mental health practices; that this project is designed to benefit our community members, primarily Transition Age Youth (TAY), and it will also support the staff members that work with our TAY; and announced that Amanda Colt, Tri-City's MHSA Innovations coordinator, would provide an overview of the project.

B. Overview and Explanation of the MHSA Innovation Plan Update

Amanda Colt, MHSA Innovations Program Coordinator, announced that the Innovation Plan is restorative practices for improving mental health; discussed community planning surveys for community members, stakeholders, anybody who had ideas or input to fill out that survey and give staff some ideas to start with; that these ideas that were given and organized five stakeholder groups, between January and February; that two new project ideas were developed; one final project was selected which is restorative practices for improving women's health. She explained that it is a three year, multi collaborative approach to improve mental wellness and resilience from trauma; that it is estimated that about 360 participants will be trained over the three years; and it will utilize Sky Breathing, trauma Informed Yoga and Restorative Practice Circles; that it will target Tri-City employees who are mental health professionals, TAY including LGBTQ and foster care, and the staff who served them; that the sustainability of this project involves training each year 10 Tri-City staff, and train the trainer so they are able to train their community members; that the estimated cost is $949,957; that the slogan for this whole plan will be 'Breathe, Heal, And Restore.' She then explained the three practices 1) Sky Breathing is an evidence-based practice that can help individuals reduce stress and clear their minds through breath, meditation; 2) Trauma Informed Yoga emphasizes the impact of trauma on the entire mind and body system and provides an approach, creating a safe and supportive space where participants can learn emotional regulation skills through connection with the breath and increased body awareness; and 3) Restorative Practices are used to bring together both offenders and victims in an attempt to repair damaged relationships, through a process of accountability and forgiveness; she then provided examples of their benefits of these techniques; provided goals of PRIMH; discussed the target population, how they will access trainings; and discussed the stakeholder process and voting results for this project, as well as the breakdown for the costs associated with the project; and the process for final approval of the MHSOAC (Mental Health Services Oversight and Accountability Commission.)
Commissioner Ryback sought clarification of the work that the consultants will be doing for the fees presented. MHSA Project Manager Barford indicated that the cost estimated was for over a three-year period offering the different trainings which includes specialized training which is train the trainer.

C. Public Comment

Reverend Jan chase, Minister of Unity Church at Pomona and convener of Compassionate Pomona meetings, spoke in favor of Sky Breathing and Restorative Practices, noting that she had experienced the link power of both skill sets, and explained that sky breathing is the perfect partner for restorative practices, which will help people build and heal relationships noting that this is something needed more than ever since COVID has brought so much isolation to our community; that she can see that Trauma Informed Yoga will enhance the effectiveness of Sky Breathing and Restorative Practices; and congratulated and thanked Tri-City for all it is and for the wonderful partner that it is in our community.

Danielle Rasshan, teacher in Pomona Unified School District, introduced her son Kai William stating that he has been able to take advantage of sky club, which was instituted in Pomona Unified for students to come and experience the sky breathing program; that she has seen the results in him; and her son wanted to provide the student perspective.

Kai William Rasshan reported that sky breathing had really helped him and giving him the skills to manage his stress and anxiety, especially right now during COVID where he is not having much social interaction; and that he has enjoyed it a lot.

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Danielle Rasshan stated that she had been a fan of the sky breathing program in the school district for quite some time; that now that she is doing the teacher training, she is learning the science behind it, noting that the tool of the breath is really unique because everybody can do it anywhere and it does not require any equipment; that once you learn the skills it is yours forever and it is accessible to anyone who can breathe; and encouraged everyone to give this deep consideration how it can impact the community.

Dr. Pramila Agrawal stated that she supports this program because when she tried it, her depression and headaches completely went away; that the sky breathing is a combination of cognitive tools and breathing practices; and explained that cognitive tools give you the awareness and breathing relaxes and decreases the tension and the stress; that the end result is that you can live a much better and happy life. She then discussed her medical background and practice.

Zahabiyah Yamasaki leaded everyone through a brief seated trauma informed yoga practice; then she stated that the best way to explain is to experience it in your own body; and thanked everyone for giving her the opportunity.

Nora Jacob, Care and Restorative Practices Coordinator for Justice for Youth, stated that she is pleased about this coordination of practices that is being proposed because restorative practices are the ones that happen in community and the others are individual; discussed restorative practices and restorative justice, and how it is practiced in a respectful area of radical equality, where each person speaks, there is deep listening, nonjudgmental and open-ended questions.

Anthony talked about how justice for youth and the TAY program has really like helped him and taught him about discipline; expressed happiness for being here because Tri-City is a cool organization; and talked about his experiences with justice for youth.

Naveen Koneru thanked the leadership for considering these programs; spoke on how this could help healthcare professionals, and provided statistics about the necessity for programming to help with the addressing the needs of the healthcare professions.

Susan Ramsundars, member of the sky team, shared what she has heard from people from their promoted courses when they ask what have you learned?; stated that it has been brilliant to be part of this process; that the project that has been developed is genuinely reflective of the collaborative way that Pomona takes care of everybody.

Commissioner Villanueva stated that he is an advocate of restorative justice and not retributive justice; that this is really going to be profound for the TAY; suggested to incorporate role-playing in terms of victim and offender; thanked the community members like Dick Bunce and Nora Jacob, because without community members, Tri-City would not be able to effectuate this innovative program; spoke in support of the proposed Innovation Program because it is self-sustained; and complimented those that are involved in this program.

D. Close the Public Hearing

There being no MHC comment, Commissioner Villanueva, and Commissioner Reyes seconded, to close the Public Hearing. The motion was carried by the following vote: AYES: Board Member Liaison Cockrell; Commissioners Reyes, Stephens, and Villanueva; Vice-Chair Ryback; and Chair Henderson. NOES: None. ABSTAIN: None. ABSENT: Commissioners Gardner, Weldon, Watson and Williams.

E. Decide on a Recommendation to the Governing Board about the MHSA Innovation Plan Update

There being no MHC comment, Commissioner Reyes, and Vice-Chair Ryback seconded, to recommend to the Governing Board to approve the MHSA Innovation Plan Update effective July 1, 2021 through June 30, 2024. The motion was carried by the following vote: AYES: Board Member Liaison Cockrell; Commissioners Reyes, Stephens, Villanueva, and Watson; Vice-Chair Ryback; and Chair Henderson. NOES: None. ABSTAIN: None. ABSENT: Commissioners Gardner, Weldon, and Williams.

CONSENT CALENDAR – GOVERNING BOARD

There being no comment, Vice-Chair Leano moved, and Board Member Cockrell seconded, to approve the Consent Calendar. The motion was carried by the following vote: AYES: Board Members Cockrell, Lantz, Nolte, Ontiveros-Cole, and Vera; Vice-Chair Leano; and Chair Carder. NOES: None. ABSTAIN: None. ABSENT: None.

5. APPROVAL OF MINUTES FROM THE APRIL 21, 2021 GOVERNING BOARD REGULAR MEETING

Recommendation: "A motion to approve the Minutes of the Governing Board Regular Meeting of April 21, 2021."

6. CONSIDERATION OF RESOLUTION NO. 580 ESTABLISHING TRI-CITY MENTAL HEALTH AUTHORITY SUPPLEMENTAL PAID SICK LEAVE POLICY NO. I.22 EFFECTIVE RETROACTIVE TO JANUARY 1, 2021

Recommendation: "A motion to adopt Resolution No. 580 establishing a Supplemental Paid Sick Leave Policy No. I.22 effective retroactive to January 1, 2021."

NEW BUSINESS CONTINUED – GOVERNING BOARD

7. CONSIDERATION OF RESOLUTION NO. 581 APPROVING THE MENTAL HEALTH SERVICES ACT (MHSA) INNOVATION PLAN UPDATE EFFECTIVE JULY 1, 2021 THROUGH JUNE 30, 2024

Executive Director Navarro thanked members of the public for attending the meeting, for providing additional information, and for supporting the project; and expressed support for this project.

Director of MHSA & Ethnic Services Hundal reported that copies of the draft plan were circulated for public comment in the community and listed all the venues; that announcements were posted in social media; and reported that she did not received any written public comment prior to the public hearing, only those that were heard today during the public comment.

There being no further comment, Board Member Lantz moved, and Board Member Cockrell seconded, to adopt Resolution No. 581 approving the MHSA Innovation Plan Update effective July 1, 2021 through June 30, 2024. The motion was carried by the following vote: AYES: Board Members Cockrell, Lantz, Nolte, Ontiveros-Cole, and Vera; Vice-Chair Leano; and Chair Carder. NOES: None. ABSTAIN: None. ABSENT: None.

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8. CONSIDERATION OF RESOLUTION NO. 582 AUTHORIZING THE EXPENDITURE OF $300,436.00 FROM ITS CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN) PLAN FUNDS TO IMPLEMENT A NEW ELECTRONIC HEALTH RECORD (EHR) SYSTEM AND A NEW CLIENT REFERRAL MANAGEMENT PLATFORM

Executive Director Navarro reported that the CFTN Plan was posted for 30 days, in all the public places, on social media, and on our website; that staff did not received any public comment; and explained that under the MHSA plan, the funds from CFTN can be for the implementation, not the ongoing cost, of the new electronic health record and a client referral platform.

There being no further discussion, Vice-Chair Leano moved, and Board Member Ontiveros-Cole seconded, to adopt Resolution No. 582 authorizing the Expenditure of $300,436.00 from its CFTN Plan Funds to implement a new Electronic Health Record (EHR) system, and a new client referral management platform. The motion was carried by the following vote: AYES: Board Members Cockrell, Lantz, Nolte, Ontiveros-Cole, and Vera; Vice-Chair Leano; and Chair Carder. NOES: None. ABSTAIN: None. ABSENT: None.

9. CONSIDERATION OF RESOLUTION NO. 583 AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE A MASTER CLOUD SERVICES AND NETWORK MANAGEMENT AGREEMENT WITH UNITE USA, INC. (UNITE US) FOR USE OF ITS SOFTWARE VIA THE PUBLIC INTERNET FOR THREE YEARS IN THE AMOUNT OF $75,000 EFFECTIVE JULY 1, 2021

Executive Director Navarro stated that Unite Us is a client referral platform for which you just approved the implementation funds; that this client platform is utilized by various counties and other providers throughout California, including the Los Angeles Department of Mental Health and their veterans services program; that this platform will allow Tri-City staff to enter referrals into a system, from which our community partners will get the referral from that system and will track for us services provided; that it is a fully HIPAA compliant platform.

Dr. Eric Hazard, Network Director for United Us, stated that United Us is platform and a way on a way to coordinate social care, focusing on connecting clinical, mental, and social care together in one platform; that they have been doing work since 2013 and are in in over 45 States; discussed current clients that utilize the platform, and the sensitive services they provide; and congratulated Tri-City on transitioning out of bankruptcy.

Executive Director Navarro indicated that community collaboration and referral is a cornerstone of our work here at Tri-City; that as demand for services continue to increase, and even more post COVID, Tri-City is looking for a way to maximize the efficiency to be able to have to serve more people, noting that this platform will allow us to do this; that it will be a three-year pilot to see if it has the impact to increase access to a full range of care for the people that we serve at Tri-City, and be able to serve a greater number of people in a timely way.

Discussion ensued regarding ending the contract for cause and how Tri-City can terminate the contract if it is not satisfied the platform services.

There being no further discussion, Board Member Vera moved, and Board Member Nolte seconded, to adopt Resolution No. 583 approving a 3-year Master Cloud Services and Network Management Agreement with Unite USA, Inc. (Unite Us) in the amount of $75,000 Effective July

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1, 2021; and authorizing the Executive Director to execute it. The motion was carried by the following vote: AYES: Board Members Cockrell, Lantz, Nolte, Ontiveros-Cole, and Vera; Vice-Chair Leano; and Chair Carder. NOES: None. ABSTAIN: None. ABSENT: None.

10. CONSIDERATION OF RESOLUTION NO. 584 AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE A MEMORANDUM OF UNDERSTANDING WITH COMMUNITY TRANSLATIONAL RESEARCH INSTITUTE/PUBLIC HEALTH FOUNDATION ENTERPRISES INC. DBA HELUNA HEALTH TO COLLABORATE IN ESTABLISHING PRACTICAL EXPERIENCE TO CLAREMONT GRADUATE UNIVERSITY STUDENTS/ INTERNS AND HEALTH COACH/NAVIGATORS

Executive Director Navarro stated that the MOU will close the loop on an MOU that we signed on March 17, 2021, to be part of a high ACEs Aware Initiative Network Planning Grant received by East Valley, the fiscal sponsor and the lead agency, and CITRI is one of the other organizations which will be utilizing graduate students to shadow and learn from Tri-City community navigators and best practice referral model for this network of care planning grant.

Board Member Vera announced that he would abstain from voting on this item because he does legal work for CGU on internship agreements.

There being no further discussion, Vice-Chair Leano moved, and Board Member Cockrell seconded, to adopt Resolution No. 584 approving MOU with Community Translational Research Institute (CTRI)/Public Health Foundation Enterprises Inc. (PHFE) dba Heluna Health; and authorizing the Executive Director to execute it. The motion was carried by the following vote: AYES: Board Members Cockrell, Lantz, Nolte, and Ontiveros-Cole; Vice-Chair Leano; and Chair Carder. NOES: None. ABSTAIN: Board Member Vera. ABSENT: None.

MONTHLY STAFF REPORTS

11. TONI NAVARRO, EXECUTIVE DIRECTOR REPORT

Executive Director Navarro reported that Tri-City is conducting Mental Health Commissioner recruitment since October, 2020; that at its April meeting the commission discussed a desire to also strategic recruitment for the youth population 18 to 25 to bring that voice back into the commission; that it is time for the Governign Board to select an Ad Hoc Committee to conduct interviews and fill those seats.

Ken Riomales, Chief Information Officer, reported that a lot of work has been doing current state assessment, determining strengths, weaknesses, opportunities, and threats within the organization, as it relates to IP, for the purposes of categorization, we decided to break it up into four main categories, security, operations, customer service, and project management, to make sure they're in line with strategic goals of the overall organization; and the various other efforts that would be beneficial to the organization such as security optimization and network improvement.

Executive Director provided a housing division update and reported that there has been a kind of a release of the valve of the state, local, and federal funds for rental assistance and support for those in our three cities; that this does not appear to be a long term trend; that we are waiting for the termination of the eviction moratoriums in June; that those funds and those programs have

gone a long way to reduce housing insecurity in the three cities; and expressed appreciation for their support on that and hoped to continue to have good news on the housing front as things progress.

Vice-Chair Leano inquired if there a second round of Non-Competitive No Place Like Home allocation. Executive Director Navarro indicated that the next round will be the fourth round and there is no date yet. Vice-Chair Leano further inquired if the allocation systematic based on metrics that we already know and if allocation will be reduced based on prior allocations. Executive Director Navarro replied in the affirmative and stated that it also depends on money that comes in from tax revenues as to how much for each division, medium, large or small County.

12. DIANA ACOSTA, CHIEF FINANCIAL OFFICER REPORT

Chief Financial Officer Acosta mention that she will still reference the bankruptcy in Tri-City's annual audited financial statements for another year, which are scheduled to be presented to the Board in October; that the auditors are scheduled to do a virtual audit in June to begin the annual audit; and that staff is finalizing the budget and will present it to Board in its July meeting.

Discussion ensued how the virtual audit is conducted.

13. LIZ RENTERIA, CHIEF CLINICAL OFFICER REPORT

Chief Clinical Officer Renteria reported the percentage of all the diagnoses that come in through our access to care program by city, noting that by far depressive disorders at this point seem to be our largest diagnosis that is pretty consistent across the three cities, followed by a schizophrenia spectrum and psychotic disorders and anxiety disorders; and shared a success story about a 47 year-old female that came into our adult outpatient program who experienced homelessness and severe mental health issues and was able to obtain employment, stable housing; and discussed the true impact of the services of Tri-City.

Board Member Vera inquired if Tri-City has been asked to provide any services to the children who are now at Fairplex for counseling. Chief Clinical Office Renteria replied in the affirmative and Cherokee federal, which is the agency that has been contracted to provide services, is writing their contracts, and noting that they will present one to Tri-City for approval.

Executive Director Navarro indicated that Tri-City had not done anything at this point; and discussed the different job tiles that they want because are recognized by the federal government as behavioral health specialists; and that staff is looking forward to present a contract to the Board at its next meeting.

14. SEEYAM TEIMOORI, MEDICAL DIRECTOR REPORT

Medical Director Teimoori stated that he provided data about the services that we provided during the second half of April, when we started the pack team in our collaboration with the Pomona Police Department, and asked if there were any questions about the data.

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15. RIMMI HUNDAL, DIRECTOR OF MHSA AND ETHNIC SERVICES REPORT

Director of MHSA & Ethnic Services Hundal reported that May is not only mental health awareness month, it is also Asian American Pacific Islander heritage month; that our AAPI advisory council was launched this month, and the kickoff event was a webinar titled 'Ending The Silence, How to Support the Asian American And Pacific Islander Community' hosted by Tri-City in partnership with university Western University of Health Science; that it was made possible by Vice-Chair Leano who did the opening remarks and lined up great speakers for us who did the introductory remarks; thanked him for his support; and announced that on May 7th, the MHSA Annual Update for Fiscal Year 2021-22 was posted for a 30-day public comment period.

16. NATALIE MAJORS-STEWART, CHIEF COMPLIANCE OFFICER REPORT

Executive Director Navarro announced that Chief Compliance Officer Majors-Stewart was out on vacation and she would answer any questions the Board might have regarding her report.

There being no further comment, Vice-Chair Leano moved, and Board Member Ontiveros-Cole seconded, to receive and file the month of May staff reports. The motion was carried by the following vote: AYES: Board Members Cockrell, Lantz, Nolte, Ontiveros-Cole, and Vera; Vice-Chair Leano; and Chair Carder. NOES: None. ABSTAIN: None. ABSENT: None.

GOVERNING BOARD / MENTAL HEALTH COMMISSION COMMENTS

Commissioner Villanueva commented that some of the unintended consequences of the pandemic such as increase of gang activity, work cannot be done with the homeless, and that there will much to do when the pandemic is over.

Vice-Chair Leano thanked MHSA Director Rimmi Hundal for an outstanding kickoff to our AAPI health and wellness advisory council; that it was such a strong response from this agency in light of the spike in anti-Asian hate incidents, and that this agency is mobilizing community stakeholders to look after vulnerable populations.

Board Member Lantz commended Vice-Chair Leano, Rimmi Hundal, and everybody that was involved in putting the webinar together because she attend and it was very well done, very informative; that she appreciated the variety of speakers; and that it was great to be a part of it.

PUBLIC COMMENT

There was no public comment.

ADJOURNMENT

At 7:22 p.m., on consensus of the Governing Board and Mental Health Commission, its Joint Meeting of May 19, 2021 was adjourned. The next Regular Meeting of the Mental Health Commission will be held on Tuesday, June 8, 2021 at 3:30 p.m. The next Regular Meeting of the Governing Board will be held on Wednesday, June 16, 2021 at 5:00 p.m., via teleconference.

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Micaela P. Olmos, JPA Administrator/Clerk

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Tri-City Mental Health Authority
AGENDA REPORT

DATE: **June 16, 2021**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Toni Navarro, LMFT, Executive Director**

BY: **Natalie Majors-Stewart, Chief Compliance Officer**

SUBJECT: **Consideration of Resolution No. 585 Establishing Mental Health Services Act (MHSA) Community Program Planning Process (CPPP) Policy and Procedure No. IV.14, Effective June 17, 2021**

Summary

The development of new policies is required at times, in order to set expectations and ensure compliance with the most current regulations, internal processes, standards of care, and best practices.

Policy and Procedure No. IV.14 – MHSA Community Program Planning Process (CPPP) has been developed and drafted, in order to officially document the policies and procedures for the Community Program Planning Process.

Background

Title 9 of the California Code Regulations specifies the standards and requirements for programs and/or services provided with Mental Health Services Act (MHSA) funds. The requirements for the Community Program Planning Process are outlined in Chapter 14, Article 3.

The MHSA Community Program Planning Process (CPPP) Policy and Procedure No. IV.14, formally documents the policies and procedures that guide requirements the Community Program Planning Process at Tri City Mental Health Authority. The new draft policy is included for Governing Board review and approval.

Funding

None Required

Recommendation

Staff recommends that the Governing Board adopt Resolution No. 585 establishing Policy and Procedure No. IV.14 – MHSA Community Program Planning Process, effective February 17, 2021.

Attachments

Attachment 2-A: Resolution No. 585 - DRAFT

Attachment 2-B: MHSA Community Program Planning Process (CPPP) Policy and Procedure No. IV.14 - DRAFT

RESOLUTION NO. 585

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY ESTABLISHING THE AUTHORITY'S MENTAL HEALTH SERVICES ACT (MHSA) COMMUNITY PROGRAM PLANNING PROCESS (CPPP) POLICY AND PROCEDURE NO: IV.14, EFFECTIVE JUNE 16, 2021

The Governing Board of the Tri-City Mental Health Authority ("Authority") does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("TCMHA" or "Authority") wishes to establish guidelines for participation, implementation, and compliance with Title 9 of the California Code Regulations, Chapter 14, Article 3, which specify the standards and requirements for the Community Program Planning Process (CPPP) under the Mental Health Services Act (MHSA).

B. The Authority, through the MSHA CPPP Policy and Procedure No. IV.14, establishes guidelines for MHSA Community Program Planning Process as the basis for developing the Three-Year Program and Expenditure Plan and Update.

2. Action

The Governing Board approves the Authority's Mental Health Services Act (MHSA) Community Program Planning Process (CPPP) Policy and Procedure No. IV.14, effective June 16, 2021.

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on June 16, 2021, by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

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ROBIN CARDER, CHAIR

APPROVED AS TO FORM:
DAROLD PIEPER, GENERAL COUNSEL

By:________________________________

ATTEST:
MICAELA OLMOS, RECORDING SECRETARY

By:________________________________

ATTACHMENT 2-A

POLICY & PROCEDURE

SUBJECT: Mental Health Services Act (MHSA): Community Program Planning Process (CPPP)	POLICY NO.: IV.14	EFFECTIVE DATE: 06/16/2021	PAGE: 1 of 4
APPROVED BY: Governing Board Executive Director	SUPERCEDES: New	ORIGINAL ISSUE DATE: 06/16/2021	RESPONSIBLE PARTIES: Director of MHSA & Ethnic Services

1. PURPOSE

1.1 To establish guidelines for the Mental Health Services Act (MHSA) Community Program Planning Process at Tri-City Mental Health Authority (TCMHA).

2. DEFINITIONS

2.1 **Community Program Planning Process (CPPP)**: The process to be used to develop Three-Year Program and Expenditure Plans, and updates in partnership with stakeholders, in order to 1) Identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the Mental Health Services Act, 2) Analyze the mental health needs in the community, and to 3) Identify and re-evaluate priorities and strategies to meet those mental health needs. (9 CCR § 3200.070)

2.2 **Underserved**: Individuals who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services, but are not provided the necessary or appropriate opportunities to support their recovery, wellness and/or resilience. (9 CCR § 3200.300)

2.3 **Unserved**: Individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved. (9 CCR § 3200.310)

2.4 **Stakeholders**: Individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families. (9 CCR § 3200.270)

3. POLICY

3.1 TCMHA shall provide for a Community Program Planning Process, as the basis for developing the Three-Year Program and Expenditure Plan and Update.

3.2 TCMHA shall ensure that the Community Program Planning Process, includes the following, at a minimum:

3.2.1 Involvement of clients with serious mental illness and/or serious emotional disturbance and their family members in all aspects of the Community Program Planning Process.

3.2.2 Participation of stakeholders, as defined in Section 3200.270

3.2.3 Training

3.3 TCMHA shall ensure that stakeholders are outreached to, invited, trained, and have the opportunity to participate in the Community Program Planning Process in accordance with Title 9 Regulations.

3.3.1 TCMHA will ensure that stakeholders reflect the diversity of the demographics of the Tri-City catchment area.

3.3.2 TCMHA will ensure that involvement of clients with serious mental illness and/or serious emotional disturbance and their family members will be in all aspects of the Community Program Planning Process.

3.3.3 TCMHA shall ensure that training is offered, as needed, to those stakeholders, clients, and when appropriate the client's family, who are participating in the Community Program Planning Process.

3.4 TCMHA shall ensure that the Community Program Planning Process is adequately staffed, and will designate positions and/or units responsible for the overall coordination and administration the Community Program Planning Process, as well as Stakeholder outreach, representation, training, and participation.

3.5 TCMHA shall ensure that training is provided as needed to the designated TCMHA Community Program Planning Process staff responsible for any of the functions listed in 3300(b), which will enable staff to establish and sustain a Community Program Planning Process.

4. PROCEDURES

4.1 The Director of MHSA will ensure that the Community Program Planning Process is aligned with the required fiscal, legal, contractual and programmatic specifications.

4.2 The MHSA Projects Manager will be designated to have oversight for the Community Program Planning Process

4.3 Stakeholder Outreach efforts will be conducted and monitored to ensure that stakeholders reflect the diversity of the demographics of the Tri-City catchment area. Outreach and engagement efforts will include (but not be limited to) the following:

4.3.1 Unserved/underserved and "difficult to reach" populations will be contacted through cultural brokers or community advocates and encouraged to participate in the Stakeholder – Community Program Planning Process.

4.3.2 Tri-City workforce will participate in the stakeholder outreach process by informing, inviting, and encouraging clients, participants, and their families to attend stakeholder meeting.

4.3.3 Specific outreach efforts will made to stakeholders who have participated in the in the past, to re-engage them in the stakeholder process.

4.3.4 Stakeholder outreach flyers and informationals will be posted at all Tri-City locations and community venues, and well as will be distributed by Community Navigators and other Tri-City staff throughout the three cities and at least 30 days in advance of any stakeholder meeting.

4.3.5 Stakeholder outreach Notifications will be posted on TCMHA website, on TCMHA Social Media Sites, and will be placed in local papers.

4.3.6 Public announcements will be made at local community meetings, including NAMI to assist with stakeholder outreach and engagement efforts.

4.3.7 Outreach emails, flyers, notifications, announcements, etc. are done in the threshold languages.

4.4 All new and returning stakeholders will be provided with orientation and training, which will include a detailed introduction to MHSA, an overview the MHSA Programs and Services at TCMHA, and the Stakeholder – Community Program Planning Process.

4.4.1 All subsequent stakeholder meetings include a brief overview of the history of MHSA, funding source, purpose and plans and programs available.

4.4.2 Stakeholder training will be provided as needed.

4.5 The Community Planning Process will include a Community Planning Survey. This survey identifies community needs, priorities, and perceived gaps in services.

4.6 The Community Planning Process for each new fiscal year will commence in the fall, and will include stakeholder meetings and specialized workgroup meetings. Meetings topics will include (but are not limited to):

4.6.1 Orientation and Training

4.6.2 The Community Planning Survey & Results

4.6.3 Identification and Discussion of Priorities and Needs

4.6.4 Review of MHSA Programs, Budgets, and Outcomes

4.6.5 Workgroup Discussions and Recommendations

4.6.6 MHSA Public Hearing Participation

4.6.7 Other topics as required, based on community needs and available funding

4.7 Meeting documentation for stakeholder and workgroup meetings involved in The Community Planning Process, may include: copies of sign-in sheets, agendas, meeting minutes, presentation slides, budgets and/or plans for review, surveys, and other relevant meetings documents/handouts.

4.8 Language interpretation (in the TCMHA threshold languages) will be available at each meeting. Additionally, all meeting materials will be offered in the TCMHA Threshold languages.

4.9 TCMHA MHSA Three-Year Program and Expenditure Plans and/or Annual Update will be developed with meaningful contribution from the Community Planning Process.

4.10 A draft of the plan will be posted on the TCMHA website for a 30-day public comment period. Additional hard copies are distributed throughout the cities of Claremont, Pomona and La Verne at local libraries, city offices and other community centers.

4.11 Once the 30-day comment period is complete, the plan will be presented to the TCMHA Mental Health Commission during the annual MHSA Public Hearing.

4.12 Following the Public Hearing, the plan will be presented to the TCMHA Governing Board for approval and adoption.

4.13 Once the Board has approved the plan, a copy will be sent to the Mental Health Services Oversight and Accountability Commission and Department of Health Care Services.

4.14 The final plan will be posted on the TCMHA website.

5. REFERENCES

5.1 California Code of Regulations: Title 9 CCR Division 1 > Chapter 14 > Article 3

Tri-City Mental Health Authority
AGENDA REPORT

DATE: June 16, 2021

TO: Governing Board of Tri-City Mental Health Authority

FROM: Toni Navarro, LMFT, Executive Director

BY: Natalie Majors-Stewart, Chief Compliance Officer

SUBJECT: Consideration of Resolution No. 586 Establishing Mental Health Services Act (MHSA) Innovation Plan Projects Policy and Procedure No. IV.15, Effective June 17, 2021

Summary

The development of new policies is required at times, in order to set expectations and ensure compliance with the most current regulations, internal processes, standards of care, and best practices.

Policy and Procedure No. IV.15 – Mental Health Services Act (MHSA) Innovation Plan Projects has been developed and drafted, in order to officially document the policies and procedures for Innovative Projects.

Background

Title 9 of the California Code Regulations specifies the standards and requirements for programs and/or services provided with Mental Health Services Act (MHSA) funds. The requirements for Innovative Projects and the use of Innovation Funds is outlined in outlined in Chapter 14, Article 9.

The MHSA Innovation Plan Projects Policy and Procedure No. IV.15, formally documents the policies and procedures that guide requirements for Innovation Plan Projects at Tri City Mental Health Authority. The new draft policy is included for Governing Board review and approval.

Funding

None Required

Recommendation

Staff recommends that the Governing Board adopt Resolution No. 586 establishing Policy and Procedure No. IV.15 – MHSA Innovation Plan Projects, effective June 17, 2021.

AGENDA ITEM NO. 3

Attachments

Attachment 3-A: Resolution No. 586 - DRAFT

Attachment 3-B: MHSA Innovation Plan Projects Policy and Procedure No. IV.15 - DRAFT

RESOLUTION NO. 586

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY ESTABLISHING THE AUTHORITY'S MENTAL HEALTH SERVICES ACT (MHSA) INNOVATION PLAN PROJECTS POLICY AND PROCEDURE NO: IV.15, EFFECTIVE JUNE 16, 2021

The Governing Board of the Tri-City Mental Health Authority ("Authority") does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("TCMHA" or "Authority") wishes to establish guidelines for participation, implementation, and compliance with Title 9 of the California Code Regulations, § 3905, 3910 and 3910.10, which specify the standards and requirements for the Innovation Plan Projects under the Mental Health Services Act (MHSA).

B. The Authority, through the MHSA Innovation Plan Projects Policy and Procedure No. IV.15, establishes guidelines for Innovation Plan Projects and for the implementation requirements at Tri-City Mental Health Authority (TCMHA).

2. Action

The Governing Board approves the Authority's Mental Health Services Act (MHSA) Innovation Plan Projects Policy and Procedure No. IV.15, effective June 16, 2021.

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on June 16, 2021, by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

____
ROBIN CARDER, CHAIR

APPROVED AS TO FORM: DAROLD PIEPER, GENERAL COUNSEL	ATTEST: MICAELA OLMOS, RECORDING SECRETARY
By:__________________________	By:__________________________

ATTACHMENT 3-A

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POLICY & PROCEDURE

SUBJECT: Mental Health Services Act (MHSA): Innovation Plan Projects	POLICY NO.: IV.15	EFFECTIVE DATE: 06/17/2021	PAGE: 1 of 7
APPROVED BY: Governing Board Executive Director	SUPERCEDES: New	ORIGINAL ISSUE DATE: 06/17/2021	RESPONSIBLE PARTIES: Director of MHSA & Ethnic Services

1. PURPOSE

To establish guidelines for Mental Health Services Act (MHSA) Innovation Plan Projects and to provide guidance on the implementation of the requirements at Tri-City Mental Health Authority (TCMHA).

2. DEFINITIONS

2.1 Client: An individual of any age who is receiving or has received mental health services. For the purposes of this policy, the term "client" includes those who refer to themselves as clients, participants, consumers, survivors, patients or ex-patients. (9 CCR § 3200.04)

2.2 Community Program Planning Process: The process to be used to develop Three-Year Program and Expenditure Plans, and updates in partnership with stakeholders, in order to 1) Identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the Mental Health Services Act, 2) Analyze the mental health needs in the community, and to 3) Identify and re-evaluate priorities and strategies to meet those mental health needs.

2.3 Innovation Component: The section of the Three-year Program and Expenditure Plan that consists of one or more Innovative Projects. (9 CCR § 3200.182)

2.4 Innovative Project: A project that the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports. (9 CCR § 3200.184)

2.5 MHSOAC: Mental Health Services Oversight and Accountability Commission - the commission that oversees the implementation of the MHSA. The MHSOAC oversees the Adults and Older Adults Systems of Care Act; Human Resources; Innovative Programs; Prevention & Early Intervention Programs; and the Children's Mental Health Services Act. The MHSOAC is also responsible for developing strategies to overcome stigma. At any time, the MHSOAC may advise the Governor or the Legislature on mental health policy. (WIC § 5845)

2.6 **Stakeholders**: Individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families. (9 CCR § 3200.270)

3. POLICY

3.1 Tri-City Mental Health Authority (TCMHA) shall develop, design and implement Innovation Plan Projects in accordance with 9 CCR § 3905, 3910 and 3910.10.

3.2 TCMHA shall ensure that each Innovation Plan Project is designed to do one of the following:

3.2.1 Introduce a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.

3.2.2 Make a change to an existing practice in the field of mental health, including but not limited to, application to a different population.

3.2.3 Apply a promising community-driven practice or approach that has been successful in non-mental health contexts or settings, to the mental health system.

3.3 Each project included in the Innovative portion of TCMHA MHSA plan shall target one of the following, as the primary purpose of the project:

3.3.1 To increase access to mental health services to underserved groups as defined in Title 9 California Code of Regulations, Section 3200.300.

3.3.2 To increase the quality of mental health services, including measurable outcomes.

3.3.3 To promote interagency and community collaboration related to mental health services or supports or outcomes.

3.3.4 To increase access to mental health services.

3.4 TCMHA shall submit an Innovative Project Plan, to the Mental Health Services Oversight and Accountability Commission, for each new Innovative Project to be funded.

3.5 TCMHA shall ensure that the Innovative Project Plan contained in the Innovation Component of the Three-Year Program and Expenditure Plans and/or Annual Updates includes all of the following, in accordance with 9 CCR § 3930 (b), (c), and (d): a description how stakeholders were involved in the plan, a comprehensive description of the Innovative Project, and a detailed budget of the Innovative Project.

3.6 TCMHA shall submit Innovation Plan Project Reports on an annual basis and at the completion of a project. Reports shall be submitted to the MHSOAC by the required due dates.

3.6.1 Annual Reports shall include:

3.6.1.1 Name of the Innovative Project.

3.6.1.2 A description of any changes that were made to the Innovative Project, during the reporting period, and the reasons for the changes.

3.6.1.3 Available evaluation data, including outcomes of the Innovative Project and information about which elements of the Project are contributing to outcomes.

3.6.1.4 Any program information collected during the reporting period.

3.6.1.4.1 Also, to be included for projects that serve individuals: The number of participants served by following categories: Age, Race, Ethnicity, Primary language, Sexual orientation, Disability, Veteran status, and Gender.

3.6.1.5 Any other relevant data.

3.6.2 Final Innovative Reports shall include:

3.6.2.1 The Name of the Innovative Project.

3.6.2.2 A brief summary of the priority purpose (related to mental illness or to an aspect of the mental health service system) for which the Innovative Project was designed and tested.

3.6.2.3 A description of any changes made to the Innovative Project during the course of implementation and evaluation and the reasons for and impact of the changes, including any changes in the timeline.

3.6.2.4 Program information collected during the reporting period.

3.6.2.4.1 Also to be included for projects that serve individuals: The number of participants served by following categories: Age, Race, Ethnicity, Primary language, Sexual orientation, Disability, Veteran status, and Gender.

3.6.2.5 Final evaluation results, including but not limited to:

3.6.2.5.1 Description of the evaluation methodology;

3.6.2.5.2 Outcomes of the Innovative Project including those related to the selected primary purpose, with a focus on whatever was new or changed compared to established mental health practices;

3.6.2.5.3 Any variation in outcomes based on demographics of participants, if applicable;

3.6.2.5.4 Assessment of which activities or elements of the Innovative Project contributed to successful outcomes;

3.6.2.5.5 Explanation of how the evaluation was culturally competent;

3.6.2.5.6 Explanation of how stakeholders contributed to the evaluation.

3.6.2.6 A report on if and how the Innovative Project will continue, the source of ongoing funding, the reason for the decision, and how stakeholders were involved in the decision.

3.6.2.7 A report on if the Innovative Project achieved its intended outcomes and a summary of what was learned.

3.6.2.8 A description of how the results of the Innovative Project were disseminated to stakeholders, and if applicable to other counties (e.g. as the County determined that the information would be of benefit to other counties).

3.6.2.9 Any other relevant data.

3.6.2.10 Copies of any presentations, reports, articles, manuals, CDs, DVDs, videos, or any other materials developed to communicate successful new or changed mental health practices, lessons learned and evaluation results of the Innovative Project.

3.7 TCMHA shall ensure that upon completion of an Innovative Project, a decision is made on how the project will be continued and incorporated into the local mental health delivery system. This decision shall include:

3.7.1 Meaningful involvement from the stakeholders;

3.7.2 Assurance that continued projects shall not be funded with Innovation Plan Funds.

3.7.2.1 If funding is required, the project (or successful elements of the project), shall be transitioned to another category of funding or incorporated into existing mental health programs or services, without the need for additional funds.

3.8 In the event of a need for an early termination of an Innovative Project, TCMHA shall ensure that the following:

3.8.1 A notification shall be made to stakeholders and the Mental Health Services Oversight and Accountability Commission within 30 days of TCMHA's decision to terminate an Innovative Project prior to the planned end date, including the reasons for the decision.

3.8.1.1 If the Innovative Project provides services to individuals with serious mental illness, the notification shall include a description of the steps

taken to protect and provide continuity of services for individuals who were being served.

3.8.1.2 TCMHA may, without involvement of stakeholders, terminate an Innovative Project prior to the planned end date, due to unforeseen legal, ethical or other risk-related reasons. In this case, the stakeholders and MHSOAC shall be informed as soon as possible but in no case more than 30 days after the decision to terminate, including the reasons for the termination.

3.8.2 Assurance that reasonably necessary steps were taken to protect and provide continuity of services for individuals with serious mental illness.

3.9 TCMHA shall summit an Innovative Project Change Request to the MHSOAC, if an Innovative Project (that was previous approved by the MHSOAC), needs to be changed for any of the following reasons:

3.9.1 A change in the primary purpose.

3.9.2 A change in the basic practice or approach that is being piloted and evaluated.

3.9.2.1 Minor changes in how the approach is being implemented are expected and do not require prior approval from the Mental Health Services Oversight and Accountability Commission. See 9 CCR § 3925 for examples of minor changes.

3.9.3 A need to expend more funds than previously approved.

3.10 Innovative Project Change Requests may be submitted to the MHSOAC: 1) as part of a Three-Year Program and Expenditure Plan, 2) as part of an Annual Update, or 3) as a separate request.

3.11 Innovative Project Change Requests shall:

3.11.1 Describe the change, the reasons for the change, and stakeholder involvement in the decision.

3.11.2 Be submitted to and approved by the MHSOAC pursuant to Section 3935, prior to implementing the change.

3.11.3 Include documentation of how the change complied with the community planning requirements and the local review requirements in Title 9 of the California Code of Regulations sections 3300 and 3315 (This only applies if the request is submitted as a separate request and not part of a Three-Year Program and Expenditure Plan or Annual Update).

3.12 TCMHA shall evaluate the effectiveness and feasibility of each Innovative Project, in accordance with the agency developed designed/selected evaluation method. The evaluation shall include the following:

3.12.1 A measurement of mental health outcomes and indicators, selected by the Authority, that are relevant to the risk of, manifestation of, and /or recovery from mental illness or to the improvement of the mental health system.

3.12.2 A measurement related to the selected primary purpose of the project.

3.12.3 An assessment the impact of whatever element(s) of the Innovative Project are new and/or changed, compared to established practices in the field of mental health.

3.12.4 The use of quantitative and/or qualitative evaluation methods to determine which elements of the Innovative Project contributed to successful outcomes, in order to support data-driven decisions about incorporating new and/or revised mental health practices into the Authority's existing systems and services and disseminating successful practices.

3.12.5 A collection and analysis of data that is necessary to complete the evaluation.

3.12.6 A culturally competent approach, that includes meaningful involvement from diverse community stakeholders.

3.12.7 Demographic information shall be collected and reported in accordance with 9 CCR § 3580.010.

4. PROCEDURES

4.1 Innovation Plan Project Oversight

4.1.1 The Director of MHSA will ensure that the Innovations Plan is aligned with the required fiscal, legal, contractual and programmatic specifications.

4.1.2 The MHSA Projects Manager will have oversight for the overall direction of Innovation Plan Projects.

4.1.3 The Innovation Coordinator will be responsible for designing, implementing, and monitoring the Innovative Project.

4.2 Innovation Plan Project Design, Implementation, and Monitoring

4.2.1 Each innovative project will be initiated with a robust Community Program Planning (CPPP) process in order to determine community needs and solicit project ideas.

4.2.2 The Community Program Planning process will include stakeholders, representatives of unserved or underserved populations, and individuals who reflect the cultural, ethnic and racial diversity of the community.

4.2.3 The Innovation Plan Project Implementation Process will include:

4.2.3.1 Engagement with Stakeholders, as part of the CPPP process.

4.2.3.2 Exploration of Needs & Development of Project Plan;

4.2.3.3 Posting of the Innovation Plan for 30-day public comment;

4.2.3.4 Submission of the Innovation Project Plan for Mental Health Commission and Governing Board approval;

4.2.3.5 Submission of the Innovation Project Plan for Mental Health Service Oversight and Accountability (MHSOAC) Approval;

4.2.4 The status of each Innovative Project will be reflected in MHSA Annual Updates and Three-Year Revenue and Expenditure Plans.

4.2.5 TCMHA will prepare an Innovation Annual Report and an Innovation Final Report upon completion of the project.

4.2.6 TCMHA will expend MHSA funds for their innovation programs upon approval by the Mental Health Services Oversight and Accountability Commission.

4.2.7 If the Innovation project is proven successful and TCMHA chooses to continue the project, the project will transition to another category of MHSA funding as appropriate.

4.2.8 TCMHA will ensure ongoing monitoring, evaluation, and reporting of Innovation projects.

4.2.9 The method(s) of evaluation and indicators for measurements will be carefully selected to determine the most comprehensive set of outcomes.

4.2.10 TCMHA will ensure that evaluation methods are culturally competent and include meaningful involvement by diverse community stakeholders.

4.2.11 Data will be gathered, analyzed and reported, to determine the overall impact of the Innovative Project as well as the elements of the Innovative Project that contributed to successful outcomes.

4.2.12 Outcomes will be used to support data-driven decisions about incorporating new and/or revised mental health practices into TCMHA's existing systems and services and disseminating successful practices.

5. REFERENCES

5.1 California Code of Regulations: Title 9 CCR Division 1 > Chapter 14 > Article 9:

Tri-City Mental Health Authority
AGENDA REPORT

DATE: **June 16, 2021**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Toni Navarro, LMFT, Executive Director**

BY: **Ken Riomales, Chief Information Officer**

SUBJECT: **Consideration of Resolution No. 587 Awarding Contract to Cerner Corporation for Electronic Health Records Software Platform Services and Authorizing the Executive Director to Execute Its Master Services Agreement for Three Years in the Amount of $867,816.00, With an Option to Extend an Additional Two Years**

Summary:

Staff is seeking Governing Board approval to award a contract to Cerner Corporation, Inc., in the amount of $867,816.00**,** beginning June 17, 2021 through June 16, 2024 with an option to extend two additional years; and authorize the Executive Director to execute Cerner's Master Services Agreement which would allow TCMHA to migrate to its Electronic Health Record (EHR) platform.

Background:

The Office of the National Coordinator for Health Information Technology's (ONC) Cures Act Final Rule passed in 2020 is designed to empower patients with their health record in the modern health IT world. It supports seamless and secure access, exchange, and use of electronic health information. It calls on the healthcare industry to adopt standardized application programming interfaces (APIs), which will help allow individuals to securely and easily access structured electronic health information using smartphone applications. The rule includes a provision requiring that patients can electronically access all of their electronic health information (EHI), structured and/or unstructured, at no cost.

TCMHA's current EHR platform was already under evaluation beginning in 2019. At that time, it was deemed unsatisfactory in meeting critical agency functions, such as a lack of consistency in submitting electronic prescription and lab requests and limitations in producing reporting utilizing client data. Additionally, upon the passing of the Cures Act, the current EHR does not meet the above interoperability requirements. TCMHA proceeded to engage a 4-month internal discovery to determine necessary and desired features in an EHR platform that would also meet interoperability requirements, followed by a formal Request for Proposal for a new EHR software platform.

The following is a high-level comparison of the cost proposals from each of the respective EHR vendors:

PROPOSAL						
Company	One-Time Costs	3-Year Contract			Optional 2-Year Extension	
	FY 2020-21	FY 2020-21	FY 2021-22	FY 2022-2023	FY 2023-24	FY 2024-25
Netsmart	$ 174,273.00	$ 324,346.00	$ 371,244.00	$ 371,244.00	$ 371,415.00	$ 371,415.00
InSync	$ 697,530.00	$ 63,012.00	$ 213,312.00	$ 213,312.00	$ 213,312.00	$ 213,312.00
Qualifacts	$ 101,420.00	$ 234,831.00	$ 216,737.00	$ 220,756.00	$ 224,916.00	$ 229,222.00
Cerner	$ 414,648.00	$ 151,056.00	$ 151,056.00	$ 151,056.00	$ 151,056.00	$ 151,056.00

Tri-City Mental Health received four responses to its Electronic Health Record Software Platform Request for Proposal (RFP). All four vendors were given the opportunity to discuss their proposal submission and present a 2-3 hour demo to the interim Chief Information Officer and the Chief Clinical Officer for a first round review. During this review, two vendors were eliminated from consideration:

- InSync – communicated they would not be able to utilize Tri-City's BAA and would not be open to negotiating their BAA nor Terms and Conditions
- Qualifacts – one of the primary expressed features needed in a new EHR was an integrated e-prescribe and e-labs function of which Qualifacts lacked.

Netsmart and Cerner were moved onto a second round of evaluation and demos with an EHR evaluation committee consisting of representatives from the Executive Team, clinical team, psychiatrist team, Finance department, Best Practices department, and MHSA programs.

Based on feedback from the evaluation committee, Cerner was chosen for the following reasons:

- Highest rated uptime and reliability – confirmed per reports from other counties.
- Most robust and mature interoperability platform
- Strong workflow and clinical process framework which will assist in reducing redundancies and inefficiencies in the current clinical workflow, in particular.
- Reliable and effective e-prescribe and e-lab features.
- Lower annual recurring costs compared to Netsmart.
- Utilized by 29 counties in California, demonstrating both platform compatibility to state legislation and a commitment to behavioral health in California.

Fiscal Impact:

These documents commit Tri-City to: the migration from its current Electronic Health Record platform to the Cerner Electronic Health Record platform for a one-time/implementation cost of $414,648, plus $151,056 billed annually for three years. $270,436 will be funded from existing Mental Health Services Act funds assigned to Capital Facilities and Technological Needs. The remaining implementation cost of $144,212 will be allocated from Realignment Funds. The monthly recurring and support service fees totaling $151,056 annually, will be billed across programs throughout the Tri-City system of care utilizing both MHSA and Realignment Funds. The optional two-year extension will impact Tri-City's budget by $302,112 for a maximum five-year total of $1,116,928.

Recommendation:

Staff recommends that the Governing Board approve Resolution No. 587 awarding a contract to Cerner Corporation for electronic health records software platform services and authorizing the Executive Director to execute its Master Services Agreement for three years in the amount of $867,816.00 with an option to extend an additional two years.

Attachments

Attachment 4-A: Resolution No. 587 - DRAFT

Attachment 4-B: Cerner & TCMHA Services Agreement for EHR Software Platform

Attachment 4-C: Cerner Corporation Proposal 09292020

Attachment 4-D: RFP for Electronic Health Record Software Platform (Issued 08-19-2020)

RESOLUTION NO. 587

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY AWARDING CONTRACT TO CERNER CORPORATION FOR ELECTRONIC HEALTH RECORDS SOFTWARE PLATFORM SERVICES AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE ITS MASTER SERVICES AGREEMENT FOR THREE YEARS IN THE AMOUNT OF $867,816.00, WITH AN OPTION TO EXTEND AN ADDITIONAL TWO YEARS

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("TCMHA" or "Authority") desires to be compliant and adopt standardized application programming interfaces (APIs), as established by the Office of the National Coordinator for Health Information Technology's (ONC) Cures Act Final Rule which was passed in 2020 to allow patients to securely and easily access electronically all of their electronic health information (EHI),

B. A Request for Proposals (RFP) for Electronic Health Record Software Platform was issued on August 8, 2020.

C. Proposals received were reviewed by an evaluating committee; accordingly, it recommends awarding a three-year contract for electronic health records software platform services to Cerner Corporation, in the amount of $867,816 commencing June 17, 2021. The optional two-year extension will impact Tri-City's budget by $302,112.

2. Action

The Governing Board awards the contract for electronic health records software platform services to Cerner Corporation, and authorizes the Executive Director to enter into, and execute, a three-year Master Services Agreement with Cerner Corporation, commencing June 17, 2021, in the amount of $867,816, with an option to extend two additional years at $302,112, for a total value of $1,169,928, for five years.

[Continued on page 2]

DRAFT

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on June 16, 2021, by the following vote:

AYES:

NOES:

ABSTAIN:

ABSENT:

____
ROBIN CARDER, CHAIR

APPROVED AS TO FORM:
DAROLD PIEPER, GENERAL COUNSEL

By:______________________________

ATTEST:
MICAELA P. OLMOS, RECORDING SECRETARY

By:______________________________

DRAFT

CERNER SERVICES AGREEMENT

This Cerner Services Agreement (the "Agreement") is made on June 17, 2021 ("Effective Date"), between

Tri-City Mental Health Authority ("Client")

a joint powers agency organized under the laws of the State of California with its administrative office at:

1717 N. Indian Hill Boulevard #B
Claremont, CA 91711, United States
Telephone: (909) 623-6131

and

Cerner Corporation ("Cerner")

a Delaware corporation with its principal place of business at:

2800 Rockcreek Parkway
Kansas City, MO 64117, United States
Telephone: (816) 221-1024

This Agreement consists of the following documents:

- Basic Terms and Conditions
- Cerner Sales Order

TRI-CITY MENTAL HEALTH AUTHORITY

Authorized Signatory: ______________________
(signature)

____
(printed name)

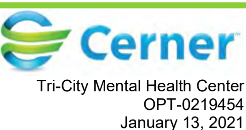
Title: ______________________

CERNER CORPORATION

Authorized Signatory: ______________________

Teresa Waller

Title: Sr. Director, Contract Management



Tri-City Mental Health Center
OPT-0219454
January 13, 2021

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ATTACHMENT 4-B

BASIC TERMS AND CONDITIONS

1. SERVICES

1.1 **Services.** Cerner agrees to provide the Services as indicated under Exhibit A (Scope of Services) hereby incorporated into and made a part of this Agreement; and as set forth in each Ordering Document. Cerner uses a shared computing utility to deliver certain Services. Cerner may leverage a public cloud infrastructure to provide the Services.

1.2 **Data Security.** Cerner has implemented reasonable security measures, systems, and procedures designed to protect against anticipated threats or hazards to the security or integrity of Client's Confidential Information. Cerner agrees to undergo an annual SSAE-18 review (or industry equivalent) of its data center operations. Upon request by Client, Cerner will provide a copy of the most recent service auditor's report.

1.3 **Client Responsibilities.** Client will use reasonable efforts to ensure that its Users do not: (i) sell, resell, lease, lend, or otherwise make available the Services in whole or in part to a third party; (ii) modify, adapt, translate, or make derivative works of the Services; (iii) transmit any viruses or programming routines intended to damage, surreptitiously intercept, or expropriate any system, data, or personal information; or (iv) sublicense or operate the Services for timesharing, rental, outsourcing, or service bureau operations, or to train persons other than its Users. Client will manage and maintain communications, connections, and devices for its Users at all locations. Client will also: (a) credential all Users and determine the correct privileges for each User, (b) use reasonable efforts to ensure that all Users use the Services in accordance with the Documentation and for no other purpose, and (c) be responsible for any activities that occur under the Client's or Users' accounts or passwords. Client will use reasonable efforts to prevent unauthorized use of the Services, and to terminate any unauthorized use. Client will promptly notify Cerner of any unauthorized use of, or access to, the Services of which it becomes aware. Client agrees to provide information requested by Cerner to verify Client's compliance with this Agreement. Client is also responsible for its security and privacy compliance, including obtaining consents and authorizations where necessary, and implementing reasonable security capabilities and policies and procedures to minimize or prevent unlawful access by Client or its Users, and access by unauthorized persons.

1.4 **Suspension of Services.** If (i) there is any threat to the security of Cerner's systems or the Services, or (ii) Client's undisputed invoices are 60 days or more overdue, in addition to any other rights and remedies (including termination rights), Cerner may, upon notice to Client, suspend the Services without liability to Client until all issues are resolved to Cerner's reasonable satisfaction.

2. THIRD-PARTY SOFTWARE, SERVICES, AND EQUIPMENT

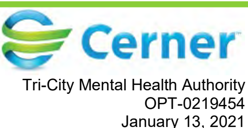
2.1 **Pass-Through Provisions.** Third-Party Services and Equipment will be provided under the applicable terms required by the third-party supplier. The Ordering Document will identify applicable pass-through terms which will be available on Cerner's website (https://passthroughprovisions.cerner.com/).

2.2 **Equipment.** The Equipment is priced FOB the supplier's point of origin. Cerner will arrange, pre-pay, and invoice Client for shipping and in-transit insurance for the Equipment. If Client has agreed in writing to a shipment date, Client agrees to pay all cancellation, re-stocking, storage and additional transportation fees due to the return or re-routing of Equipment. Cerner retains a security interest in each item of Equipment until Client pays for the Equipment.

3. PAYMENTS

3.1 **Payment.** Client will pay all invoices within thirty (30) days after receipt. Client will pay a finance charge on all undisputed amounts that are more than forty-five (45) days past due at a rate of interest equal to the lesser of 1.5% per month or the maximum permissible legal rate. Client will reimburse Cerner for reasonable collection costs, including attorneys' fees, for past due amounts.

3.2 **Taxes.** Client will pay all taxes imposed in conjunction with this Agreement, including, but not limited to, sales, use, excise, and similar taxes based on or measured by charges payable under this Agreement and imposed under authority



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of federal, state, or local taxing jurisdictions, but excluding foreign, federal, state, and local taxes on Cerner's net income or corporate existence. If tax exempt, Client will provide Cerner a copy of its sales tax exemption certificate.

3.3 **Reimbursable Expenses.** Client agrees to reimburse Cerner for the following travel expenses incurred by Cerner in its performance of Services: (a) air travel, not to exceed the coach class rate; (b) auto rentals; (c) lodging and miscellaneous expenses, such as parking, taxi fares, and fuel; and (d) a per diem rate for meals, as published and updated by the U.S. General Services Administration.

3.4 **Assignment of Payments.** Client agrees that Cerner may assign its interest in or otherwise grant a security interest in payments due pursuant to this Agreement in whole or in part to an assignee. Client will promptly acknowledge each assignment or granting of a security interest. Cerner will continue to perform its obligations under this Agreement following an assignment of payments or granting of a security interest.

4. WARRANTY, INDEMNITY, AND LIABILITY LIMITATION

4.1 **Services Warranty.** Cerner warrants that it will perform the Cerner Services in a professional manner in accordance with the applicable Solution Description.

4.2 **Cerner Indemnity.** Cerner will defend, indemnify, and hold Client and its officers, directors, employees, and agents harmless from and against third-party claims, liabilities, obligations, judgments, and causes of actions (“Third-Party Claims”) and associated costs and expenses (including reasonable attorneys' fees) to the extent arising out of (a) Cerner's negligence or willful misconduct in providing the Cerner Services, or (b) an allegation that the Cerner Services infringe a third party’s U.S. patent, trademark, or copyright. Cerner's indemnification obligation will not apply to the extent that the Third-Party Claim is based on: (i) the use of the Cerner Services in combination with any product, service, or activity (or any part thereof) not furnished, performed or recommended in writing by Cerner; (ii) the use of the Cerner Services in violation of this Agreement; or (iii) third-party content supplied or transmitted by Client or Users. If there is a Third-Party Claim relating to Client's use of the Cerner Services due to an infringement, or if, in Cerner's opinion, any of the Cerner Services are likely to become the subject of a Third-Party Claim of infringement, Cerner will, at its option and expense, and as Client’s sole and exclusive remedy, use reasonable efforts to procure the right for Client to use, replace, or modify the Cerner Services that are the subject of the infringement Third-Party Claim so that they become non-infringing or terminate the Cerner Services and provide Client with a refund of any prepaid amounts for Cerner Services not yet performed.

4.3 **Client Indemnity.** Client will defend, indemnify, and hold Cerner and its officers, directors, employees, and agents harmless from and against Third-Party Claims and associated costs and expenses (including reasonable attorneys' fees) arising out of the use of the Services by Client; provided however, that the foregoing indemnity will not apply to the extent Client has used the Services in accordance with the Documentation and applicable standards of good clinical practice, and the proximate and direct cause of the Third-Party Claim is Cerner's negligence or willful misconduct in providing the Cerner Services.

4.4 **Indemnification Process.** To be indemnified, the party seeking indemnification must: (i) give the other party timely written notice of the Third-Party Claim (unless the other party already has notice of the Third-Party Claim); (ii) give the indemnifying party authority, information, and assistance for the Third-Party Claim’s defense and settlement; and (iii) not materially prejudice the indemnifying party’s ability to satisfactorily defend or settle the Third-Party Claim. The indemnifying party has the right, at its option, to defend the Third-Party Claim at its own expense and with its own counsel. The indemnifying party has the right to settle the claim without the indemnified party’s consent so long as the settlement does not require the indemnified party to pay any money or admit fault. The indemnified party will have the right, at its option, to participate in the defense of the Third-Party Claim, with its own counsel and at its own expense, but the indemnifying party will retain control of the Third-Party Claim’s defense.

4.5 **Limitation of Liability.** EXCEPT FOR INDEMNIFICATION OBLIGATIONS AND PAYMENT OF FEES DUE UNDER THIS AGREEMENT, NEITHER PARTY IS LIABLE FOR ANY INDIRECT, SPECIAL, INCIDENTAL, PUNITIVE, OR CONSEQUENTIAL DAMAGES BASED UPON BREACH OF WARRANTY, BREACH OF CONTRACT, NEGLIGENCE, STRICT LIABILITY, OR ANY OTHER LEGAL THEORY. THE EXCLUDED DAMAGES INCLUDE, BUT ARE NOT LIMITED TO, LOSS OF PROFITS; LOSS OF SAVINGS OR REVENUE; LOSS OF USE OF THE EQUIPMENT, SOFTWARE, SERVICES, OR DATA; COST OF CAPITAL; COST OF ANY SUBSTITUTE EQUIPMENT, FACILITIES,

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OR SERVICES; THIRD PARTY CONSEQUENTIAL DAMAGES; AND INJURY TO PROPERTY. Cerner is not liable for any damages of any kind or nature related to or arising out of the Third-Party Services or Equipment. Any liability limitations set forth in the third-party pass-through provisions state the maximum liability of the applicable supplier with respect to that product or service. Notwithstanding any other provision herein, Cerner's maximum liability for any claim or series of related claims arising under this Agreement is limited to the amount paid by Client to Cerner for the affected Cerner Services during the 12 months preceding the event giving rise to the claim.

4.6 **Force Majeure.** Except for obligations to pay for Services performed and products delivered, neither party will be responsible for failing to perform due to causes beyond its reasonable control, including, but not limited to, failures by Cerner's suppliers or subcontractors, war, sabotage, riots, civil disobedience, acts of governments and government agencies, labor disputes, accidents, fires, acts of terrorism, or natural disasters. The delayed party will perform its obligations within a reasonable time after the cause of the failure has been remedied, and the other party will accept the delayed performance.

4.7 **Limitation on Actions.** Neither party may bring any action arising out of any transaction (other than failures to pay) under this Agreement more than one year after the cause of action accrues.

5. GENERAL PROVISIONS

5.1 **Termination of the Agreement.** This Agreement remains effective until all Services expire or are terminated in accordance with this Agreement.

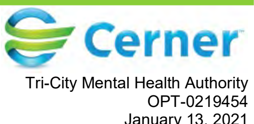
A. Termination of Agreement. Either party may terminate this Agreement if the other party materially breaches this Agreement by sending a notice specifying each breach with reasonable detail and this Agreement will be terminated, unless (i) the breaching party cures the breach within 30 days following receipt of the notice, or (ii) with respect to a breach which may not reasonably be cured within a 30-day period, the breaching party commences, is diligently pursuing cure of, and cures the breach as soon as practical.

B. Termination of Ordering Documents. Either party may terminate an Ordering Document if the other party materially breaches any provision of the Ordering Document (including any terms of this Agreement applicable to the Ordering Document) so long as the terminating party sends a notice of termination to the other party specifying each breach. The applicable Ordering Document (and any associated Services) will be terminated 30 days following delivery of the notice unless the breach is cured within the 30-day period.

C. Termination. Upon termination, Client will pay for all Services provided up to the date of termination and all other amounts owed under this Agreement. In addition, Client will immediately cease all use of the Services and will promptly destroy all copies of Cerner's Confidential Information. Cerner shall safeguard and not destroy any Client's PHI data and shall return Client's PHI, in accordance with the BAA.

5.2 **Arbitration and Injunctive Relief.** Cerner and Client will work cooperatively to resolve any dispute arising out of or relating to this Agreement (including claims relating to the negotiations and the inducement to enter into the Agreement) ("**Dispute**") amicably at appropriate management levels. If a Dispute remains unresolved and a party wishes to escalate to a formal dispute resolution forum, the party will submit the Dispute to binding arbitration under the Federal Arbitration Act ("**FAA**") and under the then-current Commercial Arbitration Rules of the American Arbitration Association, Inc. ("**AAA**"). The site of the arbitration will be in the Los Angeles, California metropolitan area. The arbitrator(s) will follow the Federal Rules of Evidence. The provisions of this Agreement will control over both the rules and procedures of the FAA, AAA, and Federal Rules of Evidence. No arbitration proceeding will include class action arbitration. The parties will share equally in the fees and expenses of the arbitrator(s) and the cost of the facilities used for the arbitration hearing, but will otherwise bear their respective fees, expenses, and costs incurred in connection with the arbitration. Judgment on any arbitration award, including damages, may be entered and enforced in any U.S. court having jurisdiction. Each party acknowledges that any breach of its obligations with respect to the other party's intellectual property rights will result in an irreparable injury for which money damages will not be an adequate remedy and that the non-breaching party is entitled to injunctive relief in addition to any other relief a court may deem proper.

5.3 **Availability of Records.** Until 4 years after the furnishing of services hereunder, Cerner will make available to the Secretary of the Department of Health and Human Services and the U.S. Comptroller General, or their representatives,



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its books, documents, and records necessary to verify the nature and extent of the costs of those services, in accordance with Section 952 of the Omnibus Reconciliation Act of 1980.

5.4 **Information Management Tools.** Client acknowledges and agrees that the Services are information management tools, many of which contemplate and require the involvement of professional medical personnel, and because medical information changes rapidly, some of the medical information and formulas may be out of date. Information provided is not intended to be a substitute for the advice and professional judgment of a physician or other professional medical personnel. Client acknowledges and agrees that physicians and other medical personnel should never delay treatment or make a treatment decision based solely upon information provided through the Services. Client further acknowledges and agrees that the Services are not intended to diagnose disease, prescribe treatment, or perform any other tasks that constitute or may constitute the practice of medicine or of other professional or academic disciplines.

5.5 **Intellectual Property.** Cerner retains all right, title, and interest, including intellectual property rights and all other rights, in the Services and Work Product. Cerner grants to Client a non-exclusive, non-transferable license to use Work Product for Client's own internal purposes in conjunction with the Services and for no other purpose.

5.6 **Confidentiality.** Except as permitted under this Agreement or as otherwise necessary to perform its obligations hereunder, Cerner and Client will not – nor will they permit their respective employees, agents, attorneys, or independent contractors to – disclose, use, distribute, sell, license, publish, or otherwise make available Confidential Information of the other party. Cerner and Client will each (a) secure and protect the other party's Confidential Information using the same or greater level of care that it uses to protect its own confidential and proprietary information of like kind, but no less than a reasonable degree of care, and (b) require their respective employees, agents, attorneys, and independent contractors who have a need to access Confidential Information to be bound by confidentiality obligations sufficient to protect the Confidential Information. Client will use Cerner Confidential Information accessed on restricted portions of Cerner.com only for the purpose of supporting its permitted use of the Services. Either party may disclose the other party's Confidential Information to the extent required by applicable law or regulation (including without limitation any applicable Freedom of Information Act or sunshine law) or by order of a court or other governmental entity, in which case the disclosing party will notify the other party as soon as practicable prior to the disclosure and no later than 5 business days after receipt of the order or request.

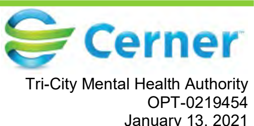
5.7 **HIPAA.** For Services requiring Cerner's use or disclosure of "protected health information" as defined under HIPAA, the parties agree to comply with the Business Associate Agreement attached as Exhibit B, which is incorporated herein by reference.

5.8 **Access to Data.** Cerner may use and disclose the Data for purposes permitted by HIPAA, and as necessary to perform and improve the Services or as agreed upon in an Ordering Document. Client agrees that Cerner may use and disclose performance and usage data for any purpose permitted by law so long as the data does not contain protected health information (as defined under HIPAA) or Client-specific identifiable information. In addition, Cerner may de-identify Data in accordance with the standards set forth in 45 C.F.R. 164.514(b) and may use and disclose such Data unless prohibited by applicable law.

5.9 **Notices.** All notices, requests, demands, or other communications relating to the other party's failure to perform or which otherwise affect either party's rights under this Agreement will be deemed properly given when furnished by receipted hand-delivery to the other party, deposited with an express courier, or deposited with the U.S. Postal Service (postage prepaid, certified mail, return receipt requested). The sender will address all notices, requests, demands, or other communications to the recipient's address as set forth on the signature page, and in the case of Cerner, to the attention of President; in the case of Client, to the attention of

5.10 **Governing Law.** This Agreement will be governed by, construed, interpreted, and enforced in accordance with the laws of the State of California.

5.11 **Severability.** This Agreement obligates the parties only to the extent that its provisions are lawful. Any provision prohibited by law will be ineffective (but only to the extent that, and in the locations where, the prohibition is applicable). The remainder of the Agreement will remain in full force and effect if the Agreement can continue to be performed in furtherance of the Agreement's objectives.



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5.12 **Assignment.** Neither party may assign this Agreement or any Ordering Document, in whole or in part, without the prior written consent of the other party, except to an affiliate or pursuant to a merger, acquisition or the purchase of all or substantially all of the party's assets; provided, however, any assignment to a competitor of the other party will be void unless the other party provides its prior written consent. Any assignment of this Agreement or any Ordering Document in violation of this section is void.

5.13 **Entire Agreement.** This Agreement constitutes the entire agreement of the parties for the subject matter of the Agreement. This Agreement supersedes and terminates any prior and contemporaneous agreements, understandings, representations, claims, statements, or negotiations with respect to the subject matter of this Agreement. This Agreement may not be amended or qualified except by a writing executed by authorized officers of each party.

5.14 **Survival.** The following sections survive termination of this Agreement: 2.1 (Pass Through Provisions); 4.3 (Cerner Indemnity) with respect to any Third Party Claims arising prior to termination; 4.4 (Client Indemnity); with respect to any Third Party Claims arising prior to termination and any use of the Services following termination; 4.6 (Limitation of Liability); 4.8 (Limitation on Actions); 5.2 (Arbitration and Injunctive Relief); 5.4 (Information Management Tools); 5.5 (Intellectual Property); 5.6 (Confidentiality); 5.9 (Notices); 5.10 (Governing Law); and 5.15 (No Hire).

5.15 **No Hire.** Cerner and Client agree that, without the prior consent of the other party, neither will offer employment to or discuss employment with any of the other party's employees until one year after this Agreement is terminated; provided, the foregoing does not prohibit a general non-targeted solicitation of employment in the ordinary course of business or prohibit a party from hiring a person who contacts the hiring party at his or her own initiative without any direct or indirect solicitation by or encouragement from the hiring party.

5.16 **Waiver.** Waivers of and consents to any term, condition, right or remedy under this Agreement must be in writing to be effective. No waiver or consent granted for one matter or incident will be a waiver or consent for any different or subsequent matter or incident.

5.17 **Purchase Orders.** If Client submits its own form of purchase order to request products or Services from Cerner, any terms and conditions on the purchase order are of no force or effect and are superseded by this Agreement.

5.18 **Independent Contractor.** Cerner is an independent contractor, and none of Cerner's employees or agents will be deemed employees or agents of Client. None of the terms in this Agreement will be construed as creating a partnership, joint venture, agency, master-servant, employment, trust, or any other relationship between Client and Cerner or any of their employees.

5.19 **Allocation of Risk.** The parties are both sophisticated entities. The prices paid, the warranties, warranty disclaimers, limitations of liability, remedy limitations, and all other provisions of this Agreement, were negotiated to reflect and support an informed and voluntary allocation of risks between Client and Cerner, and both parties waive all protections of any trade practices statutes.

5.20 **Compliance with Laws.** Each party agrees to comply with all applicable laws, rules, and regulations.

6. DEFINITIONS

6.1 **Cerner Services** means the services provided by Cerner and set forth in an Ordering Document.

6.2 **Communications Rule** means the requirements set forth in 45 CFR § 170.403, *Communications*, of the 21st Century Cures Act.

6.3 **Confidential Information** means all technical, business, financial, and other information that is disclosed by either party to the other, whether orally or in writing, any disputes between the parties, the terms of this Agreement, pricing, Services, Work Product, Data (other than Protected Health Information, as defined by the Health Insurance Portability and Accountability Act, which is protected in accordance with the Business Associate Agreement), Documentation, all information and materials accessible on Cerner.com "Client-only" access, and all non-public information related to Cerner products, services and/or methodologies. "Confidential Information" does not include (a) information publicly available through no breach of this Agreement, (b) information independently developed or previously known by Client or Cerner,

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(c) information rightfully acquired from a third party not under an obligation of confidentiality, or (d) Protected Communications.

6.4 **Data** means data that is collected, stored, processed, or generated through Client's use of the Services.

6.5 **Documentation** means the printed and on-line materials that assist Users, as updated from time to time.

6.6 **Equipment** means all equipment components provided by Cerner under an Ordering Document.

6.7 **Ordering Document** means the document (such as a schedule or sales order) setting forth the items being purchased by Client, scope of use, pricing, payment terms, and any other relevant terms, which will be a part of and be governed by the terms and conditions of this Agreement.

6.8 **Protected Communications** means those communications protected by the Communications Rule which include: (i) the usability, interoperability, or security of the Cerner Services, (ii) relevant information regarding Users' experiences when using the Cerner Services, (iii) Cerner's business practices related to exchanging electronic health information, and (iv) the manner in which a User uses the Cerner Services.

Client may only engage in Protected Communication involving the use of screenshots or videos if Client (i) does not alter the screenshot or video other than to annotate or resize it; and (ii) limits the sharing of the screenshot or video to the number and length needed to accomplish the purpose of the Protected Communication. Client may only engage in Protected Communications involving videos to the extent the video addresses temporal matters that cannot be communicated through screenshots or other forms of communication.

Protected Communications do not include the following: (i) non-user-facing aspects of the Cerner Services (such as source and object code, software documentation, design specifications, flowcharts, algorithms, file and data formats, and security vulnerabilities that are not public knowledge), (ii) communication that involves the use or disclosure of intellectual property within the Cerner Services (other than those communications which would reasonably constitute "fair use" under applicable intellectual property law), and (iii) information or knowledge solely acquired in the course of Client's participation in pre-market development and testing activities. Notwithstanding the foregoing, Protected Communications may not be restricted to the extent the communication is required by law or is about:

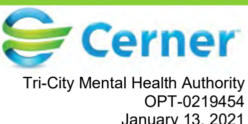
(a) adverse events, hazards, and other unsafe conditions and is made to government agencies, health care accreditation organizations, and patient safety organizations;

(b) cybersecurity threats and incidents and is made to government agencies;

(c) information blocking and other unlawful practices and is made to government agencies; or

(d) Cerner's failure to comply with a Condition of Certification requirement under the 21st Century Cures Act, or with any other requirement of this part and is made to the Office of the National Coordinator or an ONC-Authorized Certification Body.

Client recognizes that Cerner has a legitimate interest in the Protected Communications and that if Cerner is not made aware of the issues detailed in a Protected Communication, Cerner is not able to resolve, correct, or explain them. As such, Cerner encourages Client to report all such issues and Protected Communications through Cerner's standard support process. This definition shall be construed to enable full compliance with the Communications Rule.



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6.9 **Services** mean the Cerner Services and Third-Party Services, as modified and enhanced from time to time.

6.10 **Solution Description** means the document provided by Cerner describing the applicable Service.

6.11 **Third-Party Services** means the services provided by a third party and described in an Ordering Document.

6.12 **User** means an individual person to whom Client provides a unique password and sign-on ID for access to the Services.

6.13 **Work Product** means any documentation, techniques, methodologies, inventions, analysis frameworks, software, or procedures developed, conceived, or introduced by Cerner in the course of Cerner performing Services, whether acting alone or in conjunction with Client or its employees, Users, affiliates or others. Work Product does not include any Confidential Information of Client.

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EXHIBIT A

SCOPE OF SERVICES

Software Functionality Summary Sheet

Instructions: In the **Proposer Response** column, place an X in the column to indicate whether or not the requested functionality is available in the software application in your current release to all customers. In the **Comment** column, circle Yes or No to indicate whether you have additional comments regarding this specification in the Functionality section of the RFP.

Number	Specification	*Cerner Response*		*Comment?*
		Yes	No	
A1	Standard & Program Specific Client Demographic Data	X		Yes (No)
A2	Alias & Previous Name Support	X		Yes (No)
A3	Consumer Photo	X		Yes (No)
A4	Required Form Generation & Tickler System	X		Yes (No)
A5	Admission, Transfers, & Discharge Information	X		Yes (No)
A6	Referral Tracking	X		(Yes) No
A7	Referral & Admission Notes	X		(Yes) No
A8	Support for Automatic Referral Letter & Fax Generation	X		(Yes) No
A9	Discharge Planning & Referral Tracking	X		(Yes) No
A10	Family & Relationship Tracking	X		Yes (No)
A11	DSM & ICD Diagnoses	X		(Yes) No

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Number	Specification	*Cerner Response*		*Comment?*
		Yes	**No**	
A12	Master Individual Service Plans	X		Yes **No**
A13	Care Provider Tracking	X		Yes **No**
A14	Client Electronic Signature	X		Yes **No**
A15	Staff Electronic Medical Record Signature Standard Compliance	X		Yes **No**
A16	Support for Multiple Signature Requirements & Progress Note Roll-Up	X		Yes **No**
A17	Decision-Support, Evidence-Based Practice (EBP), & Assessment Tools	X		Yes **No**
A18	Custom Assessment Tools	X		**Yes** No
A19	Customizable Progress, Telephone, & Shift Notes	X		**Yes** No
A20	Group Notes	X		**Yes** No
A21	Electronic Record Pre-population	X		Yes **No**
B1	Medication Monitoring	X		Yes **No**
B2	Medical Conditions & Metrics	X		Yes **No**
B3	Medication Administration Records	X		Yes **No**
B4	Injection Administration Data Tracking	X		**Yes** No
B5	Electronic Prescription Transmission	X		**Yes** No

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Number	Specification	*Cerner Response*		*Comment?*
		Yes	**No**	
B6	Tamper-Resistant Prescription Printing	X		Yes No
B7	Links to Medication Information & Drug Interaction & Contraindications	X		Yes No
B8	Prescription Refill Reminders	X		Yes No
B9	Laboratory Interface	X		Yes No
B10	Laboratory Result & Medical Condition Alerts	X		Yes No
B11	Formulary & Medication Pre-Certification Support	X		Yes No
B12	Drug Enforcement Administration (DEA) Federal Regulation Supports	X		Yes No
B13	Patient Medication Information/Handouts	X		Yes No
B14	Laboratory Orders Sets	X		Yes No
B15	Medical Supply Inventory Support		X	Yes No
C1	Assessment Tool Support	X		Yes No
C2	Decision-Support & Compliance for ASAM Criteria for Care	X		Yes No
C3	Random Appointment Scheduling for Urinalysis & Compliance Monitoring	X		Yes No
C4	Detoxification Vital Sign Tracking Support	X		Yes No

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Number	Specification	*Cerner Response*		*Comment?*
		Yes	**No**	
D1	Resource-Based Appointment Scheduler Capabilities	X		(Yes) No
D2	Group Scheduling Support	X		Yes (No)
D3	Front Desk Cash Application	X		Yes (No)
D4	Client Arrival Notification	X		Yes (No)
D5	Front Desk Client Financial Summary Information Access	X		Yes (No)
D6	Automatic Service Generation from Scheduler	X		Yes (No)
E1	Case Management Notifications	X		Yes (No)
E2	Employment Services Data Tracking & Consumer Matching		X	(Yes) No
E3	Consumer Employment History	X		(Yes) No
E4	Expanded Employment & Support Services Data Tracking	X		(Yes) No
E5	Prevention Program & Presentation Tracking	X		Yes (No)
F1	Alerts or “Tickler” Capabilities	X		(Yes) No
F2	Satisfaction & Outcomes Tracking & Analysis	X		Yes (No)
F3	Critical Incident & Other Required Reporting	X		(Yes) No
F4	Track Progress Note Compliance	X		Yes (No)

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Number	Specification	*Cerner Response*		*Comment?*
		Yes	No	
F5	Electronic Record Release	X		**Yes** No
F6	Record Release Tracking	X		**Yes** No
F7	Electronic Medical Record Document Routing & "Role Based Charting"	X		Yes **No**
F8	VIP Medical Records Protection	X		**Yes** No
F9	Tracking HIPAA & State Specific Medical Record Requirements	X		**Yes** No
F10	Accreditation Support	X		**Yes** No
F11	Enhanced Role-Based System Access Controls	X		**Yes** No
F12	EHR Document Version Control	X		**Yes** No
F13	EHR Archiving & Purge Capability	X		**Yes** No
G1	Extensive Call Tracking & Disposition Data	X		**Yes** No
G2	Referral Workflow Tracking	X		**Yes** No
G3	Pre-Admission Checklist Support	X		Yes **No**
G4	Waitlist Tracking	X		**Yes** No
H1	Client Payer & Service Authorization Data	X		Yes **No**
H2	Case Management & Service Authorization Management Supports	X		Yes **No**

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Number	Specification	*Cerner Response*		*Comment?*
		Yes	**No**	
H3	Client Service Entry	X		Yes (No)
H4	Pre-billing Edits	X		Yes (No)
H5	Client Fee-For-Service, Per Diem, & Contract Billing	X		Yes (No)
H6	Complex Billing Requirement Support	X		Yes (No)
H7	IBHIS Integration	X		(Yes) No
H8	Standard A/R Functionality	X		Yes (No)
H9	Client Sliding Scale Fee Screen	X		Yes (No)
H10	Client Sliding Scale Fee Calculation	X		Yes (No)
H11	Electronic Remittance Posting & Waterfall Billing	X		Yes (No)
H12	Guarantor Private Pay Statements	X		(Yes) No
H13	Split Guarantor Private Pay Statements	X		Yes (No)
H14	Payer Eligibility Data Import	X		Yes (No)
H15	Consumer Fund Tracking		X	(Yes) No
H16	Medicare Incident to Billing Support	X		(Yes) No
H17	Transportation Billing	X		(Yes) No
H18	HIPAA 837 Transactions	X		Yes (No)

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Number	Specification	*Cerner Response*		*Comment?*
		Yes	**No**	
H19	Health Care Claim Acknowledgment (277CA)	X		Yes **No**
H20	Payor Financial Information (PEI) Forms	X		**Yes** No
I1	Built-In Support for Compliance Reporting	X		**Yes** No
i2	Management Metrics Dashboard	X		**Yes** No
I3	Staff Productivity Management Support Capabilities	X		**Yes** No
I4	Clinician Staff Credentialing & Privileging Support	X		**Yes** No
I5	Clinical Supervision Support	X		Yes **No**
J1	Internal Staff Alert & Messaging System	X		**Yes** No
J2	Voice Recognition Software & Transcription Support	X		**Yes** No
J3	Consumer/Family/Network Provider Portals	X		**Yes** No
J4	HIE of Service Request Info for LACDMH	X		**Yes** No
J5	HIE of CANS & PSC-35 with LACDMH	X		**Yes** No
J6	System Audit Trail/Track and Report	X		**Yes** No
J7	Client and Services Information (CSI)	X		**Yes** No

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Functional Specifications Comment (Optional)

Please comment on the individual functional specifications as referenced in Attachment A, if desired. This section is not required. Comments should be coded by specification number and name.

Number	Specification	*Comments*
A6	Referral Tracking	Referrals of every type, including internal and external, can be tracked through our referrals management dashboard. Cerner's referrals management solution supports a dashboard display that provides extensive tracking including the sending of referral/consult requests, receiving of referral/consult requests, appointments made with consulting provider within the organization, appointments kept or missed within the organization, consulting provider notes/response sent to sending provider, and sending provider receiving of consult documentation. Cerner creates a seamless referral process with external providers through a secure referral management workflow that leverages Direct Technology. This is a universal communication tool across venues and vendors to send, receive, and update statuses of referrals. Additionally, consult/referral orders allow a clinician to place an order and direct it to a specific service. Clinicians associated with that medical service can view and act on the list of consults. In addition, clinicians can forward results and documents to support consult requests to internal clinicians. These requests appear in the message center. In addition, our referral management tool supports sending and receiving referrals to and from external providers that are using the Direct Messaging standard. For referrals for admission, the referrals worklist will allow the referral coordinator to track and monitor the status of the referral. The referral coordinator can review the documentation received with the referral and accept or reject the referral based on clinical presentation.
A7	Referral & Admission Notes	Our EHR will facilitate the documentation and communication regarding each admission and case. All messages sent regarding a client will be saved within their permanent medical record with the information exchanged regarding utilization review, issues for billing staff to address, and other requirements. These documentation types can be filtered within the record for quick identification.
A8	Support for Automatic Referral Letter & Fax Generation	Cerner's referral management workflow will allow the user to manage the workflow from a single point within the EHR. Once the referral order is placed, it will flow to the referral management workflow. The workflow will allow the user to select the provider or organization the referral will be sent to, attach associated documents, and insurance information from a single page rather than having to search through the chart to find information. Once all of the components have been added, the user can generate the referral letter and continuity of care document to be sent to the designated provider. The referral details will be sent via the designated provider's preferred method of communication, either via Direct Technology or secure ad-hoc fax. Direct Technology enables the ability to send messages securely between EHRs as

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Number	Specification	*Comments*
A9	Discharge Planning & Referral Tracking	Cerner's solution will support detailed discharge planning, including the ability to send and receive information to/from community providers. As the client is being discharged, the care team will have the ability to document the discharge care plan and provide it to the client. Additionally, we support the ability to track referrals to community providers and ensure that all of the associated documentation is sent to ensure continuity of care. Referrals can be sent to community providers directly from the referrals management workflow via the community provider's preferred method of communication. Our EHR also supports the ability to send any information back to a community provider throughout the client's care and upon discharge from care. The EHR will generate a visit summary that will provide details of the care provided and the user can attach other documents to ensure the community provider has a holistic view of the client's care.
A11	DSM & ICD Diagnoses	Cerner supports ICD-10, DSM-5, and a crosswalk between the two. Once established, the diagnosis can be pulled into and auto-populate other forms such as progress notes, treatment plan, and discharge summaries. Our DSM-5 terminology package is fully integrated into diagnostic capabilities embedded within our EHR system.
A18	Custom Assessment Tools	As part of the Cerner Integrated Behavioral Health EHR offering, TCMHA is provided a robust catalog of standard, pre-defined content that includes industry-validated assessment forms, flowsheets, note templates, and more. Over 180 behavioral health-specific standard scales and assessment forms (with scoring tools) are provided to support your organization’s documentation needs. Assessments display different questions and flex according to the patient's age, gender, diagnosis, reason for visit, specialty, and location. TCMHA can also have reference text and URL links built into the clinical workflow during the localization process to support clinical information, definitions, as well as your organization’s standardized policies and procedures that promote optimal care. Reference text can link to internal or external sources and can be accessed with a click. In addition, Cerner supports the use of content from third-party providers for evidence-based clinical practice guidelines (additional fees might apply). As part of your implementation, Cerner will work with TCMHA to evaluate any additional form template requirements or organization specific requests and provide guidance on how best to use the system to meet your needs. This would be managed through our change governance process, both during implementation and after moving your system into production. Please refer to the Behavioral Health Content List document located in the Additional Reference Materials for more details concerning our vast library of assessment and scoring tools.
A19	Customizable Progress, Telephone, & Shift Notes	Our note templates can be personalized to include auto-text templates, free-text, embedded voice recognition or a combination of these tools as well as meta tagging with footnotes. They are user-customizable and flex according to the patient's age, gender, reason for visit, specialty, and location. As part of your implementation, Cerner will work with TCMHA to evaluate any additional form template requirements or organization specific requests and provide guidance on how best to use the system to meet your needs. This would be managed through our change governance process, both during implementation and after moving your system into production.

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Number	Specification	*Comments*
A20	Group Notes	Our multi-person charting tool (group notes) simplifies the workflow for documenting group therapy. The tool allows clinicians to document on multiple group members from one screen. This differentiating offering significantly decreases the time it takes to document a group therapy session by eliminating the need to re-document the same (group level) information for each attendee. By providing a multi-person platform for documentation, our goal is to provide TCMHA's group leaders with more time for patient care, by removing the repeated navigation required to jump from chart to chart. This group documentation tool also enables clinicians to capture group attendance, exact participation time for each attendee, document patient-specific participation attributes, and view, add, or modify goals/interventions for individuals attending group session or for the entire group. Once signed (with a single click), the group note flows to become a part of all the attendee's charts and the individual notes disseminate only to each individual's chart.
B4	Injection Administration Data Tracking	At the point of ordering, the provider will indicate the medication and dosage to be administered. When the medication is administered, the nurse will document administering the medication through their task function which will have an associated form. The form will allow the nurse to verify the medication and dose and then document the administration site, manufacturer, lot number, expiration date, and any necessary charge codes. All of the medication administration details will be stored with the medication for review.
B5	Electronic Prescription Transmission	Our solution has embedded the ability to e-prescribe directly into the provider's workflow. Cerner leverages the Surescripts transmission network to allow e-prescribing to more than 98% of the nation's participating pharmacies. Cerner also supports e-prescribing controlled substances on the desktop EHR with two-factor authentication following DEA requirements.
B6	Tamper-Resistant Prescription Printing	We support tamper-resistant prescription printing that complies with CMS requirements. Additionally, e-prescribe is seamlessly integrated into the clinical workflow, utilizing a third-party transmission network, Surescripts, that enables prescribing practitioners to electronically route prescriptions, inclusive of controlled substances, to community or mail order pharmacies. Cerner possesses proprietary methods for dual authentication prompting the provider to authenticate to the system with two factors that meet DEA EPCS requirements.
B7	Links to Medication Information & Drug Interaction & Contraindications	Our solution provides information regarding medication information, medication education, and drug interactions and contraindications within the ordering workflow. Our clinical decision support rules will trigger an alert if a drug interaction or contraindication is identified by the solution. The alert will require the provider to address the drug interaction or contraindication before proceeding with the workflow. The alert will contain information stating why the alert was triggered.
B8	Prescription Refill Reminders	Cerner's provider workflow page will give the provider visual indicators when the client's prescription needs to be refilled. The indicators will be visible during the appointment and be based on the last time the medication was refilled. Additionally, our solution will accept prescription refill requests directly from the pharmacy into the prescribing provider's message center for review and action.
B9	Laboratory Interface	Our solution enables the ability to interface to outside laboratories. The laboratory interface can send the order and then receive the results back into the EHR. As the results are received, they will be tracked within the client's longitudinal record over time and can be graphically trended.

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Number	Specification	*Comments*
B10	Laboratory Result & Medical Condition Alerts	The EHR will automatically route the results to the ordering provider's message center and client's medical record from the performing laboratory. For results received that fall outside of the attached reference range, the results will be categorized into normal, abnormal, and critical in the ordering provider's message center for immediate identification and review. Within the client's chart, results outside of the reference range will have a visual indicator stating if the result is normal, abnormal, or critical based on an associated color and icon.
B11	Formulary & Medication Pre-Certification Support	Partially supported. At the point of order entry, the provider will be presented with stop light coding indicating if the medication is preferred, on formulary, or off formulary based on the client's documented insurance information. In the event a medication is not on formulary, the provider will automatically be presented with appropriate therapeutic substitutions. Further development is needed for the medication pre-authorization workflow to be available in the proposed model and does not have an anticipated release date.
B12	Drug Enforcement Administration (DEA) Federal Regulation Supports	Our ePrescribing is seamlessly integrated into the clinical workflow, utilizing a third-party transmission network, Surescripts, that enables prescribing practitioners to electronically route prescriptions, inclusive of controlled substances, to community or mail order pharmacies. Cerner possesses proprietary methods for dual authentication prompting the provider to authenticate to the system with two factors that meet DEA EPCS requirements. We also support the ability to print prescriptions for controlled substances that meets DEA requirements.
B13	Patient Medication Information/Handouts	Cerner has embedded medication education directly into the EHR which can be provided to the patient at the point of ordering and/or at the point of providing the patient with additional patient education materials. Once the education is selected and provided to the patient, it will also be available for the patient in the patient portal.
B14	Laboratory Orders Sets	Cerner's solution presents TCMHA the ability to create orders sets with commonly grouped laboratory orders. Our order sets will also allow the ability to group other common orders such as medications, diagnostics, referrals, and other orders to simplify the ordering process. Order sets can be created at the organization, departmental, and provider level.
B15	Medical Supply Inventory Support	Our behavioral health solution does not currently support inventory management; however, it may in the future. Typically we see clients that are already utilizing a 3rd party to manage medication supplies.

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Number	Specification	*Comments*
C1	Assessment Tool Support	Partially supported. Cerner's system includes protocols based upon industry-standard, best practice recommended workflows for detoxification/withdrawal, which include Fall Risk scoring and a multitude of other criteria for the care and safety of the patient as well as the care team. Our content provides alcohol and drug screenings and assessments, including the Addiction Severity Index (ASI); the Alcohol Use Disorders Identification Test (AUDIT); the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C); Clinical Institute Withdrawal Assessment (CIWA-AR); the Clinical Opiate Withdrawal Scale (COWS); the Michigan Alcohol Screening Test (MAST); the Modified Alcohol, Smoking, and Substance Involvement Screening Test (Modified ASSIST); the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES); the Substance Use Assessment; the Recovery Capital Scale (which is currently in development); and more. Our system provides detoxification admission and substance use detoxification (and relapse) order sets to standardize the clinical workflow process for substance use treatment in outpatient, inpatient, and community/residential detoxification settings. Information documented can be pulled into a report, including detoxification statistics such as length of stay or drug of choice. As part of your implementation, Cerner will work with TCMHA to evaluate any additional form/assessment requirements or organization specific requests and provide guidance on how best to use the system to meet your needs. This would be managed through our change governance process, both during implementation and after moving your system into production. Please refer to the Behavioral Health Content List document located in the Additional Reference Materials for more information concerning our vast library of substance use and other assessment tools. Substance Abuse Subtle Screening Inventory (SASSI) – Adult and adolescent version Post-Acute Withdrawal Systems (PAWS) Withdrawal Assessment Scale Clinical Institute Withdrawal Assessment (CIWA)
C2	Decision-Support & Compliance for ASAM Criteria for Care	Cerner's integrated EHR includes the ASAM Assessment and provides for documentation of levels of care and justification. We do not currently have the ASAM algorithms.
C3	Random Appointment Scheduling for Urinalysis & Compliance Monitoring	Partially supported. Our system does not currently support the ability for staff to monitor compliance or to notify consumers if they have been selected for testing.
D1	Resource-Based Appointment Scheduler Capabilities	Partially supported. Our system does not currently support the ability to locate available appointments based on payer requirements or staff credentials.

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Number	Specification	*Comments*
E2	Employment Services Data Tracking & Consumer Matching	This is not something that we currently have functionality for at this time. However, we would be happy to have further discussions around how we can best meet your needs.
E3	Consumer Employment History	Tracking individual employment history (placement and dates) could be done through a form for this requirement. Anything more would require further discussion on how to best meet your needs.
E4	Expanded Employment & Support Services Data Tracking	Cerner's integrated offering provides the ability to track services to support a broad array of services to support patients in employment and daily activities. Additionally, Cerner's robust point-of care ADL and individualized task documentation offering, CareTracker (optional) provides the ability to create personalized care plans based on assessments, document on trainings and progress/lack of progress, view current medications, and document on physician appointments. We support nursing/provider workflows, documentation, and much more. Our point-of-care ADL and individualized task documentation tool (CareTracker) supports documenting developmental disabilities, behaviors, and skill development. This innovative offering allows care providers to record goals and review data in near real-time, at the point-of-care via simple-to-use, touch-screen devices. It is highly customizable and allows TCMHA's staff to monitor the progress of individual-specific plans for restorative programs, behaviors, and many other programs that might need to be monitored for an individual. Cerner would welcome further conversation about your Employment and Support Service Data Tracking requirements. Should CareTracker be
F1	Alerts or "Tickler" Capabilities	Our integrated-community behavioral health delivery model supports a robust catalog of standard content that includes recommended decision support alert notifications, prompts, and rules embedded in the clinician workflows, including due dates for evaluations and tasks. This can support users in being notified or notifying others of required components of the health record. This can also include notifications of unmet outcome measures, sending satisfaction surveys, and completing required actions. Additionally, rules and alerts can be localized during the implementation process. Cerner will work with your organization to evaluate any custom requests and provide guidance to meet your needs. Cerner's Integrated Community Behavioral Health EHR also includes a variety of enterprise-wide reporting/data extraction capabilities to meet the needs of TCMHA. This offering includes operational reporting, as well as analytics tools that provide the end user with access to data through our reporting portal. This will ensure that you can track and monitor any incomplete files or pending requirements from the system.

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Number	Specification	*Comments*
F3	Critical Incident & Other Required Reporting	Partially supported. Cerner's system can capture patient adverse events through documentation. We also identify patients at risk of adverse events though assessments and results and suggest preventative protocols. These include falls, skin breakdown, medication events, and interventions to mention a few. However, the Cerner offering provides a patient-centric electronic medical record, not a standard risk management system. We do not recommend recording incident information beyond direct patient care within the EHR, due to potential discovery issues. Cerner welcomes further conversation with TCMHA related to this requirement so we can investigate your specifications and determine whether our documentation meets this requirement. We would be happy to discuss the possibility of interfacing with a third-party incident management system. Additional fees might apply.
F5	Electronic Record Release	Our solution provides functionality for your Release of Information process. Our features include the ability to notate received requests, validate the authorization for the release of information, provide historical documentation of the information released, and support for the management of any associated reimbursement receivables. The application can track both paper-based and electronic documents that have been requested, mailed, and allows for specification for which requests apply to accounting of disclosures. You can track the following patient requests: request to restrict consent, request for confidential communications, request to access their chart, request to amend their chart, request to receive an accounting of disclosure, and tracking/reporting can be applied to all requests or just those applicable to accounting of disclosure reporting. In addition, sensitive data can be removed from the ROI by using templates excluding that information.
F6	Record Release Tracking	Our solution's request queue provides the ability to view the requests for charts and documents that have been logged into the system and their current state of completion. Full audit trails and accounting of disclosure reporting to meet the HIPAA disclosure requirements is supported.
F8	VIP Medical Records Protection	The VIP designation code distinguishes sets of person or encounter information from the rest of the population. Setting this code allows the enterprise to perform special functions, usually through reports, for these individuals. Confidentiality levels can be set on encounters as well as on users. A site can choose to determine specific encounters or encounter types that require additional security logic. For example, psychiatric visits and child abuse cases. The system compares the confidentiality level of the personnel, associated with the user at the time he/she is entered into the system. The confidentiality level of the person and/or the encounter set at the time of registration, determines if you can view information regarding the person or a specific encounter. Each site that chooses to invoke the confidentiality level indicator determines the confidentiality levels appropriate for that site, for example, LOW, MEDIUM, or HIGH. Personnel associated with a confidentiality level of LOW are unable to view encounters associated with a person that is assigned a confidentiality level of HIGH.

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Number	Specification	*Comments*
F9	Tracking HIPAA & State Specific Medical Record Requirements	Cerner complies with all guidelines and regulations set forth in the Health Insurance Portability and Accountability Act (HIPAA). It is our policy to maintain and protect individually identified health information of patients/employees and the system components in which such data resides. All patients are informed of their right to privacy and the privacy of their health information, and all patients acknowledge this notification by signature. Additionally, our standard solutions are designed to support federal regulatory requirements as appropriate to given solutions. Modifications may be needed to meet individual state requirements depending on their nature, such as for prescription formats, state regulatory submissions for public health or vital statistics reporting or other requirements. Cerner has a team that is responsible for ongoing review of all federal regulatory requirements when proposed and final rules become available. This team works to identify the priority for Cerner's solution business requirements and services that come from federal regulation. The team also works with Cerner's business units to identify current solution capabilities that may form the basis for enabling compliance with the regulatory requirements. This information is then framed into guidance through several avenues, including through reference materials, client notices, educational sessions, and other forums. Cerner provides a MACRA Playbook, curated and written by Cerner's team of regulatory experts, that is intended to provide an overview of the final rule released by CMS, translation of the programs, terms and mandates included, insight into Cerner's long-term vision for preparing clients for regulatory shifts, and guidance on how to prepare for these changes.
F10	Accreditation Support	Cerner maintains a regulatory research and strategy team that works to stay comprised of regulatory developments and impacts to the industry as well as our client base. We embed tools for easily capturing and extracting the requirements of standard behavioral health and healthcare accrediting bodies, such as the Joint Commission and CARF. We also push out tools necessary for capturing changes in regulatory requirements. However, it is up to TCMHA to extract and submit the necessary information in order to maintain their
F11	Enhanced Role-Based System Access Controls	Cerner supports position-level or role-based security, enabling TCMHA to determine which roles or positions have permission to specific tasks within an application. Every user in the system is assigned a role or position. In addition, patient-provider relationship functionality allows you to define an emergency override access option. The emergency override allows a provider that does not have an established relationship with a patient to declare an emergency relationship, if necessary. The relationship type of "emergency" is associated with all positions that could possibly declare an emergency relationship with a patient. When defining the emergency type, you can specify whether organization security and or confidentiality levels are honored or if they can be overridden. All access to patient records is logged including those occurring under emergency circumstances. We capture the details of this event to allow for full reporting to your organization and its respective members. Our solution includes auditing of all significant events (such as access events) in the system. An audit event typically contains information about who did something, what they did, what action they took, when they did it, how they did it (i.e. through which system), and what other things or people were accessed and impacted by
F12	EHR Document Version Control	All actions in the EHR are tracked with the user's name, date, and time of the action. For documents that are signed in the client's medical record and action is taken after signature to modify or update the document, the version will provide a history of all the changes made. Only users with the appropriate role-based security setting will be able to modify a document.

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Number	Specification	*Comments*
F13	EHR Archiving & Purge Capability	Partially supported. With Cerner's system design and SaaS delivery model, there is no need archive patient result data. Authorized users have immediate access to the entire patient record, including information from current and past visits. In this Remote Hosted Option (RHO) deployment, Cerner hosts, manages, and maintains the contracted system on your behalf. Cerner builds the system to meet ideal sizing and performance goals. Cerner also supports the need and capability for erasure of a patient record. However, we currently do not support the purging of specific data and/or portions of the record.
G1	Extensive Call Tracking & Disposition Data	Partially supported. Cerner's system allows for the documentation of call information for different programs. The call taker will need to access a record or create a one in order to save the documentation to a chart, but he disposition of the call can be recorded in the chart. Referral information is documented through our referrals management workflow and will allow the user to document where the referral is coming from, who it is being assigned to, and additional information for that referral.
G2	Referral Workflow Tracking	Cerner automates the workflow embedding provider order entry, leveraging an established network of providers, simplifying management for support staff, to quickly close the referrals loop and decrease turnaround times to contain healthcare costs. Our referrals management utilizes industry messaging, DirectTrust, to enable seamless, bi-directional communication between your providers and external providers in the community with options to attach any pertinent documentation. This is all completed within one view without having to toggle back and forth between screens, thus enhancing efficiency. Cerner's integrated referrals management module supports a dashboard display of new referrals in a work queue which provides extensive tracking such as sending of referral/consult request, receiving of referral/consult request, the reason for the referral, appointments made with consulting provider, appointment kept or missed, consulting provider note/response sent to sending provider, and sending provider receiving of consult documentation.
G4	Waitlist Tracking	The Queues workflow is recommended for managing appointments and patients that need further action. This workflow contains the following views: • Reschedule Requests • Standby Appointment Request • Eligibility • Appointment Requests • Requests • Consumer Demographic Update • Work Queues The Queues functionality includes the use of various data to prioritize accordingly.

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Number	Specification	*Comments*
H7	IBHIS Integration	Cerner's offering provides TCMHA with one of the most advanced billing systems on the market. We have been working for over thirty years to develop a system designed to meet the challenging, ever-changing needs of community behavioral healthcare billing and state reporting. We also have vast experience with clients utilizing our system in the state of California. Our community behavioral health billing and state reporting module utilizes web service technology for exchanging data electronically with the LACDMH's Integrated Behavioral Health Information System (IBHIS); and has a working knowledge of user authentication using x.509 certificates, PKI exchange, Certificate Authority, and third party validation authority. It communicates Admission, Update, and Discharge data to the LA County IBHIS system via the IBHIS web service functions; and provides the ability to query the IBHIS system such that users can view the LA County data sets.
H12	Guarantor Private Pay Statements	Statement options are available.
H15	Consumer Fund Tracking	This is not something that we have functionality for at this time. However, we would be happy to have further discussions around how we can best meet TCMHA's needs.
H16	Medicare Incident to Billing Support	Cerner has over thirty years of experience with community behavioral health billing. We currently have forty-five behavioral health clients in the state of California, thirty of which are community behavioral health clients. We have been working with our California-based behavioral health clients on billing and state reporting for over fifteen years. Our patient accounting module generates the X12 5010 claim files and places the file on the local network based on the user-selected location. The transmission of the files is a process completed by the users using the payer-specified instructions for file transfer.
H17	Transportation Billing	There is a transportation log within our billing module.
H20	Payor Financial Information (PEI) Forms	Our patient accounting module allows for capturing third party coverage data for patients. Additionally, the system includes patient financial forms for each patient that are captured within our integrated EHR. We would be happy to discuss this further with TCMHA in order to gain a better understanding of your specific needs and verify our interpretation of this requirement.

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Number	Specification	*Comments*
I1	Built-In Support for Compliance Reporting	Cerner can aid you in designing workflows and protocols to comply with internal controls and regulatory compliance standards where the application of technology can aid the facilities in compliance. It is ultimately the responsibility of TCMHA and its facilities to ensure they have policies and procedures in place to meet those standards. Cerner has a regulatory strategy team that reviews new rule making for regulatory developments; including federal and some state regulations. The team conducts reviews of rules for business requirements that should be reviewed with Cerner's solution strategists and development teams. These teams then determine the ability of existing solutions to comply to the new regulatory requirements. Additionally, they take the time to identify potential gaps or enhancements for development prioritization. Once determined, they develop knowledge transfer resources and sessions for associates and clients on recommended guidance to meet the new rules and regulations. Where these requirements represent solution development gaps or enhancement needs, the regulatory team works with solution teams and Cerner business units on prioritization and response planning. From there, the regulatory strategy team works with Cerner development to cover the program updates and the timeline needed to successfully implement any updates or changes. These development timelines vary based on the regulatory requirements. LA County DMH has an Integrated Behavioral Health Information System (IBHIS) which provides contracted providers or Trading Partners (TPs) the means to directly exchange information with IBHIS in a business-to-business (b2b) Electronic Data Interchange (EDI) model. The IBHIS system has a Release Candidate End point for user authentication using x.509 certificates, PKI exchange, Certificate Authority and third party validation authority. Through web service technology including but not limited to the open protocols and standards such as SOAP, WSDL, XSD, etc. Client Service, Service Request Log, Level of Care, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) data is exchanged electronically between the Cerner EHR product and IBHIS. LA County DMH gives permission for Cerner Clients to provide Cerner with their Authorization Certificate and Program ID for testing and production purposes. As previously discussed with TCMHA, Cerner is currently providing this integration utilizing our historic Cerner Community Behavioral Health EHR (Anasazi). However, this integration has not yet been brought forward to the proposed Cerner Integrated – Behavioral Health EHR. Cerner will work with TCMHA to complete this integration as part of the implementation process. Other State Reporting required in California, such as the Client and Service Information (CSI) Reporting, Office of Statewide Health Planning and Development (OSHPD) Reporting, and California Outcomes Measurement System (CalOMS) Reporting, are already part of the Integrated Product. They are separate reporting utilities to process the related consumer data and generate Transmittal files according to the state requirements of the transmittal file from the state and the clients will upload to the files according to the California DMH specifications.

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Number	Specification	*Comments*
i2	Management Metrics Dashboard	Cerner's Integrated-Community Behavioral Health hosted offering includes a variety of enterprise-wide reporting capabilities to meet the needs of TCMHA. This offering includes operational reporting, as well as analytics tools, that provide your end user with access to data through the reporting portal. For organizations with the skills and desire to develop extracts or custom and ad hoc reports, additional reporting tool sets are available within the domain. Cerner's Integrated-Community Behavioral Health offering combines tools such as Discern Analytics 2.0 (DA2), SAP Business Objects, SQL Server Reporting Services (SSRS), and our new analytics dashboards leveraging the power of Tableau to provide a robust approach to securely meet your reporting needs in a shared environment. Our reporting tools support exporting data in specific report formats, such as .csv, .pdf, .xls, and .xlsx. Users can create reports and formats for exports at regular intervals or can schedule them as one-time queries. Once exported, the data is available to use within external reporting tools. Exporting to a .csv allows for additional manipulation of the data using a wide variety of toolsets. However, data which is exported outside the system is no longer secure and becomes the responsibility of the organization to protect. Cerner is also constantly working to develop behavioral health analytics specifically designed around the needs of clients leveraging our Cerner Integrated-Community Behavioral Health solution. Analytics tools such as these can be crucial for sustainability. They can provide accountability, drive outcomes, as well as assist with predictive modeling and stratification. Our behavioral health analytics offering will include dashboards for executive leadership, operations management/supervisors, clinical effectiveness/for clinical and quality leaders, as well as a clinician dashboard/for clinical staff. These behavioral health analytics tools are being developed to provide TCMHA with interactive dashboards in an effort to empower your organization with meaningful access to key metrics for monitoring and measuring your organization's health and performance. These tools will provide real-time data visualization, a means for exploration, and decision support to help drive the overall success of your organization. Additionally, our system activity monitoring, Lights On Network, is an industry-leading advanced EHR analytics offering designed to support decision making and provide transparency into your Cerner solution. No other monitoring system provides this level of knowledge-driven analysis designed to help your organization get the most from your EHR solution. We provide this analytical web-based solution free of charge as part of an ongoing commitment to our clients and to the improvement of healthcare around the world. Our system activity monitoring provides views into system performance, system configuration, user experience and adoption, as well as organizational efficiency. Drillable dashboards provide information that will assist TCMHA in understanding how end users are using the system across your organization. TCMHA can proactively monitor the efficiency of your providers and nursing staff by specialty, facility, as well as the specific user. This allows for engaging with employees to ensure the optimal experience for your staff and clients. In addition, Cerner offers an online community via www.cerner.com to collaborate and share best practices with other members of the system activity monitoring network.

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Number	Specification	***Comments***
I3	Staff Productivity Management Support Capabilities	Cerner's system currently allows TCMHA to establish a variety of reports for use in analyzing productivity. For example, our Revenues Report can be used to establish a variety of templates for viewing revenue, hours, and units of service by payer, provider, location, type of service, mode of service, or service function code. We are in the process of developing dashboards designed to provide insight to provider productivity and provision of service details using drill down capabilities. A variety of views will be established to meet the needs of providers, managers, and executives. Additionally, to identify areas of deficiency, Cerner has various tools that measure user utilization of the system. Our Lights on Network is an interactive and intuitive dashboard of operational information, including response time performance, workload, system management metrics, and system compliance. Furthermore, it provides key insights into a provider's experience by showing performance comparisons relative to the entire network and peer sub-segments. Embedded within our Lights On Network is Cerner Advance. This is an additional tool that compares the efficiency and adoption of every clinician at your organization to their specialist peers across the country. This enables easy identification of outlier users or user groups spending significantly more time than their peers. Outlier identification then drives specific targeting by support staff within the Process Management framework. Cerner Advance then scans a number of key performance indicators and compares to a national and/or peer Cerner benchmark. Each Key Performance Indicator (KPI) is then presented alongside its Return on Investment (ROI) to the benchmark and the specific project work necessary to achieve that ROI. Cerner Advance is a suite of web-based solutions that: Presents individual user or group level efficiency and adoption data within an easy-to-use yet state-of-the-art interactive visualization Enables taking action of that data through management tools to drive a process of continuous improvement Offers a suite of reports to ensure the right work is getting done with the right users and generating the intended impact Identifies high-value, organization specific opportunities to improve at a system level through structured improvement project 22 Specialties High Opportunity Specialty (874 out of 1753 physicians) 50% high opportunity 10 Specialties Low Opportunity Specialty (208 out of 776 physicians) 27% high opportunity 16 Specialties Moderate Opportunity Specialty (153 out of 582 physicians) 34% high opportunity For more Cerner Advance details see: *https://advance.cerner.com/*

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Number	Specification	*Comments*
I4	Clinician Staff Credentialing & Privileging Support	The Cerner system allows for simple entry, updating, and tracking of current and historical credential types, effective dates, license number, and comments, along with any payer specific identifiers assigned to a provider. Standard reporting capabilities can be used to identify those professionals whose licenses will be expiring within a given timeframe. Credential types are an option when establishing conditions in which to bill an encounter within the billing modalities table for covered service. This provides a mechanism for the billing algorithm to establish a different procedure code/modifier or rate based on the credentials of the care provider rendering the encounter.
J1	Internal Staff Alert & Messaging System	Cerner's internal Message Center will facilitate communication across your organization that is related to patient care or associated to the organization. Additionally, the message center inbox streamlines communication between care providers with secure messaging capabilities and immediate access to important new information such as referrals, consults, new results, and pending documents and orders. Integration with Exchange/Outlook messaging systems is not offered or recommended because it does not meet HIPAA patient confidentiality guidelines. We offer secure messaging through our Message Center for internal communications. Cerner also offers email messaging through CernerDirect. Cerner Direct is an encrypted Internet email channel based on Direct Project standards that enable ad hoc communication between authorized physicians, healthcare systems and patients within and across communities.
J2	Voice Recognition Software & Transcription Support	Cerner is tightly integrated with Nuance Dragon Medical One to allow provider to launch both applications simultaneously and use voice recognition to dictate directly into the client's medical record. Additionally, Cerner's provider mobility solution has embedded Nuance technology to allow providers to dictate into the client's record using their mobile device. We also support back-end transcription through an HL7 interface with your preferred transcription service. The solution, Nuance Dragon Medical One is not included within Cerner's proposal. If TCMHA has not already licensed, we can work with your organization to acquire. Additional costs may apply.

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Number	Specification	*Comments*
J3	Consumer/Family /Network Provider Portals	Our patient portal enables patients to view their personal health information, collaborate with their providers, and manage their health using both desktop and mobile devices. The unique integration between our patient portal and EHR supports patient engagement by empowering patients to engage with their care team and integrating these engagement points into your providers' and support staff's primary workflows. Patient can securely message providers, view and request appointments, view their visit summaries and clinical information, complete assessments, and access additional education and resources. Within our patient portal, the personal health record allows the patient to see a consolidated view of their health information. The patient can access and manage allergies, immunizations, medications, procedures, health issues, lab results, family history, documents, and education. Patient can also download Continuity of Care Documents (CCD) and Transition of Care Documents. Patients can identify individuals for proxy access to their patient portal, such as a family member or caretaker. At an organizational level, you have the ability to determine the information that is viewable by the proxy. In addition, Cerner enables the patient to mark messages as private which hides the message and all related messages from the proxy. Cerner's patient portal also includes the option for Video Visits. The embedded video-visit workflow within EHR minimizes dual scheduling and provides easy access for both the Client and Care Provider. The Client has immediate access to their virtual-visit through their Web-Portal via a PC, tablet, or smart phone, while the Care Provider can video on their side all while directly documenting in the Client's chart simultaneously. Video-visits are offered on a per-visit basis and not currently included in the scope of this proposal. Cerner welcomes further conversation if TCMHA would like to add this functionality and integrated workflows.
J4	HIE of Service Request Info for LACDMH	Through web service technology Service Request Log data is exchanged electronically between the Cerner EHR product and IBHIS. SRL Service supports the following operations to facilitate SRL data exchange with LA County DMH/IBHIS: • Search Service Request • Get Service Request • Add Service Request • Update Service Request • Delete Service Request

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Number	Specification	*Comments*
J5	HIE of CANS & PSC-35 with LACDMH	Through web service technology Early and Periodic Screening, Diagnostic and Treatment (EPSDT) data is exchanged electronically between the Cerner EHR product and IBHIS. EPSDT Service supports the following operations to facilitate EPSDT data exchange with LA County DMH/IBHIS: • Search CANs • Add CANS • Get CANS • Update CANS • Delete CANS • Search PSC EPSDT Service • Add PSC • Get PSC • Update PSC • Delete PSC
J6	System Audit Trail/Track and Report	Cerner Millennium stores clinical history data in the patient record. Access audit data to the patient record is stored in our secure audit repository. All clinical events create new rows in the activity tables preventing loss of health care data. Each state change on the clinical event data creates a record of the user, the time and the state change. In addition to event logging, Cerner Millennium logs critical events in the security and access domains. The audit logging solution provides the foundation and context to demonstrate audit-ability, policy accountability, and continual improvement. It provides internal auditing and routine monitoring, supporting your needs for enforcing policy regarding information security and privacy. Our auditing solution supports the ability to audit access to the patient record and enables incident management through alerting and notification and definition of specific rules for monitoring suspected abuse, providing a proactive approach to safeguarding confidential data. What records were accessed, date, time, by whom, and actions that were done Cerner's auditing solution tracks and logs all activity in a patient record, including access and the specific activity performed. Each time a user performs an inquiry or transaction, the application will automatically date, time, and signature stamp that user's access code. Through this feature, a complete audit trail is made available. What fields were modified, date, time, by whom, and the changes made Cerner's auditing solution was designed to enable the audit of user actions as patient-identifiable information is accessed. This information includes data identifying the user, the patient, the context of the access, and the actions performed to the patient data, including actions that create, verify, view, modify, complete amend\error correct, and print patient information.

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Number	Specification	*Comments*
J7	Client and Services Information (CSI)	Through web service technology Client Service data is exchanged electronically between the Cerner EHR product and IBHIS. The Client Service data includes CSI data that LA County DMH shares with the California Depart of Mental Health. Client Service - Service supports the following CSI operations to facilitate Client Service - CSI data exchange with LA County DMH/IBHIS: • AddCSI • SearchCSI • GetCSI • UpdateCSI • DeleteCSI Cerner does provide separate reporting functionality for California providers that do not report to LA County IBHIS, so they are in compliance to the California Department of Mental Health (DMH) that requires County MHP's to report demographic, periodic, and service information on Mental Health clients to the Client and Service Information (CSI) System. This functionality includes a utility to process the Client, Periodic, Service, Assessment, and Key Change records and generate the CSI Transmittal file. The CSI Utility generates only one CSI Transmittal file per reporting Month and Year the clients will upload to the California DMH - CSI system. The CSI functionality provides a means for the County Client Number (CCN) of each consumer, which is usually the consumer's case number in the CICBH product.

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EXHIBIT B

BUSINESS ASSOCIATE AGREEMENT

This BUSINESS ASSOCIATE AGREEMENT ("**BAA**") is made as of this 17 day of June, 2021 (the "**Effective Date**") by and between TRI-CITY MENTAL HEALTH AUTHORITY, a Covered Entity ("**Covered Entity**" or "**CE**") and CERNER CORPORATION ("**Business Associate**" or "**BA**") (each a "**party**" and, collectively, the "**parties**").

RECITALS

A. CE is a "covered entity" under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("**HIPAA**") and, as such, must enter into so-called "business associate" contracts with certain contractors that may have access to certain protected health information.

B. Pursuant to the terms of one or more agreements between the parties, whether oral or in writing, (collectively, the "**Agreement**"), BA shall provide certain services to CE. To facilitate BA's provision of such services, CE wishes to disclose certain information to BA, some of which may constitute Protected Health Information ("**PHI**") (defined below).

C. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the Agreement in compliance with HIPAA, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("**HITECH Act**"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("**HIPAA Regulations**") and other applicable laws, including without limitation state patient privacy laws (including, to the extent applicable, the Lanterman-Petris-Short Act), as such laws may be amended from time to time.

D. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI (defined below), as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("**C.F.R.**") and contained in this BAA.

NOW, THEREFORE, in consideration of the mutual promises below and the exchange of information pursuant to this BAA, CE and BA agree as follows:

AGREEMENT

I. Definitions.

A. Breach shall have the meaning given to such term under 42 U.S.C. § 17921(1) and 45 C.F.R. § 164.402.

B. **Business Associate** shall have the meaning given to such term under 42 U.S.C. § 17921 and 45 C.F.R. § 160.103 and for the purposes of this BAA shall mean Cerner Corporation.

C. **Covered Entity** shall have the meaning given to such term under 45 C.F.R. § 160.103 and for the purposes of this BAA shall mean Tri-City Mental Health Authority.

D. **Data Aggregation** shall have the meaning given to such term under 45 C.F.R. § 164.501.

E. **Designated Record Set** shall have the meaning given to such term 45 C.F.R. § 164.501.

F. **Electronic Protected Health Information** or **EPHI** means Protected Health Information that is maintained in or transmitted by electronic media.

G. **Electronic Health Record** shall have the meaning given to such term under 42 U.S.C. § 17921(5).

H. **Health Care Operations** shall have the meaning given to such term under 45 C.F.R. § 164.501.

I. **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

J. **Protected Health Information** or **PHI** means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under 45 C.F.R. § 160.103. Protected Health Information includes Electronic Protected Health Information.

K. **Protected Information** shall mean PHI provided by CE to BA or created or received by BA on CE's behalf.

L. **Security Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

M. **Subcontractor** shall mean a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate, pursuant to 45 C.F.R. § 160.103.

N. **Unsecured PHI** shall have the meaning given to such term under 42 U.S.C. § 17932(h), 45 C.F.R. § 164.402 and guidance issued pursuant to the HITECH Act including, but not limited to that issued on April 17, 2009 and published in 74 Federal Register 19006 (April 27, 2009), by the Secretary of the U.S. Department of Health and Human Services ("**Secretary**").

II. Obligations of Business Associate.

A. **Permitted Access, Use or Disclosure.** BA shall neither permit the unauthorized or unlawful access to, nor use or disclose, PHI other than as permitted or required by the

Agreement, this BAA, or as required by law, including but not limited to the Privacy Rule. To the extent that BA carries out CE's obligations under the Privacy Rule, BA shall comply with the requirements of the Privacy Rule that apply to CE in the performance of such obligations. Except as otherwise limited in the Agreement, this BAA, or the Privacy Rule or Security Rule, BA may access, use, or disclose PHI (i) to perform its services as specified in the Agreement; and (ii) for the proper management and administration of BA or to carry out BA's legal responsibilities, provided that such access, use, or disclosure would not violate HIPAA, the HITECH Act, the HIPAA Regulations, or applicable state law. If BA discloses Protected Information to a third party, BA must obtain, prior to making any such disclosure, (i) reasonable assurances from such third party that such Protected Information will be held confidential as provided pursuant to this BAA and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and (ii) agreement from such third party to notify BA of any Breaches of confidentiality of the Protected Information, to the extent it has obtained knowledge of such Breach.

B. Prohibited Uses and Disclosures. Notwithstanding any other provision in this BAA, BA shall comply with the following requirements: (i) BA shall not use or disclose Protected Information for fundraising or marketing purposes, except as provided under the Agreement and consistent with the requirements of the HITECH Act, the HIPAA Regulations, and applicable state law, including but not limited to 42 U.S.C. § 17936, 45 C.F.R. § 164.508, and 45 C.F.R. § 164.514(f); (ii) BA shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates, 42 U.S.C. § 17935(a); 45 C.F.R. § 164.522(a) and CE has provided information around such restrictions to BA; (iii) BA shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. § 17935(d)(2); 45 C.F.R. § 164.502(a)(5); however, this prohibition shall not affect payment by CE to BA for services provided pursuant to the Agreement; and (iv) when performing services as specified in the Agreement, such access, use or disclosure will not violate HIPAA, the HITECH Act, the HIPAA Regulations or applicable state law if done or maintained by CE.

C. Appropriate Safeguards. BA shall comply, where applicable, with the HIPAA Security Rule, including but not limited to 45 C.F.R. §§ 164.308, 164.310, and 164.312 and the policies and procedures and documentation requirements set forth in 45 C.F.R. § 164.316, and shall implement appropriate safeguards designed to prevent the access, use or disclosure of Protected Information other than as permitted by the Agreement or this BAA. BA shall use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of EPHI.

D. Reporting of Improper Access, Use, or Disclosure.

1. Generally. BA shall provide an initial telephone report to CE's Compliance Contact within five (5) business days of any breach of security, or unauthorized access, use, or disclosure of PHI of which BA becomes aware and/or any access, use, or disclosure of PHI in violation of the Agreement, this BAA, or any applicable federal or state laws or regulations, including, for the avoidance of doubt, any Security Incident (as defined in 45 C.F.R. § 164.304) provided, however, that the Parties acknowledge and agree that this Section constitutes notice by BA to CE of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below). "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on BA's firewall, port scans, unsuccessful log-on

attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI.

BA shall take (i) prompt corrective action to cure any deficiencies in its policies and procedures that may have led to the incident, and (ii) any action pertaining to such unauthorized access, use, or disclosure required of BA by applicable federal and state laws and regulations.

2. Breaches of Unsecured PHI. Without limiting the generality of the reporting requirements set forth in Section D(1), BA shall report to CE any use or disclosure of the information not permitted by this BAA, including any Breach of Unsecured PHI pursuant to 45 C.F.R. § 164.410. Following the discovery of any Breach of Unsecured PHI, BA shall notify CE in writing of such Breach without unreasonable delay and in no case later than five (5) business days after discovery. The notice shall include the following information if known (or can be reasonably obtained) by BA: (i) contact information for the individuals who were or who may have been impacted by the Breach (*e.g.*, first and last name, mailing address, street address, phone number, email address); (ii) a brief description of the circumstances of the Breach, including the date of the Breach and date of discovery (as defined in 42 U.S.C. § 17932(c)); (iii) a description of the types of Unsecured PHI involved in the Breach (*e.g.*, names, social security numbers, date of birth, addresses, account numbers of any type, disability codes, diagnostic and/or billing codes and similar information); (iv) a brief description of what the BA has done or is doing to investigate the Breach and to mitigate harm to the individuals impacted by the Breach; (v) any other available information that CE is required to include in notification to the individual under 45 C.F.R. § 164.404.

3. Mitigation. BA shall establish and maintain safeguards to mitigate, to the extent practicable, any deleterious effects known to BA of any unauthorized or unlawful access or use or disclosure of PHI not authorized by the Agreement, this BAA, or applicable federal or state laws or regulations; provided, however, that such mitigation efforts by BA shall not require BA to bear the costs of notifying individuals impacted by such unauthorized or unlawful access, use, or disclosure of PHI, unless (i) otherwise agreed in writing by the parties, (2) BA bears responsibility for the unauthorized or unlawful access or use or disclosure of PHI, or (3) required by applicable federal or state laws or regulations; provided, further, however, that BA shall remain fully responsible for all aspects of its reporting duties to CE under Section D(1) and Section D(2).

E. Business Associate's Subcontractors and Agents. BA shall ensure that any agents or Subcontractors to whom it provides Protected Information agree to the same restrictions and conditions that apply to BA with respect to such PHI. To the extent that BA creates, maintains, receives or transmits EPHI on behalf of the CE, BA shall ensure that any of BA's agents or Subcontractors to whom it provides Protected Information agree to implement the safeguards required by Section C above with respect to such EPHI.

F. Access to Protected Information. To the extent BA maintains a Designated Record Set on behalf of the CE, BA shall make Protected Information maintained by BA or its agents or Subcontractors in Designated Record Sets available to CE for inspection and copying within ten (10) days of a request by CE to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.524. If BA maintains an Electronic Health Record, BA shall provide such information in electronic format to enable CE to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. § 17935(e).

G. Amendment of PHI. To the extent BA maintains a Designated Record Set on behalf of CE, within ten (10) days of receipt of a request from the CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA or its agents or Subcontractors shall make PHI available to CE so that CE may make any amendments that CE directs or agrees to in accordance with the Privacy Rule.

H. Accounting Rights. Within ten (10) days of notice by CE of a request for an accounting of disclosures of Protected Information, BA and its agents or Subcontractors shall make available to CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.528, and its obligations under the HITECH Act, including but not limited to 42 U.S.C. § 17935(c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or Subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment, or health care operations purposes are required to be collected and maintained for three (3) years prior to the request, but only to the extent BA maintains an electronic health record and is subject to this requirement under the Privacy Rule. At a minimum, the information collected and maintained shall include, to the extent known to BA: (i) the date of the disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. The accounting must be provided without cost to the individual or the requesting party if it is the first accounting requested by such individual within any twelve (12) month period. For subsequent accountings within a twelve (12) month period, BA may charge the individual or party requesting the accounting a reasonable cost-based fee in responding to the request, to the extent permitted by applicable law, so long as BA informs the individual or requesting party in advance of the fee and the individual or requesting party is afforded an opportunity to withdraw or modify the request. BA shall notify CE within five (5) business days of receipt of any request by an individual or other requesting party for an accounting of disclosures. The provisions of this Section H shall survive the termination of this BAA.

I. Governmental Access to Records. BA shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to CE and to the Secretary for purposes of determining BA's compliance with the Privacy Rule. BA shall promptly notify CE of any requests made by the Secretary and provide CE with copies of any documents produced in response to such request.

J. Minimum Necessary. BA (and its agents or Subcontractors) shall request, use, and disclose only the minimum amount of Protected Information necessary to accomplish the purpose of the request, use, or disclosure. Because the definition of "minimum necessary" is in flux, BA shall keep itself informed of guidance issued by the Secretary with respect to what constitutes "minimum necessary."

K. Permissible Requests by Covered Entity. CE shall not request BA to use or disclose PHI in any manner that would not be permissible under HIPAA or the HITECH Act if done by CE or BA. CE shall not direct BA to act in a manner that would not be compliant with the Security Rule, the Privacy Rule, or the HITECH Act.

L. Breach Pattern or Practice. If CE knows of a pattern of activity or practice of the BA that constitutes a material breach or violation of BA's obligations under this BAA or other arrangement, CE must provide notice to BA and require that BA take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, CE must terminate the applicable Agreement to which the breach and/or violation relates if feasible. If BA knows of a pattern of activity or practice of an agent or Subcontractor that constitutes a material breach or violation of the agent or Subcontractor's obligations under its BAA or other arrangement with BA, BA must provide notice to Subcontractor and require that Subcontractor take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, BA must terminate the applicable agreement to which the breach and/or violation relates if feasible.

III. Indemnification; Limitation of Liability.

A. To the extent permitted by law, BA shall indemnify, defend and hold harmless CE from any and all liability, claim, lawsuit, injury, loss, expense or damage resulting from any third party claims or enforcement actions due to any unauthorized access, use or disclosure of Protected Information, to the extent such third party claims are relating to the negligent acts or omissions of BA or its agents, Subcontractors or employees in connection with the representations, duties and obligations of BA under this Agreement. Any limitation of liability contained in the applicable Agreement shall not apply to the indemnification requirement of this provision. This provision shall survive the termination of this BAA.

B. In the event that a Breach is identified for which individual or public notification is required and to the extent that the requirement for notification is due to the negligent acts or omissions of BA, its subcontractors or agents, BA shall be responsible for the reasonable costs incurred by CE to meet all federal and state legal and regulatory disclosure and notification requirements including but not limited to costs for investigation, risk analysis, any required individual or public notification and other mutually agreed mitigation activities.

IV. Business Associate's Insurance.

BA shall obtain insurance for itself and all its employees, agents and independent contractors in an amount not less than One Million Dollars ($1,000,000) per occurrence and Two Million Dollars ($2,000,000) annual aggregate of Commercial General Liability insurance and Two Million Dollars ($2,000,000) per occurrence and Four Million Dollars ($4,000,000) annual aggregate of Errors and Omissions insurance. The Errors and Omissions insurance shall cover, among other things, Breaches. If the general liability or the errors and omissions insurance do not cover, among other things, Breaches, Business Associate should also carry Two Million Dollars ($2,000,000) per occurrence and Four Million Dollars ($4,000,000) annual aggregate of Cyber/Privacy insurance that covers, among other things, Breaches. BA shall provide CE with certificates of insurance or other written evidence of the insurance policy or policies required herein upon CE's request and execution of this BAA (or as shortly thereafter as is practicable) and thereafter at CE's request as of each annual renewal of such insurance policies during the period of such coverage.

Further, in the event of any modification, termination, expiration, non-renewal or cancellation of any of such insurance policies, BA shall give written notice thereof to CE not more than thirty (30) days following BA's receipt of such notification. If BA fails to procure, maintain or pay for the insurance required under this section, such failure will be a considered a breach of this BAA as stated in Section II.L. and V.B.

V. Term and Termination.

A. Term. The term of this BAA shall be effective as of the Effective Date and shall terminate when all of the PHI provided by CE to BA, or created or received by BA on behalf of CE, is destroyed or returned to CE.

B. Termination.

1. Material Breach by BA. Upon any material breach of this BAA by BA, CE shall provide BA with written notice of such breach and such breach shall be cured by BA within thirty (30) business days of such notice. If such breach is not cured within such time period, CE may immediately terminate this BAA and the applicable Agreement.

2. Effect of Termination. Upon termination of any of the agreements comprising the Agreement for any reason, BA shall, if feasible, return or destroy all PHI relating to such agreements that BA or its agents or Subcontractors still maintain in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, BA shall continue to extend the protections of this BAA to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible.

VI. Assistance in Litigation.

BA shall make itself and any subcontractors, employees or agents assisting BA in the performance of its obligations under the Agreements or this BAA available to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its shareholders, directors, officers, agents or employees based upon a claim of violation of HIPAA, the HITECH Act, or other laws related to security and privacy, except where BA or its subcontractor, employee or agent is named as an adverse party.

VII. Compliance with State Law.

Nothing in this BAA shall be construed to require BA to use or disclose Protected Information without a written authorization from an individual who is a subject of the Protected Information, or without written authorization from any other person, where such authorization would be required under state law for such use or disclosure.

VIII. Compliance with 42 C.F.R. Part 2.

CE is also subject to the Confidentiality of Alcohol and Drug Abuse Patient Records regulations, 42 C.F.R. Part 2, which requires certain programs to enter into contracts with qualified service organizations (as defined in 42 C.F.R. § 2.11) that may have access to certain patient medical information. BA acknowledges that in receiving, storing, processing, or otherwise dealing with any Records (as defined in 42 C.F.R. Part 2) from CE, BA is fully bound by 42 C.F.R. Part 2. BA agrees to resist in judicial proceedings any efforts to obtain access to patient records except as

permitted by 42 C.F.R. Part 2. To the extent any provisions of 42 C.F.R. Part 2 restricting disclosure of Records are more protective of privacy rights than the provisions of this BAA, HIPAA, the HITECH Act, or other applicable laws, 42 C.F.R. Part 2 controls.

CE acknowledges and agrees that BA relies on CE to identify all Protected Information that is subject to 42 CFR Part 2 and that BA is unable to itself distinguish between 42 CFR Part 2 data and other Protected Information that it uses, discloses, maintains, or transmits on behalf of CE. As such, CE agrees that it is CE's obligation to notify BA when Protected Information is protected by 42 CFR Part 2. CE further agrees to adopt and use appropriate filters and firewalls to prevent the wrongful disclosure of such information within the BA's technology. BA shall not be responsible for any use or disclosure of any information in violation of this section to the extent that BA was not made aware that the information should be protected by 42 CFR Part 2 or to the extent that CE failed to properly filter, segregate or partition such Protected Information. The parties shall mutually agree, in writing, as to how such records should be marked, or BA otherwise notified, so that BA is aware that 42 CFR Part 2 applies.

IX. Amendment to Comply with Law.

Because state and federal laws relating to data security and privacy are rapidly evolving, amendment of the Agreement or this BAA may be required to provide for procedures to ensure compliance with such developments. BA and CE shall take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule and other applicable laws relating to the security or confidentiality of PHI. BA shall provide to CE satisfactory written assurance that BA will adequately safeguard all PHI. Upon the request of either party, the other party shall promptly enter into negotiations concerning the terms of an amendment to this BAA embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule or other applicable laws. Either party's failure to negotiate in good faith any such amendment will be considered a breach of this BAA.

X. No Third-Party Beneficiaries.

Nothing express or implied in the Agreement or this BAA is intended to confer, nor shall anything herein confer upon any person other than CE, BA and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

XI. Notices.

All notices hereunder shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, or deposited with the overnight courier addressed as follows:

If to CE: Tri-City Mental Health Authority
1717 N. Indian Hill Blvd., Suite B
Claremont, CA 91711
Attn: Privacy Officer

If to BA: Cerner Corporation

2800 Rockcreek Parkway
Kansas City, MO 64117, United States
Telephone: (816) 221-1024
Attn: Chief Privacy Officer

With a copy to:

Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067
Attn: Linda Kollar, Esq.
Fax: 310-551-8181

or to such other persons or places as either party may from time to time designate by written notice to the other.

XII. Interpretation.

The provisions of this BAA shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provision in this BAA. This BAA and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. Any ambiguity in this BAA shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. Except as specifically required to implement the purposes of this BAA, or to the extent inconsistent with this BAA, all other terms of the Agreement shall remain in force and effect.

XIII. Entire Agreement of the Parties.

This BAA supersedes any and all prior and contemporaneous business associate agreements or addenda between the parties and constitutes the final and entire agreement between the parties hereto with respect to the subject matter hereof. Each party to this BAA acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, with respect to the subject matter hereof, have been made by either party, or by anyone acting on behalf of either party, which are not embodied herein. No other agreement, statement or promise, with respect to the subject matter hereof, not contained in this BAA shall be valid or binding.

XIV. Regulatory References.

A reference in this BAA to a section of regulations means the section as in effect or as amended, and for which compliance is required.

XV. Counterparts.

This BAA may be executed in one or more counterparts, each of which shall be deemed to be an original, and all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the parties hereto have duly executed this BAA as of the BAA Effective Date.

AGREED AND ACCEPTED:

Tri-City Mental Health Authority ______________________ ______________________

Name of Covered Entity	**Name of Business Associate**
Authorized Signature	**Authorized Signature**
Antonette Navarro	
Print Name	**Print Name**
Executive Director	
Print Title	**Print Title**
Date	**Date**

ATTACHMENT B

RFP COVER PAGE

Name of Person, Business or Organization:	Cerner Corporation
Type of Entity: (e.g. Sole-Proprietorship, Partnership, Corporation, Non-Profit, Public)	Corporation
Federal Tax ID Number:	43-1196944
Contact Person – Name	Angela Lee
Contact Person – Address	2800 Rockcreek Parkway North Kansas City, Missouri 64117
Contact Person – Phone Number (s)	(816) 446-1673
Contact Person – e-mail address	Angela.Lee@cerner.com

By signing this ***RFP Cover Page*** I hereby attest: that I have read and understood all the terms listed in the RFP; that I am authorized to bind the listed entity to the agreement that the parties mutually agree upon, in light of the responses and exceptions from the listed entity; and that should this proposal be accepted, I am authorized and able to secure the resources required to deliver against all terms listed within the RFP as published by TCMHA, including any amendments or addenda thereto except as explicitly noted or revised in my submitted proposal, in accordance with the agreement that the parties mutually agree upon as described above.

PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE

Marc E. Elkins, Assistant Secretary

SIGNATURE OF AUTHORIZED REPRESENTATIVE **DATE**

_______________________ 9/23/2020

ATTACHMENT 4-C

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Cerner Corporation Soc3 Report

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Cerner Integrated-Community Behavioral Health Flyer

Cerner Integrated-Behavioral Health Implementation Overview

Cerner Workstation Requirements

Chelsea Hodges Resume

Jennifer Patton Resume

Natalie Boyd Resume

Tamika Barnette Resume

TCMHA Cerner Services Agreement

Terri Hammer Resume

Zach Clouston Resume

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September 30, 2020

Tri-City Mental Health Authority
1717 N. Indian Hill Blvd, Suite B
Claremont, CA 91711
Attn: JPA Administrator/Clerk

Dear Ms. Wong:

Thank you for your interest in Cerner. Enclosed is our response to your Request for Proposal for an electronic health record software platform. This proposal will provide you with a comprehensive evaluation of Tri-City Mental Health Authority's (TCMHA) unique needs and objectives, along with an advised approach designed specifically for your organization to resolve these needs and better prepare you for the future.

TCMHA plays a critical role in its community. Its members provide direct care to its residents, lead initiatives to increase preventative care, improve social and emotional wellness, and combat the prevalence of behavioral health diagnoses. TCMHA touches the lives of every individual and family in the three cities, and the services they provide are more critical now than ever before.

Integration Across the Care Continuum

At Cerner, we work tirelessly to improve our communities. We are committed to improving the lives of those touched by every component of our solutions and services. As the industry shifts toward value-based care with an emphasis on population health, Cerner is dedicated to further enhancing our solutions to support comprehensive care across a variety of disciplines and venues.

To that end, we have designed our EHR to support care across the continuum. We recognize that behavioral health providers face unique challenges and regulatory requirements. Cerner is committed to delivering a research-based behavioral health solution that supports the needs of your expert clinicians. Developed on our powerful Millennium platform, our EHR is designed to fulfill the clinical needs and revenue cycle requirements of behavioral health along with additional services our client provide on a single platform; including primary care, long-term care, home health, and rehabilitation.

Additionally, we are propelling the industry forward by embedding intelligence into our solutions. We are excited to show you the power of our machine learning and automated tools designed to boost risk identification and prediction, improve care, and promote positive client outcomes.

Cerner Response

In this response, you will find a detailed description of our unified Behavioral Health EHR platform. Each section will include information specific to financials, delivery, technical considerations, and scope of the proposed implementation and partnership. Cerner's EHR is provided as a Software as a Service (SaaS). It boasts cutting edge behavioral health functionality, comprehensive client engagement tools (e.g., embedded telehealth functionality), interoperability, operational dashboards, and Cerner's nationally recognized remote hosting services. Our model leverages proven best practices to offer a standardized IT strategy, thus ensuring optimal outcomes and a predictive cost structure.

Cerner's Integrated Behavioral Health

Behavioral health and physical health are inextricably linked, as are the clinical services they require. Therefore, we believe that the data that supports behavioral and physical health care should be linked, as well. Cerner's Integrated Behavioral Health EHR is designed to empower health care providers and their patients to achieve a more optimal

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state of health and wellness. Our system encourages a holistic, data driven, preventative and supportive plan of care that is unique to each user and patient.

Cerner's Behavioral Health solution is ranked #1 in KLAS. We offer a unified EHR with multiple solutions and content packages designed to specifically support organizations like TCMHA. We specialize in the delivery of community-based behavioral health services.

Benefits and major features of the Cerner Integrated – Behavioral Health EHR:

- A unified EHR platform to support enhanced clinical workflows and documentation for the delivery of behavioral health (and other health disciplines)
- Enhanced Registration and Scheduling system to support client throughput
- A comprehensive Revenue Cycle and reporting engine to support community-based billing and state reporting
- Client engagement tools including a robust Patient Portal, Revenue Cycle Management, mobility tools such as Patient eSignature, and optional embedded video visits for your clients and providers enhancing your telehealth services
- Interactive dashboards to enable proactive monitoring of roles, venues, and conditions within an organization
- Cerner's remote hosting service providing predictable, uninterrupted connectivity, and world-class system support. Ranked #1 in KLAS for the past nine consecutive years
- Interoperability solutions providing tools for the secure sharing of information and messaging

Performance and the LightsOn Network

Our wide array of analytical tools enables Cerner users to assess system performance, usage, adoption, clinician productivity, and alignment to TCMHA's standards. With our LightsOn Network solution, clinicians and C-suite executives can review essential metrics vital to maximizing the impact of your EHR. We provide this analytical, cloud-based solution to bridge the gap between medical records software and network-wide ROI data needed to successfully impact your imperatives.

Conclusion

Cerner's commitment to continued growth with our Millennium behavioral health EHR is strong. Our applications are developed with the entire behavioral care team in mind. With Cerner, your clinicians will focus on the people in their care, not technology at their fingertips. An interoperable system will ease the sharing of essential data for providers to make the best decisions for the highest quality care. When combined with Cerner's successful track record with behavioral health organizations across the US, more specifically in California, the Cerner Integrated – Behavioral Health EHR offers innumerable tangible benefits. Aware of TCMHA's specific needs for the LA County/IBHIS integration, our partnership will ensure we are meeting the requirements of the state of California.

Together, Cerner and TCMHA will work hand in hand improve the quality of thousands of individuals and families you serve. We thank you for this opportunity. I hope you find this proposal to be responsive for your request, and I look forward to working with you as you enter the next stage of your selection process. In the meantime, please feel free to contact me at (816) 446-1673, or at *Angela.Lee@cerner.com* as you require additional information.

Sincerely,

Angela Lee
Senior Sales Executive
Cerner Corporation

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ATTACHMENT D

PROPOSER COMPANY WORK PROCESS INFORMATION

As part of proposal, Proposers are requested to provide detailed responses for the following:

Company Overview

Describe your company and what key qualifications you have to meet TCMHA's requirements. Ideally, this would also include information about the financial stability of your company. Please also include any relevant security certifications/audits, including the latest SSAE 16 Report/Letter (formerly known as SAS 70 SOC II).

Cerner was founded in 1979 by Neal Patterson, Cliff Illig, and Paul Gorup. In the early 1980s, Cerner delivered the first fully-automated, paperless clinical laboratory, and in the 1990s, we developed the first enterprise-wide EHR to automate the entire care process. Beginning in 2000, we ushered in an industry-leading set of capabilities around device integration. Today, Cerner is a leading U.S. supplier of health care information technology solutions that optimize clinical and financial outcomes. We offer the most comprehensive array of information software, as well as complementary hardware and devices directly from Cerner and as a reseller for third parties. In addition, we offer a broad range of services. These include implementation and training, remote hosting, operational management services, revenue cycle services, support and maintenance, health care data analysis, clinical process optimization, transaction processing, and Population Health services, including employer health centers, employee wellness programs, and third-party administrator services for employer-based health plans.

By incorporating evidenced-based assessments and scales along with a powerful toolset focused on the needs of providers in mental health and addictions settings, we have developed a comprehensive offering that not only assists with providing efficient and effective care, but also enables continuity across the care continuum. With this offering, we have been able to successfully deploy the Behavioral Health solution in a wide variety of settings. Currently the solution is being utilized for residential, acute, and outpatient settings for community-based care in correctional facilities, stand-alone mental health and addictions institutions, for developmental disability treatment, and has been adopted by large hospital systems as an integral part of their medical record. Cerner has 300 clients utilizing our Behavioral Health solutions. For the proposed Cerner Integrated SaaS model, Cerner is currently implementing at 26 locations with an additional 30+ contracted for the second half of 2020 and into 2021.

As a publicly-traded company, we have significant transparency, and our financial strength and history of success is well-documented. Over the past ten years, Cerner's revenue has grown 220% to $5.37 billion. In 2019 and the start of 2020, more than 130 client health systems signed with Cerner for the first time or recommitted their confidence in our company's vision for the future. Cerner experienced strong financial results for the full year 2019, and also announced significant initiatives highlighting Cerner's ability to deliver for clients across the continuum, while driving innovation across the industry.

Our strong commitment and vision for the future of healthcare continue to guide our large investments in research and development. Since our inception, we have invested over $8 billion in organic research and development, which is more than 15 percent of our total historical revenue. We have spent roughly $800 million in R&D in each of the past three years and anticipate maintaining that level of R&D spending through 2020. Our dedication to research and development is only one reason that in 2017 *Forbes* ranked Cerner as one of the top 100 "Most Innovative Companies in the World" across all industries for the sixth consecutive year.

Cerner's hosting services utilize ITIL, NIST-based standards for all infrastructure deployments. Cerner partners with various third parties to assist with ensuring operations are appropriate for providing health care hosting services. Routine audits conducted by external auditors provide confirmation of compliance of such standards. Please refer to our most recent Cerner Corporation Soc3 Report located in the Additional Reference Material section. If desired, additional compliance reports can be discussed with your Cerner Sales Executive, Angela Lee.

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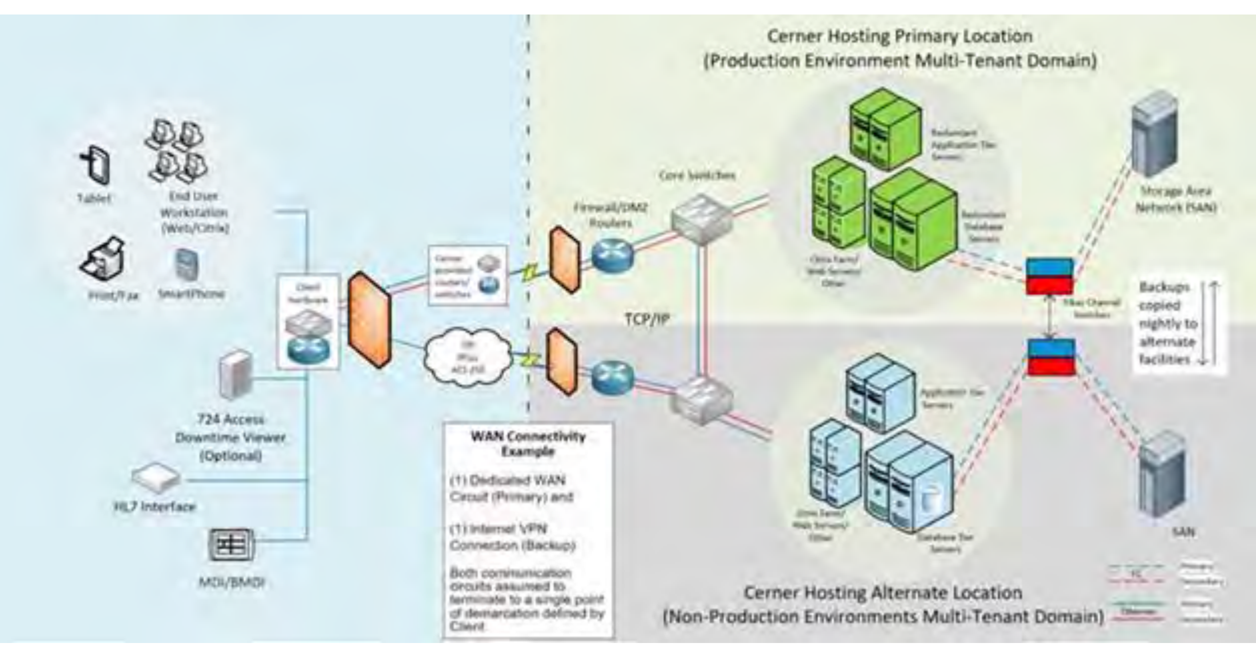
Technical Information & Infrastructure Requirements

TCMHA is looking for detailed technical information about your software solution as well as the infrastructure requirements needed to successfully deploy your application. Please detail the hardware, network, and communication infrastructure requirements needed to support your application as well as any other technical information you deem necessary to understand how to fully deploy and support your application.

Cerner's Integrated-Behavior Health offering is based on our shared cloud platform (SaaS offering). Cerner will be responsible for the hosting (including hardware, software, and licensure), design, implementation, maintenance, and upgrading of your system. TCMHA will be responsible for end user devices. Please refer to the Cerner Workstation Requirements document included in the Additional Reference Material section of this response.

For network connectivity, generally services require the implementation of either dedicated telecommunication circuits and/or a secure VPN connection for connecting into the remotely hosted services. Users will access the applications and data by communicating with Cerner via a secure, wide area network (WAN). Cerner uses Citrix for session management for most purposes for front end computing – Citrix enables compliant methods of session encryption leveraging TLS to protect patient data that is being accessed and presented within the end user session. If the data must be transmitted to another system, such as a foreign system interface, then typically a point to point encrypted VPN is used. Web application are supported via HTTPS (TLS) using 128-bit encryption. In addition, Cerner provides session configuration settings for securing the end user session and requiring a re-authentication to retrieve the abandoned session.



Cerner's hosting services are designed to provide the highest level of security for the hosting of PHI as required by HIPAA regulations. Cerner's security architecture utilizes guidance from the National Institute of Standards and Technology (NIST) (SP 800-53, Revision 4) cyber security framework with an overarching Information Security Management System (ISMS) based upon the International Organization for Standardization (ISO) ISO/IEC 27001 and ISO27002:2013 ("The Standard").

For our Cerner-Hosted systems, our clients own their data and TCMHA authorized staff have access to the system and its data, based on their role-based user privileges.

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All data is encrypted while in-transit and while at-rest. Data at rest "at the database level " encryption is realized through the use of National Institute of Standards and Technology (NIST) compliant encryption algorithms in storage arrays that connect via the SAN (256-bit encryption).

Please refer to the Cerner Workstation Requirements document located in the Additional Reference Material section.

In addition, our community behavioral health offering utilizes web service technology for exchanging several data points electronically with the LACDMH's Integrated Behavioral Health Information System (IBHIS). Cerner welcomes the opportunity to further discuss TCMHA's specific integration needs with LA County DMH/IBHIS.

Training, Implementation, Support, Data Conversion, & Software Upgrades

Describe your organization's typical approaches to training, implementation, support, data conversion, and software upgrades. Include the following detailed information in this section:

- **Provide a detailed description of your experience, ability, and process for data conversion from Welligent. Please include any known challenges and risks.**

Cerner has experience converting most commercially available systems in the market today to Cerner Millennium, including from the following vendors:

- Advantachart
- Advanced MD
- Athena
- Allscripts
- Amazing Charts
- Aprima
- Co-Path
- CPSI
- ChartLogic
- eClinicalWorks
- e-MD
- Epic
- Endoworks
- GE Centricty
- GEMMS
- Glostream
- Greenway
- Haemonetics
- IC Charts
- Intregrate
- Intergy
- Invision
- McKesson Practice Partners
- McKesson Horizon Clinicals
- McKesson Paragon
- McKesson HPF
- Medsys
- MEDHOST
- Medic
- Medent
- Meditech
- Millennium
- NextGen
- Orchard Labs
- Practice Velocity
- Soft Lab
- Sevocity
- Soarian Clinicals
- Soarian Financials
- SRS Soft
- Syngo
- Sunquest
- Varian Aria

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We anticipate no risks during data conversion. We will work with your organization to define an overall data migration and archive strategy representing all legacy systems impacted by providing professional service resources to assist your organization with loading of extracted data from legacy systems to new Cerner Millennium using Open Engine and CCL

- **The number of full-time equivalent (FTE) staff members you have in each of these operational areas.**

Cerner has over 300 associates in our Behavioral Health organization, and we have an additional 9,392 associates providing our training, support, and implementation services.

- **Information on a typical implementation services, including key tasks, timelines, and staff members involved both from your organization and the purchaser.**

Implementation Services:

Our unique implementation approach is provided at a fixed-fee and incorporated into every service we offer. Unlike many of our competitors, we include all the services (design, build, implement, and train) as part of our transparent pricing structure. Other vendors quote their software without the additional costs for third-party implementation and trainings. This is misleading and could result in project delay and cost overruns. With Cerner, all implementations are performed using our own healthcare consultancy, which is the largest in the world. Our clients are kept aware of project status, issues, and next steps through shared online tools. This ensures that any service you receive is aligned with your organizational imperatives and based on the recommended practices that are formulated from our extensive client community using our secure, disciplined, and predictable processes.

Additionally, our implementation methodology has been utilized by more than 700 clients, which equates to approximately 4,200 application projects across the globe. Over 93% of out-of-the-box Cerner standard recommended practices are adopted; 92% of our projects are on-time with fixed, predictable professional services fees; and 98% of our customers indicate they would work with us again.

Implementation Timeline:

Our Integrated-Behavioral Health EHR currently has a 10-month timeline from Kickoff to Go-Live, followed by a Post-Conversion Optimization that takes place 1-2 months after Go-Live.

Implementation Staffing:

Cerner will assemble an experienced, well-qualified team for your project who understands our system and processes to successfully complete your project. The team structure will be customized to meet your unique requirements and the scope, as well as your ability to staff the project. Prior to finalizing the contract, Cerner will work jointly with you to ensure that together we create a team with the necessary experience, insight, and professionalism. Project staffing will be finalized once project start dates have been confirmed.

Cerner's project team will include the following roles:

Leadership

Engagement Leader - The Engagement Leader is the project manager overseeing and directing the day-to-day activities of the project for the Cerner resources (including planning, scheduling, monitoring task completion and coordination with your resources on the project team). The Engagement Leader works to obtain the necessary resources to support the project and manage service delivery.

Services Operations Manager- The Services Operations Manager works with project leadership to understand project staffing requirements then develops project staffing plans and communicates assignments to project team

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associates. Responsibilities also include engaging third-party resources as required to deliver client projects, documenting and tracking all open and committed resources, and reporting on key metrics related to staffing and utilization.

Change Management

Clinical Consultant- The Clinical Consultant is the Cerner counterpart to your transformation coordinator who will work with your leaders to develop and implement strategies to manage the organizational change associated with adoption of new workflows and technology.

Adoption and Workflows

Core Consultant- The Core Consultant guides you through the design of clinical and business processes, solution and technology workflows, and the successful adoption that can lead to your achieved value. He or she will conduct super user training, will help identify opportunities for improvements, and is accountable for achieving the project's targeted outcomes.

Billing

Revenue Cycle Consultant - The Revenue Cycle Consultant will guide you through the design of the billing solution and technology workflows. He or she will conduct super user training, will help identify opportunities for improvements, and is accountable for achieving the project's targeted outcomes.

Registration

Registration and Scheduling Consultant - The Registration and Scheduling Consultant will guide you through the design of the registration and scheduling solution and technology workflows. He or she will conduct super user training, will help identify opportunities for improvements, and is accountable for achieving the project's targeted outcomes.

TCMHA's team should include the following roles:

Leadership Roles

Executive Leadership Team - Your executive leadership team commissions the project by allocating funds, providing ongoing support to the project sponsors, and setting clear direction and expectations at the project's onset. They also provide ongoing support for your project team.

IT Department

Technical Manager- The Technical Manager works closely with Cerner's technology resources as well as your other project leaders to ensure that platform strategy decisions and implementation activities are in harmony with the overall technical architecture.

Interface Manager - The Interface Manager is responsible for working with counterparts from Cerner and other suppliers to ensure effective and efficient system integration is accomplished.

Network Technician - The Network Technician focuses on primary support for network and microcomputer-based applications, maintains microcomputer systems and required applications for a dynamic set of users, and coordinates the interaction between users of these applications and the technical team. He/she also assists users in making effective use of these applications through training and problem solving. This is typically a Network Administrator or other member of the IT team who has knowledge of and management responsibilities for the network and ensuring connections are complete and stable.

Change Management

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Communications Coordinator - The Communications Coordinator works with the executive sponsor, key stakeholders, project manager and your other leaders to establish and maintain a communication plan to keep the organization aware of project updates. This role is most effective when aligned with a PMO or clinical operations team instead of the IT department.

Education/Learning Coordinator- The Education Coordinator will help develop your organization's training plan for End User Training in conjunction with project leadership. This role is typically held by a Staff Development Coordinator or other team member involved in the onboarding and training of new users.

Department Leaders

Specific Department Leaders - Clinical and operations leaders are director or manager level people who provide departmental support and guidance throughout the project.

This includes a leader from each of your departments using a Cerner solution, specifically nursing clinical and care team, physician clinical, pharmacy, registration and scheduling, HIM, patient accounting. Throughout the implementation, Cerner will create and propose implementation plans and workflows that your leaders will review and work through the revision and acceptance process.

Other

Super Users- Super Users are members of your staff and physicians with additional system and procedure training. They provide the first line of user assistance during and after activation of your new solutions, especially during evening, night and weekend shifts. Super Users participate in workflow and solution testing and contribute to your transition plan. They also help set a positive tone for the organizational change. Once your transition plan is complete, additional information regarding the selection, training and time commitments of super users is provided.

Help Desk - Help desk team members provide first line responses to questions, requests for services and system/equipment issues. They receive initial telephone calls from users and route callers to appropriate support personnel for questions, requests, or problems requiring a higher level of expertise or site visit to user's department. They keep logs of issues and report them.

Key Tasks:

For a description of key tasks, please refer to the Cerner Integrated-Behavioral Health Implementation Overview document located in the Additional Reference Material section.

- **The operations of your Help Desk, including information on 24/7 availability, how calls are prioritized, response times, whether the caller has routine access to live staff and all other information of interest to a customer.**

Our routine help desk provides support for issues that are non-critical in nature. Normal hours of support for routine issues are Monday through Friday 7 am to 7 pm Central Standard Time, exclusive of Cerner holidays and weekends. To contact this help desk, you may call or log a Service Request via our online ticketing system, eService. For urgent issues, our Immediate Response Center (IRC) is available by phone 24/7/365. Calls to both our routine help desk and our IRC will be answered by a live staff member.

Upon receiving a support call, Cerner will request an issue severity from TCMHA. This will help Cerner determine work priority by our engineering teams.

Our goal is to provide a resolution to all support calls at all severity levels. We measure our attainment through Service Level Objectives which align to every severity level:

- Technical & Application Support will strive to close 40% of Service Records within 24 hours.

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- Technical & Application Support will strive to close 65% of Service Records within 7 days.
- Technical & Application Support will strive to close 85% of Service Records within 30 days.

- **Information about User Groups.**

We have both Regional User Groups (RUGs) and Special Interest Groups (SIGS), including a SIG for Behavioral Health. These client-driven communities provide knowledge sharing as well as networking opportunities. We support the user groups with various administrative activities, including the use of our online networking tool, uCern Connect, and work with them to develop domain-specific sessions at the annual Cerner Health Conference.

- **Any other technical information you deem necessary to understand how to fully deploy and support your application.**

Our Integrated-Behavioral Health offering utilizes web service technology for exchanging several data points electronically with the LACDMH's Integrated Behavioral Health Information System (IBHIS). Cerner welcomes the opportunity to further discuss TCMHA's specific integration needs with LA County DMH/IBHIS.

- **Information about how customers are involved in the software enhancement decision process and how frequently upgrades occur.**

Since this is a shared domain, we have a change control process that is used to request a new workflow, modification to an existing workflow, or a change in build. These requests are evaluated on a regular basis for approval and prioritization. During implementation, TCMHA would engage the onsite consultant who would log a JIRA on your behalf. Post-implementation, TCMHA would call the support hotline, and Cerner would log an enhancement JIRA on your behalf.

In the Integrated Behavioral Health Model, upgrades occur at the following frequency:

- Major Release Upgrade: Annually
- Regular Service Packages: Monthly

- **How requests for customization of the software are handled.**

Our Integrated-Behavioral Health delivery model supports a robust catalog of content. Cerner will work with your organization to evaluate any custom requests and provide guidance to meet your needs. Cerner has developed the Model Experience, which is the foundation for this model. The Model Experience is the comprehensive approach to implementing Cerner solutions, workflows, and Cerner standards at your organization. Starting from the ground up with a comprehensive and concise domain, the Model Experience presents all of our standards and content within a controlled environment.

From this environment, the development of workflows and the latest capabilities are implemented to define standards. These Cerner standards, content, and configurations drive the creation of service lines that span the continuum of care, tailoring our solutions to meet the unique needs of specialties. As new content and workflows are developed and released, they are added to this standard domain to ensure that clients have the latest and most comprehensive content and workflows available.

Beyond changes coming from Cerner's standard Model Experience, Cerner can make client-specific configuration changes in a limited amount of solution areas. If additional changes are needed to meet unique workflows and business needs, clients can make requests for additional changes. These requests are reviewed and approved and made by Cerner whenever possible.

- **What are the hours and methods (phone, e-mail, web) of support for each type of technical support?**

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Technical support will be provided by Cerner's Remote Hosting Support (RHO) team. This team is available 24/7/365 for critical issues and will work to resolve issues at first pass. You may contact this team by phone, e-mail, or via a logged ticket through eService. If additional support is needed, the RHO team will engage our Immediate Response Center. Our Immediate Response Center (IRC) is available by phone 24/7/365.

Report Writing Capabilities

Please describe the report writing capability of your technology solutions, including a listing and description of standard reports, export capabilities, and compatibility with other applications, ease of use, etc. Specifically, TCMHA desires the following key elements in a report writer:

- **A report-writer interface that is comprehensive and easy to use, allowing reporting on all data elements in the system.**

Yes. Cerner's integrated offering provides an easy to use reporting tool that allows all discretely entered patient information, documented within the Cerner system, to be pulled into a report. The Cerner system empowers TCMHA with more than three hundred core standard reports as part of your Cerner Integrated Behavioral Health offering. These core reports cover the full gamut of your system's functions, including clinical, behavioral health-specific, billing, administrative functions, analytics, as well as regulatory reporting and more. Reports can be exported in a variety of formats, including CSV/Excel, text, and PDF.

Our integrated offering provides a variety of enterprise-wide reporting capabilities to meet the needs of TCMHA. This offering includes operational reporting, as well as analytics tools, that provide your authorized end users with access to data through our reporting portal. For organizations with the skills and desire to develop extracts or custom and ad hoc reports, additional reporting tool sets are available within the domain. Cerner provides a number of tools such as Discern Analytics 2.0 (DA2), SAP Business Objects, SQL Server Reporting Services (SSRS), and our new analytics dashboards (clinical, financial, and operational) leveraging the power of Tableau to provide a robust approach to securely meet your reporting needs.

Cerner has over thirty years of experience with community behavioral health, starting out in highly regulated states such as California, Texas, and New York; and continuing across most of the United States. We have more than forty-five California-based clients (thirty of which are community behavioral health clients). We maintain a team of regulatory and behavioral health experts on staff that automatically push out documentation tools necessary to support local, state, and federal regulatory changes. Through the implementation process, Cerner will work with TCMHA to evaluate any additional report template requirements or custom requests and provide guidance on how best to meet your needs.

For a listing of our current behavioral health-specific and patient accounting reports please refer to the Cerner Integrated-Community Behavioral Health – BH and Patient Accounting Reports document located in the Additional Reference Material section. A complete listing of all the included standard reports can be made available after contract signing.

- **Ability to write custom reports and write and use stored procedures.**

Yes. For organizations with the skills and desire to develop extracts or custom and ad hoc reports, reporting tool sets are available within the domain.

- **Data-warehouse and data mining capabilities.**

Cerner's integrated offering provides a variety of enterprise-wide reporting capabilities to meet your needs. This includes operational reporting that provides your end users with access to data through a reporting portal as well as a broader Enterprise Data Warehouse.

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For data mining capabilities and usage of our reporting portal, we give your end users the ability to develop extracts or custom and ad hoc reports. These are the building blocks for reporting that we see utilized on a daily basis and for operational purposes. Cerner provides a number of tools such as Discern Analytics 2.0 (DA2), SAP Business Objects, SQL Server Reporting Services (SSRS) and our new analytics dashboards (clinical, financial, and operational) leveraging the power of Tableau to provide a robust approach to securely meet your reporting needs in a shared environment.

Our data analytics reports, and dashboards are also specifically designed to support ongoing cost savings and revenue generation opportunity analyses. We've worked closely with our Behavioral Health clients to build out capabilities that support these efforts. We have leveraged their many years of experience to build out industry leading capabilities.

Outside the scope of this proposal, Cerner also offers HealtheEDW, our enterprise data warehouse capability, and HealtheAnalytics, our data analytics and services capability, which are built on HealtheIntent. More robust than traditional reporting, our analytics enables users to dynamically and easily interact with data through visualizations, rather than being limited by viewing static reports. This allows the user to quickly and easily go from a summary view at the population level to a very detailed view at the individual view within a dashboard.

Embedded within these tools are SAP Business Objects and Tableau. SAP BusinessObjects enables users to define their filters and quickly customize reports. Anyone with appropriate security access can create, run, and modify these reports. SAP BusinessObjects is a visual drag and drop interface to create queries. Users interact with a universe, which is a semantic layer shielding them from the complexity of a physical database structure. SAP BusinessObjects creates SQL queries based on the visual representation from the interface and supports creating and customizing SQL from within reports. Users can also put tables and graphs from different data sources into the same report.

Tableau supports data discovery and visualization (slicing and dicing) and allows users to interact with data versus having a static report (can handle 10M+ row data sets); typically used for quick prototyping and interactive data exploration. Capabilities include interactive data analytics to compare patient groups by payer, DRG, ICD, and additional attributes. Tableau is also used to visualize and analyze data, create workbooks, visualizations, dashboards, and stories. Users typically start with a large patient group and analyze subgroups to determine correlations between patient characteristics and outcomes such as cost and utilization.

Additionally, editing reports allows end-users to change report time dimensions, manipulate rows and columns, as well as setup and save personal preferences, and bookmarks. The tools are built to be intuitive and user-friendly, no matter the level of expertise. We embed “hover to discover” functionality where users can discover next steps in report modification by hovering their mouse. We also support the versioning of reports as modifications are made by users over time.

By developing comprehensive data warehousing and data integration capabilities for data to be shared across system boundaries, HealtheIntent can help to holistically manage populations and programs, craft interventions, evaluate the financial impact or health outcomes of policy changes and manage budgets. We designed HealtheIntent to provide greater information sharing, broader and easier access, enhanced data integration, provide timely insight, increased security and privacy, and strengthened query and analytic capability by building a unified data repository for reporting and analytics that leverage an industry-leading suite of reporting and business intelligence tools.

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- **A data dictionary and supporting documentation.**

HealtheIntent, Cerner's big data platform for reporting, analytics, and population management, reflects the importance of effective data governance. We ensure the management of the information assets entrusted to the solution and seamlessly integrate these with the management of other information components of the system. HealtheIntent utilizes the metadata management and repository solution as a reference resource as we refine and augment the information from all data sources. Data definitions are also exposed to provide a methodology for users. As data is received and used for analytic purposes, it comes with a data dictionary for data lineage and data transparency. This data dictionary is exposed to all users. We also house data dictionaries as a part of our help and reference files. We provide the data dictionary as a lookup in our analytics tools as well as provide the data models that make up the population record.

- **An extensive library of reports, with commonly used queries and sorts, which can be customized as needed by the customer.**

Yes. The reporting portal provides an extensive library, in a tab listing, of all the available reports and sorts. Authorized users can save their favorite reports for quick and easy access to frequently generated reports.

- **Ability to save and name report templates.**

Yes. Cerner’s reporting portal provides the ability for TCMHA’s authorized users to save and name favorite reports for quick and easy access to frequently generated reports.

Authorized users can create reports and formats for exports at regular intervals, run reports in batches, or schedule them as one-time queries. The generation, printing, and exporting of reports requires minimal training.

- **Ability to run reports in batches.**

Yes. TCMHA’s authorized users can run reports or report batches at scheduled regular time intervals or on demand.

- **Ability to run reports or report batches at scheduled times.**

Yes. Authorized users can run reports or report batches at scheduled regular time intervals or on demand.

- **Ability to support all state and other externally mandated reporting requirements for behavioral health and substance abuse agencies in all states in which TCMHA operates.**

Yes. The Cerner Integrated Behavioral Health EHR is well known throughout the industry for its robust community-based behavioral health billing and state reporting capabilities. Our system, with over thirty years of experience in the industry, started out in highly regulated states, including California, Texas, New York, and have a clients in a majority of the other states in the U.S.

Currently our behavioral health offering is being utilized in outpatient, residential, and inpatient/acute care settings for community-based care, state psychiatric hospitals, acute behavioral health hospitals, in correctional facilities and jails, state and county health departments, mental health and addiction treatment institutions, community outreach settings, case management, veterans/military care, crisis settings, for intellectual and developmental disability treatment, and has been adopted by large hospital systems as an integral part of their medical record.

We have long history of experience with our community behavioral healthcare clients in the state of California and maintain a team of regulatory and behavioral health experts that automatically push out documentation tools necessary to support local, state, and federal regulatory changes.

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- **Ability to create management information dashboards.**

Cerner's integrated offering combines tools such as Discern Analytics 2.0 (DA2), SAP Business Objects, SQL Server Reporting Services (SSRS), and our new analytics dashboards leveraging the power of Tableau to provide a robust approach to securely meet your reporting needs in a shared environment.

Additionally, Cerner's Integrated Behavioral Health delivery model supports a robust catalog of content, including interactive dashboards and task lists to enable proactive patient care as well as the monitoring of roles, venues, and conditions within your organization. TCMHA's staff will have access to different workflow-driven, interactive and organizer views based upon their role within your organization.

Below is a high-level description of some of our main dashboards:

- The system provides multiple interactive dashboards for your registration and scheduling departments.
- Cerner' system provides dashboards for patient tracking, bed tracking, and crisis.
- The system includes a referral view that captures inbound and outbound referrals.
- Our system includes a dynamic worklist for identifying subsets of patients and gathering relevant information, so action can be taken.
- The system provides dashboards for the behavioral healthcare provider, including a landing page with an interactive view of their calendar and message center.
- The behavioral health summary dashboard includes a multitude of interactive components to provide a snapshot view of a patient's journey toward better health.
- The behavioral health provider interactive workflow dashboard drives the workflow process of documentation, orders, assessment and treatment planning, progress notes, and more via a customizable, interactive navigation bar.
- The different role-based workflow organizer views provide patient list views with vital information, that allows hovering and/or a single click for more details as well as the ability to take action.
- The system includes our differentiating multi-person documentation (group therapy) dashboard.
- The system includes a mobile dashboard for 15 minute-checks and day program attendance.
- The clinician organizer dashboard provides clinicians with a face-up view of critical patient information including task tracking with automatic reminders giving the right information at the right time allowing the clinician to prioritize patient care and organize their day.
- The system provides a discharge summary workflow and view.
- The reporting portal is a dashboard that contains our included standard reports and reporting tools.
- The client/patient workspace dashboard is available for the billing department staff to leverage for reimbursement users, including tasks associated with reimbursement events.
- The clinical leader organizer dashboard presents an interactive dashboard that supports communication and coordination across the continuum of care as well as a comprehensive, high-level view of the patient data that clinical leaders need to be able to access quickly.

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- The Lights On dashboards include analytics capabilities to support decision making and provide transparency into your Cerner solutions.

- Our behavioral health analytics include dashboards for executive leadership, operations management/supervisors, clinical effectiveness/for clinical and quality leaders, as well as a clinician dashboard/for clinical staff.

- The CareTracker-DD module (available at a supplementary cost) provides multiple dashboards to assist in providing care for patients with intellectual and developmental disabilities. This tool contains a clinical intelligence engine that tracks, reviews, and summarizes documentation and flags potential problems. It can trend, compare, and analyze collected data to proactively monitor for changes in a patient's conditions such as vitals, weights, mood, and more.

Electronic Record Capability

Detail how your software solution will support the creation of electronic medical records as well as any other electronic data forms that TCMHA's requirements and how end users (versus you as the vendor) will be able to customize the electronic record. TCMHA is expecting to find a highly configurable system that supports its changing requirements for data collection and electronic case and medical records.

Cerner's Integrated Behavioral Health offering was designed to automate the workflow in a variety of outpatient, acute inpatient, community, and residential healthcare venues. Cerner has long history of experience with our community behavioral healthcare providers in the state of California and we maintain a team of regulatory and behavioral health experts that automatically push out documentation tools necessary to support local, state, and federal regulatory changes.

As part of the Cerner Integrated - Behavioral Health EHR offering, TCMHA is provided a robust catalog of standard workflows and content that includes industry-validated pre-defined assessment forms, flowsheets, and note templates. Over 180 behavioral health-specific standard scales and assessment forms are included to support your organization's documentation needs. Assessments display different questions and flex according to the client's age, gender, diagnosis, reason for visit, specialty, and location. We were recently awarded the Best in KLAS Category Leader award of Behavioral Health for 2020.

As part of your implementation, Cerner will work with TCMHA to evaluate any additional form template requirements or organization specific requests and provide guidance on how best to use the system to meet your needs. Your Cerner system is also localized to include facility/locations, staff, physicians, printer setup, frequencies–times, custom orders, treatment plans, and auto-text. Additionally, note templates can be personalized to include auto-text templates, free-text, embedded voice recognition, or a combination of these tools as well as meta tagging with footnotes. And, workflow dashboards and summary views can be personalized to fit each user's individual workflow.

For changes that require more global system type updates, such as access levels, assessment forms, note templates, orders, clinical charting, plans of care, reports, and advanced auto-text requests; TCMHA will work with their assigned Engagement Owner (Project Leader) to understand optimal workflows and best practice. Any desired deviations would be managed through Cerner's change governance process, both during implementation and after moving your system into production.

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Scanning, Document Management, & Record Release Capabilities

Detail how your software solution supports scanning and managing documents that are created by other parties so that they can be included in a case or medical record. Additionally, describe how the system supports releasing parts or all of the case or electronic records to other parties, both in paper and secure electronic formats.

The ability to scan documents, such as driver's license, insurance card, or portions of a person chart from another facility, is supported during registration processes, as well as any other stage of treatment.

Our solution supports a single document capture process. Single document capture is used for capturing directly into the patient's record and is completed within one-step. Images are available to other users immediately.

Our solution provides core tools to print a record. The ability to select specific encounters and time frames is available. In addition, faxing, secure email, CD, and storing to a directory for purposes such as removable devices (thumb drives) is supported.

Mobile Solutions

Detail how your software solution supports field and home-based service providers with mobile access to your software solutions. Additionally, please indicate whether you offer a "disconnected" or off-line mobile solution and describe its functionality and requirements.

We support Citrix technology for remote access over the Internet. Cerner network, information, and functionalities are accessible through the Citrix connection in the same fashion as on-site access. Cerner's system supports remote data entry, editing, viewing, and signing of reports and documentation via Citrix technologies. Our security model is role-based and does not prevent access based on location. Citrix connections provide full functionality of all our clinical applications regardless of the provider's physical location. For mobile access, TCMHA has the choice of iPad, iPhone, mobile computer, or tablet running on iOS or Android. Depending on the application set being used, a thin client implementation using Citrix or an application native to the device is used.

Cerner is constantly working to empower our clients with the mobility necessary to provide optimal care. We offer multiple time-saving mobility tools that afford that essential flexibility in providing care. The system does not currently support offline data entry. However, future functionality will support both clinic and community services with remote capabilities, so clinicians can complete their notes upon returning to the office or while in the community. Documentation includes fields to designate where the service was provided. It will include a disconnected workflow that enables the care team to document in the field (offline), then sync the device when they return to an area with Wi-Fi. There is no estimated general availability at this time as this application is still in development.

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Software Interface & Data Exchange Capabilities

Describe your organization's expertise in interfacing with common general ledger and human resource applications. Additionally, describe your experience in helping provider organizations share data with other providers and stakeholders (for example through regional health information organizations or similar provider data sharing). Note that TCMHA uses the following general ledger and human resources software applications:

The Cerner system manages transactional fiscal based activity with a distinct audit trail. The integrated offering is designed to follow accrual based, cash based, or modified methods of accounting. Separate AR, revenue, cash, contractual adjustment, unapplied payment, and write-off accounts can be established for booking the debits and credits depending on the type of activity. Reports, such as the Fiscal Journals Summary Report, can be leveraged to extract a standard data set of fiscal activity for use with some third party systems. While the Cerner offering is not fully integrated with a third party GL system, most clients find the ease of creating .csv files from the Cerner system and importing them directly into their GL products sufficient. Since system requirements vary from vendor to vendor, Cerner welcomes further discussion with TCMHA in our effort to better understand your specific needs related to interfacing with third party financial/HR systems. Additional fees might apply for building new interfaces.

Our message center streamlines communication between providers remotely, through a Citrix connection, with secure messaging capabilities and immediate access to important new information such as receiving new lab results, results to endorse, orders to be completed, orders to sign, documents to dictate, documents to sign, phone messages, forwarded documents, and referrals/consultations. Within the message center providers can also share patient needs with other providers internally (or externally through Cerner Direct if the external provider has a DirectTrust email). Any item in the message center directly related to a patient provides a direct link to the EHR (internal staff) allowing immediate access to the patient's chart, minimizing navigation and clicks required to analyze patient information. Providers can communicate with patients through our included patient portal via the message center, where patients can also view the labs and other health information.

All patient data resides on a single architecture rather than in disparate systems, which provides a holistic patient record and the ability for the clinicians and staff of TCMHA (with appropriate security) to have access to all clinically relevant patient data, including but not limited to appointments, allergies, lab results, and much more.

Cerner is leading the industry in setting the standard for interoperability, co-founding CommonWell Health Alliance with several competitors, we have advanced safe, nationwide vendor agnostic interoperability with EHR agnostic HIEs and Cerner specific HIEs to facilitate the sharing of information between local and regional organizations. The standard information we share is PAMI (Problems, Allergies, Medications, Immunizations) data and documents. We support the ability to exchange data, such as Continuity of Care Documents (CCDs/CCRs) with nearly any EHR vendor. Cerner enables patients to share their medical records with care providers by providing identity management, record locator, consent management, and trusted data access. We offer unprecedented connectivity to foreign systems with our open system design and HL-7 standard compliance. Cerner supports connectivity to CommonWell and Carequality enabled EHRs, as well as directly with a supplier or other data networks like your state HIE. This is not just a view of information, Cerner's system gives the provider the ability to view the data and reconcile it into the patient's medical record, creating a single source of truth.

For more information about our integrated offering, please refer to the Cerner Integrated-Community Behavioral Health Flyer and the Cerner-Integrated-Community Behavioral Health Overview documents located in the Additional Reference Materials.

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Experience in California

Deliver your organization's proven track record/past history with other county mental health, similar to TCMHA, of successful implementations in the California reporting to LACDMH (LA County Department of Mental Health - including support for this state's versions of electronic billing forms, interfaces with state systems, etc.

Cerner currently has forty-five behavioral health clients licensed in the state of California, thirty of which are community behavioral health clients. And, we have over fifteen years of experience with our behavioral health clients in the state of California. Our behavioral health offering is being utilized in outpatient, residential, and inpatient/acute care settings for community-based care, state psychiatric hospitals, acute behavioral health hospitals, in correctional facilities and jails, state and county health departments, mental health and addiction treatment institutions, community outreach settings, case management, veterans/military care, crisis settings, for intellectual and developmental disability treatment, and has been adopted by large hospital systems as an integral part of their medical record.

In August of 2014 we released the capability to communicate Admission, Update, and Discharge data to the LA County IBHIS system via the IBHIS web service functions, as well as the ability to query the IBHIS system so users can view the LA County data sets. We have the understanding of web service technology including, but not limited to, the open protocols and standards such as SOAP, WSDL, XSD, and more for exchanging data electronically between applications or systems. We also have a working knowledge of user authentication using x.509 certificates, PKI exchange, Certificate Authority, and third party validation authority. Cerner has been working with our clients that report to LA County IBHIS since the initial release to enhance the functionality to meet any new requirements announced by LACDMH for IBHIS reporting. We have been collaborating with our clients related to workflows, functionality design, testing with LACDMH IBHIS QA, and TEST systems prior to rolling out the functionality into a production environment.

(As previously discussed with TCMHA, Cerner is currently providing this integration utilizing our historic Cerner Community Behavioral Health EHR (Anasazi). However, this integration has not yet been brought forward to the proposed Cerner Integrated – Behavioral Health EHR. Cerner will work with TCMHA to complete this integration as part of the implementation process.)

We also support the LACDMH required Community Outreach Services (COS) – ASC X12 HIPAA 5010 837P Claiming, successfully stepping clients through claims certification testing scripts.

Plans for Compliance with Federal Standards for Meaningful Use and Electronic Health Records & Health Information Exchange (HIE)

Describe your organization's experience, current certifications, and plans to obtain certification and comply with the various Federal Standards for meaningful use of electronic health records and health information exchange.

Cerner offers solutions that have qualified for a variety of certifications, including some of the following:

- ISO 9001, 13485, and 27001
- 2015 Edition certifications for Eligible Hospitals and Eligible Providers/Clinicians that meet the Stage 3 use requirements
- CMS requirements for the use of Certified EHR Technology across Medicare EHR Incentive, Alternative Payment Model and Payment System regulatory and model program requirements

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- Application Program Interface (API) HL7-FHIR standards for patient/consumer access to their electronic health information using an application of their choice
- CAQH CORE and EHNAC for electronic payment information
- SOC 2 Type 2 Attested

Experience with Integration with Primary Care

Describe your organization's experience with aiding behavioral health providers with integrating with primary care providers through data exchange. Please provide any specific examples of customers who operate primary care services in addition to behavioral health services as well as those who are already collaborating and sharing data with primary care providers and facilities.

Cerner has a long-standing history with clients providing Behavioral Health and Primary Care services. Today we have over 300 clients using our Behavioral Health solutions, in addition to another 14,300 physician practices.

We believe it's important and beneficial to your clients to address both mental and physical wellbeing. We have been assisting our Clients provide these combined services for many years. One of our clients, Tropical Texas Behavioral Health has even been recognized by the National Council for Behavioral Health for their innovation of Primary Care and Behavioral Health services. (utilizing Cerner's Community Behavioral Health EHR) With the recent release of our Cerner Integrated – Behavioral Health EHR, we have taken even further strides in providing our Clients with a system that truly integrates care across the continuum. House on a single database and architecture, both Primary Care and Behavioral Health data and workflows would be accessible to care providers with appropriate security. We would welcome further conversations with TCMHA to understand their needs and vision the combined delivery or both Behavioral Health and Primary Care. (Primary Care is an optional Solution not currently included in this proposal; additional cost would apply)

Interoperability and the ability to share information is inherent to Cerner. Cerner is a co-founder of CommonWell Health Alliance and we have connected to Carequality to allow the ability to exchange data with connected providers across the country regardless of the EHR technology they are using. This level of connectivity is unparalleled in the market today and will allow your providers to know the patient before they walk in the door. The data exchange will include PAMPI (Problems, Allergies, Medications, Procedures, and Immunizations) data and documents. This is not a data dump, all data will be aggregated and normalized and then presented back into the care team's workflow to be reviewed and reconciled into the client's permanent record.

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ATTACHMENT A

SCOPE OF SERVICES

Software Functionality Summary Sheet

Instructions: In the **Proposer Response** column, place an X in the column to indicate whether or not the requested functionality is available in the software application in your current release to all customers. In the **Comment** column, circle Yes or No to indicate whether you have additional comments regarding this specification in the Functionality section of the RFP.

Number	Specification	*Cerner Response*		*Comment?*
		Yes	No	
A1	Standard & Program Specific Client Demographic Data	X		Yes (No)
A2	Alias & Previous Name Support	X		Yes (No)
A3	Consumer Photo	X		Yes (No)
A4	Required Form Generation & Tickler System	X		Yes (No)
A5	Admission, Transfers, & Discharge Information	X		Yes (No)
A6	Referral Tracking	X		(Yes) No
A7	Referral & Admission Notes	X		(Yes) No
A8	Support for Automatic Referral Letter & Fax Generation	X		(Yes) No
A9	Discharge Planning & Referral Tracking	X		(Yes) No
A10	Family & Relationship Tracking	X		Yes (No)
A11	DSM & ICD Diagnoses	X		(Yes) No

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Number	Specification	*Cerner Response*		*Comment?*
		Yes	**No**	
A12	Master Individual Service Plans	X		Yes **No**
A13	Care Provider Tracking	X		Yes **No**
A14	Client Electronic Signature	X		Yes **No**
A15	Staff Electronic Medical Record Signature Standard Compliance	X		Yes **No**
A16	Support for Multiple Signature Requirements & Progress Note Roll-Up	X		Yes **No**
A17	Decision-Support, Evidence-Based Practice (EBP), & Assessment Tools	X		Yes **No**
A18	Custom Assessment Tools	X		**Yes** No
A19	Customizable Progress, Telephone, & Shift Notes	X		**Yes** No
A20	Group Notes	X		**Yes** No
A21	Electronic Record Pre-population	X		Yes **No**
B1	Medication Monitoring	X		Yes **No**
B2	Medical Conditions & Metrics	X		Yes **No**
B3	Medication Administration Records	X		Yes **No**
B4	Injection Administration Data Tracking	X		**Yes** No
B5	Electronic Prescription Transmission	X		**Yes** No

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Number	Specification	*Cerner Response*		*Comment?*
		Yes	**No**	
B6	Tamper-Resistant Prescription Printing	X		**Yes** No
B7	Links to Medication Information & Drug Interaction & Contraindications	X		**Yes** No
B8	Prescription Refill Reminders	X		**Yes** No
B9	Laboratory Interface	X		**Yes** No
B10	Laboratory Result & Medical Condition Alerts	X		**Yes** No
B11	Formulary & Medication Pre-Certification Support	X		**Yes** No
B12	Drug Enforcement Administration (DEA) Federal Regulation Supports	X		**Yes** No
B13	Patient Medication Information/Handouts	X		**Yes** No
B14	Laboratory Orders Sets	X		**Yes** No
B15	Medical Supply Inventory Support		X	**Yes** No
C1	Assessment Tool Support	X		**Yes** No
C2	Decision-Support & Compliance for ASAM Criteria for Care	X		**Yes** No
C3	Random Appointment Scheduling for Urinalysis & Compliance Monitoring	X		**Yes** No
C4	Detoxification Vital Sign Tracking Support	X		Yes **No**

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Number	Specification	*Cerner Response*		*Comment?*
		Yes	**No**	
D1	Resource-Based Appointment Scheduler Capabilities	X		**Yes** No
D2	Group Scheduling Support	X		Yes **No**
D3	Front Desk Cash Application	X		Yes **No**
D4	Client Arrival Notification	X		Yes **No**
D5	Front Desk Client Financial Summary Information Access	X		Yes **No**
D6	Automatic Service Generation from Scheduler	X		Yes **No**
E1	Case Management Notifications	X		Yes **No**
E2	Employment Services Data Tracking & Consumer Matching		X	**Yes** No
E3	Consumer Employment History	X		**Yes** No
E4	Expanded Employment & Support Services Data Tracking	X		**Yes** No
E5	Prevention Program & Presentation Tracking	X		Yes **No**
F1	Alerts or "Tickler" Capabilities	X		**Yes** No
F2	Satisfaction & Outcomes Tracking & Analysis	X		Yes **No**
F3	Critical Incident & Other Required Reporting	X		**Yes** No
F4	Track Progress Note Compliance	X		Yes **No**

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Number	Specification	Cerner Response		Comment?
		Yes	No	
F5	Electronic Record Release	X		(Yes) No
F6	Record Release Tracking	X		(Yes) No
F7	Electronic Medical Record Document Routing & "Role Based Charting"	X		Yes (No)
F8	VIP Medical Records Protection	X		(Yes) No
F9	Tracking HIPAA & State Specific Medical Record Requirements	X		(Yes) No
F10	Accreditation Support	X		(Yes) No
F11	Enhanced Role-Based System Access Controls	X		(Yes) No
F12	EHR Document Version Control	X		(Yes) No
F13	EHR Archiving & Purge Capability	X		(Yes) No
G1	Extensive Call Tracking & Disposition Data	X		(Yes) No
G2	Referral Workflow Tracking	X		(Yes) No
G3	Pre-Admission Checklist Support	X		Yes (No)
G4	Waitlist Tracking	X		(Yes) No
H1	Client Payer & Service Authorization Data	X		Yes (No)
H2	Case Management & Service Authorization Management Supports	X		Yes (No)

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Number	Specification	*Cerner Response*		*Comment?*
		Yes	**No**	
H3	Client Service Entry	X		Yes (No)
H4	Pre-billing Edits	X		Yes (No)
H5	Client Fee-For-Service, Per Diem, & Contract Billing	X		Yes (No)
H6	Complex Billing Requirement Support	X		Yes (No)
H7	IBHIS Integration	X		(Yes) No
H8	Standard A/R Functionality	X		Yes (No)
H9	Client Sliding Scale Fee Screen	X		Yes (No)
H10	Client Sliding Scale Fee Calculation	X		Yes (No)
H11	Electronic Remittance Posting & Waterfall Billing	X		Yes (No)
H12	Guarantor Private Pay Statements	X		(Yes) No
H13	Split Guarantor Private Pay Statements	X		Yes (No)
H14	Payer Eligibility Data Import	X		Yes (No)
H15	Consumer Fund Tracking		X	(Yes) No
H16	Medicare Incident to Billing Support	X		(Yes) No
H17	Transportation Billing	X		(Yes) No
H18	HIPAA 837 Transactions	X		Yes (No)

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Number	Specification	*Cerner Response*		*Comment?*
		Yes	No	
H19	Health Care Claim Acknowledgment (277CA)	X		Yes (No)
H20	Payor Financial Information (PEI) Forms	X		(Yes) No
I1	Built-In Support for Compliance Reporting	X		(Yes) No
i2	Management Metrics Dashboard	X		(Yes) No
I3	Staff Productivity Management Support Capabilities	X		(Yes) No
I4	Clinician Staff Credentialing & Privileging Support	X		(Yes) No
I5	Clinical Supervision Support	X		Yes (No)
J1	Internal Staff Alert & Messaging System	X		(Yes) No
J2	Voice Recognition Software & Transcription Support	X		(Yes) No
J3	Consumer/Family/Network Provider Portals	X		(Yes) No
J4	HIE of Service Request Info for LACDMH	X		(Yes) No
J5	HIE of CANS & PSC-35 with LACDMH	X		(Yes) No
J6	System Audit Trail/Track and Report	X		(Yes) No
J7	Client and Services Information (CSI)	X		(Yes) No

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Functional Specifications Comment (Optional)

Please comment on the individual functional specifications as referenced in Attachment A, if desired. This section is not required. Comments should be coded by specification number and name.

Number	Specification	*Comments*
A6	Referral Tracking	Referrals of every type, including internal and external, can be tracked through our referrals management dashboard. Cerner's referrals management solution supports a dashboard display that provides extensive tracking including the sending of referral/consult requests, receiving of referral/consult requests, appointments made with consulting provider within the organization, appointments kept or missed within the organization, consulting provider notes/response sent to sending provider, and sending provider receiving of consult documentation. Cerner creates a seamless referral process with external providers through a secure referral management workflow that leverages Direct Technology. This is a universal communication tool across venues and vendors to send, receive, and update statuses of referrals. Additionally, consult/referral orders allow a clinician to place an order and direct it to a specific service. Clinicians associated with that medical service can view and act on the list of consults. In addition, clinicians can forward results and documents to support consult requests to internal clinicians. These requests appear in the message center. In addition, our referral management tool supports sending and receiving referrals to and from external providers that are using the Direct Messaging standard. For referrals for admission, the referrals worklist will allow the referral coordinator to track and monitor the status of the referral. The referral coordinator can review the documentation received with the referral and accept or reject the referral based on clinical presentation.
A7	Referral & Admission Notes	Our EHR will facilitate the documentation and communication regarding each admission and case. All messages sent regarding a client will be saved within their permanent medical record with the information exchanged regarding utilization review, issues for billing staff to address, and other requirements. These documentation types can be filtered within the record for quick identification.
A8	Support for Automatic Referral Letter & Fax Generation	Cerner's referral management workflow will allow the user to manage the workflow from a single point within the EHR. Once the referral order is placed, it will flow to the referral management workflow. The workflow will allow the user to select the provider or organization the referral will be sent to, attach associated documents, and insurance information from a single page rather than having to search through the chart to find information. Once all of the components have been added, the user can generate the referral letter and continuity of care document to be sent to the designated provider. The referral details will be sent via the designated provider's preferred method of communication, either via Direct Technology or secure ad-hoc fax. Direct Technology enables the ability to send messages securely between EHRs as

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Number	Specification	*Comments*
A9	Discharge Planning & Referral Tracking	Cerner's solution will support detailed discharge planning, including the ability to send and receive information to/from community providers. As the client is being discharged, the care team will have the ability to document the discharge care plan and provide it to the client. Additionally, we support the ability to track referrals to community providers and ensure that all of the associated documentation is sent to ensure continuity of care. Referrals can be sent to community providers directly from the referrals management workflow via the community provider's preferred method of communication. Our EHR also supports the ability to send any information back to a community provider throughout the client's care and upon discharge from care. The EHR will generate a visit summary that will provide details of the care provided and the user can attach other documents to ensure the community provider has a holistic view of the client's care.
A11	DSM & ICD Diagnoses	Cerner supports ICD-10, DSM-5, and a crosswalk between the two. Once established, the diagnosis can be pulled into and auto-populate other forms such as progress notes, treatment plan, and discharge summaries. Our DSM-5 terminology package is fully integrated into diagnostic capabilities embedded within our EHR system.
A18	Custom Assessment Tools	As part of the Cerner Integrated Behavioral Health EHR offering, TCMHA is provided a robust catalog of standard, pre-defined content that includes industry-validated assessment forms, flowsheets, note templates, and more. Over 180 behavioral health-specific standard scales and assessment forms (with scoring tools) are provided to support your organization’s documentation needs. Assessments display different questions and flex according to the patient's age, gender, diagnosis, reason for visit, specialty, and location. TCMHA can also have reference text and URL links built into the clinical workflow during the localization process to support clinical information, definitions, as well as your organization’s standardized policies and procedures that promote optimal care. Reference text can link to internal or external sources and can be accessed with a click. In addition, Cerner supports the use of content from third-party providers for evidence-based clinical practice guidelines (additional fees might apply). As part of your implementation, Cerner will work with TCMHA to evaluate any additional form template requirements or organization specific requests and provide guidance on how best to use the system to meet your needs. This would be managed through our change governance process, both during implementation and after moving your system into production. Please refer to the Behavioral Health Content List document located in the Additional Reference Materials for more details concerning our vast library of assessment and scoring tools.
A19	Customizable Progress, Telephone, & Shift Notes	Our note templates can be personalized to include auto-text templates, free-text, embedded voice recognition or a combination of these tools as well as meta tagging with footnotes. They are user-customizable and flex according to the patient's age, gender, reason for visit, specialty, and location. As part of your implementation, Cerner will work with TCMHA to evaluate any additional form template requirements or organization specific requests and provide guidance on how best to use the system to meet your needs. This would be managed through our change governance process, both during implementation and after moving your system into production.

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Number	Specification	*Comments*
A20	Group Notes	Our multi-person charting tool (group notes) simplifies the workflow for documenting group therapy. The tool allows clinicians to document on multiple group members from one screen. This differentiating offering significantly decreases the time it takes to document a group therapy session by eliminating the need to re-document the same (group level) information for each attendee. By providing a multi-person platform for documentation, our goal is to provide TCMHA's group leaders with more time for patient care, by removing the repeated navigation required to jump from chart to chart. This group documentation tool also enables clinicians to capture group attendance, exact participation time for each attendee, document patient-specific participation attributes, and view, add, or modify goals/interventions for individuals attending group session or for the entire group. Once signed (with a single click), the group note flows to become a part of all the attendee's charts and the individual notes disseminate only to each individual's chart.
B4	Injection Administration Data Tracking	At the point of ordering, the provider will indicate the medication and dosage to be administered. When the medication is administered, the nurse will document administering the medication through their task function which will have an associated form. The form will allow the nurse to verify the medication and dose and then document the administration site, manufacturer, lot number, expiration date, and any necessary charge codes. All of the medication administration details will be stored with the medication for review.
B5	Electronic Prescription Transmission	Our solution has embedded the ability to e-prescribe directly into the provider's workflow. Cerner leverages the Surescripts transmission network to allow e-prescribing to more than 98% of the nation's participating pharmacies. Cerner also supports e-prescribing controlled substances on the desktop EHR with two-factor authentication following DEA requirements.
B6	Tamper-Resistant Prescription Printing	We support tamper-resistant prescription printing that complies with CMS requirements. Additionally, e-prescribe is seamlessly integrated into the clinical workflow, utilizing a third-party transmission network, Surescripts, that enables prescribing practitioners to electronically route prescriptions, inclusive of controlled substances, to community or mail order pharmacies. Cerner possesses proprietary methods for dual authentication prompting the provider to authenticate to the system with two factors that meet DEA EPCS requirements.
B7	Links to Medication Information & Drug Interaction & Contraindications	Our solution provides information regarding medication information, medication education, and drug interactions and contraindications within the ordering workflow. Our clinical decision support rules will trigger an alert if a drug interaction or contraindication is identified by the solution. The alert will require the provider to address the drug interaction or contraindication before proceeding with the workflow. The alert will contain information stating why the alert was triggered.
B8	Prescription Refill Reminders	Cerner's provider workflow page will give the provider visual indicators when the client's prescription needs to be refilled. The indicators will be visible during the appointment and be based on the last time the medication was refilled. Additionally, our solution will accept prescription refill requests directly from the pharmacy into the prescribing provider's message center for review and action.
B9	Laboratory Interface	Our solution enables the ability to interface to outside laboratories. The laboratory interface can send the order and then receive the results back into the EHR. As the results are received, they will be tracked within the client's longitudinal record over time and can be graphically trended.

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Number	Specification	*Comments*
B10	Laboratory Result & Medical Condition Alerts	The EHR will automatically route the results to the ordering provider's message center and client's medical record from the performing laboratory. For results received that fall outside of the attached reference range, the results will be categorized into normal, abnormal, and critical in the ordering provider's message center for immediate identification and review. Within the client's chart, results outside of the reference range will have a visual indicator stating if the result is normal, abnormal, or critical based on an associated color and icon.
B11	Formulary & Medication Pre-Certification Support	Partially supported. At the point of order entry, the provider will be presented with stop light coding indicating if the medication is preferred, on formulary, or off formulary based on the client's documented insurance information. In the event a medication is not on formulary, the provider will automatically be presented with appropriate therapeutic substitutions. Further development is needed for the medication pre-authorization workflow to be available in the proposed model and does not have an anticipated release date.
B12	Drug Enforcement Administration (DEA) Federal Regulation Supports	Our ePrescribing is seamlessly integrated into the clinical workflow, utilizing a third-party transmission network, Surescripts, that enables prescribing practitioners to electronically route prescriptions, inclusive of controlled substances, to community or mail order pharmacies. Cerner possesses proprietary methods for dual authentication prompting the provider to authenticate to the system with two factors that meet DEA EPCS requirements. We also support the ability to print prescriptions for controlled substances that meets DEA requirements.
B13	Patient Medication Information/Handouts	Cerner has embedded medication education directly into the EHR which can be provided to the patient at the point of ordering and/or at the point of providing the patient with additional patient education materials. Once the education is selected and provided to the patient, it will also be available for the patient in the patient portal.
B14	Laboratory Orders Sets	Cerner's solution presents TCMHA the ability to create orders sets with commonly grouped laboratory orders. Our order sets will also allow the ability to group other common orders such as medications, diagnostics, referrals, and other orders to simplify the ordering process. Order sets can be created at the organization, departmental, and provider level.
B15	Medical Supply Inventory Support	Our behavioral health solution does not currently support inventory management; however, it may in the future. Typically we see clients that are already utilizing a 3rd party to manage medication supplies.

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Number	Specification	*Comments*
C1	Assessment Tool Support	Partially supported. Cerner's system includes protocols based upon industry-standard, best practice recommended workflows for detoxification/withdrawal, which include Fall Risk scoring and a multitude of other criteria for the care and safety of the patient as well as the care team. Our content provides alcohol and drug screenings and assessments, including the Addiction Severity Index (ASI); the Alcohol Use Disorders Identification Test (AUDIT); the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C); Clinical Institute Withdrawal Assessment (CIWA-AR); the Clinical Opiate Withdrawal Scale (COWS); the Michigan Alcohol Screening Test (MAST); the Modified Alcohol, Smoking, and Substance Involvement Screening Test (Modified ASSIST); the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES); the Substance Use Assessment; the Recovery Capital Scale (which is currently in development); and more. Our system provides detoxification admission and substance use detoxification (and relapse) order sets to standardize the clinical workflow process for substance use treatment in outpatient, inpatient, and community/residential detoxification settings. Information documented can be pulled into a report, including detoxification statistics such as length of stay or drug of choice. As part of your implementation, Cerner will work with TCMHA to evaluate any additional form/assessment requirements or organization specific requests and provide guidance on how best to use the system to meet your needs. This would be managed through our change governance process, both during implementation and after moving your system into production. Please refer to the Behavioral Health Content List document located in the Additional Reference Materials for more information concerning our vast library of substance use and other assessment tools. Substance Abuse Subtle Screening Inventory (SASSI) – Adult and adolescent version Post-Acute Withdrawal Systems (PAWS) Withdrawal Assessment Scale Clinical Institute Withdrawal Assessment (CIWA)
C2	Decision-Support & Compliance for ASAM Criteria for Care	Cerner's integrated EHR includes the ASAM Assessment and provides for documentation of levels of care and justification. We do not currently have the ASAM algorithms.
C3	Random Appointment Scheduling for Urinalysis & Compliance Monitoring	Partially supported. Our system does not currently support the ability for staff to monitor compliance or to notify consumers if they have been selected for testing.
D1	Resource-Based Appointment Scheduler Capabilities	Partially supported. Our system does not currently support the ability to locate available appointments based on payer requirements or staff credentials.

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Number	Specification	*Comments*
E2	Employment Services Data Tracking & Consumer Matching	This is not something that we currently have functionality for at this time. However, we would be happy to have further discussions around how we can best meet your needs.
E3	Consumer Employment History	Tracking individual employment history (placement and dates) could be done through a form for this requirement. Anything more would require further discussion on how to best meet your needs.
E4	Expanded Employment & Support Services Data Tracking	Cerner's integrated offering provides the ability to track services to support a broad array of services to support patients in employment and daily activities. Additionally, Cerner's robust point-of care ADL and individualized task documentation offering, CareTracker (optional) provides the ability to create personalized care plans based on assessments, document on trainings and progress/lack of progress, view current medications, and document on physician appointments. We support nursing/provider workflows, documentation, and much more. Our point-of-care ADL and individualized task documentation tool (CareTracker) supports documenting developmental disabilities, behaviors, and skill development. This innovative offering allows care providers to record goals and review data in near real-time, at the point-of-care via simple-to-use, touch-screen devices. It is highly customizable and allows TCMHA's staff to monitor the progress of individual-specific plans for restorative programs, behaviors, and many other programs that might need to be monitored for an individual. Cerner would welcome further conversation about your Employment and Support Service Data Tracking requirements. Should CareTracker be
F1	Alerts or "Tickler" Capabilities	Our integrated-community behavioral health delivery model supports a robust catalog of standard content that includes recommended decision support alert notifications, prompts, and rules embedded in the clinician workflows, including due dates for evaluations and tasks. This can support users in being notified or notifying others of required components of the health record. This can also include notifications of unmet outcome measures, sending satisfaction surveys, and completing required actions. Additionally, rules and alerts can be localized during the implementation process. Cerner will work with your organization to evaluate any custom requests and provide guidance to meet your needs. Cerner's Integrated Community Behavioral Health EHR also includes a variety of enterprise-wide reporting/data extraction capabilities to meet the needs of TCMHA. This offering includes operational reporting, as well as analytics tools that provide the end user with access to data through our reporting portal. This will ensure that you can track and monitor any incomplete files or pending requirements from the system.

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Number	Specification	*Comments*
F3	Critical Incident & Other Required Reporting	Partially supported. Cerner's system can capture patient adverse events through documentation. We also identify patients at risk of adverse events though assessments and results and suggest preventative protocols. These include falls, skin breakdown, medication events, and interventions to mention a few. However, the Cerner offering provides a patient-centric electronic medical record, not a standard risk management system. We do not recommend recording incident information beyond direct patient care within the EHR, due to potential discovery issues. Cerner welcomes further conversation with TCMHA related to this requirement so we can investigate your specifications and determine whether our documentation meets this requirement. We would be happy to discuss the possibility of interfacing with a third-party incident management system. Additional fees might apply.
F5	Electronic Record Release	Our solution provides functionality for your Release of Information process. Our features include the ability to notate received requests, validate the authorization for the release of information, provide historical documentation of the information released, and support for the management of any associated reimbursement receivables. The application can track both paper-based and electronic documents that have been requested, mailed, and allows for specification for which requests apply to accounting of disclosures. You can track the following patient requests: request to restrict consent, request for confidential communications, request to access their chart, request to amend their chart, request to receive an accounting of disclosure, and tracking/reporting can be applied to all requests or just those applicable to accounting of disclosure reporting. In addition, sensitive data can be removed from the ROI by using templates excluding that information.
F6	Record Release Tracking	Our solution's request queue provides the ability to view the requests for charts and documents that have been logged into the system and their current state of completion. Full audit trails and accounting of disclosure reporting to meet the HIPAA disclosure requirements is supported.
F8	VIP Medical Records Protection	The VIP designation code distinguishes sets of person or encounter information from the rest of the population. Setting this code allows the enterprise to perform special functions, usually through reports, for these individuals. Confidentiality levels can be set on encounters as well as on users. A site can choose to determine specific encounters or encounter types that require additional security logic. For example, psychiatric visits and child abuse cases. The system compares the confidentiality level of the personnel, associated with the user at the time he/she is entered into the system. The confidentiality level of the person and/or the encounter set at the time of registration, determines if you can view information regarding the person or a specific encounter. Each site that chooses to invoke the confidentiality level indicator determines the confidentiality levels appropriate for that site, for example, LOW, MEDIUM, or HIGH. Personnel associated with a confidentiality level of LOW are unable to view encounters associated with a person that is assigned a confidentiality level of HIGH.

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Number	Specification	*Comments*
F9	Tracking HIPAA & State Specific Medical Record Requirements	Cerner complies with all guidelines and regulations set forth in the Health Insurance Portability and Accountability Act (HIPAA). It is our policy to maintain and protect individually identified health information of patients/employees and the system components in which such data resides. All patients are informed of their right to privacy and the privacy of their health information, and all patients acknowledge this notification by signature. Additionally, our standard solutions are designed to support federal regulatory requirements as appropriate to given solutions. Modifications may be needed to meet individual state requirements depending on their nature, such as for prescription formats, state regulatory submissions for public health or vital statistics reporting or other requirements. Cerner has a team that is responsible for ongoing review of all federal regulatory requirements when proposed and final rules become available. This team works to identify the priority for Cerner's solution business requirements and services that come from federal regulation. The team also works with Cerner's business units to identify current solution capabilities that may form the basis for enabling compliance with the regulatory requirements. This information is then framed into guidance through several avenues, including through reference materials, client notices, educational sessions, and other forums. Cerner provides a MACRA Playbook, curated and written by Cerner's team of regulatory experts, that is intended to provide an overview of the final rule released by CMS, translation of the programs, terms and mandates included, insight into Cerner's long-term vision for preparing clients for regulatory shifts, and guidance on how to prepare for these changes.
F10	Accreditation Support	Cerner maintains a regulatory research and strategy team that works to stay comprised of regulatory developments and impacts to the industry as well as our client base. We embed tools for easily capturing and extracting the requirements of standard behavioral health and healthcare accrediting bodies, such as the Joint Commission and CARF. We also push out tools necessary for capturing changes in regulatory requirements. However, it is up to TCMHA to extract and submit the necessary information in order to maintain their
F11	Enhanced Role-Based System Access Controls	Cerner supports position-level or role-based security, enabling TCMHA to determine which roles or positions have permission to specific tasks within an application. Every user in the system is assigned a role or position. In addition, patient-provider relationship functionality allows you to define an emergency override access option. The emergency override allows a provider that does not have an established relationship with a patient to declare an emergency relationship, if necessary. The relationship type of "emergency" is associated with all positions that could possibly declare an emergency relationship with a patient. When defining the emergency type, you can specify whether organization security and or confidentiality levels are honored or if they can be overridden. All access to patient records is logged including those occurring under emergency circumstances. We capture the details of this event to allow for full reporting to your organization and its respective members. Our solution includes auditing of all significant events (such as access events) in the system. An audit event typically contains information about who did something, what they did, what action they took, when they did it, how they did it (i.e. through which system), and what other things or people were accessed and impacted by
F12	EHR Document Version Control	All actions in the EHR are tracked with the user's name, date, and time of the action. For documents that are signed in the client's medical record and action is taken after signature to modify or update the document, the version will provide a history of all the changes made. Only users with the appropriate role-based security setting will be able to modify a document.

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Number	Specification	*Comments*
F13	EHR Archiving & Purge Capability	Partially supported. With Cerner's system design and SaaS delivery model, there is no need archive patient result data. Authorized users have immediate access to the entire patient record, including information from current and past visits. In this Remote Hosted Option (RHO) deployment, Cerner hosts, manages, and maintains the contracted system on your behalf. Cerner builds the system to meet ideal sizing and performance goals. Cerner also supports the need and capability for erasure of a patient record. However, we currently do not support the purging of specific data and/or portions of the record.
G1	Extensive Call Tracking & Disposition Data	Partially supported. Cerner's system allows for the documentation of call information for different programs. The call taker will need to access a record or create a one in order to save the documentation to a chart, but he disposition of the call can be recorded in the chart. Referral information is documented through our referrals management workflow and will allow the user to document where the referral is coming from, who it is being assigned to, and additional information for that referral.
G2	Referral Workflow Tracking	Cerner automates the workflow embedding provider order entry, leveraging an established network of providers, simplifying management for support staff, to quickly close the referrals loop and decrease turnaround times to contain healthcare costs. Our referrals management utilizes industry messaging, DirectTrust, to enable seamless, bi-directional communication between your providers and external providers in the community with options to attach any pertinent documentation. This is all completed within one view without having to toggle back and forth between screens, thus enhancing efficiency. Cerner's integrated referrals management module supports a dashboard display of new referrals in a work queue which provides extensive tracking such as sending of referral/consult request, receiving of referral/consult request, the reason for the referral, appointments made with consulting provider, appointment kept or missed, consulting provider note/response sent to sending provider, and sending provider receiving of consult documentation.
G4	Waitlist Tracking	The Queues workflow is recommended for managing appointments and patients that need further action. This workflow contains the following views: • Reschedule Requests • Standby Appointment Request • Eligibility • Appointment Requests • Requests • Consumer Demographic Update • Work Queues The Queues functionality includes the use of various data to prioritize accordingly.

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Number	Specification	*Comments*
H7	IBHIS Integration	Cerner's offering provides TCMHA with one of the most advanced billing systems on the market. We have been working for over thirty years to develop a system designed to meet the challenging, ever-changing needs of community behavioral healthcare billing and state reporting. We also have vast experience with clients utilizing our system in the state of California. Our community behavioral health billing and state reporting module utilizes web service technology for exchanging data electronically with the LACDMH's Integrated Behavioral Health Information System (IBHIS); and has a working knowledge of user authentication using x.509 certificates, PKI exchange, Certificate Authority, and third party validation authority. It communicates Admission, Update, and Discharge data to the LA County IBHIS system via the IBHIS web service functions; and provides the ability to query the IBHIS system such that users can view the LA County data sets.
H12	Guarantor Private Pay Statements	Statement options are available.
H15	Consumer Fund Tracking	This is not something that we have functionality for at this time. However, we would be happy to have further discussions around how we can best meet TCMHA's needs.
H16	Medicare Incident to Billing Support	Cerner has over thirty years of experience with community behavioral health billing. We currently have forty-five behavioral health clients in the state of California, thirty of which are community behavioral health clients. We have been working with our California-based behavioral health clients on billing and state reporting for over fifteen years. Our patient accounting module generates the X12 5010 claim files and places the file on the local network based on the user-selected location. The transmission of the files is a process completed by the users using the payer-specified instructions for file transfer.
H17	Transportation Billing	There is a transportation log within our billing module.
H20	Payor Financial Information (PEI) Forms	Our patient accounting module allows for capturing third party coverage data for patients. Additionally, the system includes patient financial forms for each patient that are captured within our integrated EHR. We would be happy to discuss this further with TCMHA in order to gain a better understanding of your specific needs and verify our interpretation of this requirement.

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Number	Specification	*Comments*
I1	Built-In Support for Compliance Reporting	Cerner can aid you in designing workflows and protocols to comply with internal controls and regulatory compliance standards where the application of technology can aid the facilities in compliance. It is ultimately the responsibility of TCMHA and its facilities to ensure they have policies and procedures in place to meet those standards. Cerner has a regulatory strategy team that reviews new rule making for regulatory developments; including federal and some state regulations. The team conducts reviews of rules for business requirements that should be reviewed with Cerner's solution strategists and development teams. These teams then determine the ability of existing solutions to comply to the new regulatory requirements. Additionally, they take the time to identify potential gaps or enhancements for development prioritization. Once determined, they develop knowledge transfer resources and sessions for associates and clients on recommended guidance to meet the new rules and regulations. Where these requirements represent solution development gaps or enhancement needs, the regulatory team works with solution teams and Cerner business units on prioritization and response planning. From there, the regulatory strategy team works with Cerner development to cover the program updates and the timeline needed to successfully implement any updates or changes. These development timelines vary based on the regulatory requirements. LA County DMH has an Integrated Behavioral Health Information System (IBHIS) which provides contracted providers or Trading Partners (TPs) the means to directly exchange information with IBHIS in a business-to-business (b2b) Electronic Data Interchange (EDI) model. The IBHIS system has a Release Candidate End point for user authentication using x.509 certificates, PKI exchange, Certificate Authority and third party validation authority. Through web service technology including but not limited to the open protocols and standards such as SOAP, WSDL, XSD, etc. Client Service, Service Request Log, Level of Care, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) data is exchanged electronically between the Cerner EHR product and IBHIS. LA County DMH gives permission for Cerner Clients to provide Cerner with their Authorization Certificate and Program ID for testing and production purposes. As previously discussed with TCMHA, Cerner is currently providing this integration utilizing our historic Cerner Community Behavioral Health EHR (Anasazi). However, this integration has not yet been brought forward to the proposed Cerner Integrated – Behavioral Health EHR. Cerner will work with TCMHA to complete this integration as part of the implementation process. Other State Reporting required in California, such as the Client and Service Information (CSI) Reporting, Office of Statewide Health Planning and Development (OSHPD) Reporting, and California Outcomes Measurement System (CalOMS) Reporting, are already part of the Integrated Product. They are separate reporting utilities to process the related consumer data and generate Transmittal files according to the state requirements of the transmittal file from the state and the clients will upload to the files according to the California DMH specifications.

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Number	Specification	*Comments*
i2	Management Metrics Dashboard	Cerner's Integrated-Community Behavioral Health hosted offering includes a variety of enterprise-wide reporting capabilities to meet the needs of TCMHA. This offering includes operational reporting, as well as analytics tools, that provide your end user with access to data through the reporting portal. For organizations with the skills and desire to develop extracts or custom and ad hoc reports, additional reporting tool sets are available within the domain. Cerner's Integrated-Community Behavioral Health offering combines tools such as Discern Analytics 2.0 (DA2), SAP Business Objects, SQL Server Reporting Services (SSRS), and our new analytics dashboards leveraging the power of Tableau to provide a robust approach to securely meet your reporting needs in a shared environment. Our reporting tools support exporting data in specific report formats, such as .csv, .pdf, .xls, and .xlsx. Users can create reports and formats for exports at regular intervals or can schedule them as one-time queries. Once exported, the data is available to use within external reporting tools. Exporting to a .csv allows for additional manipulation of the data using a wide variety of toolsets. However, data which is exported outside the system is no longer secure and becomes the responsibility of the organization to protect. Cerner is also constantly working to develop behavioral health analytics specifically designed around the needs of clients leveraging our Cerner Integrated-Community Behavioral Health solution. Analytics tools such as these can be crucial for sustainability. They can provide accountability, drive outcomes, as well as assist with predictive modeling and stratification. Our behavioral health analytics offering will include dashboards for executive leadership, operations management/supervisors, clinical effectiveness/for clinical and quality leaders, as well as a clinician dashboard/for clinical staff. These behavioral health analytics tools are being developed to provide TCMHA with interactive dashboards in an effort to empower your organization with meaningful access to key metrics for monitoring and measuring your organization's health and performance. These tools will provide real-time data visualization, a means for exploration, and decision support to help drive the overall success of your organization. Additionally, our system activity monitoring, Lights On Network, is an industry-leading advanced EHR analytics offering designed to support decision making and provide transparency into your Cerner solution. No other monitoring system provides this level of knowledge-driven analysis designed to help your organization get the most from your EHR solution. We provide this analytical web-based solution free of charge as part of an ongoing commitment to our clients and to the improvement of healthcare around the world. Our system activity monitoring provides views into system performance, system configuration, user experience and adoption, as well as organizational efficiency. Drillable dashboards provide information that will assist TCMHA in understanding how end users are using the system across your organization. TCMHA can proactively monitor the efficiency of your providers and nursing staff by specialty, facility, as well as the specific user. This allows for engaging with employees to ensure the optimal experience for your staff and clients. In addition, Cerner offers an online community via www.cerner.com to collaborate and share best practices with other members of the system activity monitoring network.

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Number	Specification	*Comments*
I3	Staff Productivity Management Support Capabilities	Cerner's system currently allows TCMHA to establish a variety of reports for use in analyzing productivity. For example, our Revenues Report can be used to establish a variety of templates for viewing revenue, hours, and units of service by payer, provider, location, type of service, mode of service, or service function code. We are in the process of developing dashboards designed to provide insight to provider productivity and provision of service details using drill down capabilities. A variety of views will be established to meet the needs of providers, managers, and executives. Additionally, to identify areas of deficiency, Cerner has various tools that measure user utilization of the system. Our Lights on Network is an interactive and intuitive dashboard of operational information, including response time performance, workload, system management metrics, and system compliance. Furthermore, it provides key insights into a provider's experience by showing performance comparisons relative to the entire network and peer sub-segments. Embedded within our Lights On Network is Cerner Advance. This is an additional tool that compares the efficiency and adoption of every clinician at your organization to their specialist peers across the country. This enables easy identification of outlier users or user groups spending significantly more time than their peers. Outlier identification then drives specific targeting by support staff within the Process Management framework. Cerner Advance then scans a number of key performance indicators and compares to a national and/or peer Cerner benchmark. Each Key Performance Indicator (KPI) is then presented alongside its Return on Investment (ROI) to the benchmark and the specific project work necessary to achieve that ROI. Cerner Advance is a suite of web-based solutions that: Presents individual user or group level efficiency and adoption data within an easy-to-use yet state-of-the-art interactive visualization Enables taking action of that data through management tools to drive a process of continuous improvement Offers a suite of reports to ensure the right work is getting done with the right users and generating the intended impact Identifies high-value, organization specific opportunities to improve at a system level through structured improvement project 22 Specialties High Opportunity Specialty (874 out of 1753 physicians) 50% high opportunity 10 Specialties Low Opportunity Specialty (208 out of 776 physicians) 27% high opportunity 16 Specialties Moderate Opportunity Specialty (153 out of 562 physicians) 34% high opportunity For more Cerner Advance details see: *https://advance.cerner.com/*

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Number	Specification	*Comments*
I4	Clinician Staff Credentialing & Privileging Support	The Cerner system allows for simple entry, updating, and tracking of current and historical credential types, effective dates, license number, and comments, along with any payer specific identifiers assigned to a provider. Standard reporting capabilities can be used to identify those professionals whose licenses will be expiring within a given timeframe. Credential types are an option when establishing conditions in which to bill an encounter within the billing modalities table for covered service. This provides a mechanism for the billing algorithm to establish a different procedure code/modifier or rate based on the credentials of the care provider rendering the encounter.
J1	Internal Staff Alert & Messaging System	Cerner's internal Message Center will facilitate communication across your organization that is related to patient care or associated to the organization. Additionally, the message center inbox streamlines communication between care providers with secure messaging capabilities and immediate access to important new information such as referrals, consults, new results, and pending documents and orders. Integration with Exchange/Outlook messaging systems is not offered or recommended because it does not meet HIPAA patient confidentiality guidelines. We offer secure messaging through our Message Center for internal communications. Cerner also offers email messaging through CernerDirect. Cerner Direct is an encrypted Internet email channel based on Direct Project standards that enable ad hoc communication between authorized physicians, healthcare systems and patients within and across communities.
J2	Voice Recognition Software & Transcription Support	Cerner is tightly integrated with Nuance Dragon Medical One to allow provider to launch both applications simultaneously and use voice recognition to dictate directly into the client's medical record. Additionally, Cerner's provider mobility solution has embedded Nuance technology to allow providers to dictate into the client's record using their mobile device. We also support back-end transcription through an HL7 interface with your preferred transcription service. The solution, Nuance Dragon Medical One is not included within Cerner's proposal. If TCMHA has not already licensed, we can work with your organization to acquire. Additional costs may apply.

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Number	Specification	*Comments*
J3	Consumer/Family /Network Provider Portals	Our patient portal enables patients to view their personal health information, collaborate with their providers, and manage their health using both desktop and mobile devices. The unique integration between our patient portal and EHR supports patient engagement by empowering patients to engage with their care team and integrating these engagement points into your providers' and support staff's primary workflows. Patient can securely message providers, view and request appointments, view their visit summaries and clinical information, complete assessments, and access additional education and resources. Within our patient portal, the personal health record allows the patient to see a consolidated view of their health information. The patient can access and manage allergies, immunizations, medications, procedures, health issues, lab results, family history, documents, and education. Patient can also download Continuity of Care Documents (CCD) and Transition of Care Documents. Patients can identify individuals for proxy access to their patient portal, such as a family member or caretaker. At an organizational level, you have the ability to determine the information that is viewable by the proxy. In addition, Cerner enables the patient to mark messages as private which hides the message and all related messages from the proxy. Cerner's patient portal also includes the option for Video Visits. The embedded video-visit workflow within EHR minimizes dual scheduling and provides easy access for both the Client and Care Provider. The Client has immediate access to their virtual-visit through their Web-Portal via a PC, tablet, or smart phone, while the Care Provider can video on their side all while directly documenting in the Client's chart simultaneously. Video-visits are offered on a per-visit basis and not currently included in the scope of this proposal. Cerner welcomes further conversation if TCMHA would like to add this functionality and integrated workflows.
J4	HIE of Service Request Info for LACDMH	Through web service technology Service Request Log data is exchanged electronically between the Cerner EHR product and IBHIS. SRL Service supports the following operations to facilitate SRL data exchange with LA County DMH/IBHIS: • Search Service Request • Get Service Request • Add Service Request • Update Service Request • Delete Service Request

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Number	Specification	*Comments*
J5	HIE of CANS & PSC-35 with LACDMH	Through web service technology Early and Periodic Screening, Diagnostic and Treatment (EPSDT) data is exchanged electronically between the Cerner EHR product and IBHIS. EPSDT Service supports the following operations to facilitate EPSDT data exchange with LA County DMH/IBHIS: • Search CANs • Add CANS • Get CANS • Update CANS • Delete CANS • Search PSC EPSDT Service • Add PSC • Get PSC • Update PSC • Delete PSC
J6	System Audit Trail/Track and Report	Cerner Millennium stores clinical history data in the patient record. Access audit data to the patient record is stored in our secure audit repository. All clinical events create new rows in the activity tables preventing loss of health care data. Each state change on the clinical event data creates a record of the user, the time and the state change. In addition to event logging, Cerner Millennium logs critical events in the security and access domains. The audit logging solution provides the foundation and context to demonstrate audit-ability, policy accountability, and continual improvement. It provides internal auditing and routine monitoring, supporting your needs for enforcing policy regarding information security and privacy. Our auditing solution supports the ability to audit access to the patient record and enables incident management through alerting and notification and definition of specific rules for monitoring suspected abuse, providing a proactive approach to safeguarding confidential data. What records were accessed, date, time, by whom, and actions that were done Cerner's auditing solution tracks and logs all activity in a patient record, including access and the specific activity performed. Each time a user performs an inquiry or transaction, the application will automatically date, time, and signature stamp that user's access code. Through this feature, a complete audit trail is made available. What fields were modified, date, time, by whom, and the changes made Cerner's auditing solution was designed to enable the audit of user actions as patient-identifiable information is accessed. This information includes data identifying the user, the patient, the context of the access, and the actions performed to the patient data, including actions that create, verify, view, modify, complete amend\error correct, and print patient information.

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Number	Specification	*Comments*
J7	Client and Services Information (CSI)	Through web service technology Client Service data is exchanged electronically between the Cerner EHR product and IBHIS. The Client Service data includes CSI data that LA County DMH shares with the California Depart of Mental Health. Client Service - Service supports the following CSI operations to facilitate Client Service - CSI data exchange with LA County DMH/IBHIS: • AddCSI • SearchCSI • GetCSI • UpdateCSI • DeleteCSI Cerner does provide separate reporting functionality for California providers that do not report to LA County IBHIS, so they are in compliance to the California Department of Mental Health (DMH) that requires County MHP's to report demographic, periodic, and service information on Mental Health clients to the Client and Service Information (CSI) System. This functionality includes a utility to process the Client, Periodic, Service, Assessment, and Key Change records and generate the CSI Transmittal file. The CSI Utility generates only one CSI Transmittal file per reporting Month and Year the clients will upload to the California DMH - CSI system. The CSI functionality provides a means for the County Client Number (CCN) of each consumer, which is usually the consumer's case number in the CICBH product.

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Owner/Responsible Project Manager and Core Team.

List the owner or person in charge, and a concise statement of qualifications and experience applicable to each type of service that is to be provided. List the key staff and sub-contractors, if any, along with a brief statement of qualifications for individual members which will be assigned to provide the requested services in this RFP.

Cerner will assemble an experienced, well-qualified team for your project who understands our system and processes to successfully complete your project. The team structure will be customized to meet your unique requirements and the scope, as well as your ability to staff the project.

Below are the names and resumes of the proposed core team. Note: Cerner reserves the right to change these individuals based on staffing demands at the time of the project.

Project Manager:

Please refer to Zach Clouston Resume located in the Additional Reference Material section.

Services Operations Manager:

Please refer to Terri Hammer Resume located in the Additional Reference Material section.

Solution Architect:

Please refer to Natalie Boyd Resume located in the Additional Reference Material section.

Technical Architect:

Please refer to Tamika Barnette Resume located in the Additional Reference Material section.

Testing Lead:

Please refer to Chelsea Hodges Resume located in the Additional Reference Material section.

Knowledge Transfer and Training Lead:

Please refer to Jennifer Patton Resume located in the Additional Reference Material section.

We do not plan to use subcontractors for this project.

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ATTACHMENT C

PROPOSER'S COMPANY INFORMATION, REFERENCES AND SUBCONTRACTORS

Company Name: Cerner Corporation	Address: 2800 Rockcreek Parkway North Kansas City, Missouri 64117
Owner, Principal Officer: N/A, Cerner is a publicly-traded company.	Headquarters Location/Date of Establishment: 2800 Rockcreek Parkway North Kansas City, Missouri 64117
Email: Angela.Lee@cerner.com	Website: www.cerner.com
Phone: (816) 201-1024	Fax: (816) 474-1742

List other license(s) and corresponding numbers/classification applicable or required for the scope of work of this proposal:

N/A

Have you ever operated this business under a different name? Yes __X__ No ________

If yes, please explain:

In 1979, Cerner was originally named Patterson, Gorup, Illig & Associates, Inc. In 1984, the name was changed to Cerner, Inc. The name Cerner was derived from Latin meaning "to discern". Our name was officially changed to Cerner Corporation upon the date of our incorporation in 1986, and remains today.

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List references of projects that your company is currently *working on or completed* in the last 5 years of similar size and scope of work for this proposal:

1. Company Name: Rogers Behavioral Health
   Contact Name: Sarah Gravlin, Client Accountable Executive
   Contact e-mail: Sarah.Gravlin@cerner.com
   Contact Phone: (816) 522-8742
   Scope of Work: Millennium Behavioral Health
   Agreement Amount: Our contract value is confidential information and cannot be shared as part of this response.
   Agreement Start/End Date: 2013

2. Company Name: County of San Diego
   Contact Name: Miranda Hann, Solutions Operations Manager
   Contact e-mail: Miranda.Hann@cerner.com
   Contact Phone: (816) 206-1933
   Scope of Work: Cerner Community Behavioral Health
   Agreement Amount: Our contract value is confidential information and cannot be shared as part of this response.
   Agreement Start/End Date: 2006

3. Company Name: Sharp HealthCare
   Contact Name: Stephanie Rankin, Client Accountable Executive
   Contact e-mail: Stephanie.Rankin@cerner.com
   Contact Phone: (816) 982-7837
   Scope of Work: Millennium Behavioral Health
   Agreement Amount: Our contract value is confidential information and cannot be shared as part of this response.
   Agreement Start/End Date: 2010

On Going Legal Proceedings: Provide details on any litigation in which your firm has been engaged in the past five (5) years. If none, then write “NONE.”

Cerner considers litigation matters confidential; however, as of the date of this response, Cerner is not a party to and none of Cerner’s property is subject to any material pending legal proceedings, other than ordinary routine litigation incidental to our business, none of which would have a material adverse effect upon our ability to provide the solutions and services quoted in this response. As a public company, Cerner is required to publicly report all material pending legal proceedings and all such information can be found in Cerner’s filings with the Securities and Exchange Commission and Cerner’s Annual Report, both of which can be obtained under the Investor Relations page of www.cerner.com.

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Copy of Business License and/or Certifications. A copy of the Business License will be required after the award of contract. Contractor declares that Contractor has complied with all federal, state, and local business permits and licensing requirements necessary to conduct business.

Cerner is compliant with all federal, state, and local business permits to conduct business. Once awarded the contract, we would be happy to provide any necessary business licenses.

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ATTACHMENT E

EXCEPTION(S) TO SPECIFICATIONS AND/OR REQUEST FOR PROPOSAL

☐ We **have no** exceptions to the Scope of Work/Requirements

X We **have** exceptions to the Scope of Work/Requirements as listed below. Exceptions to the Scope of Work/Requirements stated herein shall be fully described in writing by the Proposer in the space provided below. Any alternate must be approved by Tri-City Mental Health Authority no less than 10 business days prior to the closing date.

Requirement Location	Cerner's Exceptions
A. Overall Client Information & Electronic Record Functionality	
18. Custom Assessment Tools. The system should support the ability to create custom assessment tools, including calculation, storing, and export capabilities for assessment scores. Ability to add picture files or help files for staff to view either in the tool or as a pop up. Easily be able to access and use questions that are on other assessments if wanted/needed. Have the ability to create grids and conditional requirement fields.	This functionality is partially supported. As part of the Cerner Integrated Behavioral Health EHR offering, TCMHA is provided a robust catalog of standard, pre-defined content that includes industry-validated assessment forms, flowsheets, note templates, and more. Over 180 behavioral health-specific standard scales and assessment forms (with scoring tools) are provided to support your organization's documentation needs. Assessments display different questions and flex according to the patient's age, gender, diagnosis, reason for visit, specialty, and location. TCMHA can also have reference text and URL links built into the clinical workflow during the localization process to support clinical information, definitions, as well as your organization's standardized policies and procedures that promote optimal care. Reference text can link to internal or external sources and can be accessed with a click. In addition, Cerner supports the use of content from third-party providers for evidence-based clinical practice guidelines (additional fees might apply). As part of your implementation, Cerner will work with TCMHA to evaluate any additional form template requirements or organization specific requests and provide guidance on how best to use the system to meet your needs. This would be managed through our change governance process, both during implementation and after moving your system into production. Please refer to the Behavioral Health Content List document located in the Additional Reference

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	Materials for more details concerning our vast library of assessment and scoring tools.
B. Psychiatry & Nursing Services Functionality	
11. Formulary & Medication Pre-Certification Support. The software supports tracking insurance formularies so that prescribers can select medications based upon insurance coverage and tiered formularies, if required. Additionally, it should support prescribers in the process of obtaining pre-certification for medications that require them.	This functionality is partially supported. At the point of order entry, the provider will be presented with stop light coding indicating if the medication is preferred, on formulary, or off formulary based on the client's documented insurance information. In the event a medication is not on formulary, the provider will automatically be presented with appropriate therapeutic substitutions. Further development is needed for the medication pre-authorization workflow to be available in the proposed model and does not have an anticipated release date.
C. Substance Abuse & Dependence Functionality	
1. Assessment Tool Support. The system supports the use of assorted substance abuse assessment instruments as well as the related reporting. Examples include the following: Addiction Severity Index (ASI)	This functionality is partially supported. Cerner's system includes protocols based upon industry-standard, best practice recommended workflows for detoxification/withdrawal, which include Fall Risk scoring and a multitude of other criteria for the care and safety of the patient as well as the care team. Our content provides alcohol and drug screenings and assessments, including the Addiction Severity Index (ASI); the Alcohol Use Disorders Identification Test (AUDIT); the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C); Clinical Institute Withdrawal Assessment (CIWA-AR); the Clinical Opiate Withdrawal Scale (COWS); the Michigan Alcohol Screening Test (MAST); the Modified Alcohol, Smoking, and Substance Involvement Screening Test (Modified ASSIST); the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES); the Substance Use Assessment; the Recovery Capital Scale (which is currently in development); and more. Our system provides detoxification admission and substance use detoxification (and relapse) order sets to standardize the clinical workflow process for substance use treatment in outpatient, inpatient, and community/residential detoxification settings. Information documented can be pulled into a report, including detoxification statistics such as length of stay or drug of choice. As part of your implementation, Cerner will work with TCMHA to evaluate any additional form/assessment requirements or organization specific requests and provide guidance on how best

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	to use the system to meet your needs. This would be managed through our change governance process, both during implementation and after moving your system into production. Please refer to the Behavioral Health Content List document located in the Additional Reference Materials for more information concerning our vast library of substance use and other assessment tools. • Substance Abuse Subtle Screening Inventory (SASSI) – Adult and adolescent version • Post Acute Withdrawal Systems (PAWS) • Withdrawal Assessment Scale • Clinical Institute Withdrawal Assessment (CIWA)
3. Random Appointment Scheduling for Urinalysis & Compliance Monitoring. The system supports random appointment scheduling for urinalysis for substance abuse consumers (and other required testing if needed). The functionality includes the ability for staff to monitor compliance with required testing as well as providing an easy way to notify consumers if they have been selected for testing on a specific day.	This functionality is partially supported. Our system does not currently support the ability for staff to monitor compliance or to notify consumers if they have been selected for testing.
D. Outpatient Functionality	
1. Resource-Based Appointment Scheduler Capabilities. The system would support centralized scheduling functions, including rules-based user assistance in finding available appointments based on service need, payer requirements, staff credentials and specialty areas, etc.	This functionality is partially supported. Our system does not currently support the ability to locate available appointments based on payer requirements or staff credentials.
E. Other Clinical Functionality	
2. Employment Services Data Tracking & Consumer Matching. The system should support tracking employers used in the organization's employment services programs, including data about job positions and requirements, and support for matching consumers with available positions.	This functionality is not supported at this time. This is not something that we currently have functionality for at this time. However, we would be happy to have further discussions around how we can best meet your needs.
F. Additional Compliance, Quality Assurance, & Medical Record Functionality	
1. Alerts or "Tickler" Capabilities. The software allows users to indicate required components of health/case records, files, outcome measures, satisfaction surveying, and/or required actions, and also have a companion reporting and editing system for identifying incomplete files or pending requirements. Ideally, the "tickler" system will be linked to the staff alert and messaging system.	This functionality is partially supported. Our integrated-community behavioral health delivery model supports a robust catalog of standard content that includes recommended decision support alert notifications, prompts, and rules embedded in the clinician workflows, including due dates for evaluations and tasks. This can support users in being notified or notifying others of required components of the health record. This can also include notifications of unmet outcome measures, sending satisfaction surveys, and completing required actions. Additionally, rules and

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	alerts can be localized during the implementation process. Cerner will work with your organization to evaluate any custom requests and provide guidance to meet your needs. Cerner's Integrated Community Behavioral Health EHR also includes a variety of enterprise-wide reporting/data extraction capabilities to meet the needs of TCMHA. This offering includes operational reporting, as well as analytics tools that provide the end user with access to data through our reporting portal. This will ensure that you can track and monitor any incomplete files or pending requirements from the system.
3. Critical Incident & Other Required Reporting. The software supports serious incident and other required reporting and follow-up, including tracking seclusions and restraints, medication errors, police interventions, abuse and neglect reporting, etc. Also, the software supports tracking of the investigation of suspected human rights violations, etc. The system allows the tracking of multiple events within a single critical incident if needed.	This functionality is partially supported. Cerner's system can capture patient adverse events through documentation. We also identify patients at risk of adverse events though assessments and results and suggest preventative protocols. These include falls, skin breakdown, medication events, and interventions to mention a few. However, the Cerner offering provides a patient-centric electronic medical record, not a standard risk management system. We do not recommend recording incident information beyond direct patient care within the EHR, due to potential discovery issues. Cerner welcomes further conversation with TCMHA related to this requirement so we can investigate your specifications and determine whether our documentation meets this requirement. We would be happy to discuss the possibility of interfacing with a third-party incident management system. Additional fees might apply.
13. EHR Archiving & Purge Capability. The software application should have appropriate mechanisms for archiving and retrieving historical records as well as purging records when needed.	This functionality is partially supported. With Cerner's system design and SaaS delivery model, there is no need archive patient result data. Authorized users have immediate access to the entire patient record, including information from current and past visits. In this Remote Hosted Option (RHO) deployment, Cerner hosts, manages, and maintains the contracted system on your behalf. Cerner builds the system to meet ideal sizing and performance goals. Cerner also supports the need and capability for erasure of a patient record. However, we currently do not support the purging of specific data and/or portions of the record.

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G. Additional Referral & Admission Functionality	
1. Extensive Call Tracking & Disposition Data. The system should support tracking all crisis and referral call information and data about the disposition of each call. The system should have notes capabilities to support staff in tracking important information about each referral and case. These might include notes about the utilization review process, clinical concerns, issues for billing staff to address, or other requirements.	This functionality is partially supported. Cerner's system allows for the documentation of call information for different programs. The call taker will need to access a record or create a one in order to save the documentation to a chart, but he disposition of the call can be recorded in the chart. Referral information is documented through our referrals management workflow and will allow the user to document where the referral is coming from, who it is being assigned to, and additional information for that referral.
H. Billing & Accounts Receivable Functionality	
15. Consumer Fund Tracking. The software assists staff in tracking consumer funds that are monitored by the organization, including fund receipts and disbursements.	This functionality is not supported at this time. This is not something that we have functionality for at this time. However, we would be happy to have further discussions around how we can best meet TCMHA's needs.

☐ We **have no** exceptions to any other section of the Proposal Document.

X We **have** exceptions to the Request For Proposal Document stated herein shall be fully described in writing by the Proposer in the space provided below.

Requirement Location	Cerner's Exceptions
VI. AWARD AND AGREEMENT EXECUTION	
H. Execution of Agreement	In connection with paragraph VI.H (*Execution of Agreement*), Cerner agrees that Cerner and TCMHA will need to enter into an Independent Contractor Agreement, and Cerner looks forward to negotiating in good faith with TCMHA to achieve an agreement that is acceptable to both parties. Cerner suggests that the Cerner agreement form of agreement be used as the starting point for those negotiations, as the Cerner agreement form is specifically tailored to this type of transaction and to the manner in which Cerner and its clients implement Cerner systems. To the extent that there are TCMHA-required items that are not covered in Cerner's form, or that TCMHA feels should be covered in a different way from the standard Cerner agreement, Cerner is willing to add all such provisions that the parties mutually approve to the final agreement. A copy of the TCMHA Cerner Services Agreement is attached to this Response and located in the Additional Reference Material section.

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	Paragraph VI.H (*Execution of Agreement*) suggests that TCMHA proposes being able to cancel all or any portion of the Agreement for any reason with 30 days written notice to Cerner; however, Cerner does not agree that the Agreement should permit a termination for convenience, as both parties should be committed to the transaction. Termination for an uncured breach after a suitable notice and cure period should, of course, be provided for, and Cerner is also willing to consider a provision that permits TCMHA to terminate future services in the event the funds needed for those services are not appropriated to TCMHA, so long as TCMHA gives Cerner prompt written notice of the failure to get funding and pays all fees for products and services provided up through the effective date of the termination. That provision will need to make clear that in connection with such a termination, Cerner would not be required to provide a refund of fees already paid.
I. Indemnity and Insurance Requirements 2. Other Insurance Provisions – a.	Cerner added "additional" to differentiate between named and additional insured status. "Tri-City Mental Health Authority, its officers, officials, employees, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of the Contractor including materials, parts or equipment furnished in connection with such work or operations."
I. Indemnity and Insurance Requirements 2. Other Insurance Provisions – c.	The insurance policy will not provide notice of cancellation to any party except the named insured (Cerner Corp). However, Cerner can agree to provide notice to TCMHA in the event insurance is cancelled without replacement. ~~"Each insurance policy required by this clause shall be endorsed to state that~~ Contractor agrees that coverage shall not be canceled by either party, except after thirty (30) days' prior written notice by certified mail, return receipt requested, has been given to TCMHA.""
I. Indemnity and Insurance Requirements 4. Verification of Coverage	Cerner's insurance policies are not shared in their entirety as they contain private company data. However, upon request, Cerner will provide specific clauses or definitions from the policy language, if needed. "Contractor shall furnish the TCMHA with original certificates and amendatory endorsements effecting coverage required by this clause. The endorsements should be on forms provided by TCMHA or on other than TCMHA's forms, provided those endorsements or policies conform to the requirements. All certificates and endorsements are to be received and approved by TCMHA before work commences. However, failure to obtain the required documents prior to the work beginning shall not waive the consultant's obligation to provide them. ~~TCMHA reserves the right to require complete, certified copies of all required insurance policies, including endorsements effecting the coverage required by these specifications at any time."~~
I. Indemnity and Insurance Requirements 6. Indemnification	The indemnification terms stated in paragraph VI.I.6 (Indemnification) will need adjustment to limit the covered claims to third party claims, and the exclusion will need to be expanded so that Cerner is not indemnifying for TCMHA or the other indemnitees for their own

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	negligence or willful misconduct. In addition, the indemnification terms will need to address procedural matters: the indemnitee will need to give Cerner timely written notice of the claim; give Cerner authority, information, and assistance for the claim's defense and settlement; and not materially prejudice Cerner's ability to satisfactorily defend or settle the claim.
M. Transition Services	In connection with paragraph M (*Transition Services*), Cerner agrees that the Agreement should provide for a continuation of the services, as well as for transition-related services to be provided for a period of time following the end of the regular term, whether the regular term expires or is terminated for cause. For the continuation of the regular services, the fees that were in effect for those services at the end of the regular term would continue, and for additional services that are provided relating to the transition, the fees should be mutually agreed, but for TCMHA's protection the Agreement can note that those fees will not exceed Cerner's standard rates at the time and, for professional services, Cerner's standard hourly rates at that time or any applicable rates that then apply under the Agreement. Cerner does not agree that the parties should attempt to specify in advance what the damages should be in the event of a future breach of contract, and accordingly Cerner does not agree that the transition services should be without charge if there is a termination for cause by TCMHA. The nature of the services during such a transition would evolve, so some aspects, such as any existing service level commitments, might not be applicable, depending on the circumstances. When the transition provision of the Agreement addresses the provision of data, it needs to provide for the format and structure of the copy of the data that is to be provided to TCMHA will be mutually agreed, since the format and structure will evolve over time, in addition to being what is then a standardized format and structure that is then generally accepted in the health IT industry. Regarding subparagraph 4 (*Accessing Previous EHR Software*) of paragraph M (*Transition Services*), Cerner notes that TCMHA would access data through the service, rather than by having its own archival copy of the software. That is because the system is provided only as a service, and there would be no delivery to TCMHA of a copy of any versions of the system's software. Accordingly, regarding e-discovery requests, the Agreement can provide that during the term and also during the transition period, Cerner will assist with responding to e-discovery requests for TCMHA data stored within the services and/or applicable Documentation for the purpose of litigation, arbitration, or government investigations regarding reimbursement malpractice, or other matters in which the use of such items would help establish what information was known to TCMHA and its EHR users at the time in question. As part of its transition off the services, TCMHA would be able to get a copy of its data as described above, in order to respond to future requests.
VII. GENERAL PROVISIONS	
B. Public Records – Notice Related to Proprietary/Confidential Data	The Agreement terms covering the topic noted in paragraph VII.B (*Public Records - Notice Related to Proprietary/Confidential Data*) will need to clarify that TCMHA is normally obligated to keep Cerner information confidential but that that obligation is subject to the terms of California Public Records Act that require disclosure to the public.

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	The Agreement terms should also spell out that if TCMHA receives an order or request for disclosure of information that Cerner has designated as being "confidential", "proprietary", or "trade secret", TCMHA shall notify Cerner as soon as practicable prior to such disclosure and no later than five business days after receipt of the order or request.
C. Conflict of Interest	Regarding paragraph C (*Conflicts of Interest*), Cerner is a publicly-held company and not in a position to know about any interest any elected/appointed official or employee of the TCMHA might have, for instance as a shareholder, in Cerner's being awarded the Agreement, so the first sentence will need to be removed. The Agreement can instead note that Cerner has a code of conduct (available on Cerner's public website) that addresses conflicts of interest and applies to all Cerner officers, directors, and employees. The second sentence of the paragraph needs to be narrowed to exclude employees of Cerner but can then say that Cerner has not offered to pay, paid, or agreed to pay any third party any fee, commission, percentage, brokerage fee, or gift of any kind contingent upon or in connection with, the award of the Agreement.
E. Debarred/Suspended Contractors	Regarding paragraph E (*Debarred/Suspended Contractors*), Cerner has adjusted the wording of Attachment G to reflect what Cerner can certify, for instance providing for Cerner to warrant that neither it nor any of its staff members who will be providing services directly to TCMHA onsite at a TCMHA location is restricted, excluded, or suspended from providing goods or services under any health care program funded by the Federal or State Government, directly or indirectly, in whole or in part.
F. Business Associate Agreement	Cerner has redlined some parts of TCMHA's provided BAA. Please refer to Attachment H for the noted exceptions in detail.
G. Records And Audits	The Agreement terms covering the topic noted in paragraph VII.G (*Records And Audits*) will need to clarify that the records that Cerner needs to maintain and make available to TCMHA or its authorized representative for audit purposes are those needed to show proper accounting for all charges to TCMHA under the Agreement. Accordingly, records relating to Cerner's costs would only be covered if the charges to TCMHA are based on costs, and records relating to time spent by personnel would only be covered where fees are based on a time-and-materials basis using the product of hours spent and an hourly rate. Any extensions to the stated duration of the retention period and audit right need to be agreed on by both Cerner and TCMHA, and cannot be by unilateral notice by TCMHA.
H. Governing Law and Regulations	Regarding paragraph VII.H (*Governing Law and Regulations*), the Agreement can state that the Agreement shall be governed by California law, but it should not claim that all of the services will be performed in California, as some of the services will be performed remotely by Cerner from locations outside California. The statement that Cerner must "comply with all federal, state, and local laws, standards, regulations, licenses, and permits" should be narrowed to say "all applicable federal and state laws, regulations, licenses, and permits."

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EXHIBIT F

PROPOSER PRICE PROPOSAL

Cerner Integrated – Community Behavioral Health

The Cerner Corporation is pleased to provide Tri-City Mental Health (TCMHA) with a proposal for the purchase and setup of the Cerner Integrated – Behavioral Health EHR.

Cerner's proposal provides a unified EHR that features multiple solutions and content packages specifically designed to support community providers, like TCMHA, that specialize in the delivery of mental health, substance use disorders and other behavioral health disciplines. Delivered as a Software as a Service (SaaS), it boasts cutting edge functionality including workflows specifically designed for your behavioral health professionals.

Cost Proposal Overview

Section #1: One-time costs

	Year One	Year Two	Year Three	Year Four	Year Five	Total
One-Time Fees						
Cerner Integrated - Behavioral Health	$ 387,042	$ -	$ -	$ -	$ -	$ 387,042
Transaction Services	$ 2,430	$ -	$ -	$ -	$ -	$ 2,430
Section #1 TOTAL	**$ 389,472**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 389,472**

Section #2: On-going costs

	Year One	Year Two	Year Three	Year Four	Year Five	Total
Monthly Fees						
Cerner Integrated - Behavioral Health	$ 23,316	$ 139,896	$ 139,896	$ 139,896	$ 139,896	$ 582,900
Transaction Services	$ 1,860	$ 11,160	$ 11,160	$ 11,160	$ 11,160	$ 46,500
Section #2 TOTAL	**$ 25,176**	**$ 151,056**	**$ 151,056**	**$ 151,056**	**$ 151,056**	**$ 629,400**

TOTAL (Sections 1 & 2)	**$ 414,648**	**$ 151,056**	**$ 151,056**	**$ 151,056**	**$ 151,056**	**$ 1,018,872**

Shared Computing Services; Monthly Fee:

The Cerner Integrated - Behavioral Health EHR is delivered as a Software as a Service (SaaS) model. Monthly Services Fees are inclusive of licensed software, customer support, remote hosting & hardware maintenance, Sublicenses & Subscriptions, future enhancements, and software upgrades.

Shared Computing Services; Setup Fee (Fixed Fee)

The implementation of the Cerner Integrated – Behavioral Health EHR is provided as a Fixed-Fee cost structure. The estimate is inclusive of the hours required to complete a successful implementation of the proposed project scope. This includes services related to a single data migration, domain configuration, system design & setup, super-user training, and onsite go-live support.

Design, Build, and Conversion utilizing a centralized Millennium database environment and a single "Go-Live" event

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Transaction Services

Cerner offers a variety of different Transaction Services to support your organization. Please refer to the Cerner Eligibility and Benefits Verification and the Automated Messaging Transaction Services documents located in the Additional Reference Material section of this response. Cerner can provide variations of these optional services on a per transaction volume model. We welcome further discussions to determine the appropriate scope requested and any associated costs.

General Assumptions and Notes

Based on the documentation provided by TCMHA in their Request for Proposal, Cerner has made some general assumptions related to the scope/metrics and financial estimate. We look forward to further dialogue and scope sessions between our teams to help refine our proposal and cost-estimates to ensure we are best meeting your organizational goals and initiatives.

Cerner Integrated – Behavioral Health EHR Scope:

- Services Provided:
  - Mental Health
  - Substance Use Treatment
  - Crisis Services
- # of Physical Locations: 5
- # of Concurrent Users (CCUs): 100
- # of licensed Providers / Prescribers: 5
- # of licensed Behavioral Health Professionals: 170 (DSM-5 Subscriptions)
- # Data Migration: 1 Source System
- Laboratory Interface: 1 free connection included to either Lap Corp or Quest Diagnostics
- Automated Appointment Reminders: 1,000 transactions per month
- Real-Time Eligibility & Benefits Verification: 1,000 transaction per month
- Annual Operating Expenditure: $20 mill

Historical System Data Migration

Cerner's proposal includes services to migrate a single historical system into the Cerner Integrated – Behavioral Health EHR. We would welcome further conversation with TCMHA to better understand details of the data elements and the ability to migrate this data into the new system.

Should TCMHA desire to have additional historical system migration as part of the implementation, it may result in additional Setup Fess related to these services. Cerner again would require additional conversations to better understand the data elements to be included and specifics of the historical system(s).

Integration with 3rd Party Systems/Interface Costs

In the case of interfaces that may be needed, Cerner has the capability of interfacing with 3rd Party systems using industry standards, such as HL7. Cerner welcomes further discussions to better understand data requirements necessary to meet these requests. In some instances, additional fees may be required to develop specific integration components.

- IBHIS Integration: In August of 2014 we released the capability to communicate Admission, Update, and Discharge data to the LA County IBHIS system via the IBHIS web service functions, as well as the ability to query the IBHIS system so users can view the LA County data sets. We have the understanding of web service technology including, but not limited to, the open protocols and standards such as SOAP, WSDL, XSD, and more for exchanging data electronically between applications or systems. We also have a working knowledge of user authentication using x.509 certificates, PKI exchange, Certificate Authority, and third party validation authority. Cerner has been working with our clients that report to LA County

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IBHIS since the initial release to enhance the functionality to meet any new requirements announced by LACDMH for IBHIS reporting. We have been collaborating with our clients related to workflows, functionality design, testing with LACDMH IBHIS QA, and TEST systems prior to rolling out the functionality into a production environment.

As previously discussed with TCMHA, Cerner is currently providing this integration utilizing our historic Cerner Community Behavioral Health EHR (Anasazi). However, this integration has not yet been brought forward to the proposed Cerner Integrated – Behavioral Health EHR. Cerner will work with TCMHA to complete this integration as part of the implementation process.

Travel & Accommodation Costs

The Share Computing Services - Setup Fees do not include travel costs, such as lodging, per diem, or other out-of-pocket expenses incurred by Cerner Personnel. Such expenses will be billed separately on a monthly base.

Cost of Implementation

Our response to your RFP is factual and accurate. We have made reasonable assumptions regarding metrics for projection of cost, however, should Cerner be selected as vendor of choice, we expect further conversations with TCMHA to more clearly define scope. The final EHR project may include fewer or additional solutions and professional services (e.g. interfaces, state reporting requirements, etc.…), which may impact cost. Ultimately, our goal is to ensure joint transparency regarding the scope of this EHR project.

Optional Services Summary

Optional Cerner solutions and/or workflows not included in proposal include, but not limited to Primary Care, Patient Kiosk, Video Visits, CareTracker (resident / IDD point of care documentation) and Physician Mobility. Cerner would welcome further conversations as how these solutions could provide additional functionality and benefit to your organization. Please note, additional costs may apply.

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Automated Messaging

Description:

Automated Messaging (TSEDI-CALL-MIN) is a Transaction Service that automatically contacts patients with important information via personalized phone delivery, e-mail notification or text message. Automated Messaging detects answering machines and leaves a distinct message when a person cannot be reached directly by phone. Automated Messaging logs each call or message, offering a secure audit trail for communications.

Major Features:

- For phone delivery, the medical facility or clinic office phone number is promoted to the Caller ID of person receiving the reminder.
- Ability to notify patients of multiple same day appointments with one phone call.
- Multiple call schedules may be used to handle cancellations.
- At the time of scheduling an appointment, the patient has the ability to request the appointment reminder via phone, text, email or to not receive a reminder.
- Messages are recorded using live voice talent.
- For voice calls, patients confirm the appointment or indicate appointment needs to be rescheduled using the keys on their touch tone phone. The responses are captured and reportable.
- For text messages, patients confirm the appointment of indicate appointments need to be rescheduled by responding to the text message received.
- Standard message templates are available in English and Spanish. Other languages may be recorded for an additional fee.
- Reports may be sorted by provider, location, patient or status. Reports may be auto-distributed via printer or emailed to users.

Availability:

The solution is available as described.

Special Licensing and/or System Considerations:

Automated Messaging is priced on a minimum volume transaction basis with a minimum five-year term. Minimum transaction and overages are invoiced on a monthly basis.

- Descriptions included herein relating to third party software or services are for informational purposes only. Cerner makes no representations or warranties concerning third party software or services, including the functionality or performance thereof. Third party software and services are provided solely under any applicable pass-through terms of the third party supplier.

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Solution or Service Prerequisites:

- Cerner Scheduling Management (CP-20740) *or*
- Departmental Scheduling Management (CV-22100, RA-22100, SU-22100) *or*
- Appointment Notifications Incoming (IF-29035) *or*
- Practice Management: Registration and Scheduling (PV-20247)

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Cerner Behavioral Health

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Assessments & templates

- Abnormal Involuntary Movement (AIMS)
- Addiction Severity Index (ASI)
- Adult Biopsychosocial
- Adult Needs and Strengths Assessment (ANSA)
- Adverse Childhood Experience (ACE) Screening
- Alcohol Use Disorders Identification Test (AUDIT)
- Alcohol Use Disorders Identification Test — Consumption (AUDIT-C)
- Anxiety Parent Guardian of Child 6-17
- Anxiety Guardian
- ASAM Assessment
- Barnes Akathisia Rating Scale (BARS)
- BH Certification/Recertification/Decertification
- BH Daily Living Activities (DLA20)
- BH I-SMART Discharge Iowa
- BH I-SMART Follow Up Iowa
- BH I-SMART Placement Screening Iowa
- BH Nursing Discharge Summary PowerForm
- BH Parent-Proxy Pediatric PROMIS Scale: Cognitive Function
- BH Parent-Proxy Pediatric PROMIS Scale: Meaning and Purpose
- BH Parent-Proxy Pediatric PROMIS Scale: Psychological Stress Experience
- BH Pediatric PROMIS Scale Short Form: Meaning and Purpose
- BH Therapeutic Recreation Assessment PowerForm
- BH Transmission of Transition Record PowerForm
- Brief Med Adherence Rating Scale (BARS)
- Brief Psychiatric Rating Scales
  - Adult (BPRS)
  - Child (BPRS-C)
- Brief Substance Craving Scale
- CAGE Assessment
- Calgary Depression Scale for Schizophrenia (CDSS)
- California caLOMS Standard Admission
- California caLOMS Standard Annual Update
- California caLOMS Standard Discharge
- California caLOMS Youth Admission
- California caLOMS Youth Annual Update
- California caLOMS Youth Discharge
- California CANS
- California Client and Service Information Assessment (CSI)
- California Pediatric Symptom Checklist
- CANS – Autism Spectrum Profile
- CANS Mental Health
- Certification Recertification Decertification
- Child and Adolescent Biopsychosocial Assessment
- Child and Adolescent Intake Assessment
- Child and Adolescent Needs and Strengths
  - Autism Spectrum Profile
  - Mental Health
- Child Global Assessment Scale (CGAS)
- Childhood Trauma Questionnaire (CTQ)
- Client Satisfaction Survey
- Clinical Global Impression (CGI)
- Clinical Institute Withdrawal Assessment (CIWA-AR)
- Clinical Opiate Withdrawal Scale (COWS)
- Clinician Administered Dissociative States Scale
- Clinician Administered PTSD Scale (CAPS-5)
- Cocaine Selective Severity Assessment (CSSA)
- Cognitive Test EBP
- Columbia Suicide Severity Rating Scales
  - Emergency Department Screener
  - Frequent Screener
  - Full Version Adult
  - Full Version Child
  - Inpatient Discharge
  - Military
  - Risk Assessment
  - Screening
- Combat Exposure Scale Checklist
- CRAFFT
- Crisis Evaluation
- Crisis Stabilization Assessment
- Depression
- Developmental Disabilities Comprehensive Assessment
- Developmental Disabilities Environmental checklist
- Developmental Disabilities Person-Directed Plan
- Developmental Disabilities Services Assessment
- Developmental Disabilities Supplemental Needs/Risk Assessment
- Developmental Disability Texas Adaptive Aids Implementation Plan
- Developmental Disability Texas Behavior Supports Implementation Plan
- Developmental Disability Texas CFC PAS/HAB Implementation Plan
- Developmental Disability Texas Day HAB Implementation Plan
- Developmental Disability Texas Dental Implementation Plan
- Developmental Disability Texas Host Home Companion Care Implementation Plan
- Developmental Disability Texas Individual Transportation Plan
- Developmental Disability Texas LVN Implementation Plan
- Developmental Disability Texas Occupational Therapy Service Implementation Plan
- Developmental Disability Texas Residential Support Service Implementation Plan
- Developmental Disability Texas Respite Hourly Implementation Plan
- Developmental Disability Texas RN Implementation Plan
- Developmental Disability Texas Supervised Living Implementation Plan
- Developmental Disability Texas Supported Employment Implementation Plan
- Developmental Disability Texas Transportation Implementation Plan
- Developmental Disability Virginia Face to Face Assessment
- Difficulties in Emotional Regulation Scale (DERS)
- Dissociative Experiences Scale (DES-B)
- Dynamic Appraisal of Situational Aggression (DASA)
- Dynamic Appraisal of Situational Aggression (DASA) Risk Flag Assessment
- Eating Attitudes Test (EAT-26)
- Edinburgh Postnatal Depression Scale (EPDS)
- Electroconvulsive Therapy
  - Pre and Post Checklists
  - Vitals and System Assessments
- Fagerstrom Test for Nicotine Dependence (FTND)
- Functional Assessment Rating Scale
  - Adult (FARS)
  - Child (CFARS)
- Functional Monitoring Inpatient Tool
- Generalized Anxiety Disorder 7 (GAD-7)
- Geriatric Depression Scale
  - GDS 15
  - GDS 30

*Not packaged. Available in model.
**Additional fees apply as required by the third party.

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Assessments & templates

- Hamilton Anxiety Scale (HAM-A)
- Hamilton Depression Rating Scale (HDRS)
- Health Home Eligibility Assessment
- Initial Contact
- Intake Assessment Adult
- Interpreter Services
- Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS)
- Iowa I-SMART Crisis Intervention
- Iowa I-SMART Discharge
- Iowa I-SMART Follow Up
- Iowa I-SMART Placement Screening, Admission
- Life Events Checklist (LEC-5)
  - Clinician Administered
  - Self-Report
- Master Treatment Plan
- Mental Status Exam
- Michigan Alcohol Screening Test (MAST)
- Missouri CIMOR
- Modified Alcohol, Smoking, and Substance Involvement Screening Test (Modified ASSIST)
- Modified Blessed Dementia Rating Scale
- Modified Overt Aggression Scale (MOAS)
- Monitoring of Side Effects Scale (MOSES)
- Montgomery Asberg Depression Scale (MADRS)
- Mood and Feelings Questionnaire (MFQ)
  - Parent and Child Versions
- MORE Recovery Capitol Scale
- National Institute of Drug Abuse (NIDA) Quick Screen
- New York OASAS Admission, Discharge, Transfer & Crisis
- New York Personalized Recovery Oriented Services (PROS)
- NICHQ Vanderbilt Assessment
  - Parent Follow-up
  - Parent Informant
  - Teacher Follow-up
  - Teacher Informant
- Oregon MOTS Crisis
- Oregon MOTS Involuntary Service
- Oregon MOTS Substance Use
- Orientation Memory Concentration Test
- Outpatient Intake Assessment Adult
- Patient Reported Outcome Measurement Information System (PROMIS) Scales
- Pediatric Symptom Checklist
- PHQ-A
- PHQ-9
- PHQ-15
- Pediatric Symptom Checklist (PSC)
- Primary Care PTSD Screen for DSM-5
- Problem Gambling Severity Index (PGSI)
- PROMIS Scales
- PROS CAIRS Registration Assessment
- PROS Ongoing Rehab and Support Assessment - Form
- Psychiatric Rehabilitation Readiness Determination
- Psychosocial Assessment Adult
- PTSD Checklist (PCL-5)
- Quick Inventory of Depressive Symptomatology (QIDS)
- Quick Inventory of Depressive Symptomatology (QIDS) self-report
- Recreational Therapy Assess
- Safety Plan
- Same Day Access Triage Assessment - Form
- Screen for Childhood Anxiety Related Disorders (SCARED)
  - Parent and Child Versions
- Serious Emotional Disturbance
- Serious Mental Illness Review
- Short Form Health Survey (SF-36)
- Sleep Disturbance Adult, Adolescent & Child
- Social Determinants PREPARE
- Social Interaction Anxiety Scale (SIAS)
- Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)
- Substance Use Assessment
- Systemic Clinical Outcomes Routine Evaluation 15 (SCORE-15)
- Texas ANSA
- Texas ANSA and LOC
- Texas CANS
- Texas CANS 6-17, 3-5
- Texas CANS LOC
- Texas YES Waiver CANS
- Texas Yes Waiver Clinical Eligibility
- The Daily Living Activities (DLA-20) YOUTH ages 6-18
- The Developmental Disabilities (DD) Virginia Enhanced Case Management Assessment
- Transmission Transition Record
- Traumatic Events Screening Inventory for Children (TESI-C)
- UCLA Revised Loneliness Scale
- URICA DELTA Project Reduced Drinking
- URICA Psychotherapy
- Validated Instruments Scores/Outcomes
- Vanderbilt ADHD Parent Informant
- Vanderbilt Parent Follow Up
- Vanderbilt Teacher Follow Up
- Virginia Community Consumer Submission 3 (CCS-3)
- Virginia Preadmission Screening
- Virginia Serious Mental Illness Criteria
- Virginia SED Criteria
- WilsonSims Fall Risk Assessment
- World Health Organization Disability Assessment Schedule
- Yale University PRIME Screening Test

The following are available for the Patient Reported Outcome Measurement Information System (PROMIS):

- Virginia Uniform Assessment Instrument
- Virginia WaMS VIDES (Adult, Child, Infant)
- Withdrawal Management Active View

*Not packaged. Available in model.
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Activity views*

Restraint

- Continue
- Debriefing
- Initiate Violent
- Monitoring

Room Check

Systems Assessment

Rules

Patient Safety

Suicide Risk

Two-Admission Rules

Violence Risk

Level of Responsibility

Reporting & analytics

15-Minute Safety Check Analysis

Admission Assessments

Admissions

Brief Psychiatric Rating Scale (BPRS) Analysis

Brief Psychiatric Rating Scale for Children (BPRS-C) Analysis

Children’s Global Assessment Scale (CGAS)

Current Caseload

Current Census

Current Patients on Antidepressant Medication

Current Patients on Antipsychotic Medication

Diagnosis Listing

Discharges

Employment Status

GAD-7 Report

Generalized Anxiety Disorder Scale 7 (GAD-7)

Global Assessment of Functioning (GAF)

Group Therapy Charges

Hold Order Expiration

Homeless Rates upon Admission

Hold Order Expiration

Homeless Rates upon Admission

Housing Status

Ketamine Usage

Reporting & analytics continued

KPI: Timeliness of Safety Checks

KPI: Violence Risk Assessment at Admission

Length of Stay — Current Patients

Length of Stay — Discharged Patients

Observation Level Statistics (Safety and Attendance Report)

Overdue Activities

PHQ-9 Outcomes

Readmissions

Referral Sources

Suicidal Ideation — Current Patients

Unassigned Patients

Violent Restraint Orders

Order sets

Behavioral Health Admission

Behavioral Health Pediatric Admission

Day Treatment Admission

Detoxification Admission

Discharge Orders

Interdisciplinary Plans of Care

- Altered Psychosocial Status*
- Anxiety Treatment Plan
- Psychological Impairment — Mood
- Psychological Impairment — Thought
- Self-Harm/Suicide Risk
- Sleep Problem
- Substance Use Detox
- Substance Use Relapse Prevention
- Violence Risk

Discharge summary templates*

BH Clinical Summary

BH Patient Summary

Functionality/ components

Activities (Summary Component)

Patient Safety (Summary Component)

Prescription Drug Monitoring/NARxCHECK**

Safety and Attendance (Patient Rounding)

Therapeutic Documentation (Group Notes)

Therapies and Treatment (Summary Component)

Terminology

DSM-5**

Other capabilities outside of the BH solution (may require additional licensing)

CareCompass™

CareTracker™

CareAware Connect™

Clinical Leader Organizer

Commitment Status Tracking

CommonWell Health Alliance®

Discern nCode®

Document Imaging

E-Prescribing

Enterprise Data Warehouse

Immunization Registry Import

Laboratory

Leaves Tracking

Lights On Network®

Meaningful Use Certification

Medication Administration Record

Message Center

Mobile Patient eSIG

Patient Portal

Patient Timeline

Pharmacy

Physician Hand-off

Referral Management (in Development)

Required Documentation Management

Scheduling and Revenue Cycle

Tracking Board

Unit-Based Scheduling

Voice Recognition**

Wait-List Management

Workforce Management

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Cerner Corporation

Report on Cerner Corporation's Description of its Hosting and Managed Services, "CernerWorks" and on the Suitability of the Design and Operating Effectiveness of Controls to Meet the Criteria for the Security, Availability, and Confidentiality Trust Services Categories SOC 3

For the period April 1, 2019 to March 31, 2020

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Section I - Independent service auditor's report provided by KPMG LLP

KPMG LLP
Suite 3400
312 Walnut Street
Cincinnati, OH 45202

Independent Service Auditor's Report

Board of Directors of Cerner Corporation:

Scope

We have examined Cerner Corporation's accompanying assertion titled "Cerner Corporation's Assertion " (assertion) that the controls within Cerner Corporation 's Hosting and Managed Services system in Kansas City, Missouri (system) were effective throughout the period April 1, 2019, to March 31, 2020, to provide reasonable assurance that Cerner Corporation's service commitments and system requirements were achieved based on the trust services criteria relevant to security, availability, and confidentiality (applicable trust services criteria) set forth in TSP section 100, 2017 Trust Services Criteria for Security, Availability, Processing Integrity, Confidentiality, and Privacy (AICPA, Trust Services Criteria).

Service Organization's Responsibilities

Cerner Corporation is responsible for its service commitments and system requirements and for designing, implementing, and operating effective controls within the system to provide reasonable assurance that Cerner Corporation's service commitments and system requirements were achieved. Cerner Corporation has also provided the accompanying assertion about the effectiveness of controls within the system. When preparing its assertion, Cerner Corporation is responsible for selecting, and identifying in its assertion, the applicable trust service criteria and for having a reasonable basis for its assertion by performing an assessment of the effectiveness of the controls within the system.

Service Auditor's Responsibilities

Our responsibility is to express an opinion, based on our examination, on whether management's assertion that controls within the system were effective throughout the period to provide reasonable assurance that the service organization's service commitments and system requirements were achieved based on the applicable trust services criteria. Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform our examination to obtain reasonable assurance about whether management's assertion is fairly stated, in all material respects. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

Our examination included:

- Obtaining an understanding of the system and Cerner Corporation's service commitments and system requirements
- Assessing the risks that controls were not effective to achieve Cerner Corporation's service commitments and system requirements based on the applicable trust services criteria
- Performing procedures to obtain evidence about whether controls within the system were effective to achieve Cerner Corporation's service commitments and system requirements based the applicable trust services criteria

Our examination also included performing such other procedures as we considered necessary in the circumstances.

Inherent Limitations

There are inherent limitations in the effectiveness of any system of internal control, including the possibility of human error and the circumvention of controls.

Because of their nature, controls may not always operate effectively to provide reasonable assurance that the service organization's service commitments and system requirements were achieved based on the applicable trust services criteria. Also, the projection to the future of any conclusions about the effectiveness of controls is subject to the risk that controls may become inadequate because of changes in conditions or that the degree of compliance with the policies or procedures may deteriorate.

Opinion

In our opinion, management's assertion that the controls within Cerner Corporation's Hosting and Managed Services system in Kansas City, Missouri were effective throughout the period April 1, 2019, to March 31, 2020, to provide reasonable assurance that Cerner Corporation's service commitments and system requirements were achieved based on the applicable trust services criteria is fairly stated, in all material respects.

KPMG LLP

May 14, 2020
Cincinnati, Ohio

Section II - Cerner Corporation's Assertion

Cerner Corporation's Assertion

We are responsible for designing, implementing, operating, and maintaining effective controls within Cerner Corporation's Hosting and Managed Services system in Kansas City, Missouri (system) throughout the period April 1, 2019, to March 31, 2020, to provide reasonable assurance that Cerner Corporation's service commitments and system requirements relevant to security, availability, and confidentiality were achieved. Our description of the boundaries of the system is presented in Attachment A and identifies the aspects of the system covered by our assertion.

We have performed an evaluation of the effectiveness of the controls within the system throughout the period April 1, 2019, to March 31, 2020, to provide reasonable assurance that Cerner Corporation's service commitments and system requirements were achieved based on the trust services criteria relevant to security, availability, and confidentiality (applicable trust services criteria) set forth in TSP section 100, 2017 Trust Services Criteria for Security, Availability, Processing Integrity, Confidentiality, and Privacy (AICPA, Trust Services Criteria).Cerner Corporation's objectives for the system in applying the applicable trust services criteria are embodied in its service commitments and system requirements relevant to the applicable trust services criteria.

The principal service commitments and system requirements related to the applicable trust services criteria are presented in attachment A.

There are inherent limitations in any system of internal control, including the possibility of human error and the circumvention of controls. Because of these inherent limitations, a service organization may achieve reasonable, but not absolute, assurance that its service commitments and system requirements are achieved. We assert that the controls within the system were effective throughout the period April 1, 2019, to March 31, 2020, to provide reasonable assurance that Cerner Corporation's service commitments and system requirements were achieved based on the applicable trust services criteria.

Cerner Corporation

May 14, 2020

Attachment A - Cerner Corporation's Description of its Hosting and Managed Services System in Kansas City, Missouri

Overview

Company and Operations

Cerner's health information technologies connect people, information, and systems at more than 27,500 facilities worldwide. Cerner solutions assist clinicians in making care decisions and enable organizations to manage the health of populations. The Company also offers an integrated clinical and financial system to help health care organizations manage revenue, as well as a wide range of services to support clients' clinical, financial, and operational needs. Cerner's mission is to contribute to the systemic improvement of health care delivery and the health of communities.

The focus of this report is Cerner's hosting and managed services in Kansas City, Missouri, "CernerWorks." CernerWorks is comprised of ISO 9001: 2008 certified organizations whose primary function is to host, manage, and monitor client systems. These organizations also contribute to a diverse range of Cerner initiatives that require data center and systems management expertise. CernerWorks hosts and manages systems that run Cerner-developed applications as well as key third-party applications based on the business needs of the client.

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Scope of Services

The scope of this report is the CernerWorks service offerings, which include a broad spectrum of services. Services include Remote Hosting Option (RHO) and managed services such as, Software as a Service (SaaS), Cerner Skybox, and Operational Management Services (OMS). The specific services and related customer responsibilities are defined in detail in each client's contract.

Remote Hosting Option (RHO)

In the standard RHO model, CernerWorks acts as the client's remote Information Technology (IT) department, providing the hosting and technical, management, and support of Cerner's and selected third-party's solutions while minimizing the client's investment of capital and human resources. The RHO option is available to all Cerner clients in the U.S.

An RHO client purchases Cerner software, and in many cases, also purchases end-user desktops and other devices from Cerner. The organization also subscribes to the use of system hardware and related network services delivered out of Cerner's Technology Centers (CTCs). The CTCs provide the hardware, secure hosting, connectivity, and IT expertise that keep the systems running. Application processing and data storage are hosted at each CTC and are maintained by a staff of Cerner system experts. CernerWorks is responsible for system maintenance, backups, and upgrades, and provides technical support. Continuous system monitoring identifies potential issues before they arise and ensures optimum system availability and performance.

Clients can also elect to have CernerWorks host and manage third-party applications independent of or in conjunction with the hosting service, as described above. Clients may elect to purchase their third-party application direct from the supplier or through Cerner. (Arrangements vary by contract and vendor.) Other aspects of the service are similar to the RHO service described above.

RHO service provides superior performance, security, reliability, and scalability with a lower upfront financial commitment from the client by combining hardware, networking technologies, and technical expertise. It allows healthcare organizations to leverage some of the most sophisticated and powerful IT solutions available today. RHO can provide significant cost-savings over a Client-hosted model and competitive advantages. It helps clients avoid the requirements associated with hardware depreciation and obsolescence, layered software licensing changes, and, most importantly, frees the Client's IT department to focus on the core business areas of providing health care.

Software as a Service (SaaS) Cloud Platform

Cerner's cloud platforms support a SaaS software delivery model in which software is managed and licensed by Cerner on a pay-for-use basis, centrally hosted, on-demand, and common to all clients. Cloud computing refers to the ability to store and access data and applications via the internet. There are different types of cloud offerings, most notably private cloud (a hosting model in which a client's applications are hosted within a vendor's own data center), and public cloud (where applications and services are hosted in a third-party partner's data center). There is also a hybrid cloud in which some data, application services, or capabilities are hosted in a vendor's own data center, and a third-party cloud provider hosts some.

Amazon Web Services (AWS) is Cerner's public cloud partner. AWS is a sub-service provider of Cerner, and controls owned by AWS are not included in the scope of this report. Controls owned by Cerner for clients on AWS infrastructure services are described in the narrative below. If you have questions on portions of your solution hosted by AWS, please contact your Cerner Account Executive (CAE) or

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CernerWorks Client Owner (CCO). To ensure AWS has implemented industry equivalent controls, Cerner reviews and evaluates the AWS SOC 2 Type 2 report on an annual basis.

Historically, Cerner has leveraged a private cloud hosting model in which we host and manage client applications from our own data centers. To enable the delivery of centrally deployed software in all markets, Cerner has established the Cerner Cloud Region (CCR) strategy. Based on regulatory requirements and client needs, each CCR uses a unique mix of Cerner's private and AWS' public infrastructure. Cerner associates continue to manage systems and perform code deployments for all clients within a CCR.

Cerner deploys cloud platforms on behalf of its clients within Cerner's private and hybrid cloud infrastructures. Located within Cerner CTCs, Cerner Millennium®+, HealtheIntent® and CareAware® are examples of Cerner cloud platforms

Cerner continues to build, deliver, and maintain cloud platforms and SaaS solutions using an equivalent security architecture as traditional RHO with a different method of access through the internet.

Cerner Skybox

Cerner Skybox is a suite of cloud technology infrastructure solutions designed specifically for health care. Cerner provides and manages the infrastructure platform for multiple solutions, minimizing the client's investment of capital and human resources. These solutions are available as a service to all existing Cerner clients as well as new health care clients.

Skybox provides solutions in the following areas: WAN Connectivity, Messaging (email), IT Security, and Mobility. Solutions are scalable reducing management overhead allowing clients to focus on delivery applications that add value to their organization.

Cerner Skybox provides superior performance, security, reliability, and scalability with a lower up-front financial commitment from the client by combining hardware, networking technologies, and technical expertise. It allows health care organizations to leverage a central delivery model for technology and provides significant cost-savings and competitive advantages. It also helps avoid hardware depreciation and obsolescence and frees the Client's IT department to focus on core business areas of providing health care.

Operational Management Services (OMS)

Cerner's OMS offering provides remote system management and monitoring for client-hosted *Millennium®* EMR systems, databases, and other ancillary solutions. The service emphasizes 24x7 proactive systems monitoring and management, resulting in improved reliability and availability for Cerner applications. This service leverages the same system management and monitoring toolset and skilled technical resources that Cerner's Remote Hosting Option (RHO) service utilizes.

Monitoring offers 24x7 monitoring of selected client systems via industry-standard system monitoring tools. Issues are identified and logged by an Immediate Response Center (IRC) Support Specialist, who then contacts the client Help Desk or assigned CernerWorks Production Owner (PO) as appropriate. The assigned PO is responsible for coordinating responses and seeing that issues are resolved.

Reactive Management offers 24x7 monitoring of selected client systems. Issues and critical events are identified and logged automatically by the monitoring systems. For higher severity issues, an Immediate Response Center (IRC) Support Specialists will be engaged. The response consists of either immediate break/fix activities or escalation to the appropriate PO or domain specialist. The assigned PO is responsible for coordinating responses and seeing that issues are resolved.

Remote Management offers all of the features of Monitoring and Reactive Management, plus proactive system and database management activities. Remote management includes tools along with a team of system engineers and database administrators managing components such as the operating system, (*i.e.*, disk space and errors detection, system performance), database, (*i.e.*, database environments, table

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space, performance, growth) and selected application components (*i.e.*, servers/managers, interfaces). CernerWorks system managers can also review system messages and logs, and production processes. Together these technical resources and monitoring tools optimize the client's system performance and can work proactively to prevent potential resource bottlenecks and failures, such as increasing table space, performing modifications, and tuning the system.

Cerner Hosted Disaster Recovery (DR)

Cerner's approach to Business Continuity includes multiple areas of focus and design. Cerner strongly believes that Production environments should be designed to be resilient in all areas of the system to quickly and as seamlessly as possible react to component failures. This design approach offers the highest levels of system availability that are inherently built into the base architecture of production systems. We continue to drive improvements at all levels of the system so that highly available system configurations along with software updates that are passive and non-disruptive to application functionality can offer flexibility to perform maintenance (i.e., installation of application-level code, system-level patches, etc.), as well as maintain availability for production operations due to a hardware failure, while end-users are still on the system. Cerner has a proven track record of providing remotely hosted services that have consistently demonstrated very high levels of service availability, stability, and performance.

Cerner maintains a Business Resilience Program that covers both Business Continuity and Disaster Recovery aspects of recovery and resumption. The Disaster Recovery components of the program ensure that controls are in place in order for Cerner to react to a disaster situation (i.e., a force majeure type of event). The framework of the program is primarily based on ISO 22301 - Business Continuity Management standard, with also leveraging guidelines from Disaster Recovery Institute International (DRII), Federal Continuity Directive 1, and Federal Emergency Management Agency (FEMA). Focus areas in the program include the following: Response Phase, Recovery Phase, and Resumption Phase. In the event of a significant disaster (i.e., loss of data center facility or a system becomes inoperable with no foreseeable time frame for resolution), we follow an established and documented Incident Management Plan along with applicable DR plans to restore hosting services as quickly and effectively as possible using commercially reasonable measures. Cerner's Business Resilience Program (BRP) is reviewed and exercised on a routine basis by key leaders across the organization to ensure all critical data, systems and operational imperatives have the appropriate safeguards in place to reduce risk in the event of a disaster that renders Cerner's hosting services and/or business systems completely inoperable.

Disaster Recovery Option for RHO

In addition to the base DR service provision, Cerner also offers optional DR services available for dedicated RHO systems as well as client-hosted production environments. This service is designed systems that require a fail-safe backup system to minimize downtime due to catastrophic scenarios that render a production system, entire data center, or a portion of a data center completely unrecoverable or inoperable. Options that include a committed Recovery Time Objective (RTO) are the following: "Hot Site" (6, 24, 72 hour), "Warm Site" (6, 12 day) and Database Protection (2 hour). Hot Site options use replication management technologies and dedicated hardware making it possible to restore the client's environment within the committed RTO in the event of a significant disaster (i.e., force majeure event). Cerner also offers read-only solutions specifically designed for use in the event of a *Millennium®* production system unscheduled downtime. For more information on Cerner's 724 Access Read Only, 724 Access Downtime Viewer, or DR solutions, go to Cerner.com or contact your Cerner Client Representative. (Note: Warm Site and Database Protection options are not available for client-hosted production systems.)

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All Cerner Remote Hosted Clients have disaster recovery plans stored in Cerner's Incident Connect Tool, and access is restricted only to authorized personnel. Disaster recovery plans include the following components:

- Recovery and restoration objects as agreed between Cerner and the Client.
- Roles, Responsibilities, and contact information of those responsible for recovery activities.
- Identification of essential business functions and critical assets.
- Provisions for the full restoration of the client environment.

Disaster Recovery for Software as a Service (SaaS) on Cloud Platforms

Cerner services leveraging Amazon Web Services (AWS) deployed across multiple availability zones (AZ) within data single public cloud region when feasible. An AWS region contains at least two availability zones, and each AZ consists of one or more physical data centers, each with redundant power, networking, and connectivity. Availability zones within a region are separated at a great enough distance to prevent a natural disaster from impacting multiple availability zones and are connected to each other with fast, private fiber-optic networking. The use of availability zones provides an easier and more effective way to design and operate applications and databases, making them highly available, fault-tolerant, and scalable than traditional single datacenter infrastructures or multi-datacenter infrastructures.

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Principal Service Commitments and System Requirements

Cerner designs its processes and procedures to meet its objectives for its Managed Services. Those objectives are based on Cerner's continued corporate objectives to provide technology services available in the marketplace and the service commitments we make to our clients. The processes and procedures established incorporate the laws and regulations that govern the provisioning of managed technology services, the financial, operational, and other compliance requirements required for the services. Security-related commitments are standardized and include the following:

- Maintaining an Enterprise Security Program that contains administrative, technical and physical safeguards that are appropriate for Cerner's business;
- Use of industry-standard technology deployments and security toolsets designed to protect the confidentiality, integrity, and availability of Client data in Cerner's possession;
- Protect against anticipated logical threats and vulnerabilities to Client data;
- Protect against unauthorized or unlawful access, use, or disclosure of Client data;
- Use of industry-standard encryption technologies to protect customer data both at rest and in transit; and
- Policies around how associates are trained in the handling of sensitive data

Service availability commitments to user entities are documented and communicated within Client service agreements and will vary based on service along with individual Client service objectives. Responsibilities related to contingency planning (i.e., disaster recovery) are also contained within service agreements and include information related to system recovery efforts in the event of a significant (i.e., force majeure) disaster event. Availability related commitments include the following:

- Cerner monitors baseline system performance as defined within SLAs;
- Cerner is responsible for security incident event management and is responsible for 24x7x365 continuous threat monitoring of Cerner's Platforms;
- Cerner maintains a security incident management process to investigate, mitigate and communication system security events occurring within a Platform;
- Cerner provides a redundant and highly available infrastructure designed to minimize disruptions to client environments;
- Cerner's contingency program is designed to ensure continued operation of essential technology by supporting internal and external client functions during an incident;
- Cerner tests incident management portions of Cerner's contingency planning program annually;

Cerner operates under the premise that all client data stored on Cerner's platforms is considered sensitive/confidential data and is treated accordingly. Cerner is a data steward of client stored data; however, Cerner views the client as the owner of data. Data is retained and disposed of in accordance with contractual agreements.

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Cerner establishes operational requirements that support the achievement of the service commitments, relevant laws and regulations, and other systems requirements. Such requirements are communicated in Cerner system policies and procedures, system design documentation, and contracts with customers. Information security policies define an organization-wide approach to how systems and data are protected. These include policies around how the service is designed and developed, how the system is operated, how the internal business systems and networks are managed and how employees are hired and trained.

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Components of the System

Cerner's hosting and managed services system is comprised of five key components organized to achieve the service delivery objectives outlined in each client's contract. These components include infrastructure, software, people, procedures, and data.

Infrastructure – Facilities, Equipment, and Networks

CernerWorks provides a highly available, redundant environment capable of withstanding a single component failure with no (or minimal) disruption to a contracted service. In the event, there are multiple failures of the same component type (e.g., both redundant network switches are disrupted), CernerWorks will make commercially reasonable efforts to repair or replace the failed components and return the affected service(s) to normal operation. There are three primary elements that if damaged or destroyed, may affect Cerner's ability to deliver contracted services:

Facility: Cerner Technology Centers (CTC) are designed to provide a fully redundant Power and Air Conditioning environment. Redundant UPS systems are utilized to provide temporary power in case of loss of the primary UPS system. Backup generators provide power for extended interruptions of the power source.

Infrastructure: A redundant Infrastructure is utilized for all Production environments hosted in all Cerner Technology Centers. Two separate telecommunication providers are used to provide diverse network paths from the client site to the CTC sites. (Some clients may have elected not to have some of the redundant Infrastructure components implemented in an effort to reduce costs. This affects their service availability in the case of an interruption of service). System backups are conducted in compliance with the Enterprise Backup Policy to provide a method to restore a system in case of a disaster.

Support Personnel: CernerWorks provides support staff 24x7x365 to ensure alert, prepared and knowledgeable resources are immediately available for daily operations and during a disaster. Knowledgeable personnel are staffed at multiple facilities to help ensure coverage in the case of a facility-specific event.

Software – Systems, Applications, and Utilities

A Cerner client purchases Cerner software licensing, support and maintenance, as well as their desktops and peripherals, and contracts with Cerner for implementation services. The RHO service provides the required hosting components for systems dedicated to one client as well as multi-tenant service offerings. Components required to support and operate the software include the hosting facilities, core infrastructure, servers, network, and storage. In addition to the applications purchased by clients, Cerner leverages numerous industry-standard software toolsets to support the services. All layers of the service require system management and monitoring software to ensure services maintain optimal operation. Some examples of the software used in support of the services include Remedy, Oracle Enterprise Manager, Zabbix, NetBackup, McAfee, and many others.

Cerner utilizes programs and operating software to manage business functions such as EMR solutions (including Millennium®), population health solutions (including HealtheIntent), as well as other hosted solutions utilized by Cerner's clients.

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People – Service engagement staff, infrastructure experts, system administrators, developers, solution experts, and leadership

Cerner's hosting and managed services, "CernerWorks," is comprised of two primary organizations: The Client-facing service delivery organization (also called CernerWorks or CWx) and the organization responsible for providing the infrastructure and data center services, Cerner Technology Services (CTS). It is structured to provide efficient and effective management of client systems and the facilities that house them. Additionally, Cerner's Immediate Response Center (IRC), residing in Cerner's Connect organization, works very closely with both organizations, to manage incidents on behalf of all Cerner clients.

Unless specifically noted, the use of the term CernerWorks in this document refers to the hosting and managed services.

A description of organization structure, processes, roles and responsibilities are posted on Cerner's intranet and available to internal users.

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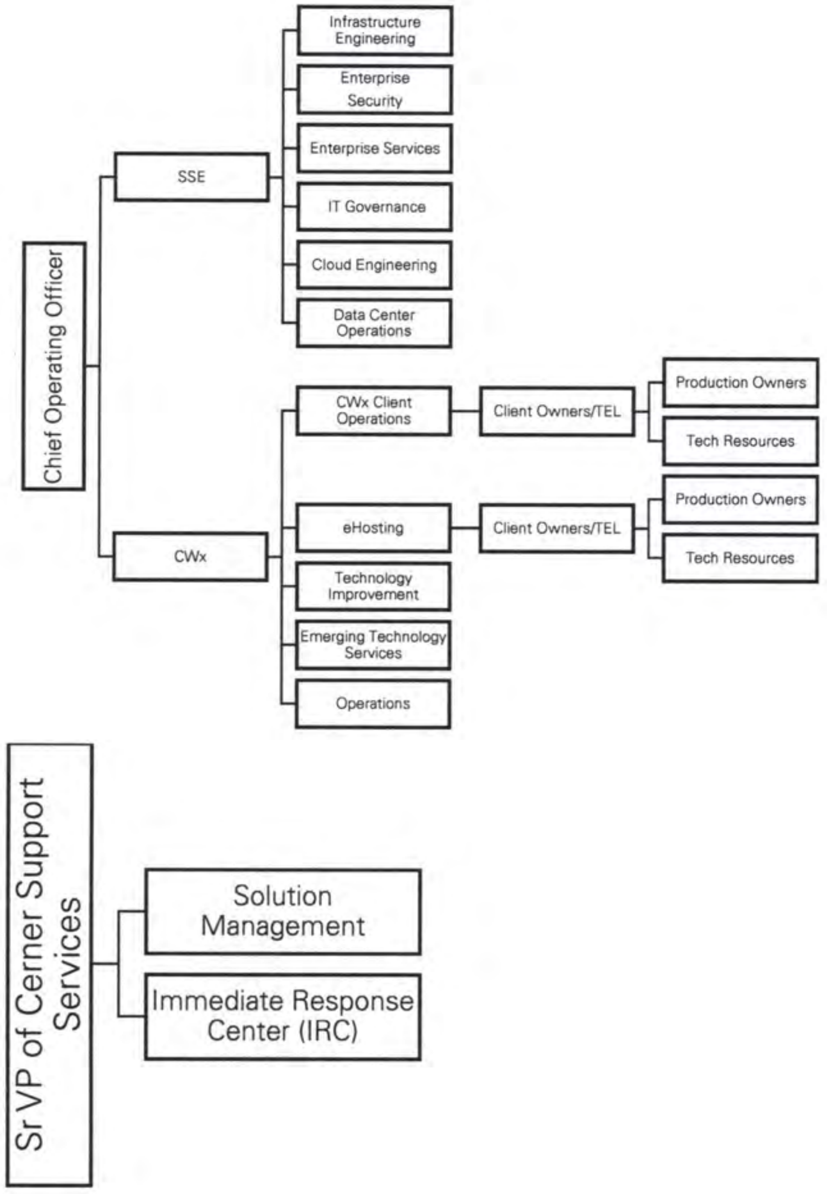

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Process and Procedures – Automated and Manual

A robust library of policies and procedures is a key component of associate training and serves as a foundation for delivering quality operations. CernerWorks leverages the Information Technology Infrastructure Library (ITIL) as the foundation and guiding philosophy for its service management operational framework. CernerWorks policies and procedures are documented and maintained in accordance with corporate documentation management policies based on ISO 9001 standards. Periodically, processes are reviewed internally for compliance and process improvement opportunities, with results being communicated to executive process owners.

Cerner designs its processes and procedures to meet its objectives for its Managed Services. Those objectives are based on Cerner's continued corporate objectives to provide the best technology services available in the marketplace and the service commitments we make to our clients. The processes and procedures established incorporate the laws and regulations that govern the provision of managed technology services, the financial, operational, and other compliance requirements required for the services. Cerner's Managed Services are subject to the security and privacy requirements of the Health Insurance Portability and Accountability Act Administrative Simplification, as amended, including relevant regulations, as well as applicable privacy and security laws and regulations in the jurisdictions in which our clients operate. Security-related commitments are standardized and include, but are not limited to, the following:

- Maintaining an Enterprise Security Program that contains administrative, technical and physical safeguards that are appropriate for Cerner's business;
- Use of industry-standard technology deployments and security toolsets designed to protect the confidentiality, integrity, and availability of Client data in Cerner's possession;
- Protect against anticipated threats or hazards to Client data;
- Protect against unauthorized or unlawful access, use, or disclosure of Client data;
- Use of industry-standard encryption technologies to protect customer data both at rest and in transit; and
- Policies around how associates are trained in the handling of sensitive data

Service availability commitments to user entities are documented and communicated within Client service agreements and will vary based on service along with individual Client service objectives. Responsibilities related to contingency planning (i.e., disaster recovery) are also contained within service agreements and include information related to system recovery efforts in the event of a significant (i.e., force majeure) disaster event.

Cerner operates under the premise that all client data stored on Cerner's platforms is considered sensitive/confidential data and is treated accordingly. Cerner is a data steward of client stored data; however, Cerner views the client as the owner of data. Client data decisions are solely the responsibility of the client.

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Data – Files, Databases, and Tables

Cerner classifies all client data as confidential data. This classification applies to information whose unauthorized disclosure, compromise, or destruction would directly or indirectly have an adverse impact on Cerner, its clients, business partners, or Associates. Cerner's clients are responsible for the data provided to Cerner for use within our hosted platforms and solutions. Clients determine what data is collected and used within Cerner's systems. As required within Cerner's master agreements and BAA documentation, Cerner maintains client data throughout the duration of the contract. Unless otherwise required and approved by Cerner's legal team, data is securely destroyed once a client has terminated their contract agreement with Cerner. All data is protected using both logical and physical safeguards, which include restriction of access to designated personnel who have a business reason to maintain such access. Additionally, encryption is required both in transit between the client's network and Cerner's and at rest. Backup files that have copies of data are secured using the same protection as native data, and these files are retained in accordance with Cerner's backup file retention policies.

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Cerner Eligibility and Benefits Verification

Description:

Cerner Eligibility and Benefits Verification (RC-20325-MIN) enables fast, easy, and secure electronic transfer of patient data between *Millennium* and Medicare, Medicaid, and many commercial payers.

Major Features:

- Provides co-pay and deductibles information for patient.
- Supports real-time processing of eligibility verification.
- Supports requests with multiple service types.
- Includes Cerner Address Validation (RC-20332)

Availability:

Cerner Millennium, Revision 2012.01.23 or greater

Special Licensing and/or System Considerations:

- *Cerner Transaction Services* are priced on a minimum volume, transaction basis for a multi-year term. Minimum transactions and overages are invoiced on a monthly basis.
- Notice:
    - *Cerner* Corporation is a non-exclusive licensee of the *United States Postal Service (USPS),* and is allowed to incorporate the Address Matching System (AMS) of the *USPS* as part of the *Cerner* software.
    - The price of the software is not established, controlled, or approved by the *USPS*. All payment related to this software shall be made payable to Cerner.
- This advertising is neither approved nor endorsed by the *USPS*.
- The following trademarks are owned by the United States Postal Service: United States Postal Service, Postal Service, Post Office , United States Post Office, USPS, the Eagle logo, ZIP + 4, ZIP Code, ZIP, CASS , CASS Certified , DPV, eLOT, RDI, LACS. This list is not exhaustive of all the trademarks belonging to the Postal Service.
- Cerner offers solutions in a shared environment for certain markets, and these offerings may require some degree of standardization and adherence to *Cerner* recommended workflows and content.
- Descriptions included herein relating to third party software or services are for informational purposes only. Cerner makes no representations or warranties concerning third party software or services, including the functionality or performance thereof. Third party software and services are provided solely under any applicable pass-through

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terms of the third party supplier.

Solution or Service Prerequisites:

- Cerner Registration Management (CP-20735) or
- Practice Management: Registration and Scheduling (PV-20247) and
- Cerner Eligibility and Benefits Submitter Setup Fee (RC-20325-STUP) and
- Cerner Eligibility and Benefits Verification Setup Fee (RC-20326)

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Cerner Integrated Community Behavioral Health

Behavioral Health and Patient Accounting/State Reports

Below is the current list of behavioral health-specific and patient accounting/state reports that are included with our Cerner Integrated Community Behavioral Health package.

This list does not include the hundreds of additional core system reports that are also part of this package.

The following report list is subject to change due to Cerner's continuous research and development efforts and our attempt to keep abreast of the ever-changing industry and regulatory demands, as well as the needs of our clients.

Behavioral Health Reports

15 Minute Safety Check Analysis Report

Admission Assessments Report

Admissions Report

Behavioral Health (BH) Diagnosis Listing Report

Behavioral Health Length of Stay - Current Patients Report

Behavioral Health Length of Stay - Discharged Patients

Behavioral Health Observation Statistics Report

Behavioral Health Readmissions Report

BH KPI: Violence Risk Assessment at Admission

Brief Psychiatric Rating Scale (BPRS) Report

Brief Psychiatric Rating Scale for Children (BPRS-C) Report

Children's Global Assessment Scale (CGAS)

Current Caseload Report

Current Census Report

Current Patients on Antidepressant Medications Report

Current Patients on Antipsychotic Medications Report

Current Patients on Ketamine Report

Discharges Report

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Employment Status Report

Generalized Anxiety Disorder Scale 7 (GAD-7) Report

Global Assessment of Functioning (GAF) Report

Group Therapy Charges Report

Hold Order Expiration Report

Homeless Rates Upon Admission Report

Housing Status Report

Overdue Activities Report

PHQ-9 Outcomes Report

Referral Sources Report

Restraint Orders Report

Suicidal Ideation - Current Patients Report

Timeliness of 15 Minute Safety Checks Report

Unassigned Patients Report

Patient Accounting and State Reports

3rd Party Billing Report

3rd Party Billing Suspense Report

3rd Party Denial/Pend Report

3rd Party Payments Received for Capitated Clients

3rd Party Payments Report

3rd Party Unapplied Payments Report

Accounts Receivable Report

Accrual Journals Report

Aged Accounts Receivable Report

Alternate Co-Pay Sliding Scale Table Listing

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Alternate MAP Table Listing

Alternate Sliding Scale Table Listing

Authorization Notification Report

Authorization Services Report

Benefit Plan Groups Listing

Benefit Plans Listing

Billed Services Suspense Report

Billing Modality Report

Bulk Entry Service Report

CARE Assignments Audit Report

CARE Assignment Suspense Report

CARE Diagnosis Suspense Report

CARE Performance Report

CARE Registration Suspense Report

California – Print Client Statements

California ADP Cost Report

California CalOMS Admissions Status Report

California CalOMS Annual Updates Report

California CalOMS Transactions Report

California ChartOne Report

California Client Financial Reviews Report

California County of Responsibility/Aid Codes Report

California CSI Clients Report

California CSI Error Records Report

California CSI Services Report

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California DMH Cost Report

California MMEF Report

California Mode Service Function Crosswalk Listing

California OSHPD Hospital Discharge Report

California Share of Cost Claiming Report

California Summary invoice Report

CaseLoad Performance Report

Cash Drawer Batch Listing

Cash Journals Report

Cash Receipts Report

Change in Fiscal Balance Audit Report

Change in Fiscal Balance Report

Chart of Accounts Listing

Claimed Services Performance Report

Claims Lag Report

Client 3rd Party Coverage Report

Client Account Summary Report

Client Aged Accounts Receivable Report

Client Assignments Report (Landscape)

Client Assignments Report (Portrait)

Client Authorization Requests Report

Client Authorizations Report

Client Financial Reviews Report

Client Financial Summary Report

Client Insurance Eligibility Report

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Client Payments Report

Client Roster Report

Client Services Listing

Client Services Management Report

Client Services Report

Client Write-Offs Report

Client/Billing Responsible Party Identification Report

Cost Accounting Methods Listing

Cost Account Service Grid Report

Cost Centers Listing

DCFS Service Billing Report

Deposits Listing

Downloaded Services Report

Downloaded Services Suspense Report

Duplicate Services Report

Exclusions of CARE Listing

Funds Listing

Health Care Claim Payment/Advice 5010 File Dump

HIPAA 5010 837I Edit File Audit Report

HIPAA 5010 837I Edit File Report

HIPAA 5010 837P Edit File Audit Report

HIPAA 5010 837P Edit File Report

HIPPA 837I Edit File Report

Illinois Record Status Report

Internal RDM Rejections Report

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Journal Audit Report

Kansas AIMS Client Record Report

Kansas AIMS Service Record Report

LA County IBHIS Transaction Report

Length of Stay Report

LS3-1 Outpatient Programs Report

LS3-3 Inpatient Programs Report

LS3-4 Community Support Programs Report

MAP Table Listing

Map/Slide Expectations Report

MIP Extract Report

Mid-Eastern Iowa County Invoice Report

Obsolete Report Template Listing

Oregon MOTS Client Status Transaction Report

Oregon MOTS Encounter Transaction Report

Pay Sources Listing

Payers Listing

Payment Applications Report

Payments and Collections Performance Report

PROS Program Activity Report

Prevention Services Report

PROS Program Activity Report

Print California County Invoices

Print Client Mailing Labels

Print Client Statements (ALX)

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Print Client Statements (ALX) (NPS Version)

Print Client Statements (ARL)

Print Client Statements (BBH)

Print Client Statements (BLR)

Print Client Statements (BLR) (NPS)

Print Client Statements (CCM)

Print Client Statements (CCT)

Print Client Statements (CLK)

Print Client Statements (CMB)

Print Client Statements (COS)

Print Client Statements (CSB)

Print Client Statements (ECK)

Print Client Statements (GAN)

Print Client Statements (GCI)

Print Client Statements (HEN)

Print Client Statements (HHS)

Print Client Statements (JBF)

Print Client Statements (JCS)

Print Client Statements (JEF)

Print Client Statements (LBH/CATS)

Print Client Statements (LDN)

Print Client Statements (MEI)

Print Client Statements (NCB)

Print Client Statement (NCW)

Print Client Statement (PAT)

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Print Client Statement (TX)

Print Client Statement (UMA)

Print Client Statement (WCH)

Print Client Statement (WDG)

Print Client Statement (WJC)

Print Contract Pay source Invoices

Print HIPAA 5010 277 Implementation Acknowledgement

Print HIPAA 5010 278 Requests

Print HIPAA 999 Implementation Acknowledgement

Print HIPAA 837I Institutional Claims (UB-04)

Print HIPAA 837P Professional Claims (HCFA 1500 (v08/05)

Print HIPAA 837P Professional Claims (HCFA 1500 (v08/05)

Print Iowa County Invoices

Registered and Unregistered Services Report

Revenues Report

RSN Batch Report (GCB)

RSN Batch Report (NCW)

RSN Batching Suspense Report (GCB)

RSN Suspense Report (NCW)

Security Events Listing

Services Codes listing

Services Exceptions Report

Sliding Scale Table Listing

Staff listing (Clinical)

Staff Listing (Security)

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Staff Login Report

Standard Bed Day Billing Report

TX Encounter Modality Report

TX MR Service Coordination Management Report

UMDAP Table Listing

Unapplied Payments Fiscal Balance Report

UnDuplicated Client Assignments Matrix Report

UnDuplicated Client Treatment Sessions Report

UnDuplicated Clients Served Matrix Report

Uniform Download Report

Units Listing

Utilization Management Report

View Listing

View Log Listing

Wyoming WCIS Event Service Report

Wyoming WCIS MIS Report

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Continuum of Care
Cerner Integrated - Community Behavioral Health

We make resilience possible.

Cerner Integrated - Community Behavioral Health

Life brings breaks and breakthroughs that affect the mind, body and spirit.

Helping patients achieve the resilience needed to handle those breaks and breakthroughs is our mission. Because health care is integrated, the EHRs that clinicians use should be, too. We work to design the tools clinicians need to provide patients with the best care possible and put them on the quickest, most direct path to resilience and a healthy lifestyle.

What is Cerner Integrated?

The integrated community behavioral health model is a single EHR that features multiple solutions and content packages designed to support health organizations that specialize in the delivery of community mental health, substance use disorder and developmental disabilities care.

What services are included in this model?

Delivery of care, operations and support roles will benefit from a Single Source of Truth™ — one EHR. The following solutions and services are in the new Cerner Integrated - Community Behavioral Health model:

- Patient portal
- Revenue cycle
- Reporting engine
- Clinical workflow, documentation and care planning
- Document capture and imaging
- Medication management and administration
- Physician documentation, ePrescribing and ePrescribing of controlled substances

Key benefits

- A single EHR to support clinical workflows for the delivery of behavioral health and primary care
- Registration and scheduling system to support client throughput
- Document scanning straight into the EHR
- Patient electronic signature capture via mobile app
- An interface that can support reference labs and connect with third-party data and lab systems

Health care is too important to stay the same.™

What to expect

- Capabilities, workflows and documentation specifically designed to support:
  - Care team, nursing and physician clinical care
  - Treatment team care planning
  - Group and individual therapy
- Clinical order entry and ePrescribing support
- Electronic Medication Administration Record (MAR)
- Clinical dashboards to enable care coordination and delivery
- An optimal user experience designed for and validated by clinicians
- Intelligence-driven workflows and clinical-decision support
- A model experience for behavioral health care organizations

Interoperability

Sharing data is the foundation of Cerner's population health mission. We are committed to harnessing innovation that supports open and interoperable platforms. The *Cerner Integrated* - Community Behavioral Health model is no different. It will enable the free flow of information across disparate systems and health care entities, improving data exchange and supporting an open collaborative development community.

About Cerner

We're continuously building on our foundation of intelligent solutions for the health care industry. Our technologies connect people and systems, and our wide range of services support the clinical, financial and operational needs of organizations of every size.

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Cerner Integrated-Community Behavioral Health

High-Level Benefits/Features

In January of 2019 we released our Cerner Integrated-Community Behavioral Health model, delivered as a software as a service. Utilizing our world-class Cerner Millennium platform, this unified EHR was designed to fulfill our clients' clinical, accounting, and reporting needs.

Since its inception, Cerner Behavioral Health has held true to our vision that we believe mental and physical health are equally important in building healthy lives and stronger communities. By incorporating evidenced-based assessments and scales along with a powerful tool set focused on the needs of providers in mental health, disability services, crisis, and addictions settings we have developed a comprehensive offering that not only assists with providing efficient and effective care, but also enable continuity across the care continuum. Cerner's Integrated-Community Behavioral Health offering is highly flexible and can be localized to meet the needs of your organization.

Currently our behavioral health offering is being utilized in residential, outpatient, and inpatient/acute care settings for community-based care, state psychiatric hospitals, acute behavioral health hospitals, in correctional facilities and jails, state and county health departments, mental health and addiction treatment institutions, community outreach settings, case management, veterans/military care, crisis settings, for intellectual and developmental disability treatment, and has been adopted by large hospital systems as an integral part of their medical record. To date, Cerner has over 632 inpatient facilities and 445 outpatient facilities, ranging from extremely large to very small in scale, that leverage our Cerner Millennium Behavioral Health solution. Additionally, we have around 155 facilities that leverage our Community Behavioral Health solution. And, we have more than 56 clients contracted with our newly released, Cerner Integrated Behavioral Health offerings (inpatient, outpatient, and community).

Below are a few high-level benefits of the Cerner Integrated-Community Behavioral Health offering.

- EHR platform to support enhanced clinical workflows and documentation for the delivery of behavioral health, primary care, and other health disciplines.
- Interactive dashboards, task lists, and role-based workflow organizers to enable proactive monitoring of roles, venues, and conditions within an organization. As well as dashboards for clinical leaders, patient tracking, bed tracking, and crisis.
- Enterprise-wide registration and scheduling system to support patient throughput.
- A comprehensive revenue cycle and reporting engine to support community-based billing and state reporting. Our billing system has over thirty years of industry-proven behavioral health experience and has a footprint across most of the United States.
- Our behavioral health content is leveraged by organizations in a multitude of countries around the world.
- Patient engagement tools including a robust patient portal and mobility tools such as patient eSignature.
- The offering includes a vast library of assessment tools, CPOE, ePrescribing/EPCS, DSM5, medication management, automatic updates to our drug information database, treatment planning, provider and group note documentation, fifteen-minute check documentation, referral management, and much more.
- Cerner's remote hosting service (voted #1 in Best in KLAS for last nine consecutive years) providing predictable, uninterrupted connectivity, and world-class system support.
- Cerner was recently awarded the Best in KLAS Category Leader award of Behavioral Health for 2020.
- Interoperability provides tools such as sharing of information, messaging, connection to CommonWell/Carequality, and Cerner Direct HISP.

- Operational reporting: Cerner offers a suite of operational reporting tools to assist in displaying operational data in a meaningful manner, creating custom reports, and easily locating available reports across an organization.

- Multimedia management and single document image capture.

- The Cerner system can allow for accessing the Aunt Bertha website from right within the workflow. The Aunt Bertha website assists in locating social service resources.

- Analytics and reporting: Cerner provides analytics designed to deliver the right information, to the right user, at the right time. This helps shed light on analytics that can be used to improve outcomes.

- Laboratory integration: The Reference Lab Network uses functionality in Cerner's network to connect acute and reference labs with a single, standard connection, eliminating the need for point-to-point connection from providers to contracted performing labs.

Frontend/Clinical Features

Behavioral healthcare providers are unique, which makes using a traditional EHR challenging. Cerner offers the ideal solution for behavioral health service providers because our system exceeds the standards of the conventional EHR. We understand the distinct and important work done by behavioral healthcare providers and supply behavioral health specific tools to support that important work. Our commitment to integrating behavioral health within the EHR begins with our research and development efforts. We understand that one important piece of the healthcare puzzle, behavioral healthcare, must take a prominent role in our larger strategy. We are deeply committed to this goal and believe that our behavioral healthcare strategy will continue to achieve far-reaching results, yielding dramatic improvements in clinical processes, better operational outcomes, significant financial incentives, and a heightened quality of life for patients. We were recently recognized for this approach, and our robust behavioral health content, as Cerner was awarded the Best in KLAS Category Leader Award for Behavioral Health in 2020.

Below are a few frontend highlights of our Cerner Integrated-Community Behavioral Health offering.

Cerner's world-class behavioral health offering was designed to automate the workflow in a variety of care settings. Our behavioral health content includes intake assessments, multiple validated evaluation tools, suicide risk screening, assault and homicide risk assessment, pain and fall risk assessment, cognitive testing, depression screening, alcohol and drug screening and assessment, crisis evaluation, and a vast library of validated psychometric tools. Cerner's behavioral health content currently includes over 180 behavioral health-specific standard scales and assessments, and we are always working to expand our robust library.

Our EHR presents clinical data within a comprehensive view enabling access to multiple areas of the medical record without toggling back and forth between screens. Our integrated behavioral health content supports treating geriatric, adult, adolescent, and pediatric/early childhood populations. It includes alerts that are configured to notify care providers of tasks and activities as they come due. It supports clinical processes and provides decision support for evaluating and examining documented patient progress, transfer-of-care, and discharge notes. High-risk alerting algorithms are embedded in the workflow to notify providers of patient changes, as well as tasks and activities needed to best provide safe, effective, and responsive care. And, reference text is built-in to support evidence-based clinical information, definitions, and standardized procedures.

Cerner's inpatient behavioral health content provides flexible treatment planning designed to support each patient with a comprehensive, problem-specific, and individualized plan for treatment. Treatment plans can be suggested based on clinical documentation. They are built to include individualized long and short-term goals and patient-specific objectives, multi-disciplinary interventions, behavioral healthcare provider and patient care orders and tasks, prescriptions, referrals to specialists, and care team communication. Cerner's treatment plans support documentation of progress and variances, producing a true clinical picture of the patient's journey toward better health.

We support outpatient treatment planning across a variety of programs and venues. The system includes values for strengths, health concerns, problems, goals, and interventions which support mental health and substance use programs. Within the plan, documentation supports clinically diagnosed needs such as depression or anxiety, as well as social determinates of health including housing, employment, or financial needs. We offer codified lists, which are then individualized to meet the patient needs. The treatment plan crosses encounters, spanning the continuum of care with multi-contributor goals and outcomes and can be signed by the patient via an iPad device.

Our behavioral health offering supports secure, multi-contributor documentation and treatment planning, meaning that numerous users can access the electronic record simultaneously.

The integrated EHR provides different note templates by type of service (such as Subjective/History of Present Illness, Review of Systems, Mental Status Exam, and many more) that automate the creation of a clinical note relating to care delivery. Embedded workflow-driven documentation tools allow the behavioral healthcare professional to complete the narrative pieces of their note within the context of their workflow while reviewing, ordering, and taking other actions in the chart. Cerner's dynamic documentation tool then aggregates workflow components into the note, thus alleviating the need for duplicate entry or having to jump back and forth between screens to complete documentation. Our flexible documentation tools enable access to patient-focused clinical information with intuitive, narrative-driven processes that facilitate the behavioral health provider's workflow with clinical documentation completed as a by-product of care. Guiding behavioral health professionals through the workflow, our EHR empowers them with the ability to select their preferred method of documentation including free-text, templates, auto-text, embedded voice recognition, or a combination of these. For further data entry efficiency, our differentiating tagging feature enables the automatic extraction of data from previously documented notes or results to be pulled into the current note, crediting the original author/source via a footnote.

Our multi-person documentation tool (group notes) simplifies the workflow for documenting group therapy. The tool allows group leaders to document on multiple group members from one screen. This differentiating offering significantly decreases the time it takes to document a group therapy session by eliminating the need to re-document the same (group level) information for each attendee. By providing a multi-patient platform for documentation, our goal is to provide your organization's group leaders with more time for patient care, by removing the repeated navigation required to jump from chart to chart. This documentation tool also enables clinicians to capture group attendance, document patient-specific participation attributes, and view, add, or modify goals/interventions for individuals attending group sessions. And, when the group note is signed, the individual notes are automatically disseminated to the appropriate individual's charts and the group note flows to all of the group member's charts in near-real time. The group notes documentation tool can be used for a variety of treatment programs, including behavioral health treatment, substance use disorder, or other treatment programs. The schedule/patient list can be easily pulled and modified at any time and the exact participation time for each group member can easily be recorded.

Cerner automates the workflow embedding provider order entry, leveraging an established network of providers, simplifying management for support staff, to quickly close the referrals loop and decrease turnaround times to contain healthcare costs. Our referrals management utilizes industry messaging, DirectTrust, to enable seamless, bi-directional communication between your providers and external providers in the community with options to attach any pertinent documentation. This is all completed within one view without having to toggle back and forth between screens, thus enhancing efficiency. Cerner's integrated referrals management module supports a dashboard display of new referrals in a work queue which provides extensive tracking such as sending of referral/consult request, receiving of referral/consult request, the reason for the referral, appointments made with consulting provider, appointment kept or missed, consulting provider note/response sent to sending provider, and sending provider receiving of consult documentation.

Another differentiator of the Cerner Integrated-Community Behavioral Health offering is that it fully supports both primary care and behavioral healthcare. The system offers a variety of tools including CPOE, ePrescribing/EPCS, DSM5, medication reconciliation/management, automatic drug database updates, and much more. The Cerner integrated EHR enables simple order entry right within the workflow. Our embedded orders management feature assist providers in placing orders and enables access to relevant patient data (current and historic) during the order conversation. Providers can review results, enter, modify, cancel, and manage orders, open documents, and perform various tasks that assist in providing the best care for their patients. Our orders management and CPOE functions include an order catalog as well as best-practice recommended, pre-built order sets. Each order sentence

and order detail can be edited by the ordering provider. Commonly prescribed medications, along with their order details, can be saved into a favorites folder for quick reference in the future to be leveraged by a single provider or shared by a group of providers.

With just a few clicks, Cerner's embedded ePrescribe functionality utilizes our orders management and a transmission network partnership with Surescripts to provide a secure, HIPAA compliant encoded communication link directly to and from participating retail pharmacies. Directly within their workflow providers simply select an appropriate generic or brand-name medication and our embedded drug database automatically checks for potential medication interactions and/or side effects. Then, a written prescription can be handed to a patient, automatically faxed to a retail pharmacy, or electronically transmitted (inclusive of controlled substances) with our ePrescribing functionality. Cerner possesses proprietary methods for dual authentication prompting the provider to authenticate into the system with two factors that meet DEA EPCS requirements for controlled substances.

We leverage our Reference Lab Network (RLN) to link providers and labs as a part of our Cerner Integrated-Community Behavioral Health package. One standard connection through the RLN allows the reference lab to receive orders from all providers connected to the networks and transmit results. The Reference Lab Network (RLN) utilizes functionality in Cerner's Network to connect facilities and reference labs with a single, standard connection, eliminating the need for point-to-point connection from providers to contracted performing labs. Currently, either a LabCorp or Quest Diagnostics connection is included with our proposed model. Any other labs might have fees associated with the connection.

Our behavioral health interactive summary view provides a snapshot of a patient's current-status and treatment to date. Our position-specific workflow organizer views guide your care providers through their workflows, allowing them to implement most of their tasks from a single landing space.

For inpatient/residential care setting, our differentiating safety and attendance tool provides a multi-patient dashboard view that is available via Wi-Fi enabled touch-screen tablets/mobile devices or workstations on wheels. It provides a unique way to electronically document 15-minute checks. This tool can eliminate the need for paper-based safety and attendance documentation. It facilitates the documentation of patient status, location, safety concerns, precautions, activities, and can include an image of each patient for easy identification purposes. The data collected flows directly into each patient's chart in near real-time. In the behavioral health outpatient venue, we offer our day program attendance tool that allows for recording data related to outpatient day program participants that also flows into the patient's charts in near real-time.

Included with our Cerner Integrated-Community Behavioral Health offering, the patient portal includes multiple patient access services designed to improve communication with patients and ease administrative processes. The patient portal enables patients to communicate via secure messaging, giving providers a chance to respond at their convenience. With our integrated scheduling management, patients can schedule and cancel appointments directly and submit visit-related information prior to their appointment. Patients can access their entire personal health record for personalized health and wellness information and education (or your organization can set up the portal to not include certain items such as visit notes, messaging, appointment requests, or refill requests). We offer online e-consultations via branching logic questionnaires, producing concise clinical summaries consumable by the patient's care team. Video visit functionality is available at a supplemental cost and provides an additional communication method to drive a variety of interactions between both providers, patients, and proxied family members.

Additionally, behavioral health-specific scales and assessments can be sent directly to patients via the patient portal. Having these assessments completed prior to an appointment can save valuable time with your patients. The assessments can be sent as needed or associated with a specific appointment type, such as setting up a rule to have every initial appointment automatically send out a PHQ-9 or another scale. Once completed, the results of the assessments can be automatically sent to the clinician's message center and will only become part of the patient's chart if accepted by said clinician. Our patient portal improves communication and empowers patients to become proactive members of their care team, while supporting a broad range of activities that occur when they interact with their healthcare organization. Cerner's patient portal is ideal for organizations that strive to offer electronic connectivity between patients and providers. The portal includes our Ignite Application Programming Interface (API) that supports linking with the Apple Health app to accept a patient's remote monitoring data (from a multitude of devices). The data retrieved can be leveraged by your organization to assist in promoting more vigorous patient engagement and an overall holistic approach to health care.

Our clinical leader organizer presents an interactive dashboard that supports communication and coordination across the continuum of care as well as a comprehensive, high-level view of the patient data that care managers, clinical leaders, charge nurses, nurse managers, and other clinical leaders need to be able to access quickly. With this innovation, frequently accessed data is displayed in the clinical leader's main view, which reduces the need for the user to drill into a chart to search for information. This view allows leaders to compare performance against goals and objectives and to identify gaps in documentation. It displays progressive patient information and potential patient risks. Patient demographics, confidentiality status, care team, resuscitation status, pain scale, and acuity are just some of the data points that can be displayed in the view.

For intellectual and developmental disabilities, Cerner's point-of care ADL and individualized task documentation offering (CareTracker DD) provides the ability to create personalized care plans based on assessments, document on trainings and progress/lack of progress, view current medications, and document on physician appointments. We support nursing/provider workflows, documentation, and much more. Our point-of-care ADL and individualized task documentation tool (CareTracker DD) supports documenting developmental disabilities, behaviors, and skill development. This innovative offering allows care providers to record goals and review data in near real-time, at the point-of-care via simple-to-use, touch-screen devices. It is highly customizable and allows your organization's staff to monitor the progress of individual-specific plans for restorative programs, behaviors, and many other programs that might need to be monitored for an individual. The tool contains a clinical intelligence engine that tracks, reviews, and summarizes documentation and flags potential problems. It can trend, compare, and analyze collected data to proactively monitor for changes in a patient conditions such as vitals, weights, mood, and more. A supplementary cost for CareTracker-DD will apply if this offering is not included with your proposed package.

Architecture/Interoperability

Cerner provides a unified architecture that allows for real-time information sharing across multiple facilities within your organization, based on preset role-based security. Our integrated behavioral health content provides the ability to capture, track, and display certain sensitive information within the behavioral health workflow and allow only privileged providers access to said protected data.

In addition, Cerner is leading the industry in setting the standard for interoperability, co-founding CommonWell Health Alliance with several competitors, we have advanced safe, nationwide vendor agnostic interoperability with EHR agnostic HIEs and Cerner specific HIEs to facilitate the sharing of information between local and regional organizations. The standard information we share is PAMI (Problems, Allergies, Medications, Immunizations) data and documents. We support the ability to exchange data, such as Continuity of Care Documents (CCDs/CCRs) with nearly any EHR vendor. Cerner enables patients to share their medical records with care providers by providing identity management, record locator, consent management, and trusted data access. We offer unprecedented connectivity to foreign systems with our open system design and HL7 standard compliance. Cerner supports connectivity to CommonWell and Carequality enabled EHRs, as well as directly with a supplier or other data networks like your state HIE. This is not just a view of information, Cerner's system gives the provider the ability to view the data and reconcile it into the patient's medical record, creating a single source of truth.

Reporting and Analytics

Cerner's Integrated EHR provides a variety of enterprise-wide reporting capabilities to meet the needs of your organization. This offering includes operational reporting, as well as analytics tools, that provide the end user with access to data through the reporting portal. For organizations with the skills and desire to develop extracts or custom and ad hoc reports, additional reporting toolsets are available within the domain. Cerner provides a number of tools such as Discern Analytics 2.0 (DA2), SAP Business Objects, SQL Server Reporting Services (SSRS), and our new analytics dashboards leveraging the power of Tableau to provide a robust approach to securely meet your reporting needs.

Cerner is constantly improving our reporting and analytics to meet the needs of our clients. Analytics tools such as these can be crucial for sustainability. They can provide accountability, drive outcomes as well as assist with predictive modeling and stratification. Our behavioral health reporting and analytics offering includes dashboards for executive leadership, operations management/supervisors, clinical effectiveness/for clinical and quality leaders, as well as a clinician dashboard/for clinical staff. These behavioral health analytics provide your organization with interactive dashboards in our effort to empower your organization with meaningful access to key metrics for

monitoring and measuring your organization's health and performance. These tools provide real-time data visualization, a means for exploration, and decision support to help drive the overall success of your organization.

Additionally, Cerner's system activity monitoring, Lights On Network, is an industry leading advanced EHR analytics offering designed to support decision making and provide transparency into your Cerner system. No other monitoring system provides this level of knowledge-driven analysis designed to help your organization get the most from your EHR. Our system activity monitoring provides views into system performance, system configuration, user experience and adoption, as well as organizational efficiency. Drillable dashboards provide information to understand how end users are using the system across your organization. Your organization can proactively monitor the efficiency of your providers and nursing staff by specialty, facility, as well as the user. This allows for engaging with employees to ensure the optimal experience for your staff and patients.

Backend/Patient Accounting and State Reporting Features

The Cerner Integrated-Community Behavioral Health offering is an end to end, comprehensive EHR and billing platform designed to be the best of the best. Our patient accounting/state reporting module supports robust revenue cycle management and provides your organization with one of the most advanced billing systems on the market. We have been working for over thirty years to develop a system designed to meet the challenging, ever-changing needs of behavioral health care billing and state reporting. Our system goes a step further than billing, as it provides superior tools and utilities to assist in revenue improvement.

Below are a few backend benefits of the Cerner Integrated-Community Behavioral Health offering.

Cerner provides a clinically driven revenue cycle, which means that as clinicians complete their documentation, charges are generated. This process encourages clinicians to complete documentation in a timely manner and safeguards against charging without the supporting documentation. In the event all supporting documentation (registration, diagnosis, staff credentials) do not exist in the EHR, Cerner's billing suspense mechanism can be used to prevent services/charges from being rendered to claims. This allows clinicians to focus on provision of service instead of having to chase down documentation or become billing experts.

Behavioral health billing is complex given the differences in the payment methodologies, rules, and requirements across payers. The Cerner offering provides your reimbursement team with comprehensive configuration to establish the billing rules and format required by each payer. The combination of payers, benefit plans, covered services, billing modalities, and billing line items are all integral to establishing the billing controls and revenue. A variety of controls can be configured by billing period for pay sources and benefits plans. These controls are used to define the unique claiming requirements for each payer/plan. The controls include claim type (837P or 837I), billing periods, claims population, diagnosis controls, account numbers, copays, authorizations, 835's, billing suspense controls, and state specific controls. For each benefit plan, covered services are established and for each covered service at least one billing modality is configured. Billing modalities are used to establish the unit of measure, units, procedure codes, modifiers, revenue codes, rounding rules, and billing conditions for an encounter. Billing line Items can also be used to consolidate encounters in a variety of methods for claiming such as daily, weekly or monthly case rates. Billing line items can also be used to total hours or units by day, week, or month or for a variety of state specific consolidation methods.

Cerner's billing suspense mechanism can be leveraged to prevent services from being rendered to claims for certain reasons. Once the suspense condition is corrected, the service is automatically billed the next time claims are generated. These suspense reasons include authorization limits, limitations on number of hours/services in a given period of time, diagnosis, multiple service restrictions on the same day, as well as a library of other type suspense controls. The Insurance Billing Suspense Report shows the suspended services along with the dollar amounts and suspense reason. This report can be used to illustrate why services cannot be billed and the A/R which cannot be billed. This is the starting point for timely management of problem areas around claiming. Our clients in have reported that they have paid rates in the high ninetieth percentile range for their claims submissions as a result of this functionality.

The system offers bill trace functionality which is tool to identify key claiming aspects, such as which payer and benefit plan and at what amount a service event will stage to bill. The details provided assist the user with

identifying how the system's algorithmic decision was made which simplifies tracking down any needed system setup and configuration to arrive at the desired outcome.

The Cerner system can be used to bill third-party payers and grants. These same features, along with financial reviews, can be used to charge patients. Financial reviews allow for capture of financial details (family size, income, income source, expenses) which can be used calculate a person's ability to pay. Financial reviews support a variety of discount methods such as sliding fee scales, maximum ability to pay (MAP), UMDAP, or family cost share. Financial reviews are intended to be updated periodically, annually, or if there is change so the most current information is being captured and leveraged while maintaining a historical trail for audit and billing.

Our insurance payment entry is HIPAA 835 compliant, providing a fast, accurate method of handling third-party payments. The Cerner system provides tools for managing paper remittances and electronic 835 files. The Health Care Claim Payment/Advice 5010 File Dump is used to print the 835 to a human-readable format for review and analysis prior to loading the 835-file into the system using the Health Care Claim Payment/Advice 5010 File Download utility. Upon completion, a control report is generated which shows payment application, along with details such as remark codes and reasons why payments were not applied in certain situations.

The Cerner system manages transactional fiscal based activity with a distinct audit trail. The integrated offering is designed to follow accrual based, cash based, or modified methods of accounting. Separate AR, revenue, cash, contractual adjustment, unapplied payment, and write-off accounts can be established for booking the debits and credits depending on the type of activity. The Cerner offering has years of experience working with several GL/accounting applications such as Great Plains, Quantum, and MIPS. While the Cerner offering is not fully integrated with a third-party GL system, most clients find the ease of creating .csv files from the Cerner system and importing them directly into their GL products sufficient.

Internal Denial reasons can be established by an organization for use within management reporting. These denial reasons are table driven and associated to HIPAA Claim Adjustment Codes for use in loading the 835 Remittance. Denial reasons can also be used to capture full or partial adjustments to an encounter. For instance, an encounter should not be claimed due to an invalid progress note. Instead of submitting this claim to the payer, an organization can adjust the balance of the encounter off the AR using an Internal Denial Reason such as Invalid Progress Note.

The included Third-Party Payment Applications Report and the Journals Audit Report can be leveraged for reporting on Denial Reasons.

The Client Aged Accounts Receivable Report can be used to manage AR for patients, including the date of last service, last financial review, slide and map percentages. These details allow users to identify those situations which may need to be corrected or patient refunds.

The Cerner Integrated-Community Behavioral Health offering allows for capturing insurance payments and applying the payment to a patient's specific service to reduce the AR in a manual or electronic format. This process results in journal transactions which track cash receipts, adjustments and receivable reduction.

Our system accommodates billing to primary, secondary, and tertiary payers (up to six payers simultaneously). When clinical documentation is completed, encounters are run through the billing algorithm to ascertain the payer, procedure codes, and charges. Upon generation of claims, the primary, secondary, and tertiary payers are optionally reported along with any prior payments or adjustment codes. When payment is received from the primary payer, it is applied electronically from the 835 or manually. If there is a partial payment or denial, the remaining balance is crossed to the next payer and staged for inclusion on the claim the next time claims are generated for the payer. Fiscal activity is recorded for the payer when transactions are crossed to the next payer.

Cerner's embedded eligibility and (insurance) benefits verification service enables fast, easy, and secure transfer of patient data between your Cerner system and Medicare, Medicaid, as well as many commercial payers. It provides real-time processing of eligibility verification, supports requests with multiple service types, and includes address validation with the US Postal Service. Eligibility checks can be performed from the patient's encounter, from a patient's demographic summary, or by utilizing an automated process in advance of scheduled appointments. We provide connectivity to over 450 payers either direct or though partnership with health care clearinghouses. A

supplementary cost for Cerner's Eligibility & Insurance Benefits and Address Verification offering will apply if it is not included with your proposed package.

Cerner tracks authorizations along with effective dates, visits, units, days, amount, limits/constraints. The system utilizes views and reports to notify when another authorization is necessary. Notification of expiring authorizations or authorizations exceeding limits are available in several locations within the system.

The client workspace dashboard is the system's landing spot for reimbursement users. It includes work tasks associated with reimbursement events such as unsupported services, services that are staged to a billing firewall, and services that need to be reviewed prior to associated fiscal activity occurring. Workspace tasks accommodate both users optionally establishing both an owner and an assigned staff member such that multiple staff members can be tasked with the oversight and completion of the task. Within the workspace, the user can readily view information about the patient including demographic and diagnosis data as well as document general notes about the patient's account. Additional features allow for easy access to commonly used reimbursement related functions within the system.

Client Involvement/Opportunities

Cerner's development roadmap is continually changing to meet the needs of integration, interoperability, mobility, and evolving regulations. The client community base is also a key driver for our future development by providing suggestions for functionality relevant to improving our solutions. Cerner encourages client involvement and offers many opportunities for participation, including the option to join our behavioral health coalition to share ideas, discuss enhancement opportunities and address challenges in the behavioral health environment. This group is made of progressive behavioral health care organizations that meet regularly to improve our solutions to better support health care delivery. By working together with our clients, we continue to make a difference in the lives of those we serve.

Development for new functionality is obtained through a variety of venues, including collaborative visionary partnerships with new and existing clients, market drivers, as well as regulatory bodies and industry trends. Our clients can request development enhancements through our online enhancement collaboration tool, the Ideas Space. Your organization's ideas can be viewed across the Cerner community to facilitate discussion, and express interest for feature and functional development.

In addition, we have both Regional User Groups (RUGs) and Special Interest Groups (SIGs) that provide group visibility across our client base according to geographic location, specialty and interests. Through annual and bi-annual meetings as well as online collaboration, discussions and priorities of these groups provide visibility to areas of development that is most important to their prospective groups.

Cerner Clinical Workstation Requirements

This document provides you with the minimum hardware and software requirements, and the recommended requirements, for different configurations of PC client systems used to access *Cerner Millennium* applications. The minimum requirements provided in this document are intended for workstations performing a range of tasks, but these minimums do not account for the unique requirements of solutions such as intensive care, cardiology, and clinical imaging. Please consult your Technical Strategist for solutions that require additional resources and the relevant documentation. The recommended requirements should meet the needs for more hardware-intensive solutions in the majority of cases.

The final system requirements of any single workstation could vary depending on the resource requirements of any non-Cerner solution present. These non-Cerner solutions could include device emulators accessing other systems (IBM 3270, 5250, and so on), electronic mail systems, web browsers, image viewers, and so on. As a client, you are responsible for determining the requirements of any non-Cerner application for which you must account in addition to the Cerner minimum requirements. Cerner Clinical Workstation Minimum Requirements

The following lists the minimum system requirements for a clinical workstation running a local installation of Cerner Millennium:

- Intel-based or equivalent, mid-range workstation
- Processor: 1 gigahertz (GHz) or faster with support for PAE, NX, and SSE2
- RAM: 2 GB with 1 GB of memory just for Millennium. This is above what the OS and other apps use.
- Hard disk space: 30 GB with 10 GB disk space minimum for local Cerner application code installation.
- Graphics card: Microsoft DirectX 9 graphics device with WDDM driver.
- Graphics resolution: 1024 x 768 and 32-bit color
- Network: 10/100 Ethernet network card
- Winsock 1.1 or higher compliant TCP/IP protocol stack
- Peripheral: 101-key keyboard and mouse or equivalent

Cerner Clinical Workstation Recommended Requirements

The following list details the recommended system requirements for a clinical workstation running a local installation of Cerner Millennium:

- An Intel-based or equivalent, high-end workstation
- Processor: Dual or More Core Processor (Class Pentium, Core 2, i3, i5, i7, Xeon or equivalent) running at 2.0GHz or greater.
- RAM: 4 GB with 2 GB of memory just for Millennium. This is above what the OS and other apps use.
- Hard disk space: 160 GB with 10 GB disk space minimum for local Cerner application code installation.
- Graphics card: Microsoft DirectX 9 graphics device with WDDM driver.
- Graphics resolution: 1024 x 768 and 32-bit color
- Network: 10/100 Ethernet network card
- Winsock 1.1 or higher compliant TCP/IP protocol stack
- Peripheral: 101-key keyboard and mouse or equivalent

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Cerner Clinical Thin-Client Workstation Requirements

Clinical Thin-Client Workstation Minimum Requirements

The following list details the minimum system requirements for a clinical workstation connecting as a Citrix or Terminal Services client:

- Processor: 1 GHz or faster
- RAM: 1 GB
- Hard disk space: 12 MB available hard drive space for Citrix client install
- Graphics resolution: 1024 x 768 and 32-bit colors
- Network: A network interface card (NIC) and TCP-IP stack.
- Peripheral: *Microsoft* mouse or 100% compatible mouse
- Peripheral: Windows-compatible sound card for sound support (optional).

Clinical Thin-Client Workstation Recommended Requirements

The following list details the recommended system requirements for a clinical workstation connecting as a Citrix or Terminal Services client:

- Intel-based or equivalent, mid-range workstation
- Processor: Dual or More Core Processor (Class Pentium, Core 2, i3, i5, i7, Xeon or equivalent) running at 2.0GHz or greater.
- RAM: 4 GB
- Hard disk space: 50 GB
- Graphics resolution: 1024 x 768 and 32-bit colors
- Network: 10/100 Ethernet network card
- Winsock 1.1 or higher compliant TCP/IP protocol stack
- Peripheral: 101-key keyboard and mouse or equivalent

Cerner Thin-Client Device Requirements

Cerner Thin-Client Device Minimum Requirements

The following list details the minimum system requirements for a thin-client device connecting to Cerner solutions through Citrix or Terminal Services:

- Processor: 1 GHz processor or greater
- RAM: 1 GB of RAM
- Hard disk space: 1 GB of Flash Disk space
- Graphics resolution: 1024 x 768 and 32-bit colors
- Network: A network interface card (NIC) and TCP/IP stack
- Peripheral: 101-key keyboard and mouse or equivalent

Cerner Thin-Client Device Recommended Requirements

The following lists the recommended system requirements for a thin-client device connecting to Cerner solutions through Citrix or Terminal Services:

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- Processor: 1 GHz processor or greater
- RAM: 1GB of RAM
- Hard disk space: 1 GB of Flash Disk space
- Graphics resolution: 1024 x 768 and 32-bit colors
- Network: A network interface card (NIC) and TCP/IP stack
- Peripheral: 101-key keyboard and mouse or equivalent

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Administration Office
1717 N. Indian Hill Blvd., Suite B
Claremont, CA 91711

REQUEST FOR PROPOSALS

FOR

ELECTRONIC HEALTH RECORDS SOFTWARE PLATFORM

August 19, 2020

ATTACHMENT 4-D

CONTACT

Jessica Wong, Interim CIO
Ph: (323)747-8340
E-mail: it_consulting@tricitymhs.org

PROPOSAL PACKET

- ❑ RFP Cover Page
- ❑ Proposer's Company Information, References and Subcontractors
- ❑ Transmittal Letter
- ❑ Owner/Responsible Project Manager and Core Team
- ❑ Proposer's Company Work Process Information
- ❑ RFP Exceptions
- ❑ Proposer Price Proposal
- ❑ On or before September 30, 2020, 5PM PST, completed Proposal Packet scanned and e-mailed to: JPA Administrator Clerk at molmos@tricitymhs.org
  OR
  Sealed and delivered via mail, overnight, or in person to:

  Tri-City Mental Health Authority
  1717 N. Indian Hill Blvd, Suite B
  Claremont, CA 91711
  Attn: JPA Administrator/Clerk
  "SEALED PROPOSAL FOR EHR SOFTWARE PLATFORM"

- The full RFP may be downloaded from TCMHA's website at www.tricitymhs.org
- All proposals must be signed by a duly authorized representative of the agency.
- All unsigned or late proposals will be rejected.
- Faxed proposals are not accepted.
- Proposals will be verified for compliance with RFP specifications and also competitively evaluated.
- A recommendation to award contract tentatively will be presented to the Governing Board at its December 16, 2020 meeting.
- TCMHA reserves the right to make no award of contract.
- We appreciate your interest in Tri-City Mental Health Authority and look forward to your response.

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TRI-CITY MENTAL HEALTH SERVICES AUTHORITY
RFP NO. 2020-0802

I. INTRODUCTION

Tri-City Mental Health Authority (TCMHA) is seeking an EHR Contractor to provide a comprehensive client data and electronic record software application to replace the current Welligent platform. All proposers shall meet the provisions, requirements and specifications listed in this Request for Proposal Document, No. 2020-0802 and must be received by TCMHA by **5:00 PM PST on September 30, 2020** at 1717 N. Indian Hill Boulevard, Suite B, Claremont, CA 91711, or scanned and emailed to molmos@tricitymhs.org.

II. AGENCY PROFILE

A. Tri-City Mental Health Authority ("TCMHA")

TCMHA was established through a Joint Powers Authority Agreement between the Cities of Pomona, Claremont and La Verne pursuant to the provisions of the Joint Exercise of Powers Act of the State of California, to deliver mental health services to the residents of the three Cities. Pursuant to the Joint Powers Authority Agreement, TCMHA is a public agency governed by a Governing Board (Legislative Body) composed of seven members; four members are a council member of his/her respective City, and three members of the Board are community members appointed by the three Cities. To carry out the Agency operations, the Governing Board develops and establishes resolutions and policies, and appoints an Executive Director to conduct the Agency's day-to-day operations.

TCMHA has a stated commitment to achieving excellence and efficiency as a public Agency serving the diverse communities of Pomona, Claremont, and La Verne through its five facilities, over 200 employees, and outpatient services. TCMHA creates an integrated system of care to ensure access and to enhance the mental and emotional health of its clients. Available services include psychotherapy, clinical case management, medication support, peer-to-peer support, psychoeducation, linkage and referral, vocational training and support, socialization activities, and community outreach.

B. The Three Cities: Pomona, Claremont, and La Verne

The City of Pomona was incorporated as a City in 1888 and became a charter City in 1911. Today, Pomona is the seventh largest city in Los Angeles County, with a population of 154,345, encompasses a land area of 22.95 sq. miles, and is located approximately 27 miles east of downtown Los Angeles in the Pomona Valley between the Inland Empire and the San Gabriel Valley. Pomona is bordered by the cities of La Verne and Claremont on the north; the Los Angeles/San Bernardino county line forms most of the city's southern and eastern boundaries. Pomona boasts a progressive economy, business opportunity, and a strong workforce. Pomona is the site of Pomona Valley Hospital Medical Center and of the Fairplex, which hosts the L.A. County Fair and the NHRA Auto Club Raceway (formerly known as Pomona Raceway). Colleges and universities located in Pomona are California State Polytechnic University (Cal Poly Pomona), Western University of Health Sciences (formerly known as College of Osteopathic Medicine of the Pacific) and DeVry University has a campus in Pomona.

The City of Claremont was founded in 1887 and incorporated in 1907; it is located approximately 30 miles east of Los Angeles, consisting of 35,000 residents and an area of 14.14 square miles. The City's development has always been closely associated with the academically acclaimed Claremont Colleges consisting of five undergraduate and two graduate higher education institutions. The community takes pride in its rich cultural, educational and architectural heritage, as well as its small-town atmosphere.

The City of La Verne was founded in 1887 and incorporated in 1906; it is situated approximately 35 miles east of Los Angeles nestled in the foothills of the San Gabriel - Pomona Valleys, consisting of a population of over 33,000 and a land area of 8.6 square miles. La Verne is a well-balanced residential community which includes a good mix of commercial and industrial uses as well as the University of La Verne, an airport and fine public and private schools.

III. SCOPE OF SERVICE

The scope of this project should include the Electronic Health Records software platform license, training, implementation/migration, and support. Please see 'Attachment A' for detailed information regarding the functional specifications required.

IV. RFP AND TIMELINE

A. RFP Schedule

- Request for Proposal (RFP) Issued: **August 19, 2020**
- Written Questions Deadline: **September 7, 2020**
- Response to Written Questions/RFP Addendum Posted: **September 14, 2020**
- **Proposals Deadline: September 30, 2020, 5:00 PM PST**
- Demos: will begin to schedule after September 30, 2020**, date and time TBD**
- Anticipated Award of Contract: **December 16, 2020**
- Anticipated Commencement of work: **December 17, 2020**

B. Explanation of Timeline

1. RFP Issued. The Request for Proposal Documents may be obtained from TCMHA's website at www.tricitymhs.org. The TCMHA will not be responsible for the completeness or accuracy of Request for Proposal Documents retrieved from any other source than directly from TCMHA.

2. Written Questions Deadline. Submit all written questions by the deadline to RFP Contact Person. Questions submitted in any other manner or format are not acceptable. All questions must be received via e-mail by **5:00 PM PST September 7, 2020** (see **RFP Schedule)**. Questions will be responded to in writing. Written summaries of all questions and answers will be published on TCMHA's website. Anonymity of the source of specific written questions will be maintained in the written responses. A clarification addendum will be issued, if necessary.

3. Response to Written Questions/RFP Addendum Posted. Answers to all questions received by the deadline and any material change to the RFP, will be listed on an addendum to the RFP and posted at www.tricitymhs.org by **September 14, 2020**. Additional written questions must be received by the RFP Contact Person no later than two (2) days after the addendum is posted. The Agency reserves the right to post additional addenda until the RFP closing date and time. Any written addendum issued during the Proposal time shall become a part of the Request for Proposal Document and shall be signed and attached to the Proposal and made a part of the Proposal submitted. It is the Proposer's responsibility to indicate acknowledgement, sign, and return addendums with their response. TCMHA reserves the right to reject any responses deemed to be non-responsive.

4. Proposal Deadline. Proposals must be received no later than the deadline specified in RFP and Proposal Timeline.

5. Proposal Evaluation Period. An Evaluation Committee will review and evaluate the proposals and make a recommendation as to which proposals to move forward.

6. Demos. TCMHA will request demos from the top three Proposer(s).

7. Anticipated Award of Contract. A formal written notice of intent to award letter will be sent to the selected Proposer; and it will include the anticipated date of the Governing Board meeting when the item will be presented for approval.

V. PROPOSAL REQUIREMENTS

A. TCMHA Contact During Formal Proposal Process

During the formal proposal process, TCMHA contact shall be Jessica Wong, Interim Chief Information Officer, (323) 747-8340, email: it_consulting@tricitymhs.org.

B. Time and Manner of Submission

A fully executed Proposal shall be scanned and emailed to molmos@tricitymhs.org no later than **5:00 p.m., Pacific Time, on September 30, 2020**.

Proposals in hard-copy form shall be submitted to and received by TCMHA Mental Health Authority's Administration Office no later than the Closing Time 5:00 p.m., Pacific Time, on **September 30, 2020**. Received proposals will be time stamped. Proposals must be in a sealed envelope, and be marked and addressed as follows:

U.S. Mail, Overnight, or Hand Delivery:

Tri-City Mental Health Authority
1717 N. Indian Hill Blvd, Suite B
Claremont, CA 91711
Attn: JPA Administrator/Clerk
"SEALED PROPOSAL FOR EHR SOFTWARE PLATFORM"

Proposals may be delivered between the hours of 8:00 AM and 5:00 PM (Pacific), Monday through Friday, excluding TCMHA holidays. Proposals delivered after the Closing Time will not be accepted.

C. Proposal Format

It is TCMHA's request that the proposals be brief and succinct. Information listed 1-8 below, including Appendices B-F, to this proposal document are required to be included in the submitted proposal. If not included, the submitted proposal will be considered incomplete; and thus, non-responsive. The proposal shall be submitted in the following format:

1. RFP Cover Page – (***Attachment B***)

2. Proposer's Company Information, References and Subcontractors (***Attachment C***)

3. Transmittal Letter. The letter signed by the authorized Proposer representative should provide an executive summary that briefly states the Proposer's interest in the services, the understanding of the work to be done, the commitment to perform the work, and irrevocable offer for 90 days from the closing date. The letter and executive summary shall be limited to no more than two (2) pages.

4. Owner/Responsible Project Manager and Core Team. List the owner or person in charge, and a concise statement of qualifications and experience applicable to each type of service that is to be provided. List the key staff and sub-contractors, if any, along with a brief statement of qualifications for individual members which will be assigned to provide the requested services in this RFP.

5. Proposer's Company Work Process Information (***Attachment D***). List former clients for whom similar or comparable services have been performed. Include the name, mailing address, mailing address, and telephone number of the appropriate contact person.

6. RFP Exceptions (***Attachment E***). Provide properly completed Exception(s) To Specifications. If Proposer has no exceptions, then Proposer must check the box, where indicated.

7. Proposer Price Proposal (***Attachment F***). The services shall include a performance and cost schedule for all services necessary to complete this project. The proposal should include a separate all-inclusive cost for each of the three years of the contract. The proposal should specify the major components, the cost breakdown by major component or phase, and the expected time of completion for each component based on the scope of services outlined in the proposal. The proposal should include, a total proposed, "not to exceed" costs of the services, including a fee and rate schedule describing all charges and hourly rates for services. Those services listed in hourly rates, shall be calculated per the Department of Industrial Relations Prevailing Wage Labor Code, if applicable. The Proposer shall state specifically what is being furnished, such as materials, labor, tools, and other equipment necessary to the complete the Scope of Services or expected number of hours with hourly rate.

Cost will not be the deciding factor in making the selection. The overall total cost to TCMHA will be considered and the degree of the importance of cost will increase with the degree of equality of the proposals in relation to the other factors on which selection is to be based.

8. Copy of Business License and/or Certifications. A copy of the Business License will be required after the award of contract. Contractor declares that Contractor has complied with all federal, state, and local business permits and licensing requirements necessary to conduct business.

VI. AWARD AND AGREEMENT EXECUTION

A. Proposal Opening

Due to COVID-19, there will be no public opening of submittal proposals. After the evaluation process is concluded and a proposed intent to award determination is made, a written notification of the proposed award will be provided to all proposers.

B. Proposal Evaluation

The proposal should give clear, concise information in sufficient detail to allow an evaluation. The agency should provide an affirmative statement that it is independent of TCMHA and that the services performed are in the capacity of independent contractors and not as an officer, agent, or employee of TCMHA.

The Proposals will be reviewed by a selection committee and evaluated based on the following criteria:

1. Proposer's qualifications, description and experience
2. Understanding and ability to perform the Scope of Work
3. References and experience with similar projects
4. Cost Proposal

C. Proposal Rejection

TCMHA reserves the right to reject any and all proposals, either in part or in its entirety; or to negotiate specific terms, conditions, compensation, and provisions on any agreements that may arise from this solicitation; to waive any informalities or irregularities in the proposals; to request and obtain, from one or more of the agencies submitting proposals, supplementary information as may be necessary for TCMHA staff to analyze the proposals; and to accept the proposal that appear to be in the best interest of TCMHA. In determining and evaluating the proposals, costs will not necessarily be controlling; the experience of those who will be providing services under the agreement, quality, equality, efficiency, utility, suitability of the services offered, and the reputation of applicants will be considered, along with other relevant factors.

D. Subcontracting

If subcontracting is contemplated, this should be discussed in your proposal. No additional subcontracting will be allowed without the express prior written consent of the TCMHA.

E. Withdrawal or Modification of Proposals

Proposals may be modified or withdrawn only by a written request received by TCMHA prior to the Request for Proposal due date (Closing Date).

F. Agreement Period

The initial agreement period shall be for three (3) years beginning on Commencement date. TCMHA can at its choice, exercise offers for two additional annual extensions for a total possible agreement period of five (5) years, subject to the annual review and recommendation of the Executive Director, the satisfactory negotiation of terms (including a price acceptable to both TCMHA and the selected agency), the concurrence of the Governing Board, and the annual availability of a budget appropriation. No price increases shall be accepted during the initial agreement period.

G. Award of a Contract

A contract may be awarded to the successful Proposer for the Project by TCMHA Governing Board, as applicable, based upon the criteria reflected in this RFP. TCMHA reserves the right to execute, or not execute, an Agreement with the successful Proposer when it is determined to be in TCMHA's best interests. This RFP does not commit TCMHA to award a contract; and no Proposal or Agreement shall be considered binding upon TCMHA until the execution of the Agreement by TCMHA and all conditions of the Agreement and/or RFP have been met.

H. Execution of Agreement

By submitting a Response, the Proposers agree to be bound to and execute an Independent Contractor Agreement for the services described in this RFP. None of the foregoing shall preclude TCMHA, at its option, from seeking to negotiate changes to the Contract prior to its execution. TCMHA may cancel all or any portion of the Agreement for any reason with 30 days written notice to Contractor. The Agreement shall be signed prior to the commencement of any work by the successful Proposer and returned, together, with the required insurance forms within fourteen (14) calendar days after the Proposer has received written notice of award. Failure to do so shall be just cause for the annulment of the award at the sole election of TCMHA.

I. Indemnity and Insurance Requirements

The awarded Proposer(s) shall comply with the insurance and indemnification requirements set forth below. If selected, Proposer shall procure and maintain for the duration of the agreement insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Contractor, his agents, representatives, employees or subcontractors.

1. Minimum Limits of Insurance. During the entire agreement time with TCMHA, the awarded Proposer shall maintain limits no less than:

INSURANCE CATEGORY	MINIMUM LIMITS
Workers' Compensation Insurance	California Statutory Minimum
Employer's Liability Insurance	$1,000,000 per accident; $1,000,000 per employee for bodily injury or disease
Commercial General Liability Insurance	$1,000,000 combined single limit per occurrence coverage for bodily and personal injury and property damage, and $2,000,000 general aggregate $1,000,000 per occurrence for bodily injury, personal injury, and property damage
Business Vehicle and Automobile Liability Insurance	$1,000,000 per occurrence for bodily injury and property damage
Cyber Liability Insurance	$1,000,000 for each occurrence or event; with an annual aggregate of $1,000,000 as further described below.
Errors and omissions Insurance (Professional Liability)	$1,000,000 per claim or occurrence and in the Aggregate, as further described below.

a. Cyber Liability Insurance**.** With limits not less than $1,000,000 for each occurrence or event with an annual aggregate of $1,000,000 covering claims including but not limited to invasion of privacy violations, breach of data, disruption of networks, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, introduction or intrusion of a virus, malware, notification, credit monitoring, breach response costs, regulatory fines and penalties, extortion and network security, and also infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, up to the policy limits. As an additional requirement, the policy should specifically contain 1st party and 3rd party protections:

- 1st Party covers notifying the Contractor's clients, credit monitoring, public relations, loss of business income or interruption, amounts to pay a cyber extortionist of the Contractor.
- 3rd Party would cover failing to anticipate or prevent the transfer of a virus to a 3rd party, 3rd party notification, misuse, disclosure or theft of confidential info, and failure to secure confidential info.

b. Professional Liability (Errors and Omission) Insurance**.** With limits not less than $1,000,000 per claim or occurrence and in the Aggregate. Such insurance coverage's definition of professional services must extend to all professional services under this contract, and all additional terms, conditions and limitation shall provide coverage sufficiently broad to respond to the duties and obligations as is undertaken by Proposer in this Contract. Such insurance coverage shall include, but not be limited to, coverage for mistakes in opinions, judgments or actions in the course and scope of providing professional services, claims involving infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress. The policy shall protect TCMHA for breach response costs as well as regulatory fines and penalties as well as credit monitoring expenses with limits sufficient to respond to these obligations.

2. Other Insurance Provisions **-** The general liability and automobile liability policies are to contain, or be endorsed to contain, the following provisions:

a. Tri-City Mental Health Authority, its officers, officials, employees, and volunteers are to be covered as insureds with respect to liability arising out of work or operations performed by or on behalf of the Contractor including materials, parts or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to the Contractor's insurance (at least as broad as ISO Form CG 20 10 11 85), as a separate Owner's and Contractor's Protective Liability Policy, or on TCMHA's own form.

b. For any claims related to this project, the Contractor's insurance coverage shall be primary insurance as respects TCMHA, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by TCMHA, its officers, officials, employees, or volunteers shall be excess of the Contractor's insurance and shall not contribute with it.

c. Each insurance policy required by this clause shall be endorsed to state that coverage shall not be canceled by either party, except after thirty (30) days' prior written notice by certified mail, return receipt requested, has been given to TCMHA.

3. Acceptability of Insurers. Insurance is to be placed with insurers with a current A.M. Best's rating of no less than A-:VII or otherwise acceptable to TCMHA.

4. Verification of Coverage. Contractor shall furnish the TCMHA with original certificates and amendatory endorsements effecting coverage required by this clause. The endorsements should be on forms provided by TCMHA or on other than TCMHA's forms, provided those endorsements or policies conform to the requirements. All certificates and endorsements are to be received and approved by TCMHA before work commences. However, failure to obtain the required documents prior to the work beginning shall not waive the consultant's obligation to provide them. TCMHA reserves the right to require complete, certified copies of all required insurance policies, including endorsements effecting the coverage required by these specifications at any time.

5. Subcontractors. Contractor shall require and verify all subcontractors maintain insurance subject to all of the requirements stated herein.

6. Indemnification. Contractor expressly agrees to defend, indemnify and hold harmless TCMHA and its Directors, officers, agents, volunteers and employees from and against any and all loss, expenses, claims, suits, damages, attorney's fees, and other costs, including all costs of defense, which any of them arising out of or resulting from Contractor's, its associates, subcontractors, or other agents' negligent acts, or refusal of Contractor to faithfully perform the work and all of the Contractor's obligations or errors or omissions or willful misconduct in the operation and/or performance under this Agreement. Contractor shall pay and satisfy any judgment, award or decree that may be rendered against TCMHA or its directors, officers, employees, or authorized volunteers, in any such suit, action, or other legal proceeding. The obligations of the contractor shall not extend to the liability of TCMHA, its directors, employees, arising out of or resulting from or in connection with the preparation or approval of maps, drawings, opinions, reports, surveys, designs or specifications, providing that the foregoing was the sole and exclusive cause of the loss, damage or injury.

J. Invoicing and Payment Process

The Contractor will bill on a monthly basis based on work performed. Invoices not including the proper purchase order or any variations may cause a delay in payment. Payment will be made after invoices are received, approved by the staff overseeing the work and the department has processed the payment. Payments will normally be made at the end of thirty (30) days unless other terms are specifically offered by the Contractor and accepted by TCMHA. TCMHA does not pay in-advance or for interest or fees for late payments.

K. Agreement Extension

At the sole discretion of TCMHA, TCMHA may, upon two months prior notice to the Contractor, extend the Agreement for two successive 12-month periods. Such extensions shall be under the same terms and conditions or as negotiated and revised in writing.
At such time as TCMHA chooses to exercise the option to extend the Agreement, the Contractor will be notified and requested to submit a written proposal detailing the next 12-months offered price for the agreement services. If the option for any 12-month period extension is not exercised, the agreement shall terminate at the end of the current period term. Any extensions shall be subject to agreement between TCMHA and the Contractor.

L. Agreement Price Adjustment Parameters

To be eligible for an Agreement Extension, the price shall either remain the same as proposed or, upon mutual agreement, can be adjusted by the 12-Month percentage change in the Consumer Price Index (CPI) for All Urban Consumers in the San Francisco, Oakland, San Jose, California index published by the Department of Labor for the most current yearly comparison three months prior to the Agreement expiration dates. For example, if the Agreement expires in February the CPI comparison would be between the November CPI for that year and the preceding year. Despite any changes in the CPI for any given twelve-month adjustment period, upward adjustment of Agreement amount shall not exceed 5 percent during any single twelve-month adjustment period.

M. Transition Services

Upon the expiration or termination of this Agreement for any reason, EHR Contrctor shall provide the services described below (the “Transition Services”) for up to (2) months if requested by TCMHA (the “Transition Period”). Transition Services shall consist of the following to the extent requested in writing by TCMHA:

1. Continuing to provide the Services required under this Agreement as of the date of termination (including applicable service levels and disaster recovery services), or such subset of such Services as TCMHA may direct; and

2. Providing all reasonable cooperation to TCMHA, its contractors and replacement EHR Contractor(s) in order for TCMHA to transition its data to a successor system, including: (i) working in good faith to provide all data in a standardized format and structure that is then generally accepted in the health IT industry or is otherwise acceptable to the TCMHA; or

(ii) assisting with the conversion of such data for use in a new EHR. The parties shall negotiate reasonably and in good faith to agree on details of the Transition Services including the deadline for completion of data conversion services.

3. Transition Fees. Fees shall not exceed the then current hourly rates that would be charged by EHR Contractor for similar services provided under the Agreement. Notwithstanding the foregoing, in the event that the Agreement is terminated by the TCMHA on the basis of the Contractor's breach of this Agreement, including a breach of the Contractor's warranty that the EHR system is certified under the Current Requirements, then the Contractor shall provide the Transition Services free of any fee, charge or set off.

4. Accessing Previous EHR Software. TCMHA may retain a secure archival copy of the most recently used software, all previous versions, and all documentation for use in responding to e-discovery requests for Documentation in its "native format."
TCMHA may use the archived software in litigation, arbitration, or government investigations regarding reimbursement malpractice, or other matters in which the use of such items would help establish what information was known to TCMHA and its EHR users at the time in question and how it appeared.

VII. GENERAL PROVISIONS

A. Independent Contractor

In performance of the work, duties and obligations assumed by the Proposer, it is mutually understood and agreed that the Proposer, including any and all of the Proposer's officers, agents and employees, will at all times be acting and performing in an independent capacity and not as an officer, agent, servant, employee, joint venture, partner or associate of TCMHA.

B. Public Records - Notice Related to Proprietary/Confidential Data

Proposer understands that the public shall have access, at all reasonable times, to all documents and information, subject to the Public Records Act, and agrees to allow access by TCMHA and the public to all documents subject to disclosure under applicable law. Proposer's failure or refusal to comply with the provision of this section shall result in the immediate cancellation of the Agreement (if awarded). Proposers are advised that the California Public Records Act (the "Act", Government Code §§6250 et seq.) provides that any person may inspect or be provided a copy of any identifiable public record or document that is not exempted from disclosure by the express provisions of the Act. Each Proposer shall clearly identify any information within its submission that it intends to ask TCMHA to withhold as exempt under the Act. Any information contained in a Proposer's submission which the Proposer believes qualifies for exemption from public disclosure as "proprietary" or "confidential" must be identified as such at the time of first submission of the Proposer's response to this RFP. Failure to identify information contained in a Proposer's submission to this RFP as "proprietary" or "confidential" shall constitute a waiver of Proposer's right to object to the release of such information upon request under the Act. TCMHA favors full and open disclosure of all such records. TCMHA will not expend public funds defending claims for access to, inspection of, or to be provided copies of any such records.

Note that wholesale use of headers/footers bearing designations such as "confidential", "proprietary", or "trade secret" on all or nearly all of a proposal is not acceptable, and may be deemed by TCMHA as a waiver of any exemption claim. Any Proposal that includes a blanket statement or limitation, which would prohibit or limit public inspection may be considered non-responsive and may be rejected. Pricing information is generally not considered proprietary information. The identification of exempt information must be specific. TCMHA assumes no responsibility for disclosure or use of unmarked data for any purposes.

C. Conflict Of Interest

Proposers, by responding to this RFP, certify that to the best of their knowledge or belief, no elected/appointed official or employee of the TCMHA is financially interested, directly or indirectly, in the purchase of goods/services specified in this RFP. Furthermore, Proposer represents and warrants to TCMHA that it has not employed or retained any person or company employed by the TCMHA to solicit or secure the award of the Agreement and that it has not offered to pay, paid, or agreed to pay any person any fee, commission, percentage, brokerage fee, or gift of any kind contingent upon or in connection with, the award of the Agreement.

D. Nondiscrimination

Proposer agrees that it shall not discriminate as to race, sex, color, age, religion, national origin, marital status, sexual identity or disability in connection with its performance under this RFP. Furthermore, Proposer agrees that no otherwise qualified individual shall solely by reason of the aforementioned be excluded from the participation in, be denied benefits of, or be subjected to, discrimination under any program or activity.

E. Debarred/Suspended Contractors

The awarded Proposer (Contractor) shall certify that no staff member, officer, director, partner, principal, or owner, or sub-contractor is excluded from any Federal health care program, or federally funded contract (***Attachment G***).

F. Business Associate Agreement

To the extent necessary, TCMHA will furnish Protected Health Information (PHI) to awarded Proposer/Contractor (Business Associate) in accordance with all applicable legal requirements to allow Contractor to provide a comprehensive client data and electronic record software application on TCMHA's behalf. Contractor is required to appropriately safeguard the PHI disclosed to it. In accordance with TCMHA's policies and procedures, Contractor will sign a *Business Associate Agreement* (***Attachment H***), accepting liability for any breach of ePHI or PHI.

G. Records And Audits

The awarded Proposer (Contractor) shall maintain accounts and records, including all working papers, personnel, property, and financial records, adequate to identify and account for all costs pertaining to the Contract and such other records as may be deemed necessary by TCMHA to assure proper accounting for all project funds, both Federal and non-Federal shares.

These records must be made available for audit purposes to TCMHA or any authorized representative, and must be retained, at the Contractor's expense, for a minimum of seven (7) years, unless the firm is notified in writing by TCMHA of the need to extend the retention period.

H. Governing Law and Regulations

The services will be performed in, construed by and interpreted according to the laws of the State of California. Proposer will comply with all federal, state, and local laws, standards, regulations, licenses, and permits. No proposal received and read may be withdrawn for a period of ninety (90) calendar days after the date fixed for opening proposals. TCMHA intends to award the Agreement within sixty (60) calendar days of receiving the proposals. TCMHA reserves the right to retain all proposals submitted and to use any ideas in a proposal regardless of whether that proposal is selected. Submission of a proposal indicates acceptance by the Proposer of the conditions contained in this request for proposals, unless clearly and specifically noted in the proposal submitted and confirmed in the agreement between TCMHA and the agency selected. There is no expressed or implied obligation for TCMHA to reimburse responding Proposers for any expenses incurred in preparing proposals in response to this request or for developing and carrying out interview presentations.
Any proposal preparation and/or travel cost in regards to this proposal is the sole responsibility of the Proposer. All proposal documents, prints and any detailed drawings shall be the property of TCMHA once submitted. TCMHA is a Joint Powers Authority formed and existing under the laws of the State of California. The successful Proposer will be required to satisfy all current legal requirements applicable to this work including Labor Code section 1061(b)(1), if applicable.

The Proposer, by submitting a response to this RFP, waives all right to protest or seek any legal remedies whatsoever regarding an aspect of this RFP. Although, it is TCMHA's intent to choose only a small number of the most qualified agency to interview with TCMHA, TCMHA reserves the right to choose any number of qualified finalists.

VIII. DEFINITIONS

A. Tri-City Mental Health Services Authority: Tri-City Mental Health Authority (TCMHA) or its authorized representative.

B. Request for Proposal Documents: The document soliciting invitation for proposal and includes basic proposal information and contractual documents.

C. Proposer: a person, corporation, partnership, or other entity who submits a proposal.

D. Proposal Packet: All requested and required Request for Proposal Documents and forms submitted by the Proposer to TCMHA.

E. Closing Time: The time and date deadline for submission of Proposal.

F. Independent Contractor: Upon TCMHA's award of the agreement a successful Proposer will become known as "Independent Contractor" or "EHR Contractor".

IX. ATTACHMENTS

Attachment A: Scope of Services

Attachment B: RFP Cover Page

Attachment C: Proposer's Company Information, References and Subcontractors

Attachment D: Proposer's Company Work Process Information

Attachment E: RFP Exceptions

Attachment F: Proposer Price Proposal

Attachment G: Contractor's Attestation

Attachment H: Business Associate Agreement

TRI-CITY MENTAL HEALTH SERVICES AUTHORITY
RFP NO. 2020-0802

ATTACHMENT A

SCOPE OF SERVICES

Tri-City Mental Health Authority (TCMHA) has identified a number of software functional requirements that apply to its business. The functional requirements are grouped into 12 categories:

A. Overall Client Information & Electronic Record Functionality
B. Psychiatry & Nursing Services Functionality
C. Substance Abuse & Dependence Functionality
D. Outpatient Functionality
E. Other Clinical Functionality
F. Additional Compliance, Quality Assurance, & Medical Record Functionality
G. Additional Referral & Admission Functionality
H. Billing & Accounts Receivable Functionality
I. Management & Performance Functionality Reporting
J. Other Core System Functionality

Contractor responses to the functional specifications will have two components:

1. Software Functionality Summary Sheet – Proposers will use the Summary Sheets at the end of this section to code their responses as to whether or not the functionality is available in their application. There are separate Summary Sheets for each of the broad areas of functionality. Additionally, Proposers can use the Comments column of the Summary Sheet to indicate that they have a comment about the specification in the Functional Specifications Comments section.

2. Functional Specifications Comments – This is the section where Proposers indicate comments, if any, regarding the specifications. Comments should be coded by specification number and name.

A. Overall Client Information & Electronic Record Functionality

1. **Standard & Program Specific Client Demographic Data.** The software supports recording all client's demographic data required for standard third- party billing functions. Additionally, it supports the ability for the organization to track demographic data specific to individual programs or services, and these data requirements are easily changeable over time.

2. **Alias & Previous Name Support.** The system should support tracking previous names and aliases for client, children, and family members throughout the system, including within the billing module.

3. **Consumer Photo.** The software supports the import and viewing of consumer photos for identification purposes.

4. **Required Form Generation & Tickler System.** The software should support generation of required forms for responsible party review and signature (e.g., financial status updates, consumer rights information, authorizations for treatment, etc.) as well as remind staff of upcoming and overdue due dates for completion.

5. **Admission, Transfers, & Discharge Information.** The software allows users to record program admission and discharge information for each client, overall and by service line or program.

6. **Referral Tracking.** The software supports tracking referral sources [INTERNAL AND EXTERNAL] and the related workflow for managing admissions to the organization's programs.

7. **Referral & Admission Notes.** The system should have notes capabilities to support staff in tracking important information about each admission and case. These might include notes about the utilization review process, issues for billing staff to address, or other requirements.

8. **Support for Automatic Referral Letter & Fax Generation.** The system should support the creating and faxing of letter to referral sources.

9. **Discharge Planning & Referral Tracking.** The software supports detailed discharge planning, including community providers referred to and their areas of expertise.

10. **Family & Relationship Tracking.** The software supports recording family members and other relationships for all clients in care.

11. **DSM & ICD Diagnoses.** The software allows users to record a DSM diagnosis (using the most up-to-date version of the DSM) and translate the diagnosis to ICD codes (using the most up-to-date version of the ICD) as required by third-party payers. This should include support for all ICD diagnoses for medical conditions. The diagnosis data should be date-sensitive.

12. **Master Individual Service Plans.** The software allows users to record all individual service plan (ISP), including identified symptoms/behaviors, problems, and goals for treatment. Elements of the service plan are easily viewable form the progress note view, as well as the ability to populate elements into the progress note. The system track start and end dates for service plan objectives, as well as, the ability to alert for upcoming due and overdue service plans.

13. **Care Provider Tracking.** The software allows users to record all assigned care providers (e.g., primary clinician, case manager, psychiatrist, etc.) and be date-of-service sensitive.

14. **Client Electronic Signature.** The software supports the ability to import and document client and responsible party signatures from signature pad devices (e.g., for consents for treatment, etc.).

15. **Staff Electronic Medical Record Signature Standard Compliance.** The software supports national standards for signing electronic medical records.

16. **Support for Multiple Signature Requirements & Progress Note Roll-Up.** The system should support instances when multiple staff members write and sign a medical record note (e.g., for day treatment services or shift notes).

17. Decision-Support, Evidence-Based Practice (EBP), & Assessment Tools. The software has tools to aid clinicians/caregivers in the treatment and service planning processes. This includes tools to assist in diagnosing conditions, selecting treatment goals and developing service plans, documenting progress towards goals, preventing medication errors, etc. This also includes standard assessment tools used by clinical staff as well as direct access to up-to-date DSM and ICD criteria for diagnosing.

18. Custom Assessment Tools. The system should support the ability to create custom assessment tools, including calculation, storing, and export capabilities for assessment scores. Ability to add picture files or help files for staff to view either in the tool or as a pop up. Easily be able to access and use questions that are on other assessments if wanted/needed. Have the ability to create grids and conditional requirement fields.

19. Customizable Progress, Telephone, & Shift Notes. The software supports clinical notes for individual, group, and family sessions, telephone contact notes, and staffing shift notes. These notes are customizable by the organization to best meet the requirements of individual programs. [Service Notes have ability to IMPORT/COPY & PASTE from other section of the chart, as well as previous notes]

20. Group Notes. The system should easily handle progress notes for group therapy services such that individual notes and "group" notes can be done simultaneously and become part of individual records.

21. Electronic Record Pre-population. The system should assist users by prepopulating commonly used forms with information already in the database or from previous versions of clinical forms when appropriate.

B. Psychiatry & Nursing Services Functionality

1. Medication Monitoring. The system should allow users to record and monitor medications for clients in care, including drug name, dosage, date range, and prescribing physician. Ideally, the system would also warn about drug interactions or contraindications.

2. Medical Conditions & Metrics. The software allows staff to track other medical conditions and have appropriate alerts as needed (e.g., for medication allergies, etc.) as well as medical metrics such as the AIMS (assessment for voluntary movement scale), weight, blood pressure, BMI (body mass index), sugar levels, height, weight, etc.

3. Medication Administration Records. The system would include a medication electronic administration record (MAR) to ensure that all medications are administered correctly to the right clients in care. Additionally, the MAR should support recording an electronic client signature to verify receipt of the medication.[EMAR REPORT NEEDED].

4. Injection Administration Data Tracking. The software supports tracking injection administration data such as the medication, dosage, administration body site, etc.

5. Electronic Prescription Transmission. The software supports sending electronic prescriptions or faxes to the external pharmacies.

6. **Tamper-Resistant Prescription Printing.** The software supports printing prescriptions that comply with CMS' requirements regarding tamper-resistant prescription pads.

7. **Links to Medication Information & Drug Interaction & Contraindications.** The software allows easy access to web-based information about drug interactions, contraindications, and client drug information.

8. **Prescription Refill Reminders.** The software reminds prescribers when client prescriptions need to be refilled.

9. **Laboratory Interface.** The software supports sending data to and from laboratories for laboratory testing as well as the ability to track laboratory results over time for individual clients.

10. **Laboratory Result & Medical Condition Alerts.** The system should support alerting clinical staff when lab results or other medical metrics are outside normal criteria.

11. **Formulary & Medication Pre-Certification Support.** The software supports tracking insurance formularies so that prescribers can select medications based upon insurance coverage and tiered formularies, if required. Additionally, it should support prescribers in the process of obtaining pre-certification for medications that require them.

12. **Drug Enforcement Administration (DEA) Federal Regulation Supports.** The system supports DEA requirements for instances such as controlled medication refills and the faxing/printing of controlled medications.

13. **Patient Medication Information/Handouts**. The system supports printing patient information for prescribed medications.

14. **Laboratory Orders Sets.** The system supports creation of sets of commonly grouped laboratory orders.

15. **Medical Supply Inventory Support.** The system supports maintaining an inventory of medical supplies [AND MEDICATION with INVENTORY TRACKING].

C. Substance Abuse & Dependence Functionality

1. **Assessment Tool Support.** The system supports the use of assorted substance abuse assessment instruments as well as the related reporting. Examples include the following: Addiction Severity Index (ASI)

- Substance Abuse Subtle Screening Inventory (SASSI) – Adult and adolescent version
- Post Acute Withdrawal Systems (PAWS)
- Withdrawal Assessment Scale
- Clinical Institute Withdrawal Assessment (CIWA)

2. **Decision-Support & Compliance for ASAM Criteria for Care**. The system supports users in determining and selecting levels of care, service modality, and the related services within these modalities in compliance with American Society of Addiction Medicine (ASAM) criteria as well as supporting compliance with the requirements of third party payers, managed care entities and other external entities, including those related to authorizations, admissions, and provider billing of services.

3. **Random Appointment Scheduling for Urinalysis & Compliance Monitoring**. The system supports random appointment scheduling for urinalysis for substance abuse consumers (and other required testing if needed). The functionality includes the ability for staff to monitor compliance with required testing as well as providing an easy way to notify consumers if they have been selected for testing on a specific day.

4. **Detoxification Vital Sign Tracking Support**. The system supports the tracking and recording of vital sign information in a detoxification unit. This includes tracking an assortment of vital signs every two hours for roughly 100 patients.

D. Outpatient Functionality

1. **Resource-Based Appointment Scheduler Capabilities.** The system would support centralized scheduling functions, including rules-based user assistance in finding available appointments based on service need, payer requirements, staff credentials and specialty areas, etc.

2. **Group Scheduling Support**. The system should also support scheduling appointment for group therapy, including support for scheduling attendance for the designated number of slots for each group. The option to auto schedule groups which automatically updates based on group enrollment for that week. It should be easy to enroll and drop client from group.

3. **Front Desk Cash Application**. The system supports self-pay payment receipt and cash application at office reception locations.

4. **Client Arrival Notification**. The software has some way of indicating in the scheduler that a client has arrived for an appointment to eliminate the need for the front desk staff to call the clinician's office. Ideally this would also indicate the time the consumer arrived to monitor wait times.

5. **Front Desk Client Financial Summary Information Access**. The software provides front desk staff easy access to summary client financial information such as co-payments required, self-pay balances, authorization statuses, required form updates, requests or notes from billing staff, etc.

6. **Automatic Service Generation from Scheduler**. The software allows users to indicate that a scheduled service has occurred so that it is available for billing without the need to re-enter service data.

E. Other Clinical Functionality

1. **Case Management Notifications.** The software supports notifying case management and psychosocial program staff of key events when they occur for clients in care (e.g., no-shows, admissions and discharges, critical incidents, etc.

2. **Employment Services Data Tracking & Consumer Matching.** The system should support tracking employers used in the organization's employment services programs, including data about job positions and requirements, and support for matching consumers with available positions.

3. **Consumer Employment History.** The system should support tracking consumer employment placement histories.

4. **Expanded Employment & Support Services Data Tracking.** The system should also support tracking a broader array of services used to support consumers in their employment and daily activities, including dependent care support services, wellness services (such as nutritional and fitness coaching), and legal and financial services.

5. **Prevention Program & Presentation Tracking.** The system should support the organization's need to track a variety of group educational and prevention programs, including sometimes tracking demographic data, such as the number of participants, attendee demographics, program type, date range while enrolled in program type, and location rather than individual attendee names.

F. Additional Compliance, Quality Assurance, & Medical Record Functionality

1. **Alerts or "Tickler" Capabilities.** The software allows users to indicate required components of health/case records, files, outcome measures, satisfaction surveying, and/or required actions, and also have a companion reporting and editing system for identifying incomplete files or pending requirements. Ideally, the "tickler" system will be linked to the staff alert and messaging system.

2. **Satisfaction & Outcomes Tracking & Analysis.** The software has the ability to track date-sensitive, program-specific satisfaction and outcome data for clients as well as having robust capabilities for analyzing this information.

3. **Critical Incident & Other Required Reporting.** The software supports serious incident and other required reporting and follow-up, including tracking seclusions and restraints, medication errors, police interventions, abuse and neglect reporting, etc. Also, the software supports tracking of the investigation of suspected human rights violations, etc. The system allows the tracking of multiple events within a single critical incident if needed.

4. **Track Progress Note Compliance.** The software has some mechanism for tracking and ensuring that progress notes have been completed and signed for all services entered and billed. Ideally, there should be flexibility in setting up the alerts and parameters regarding requirements for the progress note and other documentation.

5. **Electronic Record Release.** The software enables the easy release of all or part of an electronic medical record, both electronically and via printing. Software alson enables the ability to restrict information being released within the electronic medical record (i.e. other names in client's chart, substance use info, HIV info, etc.)

6. **Record Release Tracking.** The system should also have an audit trail for the printing parts of the medical record or releasing electronic copies of part of or all of the record.

7. **Electronic Medical Record Document Routing & "Role Based Charting".** The software supports routing medical record documents to supervisors or others for signature or approval as required. This includes the ability to support appropriate oversight of medical doctor residents and staff with specific clinical supervision requirements.

8. VIP Medical Records Protection. The software supports locking a medical record so that only specific individual staff members can access it for cases where the client is a VIP, special, or sensitive case. Need to be able to run a report on this, also.

9. **Tracking HIPAA & State Specific Medical Record Requirements.** The system will support tracking medical records rights under the HIPAA privacy standards as well as those for all states in which the organization operates.

10. **Accreditation Support.** The system should support tracking compliance with accreditation standards for the standard behavioral health and health care accrediting bodies.

11. **Enhanced Role-Based System Access Controls.** The system should have user access controls that are flexible enough to allow "on the fly" expansions of access to medical records in certain instances and require staff to document the reasons for expanded access. (For example, in an emergency clinical staff members may require access to patient records he or she might not normally see.)

12. **EHR Document Version Control.** The system should maintain and support the tracking of all versions of medical record forms.

13. **EHR Archiving & Purge Capability.** The software application should have appropriate mechanisms for archiving and retrieving historical records as well as purging records when needed.

G. Additional Referral & Admission Functionality

1. **Extensive Call Tracking & Disposition Data.** The system should support tracking all crisis and referral call information and data about the disposition of each call. The system should have notes capabilities to support staff in tracking important information about each referral and case. These might include notes about the utilization review process, clinical concerns, issues for billing staff to address, or other requirements.

2. **Referral Workflow Tracking.** The software should support tracking referral sources and the related workflow for managing admissions to the organization's programs.

3. **Pre-Admission Checklist Support.** The system should support ticker functionality for patient-specific pre-admission task completion, such as completing clinical and billing reviews and approvals, obtaining required medical equipment before admission, etc.

4. **Waitlist Tracking.** The software supports tracking clients on waitlists for specific services. This should include data used to prioritize waitlist standings (such as clinical issues, payer information, etc.)

H. Billing & Accounts Receivable Functionality

1. **Client Payer & Service Authorization Data.** The software supports date-of-service sensitive payer data and service authorizations required for billing for all clients in care (by units, sessions, and/or dollars). It includes the ability to record multiple payers for each client with standard "waterfall" logic for third-party billing.

2. **Case Management & Service Authorization Management Supports.** In addition to supporting the recording of service authorization information, the system should aid case management and/or billing staff in tracking service authorization requests, reductions, and denials; in providing staff advance warning for when authorizations will expire; and in monitoring individual staff member success in obtaining service authorizations.

3. **Client Service Entry.** The software supports user-friendly data entry of billable and non-billable services.

4. **Pre-billing Edits.** The software has edit capabilities based upon payer requirements and authorization data to prevent billing of claims that are likely to be rejected for payment. This includes more complex payer rules, such as a limitation on the number of particular services that can occur in a time frame.

5. **Client Fee-For-Service, Per Diem, & Contract Billing.** The software supports traditional outpatient billing, per diem billing, and grant or contract fund billing, including support for the billing logic of individual payers.

6. **Complex Billing Requirement Support.** Additionally the system should support more complex billing requirements such as billing net charges instead of gross, billing bed days but not ancillary charges, bundling services, allowing staff to manually edit the final bills, etc.

7. **IBHIS Integration.** The system must support integration directly into IBHIS which is the Los Angeles County Department of Mental Health's (LAC DMH) secure, web-based Health Information Exchange (HIE) system. It was designed to comply with HIPAA and improve clinical service delivery.

8. **Standard A/R Functionality.** The software supports standard accounts receivable functionality for billing third-party payers, including payment posting, contractual expense write-offs, bad debt write-off, balance billing, and rebilling.

9. **Client Sliding Scale Fee Screen.** The software supports client-specific sliding scale fees for services in both flat fees and as a percentage of the gross service charge.

10. **Client Sliding Scale Fee Calculation.** The software supports calculation of the client sliding scale fee based upon income and family size.

11. Electronic Remittance Posting & Waterfall Billing. The software supports electronic remittance posting (835) for both payments and denials and then automatic billing for paid claims to the next payer for clients ("waterfall billing").

12. Guarantor Private Pay Statements. The software supports generating guarantor private pay statements with flexible content.

13. Split Guarantor Private Pay Statements. The system should support splitting the billing between two guarantors in the instance that there is more than one guarantor for the client in care.

14. Payer Eligibility Data Import. The software supports import of payer eligibility data (270/271).

15. Consumer Fund Tracking. The software assists staff in tracking consumer funds that are monitored by the organization, including fund receipts and disbursements.

16. Medicare Incident to Billing Support. The software supports tracking both the rendering and physically present incident to supervisor for services for Medicare consumers as required. Supports a clearinghouse to submit secure SFTP file transfers to Noridian Healthcare Solutions for Medicare claims.

17. Transportation Billing. The system should support billing for consumer transportation services, including support for fixed rate and mileage-based billing

18. HIPAA 837 Transactions. Software to generate outbound HIPAA ASC X12 Health Care Professional 837 I/P transaction claims.

19. Health Care Claim Acknowledgment Transaction (277CA). Software to link an 837 to the 277CA for all claims.

20. Payor Financial Information (PFI) forms. Software has the capability to complete PFI forms electronically and store in the client's electronic health record.

I. Management & Performance Reporting Functionality Reporting

1. Built-In Support for Compliance Reporting. The system should have the ability to support all state and other externally mandated reporting requirements for providers in all states in which the organization operates. Should be able to automatically transfer required data to LACDMH and/or State organizations.

2. Management Metrics Dashboard. Ideally, the system would also support developing a management reporting dashboard to help monitor key strategic and operational metrics. Flexibility is needed for data fields. Should be able to easily add/change/remove data fields. All data fields should be easily exported into an external data file. Ad hoc reports should be easily created by selecting the needed fields for the report.

3. Staff Productivity Management Support Capabilities. The system should support management efforts to manage clinical staff productivity by recording requirement productivity standards and supporting reporting and dashboard capabilities for managing actual productivity in comparison to requirements.

4. **Clinician Staff Credentialing & Privileging Support.** The system should support tracking demographic, licensing, credentials, and payer privileges for clinical staff members. This information should be integrated into scheduling and billing functionality to aid the organization in ensuring that all payer rules are met and claims for services will be paid.

5. **Clinical Supervision Support.** The system should support tracking clinical supervision of staff members and interns, including documenting supervision events and supervisory notes.

J. Other Core System Functionality

1. **Internal Staff Alert & Messaging System.** The software supports the ability to alert and message the organization's staff for important clinical and administrative requirements either directly or via interface with Microsoft Outlook.

2. **Voice Recognition Software & Transcription Support.** The software supports the use of voice recognition software by clinical staff during clinical record keeping as well.

3. **Consumer/Family/Network Provider Portals.** The software application should support consumer, family, or network provider access to defined and discrete parts of the system via portals for various functions such as communication, data entry, screening tool/forms (with ability to sign electronically, electronic record review, etc.

4. **HIE of Service Request Information with Los Angeles County DMH**

5. **HIE of CANS & PSC-35 with Los Angeles County DMH**

6. **The system audit trail/track and report.**
   - What records were accessed, date, time, by whom, and actions that were done
   - What fields were modified, date, time, by whom, and the changes made

7. **Client and Services Information (CSI).** Software able to generate a client and service information (CSI) data file that is required by California Department of Health Care Services. Also to create a unique alpha numeric code for each client to be used as the county client number (CCN) in the CSI data file.

Instructions: In the **Proposer Response** column, place an X in the column to indicate whether or not the requested functionality is available in the software application in your current release to all customers. In the **Comment** column, circle Yes or No to indicate whether you have additional comments regarding this specification in the Functionality Proposer Comments section of the RFP.

Number	Specification	*Proposer Response*		*Comment?*
		Yes	No	
A1	Standard & Program Specific Client Demographic Data			
A2	Alias & Previous Name Support			
A3	Consumer Photo			
A4	Required Form Generation & Tickler System			

Number	Specification	*Proposer Response*		*Comment?*
		Yes	No	
A5	Admission, Transfers, & Discharge Information			
A6	Referral Tracking			
A7	Referral & Admission Notes			
A8	Support for Automatic Referral Letter & Fax Generation			
A9	Discharge Planning & Referral Tracking			
A10	Family & Relationship Tracking			
A11	DSM & ICD Diagnoses			
A12	Master Individual Service Plans			
A13	Care Provider Tracking			
A14	Client Electronic Signature			
A15	Staff Electronic Medical Record Signature Standard Compliance			
A16	Support for Multiple Signature Requirements & Progress Note Roll-Up			
A17	Decision-Support, Evidence-Based Practice (EBP), & Assessment Tools			
A18	Custom Assessment Tools			
A19	Customizable Progress, Telephone, & Shift Notes			
A20	Group Notes			
A21	Electronic Record Pre-population			
B1	Medication Monitoring			
B2	Medical Conditions & Metrics			
B3	Medication Administration Records			
B4	Injection Administration Data Tracking			
B5	Electronic Prescription Transmission			
B6	Tamper-Resistant Prescription Printing			
B7	Links to Medication Information & Drug Interaction & Contraindications			
B8	Prescription Refill Reminders			
B9	Laboratory Interface			
B10	Laboratory Result & Medical Condition Alerts			
B11	Formulary & Medication Pre-Certification Support			
B12	Drug Enforcement Administration (DEA) Federal Regulation Supports			
B13	Patient Medication Information/Handouts			
B14	Laboratory Orders Sets			
B15	Medical Supply Inventory Support			
C1	Assessment Tool Support			

Number	Specification	*Proposer Response*		*Comment?*
		Yes	**No**	
C2	Decision-Support & Compliance for ASAM Criteria for Care			
C3	Random Appointment Scheduling for Urinalysis & Compliance Monitoring			
C4	Detoxification Vital Sign Tracking Support			
D1	Resource-Based Appointment Scheduler Capabilities			
D2	Group Scheduling Support			
D3	Front Desk Cash Application			
D4	Client Arrival Notification			
D5	Front Desk Client Financial Summary Information Access			
D6	Automatic Service Generation from Scheduler			
E1	Case Management Notifications			
E2	Employment Services Data Tracking & Consumer Matching			
E3	Consumer Employment History			
E4	Expanded Employment & Support Services Data Tracking			
E5	Prevention Program & Presentation Tracking			
F1	Alerts or “Tickler” Capabilities			
F2	Satisfaction & Outcomes Tracking & Analysis			
F3	Critical Incident & Other Required Reporting			
F4	Track Progress Note Compliance			
F5	Electronic Record Release			
F6	Record Release Tracking			
F7	Electronic Medical Record Document Routing & “Role Based Charting”			
F8	VIP Medical Records Protection			
F9	Tracking HIPAA & State Specific Medical Record Requirements			
F10	Accreditation Support			
F11	Enhanced Role-Based System Access Controls			
F12	EHR Document Version Control			
F13	EHR Archiving & Purge Capability			
G1	Extensive Call Tracking & Disposition Data			
G2	Referral Workflow Tracking			

Number	Specification	*Proposer Response*		*Comment?*
		Yes	No	
G3	Pre-Admission Checklist Support			
G4	Waitlist Tracking			
H1	Client Payer & Service Authorization Data			
H2	Case Management & Service Authorization Management Supports			
H3	Client Service Entry			
H4	Pre-billing Edits			
H5	Client Fee-For-Service, Per Diem, & Contract Billing			
H6	Complex Billing Requirement Support			
H7	IBHIS Integration			
H8	Standard A/R Functionality			
H9	Client Sliding Scale Fee Screen			
H10	Client Sliding Scale Fee Calculation			
H11	Electronic Remittance Posting & Waterfall Billing			
H12	Guarantor Private Pay Statements			
H13	Split Guarantor Private Pay Statements			
H14	Payer Eligibility Data Import			
H15	Consumer Fund Tracking			
H16	Medicare Incident to Billing Support			
H17	Transportation Billing			
H18	HIPAA 837 Transactions			
H19	Health Care Claim Acknowledgment (277CA)			
H20	Payor Financial Information (PEI) Forms			
I1	Built-In Support for Compliance Reporting			
i2	Management Metrics Dashboard			
I3	Staff Productivity Management Support Capabilities			
I4	Clinician Staff Credentialing & Privileging Support			
I5	Clinical Supervision Support			
J1	Internal Staff Alert & Messaging System			
J2	Voice Recognition Software & Transcription Support			
J3	Consumer/Family/Network Provider Portals			
J4	HIE of Service Request Info for LACDMH			
J5	HIE of CANS & PSC-35 with LACDMH			
J6	System Audit Trail/Track and Report			
J7	Client and Services Information (CSI)			

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ATTACHMENT B

RFP COVER PAGE

Name of Person, Business or Organization:	
Type of Entity: (e.g. Sole-Proprietorship, Partnership, Corporation, Non-Profit, Public)	
Federal Tax ID Number:	
Contact Person – Name	
Contact Person – Address	
Contact Person – Phone Number (s)	
Contact Person – e-mail address	

By signing this ***RFP Cover Page*** I hereby attest: that I have read and understood all the terms listed in the RFP; that I am authorized to bind the listed entity into this agreement; and that should this proposal be accepted, I am authorized and able to secure the resources required to deliver against all terms listed within the RFP as published by TCMHA, including any amendments or addenda thereto except as explicitly noted or revised in my submitted proposal.

PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE

____

SIGNATURE OF AUTHORIZED REPRESENTATIVE **DATE**

____ ________________

TRI-CITY MENTAL HEALTH SERVICES AUTHORITY
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ATTACHMENT C

PROPOSER'S COMPANY INFORMATION, REFERENCES AND SUBCONTRACTORS

Company Name:	Address:
Owner, Principal Officer:	Headquarters Location/Date of Establishment:
Email:	Website:
Phone:	Fax:

List other license(s) and corresponding numbers/classification applicable or required for the scope of work of this proposal:

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Have you ever operated this business under a different name? Yes _________ No __________

If yes, please explain:

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[Continued on Page 2]

List references of projects that your company is currently *working on or completed* in the last 5 years of similar size and scope of work for this proposal:

1. Company Name:____________________Contact Name:______________
   Contact e-mail: ____________________Contact Phone: ______________
   Scope of Work: __________________________________
   Agreement Amount: ________________Agreement Start/End Date: ______________

2. Company Name:____________________Contact Name:______________
   Contact e-mail: ____________________Contact Phone: ______________
   Scope of Work: __________________________________
   Agreement Amount: ________________Agreement Start/End Date: ______________

3. Company Name:____________________Contact Name:______________
   Contact e-mail: ____________________Contact Phone: ______________
   Scope of Work: __________________________________
   Agreement Amount: ________________Agreement Start/End Date: ______________

Subcontractors to be utilized, if applicable:

1. Company Name:____________________Contact Name:______________
   Contact e-mail: ____________________Contact Phone: ______________
   Specialty:________________________Years in Business:____________
   Scope of Work:__________________________________

2. Company Name:____________________Contact Name:______________
   Contact e-mail: ____________________Contact Phone: ______________
   Specialty:________________________Years in Business:____________
   Scope of Work:__________________________________

On Going Legal Proceedings: Provide details on any litigation in which your firm has been engaged in the past five (5) years. If none, then write "NONE."

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ATTACHMENT D

PROPOSER COMPANY WORK PROCESS INFORMATION

As part of proposal, Proposers are requested to provide detailed responses for the following:

Company Overview

Describe your company and what key qualifications you have to meet TCMHA's requirements. Ideally, this would also include information about the financial stability of your company. Please also include any relevant security certifications/audits, including the latest SSAE 16 Report/Letter (formerly known as SAS 70 SOC II).

Technical Information & Infrastructure Requirements

TCMHA is looking for detailed technical information about your software solution as well as the infrastructure requirements needed to successfully deploy your application. Please detail the hardware, network, and communication infrastructure requirements needed to support your application as well as any other technical information you deem necessary to understand how to fully deploy and support your application.

Training, Implementation, Support, Data Conversion, & Software Upgrades

Describe your organization's typical approaches to training, implementation, support, data conversion, and software upgrades. Include the following detailed information in this section:

- Provide a detailed description of your experience, ability, and process for data conversion from Welligent. Please include any known challenges and risks.
- The number of full-time equivalent (FTE) staff members you have in each of these operational areas.
- Information on a typical implementation services, including key tasks, timelines, and staff members involved both from your organization and the purchaser.
- The operations of your Help Desk, including information on 24/7 availability, how calls are prioritized, response times, whether the caller has routine access to live staff and all other information of interest to a customer.
- Information about User Groups.
- Any other technical information you deem necessary to understand how to fully deploy and support your application.
- Information about how customers are involved in the software enhancement decision process and how frequently upgrades occur.
- How requests for customization of the software are handled.
- What are the hours and methods (phone, e-mail, web) of support for each type of technical support?

[Continued on Page 2]

Functional Specifications Comment (Optional)

Please comment on the individual functional specifications as referenced in "Attachment A", if desired. This section is not required.

Report Writing Capabilities

Please describe the report writing capability of your technology solutions, including a listing and description of standard reports, export capabilities, and compatibility with other applications, ease of use, etc. Specifically, TCMHA desires the following key elements in a report writer:

- A report-writer interface that is comprehensive and easy to use, allowing reporting on all data elements in the system.
- Ability to write custom reports and write and use stored procedures.
- Data-warehouse and data mining capabilities.
- A data dictionary and supporting documentation.
- An extensive library of reports, with commonly used queries and sorts, which can be customized as needed by the customer.
- Ability to save and name report templates.
- Ability to run reports in batches.
- Ability to run reports or report batches at scheduled times.
- Ability to support all state and other externally mandated reporting requirements for behavioral health and substance abuse agencies in all states in which TCMHA operates.
- Ability to create management information dashboards.

Electronic Record Capability

Detail how your software solution will support the creation of electronic medical records as well as any other electronic data forms that TCMHA's requirements and how end users (versus you as the Proposer/Contractor) will be able to customize the electronic record. TCMHA is expecting to find a highly configurable system that supports its changing requirements for data collection and electronic case and medical records.

Scanning, Document Management, & Record Release Capabilities

Detail how your software solution supports scanning and managing documents that are created by other parties so that they can be included in a case or medical record. Additionally, describe how the system supports releasing parts or all of the case or electronic records to other parties, both in paper and secure electronic formats.

Mobile Solutions

Detail how your software solution supports field and home-based service providers with mobile access to your software solutions. Additionally, please indicate whether you offer a "disconnected" or off-line mobile solution and describe its functionality and requirements.

Software Interface & Data Exchange Capabilities

Describe your organization's expertise in interfacing with common general ledger and human resource applications. Additionally, describe your experience in helping provider organizations share data with other providers and stakeholders (for example through regional health information organizations or similar provider data sharing). Note that TCMHA uses the following general ledger and human resources software applications:

- Sage Peachtree
- ADP Workforce

Experience in California

Deliver your organization's proven track record/past history with other county mental health, similar to TCMHA, of successful implementations in the California reporting to LACDMH (LA County Department of Mental Health - including support for this state's versions of electronic billing forms, interfaces with state systems, etc.

Plans for Compliance with Federal Standards for Meaningful Use and Electronic Health Records & Health Information Exchange (HIE)

Describe your organization's experience, current certifications, and plans to obtain certification and comply with the various Federal Standards for meaningful use of electronic health records and health information exchange.

Experience with Integration with Primary Care

Describe your organization's experience with aiding behavioral health providers with integrating with primary care providers through data exchange. Please provide any specific examples of customers who operate primary care services in addition to behavioral health services as well as those who are already collaborating and sharing data with primary care providers and facilities.

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ATTACHMENT E

EXCEPTION(S) TO SPECIFICATIONS AND/OR REQUEST FOR PROPOSAL

☐ We **have no** exceptions to the Scope of Work/Requirements

☐ We **have** exceptions to the Scope of Work/Requirements as listed below. Exceptions to the Scope of Work/Requirements stated herein shall be fully described in writing by the Proposer in the space provided below. Any alternate must be approved by Tri-City Mental Health]Authority no less than 10 business days prior to the closing date.

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☐ We **have no** exceptions to any other section of the Proposal Document.

☐ We **have** exceptions to the Request For Proposal Document stated herein shall be fully described in writing by the Proposer in the space provided below.

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TRI-CITY MENTAL HEALTH SERVICES AUTHORITY
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EXHIBIT F

PROPOSER PRICE PROPOSAL

Please use the following template to submit your pricing proposal.

Section #1: One-time costs						
	Year One	Year Two	Year Three	Year Four	Year Five	Total
Software License	$ -	$ -	$ -	$ -	$ -	$ -
Training	$ -	$ -	$ -	$ -	$ -	$ -
Implementation	$ -	$ -	$ -	$ -	$ -	$ -
Data Conversion	$ -	$ -	$ -	$ -	$ -	$ -
Other:	$ -	$ -	$ -	$ -	$ -	$ -
Other:	$ -	$ -	$ -	$ -	$ -	$ -
Other:	$ -	$ -	$ -	$ -	$ -	$ -
Other:	$ -	$ -	$ -	$ -	$ -	$ -
Section #1 TOTAL	$ -	$ -	$ -	$ -	$ -	$ -
Section #2: On-going costs						
	Year One	Year Two	Year Three	Year Four	Year Five	Total
Maintenance	$ -	$ -	$ -	$ -	$ -	$ -
Other:	$ -	$ -	$ -	$ -	$ -	$ -
Other:	$ -	$ -	$ -	$ -	$ -	$ -
Other:	$ -	$ -	$ -	$ -	$ -	$ -
Other:	$ -	$ -	$ -	$ -	$ -	$ -
Section #2 TOTAL	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL (Sections 1 & 2)	$ -	$ -	$ -	$ -	$ -	$ -

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ATTACHMENT G

CONTRACTOR'S ATTESTATION THAT IT NOR ANY OF ITS STAFF MEMBERS IS RESTRICTED, EXCLUDED OR SUSPENDED FROM PROVIDING GOODS OR SERVICES UNDER ANY FEDERAL OR STATE HEALTH CARE PROGRAM

____

Contractor's Name Last First

Contractor hereby warrants that neither it nor any of its staff members is restricted, excluded, or suspended from providing goods or services under any health care program funded by the Federal or State Government, directly or indirectly, in whole or in part, and the Contractor will notify the Tri-City Mental Health Authority (TCMHA) within thirty (30) days in writing of:1) any event that would require Contractor or a staff member's mandatory exclusion or suspension from participation in a Federal or State funded health care program; and 2) any exclusionary action taken by any agency of the Federal or State Government against Contractor or one or more staff members barring it or the staff members from participation in a Federal or State funded health care program, whether such bar is direct or indirect, or whether such bar is in whole or in part.

Contractor shall indemnify and hold TCMHA harmless against any and all loss or damage Contractor may suffer arising from the Federal or State exclusion or suspension of Contractor or its staff members from such participation in a Federal or State funded health care program.

Failure by Contractor to meet the requirements of this paragraph shall constitute a material breach of contract upon which TCMHA may immediately terminate or suspend this Agreement.

Is Contractor/Proposer/Vendor or any of its staff members currently barred from participation in any Federal or State funded health care program?

_____ **NO**, Contractor or any of its staff members is not currently barred from participation in any Federal or State funded health care program.

_____ **YES**, Contractor or any of its staff members is currently barred from participation in any Federal or State funded health care program. Describe the particulars on a separate page.

____________________	____________________	____________________
Date	Contractor or Vendor's Name	Contractor or Vendor's Signature
	Antonette Navarro, Executive Director	
Date	TCMHA Executive Official's Name	TCMHA Executive Official's Signature

DISTRIBUTION:

COPIES: HR Representative, Contractor, Finance

ATTACHMENT H

BUSINESS ASSOCIATE AGREEMENT

This BUSINESS ASSOCIATE AGREEMENT ("**BAA**") is made as of this ___ day of ____________, 20__ (the "**Effective Date**") by and between TRI-CITY MENTAL HEALTH AUTHORITY, a Covered Entity ("**Covered Entity**" or "**CE**") and ____ ("**Business Associate**" or "**BA**") (each a "**party**" and, collectively, the "**parties**").

RECITALS

A. CE is a "covered entity" under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("**HIPAA**") and, as such, must enter into so-called "business associate" contracts with certain contractors that may have access to certain consumer medical information.

B. Pursuant to the terms of one or more agreements between the parties, whether oral or in writing, (collectively, the "**Agreement**"), BA shall provide certain services to CE. To facilitate BA's provision of such services, CE wishes to disclose certain information to BA, some of which may constitute Protected Health Information ("**PHI**") (defined below).

C. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the Agreement in compliance with HIPAA, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("**HITECH Act**"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("**HIPAA Regulations**") and other applicable laws, including without limitation state patient privacy laws (including the Lanterman-Petris-Short Act), as such laws may be amended from time to time.

D. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI (defined below), as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("**C.F.R.**") and contained in this BAA.

NOW, THEREFORE, in consideration of the mutual promises below and the exchange of information pursuant to this BAA, CE and BA agree as follows:

AGREEMENT

I. Definitions.

A. **Breach** shall have the meaning given to such term under 42 U.S.C. § 17921(1) and 45 C.F.R. § 164.402.

B. **Business Associate** shall have the meaning given to such term under 42 U.S.C. § 17921 and 45 C.F.R. § 160.103.

C. **Consumer** is an individual who is requesting or receiving mental health services and/or has received services in the past. Any consumer certified as eligible under the Medi-Cal program according to Title 22, Section 51001 is also known as a beneficiary.

D. **Covered Entity** shall have the meaning given to such term under 45 C.F.R. § 160.103.

E. **Data Aggregation** shall have the meaning given to such term under 45 C.F.R. § 164.501.

F. **Designated Record Set** shall have the meaning given to such term 45 C.F.R. § 164.501.

G. **Electronic Protected Health Information** or **EPHI** means Protected Health Information that is maintained in or transmitted by electronic media.

H. **Electronic Health Record** shall have the meaning given to such term under 42 U.S.C. § 17921(5).

I. **Health Care Operations** shall have the meaning given to such term under 45 C.F.R. § 164.501.

J. **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

K. **Protected Health Information** or **PHI** means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under 45 C.F.R. § 160.103. Protected Health Information includes Electronic Protected Health Information.

L. **Protected Information** shall mean PHI provided by CE to BA or created or received by BA on CE's behalf.

M. **Security Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

N. **Subcontractor** shall mean a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate, pursuant to 45 C.F.R. § 160.103.

O. **Unsecured PHI** shall have the meaning given to such term under 42 U.S.C. § 17932(h), 45 C.F.R. § 164.402 and guidance issued pursuant to the HITECH Act including, but not limited to that issued on April 17, 2009 and published in 74 Federal Register 19006 (April 27, 2009), by the Secretary of the U.S. Department of Health and Human Services ("**Secretary**").

II. Obligations of Business Associate.

A. Permitted Access, Use or Disclosure. BA shall neither permit the unauthorized or unlawful access to, nor use or disclose, PHI other than as permitted or required by the Agreement, this BAA, or as required by law, including but not limited to the Privacy Rule. To the extent that BA carries out CE's obligations under the Privacy Rule, BA shall comply with the requirements of the Privacy Rule that apply to CE in the performance of such obligations. Except as otherwise limited in the Agreement, this BAA, or the Privacy Rule or Security Rule, BA may access, use, or disclose PHI (i) to perform its services as specified in the Agreement; and (ii) for the proper administration of BA, provided that such access, use, or disclosure would not violate HIPAA, the HITECH Act, the HIPAA Regulations, or applicable state law if done or maintained by CE. If BA discloses Protected Information to a third party, BA must obtain, prior to making any such disclosure, (i) reasonable assurances from such third party that such Protected Information will be held confidential as provided pursuant to this BAA and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and (ii) agreement from such third party to promptly notify BA of any Breaches of confidentiality of the Protected Information, to the extent it has obtained knowledge of such Breach.

B. Prohibited Uses and Disclosures. Notwithstanding any other provision in this BAA, BA shall comply with the following requirements: (i) BA shall not use or disclose Protected Information for fundraising or marketing purposes, except as provided under the Agreement and consistent with the requirements of the HITECH Act, the HIPAA Regulations, and applicable state law, including but not limited to 42 U.S.C. § 17936, 45 C.F.R. § 164.508, and 45 C.F.R. § 164.514(f); (ii) BA shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates, 42 U.S.C. § 17935(a); 45 C.F.R. § 164.522(a); (iii) BA shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. § 17935(d)(2); 45 C.F.R. § 164.502(a)(5); however, this prohibition shall not affect payment by CE to BA for services provided pursuant to the Agreement.

C. Appropriate Safeguards. BA shall comply, where applicable, with the HIPAA Security Rule, including but not limited to 45 C.F.R. §§ 164.308, 164.310, and 164.312 and the policies and procedures and documentation requirements set forth in 45 C.F.R. § 164.316, and shall implement appropriate safeguards designed to prevent the access, use or disclosure of Protected Information other than as permitted by the Agreement or this BAA. BA shall use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of EPHI.

D. Reporting of Improper Access, Use, or Disclosure.

1. Generally. BA shall provide an initial telephone report to CE's Compliance Contact within twenty-four (24) hours of any suspected or actual breach of security, intrusion or unauthorized access, use, or disclosure of PHI of which BA becomes aware and/or any actual or suspected access, use, or disclosure of data in violation of the Agreement, this BAA, or any applicable federal or state laws or regulations, including, for the avoidance of doubt, any Security Incident (as defined in 45 C.F.R. § 164.304).

BA shall take (i) prompt corrective action to cure any deficiencies in its policies and procedures that may have led to the incident, and (ii) any action pertaining to such unauthorized access, use, or disclosure required of BA by applicable federal and state laws and regulations.

2. Breaches of Unsecured PHI. Without limiting the generality of the reporting requirements set forth in Section D(1), BA shall report to CE any use or disclosure of the information not permitted by this BAA, including any Breach of Unsecured PHI pursuant to 45 C.F.R. § 164.410. Following the discovery of any Breach of Unsecured PHI, BA shall notify CE in writing of such Breach without unreasonable delay and in no case later than three (3) days after discovery. The notice shall include the following information if known (or can be reasonably obtained) by BA: (i) contact information for the individuals who were or who may have been impacted by the Breach (*e.g.*, first and last name, mailing address, street address, phone number, email address); (ii) a brief description of the circumstances of the Breach, including the date of the Breach and date of discovery (as defined in 42 U.S.C. § 17932(c)); (iii) a description of the types of Unsecured PHI involved in the Breach (*e.g.*, names, social security numbers, date of birth, addresses, account numbers of any type, disability codes, diagnostic and/or billing codes and similar information); (iv) a brief description of what the BA has done or is doing to investigate the Breach and to mitigate harm to the individuals impacted by the Breach; (v) any other available information that CE is required to include in notification to the individual under 45 C.F.R. § 164.404.

3. Mitigation. BA shall establish and maintain safeguards to mitigate, to the extent practicable, any deleterious effects known to BA of any unauthorized or unlawful access or use or disclosure of PHI not authorized by the Agreement, this BAA, or applicable federal or state laws or regulations; provided, however, that such mitigation efforts by BA shall not require BA to bear the costs of notifying individuals impacted by such unauthorized or unlawful access, use, or disclosure of PHI, unless (i) otherwise agreed in writing by the parties, (2) BA bears responsibility for the unauthorized or unlawful access or use or disclosure of PHI, or (3) required by applicable federal or state laws or regulations; provided, further, however, that BA shall remain fully responsible for all aspects of its reporting duties to CE under Section D(1) and Section D(2).

E. Business Associate's Subcontractors and Agents. BA shall ensure that any agents or Subcontractors to whom it provides Protected Information agree to the same restrictions and conditions that apply to BA with respect to such PHI. To the extent that BA creates, maintains, receives or transmits EPHI on behalf of the CE, BA shall ensure that any of BA's agents or Subcontractors to whom it provides Protected Information agree to implement the safeguards required by Section C above with respect to such EPHI.

F. Access to Protected Information. To the extent BA maintains a Designated Record Set on behalf of the CE, BA shall make Protected Information maintained by BA or its agents or Subcontractors in Designated Record Sets available to CE for inspection and copying within ten (10) days of a request by CE to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.524. If BA maintains an Electronic Health Record, BA shall provide such information in electronic format to enable CE to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. § 17935(e).

G. Amendment of PHI. To the extent BA maintains a Designated Record Set on behalf of CE, within ten (10) days of receipt of a request from the CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA or its agents or Subcontractors shall make PHI available to CE so that CE may make any amendments that CE directs or agrees to in accordance with the Privacy Rule.

H. Accounting Rights. Within ten (10) days of notice by CE of a request for an accounting of disclosures of Protected Information, BA and its agents or Subcontractors shall make available to CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.528, and its obligations under the HITECH Act, including but not limited to 42 U.S.C. § 17935(c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or Subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment, or health care operations purposes are required to be collected and maintained for three (3) years prior to the request, and only to the extent BA maintains an electronic health record and is subject to this requirement. At a minimum, the information collected and maintained shall include, to the extent known to BA: (i) the date of the disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. The accounting must be provided without cost to the individual or the requesting party if it is the first accounting requested by such individual within any twelve (12) month period. For subsequent accountings within a twelve (12) month period, BA may charge the individual or party requesting the accounting a reasonable cost-based fee in responding to the request, to the extent permitted by applicable law, so long as BA informs the individual or requesting party in advance of the fee and the individual or requesting party is afforded an opportunity to withdraw or modify the request. BA shall notify CE within five (5) business days of receipt of any request by an individual or other requesting party for an accounting of disclosures. The provisions of this Section H shall survive the termination of this BAA.

I. Governmental Access to Records. BA shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to CE and to the Secretary for purposes of determining BA's compliance with the Privacy Rule. BA shall immediately notify CE of any requests made by the Secretary and provide CE with copies of any documents produced in response to such request.

J. Minimum Necessary. BA (and its agents or Subcontractors) shall request, use, and disclose only the minimum amount of Protected Information necessary to accomplish the purpose of the request, use, or disclosure. Because the definition of "minimum necessary" is in flux, BA shall keep itself informed of guidance issued by the Secretary with respect to what constitutes "minimum necessary." Notwithstanding the foregoing, BA must limit its (and its agents or Subcontractors) uses and disclosures of Protected Information to be consistent with CE's minimum necessary policies and procedures as furnished to BA.

K. Permissible Requests by Covered Entity. CE shall not request BA to use or disclose PHI in any manner that would not be permissible under HIPAA or the HITECH Act if done by CE or BA. CE shall not direct BA to act in a manner that would not be compliant with the Security Rule, the Privacy Rule, or the HITECH Act.

L. Breach Pattern or Practice. If CE knows of a pattern of activity or practice of the BA that constitutes a material breach or violation of BA's obligations under this BAA or other arrangement, CE must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, CE must terminate the applicable Agreement to which the breach and/or violation relates if feasible. If BA knows of a pattern of activity or practice of an agent or Subcontractor that constitutes a material breach or violation of the agent or Subcontractor's obligations under its BAA or other arrangement with BA, BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, BA must terminate the applicable agreement to which the breach and/or violation relates if feasible.

III. Indemnification; Limitation of Liability.

To the extent permitted by law, BA shall indemnify, defend and hold harmless CE from any and all liability, claim, lawsuit, injury, loss, expense or damage resulting from or relating to the acts or omissions of BA or its agents, Subcontractors or employees in connection with the representations, duties and obligations of BA under this Agreement. Any limitation of liability contained in the applicable Agreement shall not apply to the indemnification requirement of this provision. This provision shall survive the termination of this BAA.

IV. Business Associate's Insurance.

BA shall obtain insurance for itself and all its employees, agents and independent contractors in an amount not less than One Million Dollars ($1,000,000) per occurrence and Two Million Dollars ($2,000,000) annual aggregate of Commercial General Liability insurance and Two Million Dollars ($2,000,000) per occurrence and Four Million Dollars ($4,000,000) annual aggregate of Errors and Omissions insurance. The Errors and Omissions insurance shall cover, among other things, Breaches. If the general liability or the errors and omissions insurance do not cover, among other things, Breaches, Business Associate should also carry Two Million Dollars ($2,000,000) per occurrence and Four Million Dollars ($4,000,000) annual aggregate of Cyber/Privacy insurance that covers, among other things, Breaches. BA shall provide CE with certificates of insurance or other written evidence of the insurance policy or policies required herein prior to execution of this BAA (or as shortly thereafter as is practicable) and as of each annual renewal of such insurance policies during the period of such coverage. Further, in the event of any modification, termination, expiration, non-renewal or cancellation of any of such insurance policies, BA shall give written notice thereof to CE not more than ten (10) days following BA's receipt of such notification. If BA fails to procure, maintain or pay for the insurance required under this section, CE shall have the right, but not the obligation, to obtain such insurance. In such event, BA shall promptly reimburse CE for the cost thereof upon written request, and failure to repay the same upon demand by CE shall constitute a material breach of this BAA.

V. Term and Termination.

A. Term. The term of this BAA shall be effective as of the Effective Date and shall terminate when all of the PHI provided by CE to BA, or created or received by BA on behalf of CE, is destroyed or returned to CE.

B. Termination.

1. Material Breach by BA. Upon any material breach of this BAA by BA, CE shall provide BA with written notice of such breach and such breach shall be cured by BA within thirty (30) business days of such notice. If such breach is not cured within such time period, CE may immediately terminate this BAA and the applicable Agreement.

2. Effect of Termination. Upon termination of any of the agreements comprising the Agreement for any reason, BA shall, if feasible, return or destroy all PHI relating to such agreements that BA or its agents or Subcontractors still maintain in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, BA shall continue to extend the protections of this BAA to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible.

VI. Assistance in Litigation.

BA shall make itself and any subcontractors, employees or agents assisting BA in the performance of its obligations under the Agreements or this BAA available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its shareholders, directors, officers, agents or employees based upon a claim of violation of HIPAA, the HITECH Act, or other laws related to security and privacy, except where BA or its subcontractor, employee or agent is named as an adverse party.

VII. Compliance with State Law.

Nothing in this BAA shall be construed to require BA to use or disclose Protected Information without a written authorization from an individual who is a subject of the Protected Information, or without written authorization from any other person, where such authorization would be required under state law for such use or disclosure.

VIII. Compliance with 42 C.F.R. Part 2.

CE is also subject to the Confidentiality of Alcohol and Drug Abuse Patient Records regulations, 42 C.F.R. Part 2, which requires certain programs to enter into contracts with qualified service organizations (as defined in 42 C.F.R. § 2.11) that may have access to certain patient medical information. BA acknowledges that in receiving, storing, processing, or otherwise dealing with any Records (as defined in 42 C.F.R. Part 2) from CE, BA is fully bound by 42 C.F.R. Part 2. BA agrees to resist in judicial proceedings any efforts to obtain access to patient records except as permitted by 42 C.F.R. Part 2. To the extent any provisions of 42 C.F.R. Part 2 restricting disclosure of Records are more protective of privacy rights than the provisions of this BAA, HIPAA, the HITECH Act, or other applicable laws, 42 C.F.R. Part 2 controls.

IX. Amendment to Comply with Law.

Because state and federal laws relating to data security and privacy are rapidly evolving, amendment of the Agreement or this BAA may be required to provide for procedures to ensure compliance with such developments. BA and CE shall take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule and other applicable laws relating to the security or confidentiality of PHI. BA shall provide to CE satisfactory written assurance that BA will adequately safeguard all PHI. Upon the request of either party, the other party shall promptly enter into negotiations concerning the terms of an amendment to this BAA embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule or other applicable laws. CE may terminate the applicable Agreement upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the Agreement or this BAA when requested by CE pursuant to this Section or (ii) BA does not enter into an amendment to the Agreement or this BAA providing assurances regarding the safeguarding of PHI that CE, in its reasonable discretion, deems sufficient to satisfy the standards and requirements of applicable laws, within thirty (30) days following receipt of a written request for such amendment from CE.

X. No Third-Party Beneficiaries.

Nothing express or implied in the Agreement or this BAA is intended to confer, nor shall anything herein confer upon any person other than CE, BA and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

XI. Notices.

All notices hereunder shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, or deposited with the overnight courier addressed as follows:

If to CE:

Tri-City Mental Health Authority
1717 N. Indian Hill Blvd., Suite B
Claremont, CA 91711
Attn: Privacy Officer

If to BA:

With a copy to:

Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067
Attn: Linda Kollar, Esq.
Fax: 310-551-8181

or to such other persons or places as either party may from time to time designate by written notice to the other.

XII. Interpretation.

The provisions of this BAA shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provision in this BAA. This BAA and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. Any ambiguity in this BAA shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. Except as specifically required to implement the purposes of this BAA, or to the extent inconsistent with this BAA, all other terms of the Agreement shall remain in force and effect.

XIII. Entire Agreement of the Parties.

This BAA supersedes any and all prior and contemporaneous business associate agreements or addenda between the parties and constitutes the final and entire agreement between the parties hereto with respect to the subject matter hereof. Each party to this BAA acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, with respect to the subject matter hereof, have been made by either party, or by anyone acting on behalf of either party, which are not embodied herein. No other agreement, statement or promise, with respect to the subject matter hereof, not contained in this BAA shall be valid or binding.

XIV. Regulatory References.

A reference in this BAA to a section of regulations means the section as in effect or as amended, and for which compliance is required.

XV. Counterparts.

This BAA may be executed in one or more counterparts, each of which shall be deemed to be an original, and all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the parties hereto have duly executed this BAA as of the BAA Effective Date.

AGREED AND ACCEPTED:

Tri-City Mental Health Authority	
Name of Covered Entity	**Name of Business Associate**
Authorized Signature	**Authorized Signature**
Antonette Navarro	
Print Name	**Print Name**
Executive Director	
Print Title	**Print Title**
Date	**Date**

Tri-City Mental Health Authority
AGENDA REPORT

DATE: **June 16, 2021**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Toni Navarro, LMFT, Executive Director**

BY: **Rimmi Hundal, Director of MHSA and Ethnic Services**

SUBJECT: **Approval of the Community Wellbeing Grant for FY 2021-22 under the Community Capacity Building Project of the Prevention and Early Intervention (PEI) Plan**

Summary:

In February 2010, the Governing Board approved the Community Wellbeing Project to be funded under the Mental Health Services Act - Prevention and Early Intervention (MHSA-PEI) Plan. Accordingly, Community Wellbeing Grants are awarded annually as part of the Community Wellbeing Project. For upcoming Fiscal Year 2021-22, Tri-City received a total of 30 applications and 17 are being presented to the Governing Board for its approval to award the funding.

Background:

During the Prevention and Early Intervention planning in February 2010, under the Mental Health Services Act, Stakeholders identified the Community Capacity Building Project. The Community Wellbeing Program/Grants is a part of the Community Capacity Building Project designed to help communities develop and implement community-driven plans to improve and sustain the mental and emotional wellbeing of their members. The program reflects several foundational premises, including:

- Families and communities have primary responsibility for promoting and sustaining the mental and emotional wellbeing of their members;
- Families and communities have strengths and assets that already support their members' health and wellbeing;
- With culturally appropriate support and training, communities can leverage and extend their strengths and assets to improve and sustain the wellbeing of their members over time.

Under the Community Wellbeing Program, communities can apply for funding for up to $10,000 from a community grants fund to support community-driven actions that focus on mental and emotional wellbeing.

There is a lifetime award limit of three years. In addition to the monies, communities receive ongoing training and support from Tri-City staff so that they are able to generate and analyze reliable and timely data to assess the effectiveness of their efforts.

Communities will also be able to participate in various learning circles and other meeting structures that help them share and receive lessons learned with other communities who are also participating in this program.

Fiscal Impact

Awarding the sixteen (17) Wellbeing Grants will impact Tri-City's PEI budget by $85,300.00 in Fiscal Year 2021-22. Tri-City has the funds available to support this project.

Recommendation

Staff recommends that the Governing Board awards the selected Community Wellbeing Grants totaling $85,300.00 to be funded under the MHSA-PEI Plan in Fiscal Year 2021-22.

Attachments

Attachment 5-A: 2021-22 Community Wellbeing Program Selected Applicants Summary

Attachment 5-B: Sample Contract for Community Wellbeing Grant

Fiscal Year 2021-22 CWB Descriptions

Community Name:	Assistance League of Pomona Valley
Fiscal Sponsor:	Assistance League of Pomona Valley
Amount:	$6,000
Community Description:	Operation School Bell program will focus on children ages 13-18 years of age. Each student will receive a weeks' worth of new school clothing. The goal is help empower students to succeed in school and increase self-esteem by providing new school clothing.

Community Name:	Boys and Girls Club of Parkside
Fiscal Sponsor:	Boys and Girls Club of Parkside
Amount:	$5,000
Community Description:	Boys and Girls is located at Parkside Affordable Housing which has 62 units. This grant will fund The Great Futures program that focuses on character/leadership development for youth 7 to 17 years old. Their curriculum included resisting the use of substance use, building community, improve communication skills, treating each other well and how to solving problems.

Community Name:	Bright Prospect
Fiscal Sponsor:	Bright Prospect
Amount:	$5,000
Community Description:	Bright Prospect Community Wellness Academy project will provide a series of workshops focused on mental health awareness and wellbeing for students ages 14 to 25 years of age and parents in their community. Some of the main challenges they have identifies are communication gaps between students and parents about emotional stress, cultural norms and the stigma associated with mental illness, and how to recognize early signs of mental illness.

Community Name:	Casa Colina Hospital and Centers for Health
Fiscal Sponsor:	Casa Colina Hospital and Centers for Health
Amount:	$5,000
Community Description:	TAY No Limits Creative Arts Program will provide art (e.g. painting, writing, cooking, music) as the medium to help transitional age youth (TAY) with special needs to build a community support system that will help decrease feelings of loneliness, depression, anxiety, and isolation. The goal of this project will be to provide a safe, comfortable environment for the TAY participants to express themselves using creative arts in a safe space.

Community Name:	Children and Youth in Pomona
Fiscal Sponsor:	House of Ruth
Amount:	$2,700
Community Description:	This project focuses on "Free to be Me" self-esteem building workshop and mentorship program to children living in Pomona ages 7-12 years old. The goal of the workshop and mentorship program is to provide young people with tools to cope with stress, build their self-esteem, and have ongoing support from their older peers. This project aims to normalize and de-stigmatize mental health struggles for young people, provide tangible resources and tools, and open the conversation to encourage reaching out for help when in need.

Fiscal Year 2021-22 CWB Descriptions

Community Name:	Outdoor Early Childhood Extension
Fiscal Sponsor:	City of Knowledge
Amount:	$5,000
Community Description:	The Outdoor Early Childhood Extension project that will be funded will add an outdoor learning component to be able to accommodate the Preschool, Pre-Kindergarten and Kindergarten students who have been away from school since March 2020 due to COVID-19. This project will help address the physical, mental, and social wellbeing of the children through play, interaction with nature and activities that will be compliant with COVID-19 regulations.

Community Name:	Claremont USD
Fiscal Sponsor:	Claremont USD
Amount:	$5,000
Community Description:	Claremont USD Wellness Strong Website project will embody student wellness as evidenced by: psycho-education, links to groups for students, both for connectedness and social/emotional at the student's specific school site. It will offer updated ways to access social/emotional supports and information in the community, crisis support resources, calendar of events for the latest offerings of speakers and trainings, along with family wellness activities and training for parents and staff of students.

Community Name:	dA Center for the Arts
Fiscal Sponsor:	dA Center for the Arts
Amount:	$5,000
Community Description:	The project Health and Wellness for Families through the Arts in open spaces will provide De Colores a multi-disciplinary arts program with an interactive, accessible, inclusive, and equitable puppetry, storytelling, music, park ranger exploration and hands-on art project program designed to motivate and strengthen the connections of parents with their children ages 0-5.

Community Name:	God's Pantry
Fiscal Sponsor:	God's Pantry
Amount:	$6,000
Community Description:	The Student Meal Delivery Program is a partnership with Pomona Unified School District. This project will focus on students with developmental disabilities ages 16-25 years old, all whose families are currently living out of motels or in unstable living conditions and do not have regular access to a kitchen. Students will receive a crockpot, a weekly recipe, as well as ingredients for the week's recipe. This project serves not only by physically providing meals but relieving some of the stress (physically, mentally and emotionally) that food insecurity brings.

Fiscal Year 2021-22 CWB Descriptions

Community Name:	Health Bridges
Fiscal Sponsor:	Draper Center for Community Partnerships
Amount:	$5,000
Community Description:	Health Bridges will provide a year-long health workshops series for high school seniors. This workshop series will be in partnership with PAYS (Pomona Academy for Youth Success), a college access program under Draper Center for Community Partnerships. This workshop series will aim to educate and empower students about their knowledge of both health and healthcare systems, especially as they transition to college.

Community Name:	Just Us 4 Youth
Fiscal Sponsor:	Just Us 4 Youth
Amount:	$6,000
Community Description:	The TAY Outreach and Support Vehicle project addresses the two needs within the current program; assisting clients in the program get to vital appointments, report to work, learn to drive, and other events or outings. Deliver supplies, outreach and serve future clients in the general Tri-City area and take them off the streets. This project will help current clients improve their mental health, safety and reach their goals.

Community Name:	Latino Latina Roundtable
Fiscal Sponsor:	Latino Latina Roundtable
Amount:	$5,000
Community Description:	The Community Connections for Youth project will focus on supporting young people ages 14-24 years old and removing barriers to accessing mental health. This project will offer workshops such as mental health first aid, ACEs awareness, and other culturally relevant models that talk about mental health and the importance of spaces that honor experiences and are transformative. Removing the shame and doubt that prevent people from seeking support and finding resources.

Community Name:	Oasis KGI Commons
Fiscal Sponsor:	NCCD-Claremont Properties LLC
Amount:	$5,000
Community Description:	The aims of the project Oasis KGI (Keck Graduate Institute) Commons are two-fold. First, it will focus on converting one of their preexisting storage rooms into a space where students can meditate and practice yoga. Creating a peaceful space where students can visit to take a break and meditate. Second, this project will also create a community garden in one of their community's green spaces.

Fiscal Year 2021-22 CWB Descriptions

Community Name:	PFLAG Claremont
Fiscal Sponsor:	PFLAG Claremont
Amount:	$6,000
Community Description:	The PFLAG Claremont Youth Group project will focus on youth and young adults in the cities of Pomona, Claremont and La Verne to provide a safe and educational environment for youth in the area. This project will help youth navigate their own coming out process and provide emotional support to queer and questioning youth in the area. The hope of this project is that youth and young adults could attend chapter meetings and leave feeling as though they have the necessary tools and resources to work through anything they may be experiencing as young LGBTQ+ individuals and allies.

Community Name:	Pomona Pride Center
Fiscal Sponsor:	Pomona Pride Center
Amount:	$6,000
Community Description:	The LGBTQ Youth Health & Education Mentorship Program will focus on promoting health and educational well-being of the LGBTQ communities in the Tri-City area through mentorship program that will include webinars and informational workshops that lead up to a half-day in person (or virtually) symposium.

Community Name:	Pomona Students Union
Fiscal Sponsor:	Gente Organizada
Amount:	$5,000
Community Description:	The SEEDS of Pomona youth media project is a youth powered initiative that developed out of the social action group, the Pomona Students Union (PSU). PSU youth organizers identifies "artvism" as a strategy to create a more equitable Pomona by creating compelling content that educates and inspires community members to support grassroots organizing efforts. This will help grow their youth-led programs and address the lack of awareness and access to mental health services. Help fortify the youth and encourage resilience, empowerment, and improved health outcomes across the community. This project will use both regularly scheduled in-person and virtual learning media workshops.

Community Name:	Pomona Hope
Fiscal Sponsor:	Pomona Hope
Amount:	$2,600
Community Description:	The Wellness Workshop project is a partnership with Azusa Pacific University Bachelor's in Social Work Program. A BSW intern will lead weekly workshops for K-8th grade. This project will include lessons on self-care, tools for managing stress, identifying healthy relationships, and how to seek help in a crisis. This will help increase their knowledge of mental health and resources available to the students and their parents.

TRI-CITY MENTAL HEALTH
COMMUNITY WELLBEING GRANT AGREEMENT

This AGREEMENT is by and between **Bright Prospect**, (GRANTEE) with its principal office of operations at **1460 E. Holt Ave Ste.74 Pomona, CA 91767** and its fiscal sponsor, **Bright Prospect,** (FISCAL SPONSOR) a 501(c)(3) organization organized under the laws of the State of California with its principal office of operations at **1460 E. Holt Ave Ste.74 Pomona, CA 91767** (GRANTEE AND FISCAL SPONSOR together as the GRANTEES) and Tri-City Mental Health Center, a Joint Powers Agency organized under the laws of the State of California with its administrative office at 1717 N. Indian Hill Boulevard, Claremont, California 91767, (Tri-City).

WHEREAS, Tri-City has received approval from the California State Department of Mental Health to implement a Community Capacity and Wellbeing (CCW) program as defined in Tri-City's Prevention and Early Intervention (PEI) Plan; and

WHEREAS, the award of funds to communities to implement programs that qualify under the PEI CCW program to provide prevention and early intervention of mental health illness is an integral part of such PEI Plan and will benefit residents in the cities of Claremont, La Verne and Pomona; and

WHEREAS, GRANTEES have submitted to Tri-City a Community Wellbeing Project that has met all of the required criteria to qualify as a PEI CCW program project that will promote prevention and early intervention of mental health illness; and

WHEREAS, Tri-City is willing to fund the Community Wellbeing Project proposed by the GRANTEES as part of its approved CCW program in accordance with its budget, in consideration of the terms and conditions of this AGREEMENT;

NOW, THEREFORE, in consideration of the covenants, conditions, and stipulations hereinafter expressed, and in consideration of the mutual benefits to be derived there from, the parties hereby mutually agree as follows:

1. SCOPE OF PROJECT: GRANTEE shall perform the activities as described in the proposal entitled **Bright Prospect**, which is attached hereto as Attachment A and made a part of this AGREEMENT, and is hereafter referred to as "PROJECT."

   Any requested modification to the project and/or budget must be submitted in writing using the Project Modification Form. Any modifications requested by the GRANTEE must be approved by Tri-City prior to funds being spent in a way inconsistent with the approved budget or plan.

2. PRINCIPAL SUPERVISORS: PROJECT shall be under the supervision of **Evan Sotelo** who shall serve as Project Leader; **Rachel Rosenbaum** who shall serve as Community Leader; and **Rachel Rosenbaum** who shall serve as Fiscal Sponsor Representative. If for any reason the Principal Supervisors shall be unable to continue to serve and a successor acceptable to both parties is not available, this AGREEMENT shall be terminated as hereafter provided.

3. PERIOD OF PERFORMANCE: The activities of PROJECT shall commence immediately upon execution of this agreement and continue through completion, not later than **June 30, 2022**. This period will be subject to modification or renewal only by mutual written agreement of the parties hereto.

4. PAYMENT OF COSTS: In consideration of GRANTEE'S performance hereunder, Tri-City agrees to support GRANTEE'S costs incurred conducting the activities of this PROJECT, in the amount not to exceed **Five Thousand** dollars(**5000**). This amount shall not be exceeded by GRANTEE without the written authorization of Tri-City. A payment equal to 25% (1250) of the total granted amount shall be made to GRANTEE upon execution of this agreement. All remaining payments equal to 25% of the total granted amount shall be made to GRANTEE quarterly upon receipt of GRANTEE's quarterly Financial Report, if justified. Justification of any subsequent payments shall be rebuttably presumed if the sum of Spent Funds and Projections for the Next Quarter exceeds the amount received by GRANTEE in the previous quarters. Should justification of additional payments not be met, payment shall be withheld until a Financial Report meeting justification is received by Community Wellbeing Program Staff, no later than June 30, 2022.

   If the funds are needed earlier in any given quarter to continue project activities, an advance of funds may be requested by completing an Early Distribution of Funds Request Form and submitting it to Community Wellbeing Program staff. The Early Distribution of Funds Request Form must be accompanied by invoices from funds spent and projections. Funds will be advanced following review and approval of GRANTEE's request.

   The payments due under the AGREEMENT shall be made payable to **Bright Prospect,** and the initial payment shall be mailed with a copy of this AGREEMENT to:

   Bright Prospect
   ATTN: Elizabeth Zamora
   1460 E. Holt Ave Ste. 74
   Pomona, CA 91767

5. POLICIES AND PROCEDURES: The PROJECT conducted hereunder shall be performed in accordance with the policies and procedures of GRANTEE AND ITS FISCAL SPONSOR.

6. REPORTS: GRANTEE shall deliver to Tri-City quarterly reports showing the detail of expenditures to date and projections for following quarter as applicable until the PROJECT is complete. Financial Reports shall be due fifteen (15) days after quarter ends: October 15th, Jan 15th, April 15th, and July 15th. Reports shall be signed by Project Leader, Community Leader, and Fiscal Sponsor Representative confirming review and accuracy of report. In addition, the GRANTEE shall deliver the results of PROJECT performed within ninety (90) days of the completion of PROJECT.

7. RESPONSIBILITY OF FISCAL SPONSOR: Fiscal Sponsor is responsible for review and accuracy of all supporting documentation related to PROJECT including Financial Report. Additionally, Fiscal Sponsor shall be responsible for maintaining records of expenditures related to PROJECT for a period of five (5) years following conclusion of the project.

8. SPECIAL FUNDING PROVISIONS. This PROJECT is funded by California Mental Health Services Act funds. As such, the use of the funds is subject to certain obligations and limitations that are set forth in Attachment B and made a part of this AGREEMENT. GRANTEES covenant and agree to comply with the provisions of Attachment B.

9. TERMINATION: Performance under this AGREEMENT may be terminated by either party upon thirty (30) days written notice to the authorized personnel listed in the notices section of this agreement. Upon termination by Tri-City, GRANTEES will be entitled to retain sufficient funds to reimburse it for all costs and non-cancelable commitments incurred in performance of the AGREEMENT prior to the date of termination in an amount not to exceed

the total commitment set forth in Paragraph 4. Upon termination by GRANTEES, all costs and non-cancelable commitments incurred thereafter will be the responsibility of GRANTEES. GRANTEES will return any unused funds to Tri-City within three (3) months of the written notice of termination.

10. INDEMNIFICATION: GRANTEES shall jointly and severally indemnify, defend and hold harmless Tri-City, its officers, employees, representatives, and agents from and against any and all claims, liability, loss, damage, demands, suits, judgments, expenses and costs (including without limitation costs and fees of litigation) of every nature arising out of or in connection with the GRANTEES' negligent acts, willful misconduct, or omissions arising from, or alleged to arise from, or related to, performance hereunder or its failure to comply with any of its obligations contained in the agreement, except such loss or damage which was caused by the sole negligence or willful misconduct of Tri-City.

11. PROPRIETARY INFORMATION: Any proprietary information disclosed by one party to the other shall be disclosed in writing and designated as proprietary, or if disclosed orally, shall be confirmed in writing and designated proprietary within thirty (30) days of such disclosure. A party receiving proprietary information, hereunder referred to as "RECIPIENT," agrees to use the proprietary information only for the purpose of this AGREEMENT and further agrees that it will not disclose or publish such information except that foregoing restrictions shall not apply to:

    (a) information which is or becomes publicly known through no fault of RECIPIENT;
    (b) information learned from a third party entitled to disclose such information;
    (c) information already known to or developed by RECIPIENT prior to receipt hereunder, as shown by RECIPIENT'S prior written records;
    (d) information which is published in the necessary course of the prosecution of patent applications based upon inventions developed pursuant to this AGREEMENT; or
    (e) information required to be disclosed by operation of law or court order.

    The obligation of confidentiality imposed by this provision shall expire two (2) years following the expiration or termination of this AGREEMENT. Each party will use a reasonable degree of care to prevent the inadvertent, accidental, unauthorized or mistaken disclosure or use by its employees of proprietary information disclosed hereunder.

12. USE OF NAMES: GRANTEES shall not employ or use the name of Tri-City in any promotional materials, advertising, or in any other manner without the prior express written permission of Tri-City, except that Tri-City and GRANTEES may, during the term of this Agreement or thereafter state that Tri-City is sponsoring, or has sponsored, the PROJECT.

13. NOTICES: Any notice given under this AGREEMENT shall be in writing to the individuals below and shall be deemed delivered three (3) days after deposit in the United States mail, certified or registered, postage prepaid, and addressed to the parties as follows:

Grantees:

Bright Prospect
Evan Sotelo and Elizabeth Zamora
1460 E. Holt Ave Ste 74
Pomona, CA 91767

Bright Prospect
ATTN: Elizabeth Zamora
1460 E. Holt Ave Ste 74

Pomona, CA 91767

Tri-City:

Tri-City Mental Health Center
1717 N. Indian Hill Boulevard #B
Claremont, CA 91711-2788
Attn: Rimmi Hundal
(909) 623-6131
E-Mail: rhundal@tricitymhs.org

14. INDEPENDENT PARTIES: For purpose of this AGREEMENT, the parties hereto shall be independent contractors and shall at all times be considered neither an agent nor employee of the other. No joint venture, partnership, or like relationship is created between the parties by this AGREEMENT. Tri-City and FISCAL SPONSOR are independent legal entities and none have any authority to act for, or on behalf of, or bind another to, any contract, without the other's written approval or except as otherwise expressly set forth in this AGREEMENT.

15. ASSIGNMENTS: This AGREEMENT shall be binding upon and inure to the benefit of the parties hereto, and may be assigned only to the successors of these parties. Any other assignment by either party without prior written consent of the other party shall be void.

16. OWNERSHIP: Title to any equipment purchased or manufactured in performance of the PROJECT funded under this AGREEMENT shall vest with Tri-City.

17. FORCE MAJEURE: GRANTEES shall not be liable for any failure to perform as required by this AGREEMENT, to the extent such failure to perform is caused by any of the following: labor disturbances or disputes of any kind, accidents, failures of any required governmental approval, civil disorders, acts of aggression, acts of God, energy or other conservation measures, failure of utilities, mechanical breakdowns, material shortages, disease, or similar occurrences.

18. SEVERABILITY: In the event that a court of competent jurisdiction holds any provision of this AGREEMENT to be invalid, such holding shall have no effect on the remaining provisions of this AGREEMENT, and they shall continue in full force and effect.

19. SIMILAR RESEARCH: Nothing in this AGREEMENT shall be construed to limit the freedom of GRANTEES, or of its agents who are participants under this AGREEMENT, to engage in similar activities under other grants, contracts, or agreements with parties other than Tri-City.

20. GOVERNING LAW: The formation, interpretation and performance of this AGREEMENT shall be governed by the laws of the State of California. Venue for mediation, arbitration and/or actions arising out of this AGREEMENT shall be in Los Angeles County, California.

21. AUTHORITY: Each party represents to the other that the person signing on its behalf has the legal right and authority to execute, enter into and bind such party to the commitments and obligations set forth herein.

22. COUNTERPARTS: This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement.

23. ENTIRE AGREEMENT: Unless otherwise specified herein, this AGREEMENT embodies the entire understanding of the parties for this PROJECT and any prior contemporaneous representations, either oral or written, are hereby superseded. No amendments or changes to this AGREEMENT including, without limitation, changes in the activities of the PROJECT, total estimated cost, and period of performance, shall be effective unless made in writing and signed by authorized representatives of both parties. If any provisions stated in the AGREEMENT, resulting purchase orders, and the project proposal are in conflict, the order of precedence, from first to last shall be: (a) Attachment B, (b) AGREEMENT, (c) other attachments, (d) the project proposal, and (e) the purchase order, it being understood and agreed that any purchase order or similar document issued by GRANTEES will be for the sole purpose of establishing a mechanism for payment of any sums due and owing hereunder. Notwithstanding any terms and conditions contained in said purchase order, the purchase order will in no way modify or add to the terms of this AGREEMENT.

IN WITNESS WHEREOF, the parties hereto have executed this AGREEMENT by their duly authorized officers or representatives as of the latest date set forth below.

TRI-CITY

TRI-CITY MENTAL HEALTH CENTER

By:______________________________
Antonette (Toni) Navarro, LMFT
Executive Director
Dated:__________________________

GRANTEES

Bright Prospect

By:______________________________
Rachel Rosenbaum
Community Leader

Dated:__________________

By:______________________________
Evan Sotelo
Project Leader

Dated:__________________

Fiscal Sponsor

By:______________________________
Rachel Rosenbaum
Fiscal Sponsor Representative

Dated:__________________

Tri-City Mental Health Authority
AGENDA REPORT

DATE: **June 16, 2021**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Toni Navarro, LMFT, Executive Director**

BY: **Debbie Johnson, LMFT, Child and Family Services Program Manager**

SUBJECT: **Consideration of Resolution No. 588 Authorizing the Executive Director to Execute a Memorandum Of Understanding with the Claremont Unified School District (CUSD) for Specialty Mental Health Services for Three Years, Effective July 1, 2021**

Summary:

Tri-City staff requests Governing Board approval to renew the Memorandum of Understanding with Claremont Unified School District (CUSD) to continue collaboration on addressing mental health needs for students, assists with linkage, referrals, and overall mental health services.

Background:

The collaboration between CUSD and Tri-City's School Partnership Team (SPT) within the Child and Family Services Department facilitates access to mental health services for students and families. Specifically, the establishment and maintenance of a formal MOU improves access to services for students by addressing barriers quickly by creating the opportunity to provide assessments on school site, and extra support for families who are struggling to access mental health services. In addition, the collaboration, which includes regularly scheduled monthly meetings between CUSD and Tri-City SPT staff helps to keep CUSD abreast of Tri-City services such as community trainings, webinars, and most recent Claremont PACT team.

The SPT consists of five clinicians, one mental health specialist (MHS), and a clinical supervisor. One clinician in the school partnership program is allocated to the CUSD MOU to provide full-time support and the MHS and Supervisor are also allocated to provide a portion of their time to CUSD

Fiscal Impact:

No fiscal impact. The students and families served by this MOU are local area residents who would otherwise be served at Tri-City clinic sites.

Recommendation:

Staff recommends that the Governing Board adopt Resolution No. 588 approving the MOU with the Claremont Unified School District and authorizing the Executive Director to execute the MOU.

Attachments

Attachment 6-A: Resolution No. 588 - DRAFT

Attachment 6-B: CUSD & TCMHA MOU for Specialty Mental Health Services Effective 07-01-2021- DRAFT

RESOLUTION NO. 588

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE A MEMORANDUM OF UNDERSTANDING WITH THE CLAREMONT UNIFIED SCHOOL DISTRICT (CUSD) FOR SPECIALTY MENTAL HEALTH SERVICES FOR THREE YEARS, EFFECTIVE JULY 1, 2021

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("TCMHA" or "Authority"), is certified by the California Board of Behavioral Sciences as provider of mental health services.

B. The Authority desires to provide mental health services to certain Claremont Unified School District (CUSD) students and their families identified and referred by the District; and approves to render services pursuant to the terms of the Memorandum of Understanding with CUSD.

2. Action

The Governing Board approves the Memorandum of Understanding (MOU) for mental health services with Claremont Unified School District (CUSD) to be effective July 1, 2021, and authorizes the Executive Director to execute the MOU.

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on June 16, 2021, by the following vote:

AYES:

NOES:

ABSTAIN:

ABSENT:

____
ROBIN CARDER, CHAIR

APPROVED AS TO FORM:
DAROLD PIEPER, GENERAL COUNSEL

By:________________________________

ATTEST:
MICAELA P. OLMOS, RECORDING SECRETARY

By:________________________________

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AGREEMENT FOR SERVICES

THIS AGREEMENT FOR SERVICES ("Agreement") is made and entered into as of July 1, 2021 ("Effective Date") by and between CLAREMONT UNIFIED SCHOOL DISTRICT, a public agency of the State of California with its administrative office at 170 West San Jose Avenue, Claremont, California 91711 ("District"), and TRI-CITY MENTAL HEALTH AUTHORITY, a joint powers agency organized under the laws of the State of California with its administrative office at 1717 N. Indian Hill Boulevard, #B, Claremont, California 91711 ("Provider"). District and Provider are sometimes individually referred to as a "Party" and collectively as "Parties."

RECITALS

A. WHEREAS, District desired to provide mental health services to certain of District's students and their families identified and referred by District.

B. WHEREAS, Provider is certified by the California Board of Behavioral Sciences as a provider of mental health services and is experienced in the provision of such services.

C. WHEREAS, the Board of Education ("Board") of the District desires to contract with Provider to provide the Services (as defined below) and provider desires to render the Services pursuant to the terms of this Agreement.

OPERATIVE PROVISIONS

NOW, THEREFORE, in consideration of the above facts and of the covenants and agreements contained herein, the Parties hereto agree that:

1. Term. The term of this Agreement ("Term") shall commence on July 1, 2021, and terminate on June 30, 2024, unless terminated earlier pursuant to Section 11 hereof.

2. Services.

2.1 As directed by District, Provider shall provide appropriate mental health services to certain of District's specialty mental health services-eligible children and their families identified and referred by District, such services to include, without implied limitation, the following: individual, collateral, family and group psychotherapy services, counseling and case management services to be provided at District school sites. The services described in this Section and the Products shall hereinafter collectively be referred to as the ("Services").

2.2 District shall make available to Provider, as necessary and to the extent reasonably possible, District facilities suitable for the confidential nature of the Services to be provided hereunder. In the event such District facilities are not available or appropriate at a given time for a student/family receiving Services hereunder. District shall make arrangements with Provider for a suitable alternative location approved by District.

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3. Remuneration.

3.1 Provider shall not be entitled to any compensation or benefit from District of any kind or type for the Services to be provided hereunder. Provider understands and acknowledges that its sole source of remuneration for the Services provided hereunder is any reimbursement Provider may successfully obtain from Medi-Cal or other available funding sources.

3.2 Provider shall not charge families for any Services rendered under this Agreement unless such Services and charges are clearly identified in writing signed by the parents/guardians. In no event shall the agreed-upon charges obligate District financially, or shall District incur any obligation or expense in connection therewith.

4. Independent Contractor.

4.1 In connection with the performance of the Services, the District and Provider acknowledge that Provider is an independent contractor and not an officer, agent or employee of the District. Consequently, Provider shall be responsible for paying all required state and federal income taxes, social security contributions, and other mandatory taxes and contributions. Provider acknowledges that, as an independent contractor, Provider is not covered by District under California workers' compensation, unemployment insurance or other employment-related laws.

4.2 District and Provider hereby acknowledge that the Provider shall determine Provider's own hours of work and work location; purchase, lease and/or maintain Provider's own office, facilities and equipment, except those District facilities made available to Provider to provide the Services hereunder; hire, fire, direct and control Provider's agent(s), employee(s) or other representative(s) at Provider's sole discretion; and shall be available to perform services for other school districts and/or the general public.

4.3 Provider shall assume all ordinary expenses incurred in the performance of this Agreement. Such ordinary expenses shall include, without implied limitation, document reproduction expenses and telephone charges. Services and expenses that are above the ordinary and may require shall not be reimbursable unless previously authorized in writing by the District's Designee and shall be covered by a specific Addendum to this Agreement.

4.4 In performing the Services specified by District as set forth above, Provider shall determine the methods, details, and means of providing such Services. However, upon request, Provider shall submit an oral and/or written summary of Provider's methods, details and means of providing such Services.

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4.5 Provider shall provide all services under this Agreement in a skillful and competent manner, consistent with the standards generally recognized as employed by others in the same profession in California. Provider represents and maintains that Provider is skilled in the professional calling necessary to perform the Services. Provider warrants that all employees shall have sufficient skill and experience to perform he Services assigned to them. Provider represents that Provider, Provider's employees have all licenses, permits, qualification and approvals of whatever nature that are legally required to perform the Services.

5. Criminal Background Check.

5.1 Provider shall and all of Provider's employees shall comply with all requirements related to fingerprinting set forth in California Education Code Section 45125.1, and all District Administrative Regulations related to Fingerprint Background Check prior to any substantial contact with any students, including, without implied limitation, prior to coming onto District's school grounds or having any contact with District's students in locations other than District school grounds.

5.2 Prior to the commencement of Services, Provider shall register with the California Department of Justice for subsequent offender notification of its employees who provide Services to District's students.

6. Child Abuse Reporting.

6.1 Provider warrants and represents to District that all staff members, including volunteers, is familiar with and agrees to adhere to child abuse reporting obligations and procedures under California law, including, but not limited to, California Education Code Section 49370 and California Penal Code Section 11166 et seq. Provider shall provide annual training to all its employees regarding mandated reporting of child abuse. Provide warrants and represents that all staff members will abide by such laws in a timely manner.

6.2 Unless prohibited by law, Provider shall submit immediately, and no later than within twenty-four (24) hours, by facsimile and mail, provide an accident or incident report to the District when it becomes aware of reportable circumstances, including, but not limited to, allegations of molestation or child abuse, pertaining to children under Provider's supervision pursuant to this Agreement.

7. Confidentiality. Provider shall maintain the confidentiality of all information and records received in the course of providing the Services, in accordance with the provision of applicable federal and state status and regulations including but not limited to California Welfare and Institution Code Section 5328. This requirement shall extend beyond the effective termination or expiration date of this Agreement. This Section shall not be construed as prohibiting either party hereto from disclosing information to the extent required by law regulation, or court order, provided such party notifies the other promptly after becoming aware of such obligations and permits the other party to seek a protective order or otherwise to challenge or limit such required disclosure.

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8. Health Insurance Portability and Accountability Act (“HIPAA”). In accordance with the Health Insurance Portability and Accountability Act and the associated HIPAA regulations (45 CFR Parts 160 and 164), the parties to this Agreement shall establish and implement appropriate safeguards for any Protected Health Information (PHI), as deferred under HIPAA, that may be created, received, used or disclosed by them in connection with the Services and this Agreement.

9. Insurance. Provider shall, at Provider’s expense, obtain and file with District, a certificate of insurance before commencing any services under this Agreement as follows:

9.1 **Workers Compensation Insurance**: Minimum statutory limits.

9.2 **Commercial General Liability And Property Damage Insurance**: General Liability and Property Damage Combined $2,000,000.00 per occurrence including comprehensive form, personal injury, broad form personal damage, contractual and premises/operation, all on an occurrence basis. If an aggregate limit exists, it shall apply separately or be no less than two (2) times the occurrence limit.

9.3 **Automobile Insurance**: $1,000,000.00 per occurrence.

9.4 **Sexual Abuse and Molestation Insurance:** $1,000,000.00 per occurrence.

9.5 **Notice Of Cancellation**: The District requires 30 days written notice of cancellation. Additionally, the notice statement on the certificate should include the wording “failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives.”

9.6 **Certificate Of Insurance**: Shall name the District, its board members or trustees, officers, agents, employees, representatives, and volunteers" as additional insureds.

10. Indemnity.

10.1 Provider agrees to indemnify, defend and hold harmless District, its board members or trustees, officers, agents, employees, representatives, and volunteers from any and all demands, claims or liability of personal injury, including wrongful death, and property damage of any nature, caused by or arising out of negligent acts, errors or omissions of Provider, its board members or trustees, officers, agents, employees, representatives, and volunteers arising out of or in connection with the performance of Services under this Agreement, including, without implied limitation, the payment of all consequential damages and reasonable attorneys’ fees and other related costs and expenses.

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10.2 District agrees to indemnify, defend and hold harmless Provider, its board members or trustees, officers, agents, employees, representatives, and volunteers from any and all demands, claims or liability of personal injury, including wrongful death, and property damage of any nature, caused by or arising out of negligent acts, errors or omissions of District, its board members or trustees, officers, agents, employees, representatives, and volunteers arising out of or in connection with the performance of Services under this Agreement, including, without implied limitation, the payment of all consequential damages and reasonable attorneys' fees and other related costs and expenses.

11. Termination. Except as provided in this Agreement, this Agreement may be terminated by either party, for any reason, during the Term of this Agreement by giving thirty (30) days' written notice to the other party.

12. Delivery of Notices. All notices permitted or required under this Agreement shall be given to the respective parties at the following address, or at such other address as the respective parties may provide in writing for this purpose:

PROVIDER:

Tri-City Mental Health Authority
1717 N. Indian Hill Boulevard, #B
Claremont, California 91711
Attn: Executive Director

DISTRICT:

Claremont Unified School District
170 W. San Jose Avenue
Claremont, California 91711
Attn: Assistant Superintendent

Such notice shall be deemed made when personally delivered or when mailed, forty-eight (48) hours, after deposit in the US. Mail, first class postage prepaid and addressed to the party at its applicable address. Actual notice shall be deemed adequate notice on the date actual notice occurred, regardless of the method of service.

13. Non-Discrimination and Equal Employment Opportunity. In the performance of this Agreement, Provider shall not discriminate against any employee or applicant for employment because of race, color, creed, religion, sex, marital status, national origin, ancestry, age, physical or mental disability, medical condition, sexual orientation or gender identity. Provider will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, creed, religion, sex, marital status, national origin, ancestry, age, physical or mental handicap, medical condition, and sexual orientation or gender identity.

14. Licenses. Provider declares that Provider has complied with all federal, state, and local business permits and licensing requirements necessary to provide Services under this Agreement.

15. Entire Agreement. This Agreement shall become effective upon its approval and execution by both Parties. This Agreement and any other documents incorporated herein by specific reference, represents the entire and integrated agreement between the Parties.

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This Agreement supersedes all prior agreements, written or oral, between the District and Provider relating to the subject matter of this Agreement. This Agreement may not be modified, changed or discharged in whole or in part, except by an agreement in writing signed by the District and Provider. The validity or unenforceability of any provision of this Agreement declared by a valid judgment or decree of a court of competent jurisdiction, shall not affect the validity or enforceability of any other provision of this Agreement. No delay or omission by District or Provider in exercising any right under this Agreement will operate as a waiver of that or any other right. A waiver or consent given by District on any one occasion is effective only in that instance and will not be construed as a bar to or waiver of any right on any other occasion or a waiver of any other condition of performance under this Agreement.

16. Authority. Both Provider and District warrant that the individuals who have signed the Agreement have the legal power, right, and authority to make this Agreement and bind each respective Party.

17. Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

18. Education Code Section 17604. In accordance with California Education Code Section 17604, this Agreement is not valid or an enforceable obligation against the District until approved or ratified by motion of the Governing Board duly passed and adopted.

19. Execution**.**

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Effective Date.

PROVIDER:
Tri-City Mental Health Authority

By: ________________________________
Antonette Navarro, Executive Director

Attest:

By: ________________________________
Micaela P. Olmos
JPA Administrator/Clerk

DISTRICT:
Claremont Unified School District

By: ________________________________
Julie Olesniewicz, Ed.D., Superintendent

Approved by Board: ___________________

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Tri-City Mental Health Authority
AGENDA REPORT

DATE: **June 16, 2021**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Toni Navarro, LMFT, Executive Director**

SUBJECT: **Consideration of Resolution No. 589 Authorizing the Executive Director to Execute an Addendum to the Software Services Agreement with Welligent for One-Year in the Amount of $115,500 Effective July 1, 2021**

Summary

Over the next year, Tri-City will transition to a new electronic health record (EHR) in order to ensure operational efficiency and to ensure compliance with upcoming regulatory requirements. Staff is requesting the Governing Board authorize the Executive Director to execute an Addendum to extend one-year the existing software services agreement with the Agency's current EHR platform provider, Welligent, in the amount of $115,500.

Background

In 2010, Tri-City adopted the use of an electronic health record in order to improve medical record efficiency, more effectively standardize client record documentation, and move into compliance with then emerging federal regulations for Medicaid providers. Tri-City chose to contract with Welligent, an electronic records platform company that was originally servicing educational agencies and was newly moving into the behavioral health services industry. As electronic health record regulations, requirements, and Medi-Cal provider expectations have evolved in the past few years, Welligent has struggled to keep up with the necessary technology updates necessary for Tri-City, a public behavioral health agency, to operate as efficiently and effectively as needed. Tri-City's current contract with Welligent expires on June 30, 2021.

At the end of Fiscal Year 2019-2020, the decision was made to issue a Request For Proposals for Electronic Health Records Software Platform to ensure Tri-City's continued compliance with laws and regulations; however, as a result of several factors including the COVID-19 pandemic, Tri-City has yet to onboard a new EHR system and will need to extend its contract with Welligent through Fiscal Year 2021-22.

Fiscal Impact

It will cost $115,500 to extend the Welligent software services agreement for one-year as Tri-City transitions to a new electronic health record will be charged across the Tri-City system of care utilizing both MHSA and Realignment Funds.

Recommendation

Staff recommends that the Governing Board approve Resolution No. 589 approving the Addendum to the Software Services Agreement with Welligent for one-year in the amount of $115,500 effective July 1, 2021; and authorizing the Executive Director to execute it.

Attachments

Attachment 7-A: Resolution No. 589 - DRAFT

Attachment 7-B: Addendum to Welligent Software Services Agreement – Effective July 1, 2021

RESOLUTION NO. 589

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE AN ADDENDUM TO THE SOFTWARE SERVICES AGREEMENT WITH WELLIGENT FOR ONE-YEAR IN THE AMOUNT OF $115,500 EFFECTIVE JULY 1, 2021

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("TCMHA" or "Authority") desires to sign an Amendment to the existing software services agreement with the Agency's current EHR platform provider, Welligent.

B. It will cost $115,500 to extend the Welligent software services agreement for one-year as Tri-City transitions to a new electronic health record software platform.

2. Action

The Governing Board approves the Addendum to the Software Services Agreement with Welligent for one-year in the amount of $115,500 effective July 1, 2021; and authorizes the Executive Director to execute it.

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on June 16, 2021, by the following vote:

AYES:

NOES:

ABSTAIN:

ABSENT:

____
ROBIN CARDER, CHAIR

APPROVED AS TO FORM:
DAROLD PIEPER, GENERAL COUNSEL

By:______________________________

ATTEST:
MICAELA P. OLMOS, RECORDING SECRETARY

By:______________________________

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ATTACHMENT 7-A

DocuSign Envelope ID: 1F80E72E-40BA-42ED-A673-103F4E6AF84E

ADDENDUM TO WELLIGENT SOFTWARE SERVICE AGREEMENT
FOR
WELLIGENT SUBSCRIPTION RENEWAL

This Addendum to Software Service Agreement ("Addendum") is made as of 5/25/2021 (the "Effective Date") by and between Welligent, LLC ("Welligent") and Tri City Mental Health Center ("Customer"), as an amendment to the original Software Service Agreement ("Agreement") entered into by both parties on 04/21/2010 and as amended 05/10/2017 ("Addendum 1") and 05/31/20 ("Addendum 2")]. The purpose of this Addendum is to serve as a renewal of Customer's contract term and user-based subscription fees. Welligent and Customer hereby agree as follows:

1. The Agreement is hereby amended as set forth in this Addendum;

2. Customer wishes to renew the term specified in the original Agreement and Addendum 1 and 2 or requests an expansion of its user license and related fees due to Customer's actual usage which exceeds the contracted user license specified in the Agreement;

3. All capitalized terms not otherwise defined in this Addendum have the meanings ascribed to them in the Agreement;

4. Except as specifically amended by this Addendum, the definitions, terms and conditions of the Agreement remain in full force and effect. This Addendum, the Agreement and the related exhibits contain the entire Agreement of the parties with respect to the subject matter hereof and there are no other agreements modifying the same;

5. This Addendum may be executed in one or more counterparts, each of which will be deemed an original, and all of which taken together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the parties hereto have caused this Addendum to be executed by their respective duly authorized representatives as of the day and year first above written.

WELLIGENT, INC.		**CUSTOMER NAME**	
Signature:	DocuSigned by: [signature] 5D93AB52E265433...	**Signature:**	
Name:	Andy McCraw	**Name:**	Antonette (Toni) Navarro
Title:	President	**Title:**	Executive Director
Effective Date:	5/27/2021	**Effective Date:**	

ATTACHMENT 7-B

WELLIGENT ADDENDUM PROVISIONS

The purpose of this Addendum is to serve as a renewal of Customer's contract term, user license and related fees.

1. **Modification to Existing Agreement.** Welligent and Customer jointly agree to modify or replace the following Agreement and Exhibit provisions with the accompanying new language:

   A. Agreement Exhibit D, Welligent Recurring Software Fees. Welligent and Customer agree to replace Exhibit A with the fee schedules included at Appendix A. This Appendix lists the subscription fees Customer shall pay during the term along with any Third Party software services and recurring fees.

   B. Agreement Section 14(a), Term. Welligent and Customer agree to replace the listed sections of the Agreement with the following language:

   This Agreement shall become effective when executed by both parties as of the date set forth on the signature page hereto, and unless sooner terminated as provided herein, shall remain in force until 06/30/2022. Following the Renewal Term, Customer and Welligent shall have the right to negotiate additional contract terms.

2. **Survival.** All provisions of this Addendum or the original Agreement that pertain to protection of the Welligent Intellectual Property, non-disclosure of Confidential Information, and payment of fees shall survive termination of this Agreement.

3. **Modifications.** Modifications and amendments to this Addendum or the original Agreement, including modifications and amendments to any schedule or other attachment hereto, shall be enforceable only if in writing and signed by authorized representatives of both parties.

4. **Severability.** If any provision of this Agreement is held to be invalid or unenforceable for any reason, the remaining portions of this Agreement shall remain in full force and effect in accordance with its terms, disregarding such unenforceable or invalid provision(s).

Appendix A - Order Sheet for Welligent Existing Customer License Renewal

Welligent Order Sheet Standard Terms and Conditions

We appreciate the opportunity to present this order sheet to your organization. Quotes are valid for 30 days from Original Quote Date listed below. Welligent will begin invoicing for items in Section A at order sheet execution. Where applicable, please see the attached Welligent Addendum for for additional terms and conditions and information related to Welligent software or Third Party Integration services. This agreement shall remain in effect for the contract term specified in the Contract Term Information section below. Following the term, Customer and Welligent may renew the software and integration services under a separate order sheet and terms. In Section A below, Welligent has provided its software options along with all requested Third Party integrations for the renewal term. Welligent's fees are recurring monthly fees based on the included numbers of units listed in Section A. Welligent's license fees are fixed for the term and additional user licenses used or requested beyond the included units may impact your fees. Please review the order sheet and contact your Client Success Manager if you have additional questions.

Tri City Mental Health Center
ATTN: Antonette (Toni) Navarro
anavarro@tricitymhs.org
1900 Royalty Drive
Pomona, CA 91767

Original Quote Date: 5/25/2021
Valid Through: 6/24/2021

Contract Term Information

Renewal Term: 1 Year
Effective Date: 7/1/2021
Renewal Date: 6/30/2022

A. Customer Welligent Software License Options

#	Included Welligent & Third Party Software Licenses	Units	Rate	Rate Unit	Monthly Fees
1	Welligent Version 8 Cloud-based EHR user licenses	175	$55	per-user/mo	$9,625
3	Change Healthcare Commerical clearinghouse	per usage	$18	per-NPI/mo	per usage
4	Welligent ePrescribing by Change Healthcare (up to 7 eRX providers)	7	$85	per-eRx/mo	included
	Total Annual Welligent Recurring Software Fees:				**$115,500**

B. Welligent Order Sheet Special Terms and Conditions

[Add any special terms and conditions, especially any escalation provisions]

C. Order Sheet Acceptance by Customer

Signature

Antonette (Toni) Navarro Executive Director

Name and Title

5/25/2021

Date

#	Welligent Services and Options	#	Rate	Unit
1	Welligent Version 8 Cloud-based EHR user licenses[1]	30	$50	Per-user
2	Welligent Express mobile app user licenses	10	$10	Per-user
3	Emdeon® Commercial clearinghouse	1	$20	Per-NPI/mo
4	Welligent ePrescribing by Emdeon®	1	$75	Per-eRx/mo
5	Emdeon® standard lab interface setup (1 lab)	1	$75	Per-Lab/mo
6	John Wiley & Sons Practice Planners® Libraries	15	$12	Per-User/mo
7	Welligent PM or technical support hours (Annual Support)	5	$225	Per-year
Total Monthly Contractor Fees – Years 2 and 3 (excludes line item #7):				
Total Contractor Fees – Years 2 (includes line item #7):				
Total Contractor Fees – Years 3 (includes line item #7):				
Total Contractor Fees – Years 2 and 3:				

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Monthly Fees
$1,500
$100
$20
$75
$75
$180
$1,125/year 1 $1,125/year 2
$1,950
$24,525
$25,751
$50,276

Tri-City Mental Health Authority
AGENDA REPORT

DATE: **June 16, 2021**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Toni Navarro, LMFT, Executive Director**

SUBJECT: **Consideration of Resolution No. 590 Authorizing the Executive Director to Execute an Agreement With Kairos Partners, LLC for I.T. Consulting Services in an Amount Not To Exceed $25,000 Effective June 17, 2021**

Summary

Since January 2020, Kairos Partners, LLC has provided information technology (I.T.) consultation services to Tri-City, assisting the Agency in establishing a more efficient and effective I.T. department; and with the recruitment and hiring of a permanent Chief Information Officer. The Executive Director is requesting to execute an agreement that will extend consultation services with Kairos Partners, LLC, not to exceed $25,000, in order to support Tri-City's newly hired Chief Information Officer and I.T. team to complete I.T. projects that are in process including a new electronic health record migration, a regulatory required security assessment, and an agencywide new hardware rollout.

Background

In Fall of 2019 Kairos Partners, LLC conducted a full I.T. systems evaluation and organizational structural assessment of Tri-City that resulted in a contract for interim Chief Information Officer services to assist the Agency in establishing a more efficient and effective I.T. department and ensuring Tri-City had the most up to date I.T. systems and was operating in full compliance with its State and County obligations.

In April of 2021, Tri-City hired its permanent Chief Information Officer, Ken Riomales, and the Kairos Partners, LLC consultant, Jessica Wong, has finished out her contract working alongside the Tri-City CIO to onboard and orient him to the tasks identified for completion within the next few months and the projects already in process.

Given the number of tasks in process and the ongoing training of Tri-City's existing I.T. team to bring them up to capacity with the new systems being implemented, it is necessary to extend the services of the Kairos Partner, LLC consultant for a while longer.

Fiscal Impact

The $25,000 in consulting services to be provided by Kairos Partners, LLC will be charged to Realignment funds beginning June 17, 2021. Costs incurred in this fiscal year will not

exceed allocations previously approved by the Governing Board in the current budget. The remaining costs will be accounted for in Fiscal Year 2021-22 budget.

Recommendation

Staff recommends that the Governing Board adopt Resolution No. 590 approving an agreement with Kairos Partners, LLC for I.T. Consulting Services, not to exceed the amount of $25,000, effective July 1, 2021; and authorizing the Executive Director to execute it.

Attachments

Attachment 8-A: Resolution No. 590 - DRAFT

Attachment 8-B: TCMHA and Kairos Partners Agreement for I.T. Consulting Services - DRAFT

RESOLUTION NO. 590

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY APPROVING AN AGREEMENT WITH KAIROS PARTNERS, LLC FOR INFORMATION TECHNOLOGY (I.T.) CONSULTING SERVICES AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE THE AGREEMENT

The Governing Board of the Tri-City Mental Health Authority ("Authority") does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("TCMHA" or "Authority"), desires to approve an agreement with Kairos Partners, LLC to provide Information Technology (I.T.) consulting services to the Authority.

B. The Authority affirms that Kairos Partners, LLC is an independent contractor and not an employee, agent, joint venture or partner of Tri-City. The Agreement does not create or establish the relationship of employee and employer between Contractor and Tri-City.

C. The Authority shall pay a consultant fee of $150/hour; and shall not exceed $25,000 for all services provided.

2. Action

The Authority's Executive Director is authorized to enter into, and execute, an Agreement with Kairos Partners, LLC for I.T. consulting services, not to exceed the amount of $25,000, effective July 1, 2021.

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on June 16, 2021, by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

____
ROBIN CARDER, CHAIR

APPROVED AS TO FORM:
DAROLD PIEPER, GENERAL COUNSEL

By:____________________________

ATTEST:
MICAELA P. OLMOS, RECORDING SECRETARY

By:____________________________

ATTACHMENT 8-A

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INDEPENDENT CONTRACTOR AGREEMENT

BETWEEN THE

TRI-CITY MENTAL HEALTH AUTHORITY

AND

KAIROS PARTNERS. LLC

DATED

June 17, 2021

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AGREEMENT

1. PARTIES AND DATE.

THIS AGREEMENT (hereinafter "Contract" or "Agreement") is made and entered into on the 17th day of June, 2021 ("Agreement Date") by and between the TRI-CITY MENTAL HEALTH AUTHORITY, a joint powers agency organized under the laws of the State of California with its administrative office at 1717 N. Indian Hill Boulevard, #B, Claremont, California 91711 (hereinafter "TCMHA") and KAIROS PARTNERS, LLC, a subsidiary of UDK International, with its principal place of business at 164 Carlton, Pasadena, CA 91103 (hereinafter "Contractor"). TCMHA and Contractor are sometimes individually referred to as a "Party" and collectively as "Parties."

2. CONTRACTOR.

The express intention of the parties is that Contractor is an independent contractor and not an employee, agent, joint venture or partner of TCMHA. Nothing in this Agreement shall be interpreted or construed as creating or establishing the relationship of employee and employer between Contractor and TCMHA or any employee or agent of Contractor. At all times Contractor shall be an independent contractor and Contractor shall have no power to incur any debt, obligation, or liability on behalf of TCMHA without the express written consent of TCMHA. Neither TCMHA nor any of his agents shall have control over the conduct of Contractor or any of Contractor's employees, except as set forth in this Agreement. In executing this Agreement, Contractor certifies that no one who has or will have any financial interest under this Agreement is an officer or employee of TCMHA.

3. SCOPE OF SERVICES.

Contractor shall provide the specified Information Technology Consulting Services and/or materials as set forth in 'Exhibit A.'

4. PERFORMANCE OF SERVICES.

Contractor reserves the sole right to control or direct the manner in which services are to be performed. Contractor shall retain the right to perform services for other entities during the term of this Agreement, so long as they are not competitive with the services to be performed under this Agreement. Contractor shall neither solicit remuneration nor accept any fees or commissions from any third party in connection with the Services provided to TCMHA under this Agreement without the expressed written permission of TCMHA. Contractor warrants that it is not a party to any other existing agreement which would prevent Contractor from entering into this Agreement or which would adversely affect Contractor's ability to fully and faithfully, without any conflict of interest, perform the Services under this Agreement.

5. SUBCONTRACTORS.

Neither party hereto may assign this Agreement, nor will Contractor subcontract any service requested hereunder to contractor(s) unless consented to in writing by the Executive Director of TCMHA.

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6. TIME AND LOCATION OF WORK.

Contractor shall perform the services required by this Agreement at any place or location and at any time as Contractor deems necessary and appropriate, so long as the services are provided within the manner and time frames outlined in 'Exhibit A'.

7. TERMS.

The services and/or materials furnished under this Agreement shall commence on June 17, 2021, and shall be and remain in full force and effect until amended or terminated with the completion of IT Strategic Consulting services, unless terminated in accordance with the provisions of Section 8 below.

8. TERMINATION. This Agreement may be terminated only as follows:

a. Written Election. Either party may terminate this Agreement at any time, without cause, upon thirty (30) calendar days prior written notice to the other party. Contractor agrees to cooperate fully in any such transition, including the transfer of records and/or work performed.

b. Breach. TCMHA, in its sole discretion, may terminate this Agreement "for cause" effective upon written notice to Contractor if Contractor has committed a material default under, or a breach of, this Agreement or has committed an act of gross misconduct. Contractor's failure to complete the Information Technology Strategic Consulting Services on a timely basis shall constitute a material breach of this Agreement. For the purposes of this Agreement, the term "act of gross misconduct" shall mean the commission of any theft offense, misappropriation of funds, dishonest or fraudulent conduct, or any violation of any of the provisions under this Agreement.

c. Non-payment. Contractor, in its sole discretion, may terminate this Agreement effective upon written notice to TCMHA if TCMHA fails to pay the Compensation as defined in Section 9 (other than amounts which are subject to a good faith dispute between the parties) to Contractor within thirty (30) calendar days of the applicable payment's due date.

d. Effect of Termination. No termination of this Agreement shall affect or impair Contractor's right to receive compensation earned for work satisfactorily completed through the effective date of termination. In the event of termination, Contractor shall immediately deliver all written work product to TCMHA, which work product shall be consistent with all progress payments made to the date of termination.

9. COMPENSATION. For the full performance of this Agreement:

a. TCMHA shall pay Contractor an amount not to exceed amount as stated in Contractor Proposal, incorporated herein as 'Exhibit A', within thirty (30) days following receipt of invoice and satisfactory completion/delivery of services/goods in a manner consistent with professional/industry standards for the area in which Contractor operates, as detailed in Section 3 of this Agreement. TCMHA is not responsible for paying for any work done by Contractor or any subcontractor above and beyond the not to exceed amount.

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b. Contractor is responsible for monitoring its own forces/employees/agents/ subcontractors to ensure delivery of goods/services within the terms of this Agreement. TCMHA will not accept or compensate Contractor for incomplete goods/services.

c. Contractor acknowledges and agrees that, as an independent contractor, the Contractor will be responsible for paying all required state and federal income taxes, social security contributions, and other mandatory taxes and contributions. TCMHA shall neither withhold any amounts from the Compensation for such taxes, nor pay such taxes on Contractor's behalf, nor reimburse for any of Contractor's costs or expenses to deliver any services/goods including, without limitation, all fees, fines, licenses, bonds, or taxes required of or imposed upon Contractor. TCMHA shall not be responsible for any interest or late charges on any payments from TCMHA to Contractor.

10. LICENSES.

Contractor declares that Contractor has complied with all federal, state, and local business permits and licensing requirements necessary to conduct business.

11. PROPRIETARY INFORMATION.

The Contractor agrees that all information, whether or not in writing, of a private, secret or confidential nature concerning TCMHA's business, business relationships or financial affairs (collectively, "Proprietary Information") is and shall be the exclusive property of TCMHA. The Contractor will not disclose any Proprietary Information to any person or entity, other than persons who have a need to know about such information in order for Contractor to render services to TCMHA and employees of TCMHA, without written approval by Executive Director of TCMHA, either during or after its engagement with TCMHA, unless and until such Proprietary Information has become public knowledge without fault by the Contractor. Contractor shall also be bound by all the requirements of HIPAA.

12. GENERAL TERMS AND CONDITIONS.

a. Indemnity. Contractor agrees to indemnify, defend and hold harmless TCMHA, its officers, agents and employees from any and all demands, claims or liability of personal injury (including death) and property damage of any nature, caused by or arising out of the performance of Contractor under this Agreement. With regard to Contractor's work product, Contractor agrees to indemnify, defend and hold harmless TCMHA, its officers, agents and employees from any and all demands, claims or liability of any nature to the extent caused by the negligent performance of Contractor under this Agreement.

b. Insurance. Contractor shall obtain and file with TCMHA, at its expense, a certificate of insurance before commencing any services under this Agreement as follows:

i. **Workers Compensation Insurance**: Minimum statutory limits.

ii. **Automobile Insurance**: By its signature hereunder, Contractor certifies that Contractor and its employees performing services under this Agreement have automobile insurance.

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iii. **Errors And Omissions Insurance**: $1,000,000.00 aggregate.

iv. **Commercial General Liability And Property Damage Insurance**: General Liability and Property Damage Combined. $2,000,000.00 per occurrence including comprehensive form, personal injury, broad form personal damage, contractual and premises/operation, all on an occurrence basis. If an aggregate limit exists, it shall apply separately or be no less than two (2) times the occurrence limit.

v. **Notice Of Cancellation**: TCMHA requires 30 days written notice of cancellation. Additionally, the notice statement on the certificate should not include the wording "endeavor to" or "but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives."

vi. **Certificate Of Insurance**: Prior to commencement of services, evidence of insurance coverage must be shown by a properly executed certificate of insurance by an insurer licensed to do business in California, satisfactory to TCMHA, and it shall name "TCMHA Mental Health Authority, its elective and appointed officers, employees, and volunteers" as additional insureds.

vii. To prevent delay and ensure compliance with this Agreement, the insurance certificates and endorsements must be submitted to:

Tri-City Mental Health Authority
Attn: Executive Director
1717 N. Indian Hill Boulevard, #B
Claremont, CA 91711-2788

c. Non-Discrimination and Equal Employment Opportunity. In the performance of this Agreement, Contractor shall not discriminate against any employee, subcontractor, or applicant for employment because of race, color, creed, religion, sex, marital status, national origin, ancestry, age, physical or mental disability, medical condition, sexual orientation or gender identity. Contractor will take affirmative action to ensure that subcontractors and applicants are employed, and that employees are treated during employment, without regard to their race, color, creed, religion, sex, marital status, national origin, ancestry, age, physical or mental handicap, medical condition, sexual orientation or gender identity.

d. Security and Background Investigation. Contractor and its employees performing services under this Agreement shall undergo and pass a background investigation as a condition of beginning and continuing to perform services under this Agreement. Such background investigation must be obtained through fingerprints submitted to the California Department of Justice to include State, local, and federal-level review, which may include, but shall not be limited to, criminal conviction information. The fees associated with the background investigation shall be at the expense of the Contractor, regardless if the member of Contractor's staff passes or fails the background investigation. If a member of Contractor's staff does not pass the background investigation, TCMHA may request that the member of Contractor's staff be immediately removed from performing services under the Agreement at any time during the term of this Agreement. Disqualification of any member of Contractor's staff pursuant to this Paragraph 12 (d) shall not relieve Contractor of its obligation to complete all work in accordance with the terms and conditions of this Contract.

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e. Changes to the Agreement. This Agreement shall not be assigned or transferred without advance written consent of TCMHA. No changes or variations of any kind are authorized without the written consent of the Executive Director. This Agreement may only be amended by a written instrument signed by both parties. The Contractor agrees that any written change or changes in compensation after the signing of this Agreement shall not affect the validity or scope of this Agreement and shall be deemed to be a supplement to this Agreement and shall specify any changes in the Scope of Services.

f. Records. All reports, data, maps, models, charts, studies, surveys, calculations, photographs, memoranda, plans, studies, specifications, records, files, or any other documents or materials, in electronic or any other form, that are prepared or obtained pursuant to this Agreement and that relate to the matters covered hereunder shall be and remain the property of TCMHA. Contractor will be responsible for and maintain such records during the term of this Agreement. Contractor hereby agrees to deliver those documents to TCMHA at any time upon demand of TCMHA. It is understood and agreed that the documents and other materials, including but not limited to those described above, prepared pursuant to this Agreement are prepared specifically for TCMHA and are not necessarily suitable for any future or other use. Failure by Contractor to deliver these documents to TCMHA within a reasonable time period or as specified by TCMHA shall be a material breach of this Agreement. TCMHA and Contractor agree that until final approval by TCMHA, all data, reports and other documents are preliminary drafts not kept by TCMHA in the ordinary course of business and will not be disclosed to third parties without prior written consent of both parties. All work products submitted to TCMHA pursuant to this Agreement shall be deemed a "work for hire." Upon submission of any work for hire pursuant to this Agreement, and acceptance by TCMHA as complete, non-exclusive title to copyright of said work for hire shall transfer to TCMHA. The compensation recited in Section 9 shall be deemed to be sufficient consideration for said transfer of copyright. Contractor retains the right to use any project records, documents and materials for marketing of their professional services.

g. Business Associate Agreement. To the extent necessary, TCMHA will furnish Protected Health Information (PHI) to Contractor (Business Associate) in accordance with all applicable legal requirements to allow Contractor to perform Information Technology Strategic Consulting services on TCMHA's behalf. Contractor is required to appropriately safeguard the PHI disclosed to it. In accordance with TCMHA's policies and procedures, Contractor will sign a *Business Associate Agreement*, incorporated herein as 'Exhibit B', accepting liability for any breach of ePHI or PHI.

h. Contractor Attestation. Also in accordance with TCMHA's policies and procedures, TCMHA will not enter into contracts with individuals, or entities, or owners, officers, partners, directors, or other principals of entities, who have been convicted recently of a criminal offense related to health care or who are debarred, excluded or otherwise precluded from providing goods or services under Federal health care programs, or who are debarred, suspended, ineligible, or voluntarily suspended from securing Federally funded contracts. TCMHA requires that Contractor certifies that no staff member, officer, director, partner, or principal, or sub-contractor is excluded from any Federal health care program, or federally funded contract and will sign attached *Contractor's Attestation That Neither It Nor Any Of Its Staff Members Are Restricted, Excluded Or Suspended From Providing Goods Or Services Under Any Federal Or State Health Care Program*, incorporated herein as 'Exhibit C'.

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i. Governing Law, Jurisdiction and Venue. This Agreement shall be governed by, and construed in accordance with, the laws of the State of California. Contractor agrees and consents to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this Agreement and further agrees and consents that venue of any action brought hereunder shall be exclusively in the County of Los Angeles, California.

13. REPRESENTATIVE AND NOTICE.

a. TCMHA's Representative. TCMHA hereby designates its Executive Director to act as its representative for the performance of this Agreement ("TCMHA's Representative"). TCMHA's Representative shall have the power to act on behalf of TCMHA for all purposes under this Agreement.

b. Contractor's Representative. Contractor warrants that the individual who has signed the Agreement has the legal power, right, and authority to make this Agreement and to act on behalf of Contractor for all purposes under this Agreement.

c. Delivery of Notices. All notices permitted or required under this Agreement shall be given to the respective parties at the following address, or at such other address as the respective parties may provide in writing for this purpose:

If to TCMHA:

Tri-City Mental Health Authority
1717 N. Indian Hill Boulevard, #B
Claremont, CA 91711-2788
Attn: Executive Director

If to Contractor:

Kairos Partners, LLC
164 Carlton Avenue
Pasadena, CA 91103
Attn: Chief Operations Officer

Any notices required by this Agreement shall be deemed received on (a) the day of delivery if delivered by hand during receiving Party's regular business hours or by facsimile before or during receiving Party's regular business hours; or (b) on the third business day following deposit in the United States mail, postage prepaid, to the addresses set forth below, or to such other addresses as the Parties may, from time to time, designate in writing pursuant to the provision of this Section. Actual notice shall be deemed adequate notice on the date actual notice occurred, regardless of the method of service.

14. EXHIBITS. The following attached exhibits are hereby incorporated into and made a part of this Agreement:

Exhibit A: Proposal from Contractor dated May 17, 2021

Exhibit B: Business Associate Agreement

Exhibit C: Contractor's Attestation That Neither It Nor Any Of Its Staff Members Are Restricted, Excluded Or Suspended From Providing Goods Or Services Under Any Federal Or State Health Care Program

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15. ENTIRE AGREEMENT.

This Agreement shall become effective upon its approval and execution by TCMHA. This Agreement and any other documents incorporated herein by specific reference, represents the entire and integrated agreement between the Parties. Any ambiguities or disputed terms between this Agreement and any attached Exhibits shall be interpreted according to the language in this Agreement and not the Exhibits. This Agreement supersedes all prior agreements, written or oral, between the Contractor and TCMHA relating to the subject matter of this Agreement. This Agreement may not be modified, changed or discharged in whole or in part, except by an agreement in writing signed by the Contractor and TCMHA. The validity or unenforceability of any provision of this Agreement declared by a valid judgment or decree of a court of competent jurisdiction, shall not affect the validity or enforceability of any other provision of this Agreement. No delay or omission by TCMHA in exercising any right under this Agreement will operate as a waiver of that or any other right. A waiver or consent given by TCMHA on any one occasion is effective only in that instance and will not be construed as a bar to or waiver of any right on any other occasion or a waiver of any other condition of performance under this Agreement.

16. EXECUTION.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Agreement Date.

TRI-CITY MENTAL HEALTH AUTHORITY	**KAIROS PARTNERS, LLC**
By:______________________________	By: ______________________________
Antonette Navarro, Executive Director	Jessica Wong, Chief Operating Officer

Attest:

By:______________________________
Micaela P. Olmos,
JPA Administrator/Clerk

Approved as to Form and Content:
DAROLD D. PIEPER, ATTORNEY AT LAW

By:______________________________
Darold D. Pieper, General Counsel

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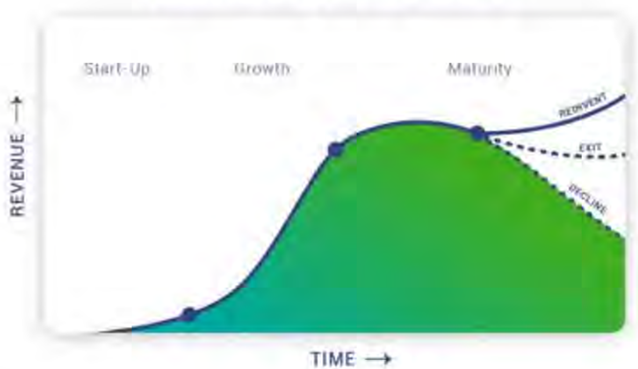
EXHIBIT A

ABOUT KAIROS PARTNERS

Kairos Partners is a group of experienced small business consultants that understand the challenges of growing small businesses, start-ups, and non-profits. Working with a variety of clients at any stage in the business life-cycle, we engage businesses in a collaborative process to identify and strategically resolve any issues and challenges that prevent a company from achieving its fullest potential.



From day one, Kairos Partners seeks to build a strong partnership with its clients, taking time to meet with employees from every department and of all functions to listen, ask questions, and make sure we fully understand your industry, business, and objectives. We strive to build a collaborative environment that encourages dialogue and feedback. Our firm operates with deep integrity, passion, and a talent for delivering results through building relationships with employees, a deep understanding of company needs, innovative strategic planning, and superior execution.

Common obstacles to growth are people, technology, and processes. We have experience with all three – getting the right people in place, while using the right technology to execute efficient and effective processes.

OUR CONSULTING SERVICES

- Strategy Consulting
- IT Managed Services
- Cybersecurity Consulting/Services
- Interim and Virtual CIO/CTO Services
- Marketing Research/Plan Development
- Audits and Assessments
- Business Coaching
- Project Implementation and Management

SECTION I: STRATEGIC CONSULTING

IMPLEMENTATION OF STRATEGIC CONSULTING

All too commonly, business leaders only manage IT as a technical function. The IT systems, IT organization, and IT processes may be designed well from a technical perspective but poorly aligned from a business perspective. This can be the result of changes in business direction, sudden or long-term growth, acquisitions, or disruption that create dissonance between what the business needs and what IT is providing.

Our approach to consulting services is highly strategic and includes the following areas of focus:

BUSINESS AND IT ALIGNMENT. All IT processes begin with a review of the mission, vision, goals, and strategy of the business, so that we can derive the implications for IT–what IT needs to be and do in order to support the business strategy and deliver business value. Conversely, what capabilities can IT implement that can form the basis for new business models?

IT FUTURE STATE VISION. We concurrently hold the mission, vision, and goals of the company in mind while developing the future state vision and strategic plan. We work with all departments through the visioning stage of IT strategy, envisioning a future state where IT systems, technology, people, and processes are fully aligned with the business strategy and taking into account the particular needs of each department. This stage can also include "art of the possible" workshops, where our IT strategy consultants explore what new and innovative technologies have most relevance to your business, and which you should consider for adoption.

CHANGE MANAGEMENT. Organizations often desire to be more efficient and effective, but change can be difficult. Plans themselves do not capture value; value is realized only through the sustained, collective actions of the employees who are responsible for designing, executing, and living with the changed environment. Our CIO approach recognizes the need for adoption of a formal and early approach for managing change — beginning with the leadership team and then engaging key stakeholders and leaders.

IT STRATEGIC INITIATIVES. We define the desired future state, the major initiatives, and the priorities for implementation, which include summary descriptions and budgetary estimates for each of the major initiatives of the IT roadmap. Strategic initiatives can include new business application systems and IT capabilities, upgrades, IT infrastructure improvements, IT organizational changes or restructuring, IT process improvements, IT governance structures, and risk management programs.

SCOPE OF AN IT STRATEGY

A complete IT strategy covers the following areas, which our consultants selectively tailor according to your needs:

IT APPLICATIONS PORTFOLIO: The business applications that the organization will utilize in support of business processes. These commonly include EHR, ERP, CRM, HR/HCM, business intelligence/analytics, and a wide variety of industry-specific systems. Virtual CIO services encompass the entire application implementation process from research and design to RFPs to implementation roadmaps.

IT INFRASTRUCTURE: The technical architecture of hardware, operating systems, databases, end-user computing platforms, networking, communications, and facilities. This also includes use of newer cloud platforms to replace on-premises IT infrastructure and systems.

SECTION I: STRATEGIC CONSULTING (CONT.)

IT SERVICE MANAGEMENT: Decisions concerning how and where IT services should be delivered and by whom, whether by internal IT work groups or by outsourcing or managed services providers.

IT ORGANIZATIONAL DESIGN: IT is not just a matter of technology–it is also about people. Our IT strategic plans also include evaluation of current skills and staffing levels, identification of skills gaps, and designing the optimal IT organizational structure to carry out the road map. If needed, we can also assist in the recruiting process for new IT personnel.

IT MANAGEMENT BEST PRACTICES: IT has its own internal processes, which should utilize proven best practices. These include best practices for IT governance, IT financial management, IT operations, IT security and risk management, applications development, and innovation.

CONSULTING SCOPE

This engagement includes, but is not limited to the following:

- Assisting the Tri-City CIO with special projects and project management as needed
- The upcoming EHR implementation
- Managing and running any potential RFP processes, including networking vendors, security vendors, and application support vendors
- Providing support and training to the IT team as determined by the Tri-City CIO

SECTION II: FEE SCHEDULE

Kairos Partners will provide Tri-City Mental Health (“Client) with the Strategic Consulting Services as defined in Section I above.

As part of this Agreement, Kairos Partners will provide a dedicated Managing Principal Consultant, Jessica Wong, to fulfill the role of Strategic Consultant. Additional engineering support is available for an additional charge. Rates are indicated in the chart below:

SUPPORT TIER	RATE
Consultant	$150/hour
Level 1 Engineer	$75/hour
Level 2 or 3 Engineer	$120/hour
Senior or Principle Engineer	$150/hour
After-Hours On-Site Support	+25%, minimum 3 hours

Consulting Services ~~Retainer (ongoing retainer basis)~~ Shall Not Exceed **$ 25,000**

MONTHLY TOTAL: **Monthly invoices issued based on Time and Expense**

TERMS

Any amount due to Kairos Partners under this Agreement shall be payable in full within 30 days of receipt of an invoice therefore, without withholding, deduction or offset of any amounts for any purpose. ~~Any amount not paid within 30 days of the due date of each invoice shall be subject to an interest charge equal to the lesser of 5% monthly or the maximum interest charge permissible under applicable law, payable on demand.~~ Any charges not disputed by Client in good faith within 14 days of the receipt of an invoice therefore will be deemed approved and accepted by Client.

EXHIBIT B

BUSINESS ASSOCIATE AGREEMENT

This BUSINESS ASSOCIATE AGREEMENT ("**BAA**") is made as of this 18th day of September, 2019 (the "**Effective Date**") by and between TRI-CITY MENTAL HEALTH AUTHORITY, a Covered Entity ("**Covered Entity**" or "**CE**") and Kairos Partners, LLC, a subsidiary of UDK International, ("**Business Associate**" or "**BA**") (each a "**party**" and, collectively, the "**parties**").

RECITALS

A. CE is a "covered entity" under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("**HIPAA**") and, as such, must enter into so-called "business associate" contracts with certain contractors that may have access to certain consumer medical information.

B. Pursuant to the terms of one or more agreements between the parties, whether oral or in writing, (collectively, the "**Agreement**"), BA shall provide certain services to CE. To facilitate BA's provision of such services, CE wishes to disclose certain information to BA, some of which may constitute Protected Health Information ("**PHI**") (defined below).

C. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the Agreement in compliance with HIPAA, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("**HITECH Act**"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("**HIPAA Regulations**") and other applicable laws, including without limitation state patient privacy laws (including the Lanterman-Petris-Short Act), as such laws may be amended from time to time.

D. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI (defined below), as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("**C.F.R.**") and contained in this BAA.

NOW, THEREFORE, in consideration of the mutual promises below and the exchange of information pursuant to this BAA, CE and BA agree as follows:

AGREEMENT

I. Definitions.

A. Breach shall have the meaning given to such term under 42 U.S.C. § 17921(1) and 45 C.F.R. § 164.402.

B. Business Associate shall have the meaning given to such term under 42 U.S.C. § 17938 and 45 C.F.R. § 160.103.

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C. Consumer is an individual who is requesting or receiving mental health services and/or has received services in the past. Any consumer certified as eligible under the Medi-Cal program according to Title 22, Section 51001 is also known as a beneficiary.

D. **Covered Entity** shall have the meaning given to such term under 45 C.F.R. § 160.103.

E. **Data Aggregation** shall have the meaning given to such term under 45 C.F.R. § 164.501.

F. **Designated Record Set** shall have the meaning given to such term 45 C.F.R. § 164.501.

G. **Electronic Protected Health Information** or **EPHI** means Protected Health Information that is maintained in or transmitted by electronic media.

H. **Electronic Health Record** shall have the meaning given to such term under 42 U.S.C. § 17921(5).

I. **Health Care Operations** shall have the meaning given to such term under 45 C.F.R. § 164.501.

J. **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

K. **Protected Health Information** or **PHI** means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under 45 C.F.R. § 160.103. Protected Health Information includes Electronic Protected Health Information.

L. **Protected Information** shall mean PHI provided by CE to BA or created or received by BA on CE's behalf.

M. **Security Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

N. **Subcontractor** shall mean a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate, pursuant to 45 C.F.R. § 160.103.

O. **Unsecured PHI** shall have the meaning given to such term under 42 U.S.C. § 17932(h), 45 C.F.R. § 164.402 and guidance issued pursuant to the HITECH Act including, but not limited to that issued on April 17, 2009 and published in 74 Federal Register 19006 (April 27, 2009), by the Secretary of the U.S. Department of Health and Human Services ("**Secretary**").

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II. Obligations of Business Associate.

A. Permitted Access, Use or Disclosure. BA shall neither permit the unauthorized or unlawful access to, nor use or disclose, PHI other than as permitted or required by the Agreement, this BAA, or as permitted or required by law, including but not limited to the Privacy Rule. To the extent that BA carries out CE's obligations under the Privacy Rule, BA shall comply with the requirements of the Privacy Rule that apply to CE in the performance of such obligations. Except as otherwise limited in the Agreement, this BAA, or the Privacy Rule or Security Rule, BA may access, use, or disclose PHI (i) to perform its services as specified in the Agreement; and (ii) for the proper administration of BA, provided that such access, use, or disclosure would not violate HIPAA, the HITECH Act, the HIPAA Regulations, or applicable state law if done or maintained by CE. If BA discloses Protected Information to a third party, BA must obtain, prior to making any such disclosure, (i) reasonable assurances from such third party that such Protected Information will be held confidential as provided pursuant to this BAA and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and (ii) agreement from such third party to promptly notify BA of any Breaches of confidentiality of the Protected Information, to the extent it has obtained knowledge of such Breach.

B. Prohibited Uses and Disclosures. Notwithstanding any other provision in this BAA, BA shall comply with the following requirements: (i) BA shall not use or disclose Protected Information for fundraising or marketing purposes, except as provided under the Agreement and consistent with the requirements of the HITECH Act, the HIPAA Regulations, and applicable state law, including but not limited to 42 U.S.C. § 17936, 45 C.F.R. § 164.508, and 45 C.F.R. § 164.514(f). (ii) BA shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates, 42 U.S.C. § 17935(a); 45 C.F.R. § 164.522(a); (iii) BA shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. § 17935(d)(2); 45 C.F.R. § 164.502(a)(5); however, this prohibition shall not affect payment by CE to BA for services provided pursuant to the Agreement.

C. Appropriate Safeguards. BA shall comply, where applicable, with the HIPAA Security Rule, including but not limited to 45 C.F.R. §§ 164.308, 164.310, and 164.312 and the policies and procedures and documentation requirements set forth in 45 C.F.R. § 164.316, and shall implement appropriate safeguards designed to prevent the access, use or disclosure of Protected Information other than as permitted by the Agreement or this BAA. BA shall use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of EPHI.

D. Reporting of Improper Access, Use, or Disclosure.

1. Generally. BA shall provide an initial telephone report to CE's Compliance Contact within twenty-four (24) hours of any suspected or actual breach of security, intrusion or unauthorized access, use, or disclosure of PHI of which BA becomes aware and/or any actual or suspected access, use, or disclosure of data in violation of the Agreement, this

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BAA, or any applicable federal or state laws or regulations. BA shall take (i) prompt corrective action to cure any deficiencies in its policies and procedures that may have led to the incident, and (ii) any action pertaining to such unauthorized access, use, or disclosure required of BA by applicable federal and state laws and regulations.

2. **Breaches of Unsecured PHI.** Without limiting the generality of the reporting requirements set forth in Section D(1), BA shall report to CE any use or disclosure of the information not permitted by this BAA, including any Breach of Unsecured PHI pursuant to 45 C.F.R. § 164.410. Following the discovery of any Breach of Unsecured PHI, BA shall notify CE in writing of such Breach without unreasonable delay and in no case later than three (3) days after discovery. The notice shall include the following information if known (or can be reasonably obtained) by BA: (i) contact information for the individuals who were or who may have been impacted by the Breach (*e.g.*, first and last name, mailing address, street address, phone number, email address); (ii) a brief description of the circumstances of the Breach, including the date of the Breach and date of discovery (as defined in 42 U.S.C. § 17932(c)); (iii) a description of the types of Unsecured PHI involved in the Breach (*e.g.*, names, social security numbers, date of birth, addresses, account numbers of any type, disability codes, diagnostic and/or billing codes and similar information); (iv) a brief description of what the BA has done or is doing to investigate the Breach and to mitigate harm to the individuals impacted by the Breach; (v) any other available information that CE is required to include in notification to the individual under 45 C.F.R. § 164.410.

3. **Mitigation.** BA shall establish and maintain safeguards to mitigate, to the extent practicable, any deleterious effects known to BA of any unauthorized or unlawful access or use or disclosure of PHI not authorized by the Agreement, this BAA, or applicable federal or state laws or regulations; provided, however, that such mitigation efforts by BA shall not require BA to bear the costs of notifying individuals impacted by such unauthorized or unlawful access, use, or disclosure of PHI, unless (i) otherwise agreed in writing by the parties, (2) BA bears responsibility for the unauthorized or unlawful access or use or disclosure of PHI, or (3) required by applicable federal or state laws or regulations; provided, further, however, that BA shall remain fully responsible for all aspects of its reporting duties to CE under Section D(1) and Section D(2).

E. Business Associate's Subcontractors and Agents. BA shall ensure that any agents or Subcontractors to whom it provides Protected Information agree to the same restrictions and conditions that apply to BA with respect to such PHI. To the extent that BA creates, maintains, receives or transmits EPHI on behalf of the CE, BA shall ensure that any of BA's agents or Subcontractors to whom it provides Protected Information agree to implement the safeguards required by Section C above with respect to such EPHI.

F. Access to Protected Information. To the extent BA maintains a Designated Record Set on behalf of the CE, BA shall make Protected Information maintained by BA or its agents or Subcontractors in Designated Record Sets available to CE for inspection and copying within ten (10) days of a request by CE to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.524. If BA maintains an Electronic Health Record, BA shall provide such information in electronic format to enable CE to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. § 17935(e).

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G. Amendment of PHI. To the extent BA maintains a Designated Record Set on behalf of CE, within ten (10) days of receipt of a request from the CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA or its agents or Subcontractors shall make PHI available to CE so that CE may make any amendments that CE directs or agrees to in accordance with the Privacy Rule.

H. Accounting Rights. Within ten (10) days of notice by CE of a request for an accounting of disclosures of Protected Information, BA and its agents or Subcontractors shall make available to CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.528, and its obligations under the HITECH Act, including but not limited to 42 U.S.C. § 17935(c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or Subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment, or health care operations purposes are required to be collected and maintained for three (3) years prior to the request, and only to the extent BA maintains an electronic health record and is subject to this requirement. At a minimum, the information collected and maintained shall include, to the extent known to BA: (i) the date of the disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. The accounting must be provided without cost to the individual or the requesting party if it is the first accounting requested by such individual within any twelve (12) month period. For subsequent accountings within a twelve (12) month period, BA may charge the individual or party requesting the accounting a reasonable fee based upon BA's labor costs in responding to the request and a cost-based fee for the production of non-electronic media copies, so long as BA informs the individual or requesting party in advance of the fee and the individual or requesting party is afforded an opportunity to withdraw or modify the request. BA shall notify CE within five (5) business days of receipt of any request by an individual or other requesting party for an accounting of disclosures. The provisions of this Section H shall survive the termination of this BAA.

I. Governmental Access to Records. BA shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to CE and to the Secretary for purposes of determining BA's compliance with the Privacy Rule. BA shall immediately notify CE of any requests made by the Secretary and provide CE with copies of any documents produced in response to such request.

J. Minimum Necessary. BA (and its agents or Subcontractors) shall request, use, and disclose only the minimum amount of Protected Information necessary to accomplish the purpose of the request, use, or disclosure. Because the definition of "minimum necessary" is in flux, BA shall keep itself informed of guidance issued by the Secretary with respect to what constitutes "minimum necessary." Notwithstanding the foregoing, BA must limit its (and its agents or Subcontractors) uses and disclosures of Protected Information to be consistent with CE's minimum necessary policies and procedures as furnished to BA.

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K. Permissible Requests by Covered Entity. CE shall not request BA to use or disclose PHI in any manner that would not be permissible under HIPAA or the HITECH Act if done by CE or BA. CE shall not direct BA to act in a manner that would not be compliant with the Security Rule, the Privacy Rule, or the HITECH Act.

L. Breach Pattern or Practice. If CE knows of a pattern of activity or practice of the BA that constitutes a material breach or violation of BA's obligations under this BAA or other arrangement, CE must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, CE must terminate the applicable Agreement to which the breach and/or violation relates if feasible. If BA knows of a pattern of activity or practice of an agent or Subcontractor that constitutes a material breach or violation of the agent or Subcontractor's obligations under its BAA or other arrangement with BA, BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, BA must terminate the applicable agreement to which the breach and/or violation relates if feasible.

III. Indemnification; Limitation of Liability. To the extent permitted by law, BA shall indemnify, defend and hold harmless CE from any and all liability, claim, lawsuit, injury, loss, expense or damage resulting from or relating to the acts or omissions of BA or its agents, Subcontractors or employees in connection with the representations, duties and obligations of BA under this Agreement. Any limitation of liability contained in the Co shall not apply to the indemnification requirement of this provision. This provision shall survive the termination of this BAA.

IV. Business Associate's Insurance. BA shall obtain insurance for itself and all its employees, agents and independent contractors in an amount not less than One Million Dollars ($1,000,000) per occurrence and Two Million Dollars ($2,000,000) annual aggregate of Commercial General Liability insurance and Two Million Dollars ($2,000,000) per occurrence and Four Million Dollars ($4,000,000) annual aggregate of Errors and Omissions insurance. The Errors and Omissions insurance shall cover, among other things, Breaches. BA shall provide CE with certificates of insurance or other written evidence of the insurance policy or policies required herein prior to execution of this BAA (or as shortly thereafter as is practicable) and as of each annual renewal of such insurance policies during the period of such coverage. Further, in the event of any modification, termination, expiration, non-renewal or cancellation of any of such insurance policies, BA shall give written notice thereof to CE not more than ten (10) days following BA's receipt of such notification. If BA fails to procure, maintain or pay for the insurance required under this section, CE shall have the right, but not the obligation, to obtain such insurance. In such event, BA shall promptly reimburse CE for the cost thereof upon written request, and failure to repay the same upon demand by CE shall constitute a material breach of this BAA.

V. Term and Termination.

A. **Term**. The term of this BAA shall be effective as of the Effective Date and shall terminate when all of the PHI provided by CE to BA, or created or received by BA on behalf of CE, is destroyed or returned to CE.

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B. **Termination.**

1. **Material Breach by BA**. Upon any material breach of this BAA by BA, CE shall provide BA with written notice of such breach and such breach shall be cured by BA within thirty (30) business days of such notice. If such breach is not cured within such time period, CE may immediately terminate this BAA and the applicable Agreement.

2. **Effect of Termination**. Upon termination of any of the agreements comprising the Agreement for any reason, BA shall, if feasible, return or destroy all PHI relating to such agreements that BA or its agents or Subcontractors still maintain in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, BA shall continue to extend the protections of this BAA to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible.

VI. Assistance in Litigation. BA shall make itself and any subcontractors, employees or agents assisting BA in the performance of its obligations under the Agreements or this BAA available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its shareholders, directors, officers, agents or employees based upon a claim of violation of HIPAA, the HITECH Act, or other laws related to security and privacy, except where BA or its subcontractor, employee or agent is named as an adverse party.

VII. Compliance with State Law. Nothing in this BAA shall be construed to require BA to use or disclose Protected Information without a written authorization from an individual who is a subject of the Protected Information, or without written authorization from any other person, where such authorization would be required under state law for such use or disclosure.

VIII. Compliance with 42 C.F.R. Part 2. CE is also subject to the Confidentiality of Alcohol and Drug Abuse Patient Records regulations, 42 C.F.R. Part 2, which requires certain programs to enter into contracts with qualified service organizations (as defined in 42 C.F.R. § 2.11) that may have access to certain patient medical information. BA acknowledges that in receiving, storing, processing, or otherwise dealing with any Records (as defined in 42 C.F.R. Part 2) from CE, BA is fully bound by 42 C.F.R. Part 2. BA agrees to resist in judicial proceedings any efforts to obtain access to patient records except as permitted by 42 C.F.R. Part 2. To the extent any provisions of 42 C.F.R. Part 2 restricting disclosure of Records are more protective of privacy rights than the provisions of this BAA, HIPAA, the HITECH Act, or other applicable laws, 42 C.F.R. Part 2 controls.

IX. Amendment to Comply with Law. Because state and federal laws relating to data security and privacy are rapidly evolving, amendment of the Agreement or this BAA may be required to provide for procedures to ensure compliance with such developments. BA and CE shall take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule and other applicable laws relating to the security or confidentiality of PHI. BA shall provide to CE satisfactory written assurance that BA will adequately safeguard all PHI. Upon the request of either party, the other party shall promptly enter into negotiations concerning the terms of an amendment to this BAA embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act,

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the Privacy Rule, the Security Rule or other applicable laws. CE may terminate the applicable Agreement upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the Agreement or this BAA when requested by CE pursuant to this Section or (ii) BA does not enter into an amendment to the Agreement or this BAA providing assurances regarding the safeguarding of PHI that CE, in its reasonable discretion, deems sufficient to satisfy the standards and requirements of applicable laws, within thirty (30) days following receipt of a written request for such amendment from CE.

X. No Third-Party Beneficiaries. Nothing express or implied in the Agreement or this BAA is intended to confer, nor shall anything herein confer upon any person other than CE, BA and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

XI. Notices. All notices hereunder shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, or deposited with the overnight courier addressed as follows:

If to CE:	Tri-City Mental Health Authority 1717 N. Indian Hill Blvd., Suite B Claremont, CA 91711 Attn: Privacy Officer
If to BA:	Kairos Partners, LLC 164 Carlton Avenue Pasadena, CA 91103 Attn: Jessica Wong, Chief Operations Officer
With a copy to:	Hooper, Lundy & Bookman, P.C. 1875 Century Park East, Suite 1600 Los Angeles, CA 90067 Attn: Hope Levy-Biehl, Esq. Fax: 310-551-8181

or to such other persons or places as either party may from time to time designate by written notice to the other.

XII. Interpretation. The provisions of this BAA shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provision in this BAA. This BAA and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. Any ambiguity in this BAA shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. Except as specifically required to implement the purposes of this BAA, or to the extent inconsistent with this BAA, all other terms of the Agreement shall remain in force and effect.

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XIII. Entire Agreement of the Parties. This BAA supersedes any and all prior and contemporaneous business associate agreements or addenda between the parties and constitutes the final and entire agreement between the parties hereto with respect to the subject matter hereof. Each party to this BAA acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, with respect to the subject matter hereof, have been made by either party, or by anyone acting on behalf of either party, which are not embodied herein. No other agreement, statement or promise, with respect to the subject matter hereof, not contained in this BAA shall be valid or binding.

XIV. Regulatory References. A reference in this BAA to a section of regulations means the section as in effect or as amended, and for which compliance is required.

XV. Counterparts. This BAA may be executed in one or more counterparts, each of which shall be deemed to be an original, and all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the parties hereto have duly executed this BAA as of the BAA Effective Date.

AGREED AND ACCEPTED:

TRI-CITY MENTAL HEALTH AUTHORITY	KAIROS PARTNERS, LLC
Name of Covered Entity	**Name of Business Associate**
Authorized Signature	**Authorized Signature**
Antonette Navarro	Jessica Wong
Print Name	**Print Name**
Executive Director	Chief Operations Officer
Print Title	**Print Title**
Date	**Date**

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EXHIBIT C

CONTRACTOR'S ATTESTATION THAT NEITHER IT NOR ANY OF ITS STAFF MEMBERS ARE RESTRICTED, EXCLUDED OR SUSPENDED FROM PROVIDING GOODS OR SERVICES UNDER ANY FEDERAL OR STATE HEALTH CARE PROGRAM

KAIROS PARTNERS, LLC

____
Contractor's Name Last First

Contractor hereby warrants that neither it nor any of its staff members is restricted, excluded, or suspended from providing goods or services under any health care program funded by the Federal or State Government, directly or indirectly, in whole or in part, and the Contractor will notify the Tri-City Mental Health Authority (TCMHA) within thirty (30) days in writing of: 1) any event that would require Contractor or a staff member's mandatory exclusion or suspension from participation in a Federal or State funded health care program; and 2) any exclusionary action taken by any agency of the Federal or State Government against Contractor or one or more staff members barring it or the staff members from participation in a Federal or State funded health care program, whether such bar is direct or indirect, or whether such bar is in whole or in part.

Contractor shall indemnify and hold TCMHA harmless against any and all loss or damage Contractor may suffer arising from the Federal or State exclusion or suspension of Contractor or its staff members from such participation in a Federal or State funded health care program.

Failure by Contractor to meet the requirements of this paragraph shall constitute a material breach of contract upon which TCMHA may immediately terminate or suspend this Agreement.

Is Contractor/Proposer/Vendor or any of its staff members currently barred from participation in any Federal or State funded health care program?

_____ **NO**, Contractor or any of its staff members is not currently barred from participation in any Federal or State funded health care program.

_____ **YES**, Contractor or any of its staff members is currently barred from participation in any Federal or State funded health care program. Describe the particulars on a separate page.

Date	Jessica Wong, Chief Operations Officer Contractor or Vendor's Name	Contractor or Vendor's Signature
Date	Antonette Navarro, Executive Director TCMHA Executive Official's Name	TCMHA Executive Official's Signature

<u>DISTRIBUTION</u>:

ORIGINAL
COPIES: HR Representative
Contractor
Finance

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Tri-City Mental Health Authority
AGENDA REPORT

DATE: **June 16, 2021**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Toni Navarro, LMFT, Executive Director**

BY: **Rimmi Hundal, Director of MHSA and Ethnic Services**
Dana Barford, MHSA Projects Manager

SUBJECT: **Consideration of Resolution No. 591 Adopting the Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2021-22 as Recommended by TCMHA Mental Health Commission**

Summary

The Welfare and Institutions Code Section (WIC) 5847 states that county mental health programs shall prepare and submit a Three Year Program and Expenditure Plan followed by Annual Updates for all Mental Health Services Act (MHSA) programs and expenditures. The MHSA Projects Manager presented an overview of the (MHSA) Annual Update for FY 2021-22 for the Tri-City Mental Health Commission during the Public Hearing held on June 8, 2021. This plan was endorsed by the Commission and is now presented to the Governing Board for approval and adoption.

Background

This MHSA Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2021-22 was posted on May 7, 2021, and the required minimum 30-day review process ended on June 8, 2021. Staff circulated a draft of the Annual Update by making electronic copies available on TCMHA's website. Several methods of collecting feedback were available such as phone, fax, email, mail, and comment cards. All comments received regarding this plan were shared during the Public Hearing held on June 8, 2021.

Stakeholder involvement is a critical component to the decade-long success of the MHSA process for Tri-City and staff continue to value and empower them throughout the community planning process. In preparation of this Annual Update, community members were invited to participate in stakeholder meetings and workgroups focusing on reviewing current MHSA programming and identifying possible gaps in service.

During the MHSA Public Hearing, attendees were presented with any stakeholder feedback which is included in this plan. The Mental Health Commission endorsed the (MHSA) Annual Update for Fiscal Year 2021-22 at that time.

Fiscal Impact

The Agency has funds available under MHSA to support the (MHSA) Annual Update for Fiscal Year 2021-22.

Recommendation

Staff recommends that the Governing Board adopt Resolution No. 591 approving the Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2021-22.

Attachments

Attachment 9-A: Resolution No. 591 - DRAFT

Attachment 9-B: MHSA (MHSA) Annual Update for Fiscal Year 2021-22.

RESOLUTION NO. 591

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY ADOPTING ITS MENTAL HEALTH SERVICES ACT (MHSA) ANNUAL UPDATE FOR FY 2021-22

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("TCMHA") wishes to adopt the Authority's Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2021-22, as recommended by the Authority's Mental Health Commission.

B. The Welfare and Institutions Code Section (WIC) 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan followed by Annual Updates for all Mental Health Services Act (MHSA) programs and expenditures.

C. The MHSA Annual Update was developed through a Community Planning Process wherein stakeholders and community members participate in reviewing and recommending programming and services.

2. Action

A. The Governing Board approves the Authority's MHSA Annual Update for Fiscal Year 2021-22; and authorizes the Executive Director, or designee, to prepare and submit any and all reports related thereto.

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on June 16, 2021, by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

____
ROBIN CARDER, CHAIR

APPROVED AS TO FORM:
DAROLD PIEPER, GENERAL COUNSEL

By:______________________________

ATTEST:
MICAELA P. OLMOS, RECORDING SECRETARY

By:______________________________

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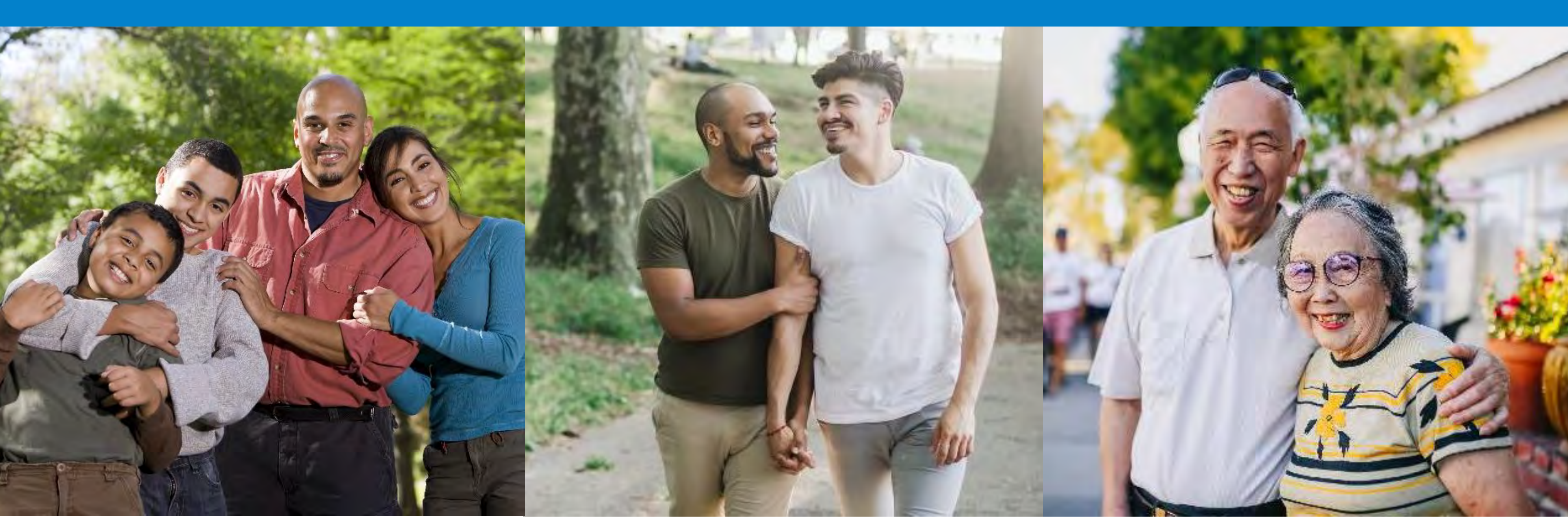
MENTAL HEALTH SERVICES ACT (MHSA)

ANNUAL UPDATE

Annual Update FY 2021-22



ATTACHMENT 9-B

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County: TRI-CITY MENTAL HEALTH AUTHORITY

Local Mental Health Director Name: TONI (ANTONETTE) NAVARRO Telephone Number: (909) 623-6131 E-mail: anavarro@tricitymhs.org	**Program Lead** Name: RIMMI HUNDAL Telephone Number: (909) 784-3016 E-mail: rhundal@tricitymhs.org
County Mental Health Mailing Address: 1717 N. Indian Hill Boulevard Suite B, Claremont, CA 91711	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three- Year Program and Expenditure Plan or Annual Update, including stakeholder participation and non-supplantation requirements.

This MHSA Annual Update Plan has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft MHSA Annual Update Plan was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The Annual Update FY 2021-22 and Expenditure Plan, attached hereto, was adopted by the Tri-City Governing Board on June 16, 2021.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached Annual Update FY 2021-22 and Expenditure Plan are true and correct.

DRAFT

Toni (Antonette) Navarro

Local Mental Health Director/Designee (PRINT)
County: TRI-CITY MENTAL HEALTH AUTHORITY

Signature

Date

MHSA County Fiscal Accountability Certification

County/City: TRI-CITY MENTAL HEALTH AUTHORITY

___ Three-Year Program and Expenditure Plan _X_ Annual Update ___ Annual Revenue and Expenditure Report

Local Mental Health Director Name: TONI (ANTONETTE) NAVARRO Telephone Number: (909) 623-6131 E-mail: anavarro@tricitymhs.org	**County Auditor-Controller/ City Financial Officer** Name: DIANA ACOSTA Telephone Number: (909) 451-6434 E-mail: dacosta@tricitymhs.org
Local Mental Health Mailing Address: 1717 N. Indian Hill Boulevard Suite B, Claremont, CA 91711	

I hereby certify that the MHSA Annual Update Plan FY 2021-22 is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Toni (Antonette) Navarro

Local Mental Health Director/Designee	Signature	Date

I hereby certify that for the fiscal year ended June 30, 2020, the County/City has maintained an interest- bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated October 19, 2020 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund. I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Diana Acosta

County Auditor Controller/ City Financial Officer	Signature	Date

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Executive Summary

Since 1960, Tri-City Mental Health Authority has served as the mental health provider for the Tri-City area. Through a Joint Powers Authority, TCMHA serves in a “county” capacity for the purposes of delivering quality mental health services for the cities of Claremont, La Verne, and Pomona with a combined population which exceeds 220,000.

In FY 2019-20, TCMHA served approximately 2,823 unduplicated clients who were enrolled in formal services. TCMHA currently has 1 9 0 full-time and 2 0 part-time employees and an annual operating budget of 28.1 million dollars. TCMHA strives to reflect the diversity of its communities through it hiring, language spoken, and cultural competencies.

MHSA Community Planning Process

Stakeholder engagement has always been an important component of the community planning process. Input and feedback from community members are critical to help shape the direction and planning for future MHSA programing. Historically, stakeholders are invited to attend community meetings three to four times a year where they are provided with updates related to MHSA programs, new funding and current and future legislation.

Since the onset of COVID-19, community gatherings are prohibited which makes frequent communication with stakeholders even more critical to ensure they are aware of resources and support services that are available to them and the community at large. Stakeholder meetings and workgroups were transitioned to a virtual platform in addition to emails sent with links to online trainings and virtual webinars as well as service updates.

In preparation for this Annual Update for FY 2021-22, the following virtual stakeholder events were convened:

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MHSA Event	Total Number
Community Planning Process Survey	1
Stakeholder Meetings	3
MHSA Workgroups	5
Public Hearing	1

MHSA Plans and Funding Components

Passed by California voters in November 2004, Proposition 63, also known as the Mental Health Services Act (MHSA), created a dedicated 1% increase in income taxes on personal income over $1 million to be used for community mental health services.

The following chart reflects the distribution of MHSA funding among the five plans implemented by Tri- City Mental Health. Community Service and Supports (CSS), Prevention and Early Intervention (PEI), and Innovation plans (INN) have specific percentages. Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CFTN) are one-time funds allocated at the

time of plan development. However, both WET and CFTN plans are eligible to receive additional funds through transfers from unspent CSS plan funds, which receives the largest allotment of MHSA funds. However, certain criteria and requirements apply.

MHSA Plan	MHSA Funding Allocation
Community Services and Supports	76%
Prevention and Early Intervention	19%
Innovation	5%
Workforce Education and Training	One-time funds eligible for transfer funds from CSS Plan
Capital Facilities and Technological Needs	One-time funds eligible for transfer funds from CSS Plan

MHSA Plans and COVID–19 Pandemic

In March of 2020, Tri-City Mental Health began to experience the prelude to the COVID-19 pandemic. By the end of March, it became clear that the outbreak of COVID-19 would dramatically change the course and method of how mental health services would be delivered in the cities of Claremont, La Verne and Pomona.

For MHSA programs, service delivery meant discontinuing in-person stakeholder meetings, Wellness Center support groups, and community trainings. These were replaced with a "virtual approach" where TC staff were quickly trained and equipped to transition to online "zoom" meetings hosted on a RingCentral platform. Equipping staff and departments with the needed technology to provide this level of tele-health and tele-training, became a high priority for Tri-City.

As a result, the outcomes and participation rates for the MHSA programs were greatly impacted. Programs that rely heavily on face-to-face communication and engagement experienced a decline in attendance and participation during the last several months of FY 2019-20. This reduction is reflected in many of the MHSA program outcomes and participate numbers indicated below. Conversely, community embedded programs such as the Intensive Outreach and Engagement Team, experienced an increase in contacts due to their continued presence outside of the Agency and acting as one of the first points of contact for individuals in the community seeking crisis services.

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Community Service and Supports (CSS)

Community Service and Supports (CSS) plan provides funding to support direct services for individuals with severe mental illness. The CSS plan receives 76% of the total MHSA funding allocation with a minimum of 51% of this funding going to Full Service Partnership (FSP).

Program Name	Notable Changes FY 2019-20
Full Service Partnerships	The number of individuals served increased from 581 in FY 2018-19 to 636 in FY 2019-20.
Community Navigators	The number of individuals served decreased from 2,082 in FY 2018-19 to 1,578 in FY 2019-20.
Wellness Center	Individuals served has decreased from 2,2,64 in FY 2018-19 to 1,703 in FY 2019-20.
Supplemental Crisis Services / Intensive Outreach and Engagement Team	The number of supplemental crisis calls received decreased from 125 in FY 2018-19 to 115 in FY 2019-20. However, the number of individuals served by IOET increased from 674 in FY 2018-19 to 979 in FY 2019-20.
Field Capable Clinical Services for Older Adults	The number of unique individuals served decreased from 34 in FY 2018-19 to 26 in FY 2019-20.
Permanent Supportive Housing	Increased efforts were made to provide additional support in helping individuals maintain their housing. There was an increased from 75 in FY 2018-19 to 113 in FY 2019-20.

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Prevention and Early Intervention (PEI)

This plan provides funding to help recognize the early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination. The PEI plan receives 19% of the total MHSA funding allocation with a minimum of 51% allotted for programs focused on ages 0-25.

Program Name	Notable Changes FY 2019-20
Community Wellbeing Program	The number of community members represented from grantee communities increased from 2,087 in FY 2018-19 to 2,941 in FY 2019-20.
Community Mental Health Trainings	Number of individuals trained in community mental health increased from 330 in in FY 18-19 to 940 in FY 19-20. Number of community mental health trainings increased from 21 in FY 2018- 19 to 54 trainings in FY 2019-20.
Stigma Reduction and Suicide Prevention	The number of stigma reduction presentations decreased from 24 in FY 2018-19 to 15 in FY 2019-20.
TAY and Older Adult Wellbeing: Peer Mentor Program	The number of active peer mentors has remained constant from FY 2018-19 to FY 2019-20. Number of unique participants increased from 235 in FY 2018-19 to 335 in FY 2019-20.
Family Wellbeing Program	The number of unique individuals served increased from 1,230 in FY 2018-19 to 1,287 in FY 2019-20.
NAMI Ending the Silence	The number of presentations has remained constant the last two years. The number of attendees has increased from 94 in FY 2018-19 to 346 in FY 2019-20.
Housing Stability Program	The number of new landlord contacts decreased from 32 in FY 2018-19 to 22 in FY 2019-20. The number of landlord luncheons decreased from 14 in FY 2018-19 to 9 in FY 2019-20.
Therapeutic Community Gardening	The number of unique TCG individuals decreased from 164 in FY 2018-19 to 82 in FY 2019-20. The number of groups held decreased from 299 in FY 2018-19 to 225 in FY 2019-20. Also, Individuals attending groups decreased from 1,027 in FY 2018-19 to 543 in FY 2019-20.
Early Psychosis Program	The PIER and UCLA trainings scheduled for spring of 2020 were delayed until the fall of 2020 due to the pandemic. The trainings will now be virtual.
Wellness Center PEI Programs (TAY and Older Adults)	The number of unique individuals served increased from 419 in FY 2018-19 to 741 in FY 2019-20.

Please see individual summaries for detailed information regarding each of these programs.

Innovation (INN)

The Innovation Plan provides funding for short-term projects - one to five years - that explore novel efforts to strengthen aspects of the mental health system. Five percent of MHSA funding received by Counties is allotted for Innovation programing.

Program Name	Notable Changes FY 2019-20
Help@Hand/Tech Suite Project	The original Tech Suite proposal targeted older adults, TAY, and monolingual speakers. Since the onset of the pandemic, this project will expand to encompass other populations that may have been severely impacted by COVID-19.

Workforce Education and Training (WET)

The Workforce Education and Training (WET) program focuses on improving the effectiveness of people currently providing support and services in the Tri-City area as well as preparing the community for careers in mental health. Clinical and non-clinical staff, family, community caregivers and volunteers are the primary recipients of the education and training offered through the WET Plan. The WET plan received a one-time allocation of funds when originally approved, but retains the option of receiving additional monies through a transfer of unspent funds from the Community Services and Supports Plans with stakeholder approval.

Program Name	Changes observed in FY 2019-20
Staff Trainings	Number of courses completed by staff through Relias increased from 1,012 in FY 2018-19 to 2,059 in FY 2019-20.
Service Learners [i.e. Volunteers]	The number of applicants who became Service Learners decreased from 39 in FY 18-19 to 21 in FY 2019-20. Service Learner hours decreased from 4,181 in FY 18-19 to 2,232 in FY 19-20.

Capital Facilities and Technological Needs (CFTN)

Capital Facilities and Technological Needs provides funding for building projects, improving the infrastructure of mental health providers, and increasing technological capacity to improve the delivery of mental health services. The CFTN plan received a one-time allocation of funds when originally approved, but retains the option of receiving additional monies through a transfer of unspent funds from the Community Services and Supports Plans with stakeholder approval.

Program Name	Changes observed in FY 2019-20
Capital Facilities and Technological Needs	In March 2020, Tri-City's Governing Board approved the expenditure of CFTN funds in the amount of $970,968.00 to make improvements for two TCMH locations: MHSA Administration Office and the Therapeutic Community Garden. Work will begin in FY 2020-21.

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Tri-City's Annual Update FY 2021-22 to the Three-Year Revenue and Expenditure Plan for FY 2020-21 through FY 2022-23, was posted for a 30-day public review and comment period from May 7, 2021 to June 8, 2021. The MHSA Public Hearing will be held on June 8, 2021 and hosted by Tri-City's Mental Health Commission. At that time, the Mental Health Commission will recommend approval of the MHSA Annual Update FY 2021-22 to the Tri-City Governing Board. The Tri-City Governing Board is scheduled to act on this recommendation and adopt the MHSA Annual Update FY 2021-22 on June 16, 2021.

Introduction to Tri-City Mental Health Authority

Tri-City Mental Health Authority has been the leading mental health provider and authority for the cities of Claremont, La Verne, and Pomona since 1960. Through a Joint Powers Authority, Tri-City celebrates 60 years as the main gateway to quality mental health services and support. With a combined population which exceeds 220,000, these three cities are considered integrated into a single "county" while demonstrating distinct differences within each city.

Total Population by City				
	La Verne	Claremont	Pomona	Tri-City Area
Total population	35, 614	36,561	157,298	**229,473**
Source: United Way 2007 Zip Code Data Book San Gabriel Valley				

The following tables indicate the total population by age group and ethnicity:

Total Population by Age Group					
City: / **Age group:**	**La Verne**	**Claremont**	**Pomona**	**Tri-City Area**	**% by age**
0-15	7,524	6,191	46,910	60,625	26.42%
16-25	4,734	4,854	21,884	21,472	13.71%
26-59	16,124	17,341	68,084	101,549	44.25%
60+	7,232	8,175	20,420	35,827	15.61%
Totals	**35,614**	**36,561**	**157,298**	**229,473**	**100.00%**
Source: United Way 2007 Zip Code Data Book San Gabriel Valley + extrapolation					

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Total Population by Ethnicity					
City: / Ethnicity:	La Verne	Claremont	Pomona	Tri-City Area	% by ethnicity
African American	1,155	1,774	11,735	14,664	6.39%
Asian Pacific Islander	2,474	4,479	10,634	17,587	7.66%
Hispanic/Latinx	8,790	6,338	111,330	125,458	54.67%
Native American	156	94	634	884	0.39%
White	22,243	22,886	21,882	66,951	29.18%
Other	46	93	149	288	0.13%
Two or more races	750	897	1,994	3,641	1.58%
Totals	**35,614**	**36,561**	**157,298**	**229,473**	**100.00%**

Source: United Way 2007 Zip Code Data Book San Gabriel Valley

Claremont is located 30 miles east of downtown Los Angeles in the Pomona Valley, at the foot of the San Gabriel Mountains and is home to the Claremont Colleges, tree-line streets and numerous historic building. Located to the west of Claremont is the city of La Verne. Originally named Lordsburg, La Verne was known as the “Heart of the Orange Empire” due to the flourishing citrus trees which dominated the area until World War II. The largest city to make up the tri-city area is Pomona, which is located just south of the city of La Verne. Pomona is home to California State Polytechnic University, Pomona (Cal Poly Pomona) and the site of the Fairplex, which hosts the Los Angeles County Fair. The tri-city area is also home to seven colleges and universities.

The following table reflects the current demographics for the combined cities of Claremont, La Verne, and Pomona:

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Selected Data for Tri-City (Pomona, Claremont, La Verne) U.S. Census Data	Tri-City (Pomona, Claremont, La Verne)
Population	
Population estimates, July 1, 2019, (V2019)	219,931
Population estimates base, April 1, 2010, (V2019)	215,035
Population, percent change - April 1, 2010 (estimates base) to July 1, 2019, (V2019)	2.3%
Population, Census, April 1, 2010	215,047
Age and Sex	
Persons under 5 years, percent	6.8%
Persons under 18 years, percent	23.8%
Persons 65 years and over, percent	12.9%
Female persons, percent	51.2%
Race and Hispanic Origin	
White alone, percent	56.2%
Black or African American alone, percent	5.5%
American Indian and Alaska Native alone, percent	1.6%
Asian alone, percent	10.6%
Native Hawaiian and Other Pacific Islander alone, percent	0.1%
Two or More Races, percent	4.8%
Hispanic or Latinx, percent	58.8%
White alone, not Hispanic or Latinx, percent	23.0%
Population Characteristics	
Veterans, 2014-2018	6769
Foreign born persons, percent, 2014-2018	29.0%
Housing	
Owner-occupied housing unit rate, 2014-2018	57.5%
Median value of owner-occupied housing units, 2014-2018	$525,033
Median selected monthly owner costs -with a mortgage, 2014-2018	$2,350
Median selected monthly owner costs -without a mortgage, 2014-2018	$579
Median gross rent, 2014-2018	$1,450
Families and Living Arrangements	
Households, 2014-2018	62,200
Persons per household, 2014-2018	3.54
Living in same house 1 year ago, percent of persons age 1 year+, 2014-2018	86.0%
Language other than English spoken at home, percent of persons age 5 years+, 2014-2018	53.9%
Computer and Internet Use	
Households with a computer, percent, 2014-2018	92.2%
Households with a broadband Internet subscription, percent, 2014-2018	84.8%
Education	
High school graduate or higher, percent of persons age 25 years+, 2014-2018	60.8%
Bachelor's degree or higher, percent of persons age 25 years+, 2014-2018	26.9%

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Health	
With a disability, under age 65 years, percent, 2014-2018	7.0%
Persons without health insurance, under age 65 years, percent	11.9%
Economy	
In civilian labor force, total, percent of population age 16 years+, 2014-2018	62.2%
In civilian labor force, female, percent of population age 16 years+, 2014-2018	55.4%
Total accommodation and food services sales, 2012 ($1,000)	108,300
Total health care and social assistance receipts/revenue, 2012 ($1,000)	501,808
Total manufacturers' shipments, 2012 ($1,000)	436,916
Total merchant wholesaler sales, 2012 ($1,000)	891,550

To ensure that our workforce demographics are comparable to those of our client demographics, Tri-City's current workforce represents a culturally diverse reflection of the community we serve. With regard to recruitment and selection, Tri-City's Human Resources Department actively seeks out recruitment advertisement opportunities with a variety of culturally specific organizations and associations and advertises with and participates in employment fairs.

Hiring bicultural and bilingual staff that reflect the populations with disparities

The following chart reflects a comparison between Tri-City staff and the demographics of the cities we serve. The Hispanic/Latinx, Black/African American and Native Hawaiian/Pacific Islander populations are successfully represented by Tri-City staff while the Asian and Native American/Alaska Native continue to be a focus for recruitment.

Average Demographic for Cities of Claremont, La Verne and Pomona	
White	29.18%
Hispanic/Latinx	54.67%
Asian	7.66%
Black/African American	6.39%
Native American/Alaska Native	0.39%
Native Hawaiian/Pacific Islander	0.33%
Other	1.3%
Two or More Races	1.58%

Average Demographics for Tri-City Mental Health Staff	
White	16.35%
Hispanic/Latinx	54.33%
Asian	8.17%
Black/African American	9.62%
Native American/Alaska Native	0.48%
Native Hawaiian/Pacific Islander	0.48%
Other	9.62%
Two or More Races	0.96%

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Mental Health Services Act

Passed by California voters in November 2004, Proposition 63, also known as the Mental Health Services Act (MHSA), created a dedicated 1% increase in income taxes on personal income over $1 million to be used for community mental health services. These new tax revenues were the first expansion of funding for mental health services in many years.

To access these funds, local mental health systems like Tri-City Mental Health Authority are required to engage a broad range of stakeholders and prepare five substantive plans:

Community Service and Supports (CSS)
(CSS approved in 2009) This plan provides intensive treatment and transition services for people who experience serious and persistent mental illness or severe emotional disturbances or who are at risk of SMI/SED.

Prevention and Early Intervention (PEI)
(PEI approved in 2010) These programs focus on early intervention and prevention services in addition to anti-stigma efforts.

Workforce Education and Training (WET)
(WET approved in 2012) The WET efforts focus on strengthening and supporting existing staff and caregivers through trainings while also focusing on attracting new staff and volunteers to ensure future mental health personnel.

Innovation (INN)
(INN approved in 2012) Innovation consists of short–term projects, one to five years, that explore novel efforts to strengthen aspects of the mental health system.

Capital Facilities and Technological Needs (CFTN)
(CFTN approved in 2013) This plan focuses on improvements to facilities, infrastructure and technology of the local mental health system

MHSA funds allocated to counties, including Tri-City Mental Health, are distributed among the five MHSA plans based on the following percentages:

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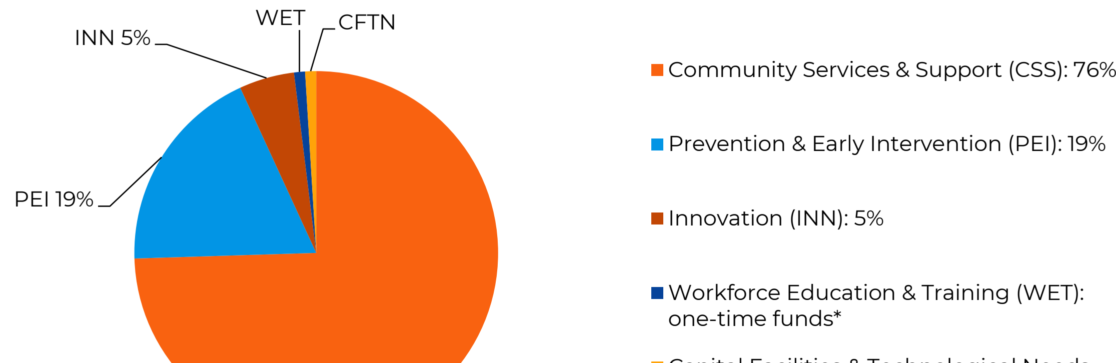
MHSA Funding Allocations



Community Planning Process

The Mental Health Services Act (MHSA) emphasizes and requires counties to implement a robust stakeholder process known as the Community Planning Process. This practice focuses on engaging a large sample of community members and professionals who provide input and actively participate in the creation of programs designed to meet the needs of the unserved and underserved populations of each county.

By fostering diverse stakeholder involvement, Tri-City Mental Health continues to value and empower these participants throughout the community planning process. Our stakeholders consist of a combination of "seasoned veterans" who have actively participated in this process since 2008 and are well versed in the history and the trends of our MHSA process. In addition, new stakeholders are recruited annually to provide a fresh perspective to this critical process.

In March of 2020, it became clear that the outbreak of the COVID -19 pandemic would dramatically change the course and method of how mental health services and stakeholder meetings would be conducted within the cities of Claremont, La Verne and Pomona. Beginning in April 2020, Tri-City launched our stakeholder meetings and workgroups virtually in response to COVID-19 restrictions. This change resulted in a reduction in participation due to a variety of issues including lack of technology or knowledge of use on the part of stakeholders, in addition to difficulty in reaching participants through emails or phone. Previous outreach efforts included in-person announcements at community meetings and distribution of flyers at local agencies, libraries, community centers and city government locations. With the widespread closures of these critical community sites, notification of stakeholder meetings was limited to email distribution lists, website posting and social media.

The following categories of stakeholders and community members were included in the community planning notifications: consumers and individuals with lived experience, local community providers; leaders of community groups in unserved and underserved communities; old adults, adults, transition age youth and families with children; representatives from the three cities of Claremont, La Verne and Pomona as well as local school districts, colleges and universities; veterans; law enforcement, primary health care providers; mental health, physical health and drug and alcohol treatment providers; faith- based community representatives; representatives from the LGBTQ community; and many others. Stakeholders participate in all aspects of the Mental Health Services Act, including policy development, planning, implementation, monitoring, improvement, evaluation, and budget allocations.

Prior to the COVID-19 pandemic, Tri-City held two identical in-person stakeholder meetings-one in the morning and one in the evening- to accommodate participant's schedules. Spanish interpreters were available for each meeting. When the community planning process began in the fall of 2020, the first virtual Stakeholder Meeting and MHSA Orientation for FY 2020-21, was held on Wednesday, September 30 with 41 participants. Of those in attendance; 40% were new stakeholders and 32% have been a part of Tri-City's stakeholder process for over 3 years. The presentation focused on providing both new and existing stakeholders with an overview of the Mental Health Services Act (MHSA) as well as a description of current MHSA programs. Following the comprehensive presentation, 100% of stakeholders polled indicated they support Tri-City's current MHSA programs as stated or agreed with the majority of the programs.

The first of the MHSA workgroups began on October 15, 2020 and focused on reviewing the Community Service and Support (CSS) and Prevention and Early Intervention (PEI) programs in

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greater detail. Workgroups for the review and creation of new Innovation projects began in January 2021. The following chart reflects the MHSA community meeting schedule for FY 2020-21.

Community Planning Process FY 2020-21

Community Event	Dates	Topics
Stakeholder Meetings	09/30/2020	MHSA Orientation and Community Planning Process
CSS Workgroups	10/15/2020	Review of Community Services and Supports Programs
PEI Workgroups	10/15/2020	Review of Prevention and Early Intervention Programs
INN Workgroup	01/21/2021 02/4/2021 02/11/2021	Review of current Innovation (INN) project, Help@Hand, and new Innovation project proposals
INN Focus Group	02/16/2021 02/18/2021 02/11/2021	Focus group participants reviewed applications for Help@Hand INN Project
Stakeholder Meeting	03/04/2021	Stakeholders reviewed the new Innovation project, *Restorative Practices for Improving Mental Health (RPIMH)*, recommendations and new projects
Stakeholder Meeting	04/08/2021	Stakeholders reviewed the new Capital Facilities and Technological Needs (CFTN) plan, addition to NAMI Program, and overview of FY 2021-22 Annual Update
Draft Innovation Project – RPIMH	04/09/2021	Posted for 30-Day Comment Period
Draft CFTN Plan	04/09/2021	Posted for 30-Day Comment Period
Draft FY 2021-22 Annual Update	05/07/2021	Posted for 30-Day Comment Period
INN Project RPIMH and CFTN Plan	05/19/2021	Presented to the Mental Health Commission and Governing Board for approval
MHSA Public Hearing	06/08/2021	Hosted by the Mental Health Commission - Annual Update FY 2021-22 Review
Governing Board	06/16/2021	Governing Board will vote to adopt the Annual Update FY 2021-22

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MHSA Community Planning Survey

Following the September 2020 stakeholder meeting, participants were emailed and encouraged to complete Tri-City's MHSA Planning Process Survey to share their thoughts and concerns regarding the availability of support services. This annual community planning survey is used to identify the

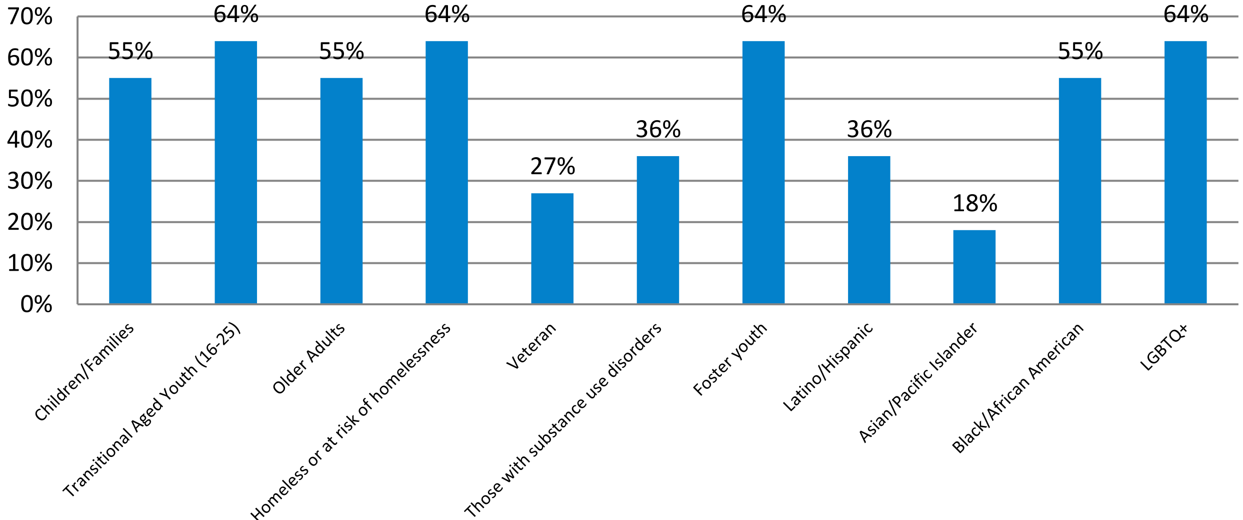
needs and priorities of the three cities. These results are then presented to workgroups who review current MHSA programing and make recommendations for staff consideration. Survey results were then shared with community stakeholders during the stakeholder workgroup and incorporated into this MHSA Annual Update for FY 2021-22. This survey is just one of many opportunities where stakeholders are able to share their voice regarding the needs of the communities.

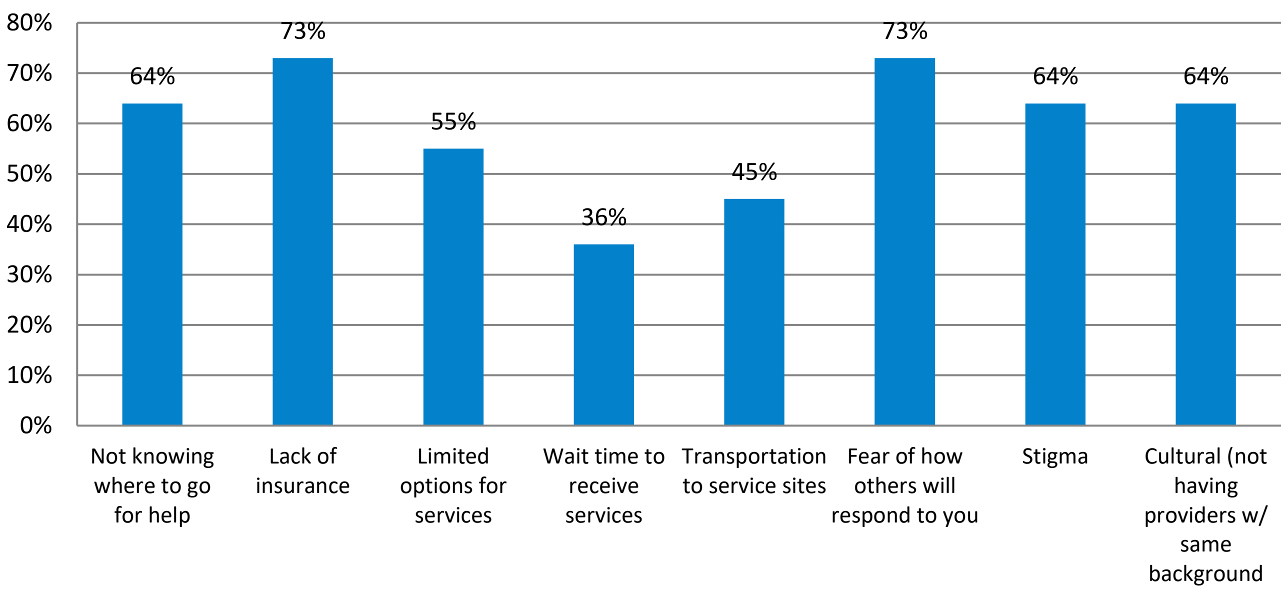
Survey Results

As a result of the COVID -19 pandemic, there was a reduction in the number of surveys completed. The survey included questions regarding the needs of the community, perceived barriers to services and suggestions or recommendations for future services or programs that may not currently be offered. Survey results identify the top priority populations as Transition Age Youth, Homeless, Foster Youth and LGBTQ+. The most popular concerns related to barriers to services were lack of insurance and stigma.

Complete survey results are included in the Appendix.

Indicate the population(s) you feel is most unserved/underserved in the above mentioned communities. (Check all that apply.)





30-Day Public Comment Period and Public Hearing

Tri-City Mental Health's Annual Update FY 2021-22 to the Three-Year Program and Expenditure Plan for FY 2020-21 through FY 2022-23 provides a comprehensive overview of the MHSA projects and programs funded through the Mental Health Services Act, based on data collected during FY 2019-20. The draft of this Annual Update was posted on May 7, 2021 for a 30-day public comment period. Staff circulated a draft of the Annual Update by making electronic copies available on TCMH 's website and providing printed copies at various public locations, where possible, following COVID-19 guidelines. Several methods of collecting feedback were available including phone, fax, email, mail, and comment cards. Questions received during the 30-day public comment period will be addressed in detail during the Public Hearing hosted by Tri-City's Mental Health Commission scheduled for June 8, 2021.

At that time, the Mental Health Commission will review and recommend approval of the MHSA Annual Update FY 2021-22 to the Tri-City Governing Board. The Tri-City Governing Board is scheduled to act on this recommendation and adopt the MHSA Annual Update FY 2021-22 on June 16, 2021.

MHSA Workgroup Recommendations

During the recent MHSA workgroup deliberations, participants were invited to review the current Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) projects and identify gaps in services as well as recommendations for general improvements and/or potential new projects to be funded through CSS dollars and/or PEI budgets. In addition, a community workgroup was convened to review both current and potential Innovation project concepts for future implementation.

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The stakeholders endorsed the proposed recommendations which are included in this MHSA Annual Update and Expenditure Plan. Based on feedback provided by these participants, the following is a brief summary of the recommendations made and endorsed through the stakeholder process:

Community Services and Supports (CSS) – This plan provides funding to support direct services for individuals with severe mental illness.

Full-Service Partnership (FSP)

Full-Service Partnerships are for individuals who experience severe mental illness and are at risk of homelessness or other devastating consequences. The program uses a "whatever it takes" approach to help people recover. The plan can include all needed services, including but not limited to traditional mental health services and safe housing. Recommendations include:

- Continue the FSP programs as stated
- Increase partnering with community resources to identify housing opportunities
- Continuing to work with internal and external medication services team to connect individuals to appropriate medical resources (in-home services, medical case management and skilled nursing)
- Maintain trainings designed to engage consumers effectively through Tele-Health

Community Navigators (CN)

Community Navigators assist individuals in the Tri-City area connect to local resources, including informal community supports and available formal services. Navigators also provide education and stigma reduction services to local communities and organizations.

- Continue the Community Navigator programing as stated
- Maintain recommended COVID-19 safety guidelines
- Meet with individuals in the community or local facilities utilizing personal protection equipment (PPE)
- Utilize technology (mobile phones and laptops) to research and access resources and support services as requested by community members

Wellness Center (WC)

The Wellness Center is a community hub for activities that promote recovery, resiliency and wellness for residents of the Tri-City area. The Wellness Center is open to people of all ages, focusing especially on people in recovery and their families. The Wellness Center sponsors support groups, and provides an array of holistic services through collaboration with other community partners.

- Continue Wellness Center programing as stated
- Continue to follow recommend COVID-19 safety guidelines
- The Center anticipates opening up at 25% capacity once the state and county approves the re- opening of indoor spaces

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Supplemental Crisis Services | Intensive Outreach and Engagement Team (SCS and IOET)

The Supplemental Crisis Services program provides after-hours and weekend phone support to individuals who are experiencing a crisis and who currently are not receiving TCMH services. Crisis walk-in services are also available during business hour at Tri-City's clinic location. The Intensive Outreach and Engagement Team (IOET) serves as the conduit to individuals who are unable to access mental health services on their own. The IOET also connects with individuals upon discharge from local emergency rooms to reassess them for longer term treatment and services, as needed.

- Continue Supplemental Crisis Services/Intensive Outreach and Engagement Team programs as stated
- Strive to remove barriers by adapting the environment while adhering to the polices set forth by elected officials and the agency as far as safety is concerned
- Develop PACT-Psychiatric Assessment Care Team to include a Licensed Psychiatric Technician and a Licensed Therapist to Communicate, Collaborate and Coordinate real time assessment services in the City of Claremont

Field Capable Clinical Services for Older Adults (FCCS)

Through this program, TCMH staff members provide mental health services to older adults where they are, such as in their homes, senior centers, and medical facilities.

- Continue Field Capable Clinical Services for Older Adults program as stated
- Attend elder-based trainings on integrated care
- Seek alternative ways (phone, video conferencing) to outreach to elder-based community programs

Permanent Supportive Housing (PSH)

Permanent supportive housing units are short-term living spaces where people who are homeless or at risk of homelessness, and who suffer from one or more mental illnesses, can receive an array of services designed to support their recovery.

- Continue Permanent Supportive Housing program as stated
- Create new groups that can be conducted over the phone
- Focus on providing tenants with groups for entertainment, resources, community connection within their sites, and a place for parents to share tips for their new role as teacher assistants
- Continue the Supportive Options and Referral groups to be conducted over the phone

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Prevention and Early Intervention (PEI) – This plan provides funding to help recognize the early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination.

Community Wellbeing Program (CWB)

This program provides small grants and technical assistance to help communities build their capacity to strengthen the wellbeing of their members and the community as a whole.

- Continue the Community Wellbeing Program as stated
- Maintain programing virtually through RingCentral
- Offer fillable forms to make it easier for grantees to sign, complete and submit forms
- Focus outreach efforts through emails, phone calls and social media

Community Mental Health Trainings (CMHT)

Community Mental Health Trainers offer community trainings including Mental Health First Aid and workshops based on the Recovery Model, Non-Suicidal Self-Harm and parenting classes.

- Continue CMHT program as stated
- Community Trainings will continue to be delivered virtually on Ring Central Webinar
- Provide a community needs assessment to see what topics/information community members/partners need/want during this time as well as look at when they are available to attend webinars (days/times)
- Offer monthly community webinars and virtual trainings to community partners per their request.
- Increase use of Tri-City's website and social media to share marketing and outreach materials with our community partners for upcoming webinars/trainings

Stigma Reduction | Suicide Prevention

Tri-City's stigma reduction efforts consist of three main components: Room4Everyone, Courageous Minds/Creative Minds, and Green Ribbon Week. Suicide prevention efforts include offering the safeTALK alertness training which provides participants with the skills needed to recognize the signs of suicide in an individual and connect them quickly and safely with the appropriate resources and support services.

- Continue Stigma Reduction and Suicide Prevention Program as stated
- Review the current community needs assessment and adapt the presentation schedule to include topics prioritized by the community.
- Convert paper program surveys to an online survey monkey which will allow them to be administered directly at the end of presentations

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- Begin using short video clips as well as Facebook Live and IGTV (Instagram TV) in order to reach more individuals through social media

Older Adult Wellbeing/Transition Age Youth Wellbeing (Peer Mentor and Wellness Center Programs)

The Peer Mentor program trains volunteers from the Tri-City area who want to learn how to provide support to peers (mentees) who are in emotional distress. Individuals attending the TAY and Older Adult programing located at the Wellness Center benefit from specialized support groups and activities targeting their specific needs.

- Continue Peer Mentor Program as stated
- Peer Mentor training will be conducted via RingCentral Meeting
- Meetings with mentees will continue via telephone
- Wellness Roundtable will be hosted virtually via RingCentral and new Wellness Roundtable topics will be created (Proud to be me, Coping during COVID-19 etc.)
- Continue training, "Working with Older Adults during COVID-19", for outside agencies
- Collaborate with Claremont Scripps College and provide training and support to transition age youth during COVID-19

Family Wellbeing Program (FWB)

In this prevention program, staff and volunteers build trusting relationships and provide support to family members and caregivers of people who experience mental illness.

- Continue Family Wellbeing Program as stated
- Focus on creation of a new children's group, strengthening existing groups, and partnering with new agencies in the community
- Transition groups and events to a virtual platform
- Host a virtual summer camp, if COVID restrictions continue

Housing Stability Program (HSP)

The Housing Stability Program is a prevention program designed to help people with mental illness maintain their current housing or find more appropriate housing.

- Continue Housing Stability Project as stated
- Work with Community Trainers to identified a need and design for trainings for our property owners and landlords to address responding to tenants in difficult situations
- Adapting outreach by assisting with housing referrals that involve evictions or landlord issues

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- Update Good Tenant Curriculum with new topics brought suggested by previous participants including housing information related to COVID-19
- Begin hosting regular landlord housing forums to provide a virtual round table for landlords.

Therapeutic Community Gardening (TCG)

The Therapeutic Community Gardening program helps participants decrease their isolation and experience mental health benefits through participation in horticulture/gardening activities and group therapy exercises.

- Continue Therapeutic Community Gardening Program as stated
- Connect to new community partners who work with the K-12 system to increase transition age youth (TAY) outreach options
- Maintain preexisting participation in the La Verne Youth and Family Action Committee in order to outreach to TAY and their families.
- Outreach at Pomona Fairplex, Fall in the Farm, a family event that sees hundreds of TAY during the event
- Attended events at the TAY space for outreach such as the Christmas Tree Lighting ceremony
- Ongoing internal outreach to TC staff by providing monthly harvests, flyers and emails to staff who work with TAY population

Early Psychosis Program (EPP)

The Early Psychosis Program addresses the identification and diagnosis of individuals who are suffering from psychosis and are not currently enrolled in mental health services.

- Continue Early Psychosis Program as stated
- Confirm that PIER training will occur virtually to expedite the launch of this program
- Adapt all presentation to be conducted virtually
- Adapt outreach strategies to be conducted via phone
- Provide services via telehealth and trainings via RingCentral

Innovation (INN) – This plan provides funding for short-term projects, one to five years, that explore novel efforts to strengthen aspects of the mental health system.

Help@Hand | Tech Suite Project

This project hopes to increase access to mental health care by providing a non- traditional system through the use of computers, tablets and smartphones, targeting individuals who may be reluctant to access services through a more formal clinical setting.

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- Continue the Help@Hand project as stated
- Review preapproved online applications for possible pilot project
- Consider other strategies to fast-track the launch of this project

Additional proposals approved during the Community Planning Process for FY 2021-22

Capital Facilities and Technological Needs (CFTN)

Tri-City Mental Health (TCMH) intends to expend existing MHSA funds assigned to Capital Facilities and Technological Needs to implement a new Electronic Health Record system and client referral management platform.

The Office of the National Coordinator for Health Information Technology's (ONC) Cures Act Final Rule passed in 2020 is designed to empower patients with their health record in the modern health IT world. It supports seamless and secure access, exchange, and use of electronic health information. The rule is designed to give patients and their healthcare providers secure access to health information. It also aims to increase innovation and competition by fostering an ecosystem of new applications to provide patients with more choices in their healthcare. It calls on the healthcare industry to adopt standardized application programming interfaces (APIs), which will help allow individuals to securely and easily access structured electronic health information using smartphone applications. The rule includes a provision requiring that patients can electronically access all of their electronic health information (EHI), structured and/or unstructured, at no cost.

To meet the needs of the ONC rule, TCMH intends to migrate its current EHR platform from Welligent to the Cerner Electronic Health record platform. TCMH is seeking stakeholder approval for a portion of the implementation costs of the Cerner EHR platform.

Additionally, TCMH does not currently have a centralized referral management platform. Such a system would allow TCMH to ensure the quality of referrals delivered by TCMH, as well as allow for both increased transparency and follow-up from both the TCMH clinical and Community Navigator staff as well as the participants.

The final draft of the new Capital Facilities and Technological Needs project has been endorsed by stakeholders and posted for a 30-day public review and comment period from April 9 to May 10, 2021. Once the 30-day comment period is complete, the proposal will be presented to the Mental Health Commission and Tri-City Governing Board during their joint meeting scheduled for May 19, 2021. Tri-City staff will be seeking approval and adoption for this plan at that time.

Technological Platform	Projected Funding
Cerner Electronic Health Record System Implementation	$270,436
Unite US Platform Implementation	$30,000

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NAMI Community Capacity Building

In FY 2011-12, NAMI Pomona Valley entered into a partnership under Tri-City Mental Health's Prevention and Early Intervention Plan to provide training in schools located in the cities of Claremont, La Verne and Pomona. Under the NAMI Community Capacity Building program, this training focused on identifying the early warning signs on mental illness and how to address them. This training called Parents and Teachers as Allies, was directed at teachers and parents and played an important role in educating communities on mental illness as well as reducing stigma.

In July 2019, Parents and Teachers as Allies (PTAA) was replaced by a more comprehensive training called Ending the Silence (ETS). This replacement program included the same components as PTAA as well as a component dedicated to training students to recognize these early warning signs of MI and how to respond and support their peers. In addition, ETS contains a strong focus on suicide prevention which is considered a critical feature of this training.

In the spring of 2020, the impact of COVID-19 led to restrictions on community and school-based trainings. This created limited access of school personnel, parents and students which resulted in a decline in the number of ETS presentations made. It also sparked an increase in requests for a more generalize training on mental health. During this time, NAMI Pomona Valley began to consider the expansion of their program, NAMI 101, which serves as a gateway to other support programs offered through this organization. The strategy was to include both Ending the Silence and NAMI 101 as training options under the NAMI Community Capacity Building program.

On April 8, 2021, stakeholders unanimously agreed to add NAMI 101 to the existing Ending the Silence program thereby creating two training options for community members. The original funding allocation for ETS of $35,500 per year will remain the same and NAMI Pomona Valley will now be able to submit invoices for both programs under this revised plan.

This program modification is made part of the MHSA Annual Update for FY 2021-22 and will be posted on May 7, 2021 for a 30-day comment period. Once the 30-day comment period is complete, the plan will be presented to the Mental Health Commission during the Public Hearing on June 8, 2021 for endorsement and then to the Tri-City Governing Board on June 16, 2021 for their approval and adoption.

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New Innovation Project Proposal

Restorative Practices for Improving Mental Health	
Total Amount Requested	$949,957
Duration of INN Project	Three Years: July 2021 – June 2024

In January of 2021, community members and Tri-City staff came together to begin the process of identifying a new Innovation project. Innovation workgroup participants consisted of fifteen members who reflect a diverse group of individuals. These individuals represented Tri-City staff, faith-based leaders, community members involved in juvenile justice, LGBTQ, and transition age youth.

Community engagement and collaboration have long been the driving forces behind the success of the projects and programs implemented by Tri-City Mental Health under the Mental Health Services Act. This long-standing alliance is the undertone of the Restorative Practices for Improving Mental

Health (RPIMH) project which is comprised of a combination of three evidence-based practices, SKY Breathing, Trauma Informed Yoga, and Restorative Practice Circles, which are typically delivered independently and address distinct elements related to physical health and emotional health of participants. Each of these practices are normally offered separately for a fee and as such, may not meet the individual needs of the participants. In addition, the cost is often times prohibitive for the disadvantaged youth we serve.

This project is proposing to combine these three practices into a single course of treatment or healing aimed at addressing the deficits in mental and emotional support currently available in this area. Two target populations are identified and will be engaged for this project: 1) Tri-City clinical and non-clinical staff who are experiencing the effects of COVID 19 leading to elevated stress and potential burnout; and 2) Transition Age Youth (TAY) ages 16-25, who reside within the Tri-City catchment area, including TAY who are at risk due to COVID-19, those who are residing in foster care, or identify as LGBTQ, as well as the staff that support them.

The final draft of the new Innovation project, Restorative Practices for Improving Mental Health (RPIMH), has been endorsed by stakeholders and posted for a 30-day public review and comment period from April 9 to May 10, 2021. In addition, the RPIMH project proposal was submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for concurrent technical assistance and feedback.

Once the 30-day comment period is complete, the proposal will be presented to the Mental Health Commission and Tri-City Governing Board during their joint meeting scheduled for May 19, 2021. Tri-City staff will be seeking approval and adoption for this plan. The final step will be to submit the plan for final approval to the Mental Health Services Oversight and Accountability Commission.

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MHSA Programs

The following pages contain descriptions of each MHSA-funded program. The descriptions include updates to the program's development; performance outcomes; and cost per participant calculations for programs that provide direct services.

The services provided for Fiscal Year 2019-20 are highlighted in each program summary by age group, number of clients served, and average cost per person.

Community Services and Supports (CSS)

The Community Services and Supports (CSS) Plan provides intensive treatment and transition services for people who suffer with serious and persistent mental illness or severe emotional disturbances, or who are at risk of SMI/SED.

- Full-Service Partnerships
- Community Navigators
- Wellness Center
- Supplemental Crisis Services | Intensive Outreach & Engagement Team
- Field Capable Clinical Services for Older Adults
- Permanent Supportive Housing

Full-Service Partnerships

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	_X_ CSS	___ PEI	___ INN	___ WET	____ CFTN
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:

Program Description

Full-Service Partnerships (FSPs) are for people who are experiencing severe mental illness and at risk of homelessness or other devastating consequences. The program uses a "whatever it takes" approach to help people recover. The plan can include all needed services, including but not limited to traditional mental health services and safe housing.

Target Population

Unserved and underserved individuals targeting four groups: Children ages 0-15, Transition Age Youth ages 16-25, Adults ages 26-59 and Older Adults ages 60 and over, with severe and persistent mental illness.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+
Number Served FY 2019-20	106	147	317	66
Cost Per Person	$11,913	$12,338	$11,613	$8,232

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Program Update

In FY 2019-20, the Full-Service Programs (FSP) program experienced several successes including an increase in the number of dual diagnosis clients who entered into substance use inpatient treatment programs. This improvement is attributed to strong support and collaboration between the Substance Use Disorder (SUD) program and Tri-City's clinical team.

FSP staff have also noted an upsurge in family involvement for clients. This growth is attributed to an increased focus on engagement and meeting with family members in sessions and safety planning. This has resulted in clients feeling more confident to manage their symptoms as well as an increase in "graduations" (lower level of care or no further care needed) from the FSP program.

Another successful team approach between Tri-City clinical and housing staff, has led to a reduction in the number of homeless consumers residing in motels while increasing the number of individuals who are successfully housed. This collaborative strategy includes training staff on how to identify resources available to consumers through reference guides, trainings, and how to effectively guide clients.

Challenges and Solutions

One of the most critical challenges remains adequate staffing. During FY 2019-20, the FSP program experienced a lower level of staffing which resulted in a higher caseload for each staff member.

Several times throughout the year, peaks in referrals reach as many as 10 per month. In response to this increased demand, the leadership team expedited interviewing and hiring processes as well as working with the human resource department to identify additional recruiting ideas. In response to these efforts the staffing numbers for FSP have improved.

Additional difficulties included a noted increase in consumers experiencing homelessness. To address the increase in clients struggling with homelessness, FSP staff have improved tracking and monitoring practices specific to support services offered to consumers to identify permanent stable housing. Leadership team members continue to attend community meetings and partnership meetings to develop a better understanding of the resources available. Referral guides and references were also created so that staff could efficiently support clients seeking housing.

COVID-19 Response

Some of the challenges experienced since the onset of COVID-19 include, 1) lack of comfort for clients with the new tele-health approach due to privacy issues; 2) lack of access to internet or appropriate technology to engage in tele-health; 3) difficulty locating clients who are transient and not reachable by phone; and 4) clients in the community refusing to follow safety protocol such as wearing a mask.

In response to these concerns the FSP department has designated specified “safe area” in the office to conduct in-person sessions and address crises situations. This space has proven to be very helpful for clients who are not able to use tele-health or have been difficult to engage in treatment via tele-health.

In addition, a kiosk station has been created in the office for consumers who are not able to use tele-health at home or do not have access to the internet. This allows the clients to come to the office and engage in medication appointments, assessments, or regular sessions using RingCentral on the kiosk. This option has proven successful for clients who are better able to engage in their psychiatrist appointments as well as families residing in motels or those with privacy challenges in the home.

Prior to the outbreak of COVID 19, staff were able to consult with other team members and supervisors quickly and easily due to the close proximity of their offices. Since the pandemic restrictions were imposed, there are limited staff on site. At times, staff have reported this new “normal” has required additional planning and forethought in order to anticipate the needs of the clients and respond appropriately. Initially there was a disconnect between teams resulting in a delay in response times. However, once virtual meetings and telehealth became standard procedures, this concern was alleviated.

Cultural Approach

Cultural consideration is a critical component to the delivery of services through Full Service Partnerships. Challenges include parents of children receiving services may have difficulty understanding the value of treatment due to stigma associated with mental health within their culture. Tri-City’s hiring practice of engaging staff who are reflective of the community, helps to address these concerns. At this time 9 of the 13 FSP staff are bilingual Spanish speaking and outreach and intake materials are available in multiple languages. Support staff who are able to relate to clients and/or family members on a cultural basis are available to become part of the clients support team.

Cultural bias is also address through the FSP programs. Discussion topics and trainings for staff include how implicit bias can contribute to creating barriers for underserved and unserved

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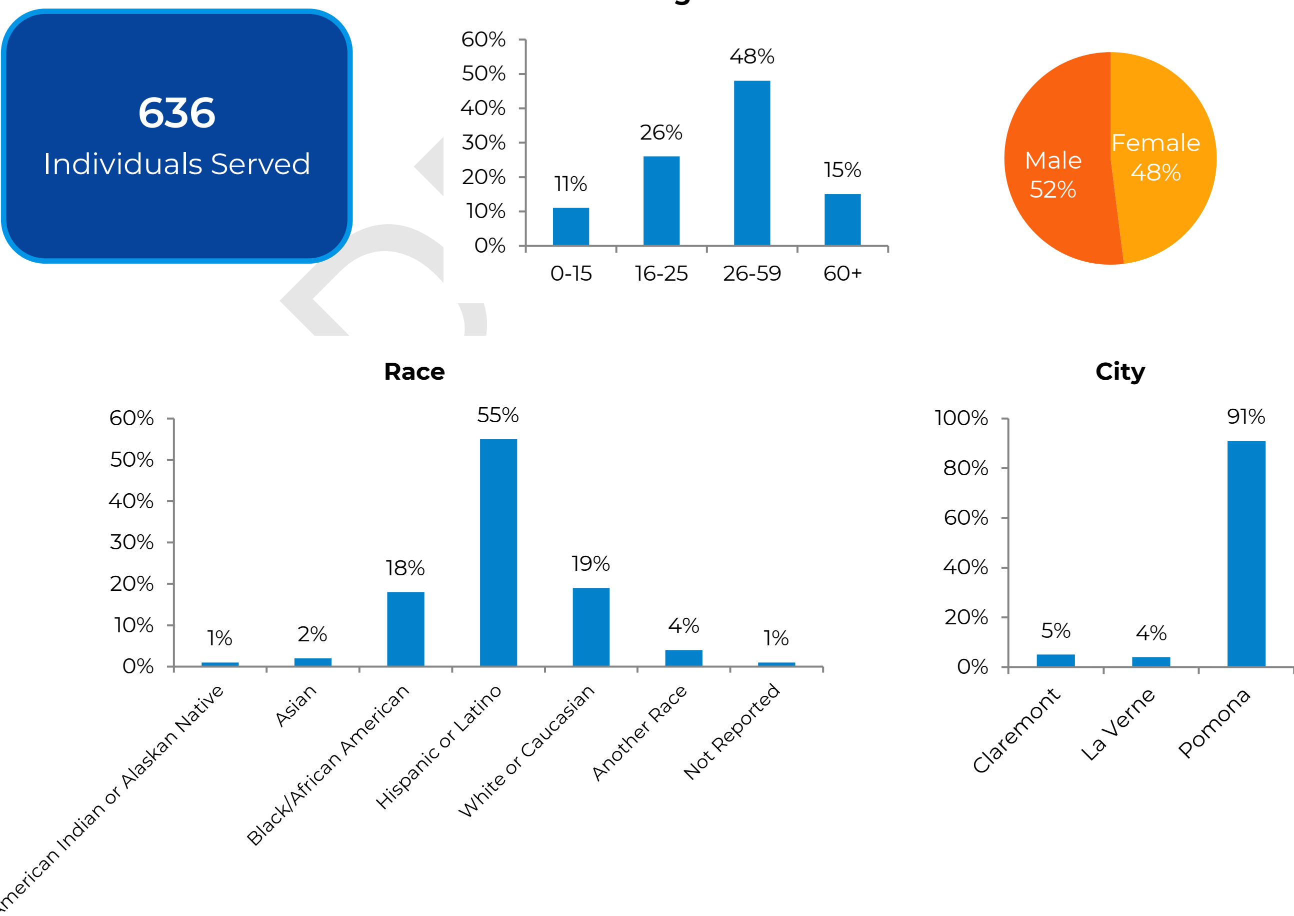
consumers who are looking to access FSP programing. Open discussions regarding "school to prison pipeline" and racial disparities help staff to understand the challenges for BIPOC (Black, Indigenous and People of Color) clients when seeking mental health services. Additional efforts include:

1. Ongoing conversations with staff regarding the impact of implicit bias on access to services;
2. Providing accessible times and locations for services; and
3. If tele-health is more convenient and effective for a family, exploring this as an ongoing option to provide services.

For LGBTQ+ clients, first and foremost, the FSP team strives to understand the barriers and stigma facing these individuals regarding access to services. The FSP staff assume a role of cultural humility and when possible, try to incorporate someone in the team with lived experienced that can relate to the barriers that the LGBTQ+ population experience. For family members, treatment teams attempt to provide collateral support and family sessions to increase empathy and understanding.

PROGRAM: Full-Service Partnerships (FSP)

HOW MUCH DID WE DO?



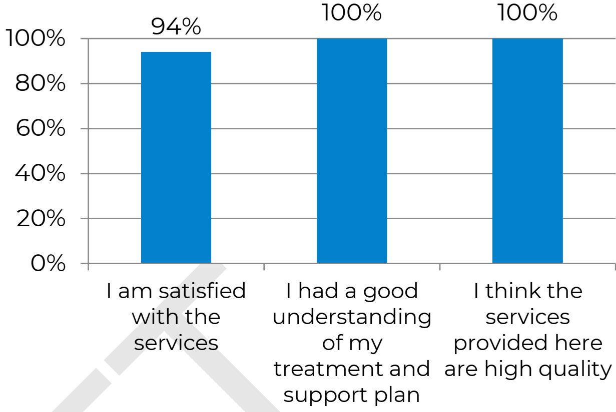
HOW WELL DID WE DO IT?

FSP Adult

Percent of clients (Strongly Agree/Agree) to the following statements

Statement	Percent
I like the services I received here	100%
I had a good understanding of my treatment and support plan	95%
I think the services provided here are high quality	97%

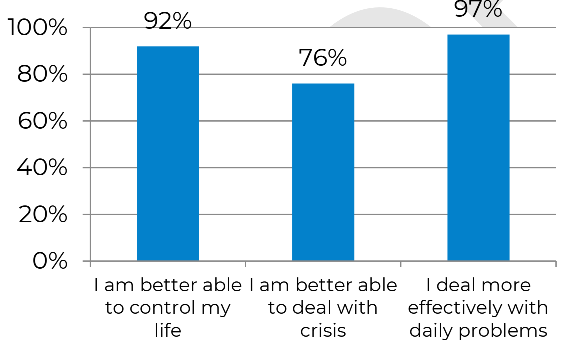
FSP Children & TAY



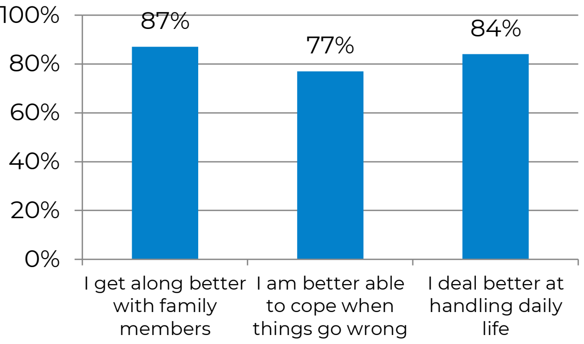
IS ANYONE BETTER OFF?

As a direct result of the services I received:

FSP Adult



FSP Children & TAY



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Community Navigators

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	_X_ CSS	___ PEI	___ INN	___ WET	____ CFTN
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:

Program Description

Community Navigators provide a connection to local resources, including informal community supports and available formal services. Navigators also provide education and stigma reduction services to local communities and organizations.

Target Population

Tri-City clients, staff, community members and local organizations who request referrals and linkage to clinically and culturally appropriate resources and services.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+
Number Served FY 2019-20	62	167	1,148	201
Cost Per Person	$234.00	$234.00	$234.00	$234.00

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Program Update

The Community Navigators continue to be a vital part of community collaboration. Their extensive knowledge of local resources and systems of support allows them to effectively bridge the gap between the needs of individuals with mental health challenges and the most appropriate level of care and communal supports. Due to funding received through Measure H (Los Angeles County sales tax designated to provide funding for homeless services and short-term housing), four additional Community Navigators were hired to expand this critical team dedicated to providing culturally appropriate community resources.

Challenges and Solutions

Limited housing and shelter options continues to be a challenge. However, the funding received through Measure H, has expanded available housing options by providing beds through the Hope for Home Services Center. In addition, the Measure H funding provided funding for short term motel vouchers for families with children experiencing homelessness. The grant also provides homeless prevention funds that Community Navigators are able to use when they are working with families or individuals at risk of losing their housing, support with rent and utility bills, or who need move in assistance once permanent housing is located.

Other limitations include psychiatrists who accept Medi-Cal health plans. Individuals who do not meet medical necessity or only require medication support find this challenge to be difficult. When assisting individuals who need strictly medication support, clients are encouraged to follow up with

their primary care physician who often times can assist with the medication support or a referral to a psychiatrist that can take the clients Medi-Cal health plan.

COVID-19 Response

As an active presence in the community, COVID-19 created a challenge for the Community Navigators as they worked quickly to establish protective protocols that would allow them to continue to provide resources and support while following safety guidelines. Tri-City was able to quickly implement many safety measures including access to Personal Protection Equipment (PPE), hand sanitizer, and disinfecting wipes, in order to appropriately meet with clients when needed.

Assistance was provided via 3-way calling using available technology to assist in connecting individuals with available resources. In-person meetings with Navigators were made possible by dividers made available when clients lose their phone or don't have one available.

COVID 19 made it more difficult to assist some individuals and families due to the sudden closure of multiple agencies. Many resources became limited or very difficult to access such as the Department of Public Social Services and Employment Development Department for unemployment which was a huge need. Access to shelters become a challenge due to quarantine requirements and additional screening and added safety measures including medical clearance. Additional resources such as local showers were forced to close during the pandemic. As temperatures began to rise, local Cooling Centers in the service area were scarce due to Community Centers remaining closed.

Finally, the work load also increased since additional case management was required. At the beginning of the pandemic, the CN's were concerned about meeting and assisting clients due to being essential workers. However, with the availability of PPE and other protections, the team was quickly able to adjust to the changes. Since the CN's are community based, they were able to expand their duties to include referrals to Project Room Key (PRK), a program for homeless individuals who are elderly or who have health issues which puts them at higher risk of complications of COVID-19. Community Navigators also assisted at Motel 6, a PRK motel located in Pomona. There they assist with resources and support. The Navigator program also started assisting at the Sheraton hotel, which is being used as an isolation center for individuals and families who are COVID positive and do not have a location to appropriately isolate.

Cultural Approach

With a significant Spanish-speaking population in the tri-city area, it is critical for this program to receive assistance from bilingual staff. There are currently three languages spoken by the CN's including Spanish and Vietnamese. With the recent addition of a Vietnamese–speaking Navigator, the program will be able to increase their outreach efforts to the Vietnamese community, which has proven difficult to engage in the past.

The Community Navigator program receives ongoing cultural inclusion training to better assist the populations they serve. By identifying resources that are culturally appropriate, CN's are better able to provide support for individuals who experience these additional barriers.

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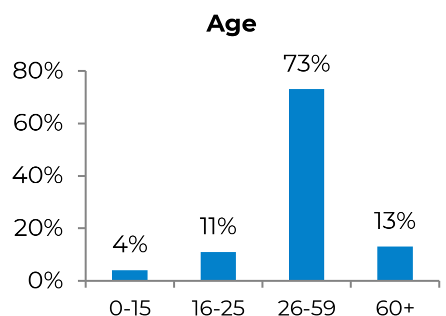
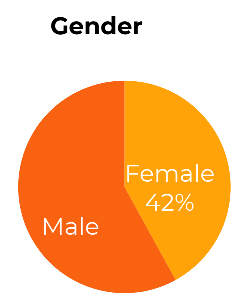
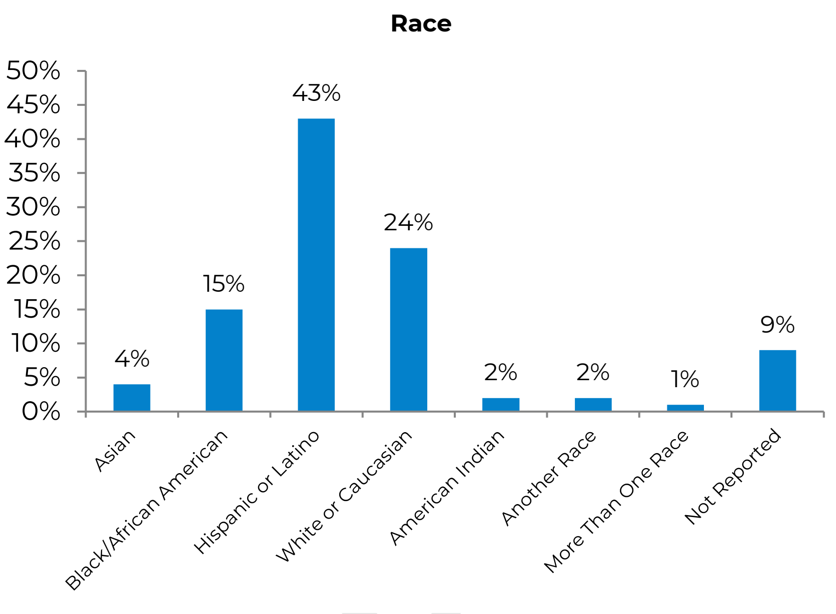
PROGRAM: Community Navigators

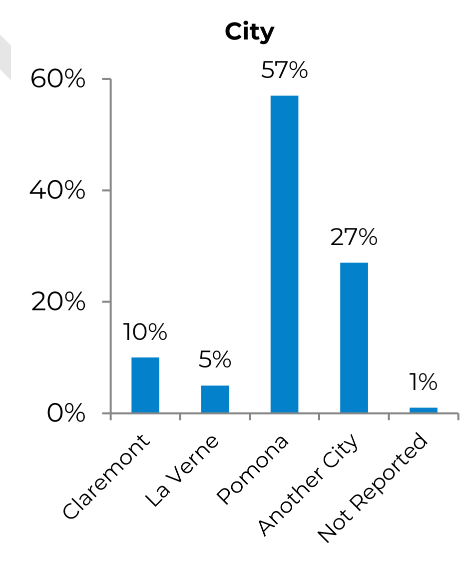
HOW MUCH DID WE DO?

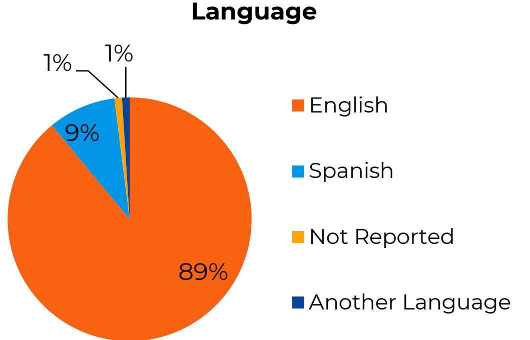
1,578
Unique Individuals Served

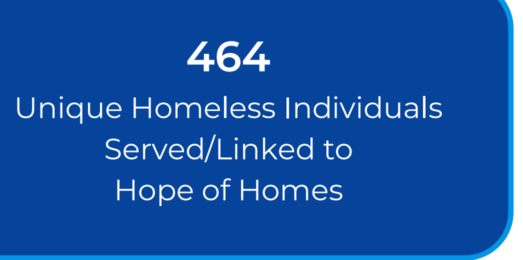


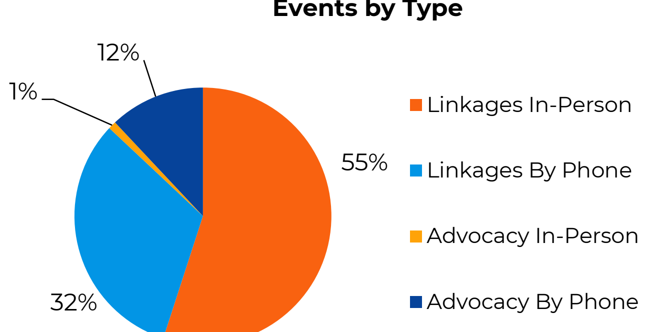




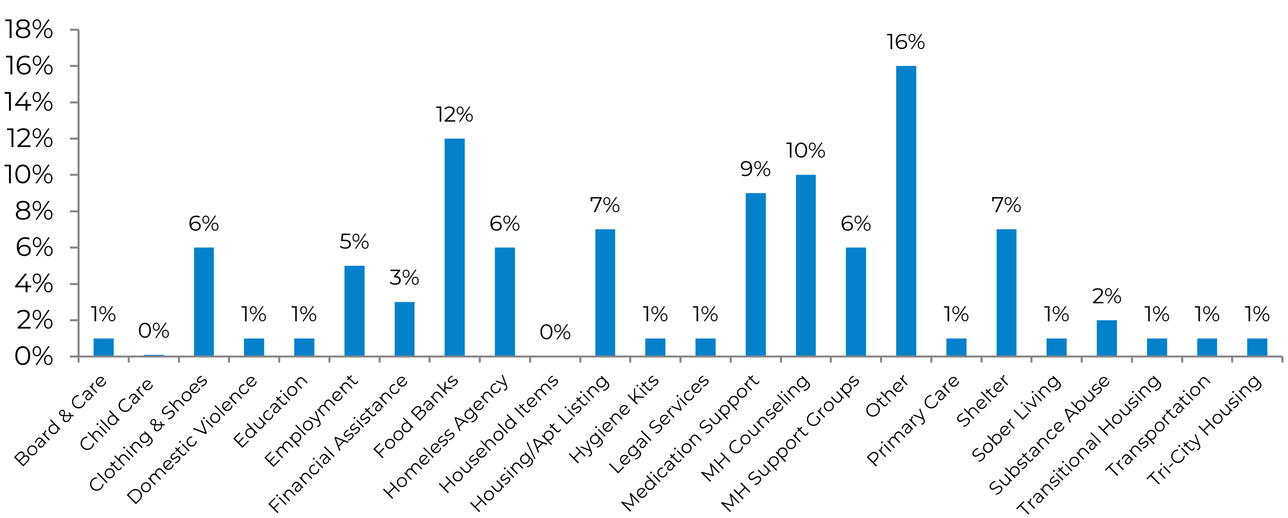


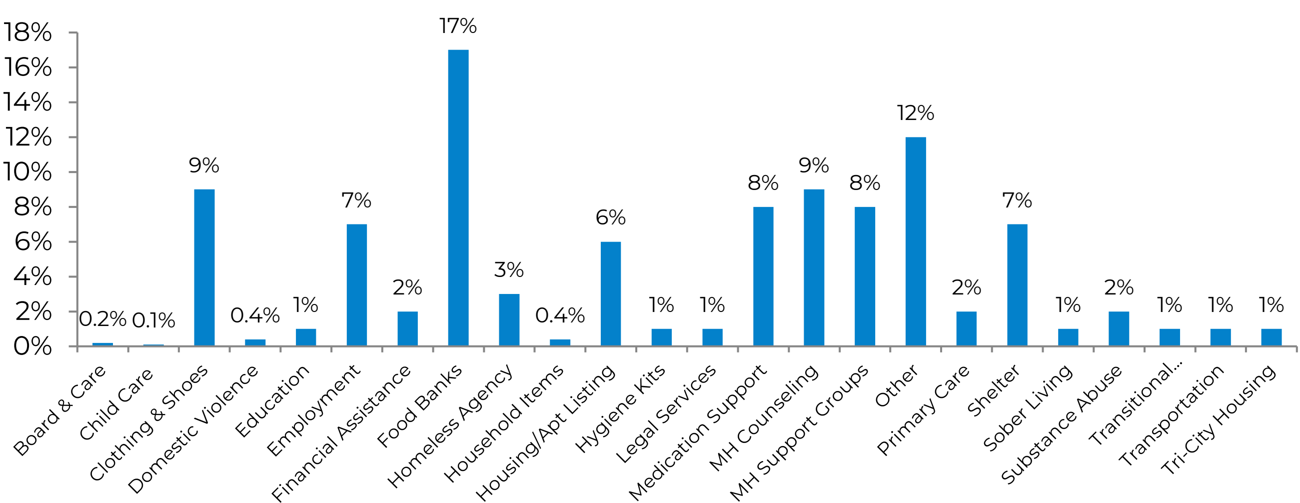






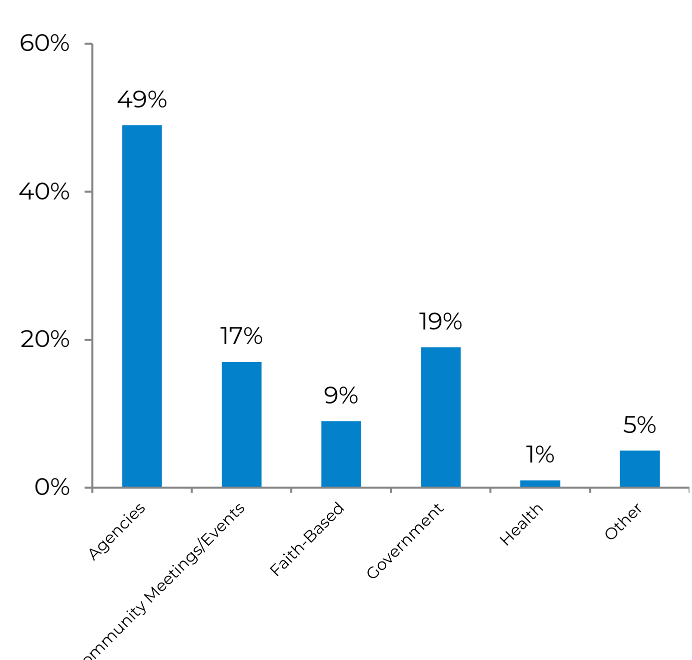
4,429
Contacts Made to Community Navigators



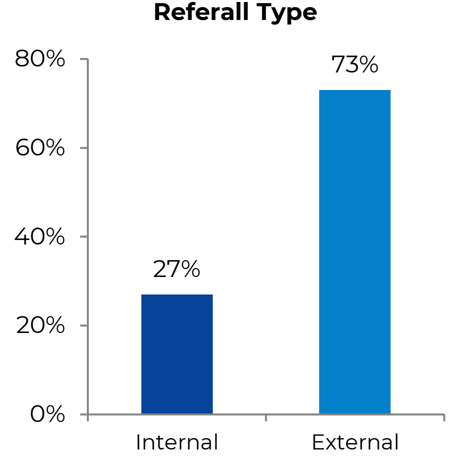


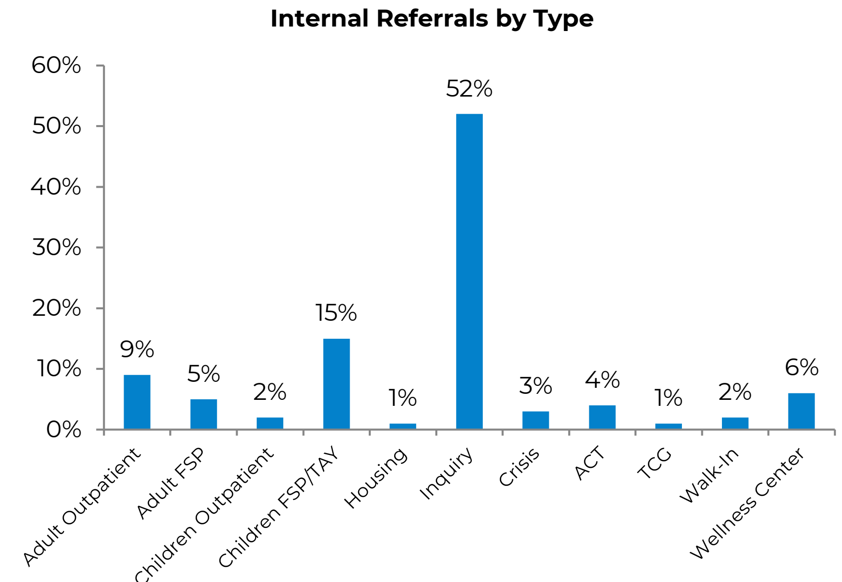
78
Locations Outreached by Navigators

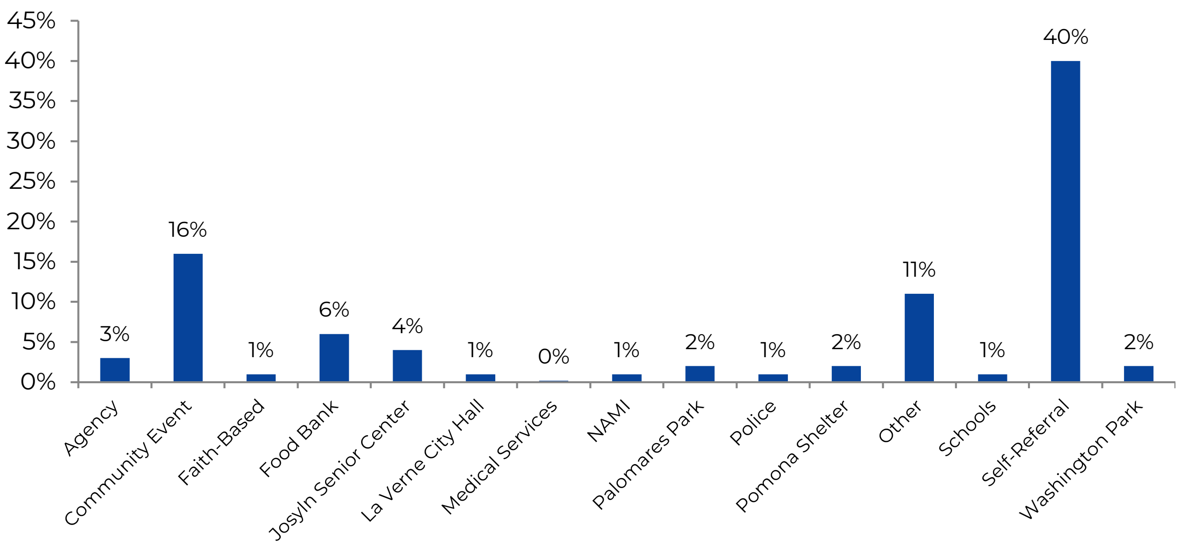
1,145
Total Community Members Engaged by Navigators Through Outreach

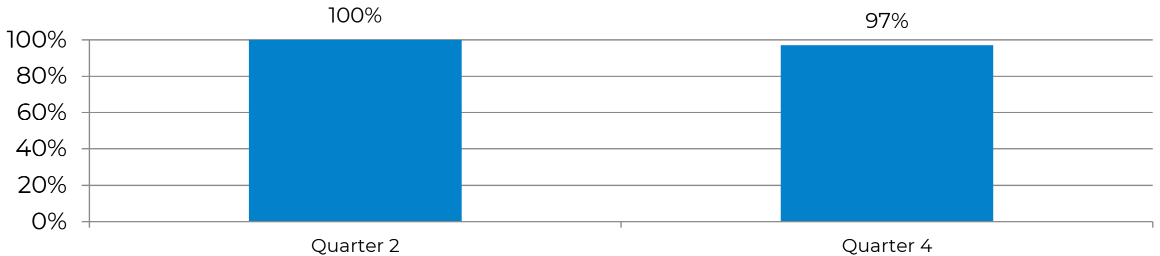


HOW WELL DID WE DO IT?

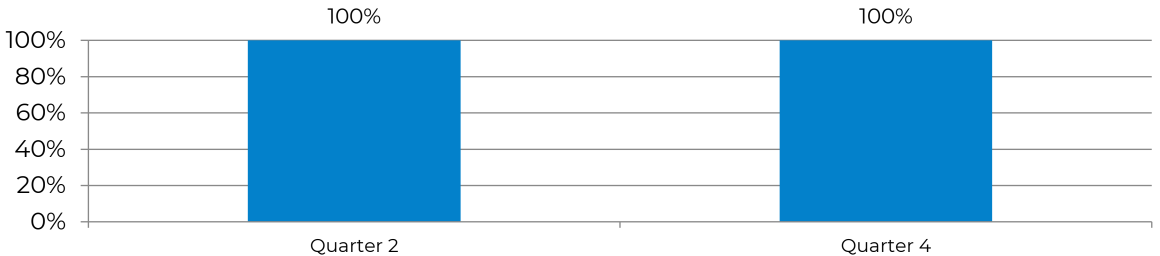








IS ANYONE BETTER OFF?



Wellness Center

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	_X_ CSS	_X_ PEI	___ INN	___ WET	____ CFTN
(CSS) Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
(PEI) Target Population:	___ 0-15	_X_ 16-25	___ 25-69	_X_ 60+	Other:

Program Description

The Wellness Center serves as a community hub that sponsors support groups, and provides an array of holistic services through collaboration with other community partners. Specialized services include activities focused on TAY, older adults and employment support

Target Population

The Wellness Center promotes recovery, resiliency and wellness for residents of the Tri-City area. The Wellness Center is open to people of all ages, focusing especially on people in recovery and their families.

CSS Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	52	406	1,128	143	23
Cost Per Person	$727.00	$727.00	$727.00	$727.00	$727.00

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Program Update

As a popular center for community connection, the Wellness Center (WC) continues to provide support services for a variety of needs. One of the most critical is the extensive employment services available to individuals who are seeking employment and are looking for additional guidance through the process. Over one hundred participants obtained employment in FY 2019-20. The Wellness Center's Peers 2 Careers (peer employment pipeline) program continues to be a primary focus by offering support to individuals who are seeking help with vocational goals.

Programing dedicated to transition age youth, (TAY) continues its efforts to outreach and engage with local community organizations which serve this important age group. By partnering with local organizations such as the Compass Point Center located at the David & Margaret Youth and Family Services, WC staff are able to provide support to TAY that will utilize the drop in center once it reopens.

Challenges and Solutions

Challenges experienced during FY 2019-20 for the Wellness Center include engaging the homeless populations, specifically transition age youth. In order to attract this essential population, the hours of

operation for groups and activities were modified to better match their schedules. TAY staff have actively engaged with local organizations that serve TAY with the goal of hosting groups at their sites in hopes of connecting these individuals to the Wellness Center.

Senior programing continues to struggle during this past year. In response to this, the WC created a position specifically dedicated to targeting the needs of the old adult population. This new position will focus on identifying the needs of older adults and coordinate services and support groups to meet their unique requirements.

COVID-19 Response

Due to the COVID 19 pandemic, the Wellness Center suspended all in-person groups and quickly switched to a virtual format. One of the main challenges that the Center faced in this new format pertains to technological challenges. On the one hand, staff experienced a steep learning curve as the transition to the tele-health platform was implemented. Equipment shortages and access to system networks posed a challenge at the onset. Additional challenges include connecting with participants due to the digital divide. Most participants were hesitant to engage over this new platform due to either lacking the right type of equipment (i.e. phone, email) or their mental health symptomology.

Targeting this digital divide is one way in which the Center intends to enhance their practices. Limited technology disproportionately affects the communities we serve. Thus, making it a priority to ensure that any barriers stemming from technology are addressed.

In spite of these challenges, the Wellness Center continues to operate albeit with a reduction in accessibility, while following all Center for Disease Control (CDC), state and county safety guidelines. The computer lab remains open with modified capacity due to social distancing and mask regulations.

Cultural Approach

The Wellness Center is considered to be one of the most ethnically diverse programs within the Agency. The program addresses linguistic barriers through bilingual staff, along with the Agency's language lines. All informational materials are available in the three major languages spoken by the local community; English, Spanish, and Vietnamese.

Outreach efforts are coordinated to align with the cultural and linguistic needs of the target community. This is achieved by building trusted and matching individuals with reliable staff members that have similar experiences and a vested interest in each group's well-being.

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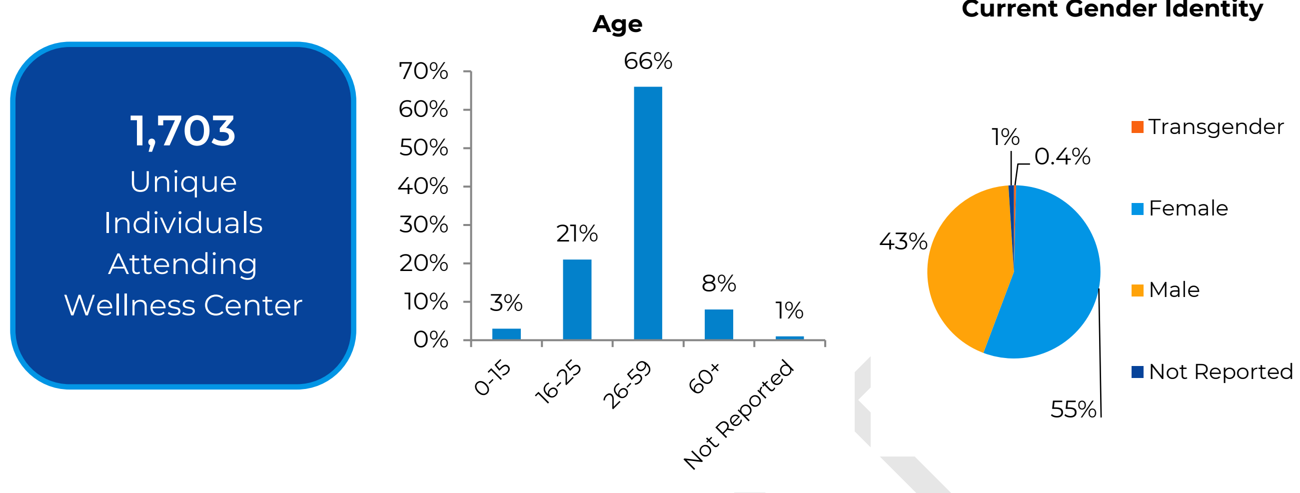
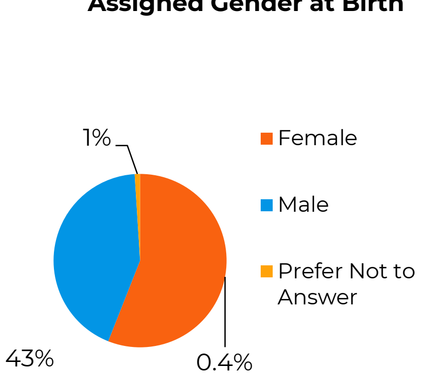
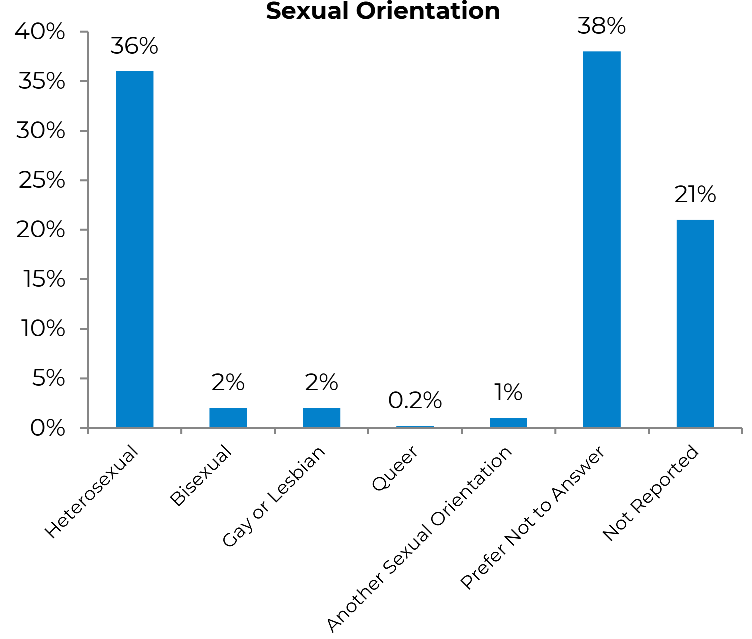
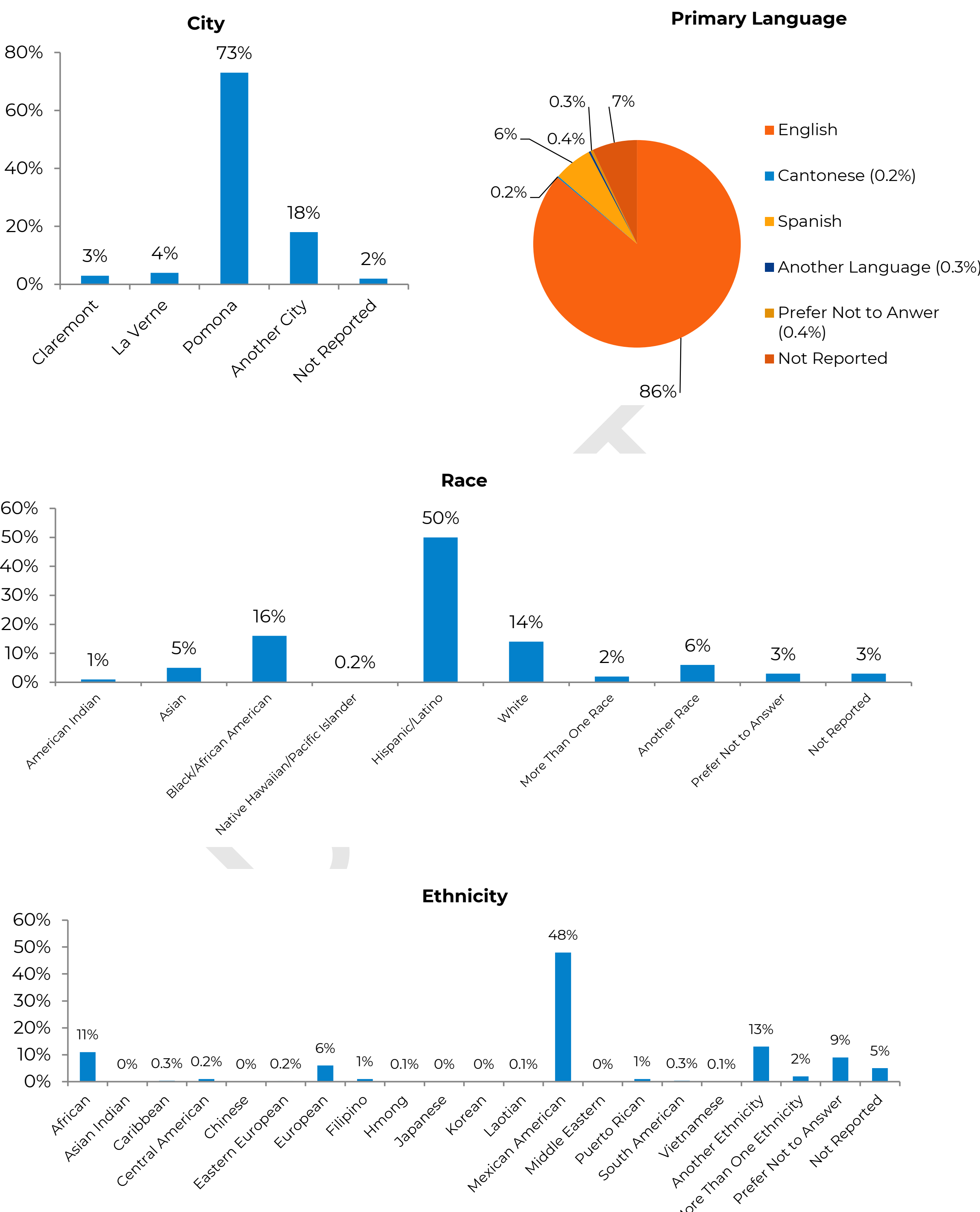
PROGRAM: Wellness Center – CSS

HOW MUCH DID WE DO?








City
80%
60%
40%
20%
0%
3%
4%
73%
18%
2%
Claremont
La Verne
Pomona
Another City
Not Reported
Primary Language
0.3%
7%
6%
0.4%
0.2%
86%
English
Cantonese (0.2%)
Spanish
Another Language (0.3%)
Prefer Not to Anwer (0.4%)
Not Reported
Race
60%
50%
40%
30%
20%
10%
0%
1%
5%
16%
0.2%
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2%
6%
3%
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American Indian
Asian
Black/African American
Native Hawaiian/Pacific Islander
Hispanic/Latino
White
More Than One Race
Another Race
Prefer Not to Answer
Not Reported
Ethnicity
60%
50%
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Central American
Chinese
Eastern European
European
Filipino
Hmong
Japanese
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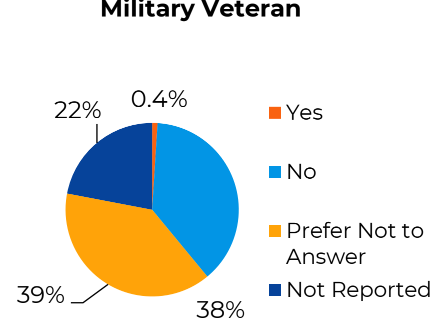
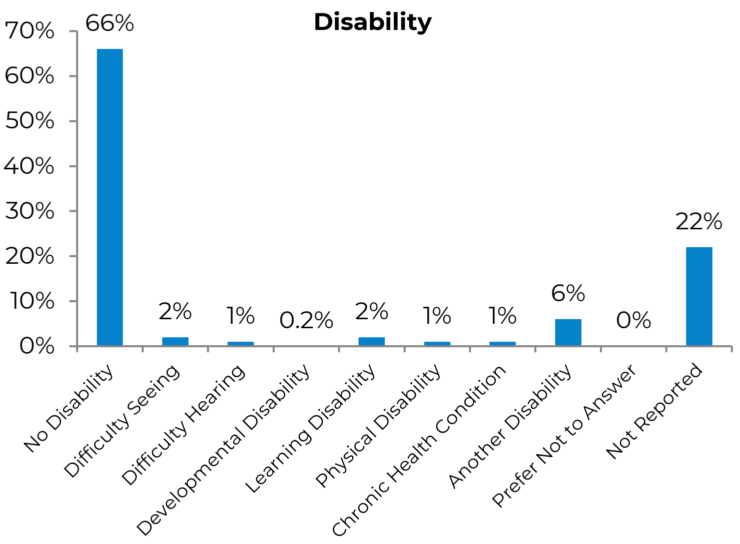
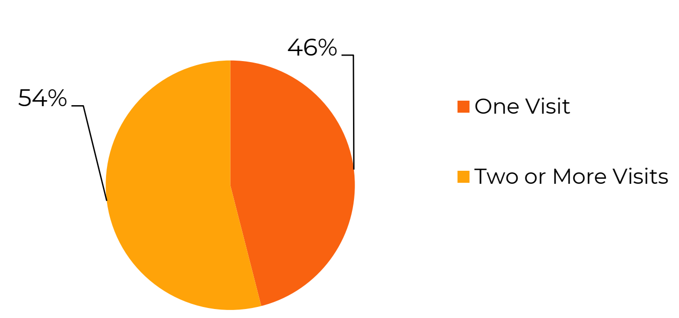
Mexican American
Middle Eastern
Puerto Rican
South American
Vietnamese
Another Ethnicity
More Than One Ethnicity
Prefer Not to Anwer
Not Reported





HOW WELL DID WE DO IT?

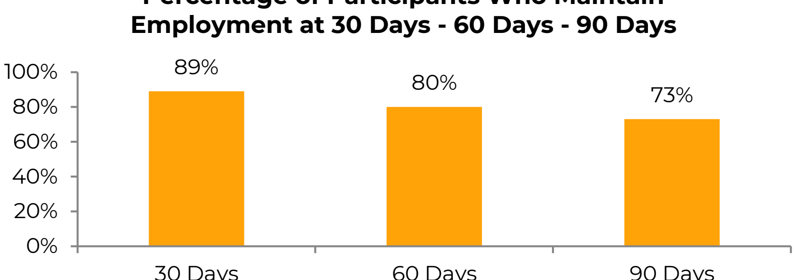
15,380
Number of Attendees at Wellness Center Events

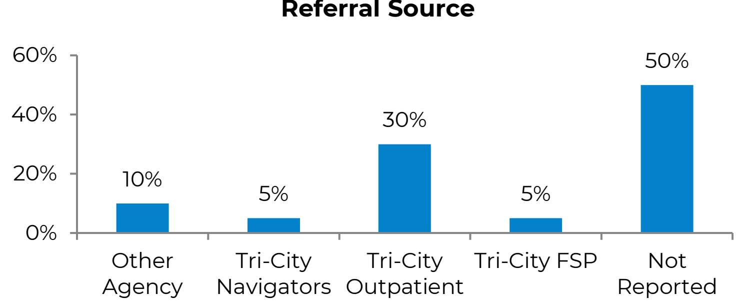


Group Name	Number of Times Group Was Held
Community Meeting PUSD	1
Group – Adult Orientation	25
Group – Anger Management	74
Group – Anxiety	44
Group – Anxiety Relief	44
Group – Anxiety Relief (Heavenly)	7
Group – Attendance Letter	48
Group – Brief Check-in	4

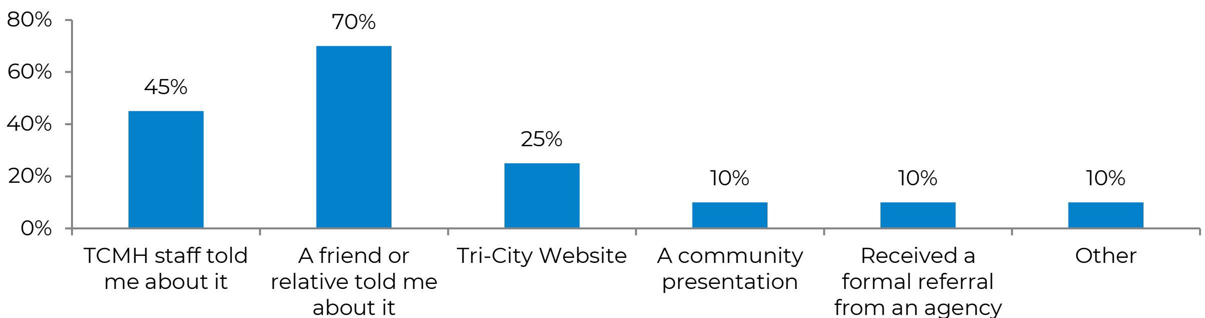
Group – Dual Recovery Anonymous	105
Group – Freedom Through Reality	50
Group - Lose the Blues	50
Group – Men's Depression	51
Group – Obsessive Compulsive D/O	15
Group – One-One-One	13
Group – Positive Direction	39
Group – Phone Call	84
Group – Senior Calm	2
Group – Strong Women	44
Group – Tranquility	41
Group – Wellness Center Committee	7
Group – Women's Self-Esteem	36
Group – Yoga	2
Group Español – Dirección Positiva	35
Group Español – Sobrellevando La Ansiedad	45
Group Español – Socialization	45
Other – Meeting	187
Other – PC Lab	252
Other – Volunteer	8
Vocational – Attendance Letter	8
Vocational – Computer Classes (Advanced)	15
Vocational – Computer Classes (Intermediate)	13
Vocational – Computer Classes (Beginner)	19

Vocational – Educational/School	44
Vocational – Employment Workshop	106
Vocational – GED Prep	27
Vocational – Hiring Event	15
Vocational – IRS Tax Credit	3
Vocational – Job Search	236
Vocational – Literacy Group	29
Vocational – Money Management	9
Vocational – One-on-One	80
Vocational – Peers to Careers	4
Vocational – Phone Call	163
Vocational – Resume/Interview	47
Vocational – Work Maintenance	66
Blank Events	55

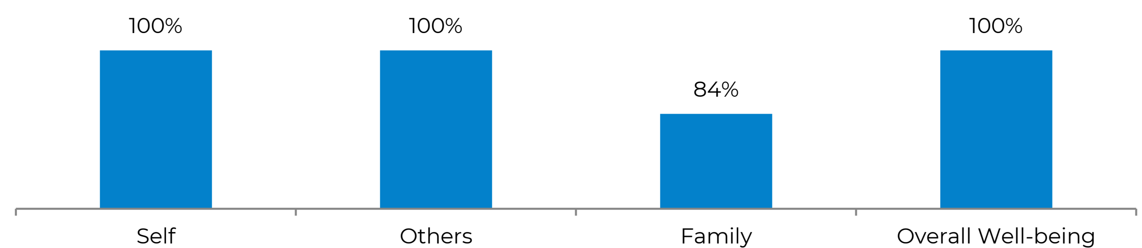




95%
Satisfied with Wellness Center Programs



IS ANYONE BETTER OFF?



DRAFT

Supplemental Crisis Services

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	_X_ CSS	___ PEI	___ INN	___ WET	____ CFTN
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:

Program Description

The Supplemental Crisis Services (SCS) program provides after-hours and weekend phone support to individuals who are experiencing a crisis and who currently are not receiving TCMHC services. Crisis walk-in services are also available during business hours at Tri-City's clinic location. Through follow-up efforts by the Intensive Outreach and Engagement Team (IOET), individuals located in the community who are having difficulty connecting with and maintaining mental health support are able to receive services in an effort to help reduce the number of repeat hospitalizations and guide these individuals to the most appropriate care.

Target Population

Individuals in crisis and currently not enrolled in Tri-City for services, who are seeking mental health support after-hours. Individuals located in the community who are having difficulty connecting with and maintaining mental health support.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	53	144	639	120	202
Cost Per Person	$636.00	$636.00	$636.00	$636.00	$636.00

Program Update

During FY 2019-20, the crisis calls remained consistent with 115 Supplemental Crisis contacts received. The primary reason for these contacts were individuals experiencing mental health symptoms and seeking support. Additional reasons include calls made regarding support for someone else's wellbeing and seeking resources.

However, there is a noted increase in the number of contacts for the Intensive Outreach and Engagement Team compared with the previous year. In FY 2018-19 there were 674 IOET contacts compared to 979 contacts in FY 2019-20. In addition, there is a significant increase in the number of IOET cases that were open for services going from 300 in FY 2018-19 to 450 in FY 2019-20. This increase speaks to the increased need generated by the COVID 19 pandemic and the critical role this team plays in the ability to connect with community members in crisis and guide them into appropriate services based on their needs and input.

The foundation of the Intensive Outreach and Engagement (IOE) team rests on the philosophy of inclusion and striving to meet every individual they serve, where they are. The IOE team utilizes a

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field-based team approach that allows access to the known “hot spots” (locations where disenfranchised individuals gather) within the communities they serve. This includes, but is not limited to; encampments, parks, abandoned buildings, freeway underpasses, Hope 4 Home service center and even home visits. A “whole person system of care” approach is applied where all aspects of the individual are addressed.

Challenges and Solutions

As a community response team, the IOET provides a flexible approach to working within the community and adapting the environment while adhering to policies set by officials and the Agency regarding safety and service. Changes in staff during FY 2019-20, included the loss of a psychiatric technician; and addition of a case manager and therapist.

COVID-19 Response

Since the COVID 19 pandemic, the Supplemental Crisis Services (SCS), Intensive Outreach and Engagement Team (IOET), and Medication Support Team (MST) have continued to work on site. Workloads have increased as expected for the IOET and MST located at Tri-City’s Adult Clinic. While other departments are forced to work remotely, the IOET, MST and SCS teams have become the “go to teams” for a majority of client services and provision of care which include real-time follow-ups, medication services, linkages, assessments, referrals, etc.

Staff continue to follow county and state safety guidelines while navigating barriers presented due to the pandemic, in order to provide a “whole person system of care” approach to services.

Future efforts include the development of the PACT-Psychiatric Assessment Care Team. This additional support service is designed to aid the city of Claremont, by providing a licensed psychiatric technician and licensed therapist to communicate, collaborate and coordinate real-time assessment services within this city.

Cultural Approach

In order to provide culturally linguistic support, bilingual therapists are available to respond to calls triaged through the Supplemental Crisis call lines. In addition, the Community Navigators coordinate with the SCS team to link callers to culturally appropriate resources and services.

The Intensive Outreach and Engagement team (IOE) was specifically designed to reach underserved populations. The IOE team is comprised of eight staff members; 5 are bi-lingual. All IOE team brochures are in available in both English and Spanish, and when needed, the IOE team utilizes the Agency’s Language Line to connect individuals to multiple systems of care, and to ensure that there are no disruptions/delays to accessing systems of care.

The IOE team is supportive of the LGTBQ+ community, and incorporates literature regarding resources and referrals that are inclusive and informative on how to access both formal and informal services though a number of different avenues (traditional office, phone, or other electronic media). In addition, the IOE team is represented on the Agency’s Cultural Competence Committee, where this representative is able to regularly disseminate information regarding trauma and stigma based awareness, as well as support groups that are specifically designed to meet the needs of the LGBTQ+ community.

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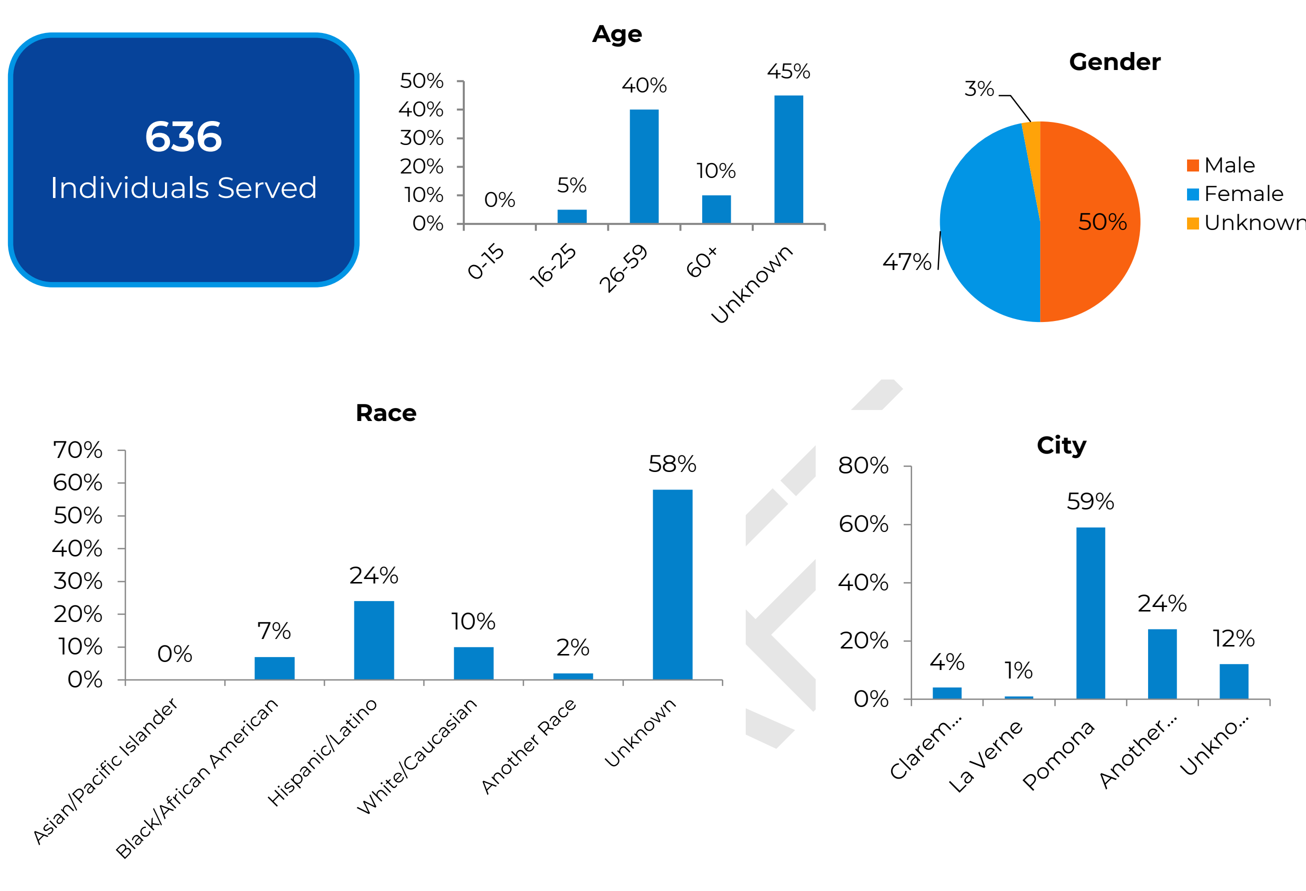
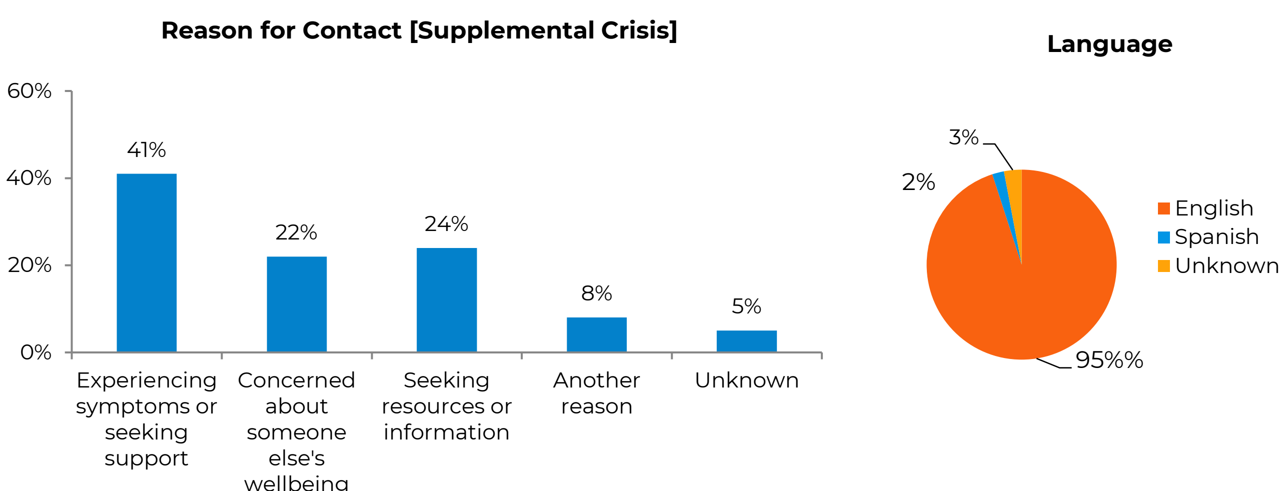
PROGRAM: Supplemental Crisis Services

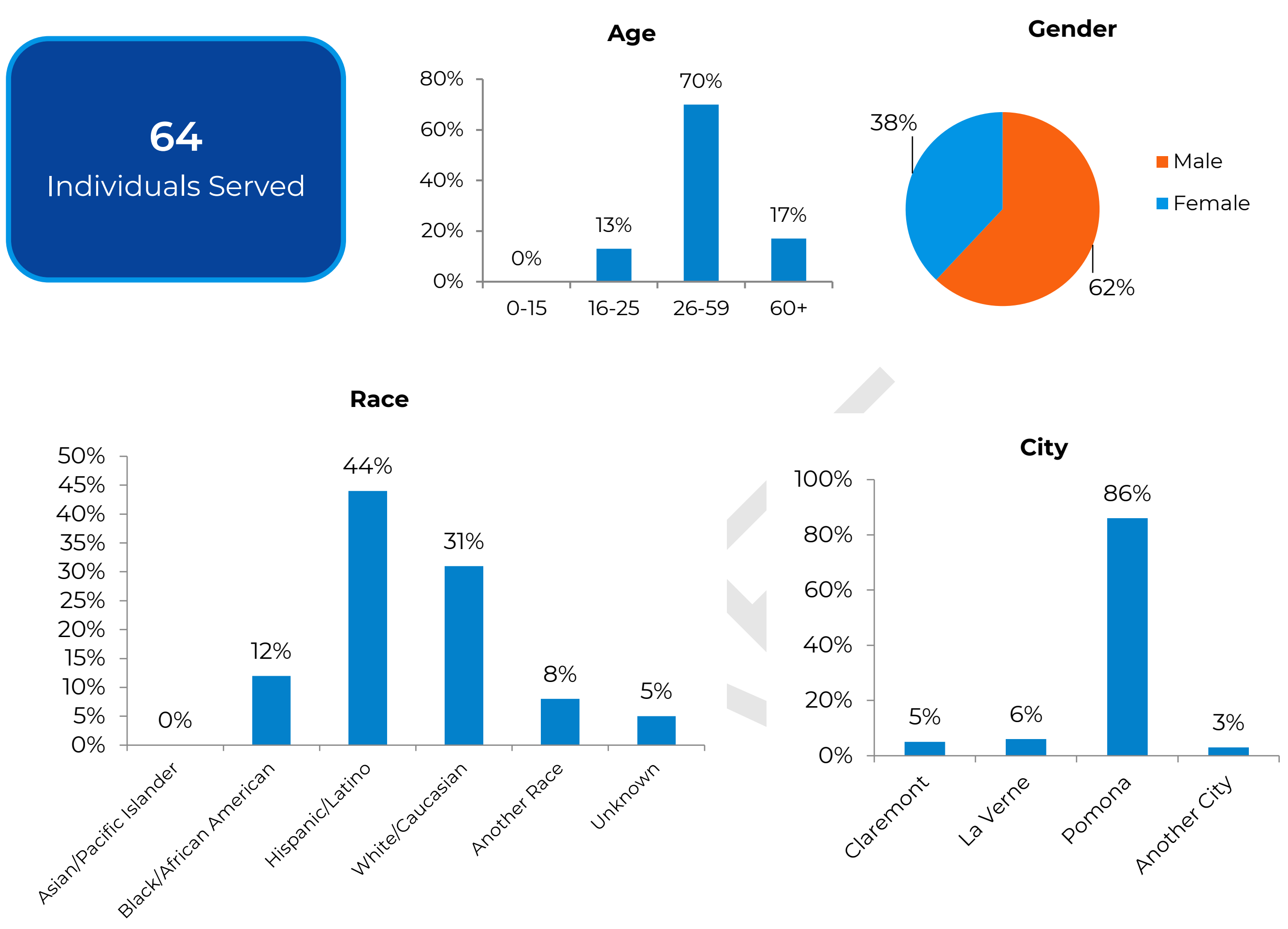
HOW MUCH DID WE DO?





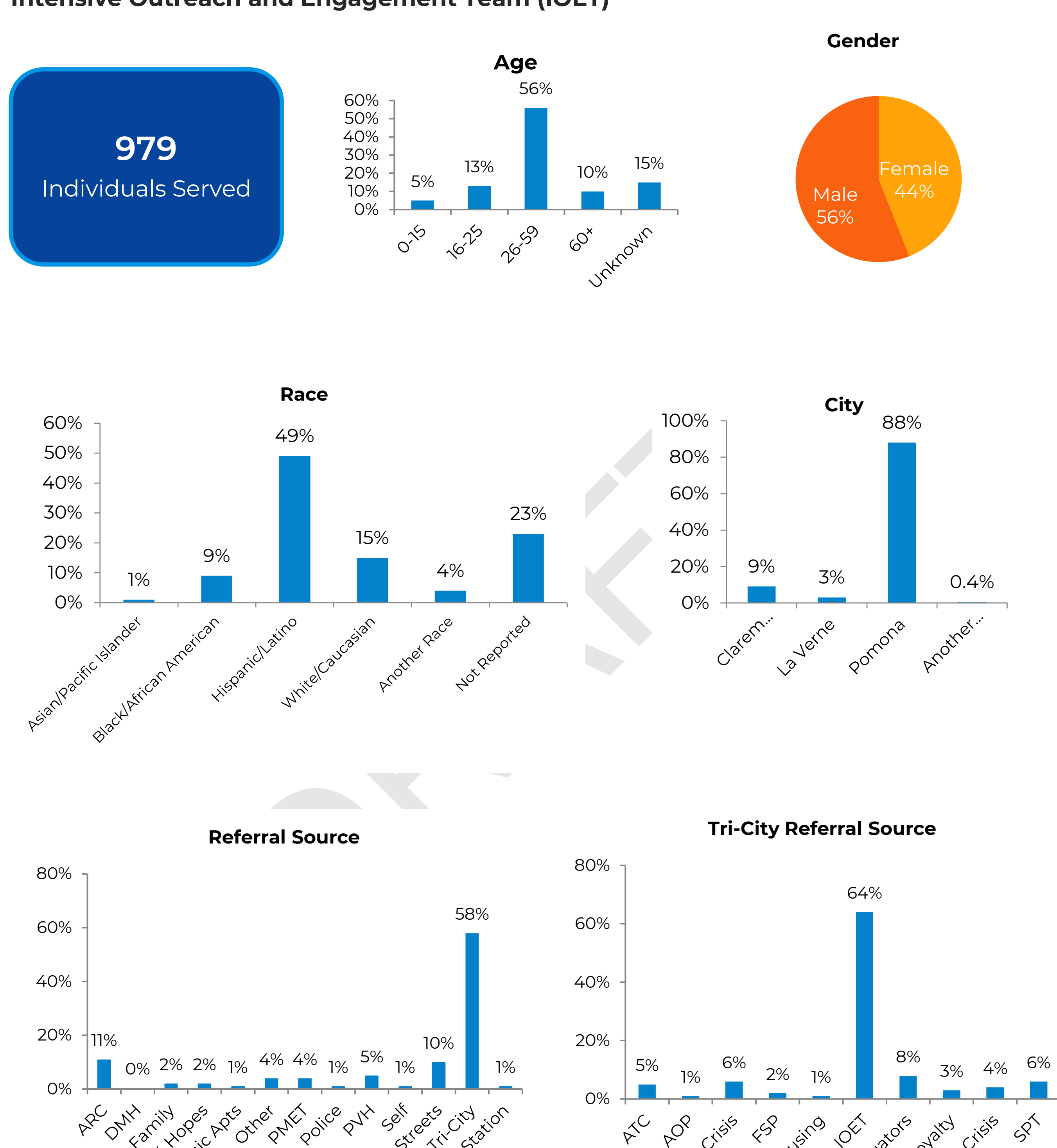
Crisis Walk-in

64
Individuals Served



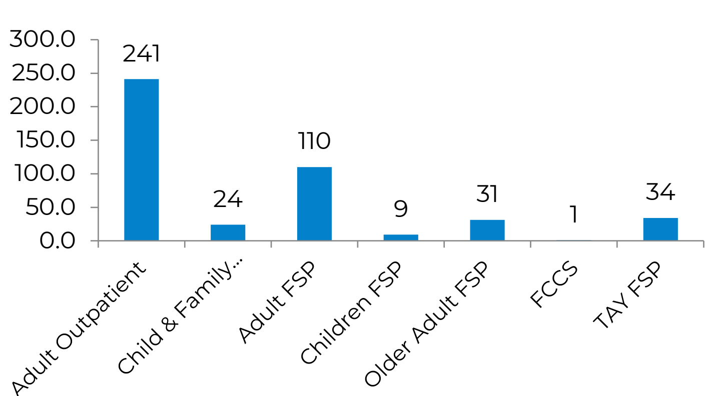
80%
Crisis Walk-Ins Also Outreached by the Intensive Outreach and Engagement Team

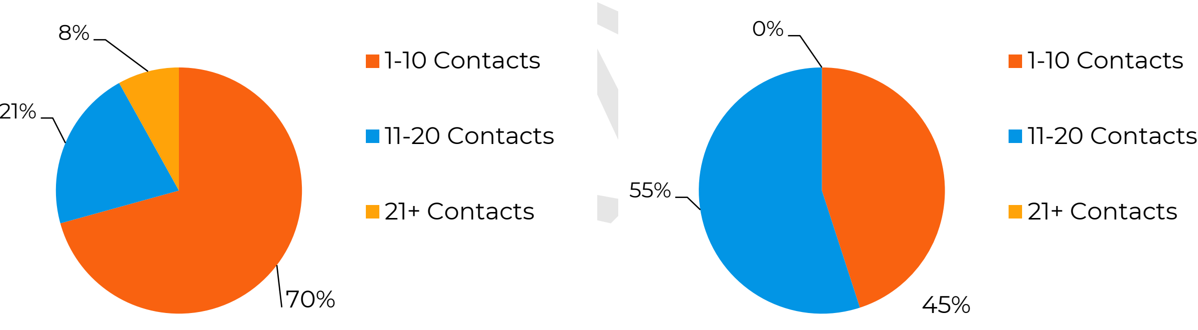
Intensive Outreach and Engagement Team (IOET)

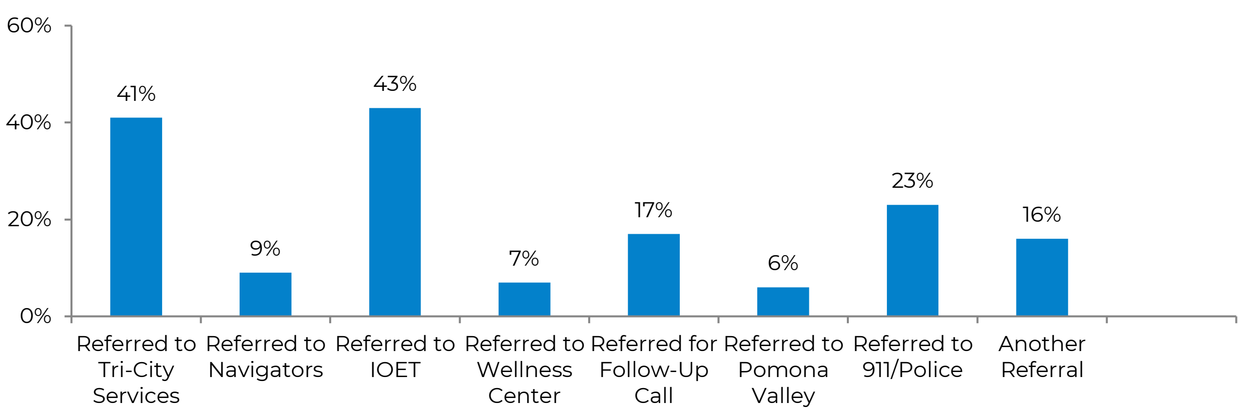


HOW WELL DID WE DO IT?

450
Individuals were Opened for Services at Tri-City through the Intensive Outreach and Engagement Team

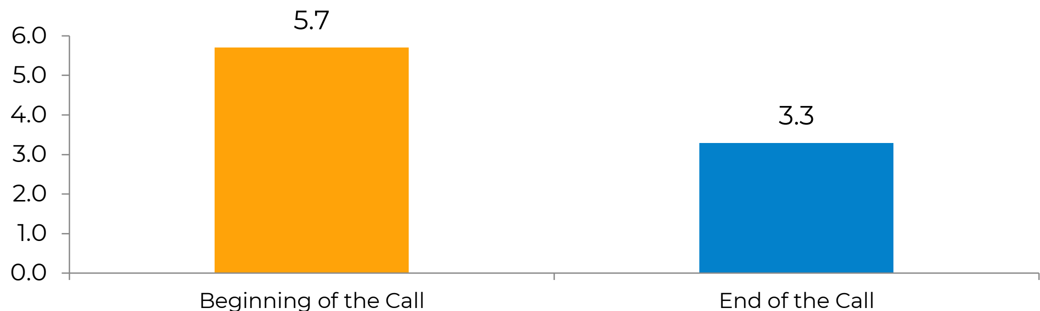






IS ANYONE BETTER OFF?

Level of Distress for Crisis Callers



DRAFT

Field Capable Clinical Services for Older Adults

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	_X_ CSS	___ PEI	___ INN	___ WET	____ CFTN
Target Population:	___ 0-15	___ 16-25	___ 25-69	_X_ 60+	Other:

Program Description

Through the Field Capable Clinical Services for Older Adults (FCCS) program, TCMH staff members provide mental health services to older adults at their location including their home, senior centers, and medical facilities.

Target Population

Older adults, ages 60 and over, who are experiencing barriers to mental health service due to a variety of issues including lack of transportation, stigma or isolation.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+
Number Served FY 2019-20	N/A	N/A	N/A	26
Cost Per Person	N/A	N/A	N/A	$2,526

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Program Update

The Field Capable Clinical Services for Older Adults (FCCS) continues to be a dedicated program to serve the needs of older adults, ages 60 and over. In FY 2019-20, the program experienced a loss of staff when the assigned FCCS clinician left the program in December 2019. However, this program was originally designed to be a continuation of the Full-Service Partnership (FSP) program for this critical population. In response to this loss of staff, clients were reassigned to FSP staff who were able to provide the same high quality of service and continuity of support for each client. A new FCCS clinician was hired in June of 2020 and is currently supporting these clients as well.

Challenges and Solutions

A portion of the FCCS clients seem to struggle with “graduating” from the FCCS program and transitioning to their insurance-designated primary care provider. Staff have addressed this issue by lending support with ongoing connections to Tri-City’s system of care and other MHSA programs including the Wellness Center, Peer Mentors, and the Therapeutic Community Garden which contribute to increasing socialization and healthy relationship formation.

COVID-19 Response

The COVID 19 pandemic greatly impacted the ability of FCCS staff to provide regular field-based services. In response to this, staff quickly implemented video conferencing/phone sessions where FCCS clients were provided with cell phones, as needed. Staff noted an increased need for support

related to food resources. Staff began delivering groceries to clients while also locating alternative food resources, including food delivery services. Field visits for wellness checks continued with staff utilizing appropriate safety precautions including using personal protective equipment and social distancing.

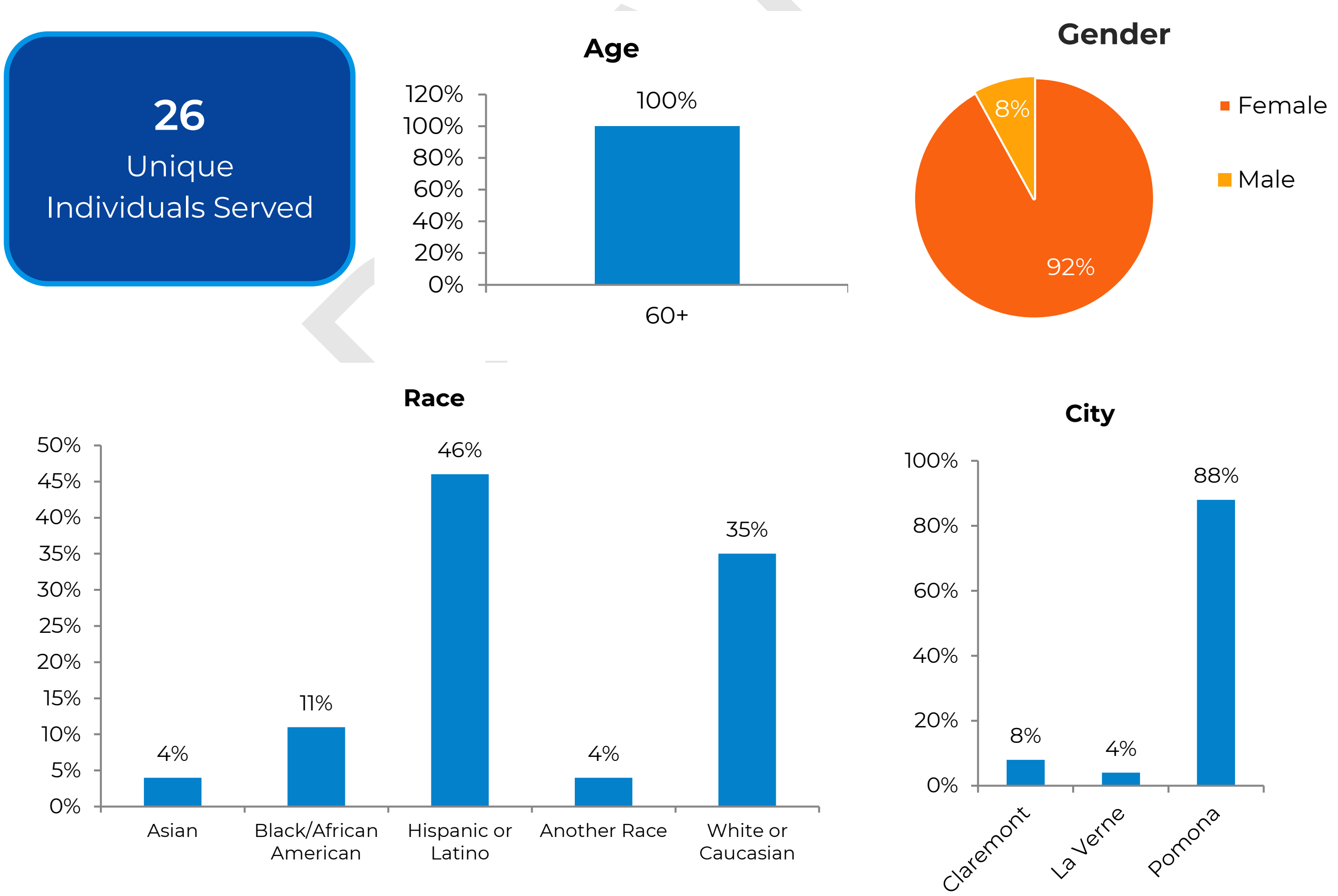
Cultural Approach

Program staff include a diverse group of individuals, (racial, cultural, gender, age) led by a bilingual (Spanish speaking) FCCS clinician. Community Navigators are utilized to identify and provide culturally appropriate resources for clients as needed. All program brochures are available in both English and Spanish and an approved language line is also available.

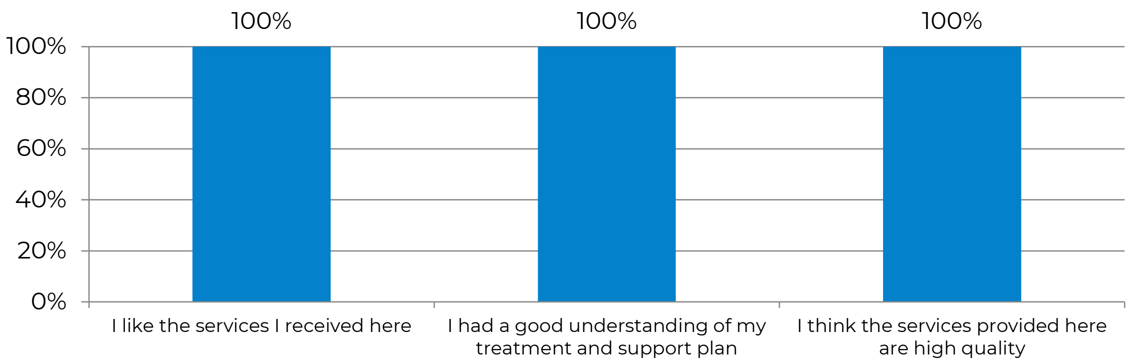
As staffing stabilizes, program goals include increasing outreach efforts utilizing the bilingual FCCS clinician to increase FCCS enrollment and community collaboration, as well as more fully develop the FCCS program. Additionally, efforts are underway to identify trainings that specifically focus on integrated care for elders with the goal of enhancing current services.

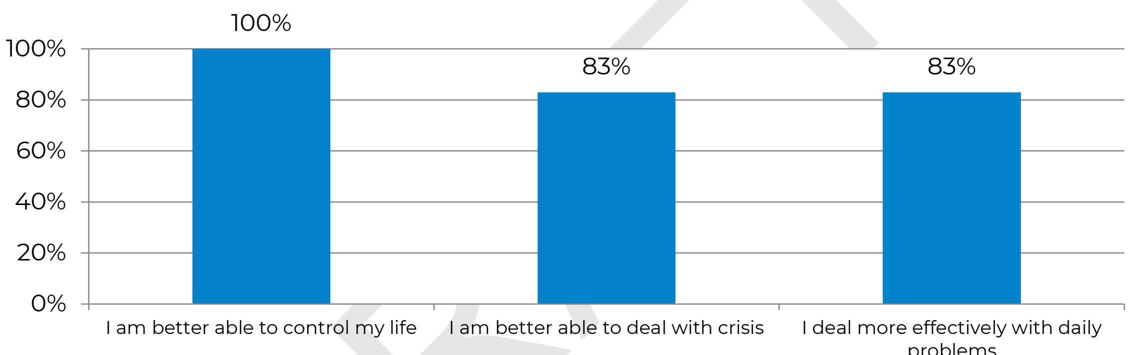
PROGRAM: Field Capable Clinical Services for Older Adults (FCCS)

HOW MUCH DID WE DO?



IS ANYONE BETTER OFF?





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Permanent Supportive Housing

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	_X_ CSS	___ PEI	___ INN	___ WET	____ CFTN
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:

Program Description

Permanent supportive housing units are short-term living spaces where individuals who are homeless or at risk of homelessness and suffer from one or more mental illness, can receive an array of services designed to support their recovery. Permanent supportive housing has proven to be a significant part of successful recovery plans for many people with serious mental illness. Such housing enables successful pathways to recovery and, ultimately, can reduce the cost of other services such as emergency room visits and incarceration.

Target Population

Tri-City clients living with severe and persistent mental illness and their family members.

MHSA Housing Projects						
Location	Studio	One Bedroom	Two Bedroom	Three Bedroom	Notes and Amenities	Total Units
Parkside Apartments	0	16	5	0	Computer stations, lounge area and kitchen	21
Cedar Springs Apartments	0	5	3	0	TAY (ages 16-25) with family	8
Holt Family Apartments	0	11	11	3	Opening April 30	25
Claremont / Baseline Project (Home)	0	0	2	0	Two separate wings with large living room and kitchen. Two bedrooms on each side.	2
Park Ave Apartments	2	6	0	0	Programs provided on site	8
Total Units	2	38	21	3		64

Program Update

In July of 2019, the City of Pomona reached out to Tri City Mental Health regarding new housing vouchers, offered through Anthem Blue Cross, that were available for individuals who were homeless in Pomona. In response, Tri-City's Permanent Supportive Housing (PSH) team collaborated with the

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City of Pomona, Volunteers of America, Union Station Homeless Services, Prototypes, and Hathaway Sycamores Child and Family Services, to support 17 individuals to apply for the vouchers and secure housing by the end of August, 2019. Anthem Blue Cross identified this first round of vouchers as a pilot process and, due to the PSH's swift response and diligence in getting all vouchers secured, created an opportunity for more vouchers in the future.

Regular check-ins as well as responding to the needs of Tri-City's tenants, is a critical component to the success of this housing program. During conversations held between Parkside Family Apartments and the Residential Service Coordinators, they noted that multiple residents mentioned their struggles with maintaining their sobriety as the site's entrance and exit face a liquor store. In response, the PSH team reached out to Tri-City's Substance Use Disorder team and identified a need for an on-site substance use support group. By October 2019, staff launched a Wellness and Recovery group where all tenants are able to attend without leaving the property and thereby avoiding blatant temptation.

Challenges and Solutions

One of the ongoing challenges for this program is helping individuals accept and manage their expectations regarding affordable housing in the tri-city area. When following-up with client housing referrals from Tri-City's clinical teams, staff encountered a number of individuals who were focused on securing subsidized housing through project or tenant-based vouchers, even though they did not qualify. While discussing other housing options with these individuals on fixed incomes, they were reluctant to work with the housing team to look for more affordable single rooms for rent, which they would qualify for based on their current income. Although they may know other individuals who were able to secure this desirable level of housing, they find it difficult to accept how problematic it can be for individuals in their situation.

Through the Coordinated Entry System, a streamlined system designed to efficiently match people experiencing homelessness to available housing, shelter, and services, PHS staff are able to help individuals and families apply for diverse housing opportunities. However, this requires extensive application documentation and staff have noted that the application process can be prolonged due the need to gather documents, specifically, verifications of homelessness and disability. However, as staff become more familiar with the new application process and the required documentation, staff are engaging in proactive conversations with clients so they are prepared once they are matched to a housing option.

Future efforts include identifying a group of individuals who previously struggled with obtaining and maintaining housing and would like to share their stories with others who are currently trying to obtain housing. These "alumni" individuals are able to share a real perspective on the investment of time and effort to ensure a successful housing journey. By hearing it from their peers, we hope it helps clients understand and become receptive to the housing plans identified for them.

COVID-19 Response

In March 2020, the majority of communication moved to a virtual platform. All partner meetings are held virtually and communication continues via phone or email outside of those meetings. Team meetings with housing referrals and clinical teams have mostly been virtual or over the phone.

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Residential Service Coordinators (Tri-City staff assigned to housing sites) continued their regular communication with MHSA tenants via phone. Not all clients have access to smart phones, laptops, or are savvy when it comes to technology. Staff also recognize in-person support benefits some clients so staff have arranged meetings where one housing or clinical staff is present with the client and the rest of the team joins virtually.

PSH staff conduct regular visits, using personal protective equipment, at the Transition Housing site, to confirm that all building needs are being met and to identify resources residents may need. Since staff are no longer physically located at the properties, there is a loss of visual contact that usually helps them to better understanding how their tenants are doing.

Cultural Approach

Recognizing the cultural influences and needs of clients is important when considering housing options. Four of the six housing staff are bilingual in English and Spanish. In addition, staff are able to connect individuals with the official Language Line for additional assistance, if needed.

In serving clients in Tri-City's housing programs, staff are able to assist clients who express concern regarding their rights as tenants. By referencing laws related to Housing Rights, staff are able to help clients identify if a situation violates the Fair Housing Laws and help them understand what steps they can take to address them. Tri-City clinicians are encouraged to refer clients to PSH's Open Door group to allow them to engage in conversations with other residents and become better informed of their rights and responsibilities as tenants.

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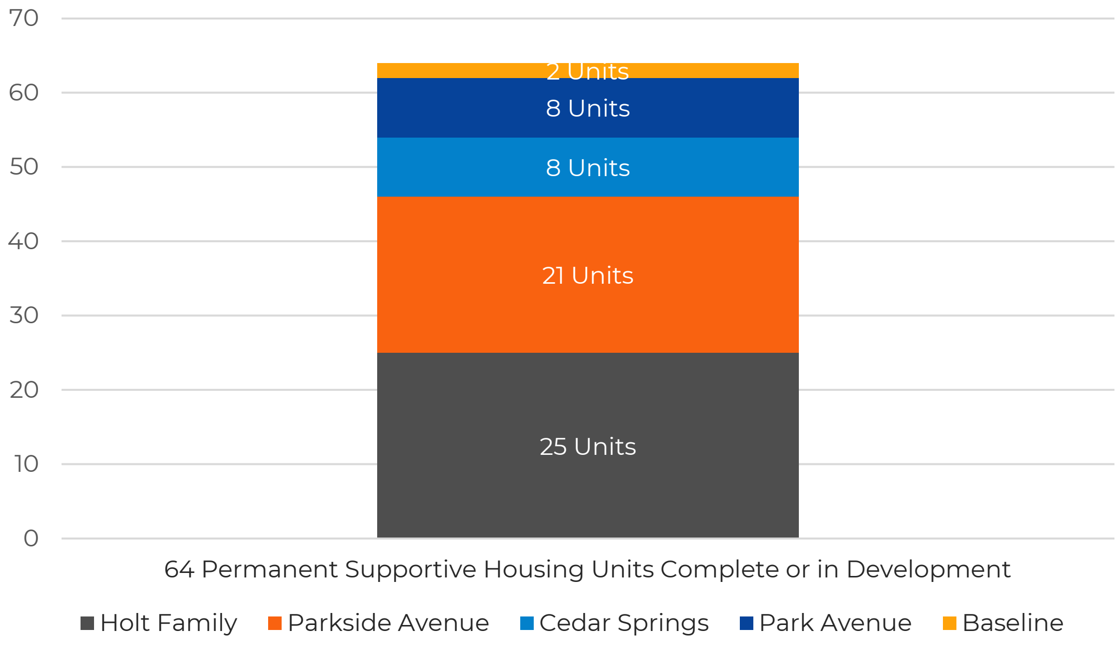
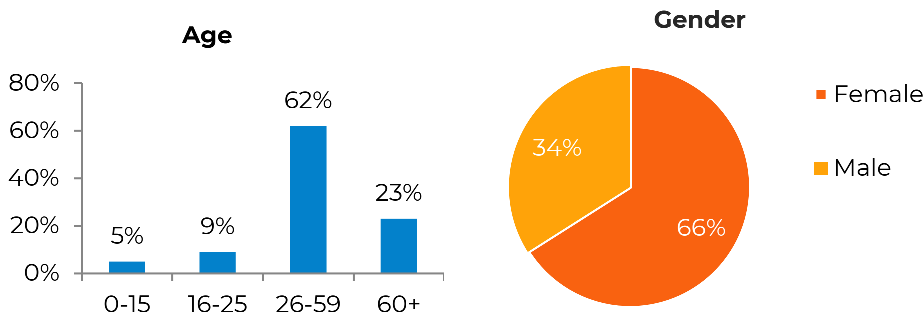
PROGRAM: Permanent Supportive Housing (PSH)

HOW MUCH DID WE DO?



250
Individuals Served with Housing Needs


Age
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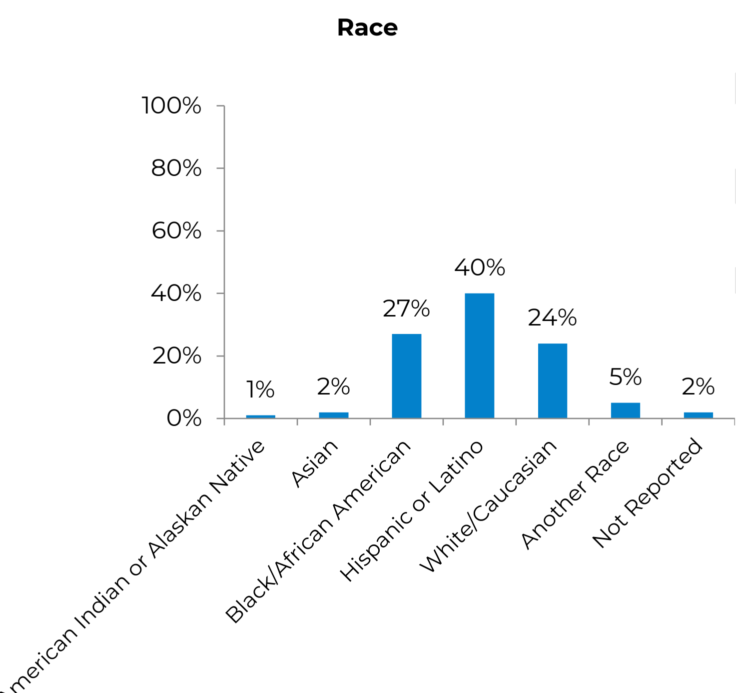
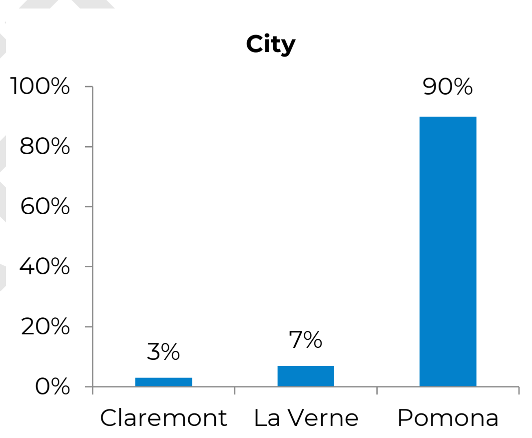
60%
40%
20%
0%
5%
9%
62%
23%
0-15
16-25
26-59
60+
Gender
34%
66%
Female
Male


Race
100%
80%
60%
40%
20%
0%
1%
2%
27%
40%
24%
5%
2%
American Indian or Alaskan Native
Asian
Black/African American
Hispanic or Latino
White/Caucasian
Another Race
Not Reported


City
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80%
60%
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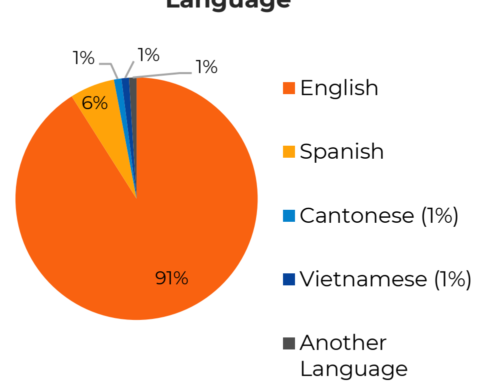
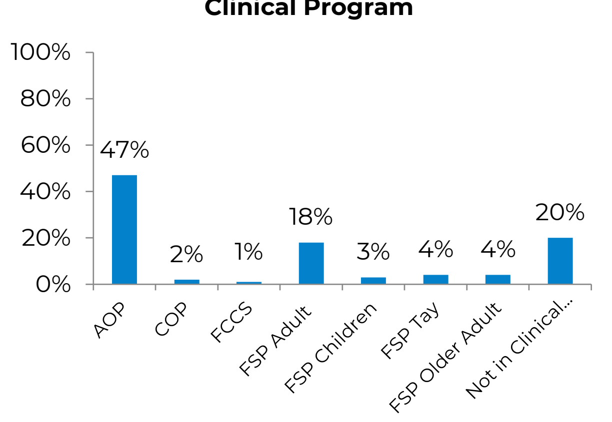
20%
0%
3%
7%
90%
Claremont
La Verne
Pomona


Language
1%
1%
1%
6%
91%
English
Spanish
Cantonese (1%)
Vietnamese (1%)
Another Language


Clinical Program
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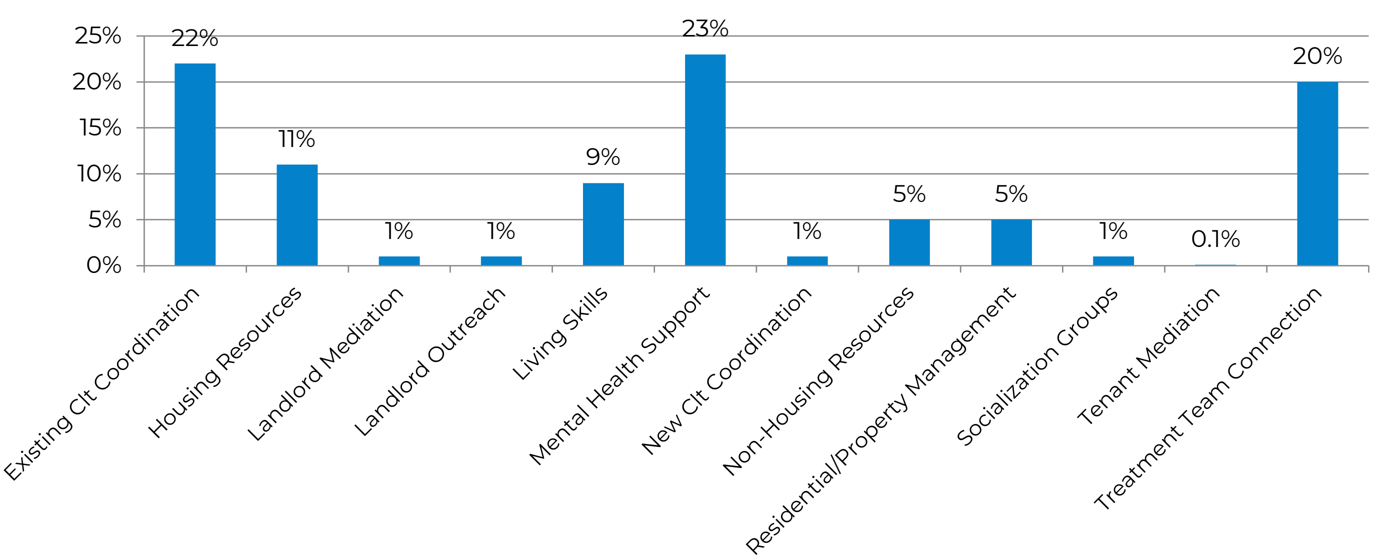
40%
20%
0%
47%
2%
1%
18%
3%
4%
4%
20%
AOP
COP
FCCS
FSP Adult
FSP Children
FSP Tay
FSP Older Adult
Not in Clinical...

HOW WELL DID WE DO IT?

28
Housing Clients Discharged Due to Lower Level of Care or No Further Care Needed

938
Housing Actions



IS ANYONE BETTER OFF?

4	113	23	66	69
Unique Individuals Assisted with Eviction Prevention	Unique Individuals Assisted with Maintaining Their Housing	Unique Individuals Secured Housing Either in Tri-City or Elsewhere	Unique Individuals Assisted with Obtaining Housing	Unique Individuals Connected to Housing Resources

MHSA Regulations for Prevention and Early Intervention

"The County shall identify each Program funded with Prevention and Early Intervention funds as a Prevention Program, Early Intervention Program, Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Stigma and Discrimination Reduction Program, Suicide Prevention Program, Access and Linkage to Treatment Program, or Program to Improve Timely Access to Services for Underserved Populations".

Prevention and Early Intervention Regulations/July 1, 2018
(Title 9 California Code of Regulations, Division 1, Chapter 14 MHSA)

Per the Regulations stated above, Counties are required to identify each program funded under their Prevention and Early Intervention Plan by one or more of the following categories:

Prevention and Early Intervention Plan Required Categories/Programs

1. **Prevention Program**
   a. Housing Stability Program
   b. Therapeutic Community Gardening
2. **Early Intervention Program**
   a. Early Psychosis Program
   b. TAY and Older Adult Wellbeing (Peer Mentor Program)
   c. Therapeutic Community Gardening
3. **Access and Linkage to Treatment Program**
   a. Early Psychosis Program
   b. Family Wellbeing Program
   c. Housing Stability Program
   d. TAY and Older Adult Wellbeing (Peer Mentor Program)
   e. Therapeutic Community Gardening
   f. Wellness Center (TAY and Older Adults)
4. **Stigma and Discrimination Reduction**
   a. Community Mental Health Trainings
   b. Community Wellbeing Program
   c. Early Psychosis Program
   d. Family Wellbeing Program
   e. Housing Stability Program
   f. TAY and Older Adult Wellbeing (Peer Mentor Program)
   g. Therapeutic Community Gardening
   h. Wellness Center (TAY and Older Adults)
5. **Outreach for Increasing Recognition for Early Signs of Mental Illness Program**
   a. Community Mental Health Trainings
   b. Community Wellbeing Program
   c. Early Psychosis Program
   d. Family Wellbeing Program
   e. Housing Stability Program
   f. TAY and Older Adult Wellbeing (Peer Mentor Program)
   g. Therapeutic Community Gardening
   h. Wellness Center (TAY and Older Adults)
6. **Suicide Prevention**
   a. Stigma Reduction/Suicide Prevention
   b. NAMI: Ending the Silence
   c. TAY and Older Adult Wellbeing (Peer Mentor Program)

Community Wellbeing Program

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	___ 25-69	___ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention		___ Prevention and Early Intervention	

Program Description

The program provides small grants up to $10,000 and technical assistance to help communities build their capacity to strengthen the wellbeing of their members and the community as a whole. The program focuses on providing support to communities at greater risk for mental illness.

Target Population

Local communities (defined as a group of individuals who rely on each other for support and can act together) who are interested in building their own capacity to strengthen the wellbeing of their members.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+
Number Served FY 2019-20	2,794	59	59	29

Program Update

The Community Wellbeing Grant program awarded 11 grants in FY 2019-20. These grantees represent 2,941 individuals and the following agencies and organizations: City of Pomona After School Recreation, Claremont Unified School District, Gente Organizada, Kennedy Austin Foundation, NAMI African American Parents, NAMI Padres Efectivos, Newcomers Access Center, Parkside Boys and Girls Club, Simons Middle School, STEM Club City of Knowledge and The Greener STEMs Club. Programs offered through this groups include afterschool learning activities, tutoring, gardening, parenting classes, support groups, public speaking skills, STEM clubs, that improved the wellbeing of their communities.

Challenges and Solutions

There were not significant challenges for this program in FY 2019-20. One notable change was the transition of the Community Capacity Organizer to another position. However, this position was quickly filled and the grant process continued seamlessly and with continued support.

COVID-19 Response

As with other MHSA programing, the Community Wellbeing Grant program was moved to a virtual platform with staff working remotely. Meetings that previously took place in person were now conducted through RingCentral.

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Beginning with the onset of COVID 19, all grantees were required to make modifications to their projects. Participants identified how their communities were impacted by the pandemic and how these modifications would be implemented. All correspondence and communication were handled through RingCentral, phone calls and emails.

When preparing for the next round of grants, the CWB staff modified their application and interview process to comply with local, state and federal guidelines regarding COVID-19. This included conducting all application reviews and participant interviews via RingCentral. Future protocol for this program will continue as stated until the COVID 19 restrictions are lifted.

Cultural Approach

The Community Wellbeing Program collaborates with an array of grantees that provide services to the underserved and unserved communities. These grantees also network and collaborate with each other to continue to provide services to these communities. In addition, staff continue to outreach and network with local agencies who focus on providing services to the underserved and unserved communities.

In response to addressing barriers to service; grantees are notified via email of any upcoming Tri-City programs, services, webinars, community connections webinars, mental health trainings that address these barriers. Grantees are encouraged to spread the word within their communities so they can participate in any of these educational opportunities.

The Community Capacity Organizer for this program is bilingual and able to communicate effectively in both English and Spanish. In addition, all flyers, brochures, grant applications, and supporting documents are available in both English and Spanish.

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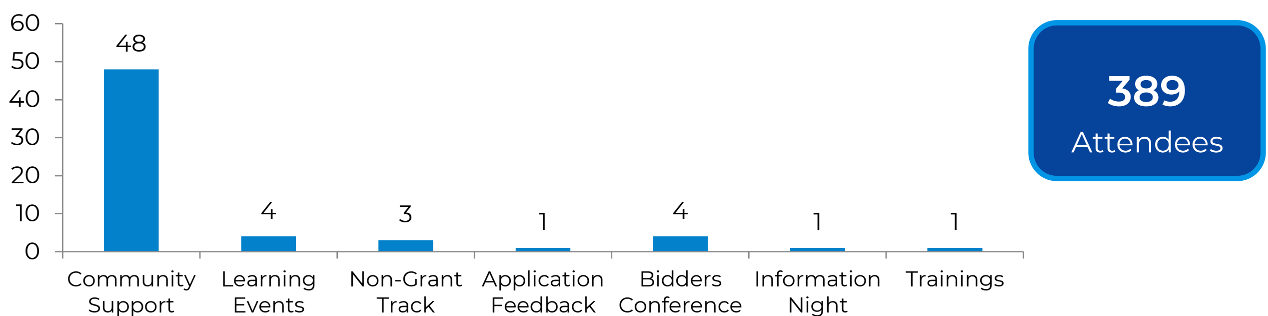
PROGRAM: Community Wellbeing Program (CWB)

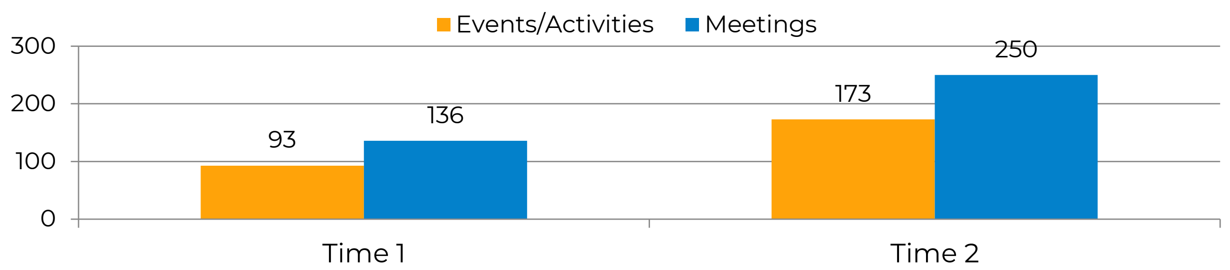
HOW MUCH DID WE DO?

11	2,941	1,781
Community Grantees Chosen	Community Members Represented in 10 out of 11 Grantees	Number of People Who Benefited from Grantee Activities from 10 out of 11 Grantees

Number of Events Held by Community Capacity Organizer

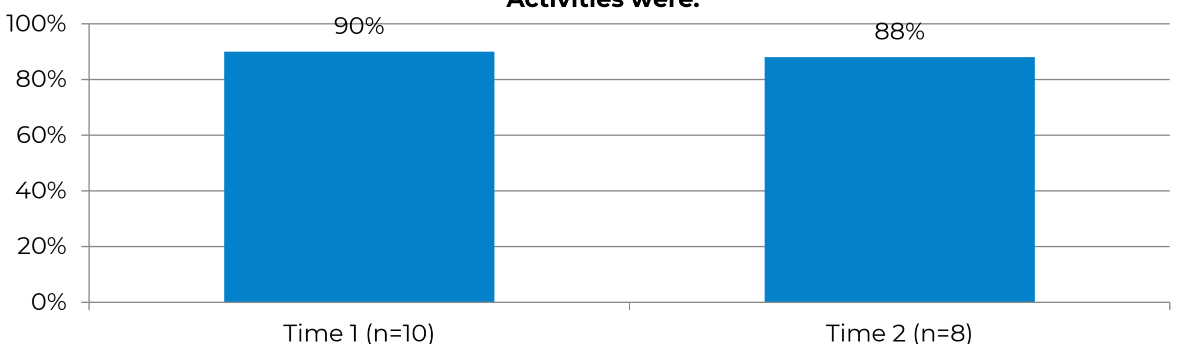


Number of Community Events/Activities and Meetings

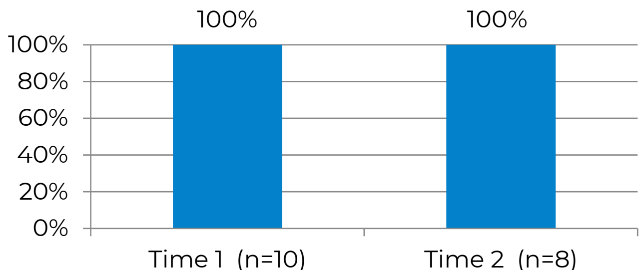


HOW WELL DID WE DO IT?

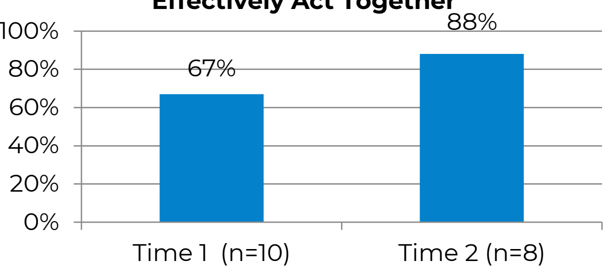
Percentage of Grantees who Report How Successful Their Community's Activities were:



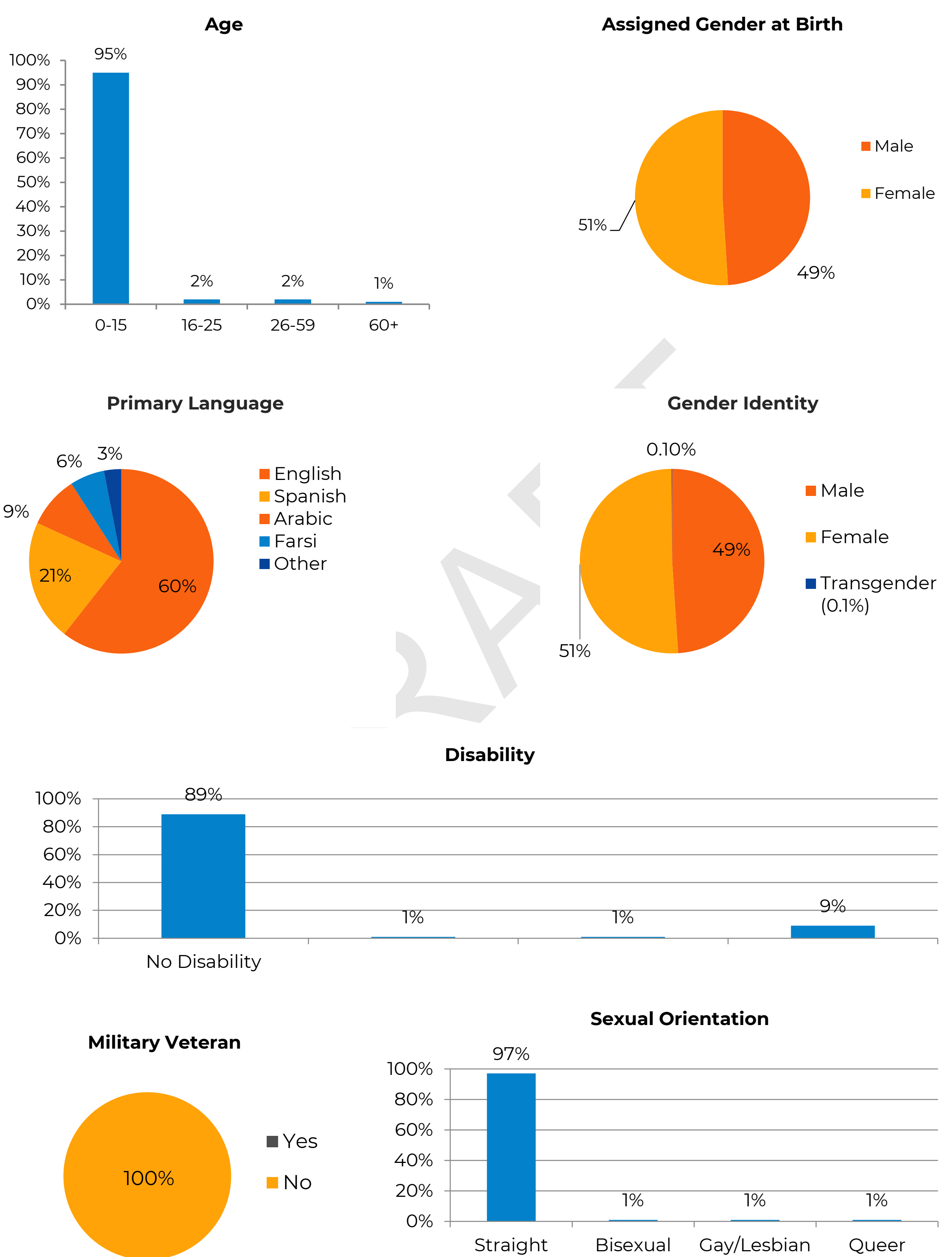
Percentage of Grantees Who Report Improvement in Supporting Each Other

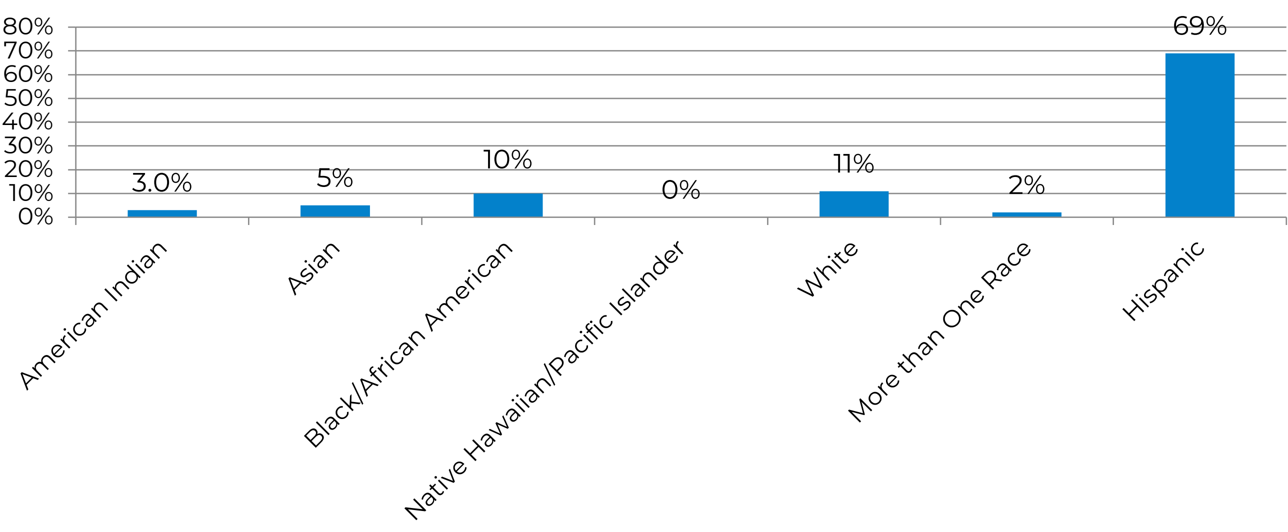


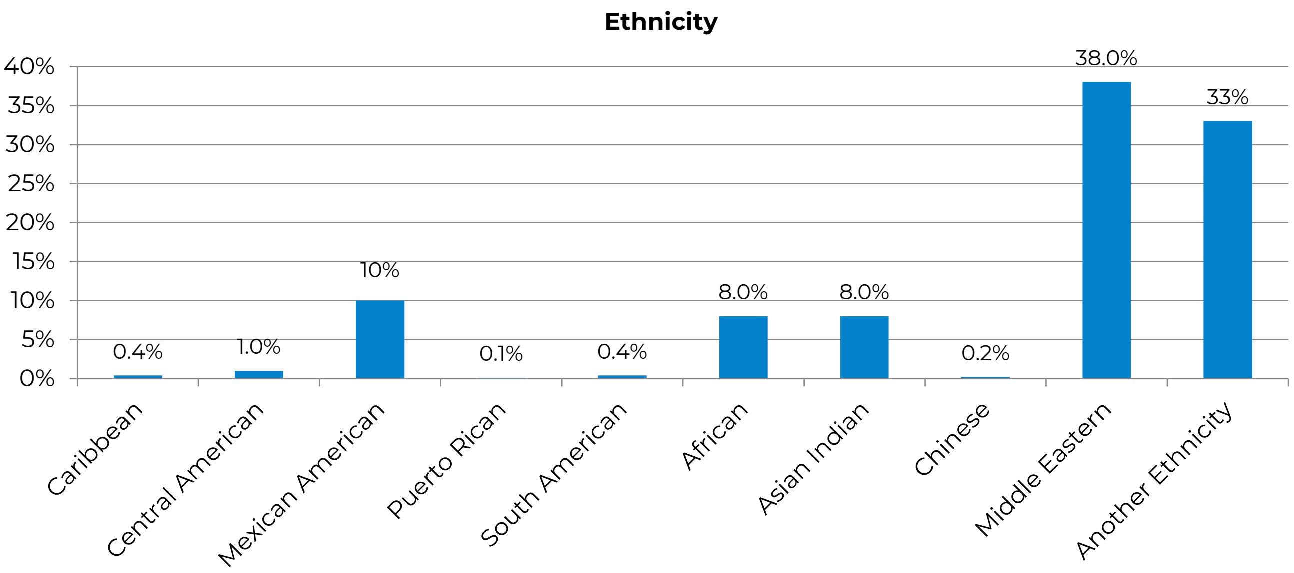
Percentage of Grantees Who Report Improvement in Their Ability to Effectively Act Together



PEI DEMOGRAPHICS




Race
80%
70%
60%
50%
40%
30%
20%
10%
0%
3.0%
5%
10%
0%
11%
2%
69%
American Indian
Asian
Black/African American
Native Hawaiian/Pacific Islander
White
More than One Race
Hispanic


Ethnicity
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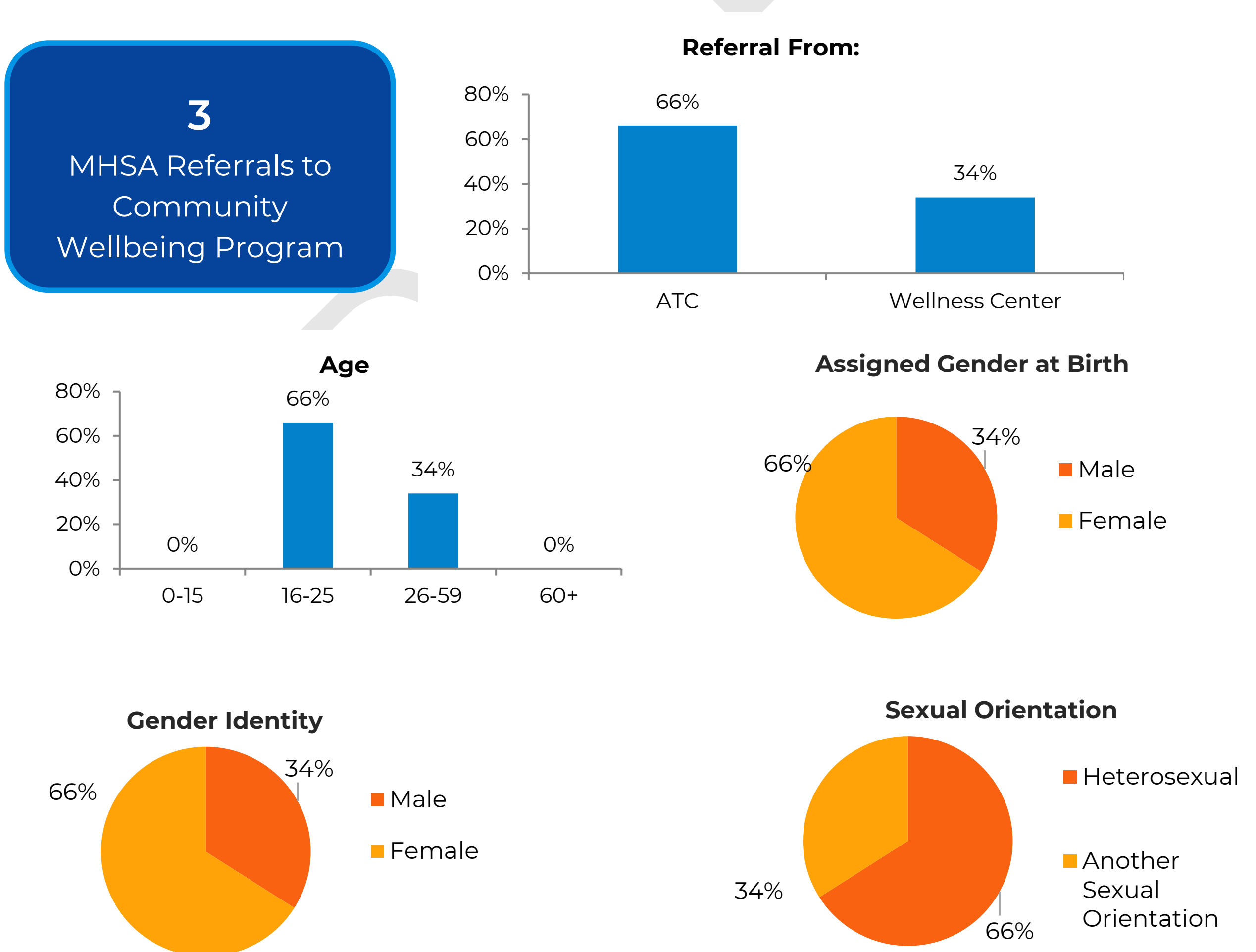
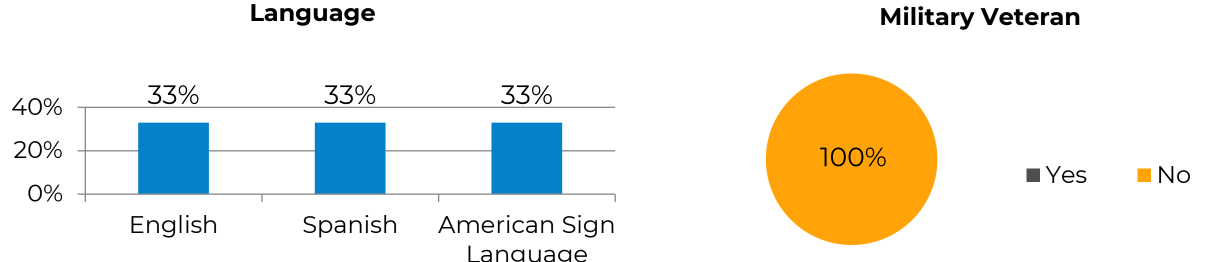
35%
30%
25%
20%
15%
10%
5%
0%
0.4%
1.0%
10%
0.1%
0.4%
8.0%
8.0%
0.2%
38.0%
33%
Caribbean
Central American
Mexican American
Puerto Rican
South American
African
Asian Indian
Chinese
Middle Eastern
Another Ethnicity

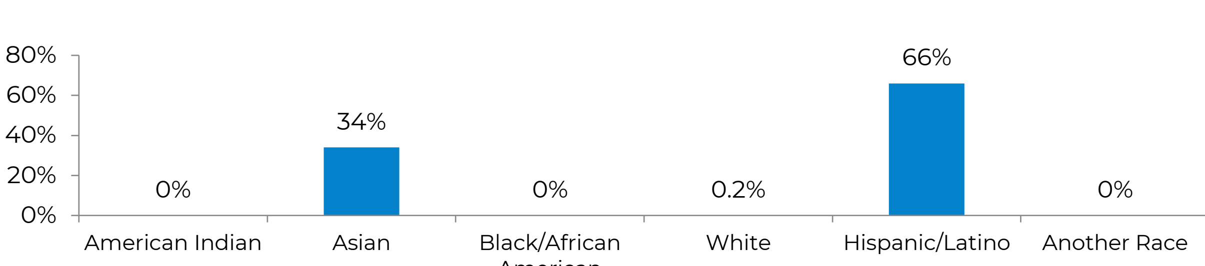
Number of Potential Responders	2,941
Setting in Which Responders were Engaged	Community, Schools, Health Centers, Workplace and Outdoors
Type of Responders Engaged	TAY, teachers, LGBTQ+, families, religious leaders, and those with lived experience
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

PEI Demographics Based on MHSA Referrals




Language
40%
20%
0%
33%
33%
33%
English
Spanish
American Sign Language
Military Veteran
100%
Yes
No


Race
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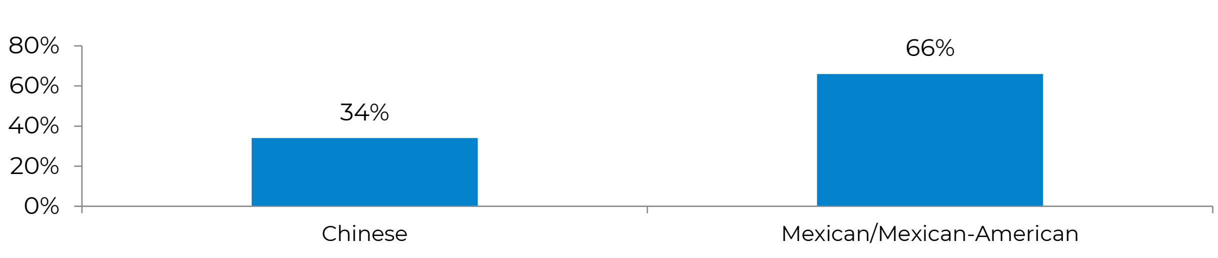
40%
20%
0%
0%
34%
0%
0.2%
66%
0%
American Indian
Asian
Black/African American
White
Hispanic/Latino
Another Race


Ethnicity
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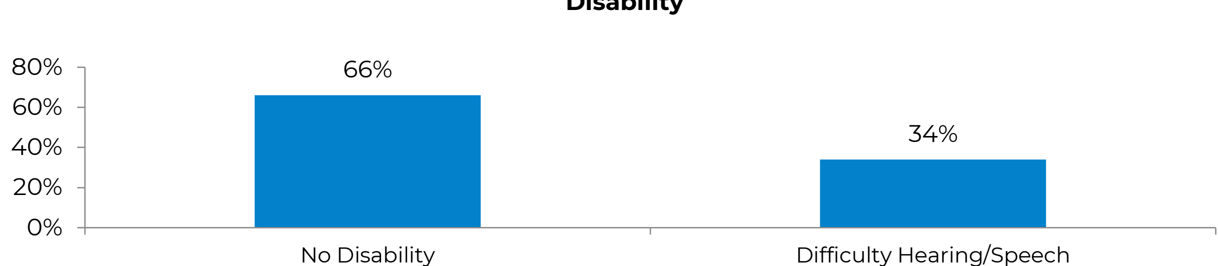
60%
40%
20%
0%
34%
66%
Chinese
Mexican/Mexican-American


Disability
80%
60%
40%
20%
0%
66%
34%
No Disability
Difficulty Hearing/Speech

Community Mental Health Trainings

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	___ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention		___ Prevention and Early Intervention	

Program Description

Community Mental Health Trainers offer free group trainings including Mental Health First Aid (MHFA), Adverse Childhood Experiences [ACE], Community Resiliency Model [CRM], Motivational Interviewing [MI], and Everyday Mental Health [EMH] as well as workshops based on the Recovery Model, Non-Suicidal Self-Harm and parenting classes. Since the onset of COVID-19, these trainings are now offered virtually.

Target Population

Tri-City staff, community members, local schools and agencies who are interested in learning how to recognize the early warning signs of mental illness and appropriately intervene to provide support.

Community Mental Health Trainings FY 2019-20	54
Individuals Trained	940

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Program Update

The Community Mental Health Trainings continue to be a popular program within the tri-city area. The extensive menu of training options, and the flexibility of Tri-City's staff in adapting trainings to their audiences, has allowed this program to expand the type of trainings offered.

In July 2019, Pomona Unified School District (PUSD) asked Tri-City to host a series of mental health and wellness workshops for PUSD summer students and exchange students from China. Claremont Graduate University's Social Work Program, in collaboration with Western Colleges' Nursing Program requested a series of Tri-City trainings on Adverse Childhood Experiences [ACE], Community Resiliency Model [CRM], Motivational Interviewing [MI], and Everyday Mental Health [EMH] to graduate students in each of their programs. Western University invited Tri-City to provide an ACES presentation to over 100 of their medical students from their Pomona campus and a satellite campus in Oregon virtually ACEs Aware Grant.

Challenges and Solutions

With this growing popularity, it became clear that a dedicated program staff/trainer was needed to oversee this essential program. A second challenge was the limited curriculum available in Spanish in addition to the lack of a bilingual trainers. These issues were addressed and resolved when this position was filled in July 2020.

COVID-19 Response

As with all MHSA programing, staff began working remotely with all communication conducted through RingCentral, email and/or by phone. Similar to staff, all communication with community partners were managed through phone/email.

As expected, all scheduled events, trainings, and programs had to be canceled due to physical/social distancing requirements without the ability to reschedule. Instead, communication focused on providing resources, information, updates, and virtual webinars regarding COVID-19.

COVID-19 significantly impacted the ability to immediately provide the same level of trainings as prior to the pandemic. Access to a virtual platform and the modification to the "in-person" trainings took time to execute. Many community partners did not have a virtual platform in place in order to receive the training virtually. In addition, the pandemic caused many community partners to shut down which limited communication for a significant period of time, including local school districts and colleges who were busy transitioning to a virtual learning environment with very little notice or preparation.

As of April 2020, all community trainings were offered virtually through the RingCentral Webinar platform. CMHT began providing weekly webinars on topics that were already a part of Tri-City's training series. Notification of these trainings were posted on Tri-City's webpage, social media accounts, and emails.

Cultural Approach

Prior to COVID-19, Community Mental Health trainers (CMHT) were able to address cultural barriers through in-person connections with under/unserved communities and by building relationships with organization that work, serve, and support these communities, by providing information, services, and trainings.

By working closely with Tri-City's Stigma Reduction Program, CMHTs share information on how to reduce stigma that impacts community partners from seeking, accessing, and utilizing services. By reaching out to organizations to set-up trainings, share information, and educate them on what mental illness/wellness is, it's impact, and accessible services, staff are able to share resources available to help prevent and support someone who's experiencing a mental health challenge.

Tri-City has hired a bilingual/Spanish full-time program staff to provide trainings in Spanish. Trainings and webinars will be available in English and Spanish in addition to marketing materials available in both languages as well.

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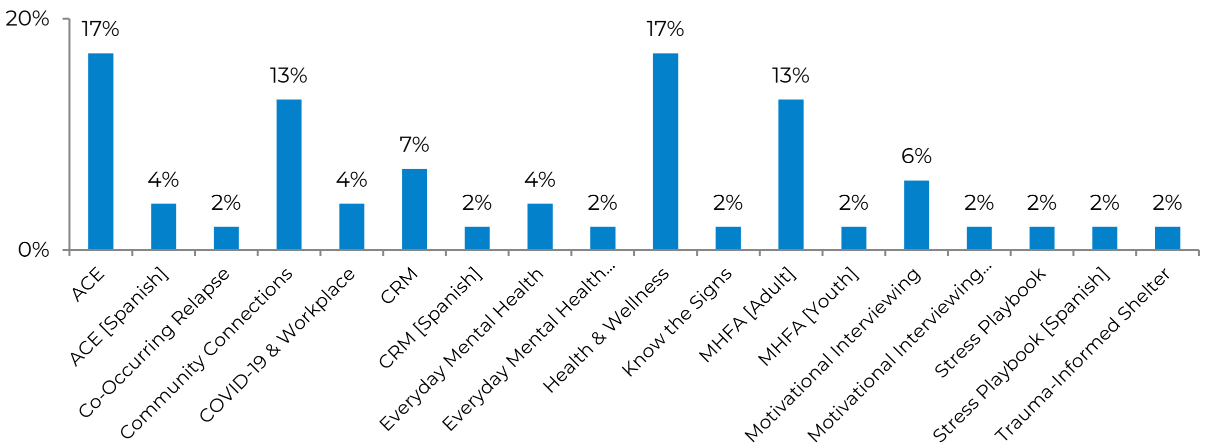
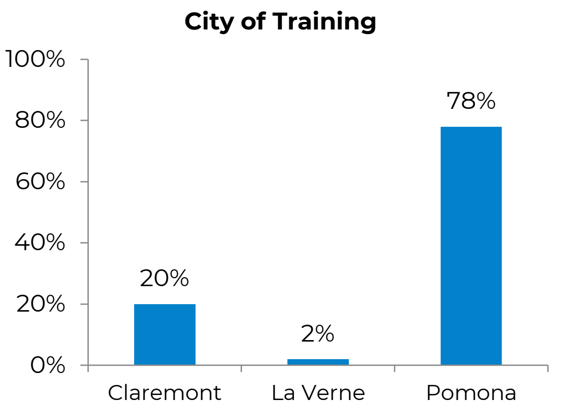
PROGRAM: Community Mental Health Trainings (CMHT)

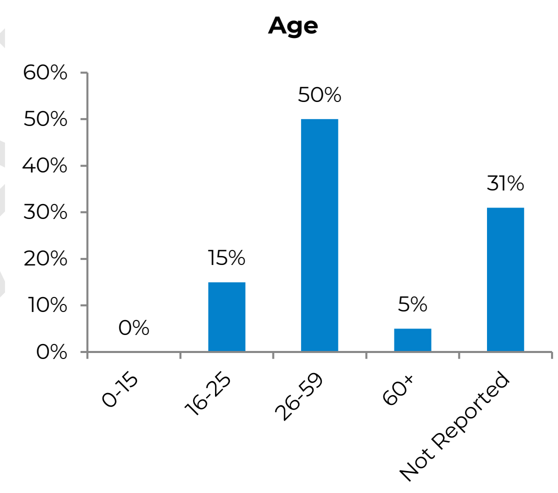
HOW MUCH DID WE DO?

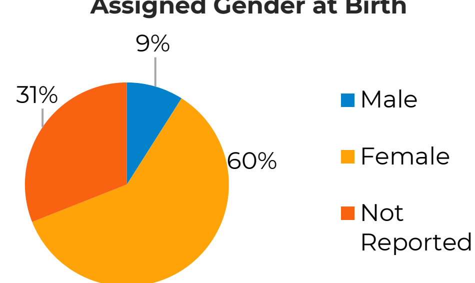
940
Individuals Served

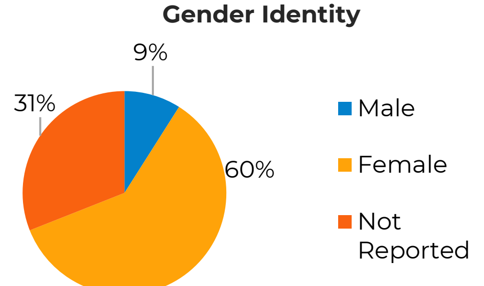
54
Community Mental Health Trainings

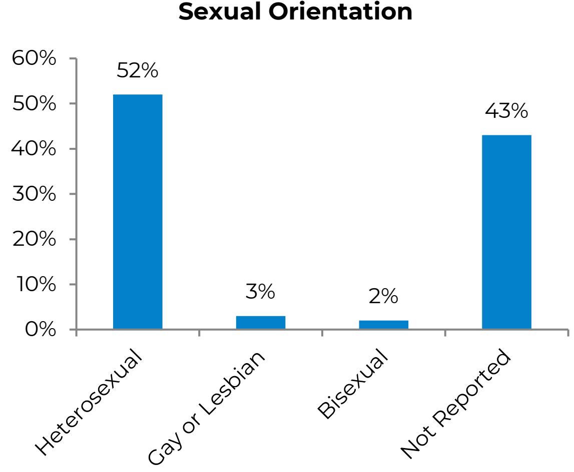

Community Mental Health Trainings
20%
0%
17%
4%
2%
13%
4%
7%
2%
4%
2%
17%
2%
13%
2%
6%
2%
2%
2%
2%
ACE
ACE [Spanish]
Co-Occurring Relapse
Community Connections
COVID-19 & Workplace
CRM
CRM [Spanish]
Everyday Mental Health
Everyday Mental Health...
Health & Wellness
Know the Signs
MHFA [Adult]
MHFA [Youth]
Motivational Interviewing
Motivational Interviewing...
Stress Playbook
Stress Playbook [Spanish]
Trauma-Informed Shelter

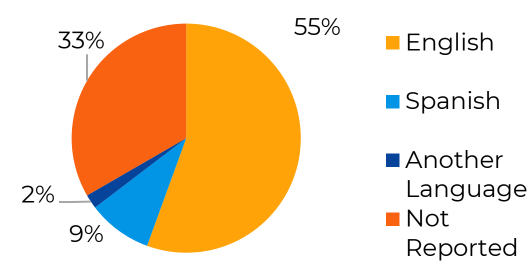

City of Training
100%
80%
60%
40%
20%
0%
20%
2%
78%
Claremont
La Verne
Pomona

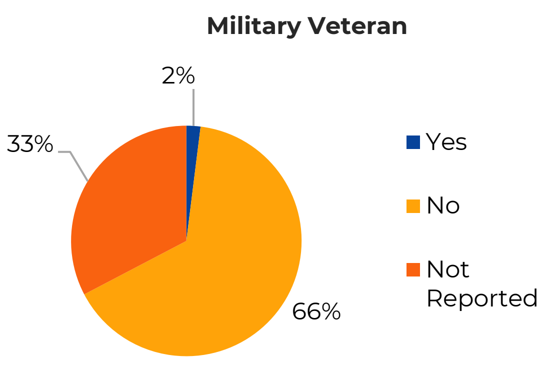

Age
60%
50%
40%
30%
20%
10%
0%
0%
15%
50%
5%
31%
0-15
16-25
26-59
60+
Not Reported

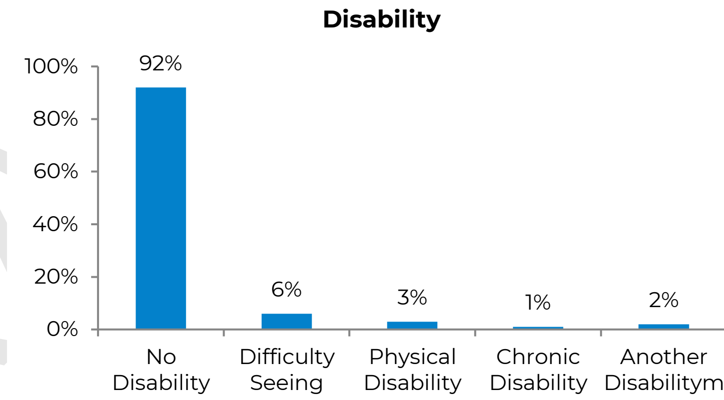

Assigned Gender at Birth
9%
31%
60%
Male
Female
Not Reported

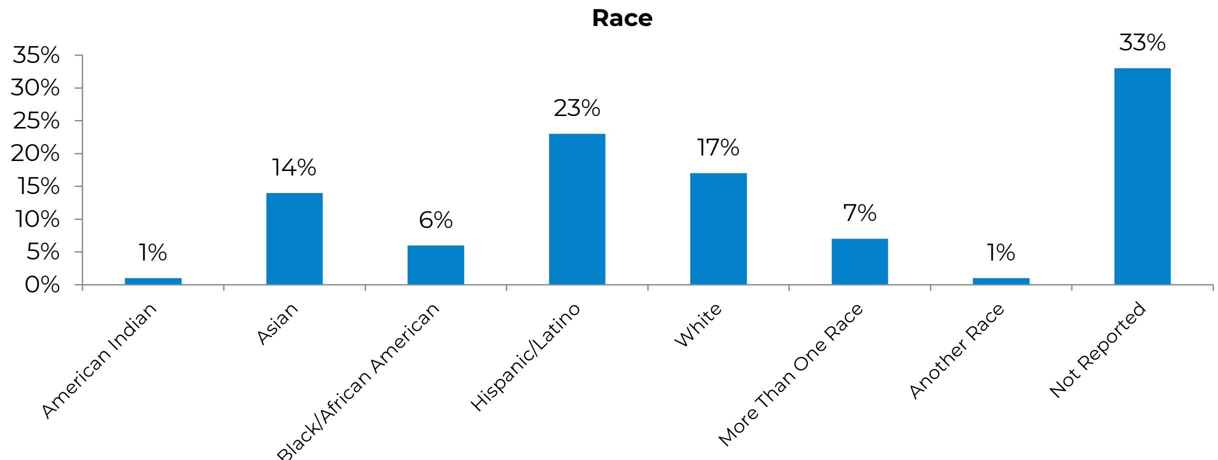

Gender Identity
9%
31%
60%
Male
Female
Not Reported

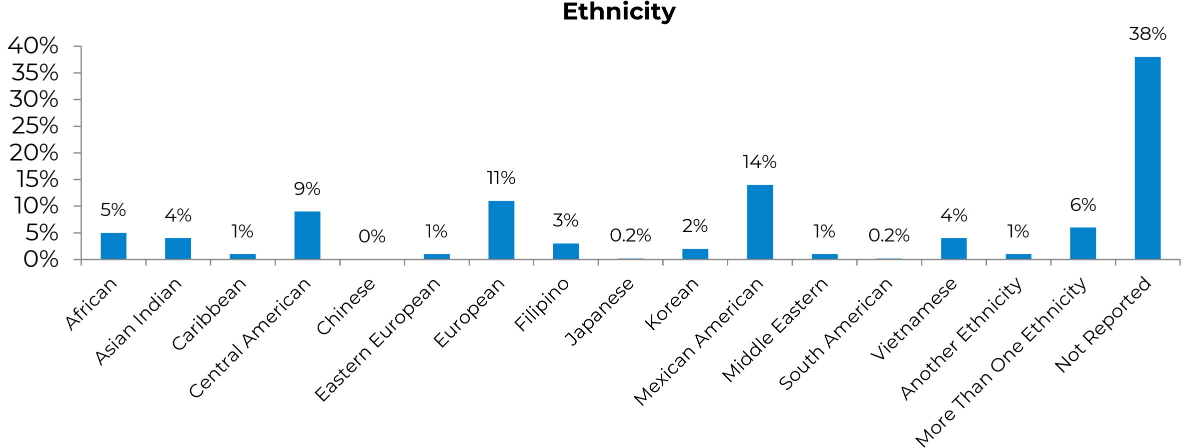

Sexual Orientation
60%
50%
40%
30%
20%
10%
0%
52%
3%
2%
43%
Heterosexual
Gay or Lesbian
Bisexual
Not Reported


Primary Language
33%
55%
2%
9%
English
Spanish
Another Language
Not Reported


Military Veteran
2%
33%
66%
Yes
No
Not Reported

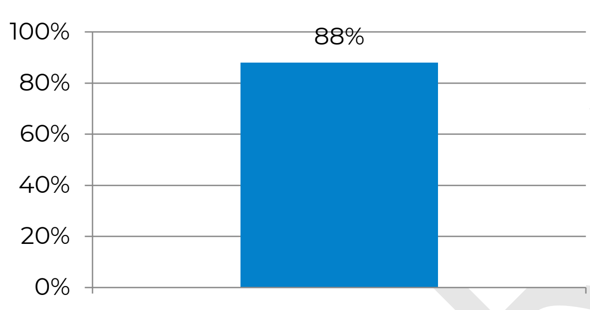

Disability
100%
80%
60%
40%
20%
0%
92%
6%
3%
1%
2%
No Disability
Difficulty Seeing
Physical Disability
Chronic Disability
Another Disabilitym


Race
35%
30%
25%
20%
15%
10%
5%
0%
1%
14%
6%
23%
17%
7%
1%
33%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More Than One Race
Another Race
Not Reported

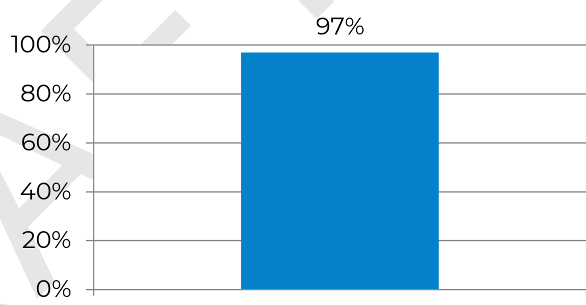


HOW WELL DID WE DO IT?

Percentage of participants who report the training was relevant to their day to day activities:



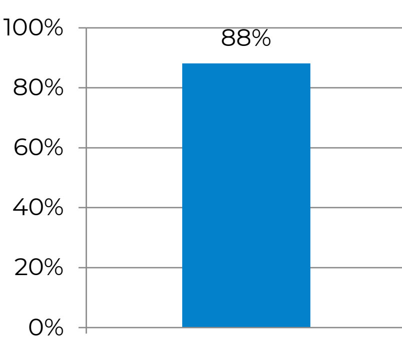
Percentage of participants who rated the training session as good or excellent



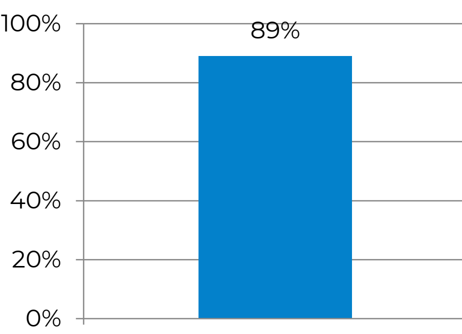
DRAFT

IS ANYONE BETTER OFF?

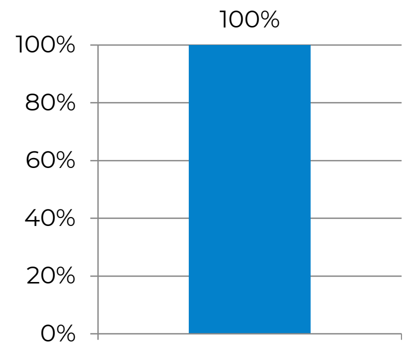
Percentage of participants who report feeling confident in using or applying the skills learned in the training:



Percentage of participants who report feeling more confident reaching out to someone who may be experiencing a mental health challenge or crisis



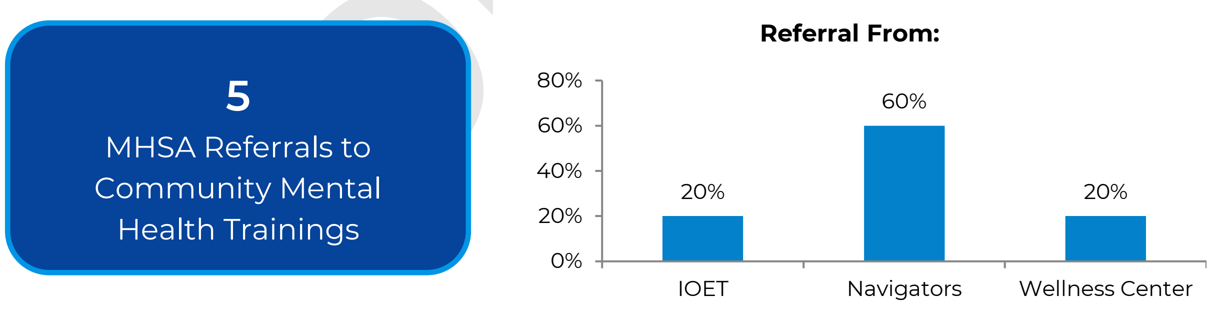
Percentage of participants who would recommend the training to others:

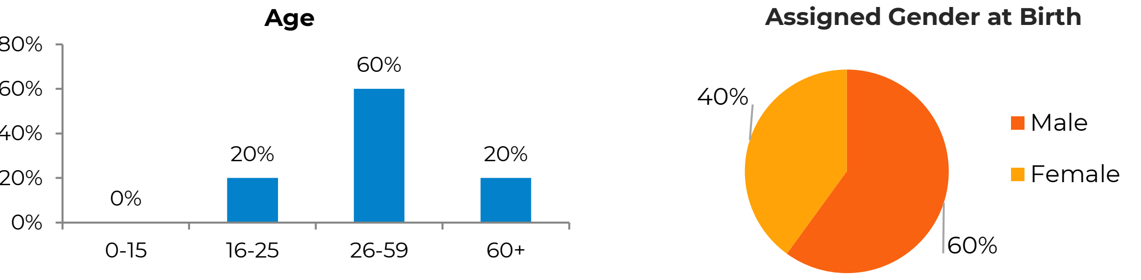


Number of Potential Responders	940
Setting in Which Responders were Engaged	Community, schools and colleges
Type of Responders Engaged	TAY, adults, seniors, landlords and students
Underserved Populations	Black/African American, Asian American/Pacific Islander, Hispanic/Latino, Native American, Refugee/Immigrant, Lesbian/Gay/Bisexual/Transgender/Questioning, Transition Age Youth, Older Adults, and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

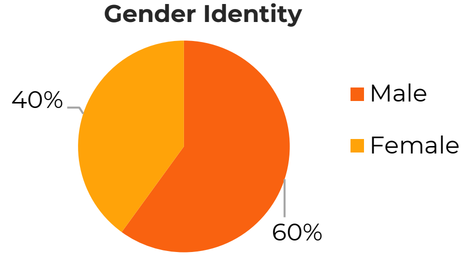
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

PEI Demographics Based on MHSA Referrals

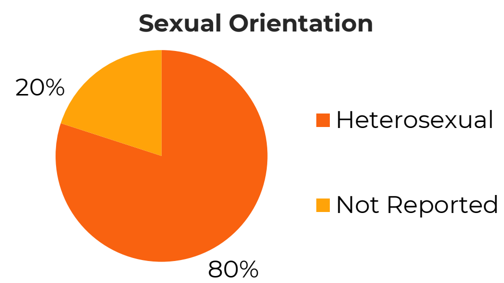




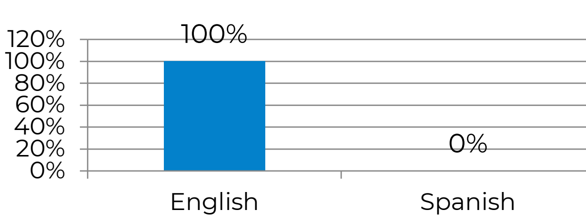
Gender Identity



Sexual Orientation

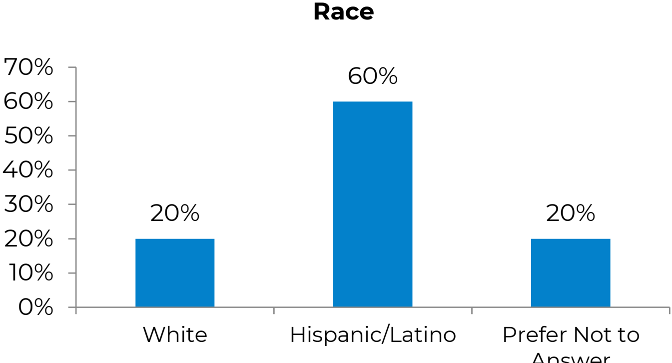


Language

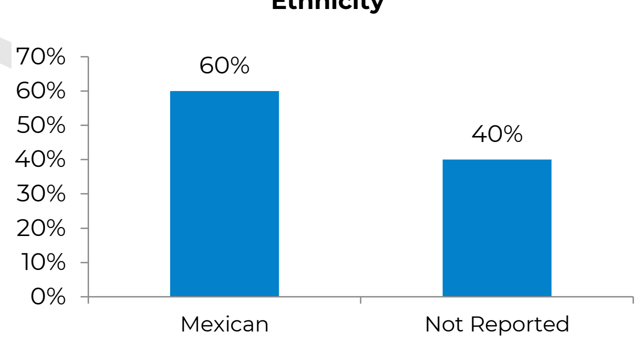


Military Veteran

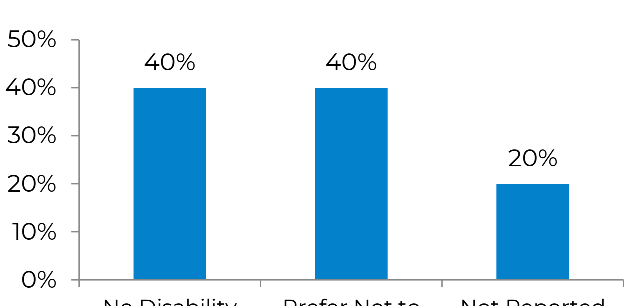
Race



Ethnicity



Disability



Stigma Reduction and Suicide Prevention

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention		___ Prevention and Early Intervention	

Program Description

Tri-City's stigma reduction effort is encompassed under Room4Everyone and includes a website focused on stigma reduction, along with several other components designed to empower individuals suffering with mental health challenges and awareness to the stigma related to mental illness. Suicide prevention efforts include offering the safeTALK alertness training which provides participants with the skills needed to recognize the signs of suicide in an individual and connect them quickly and safely with the appropriate resources and support services.

Target Population

Community members, agencies and organizations located in the Tri-City region (cities of Claremont, Pomona, and La Verne).

Number of Individuals Served FY 2019-20	206

Program Update

On September 10, 2019, a World Suicide Prevention Day event was hosted in collaboration with NAMI Pomona Valley. This public event screened the documentary "Suicide: The Ripple Effect', a feature length film which documents the suicide attempt of Kevin Hines, the impact of his suicide attempt on others, and his later work as a mental health advocate. We Connect, We Live, We Thrive was the theme of the event. It focused on screening the film, stories of suicide survivors and community partners who have opportunity for community members to connect and get involved right away.

The annual Creative Minds Art Gallery reception theme was 'Let's Celebrate'. Notable entries included a class project submitted by Claremont High School's photography class. This was a wonderful example of collaboration between Tri-City and local schools in raising awareness of the connection of mental health and the arts.

Challenges and Solutions

Challenges during this period included the fact that the curriculum used for suicide prevention, SAFETALK, continues to be only available in English. In addition, the training is four hours long and some participants feel this is too long. The topic of suicide can be very sensitive and challenging for participants to stay engaged for that extended period of time or feel comfortable asking questions.

In response to these concerns, staff have started using Know the Signs, another suicide prevention training/presentation, which is available in Spanish, and can be presented by any staff member.

DRAFT

A second challenge focuses on the stigma reduction presentations which are delivered by a Courageous Minds speaker (person who identifies with lived experience). However, due to scheduling and personal responsibilities, it has been a challenge to maintain speakers to be a part of this program. Staff have connected with Tri-City clinicians and MHSA programs to identify potential clients/participants who would be a great fit for this speaker program.

COVID-19 Response

The impact of COVID 19 for this program primarily involved the cancellation of community events including Green Ribbon Week, a popular week-long series of events focusing on stigma reduction. Outreach efforts were also curtailed since local schools, agencies, and community-based sites were closing in response to the pandemic.

By utilizing RingCentral, a virtual platform, staff were able to offer webinars focusing on a wide-range of topics and promote virtual events, presentations and trainings. In consideration of the impact of individuals in the community being socially isolated, staff designed weekly session called Community Connections that highlighted a specific skill or topic each week and allowed attendees to participate virtually through their cameras and microphones.

Cultural Approach

Striving to offer and provide trainings, presentations and information to diverse communities and neighborhoods across all three cities is one way the stigma reduction program attempts to reach as many individuals as possible. Multi- language trainings are made possible through the collaboration of program staff and bilingual staff members who co-facilitate. When promoting events like art workshops and art reception, flyers are available in both English and Spanish.

The Stigma Reduction program works on reducing stigma by creating a safe space for presentations and trainings that are culturally sensitive and beneficial for all participants. The meaning of "Room4Everyone" expands beyond those with and without mental health conditions. It also refers to finding ways we are more alike than different, no matter what the differences are. Barriers experienced by the LGBTQ community are reduced by having materials that reflect the specifics of mental health on members of their community. Presentations and trainings dedicated to this important population touches on topics that are relevant and provides an opportunity for discussions, provide inclusion, and allow for questions from heterosexual and cisgender attendees to help increase their understanding.

PROGRAM: Stigma Reduction and Suicide Prevention

HOW MUCH DID WE DO? Stigma Reduction

15
Stigma Reduction Presentations

20
Courageous Minds Speakers Shared

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Type of Stigma Reduction Presentations

Presentation	Percent
Stigma [Courageous Minds...	47%
Thriving	6%
Mindfulness	7%
Creative Journaling	6%
Co-Occurring Disorders	7%
Storytelling	6%
Personal Stories	6%
Faith & Recovery	6%
As a Therapist	6%

Presentations by City

City	Percent
Claremont	6%
La Verne	20%
Pomona	73%

1,656
Promotional Materials Distributed

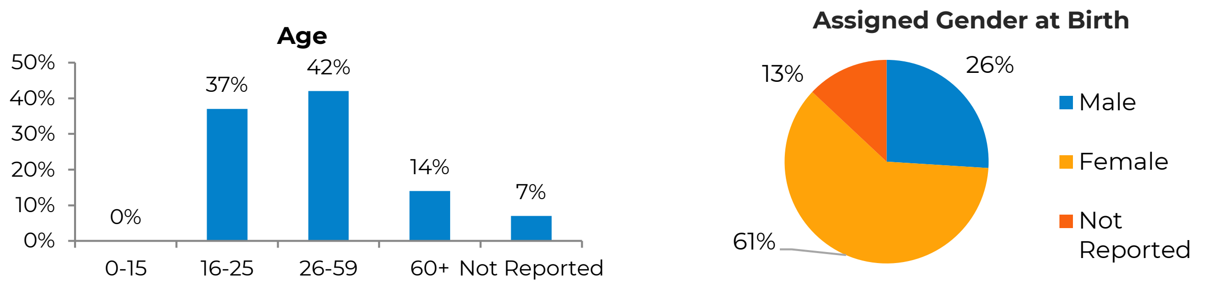
City of Promotional Materials

City	Percent
Claremont	6%
La Verne	22%
Pomona	67%
Other City	6%

Type of Distributed Promotional Materials

Type	Count
Flyers, Brochures, Posters	807
Green Ribbons, Bracelets, Buttons	849

Demographics Based on Participants Who Completed Stigma Reduction Surveys (n=117)



Gender Identity

- Male: 28%
- Female: 66%
- Not Reported: 6%

Race

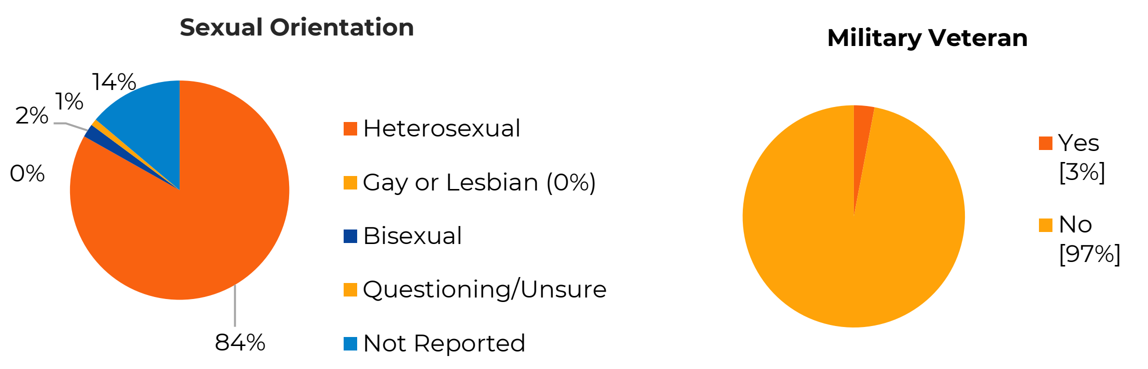
35%
30%
25%
20%
15%
10%
5%
0%

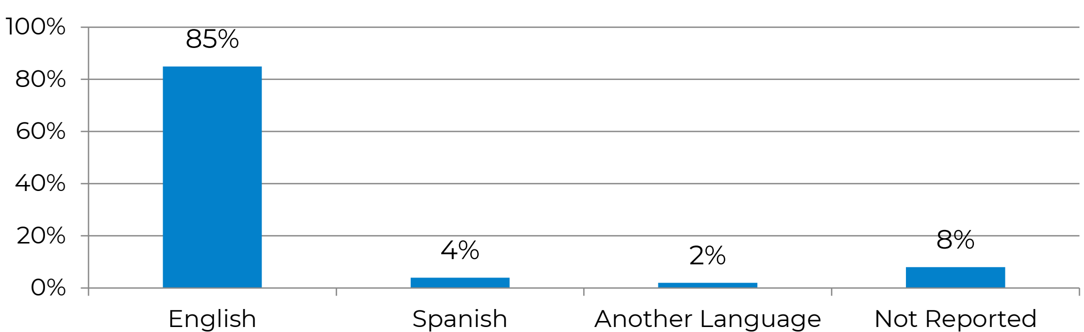
- American Indian: 0%
- Asian: 11%
- Black/African American: 11%
- Hispanic/Latino: 32%
- Native Hawaiian/Pacific Islander: 1%
- White: 27%
- More than one race: 9%
- Not reported: 9%

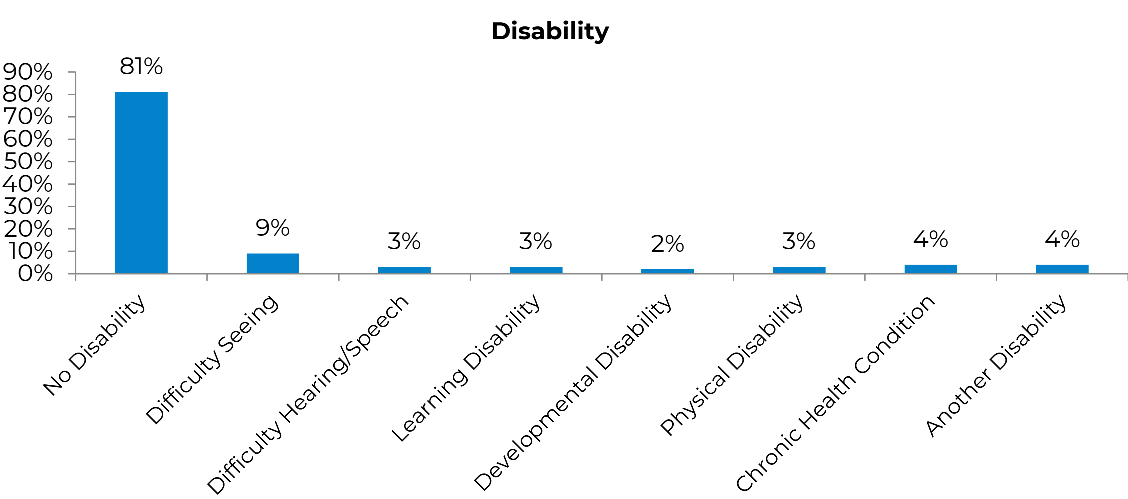
Ethnicity

25%
20%
15%
10%
5%
0%

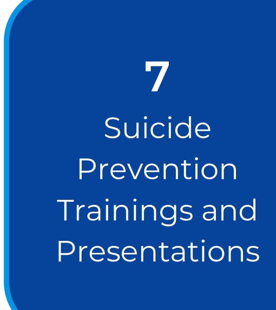
- African: 10%
- Asian Indian/ South Asian: 1%
- Cambodian: 1%
- Caribbean: 1%
- Central American: 9%
- Chinese: 6%
- Eastern European: 1%
- European: 9%
- Japanese: 0.2%
- Korean: 1%
- Mexican/Mexican American: 23%
- Middle Eastern: 1%
- More Than One Ethnicity: 14%
- Salvadorian: 1%
- South American: 0.2%
- Vietnamese: 4%
- Another Ethnicity: 2%
- Not Reported: 20%

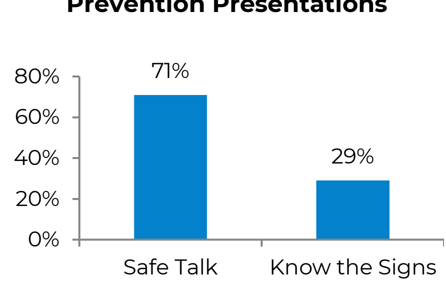


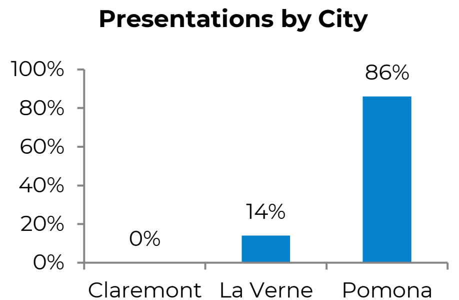




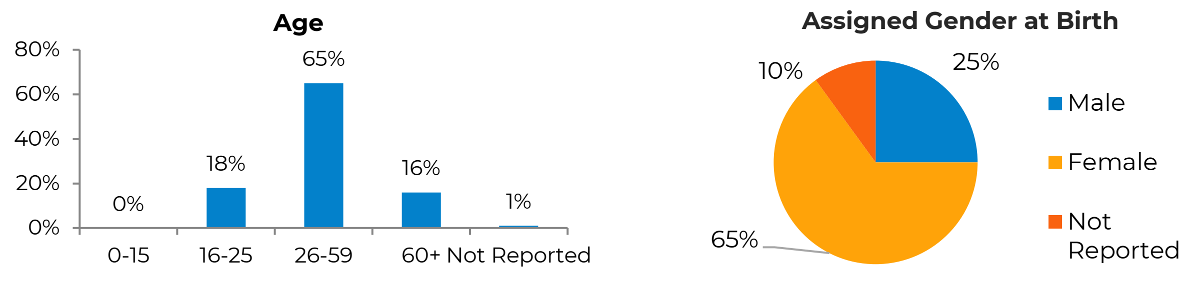
HOW MUCH DID WE DO? Suicide Prevention







Demographics Based on Participants Who Completed Safe Talk Surveys (n=89)



Gender Identity

8%
25%
67%
Male
Female
Not Reported

Sexual Orientation

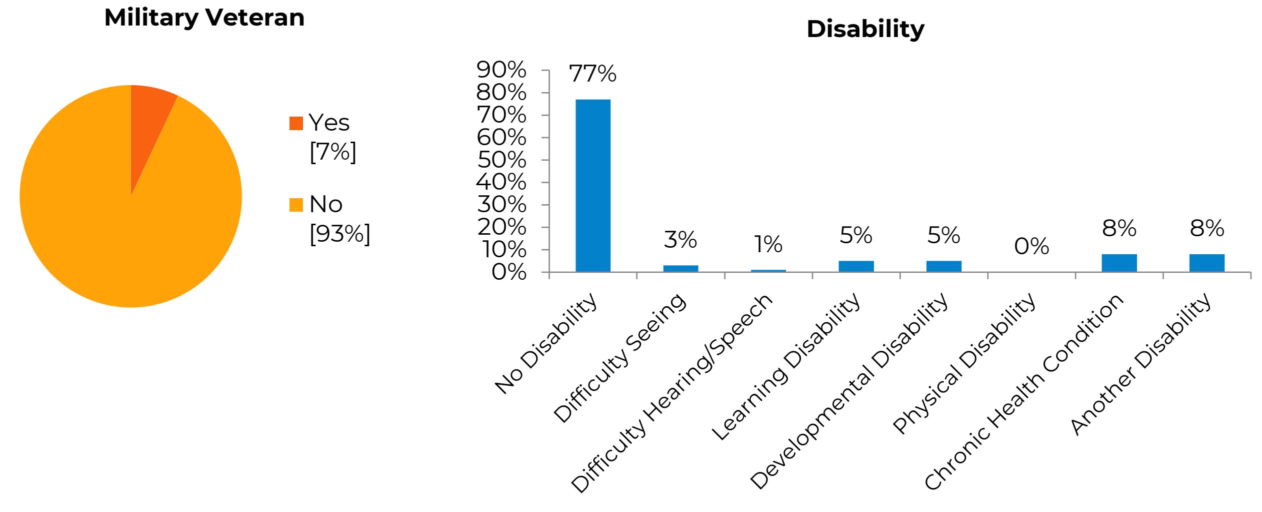
18%
2%
4%
75%
Heterosexual
Gay or Lesbian [4%]
Bisexual [2%]
Not Reported

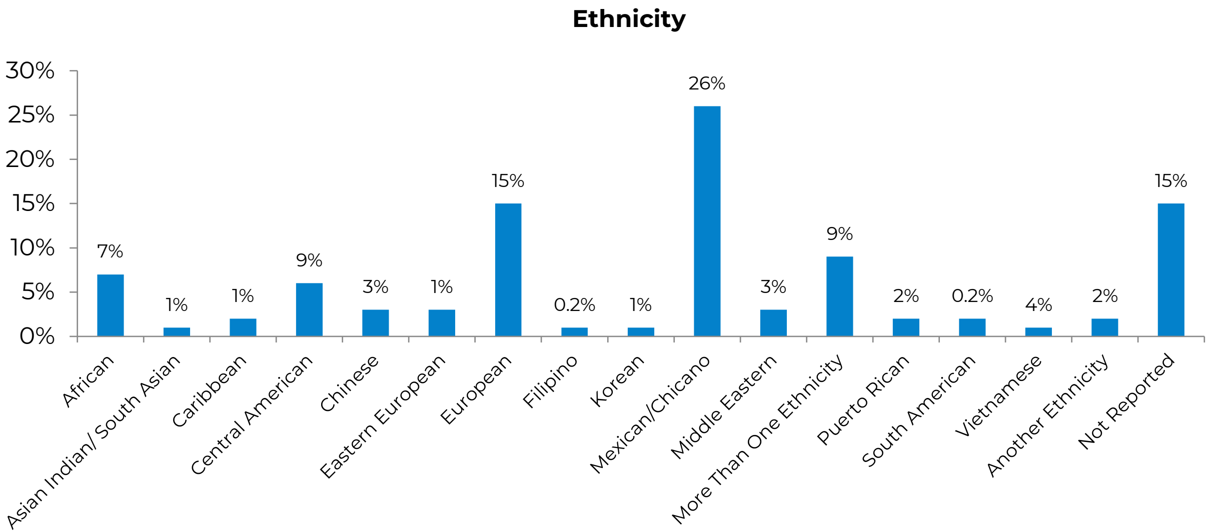
Race

40%
35%
30%
25%
20%
15%
10%
5%
0%
1%
9%
12%
38%
33%
6%
1%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More than one race
Not reported

Primary Language

100%
80%
60%
40%
20%
0%
84%
5%
11%
English
Spanish
Not Reported

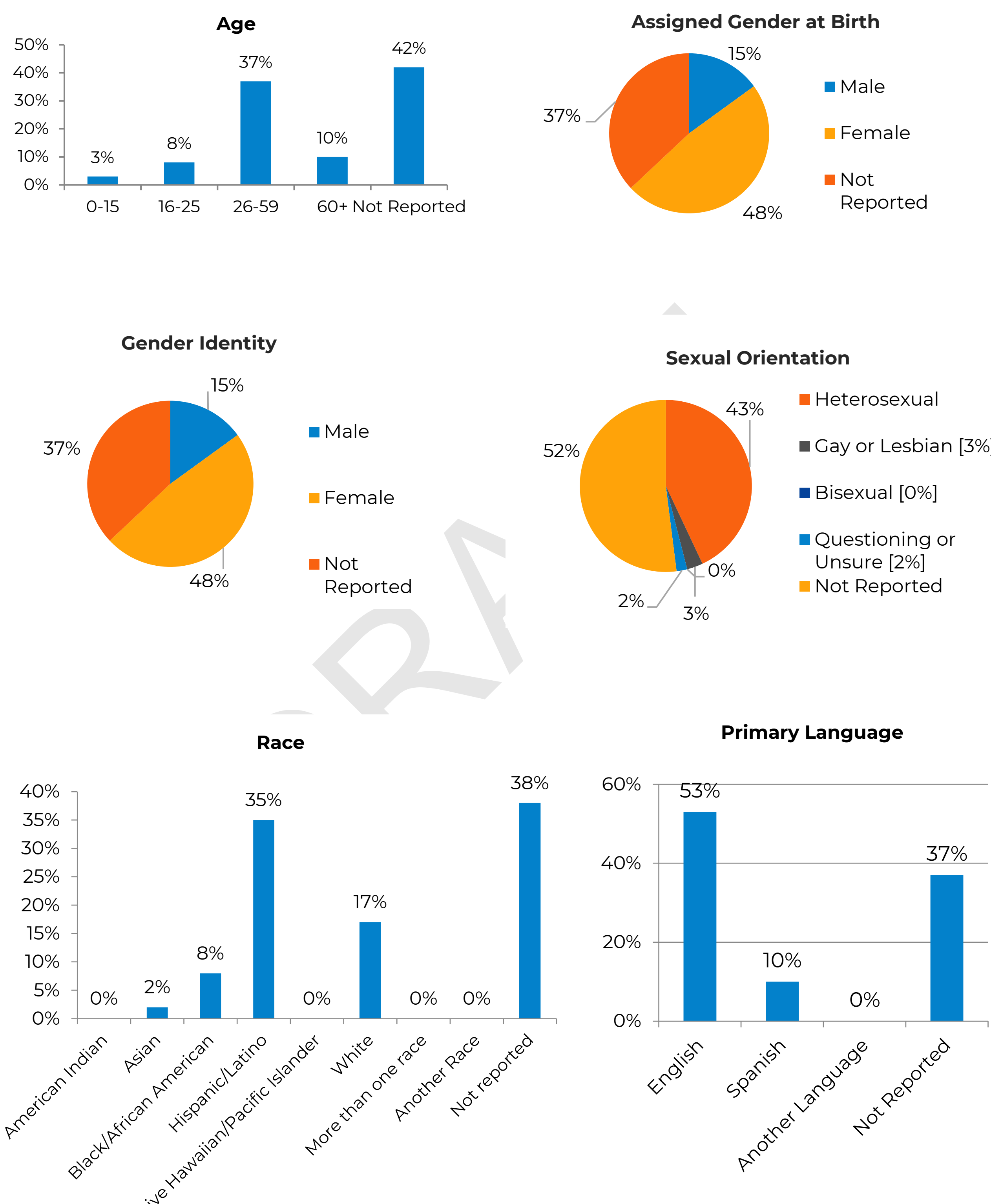


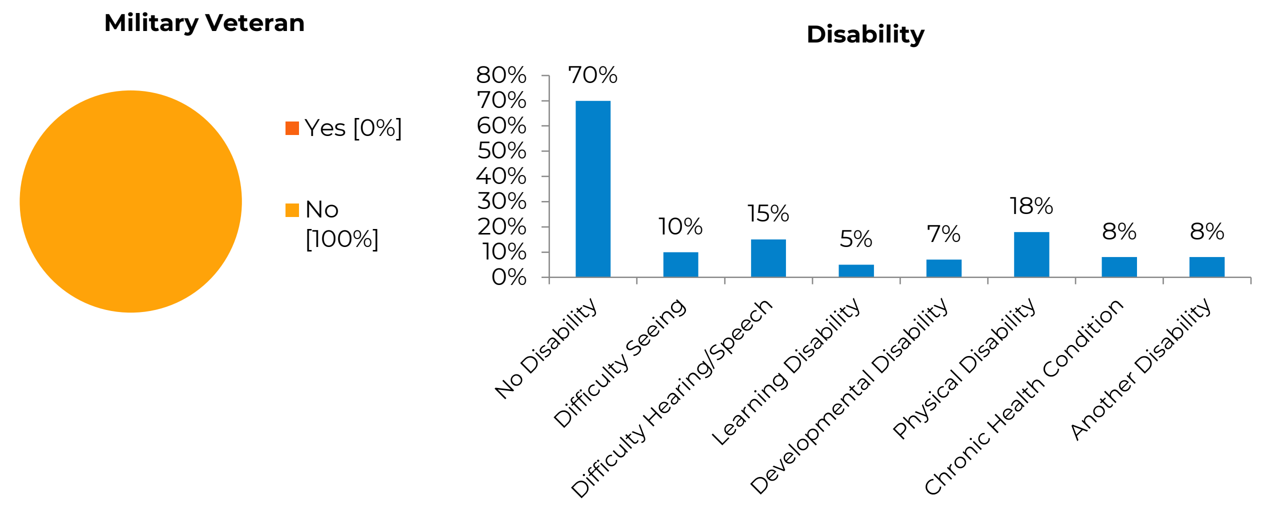


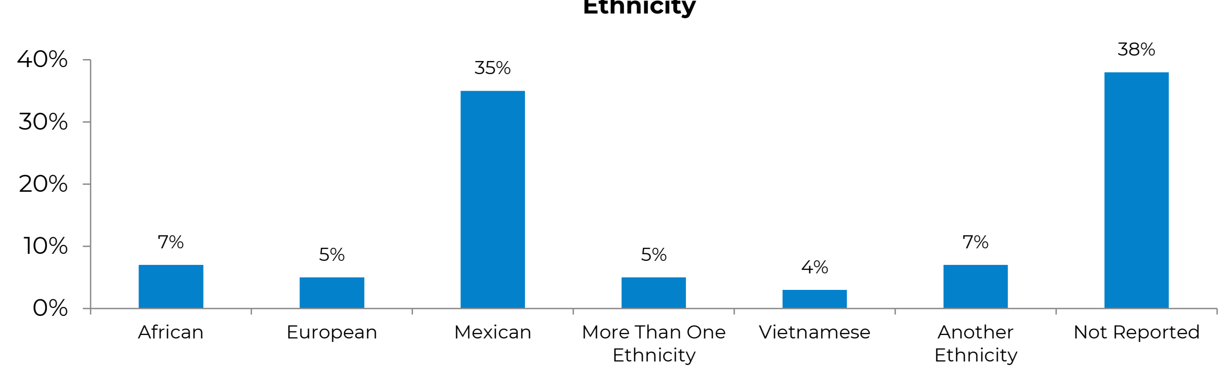
HOW MUCH DID WE DO? Creative Minds Art Gallery

3	98	81
Creative Minds Art Events Were Held	Individuals Participated in Creative Minds Art Workshop and Gallery	Art Pieces Were Submitted to the Creative Minds Art Gallery

Demographics Based on Participants Who Completed Art Workshop Surveys





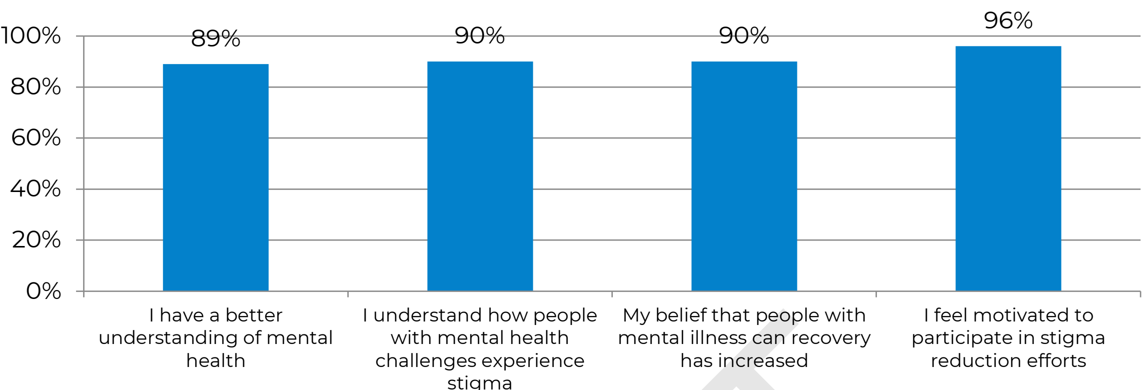


HOW WELL DID WE DO IT?

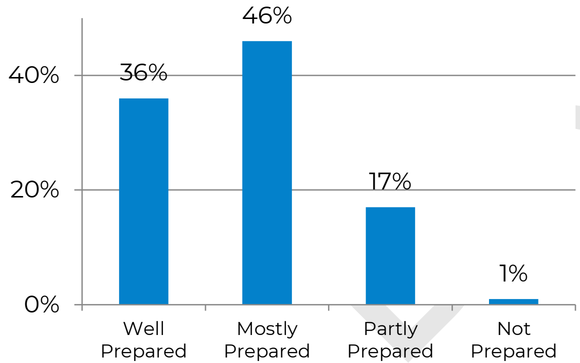
Website Hits Data from July 2019 to December 2019

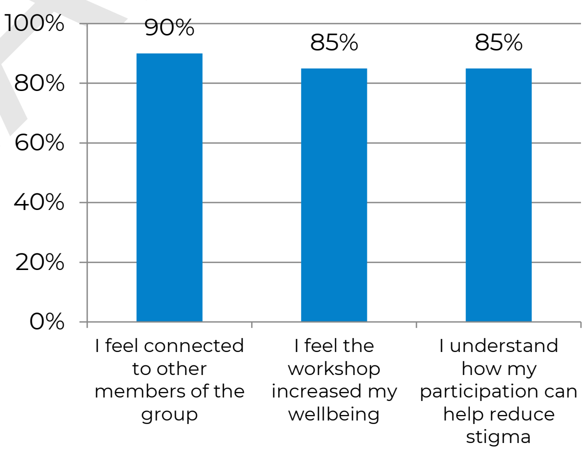
IS ANYONE BETTER OFF?

Stigma Reduction



Suicide Prevention





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Number of Potential Responders	401
Setting in Which Responders were Engaged	Community, schools, colleges, health centers, workplace, shelters, online and outdoors
Type of Responders Engaged	TAY, adults, seniors, teachers, LGBTQ+, families, suicide attempters/survivors, religious leaders and those with lived experience
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

0
MHSA Referrals to Stigma Reduction or Suicide Prevention Programs

DRAFT

Older Adult and Transition Age Youth Wellbeing

Both the Older Adult Wellbeing and the Transition Age Youth Wellbeing programs are comprised of two projects: Peer mentoring and specialty groups/programing offered at the Wellness Center specific to TAY and older adults needs.

Peer Mentor and Wellness Center PEI Programs

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	___ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	___ Prevention	___ Early Intervention	_X_ Prevention and Early Intervention		

Program Description

Trained volunteers (peer mentors) from the tri-city area provide support to peers (mentees) who are in emotional distress. Peer mentors offer both individual and group support, and additional assistance through linkage to community resources that are both age and culturally matched to each individual mentee. Individuals attending the TAY and Older Adult programing located at the Wellness Center benefit from specialized support groups and activities targeting their specific needs.

Target Population

Transition Age Youth (TAY ages 18-25) and Older Adults (ages 60 and over)

Peer Mentor/Mentees				
Age Groups	TAY 18-25	Adults 26-59	Older Adults 60+	Unknown
Mentors FY 2019-20	14	12	4	0
Mentees FY 2019-20	25	39	23	0
Groups FY 2019-20	0	29	20	286
Cost Per Person	$109	$119	$119	N/A

DRAFT

Wellness Center (PEI TAY and Older Adults)					
Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	56	502	56	99	4
Cost Per Person	$727	$727	$727	$727	$727

Peer Mentor Program

Program Update

The Peer Mentor program continues to support both mentors (individuals providing the support) and mentees (individuals receiving the support). Peer Mentors focused on engaging individuals with lived experience who apply and then are trained to provide support to community members who are seeking a non- clinical level of care. These services are offered in English, Spanish, Vietnamese and Cantonese.

In FY 2019-20, this program sustained 30 dedicated and highly trained community mentors. Of these 30 mentors, 19 identified with lived experience who were able to provide an empathic level of support based on personal experience.

In addition to one-on-one sessions, this program offers support groups as well. Two of the critical populations supported through these groups include older adults and the LGBTQ+.

Challenges and Solutions

The number of mentors identifying themselves with lived experience continue to increase each year. This can be a significant benefit for mentees who are looking to connect with another peer. However, one of the challenges for staff has been to provide adequate and meaningful support for the needs of our mentors as well.

Additional challenges include engaging the homeless population and older adults. Over the next fiscal year, staff will continue to work on engaging these individuals through one-on-one support via telephone. Efforts will also include an increase focus on self-care and wellbeing to help mentors, specifically those who identify with lived experience, to ensure that they receive adequate support to help minimize/reduce any mental health symptoms.

COVID-19 Response

Since the outbreak of COVID-19, the Peer Mentor Program moved its service delivery to phone and virtual platforms. Historically, many mentors take a summer break and return in the fall. However, with the onset of COVID-19, several of the mentors continued to offer support throughout summer break due to the increased need since the onset of the pandemic. Trainings continued as well in order to provide the mentors with up-to-date COVID-19 information and how they can best support their mentees. The Peer Mentor wellbeing activities, normally held in person, were temporarily put on hold. However, staff began to brainstorm to create virtual wellness roundtables where the groups can continue to meet virtually.

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As expected with the pandemic, there was an increase in referrals in a short period of time thereby increasing the number of mentees each mentor had on their case load. Since the majority of mentors who provide services to the community identify themselves with lived experience, group meetings and individual supervisions were also increased to provide extra support to these mentors as they continued to provide extra support to mentees.

Cultural Approach

Peer mentors identify with numerous local communities (African American, Asian, Latino, Bisexual, Gay, Native American, TAY, Older Adult and Physically disabled). The majority of the mentors are bilingual and provide services in English, Spanish, Tamil, Hindi, Malayalam, Korean, Cantonese. In addition, the PM program currently has mentors who identify in the LGBTQ+ community who provide input and feedback on how to engage with others in the community.

Peer Mentoring programing focus on providing serves to individuals with limited mobility, limited access to transportation, monolingual individuals, LGBTQ, homelessness, and transition age youth. Presentations also focus on the veteran population in addition to providing multiple wellbeing activities in the communities. In addition, the program provides bilingual and monolingual senior socialization groups at local parks and mental wellbeing activities at senior living locations where residents may experience limited mobility and lack of transportation.

Wellness Center Programs: Transition Age Youth and Older Adults

Transition age youth (TAY) and older adults are considered critical populations in need of support yet tend to be some of the most difficult to engage. Reasons include issues related to stigma and difficulty with transportation. In an effort to meet the needs of these individuals, the Wellness Center has created programs utilizing Prevention and Early Intervention (PEI) funding to create programing specific to the needs and interests of these, often considered, at-risk individuals.

Program Update

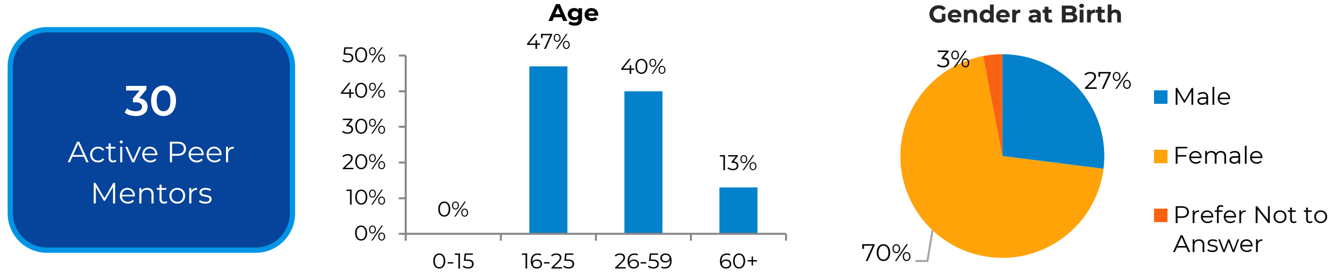
In an effort to build participation in the TAY programing, Wellness Center staff have focused their outreach efforts on collaborating with local service organizations who work with this age group. Prior to COVID-19, the Wellness Center saw a slight increase in the number of groups offered as well as the number of unique individuals who attended the Center. Although the COVID -19 pandemic has since impacted onsite groups, efforts continue to build a relationship with these community organizations which will allow for a smooth transition for TAY to come to the Wellness Center once the pandemic has abated.

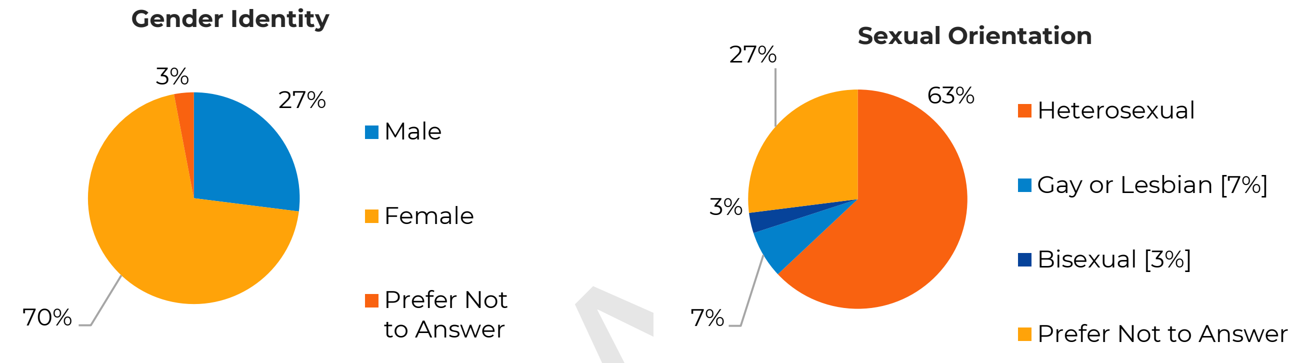
The Wellness Center's older adult programing continues to struggle with engagement and attendance. Recognizing the unique needs of this population, the Center created a Mental Health Specialist position where this staff member is dedicated to engaging older adults throughout the community and developing age appropriate activities and support groups based on their needs.

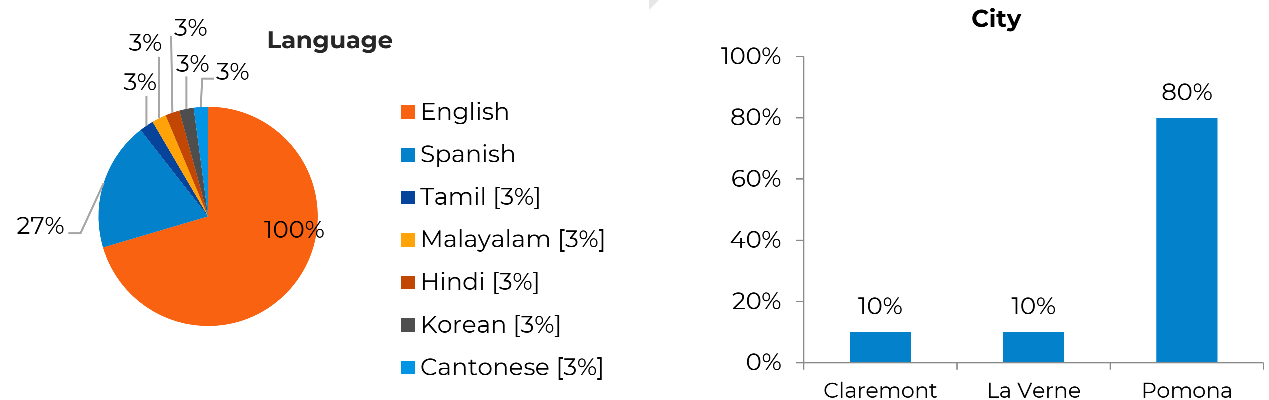
DRAFT

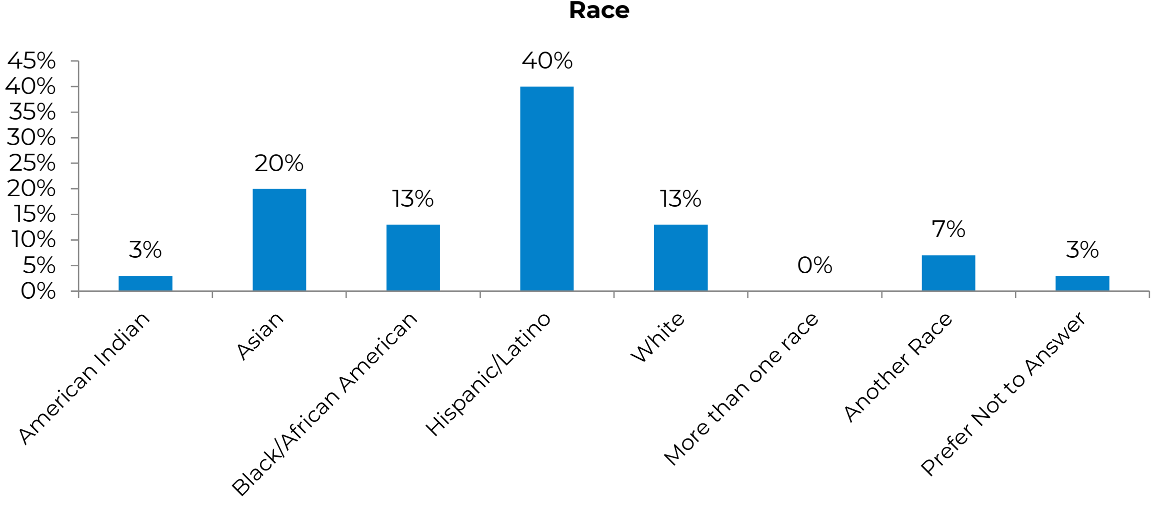
PROGRAM: Peer Mentoring

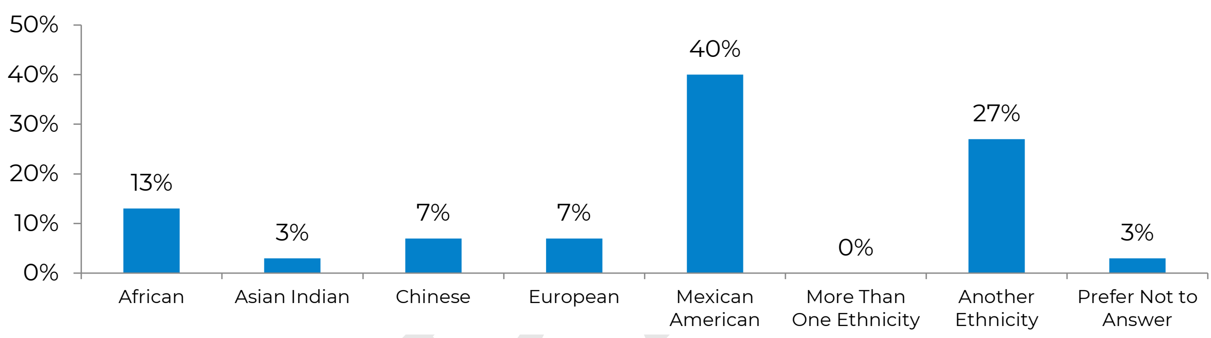
HOW MUCH DID WE DO?

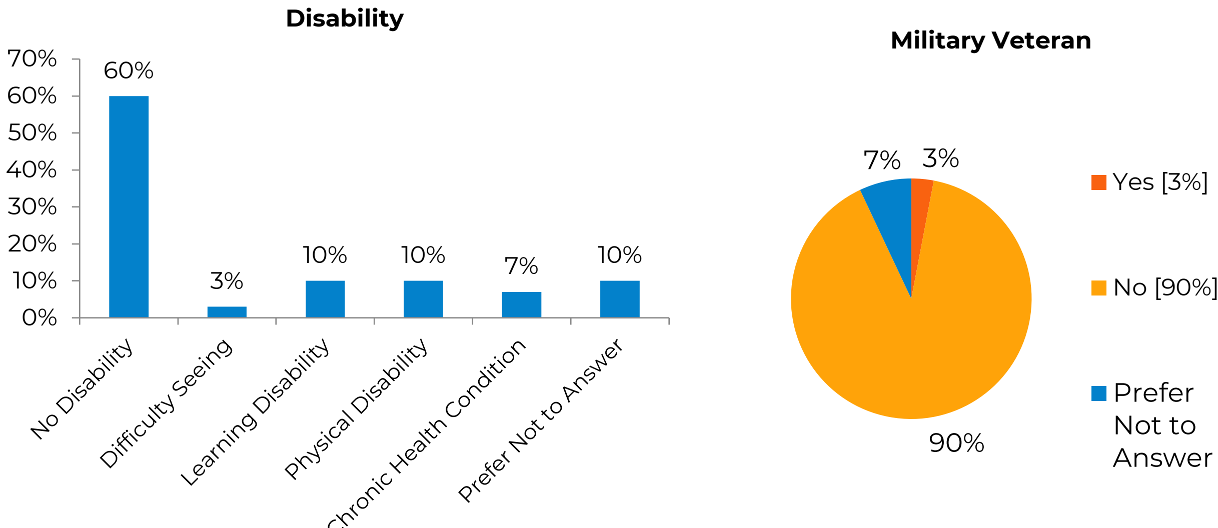




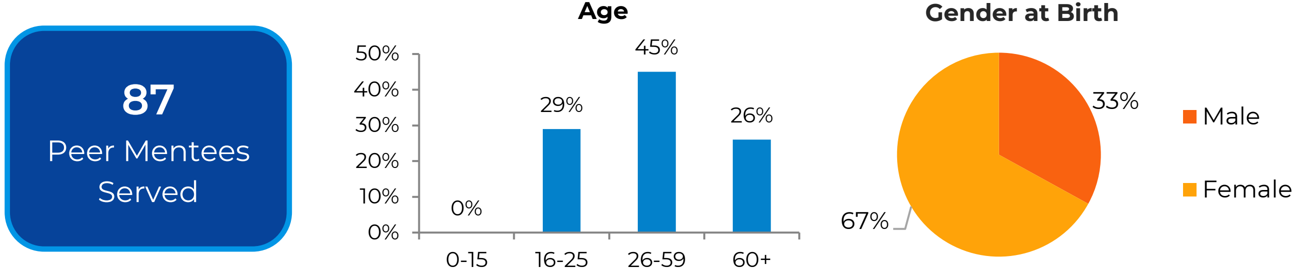



Race
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
3%
20%
13%
40%
13%
0%
7%
3%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More than one race
Another Race
Prefer Not to Answer


Ethnicity
50%
40%
30%
20%
10%
0%
13%
3%
7%
7%
40%
0%
27%
3%
African
Asian Indian
Chinese
European
Mexican American
More Than One Ethnicity
Another Ethnicity
Prefer Not to Answer


Disability
70%
60%
50%
40%
30%
20%
10%
0%
60%
3%
10%
10%
7%
10%
No Disability
Difficulty Seeing
Learning Disability
Physical Disability
Chronic Health Condition
Prefer Not to Answer
Military Veteran
7%
3%
90%
Yes [3%]
No [90%]
Prefer Not to Answer

Peer Mentee Demographics



Gender Identity

32%
68%
Male
Female

Sexual Orientation

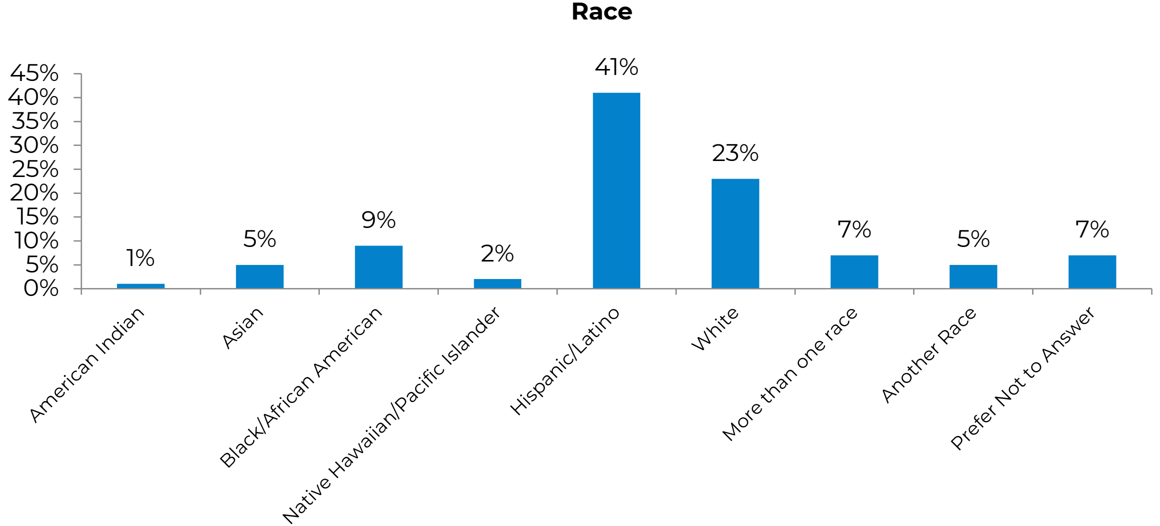
1%
14%
1%
1%
3%
80%
Heterosexual
Gay or Lesbian [3%]
Bisexual [1%]
Queer [1%]
Prefer Not to Answer [14%]
Another Sexual Orientation [1%]

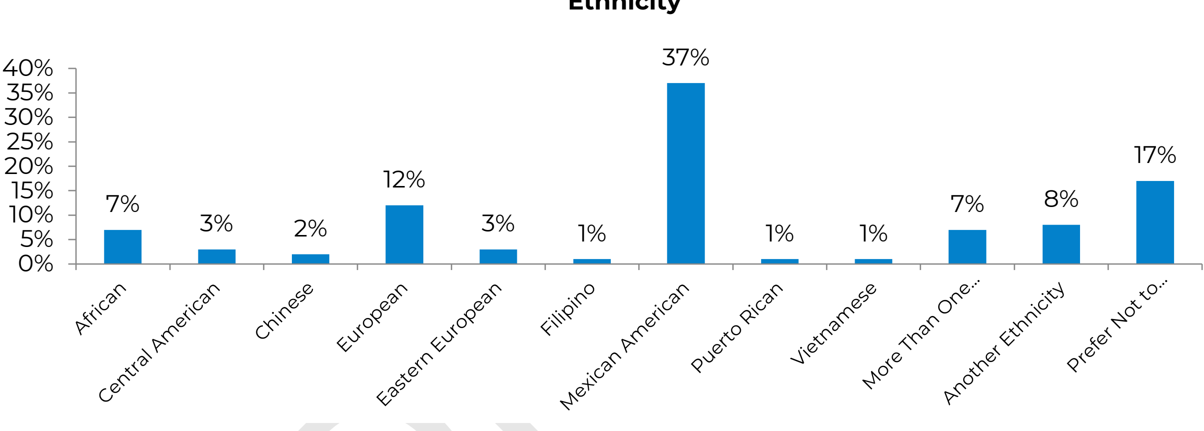
Language

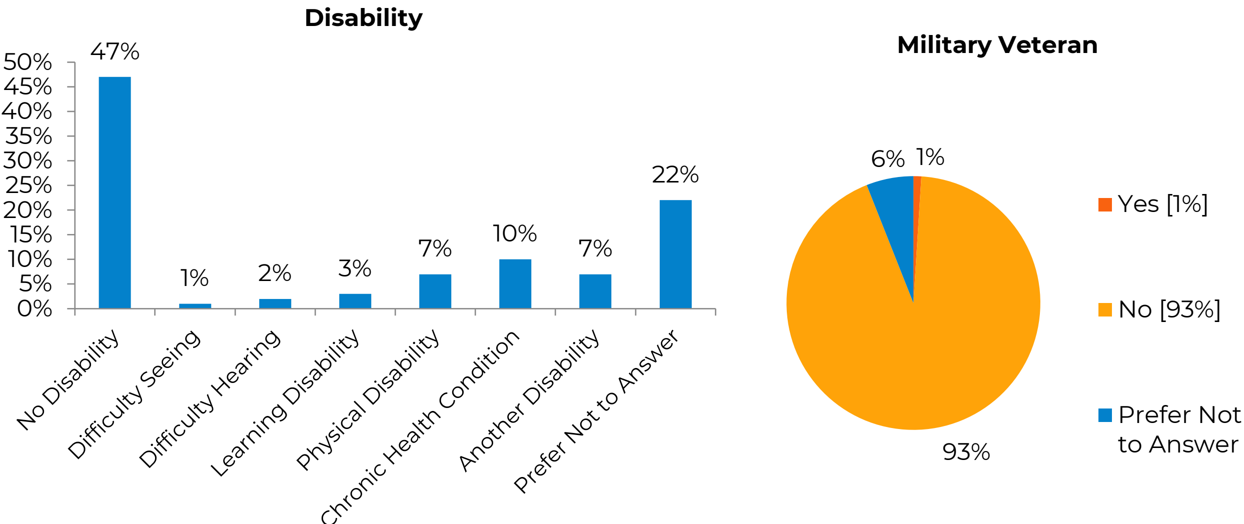
1%
1%
12%
86%
English
Spanish
Vietnamese [1%]
Cantonese [1%]

City

100%
80%
60%
40%
20%
0%
7%
12%
81%
Claremont
La Verne
Pomona


Race
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
1%
5%
9%
2%
41%
23%
7%
5%
7%
American Indian
Asian
Black/African American
Native Hawaiian/Pacific Islander
Hispanic/Latino
White
More than one race
Another Race
Prefer Not to Answer

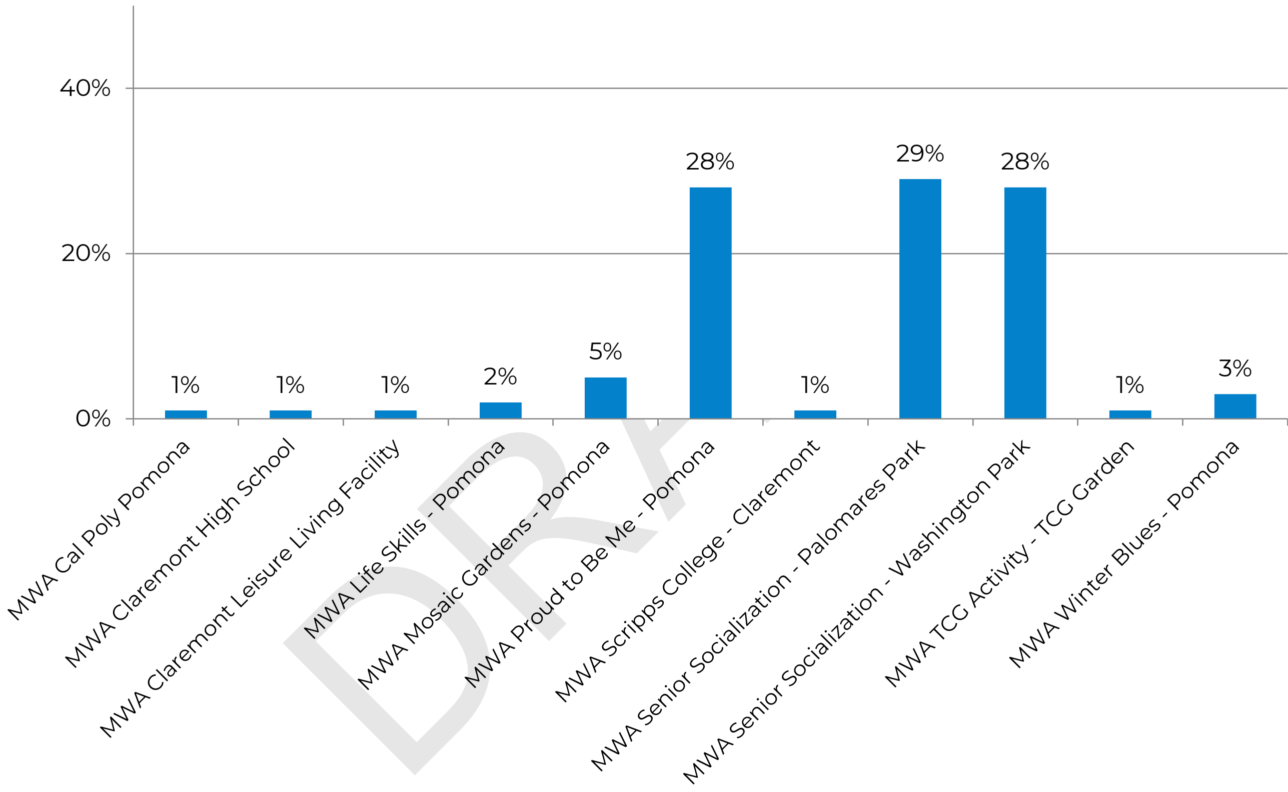

Ethnicity
40%
35%
30%
25%
20%
15%
10%
5%
0%
7%
3%
2%
12%
3%
1%
37%
1%
1%
7%
8%
17%
African
Central American
Chinese
European
Eastern European
Filipino
Mexican American
Puerto Rican
Vietnamese
More Than One...
Another Ethnicity
Prefer Not to...


Disability
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
47%
1%
2%
3%
7%
10%
7%
22%
No Disability
Difficulty Seeing
Difficulty Hearing
Learning Disability
Physical Disability
Chronic Health Condition
Another Disability
Prefer Not to Answer
Military Veteran
6%
1%
93%
Yes [1%]
No [93%]
Prefer Not to Answer

Mental Wellbeing Activities Occurred from July 2019 through March 2020

335
Unique Participants at Peer Mentor Mental Wellbeing Activities

856
Duplicated Participants at Peer Mentor Mental Wellbeing Activities



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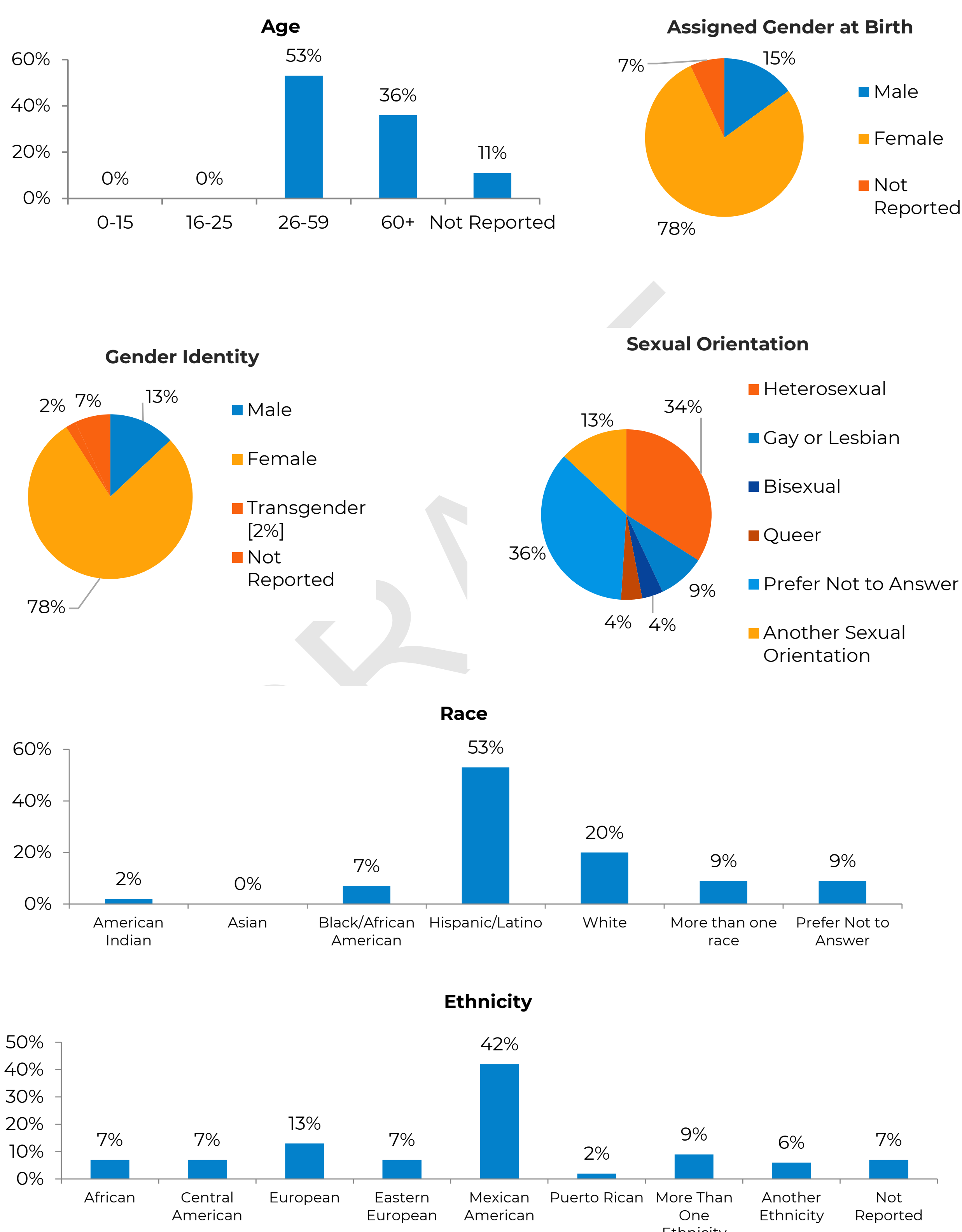
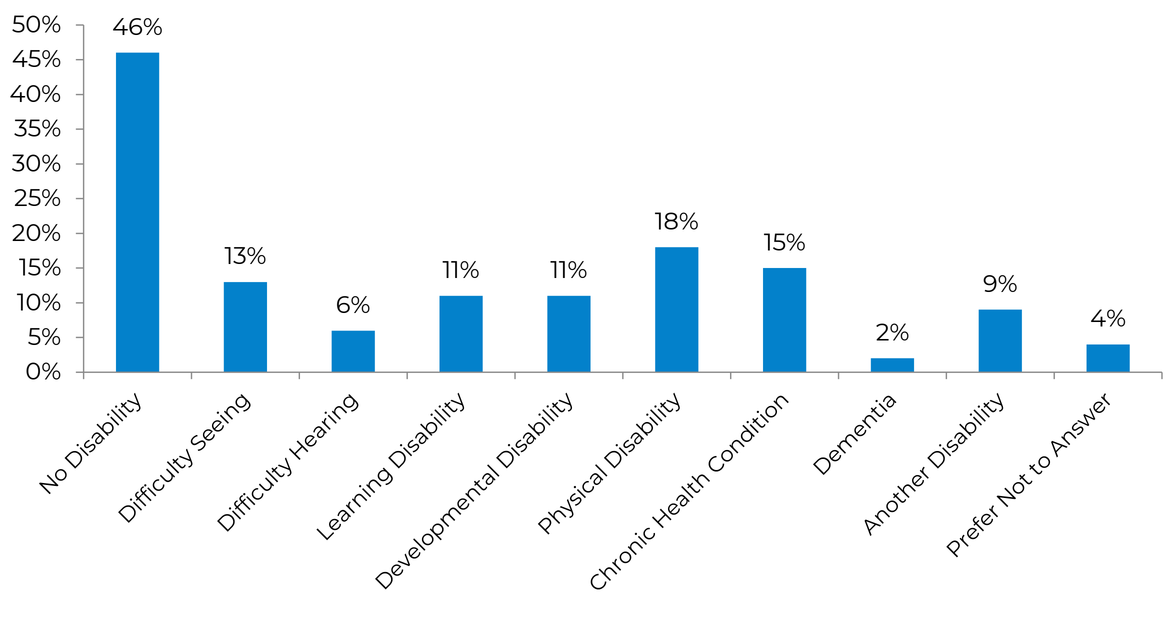
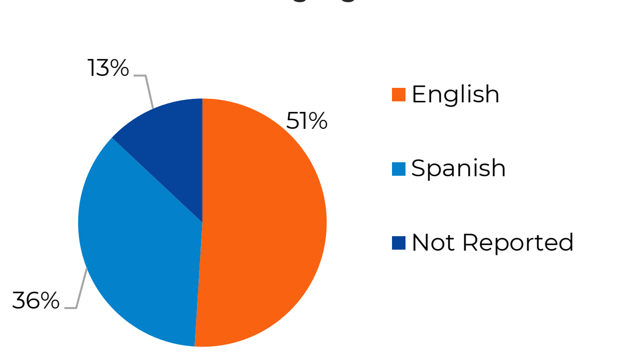
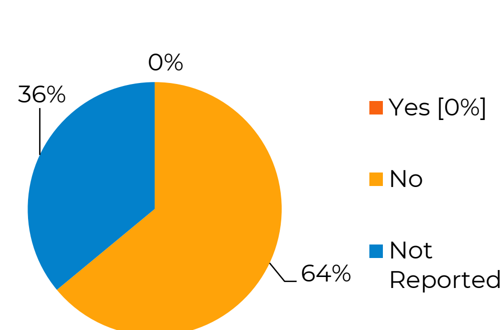
29
Peer Mentor Trainings

PEI Demographics Based on Mental Wellbeing Participants Who Completed Mental Wellbeing Mentor Surveys (n=55)




Disability
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
46%
13%
6%
11%
11%
18%
15%
2%
9%
4%
No Disability
Difficulty Seeing
Difficulty Hearing
Learning Disability
Developmental Disability
Physical Disability
Chronic Health Condition
Dementia
Another Disability
Prefer Not to Answer


Language
13%
51%
36%
English
Spanish
Not Reported


Military Veteran
0%
36%
64%
Yes [0%]
No
Not Reported

HOW WELL DID WE DO IT?

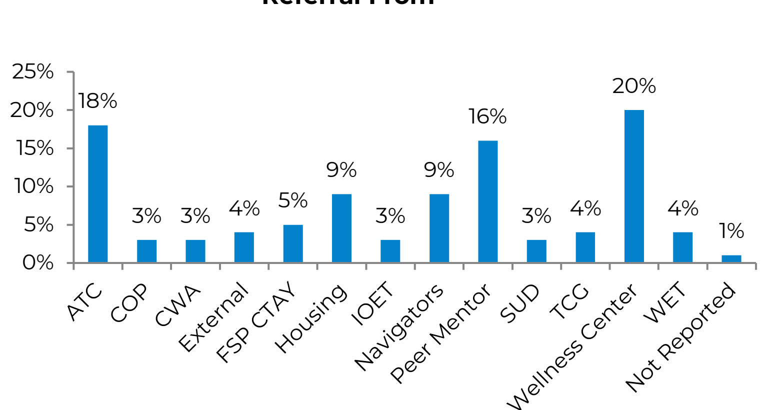
77%	100%	1,419	96%	19
59 out of 77 Referrals Became Mentees	Peer Mentees Reported Feeling Comfortable with Their Peer Mentor	Service Learner Hours Completed by Peer Mentors	Individuals Enjoy Participating in Peer Mentor Mental Wellbeing Activities	Peer Mentors Self-Identify with Lived Experience, 8 of those 19 Being New Peer Mentors

IS ANYONE BETTER OFF?

100%	100%	85%
Peer Mentors Reported Becoming a Peer Mentor Has Made a Positive Impact in Their Lives	Peer Mentees Agreed Peer Mentors Provided Helpful Support in Their First Session	Individuals Feel More Confident from the Skills Learned in Peer Mentor Mental Wellbeing Activities

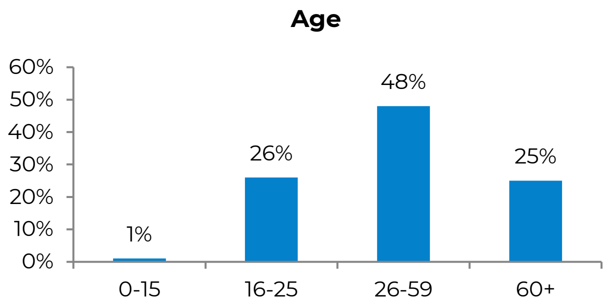
Number of Potential Responders	442
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	TAY, adults, seniors, and those with lived experience
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition age youth, older adults, and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

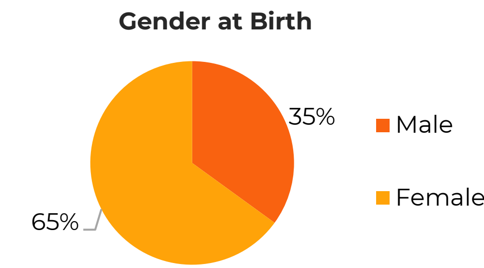
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

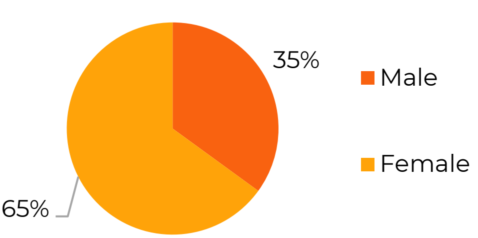


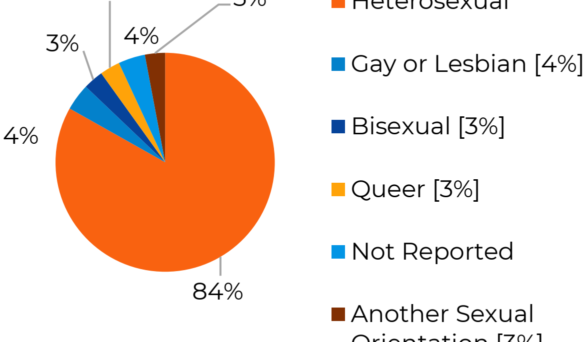
2.5 Days
Average Time Between Referral and Contact from Peer Mentor Program

PEI Demographics Based on MHSA Referrals









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Language

14%

86%

English Spanish

Military Veteran

5%
7%
4%
84%

Yes
No
Not Reported
Prefer Not to Answer

Race

60%
50%
40%
30%
20%
10%
0%

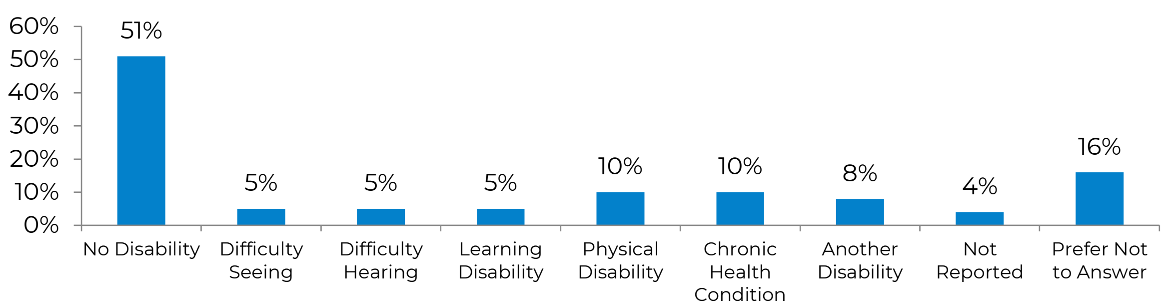
1% American Indian
4% Asian
9% Black/African...
52% Hispanic/Latino
29% White
1% More than one race
3% Another Race
1% Prefer Not to Answer

Ethnicity

50%
40%
30%
20%
10%
0%

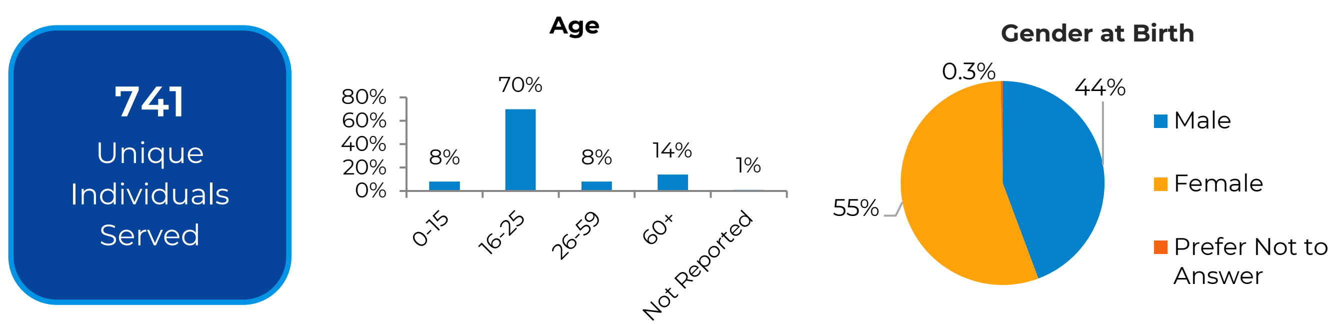
10% African
6% Central American
3% Chinese
14% European
1% Hmong
44% Mexican
1% Native American
1% Puerto Rican
1% More Than One Race
3% Another Race
14% Prefer Not to Answer
2% Not Reported

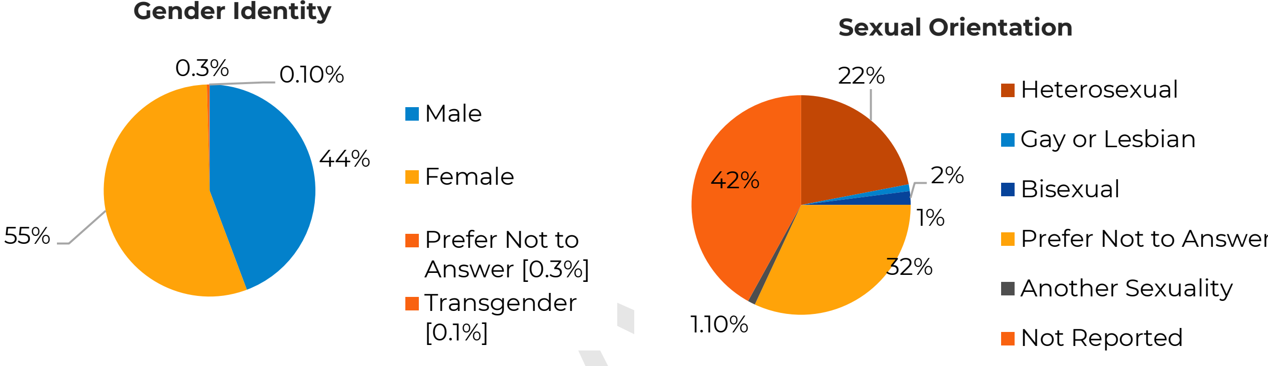
Disability

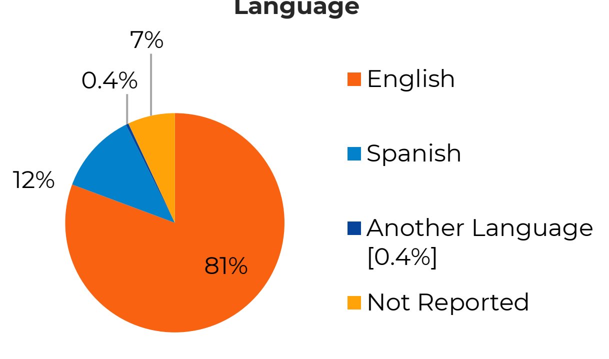


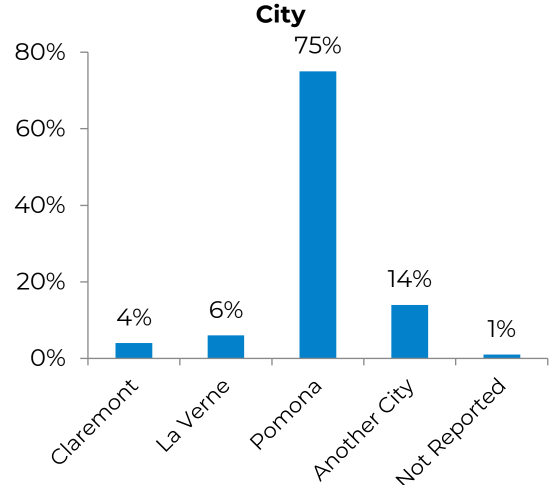
PROGRAM: Wellness Center - PEI

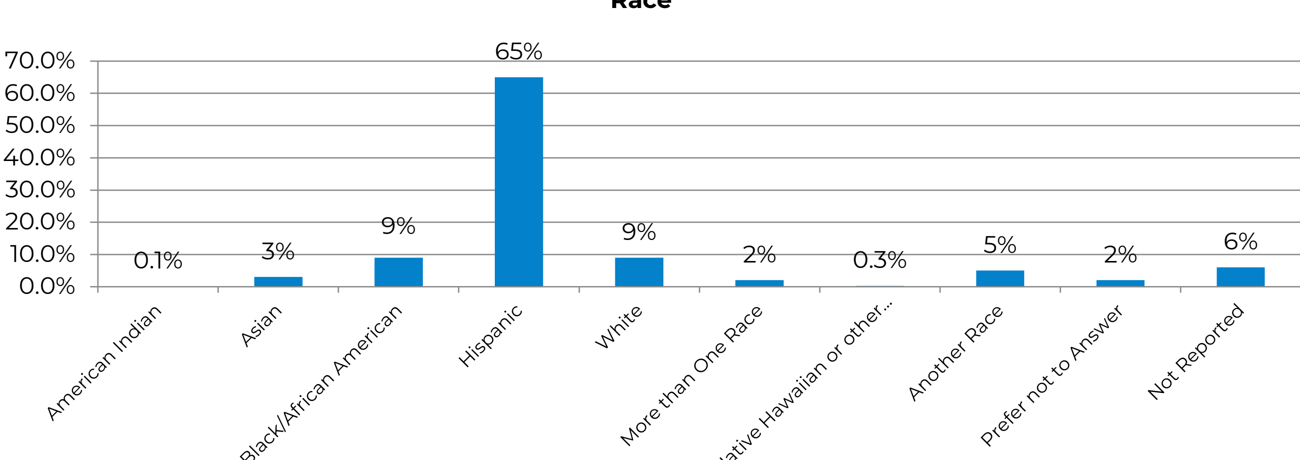
HOW MUCH DID WE DO?

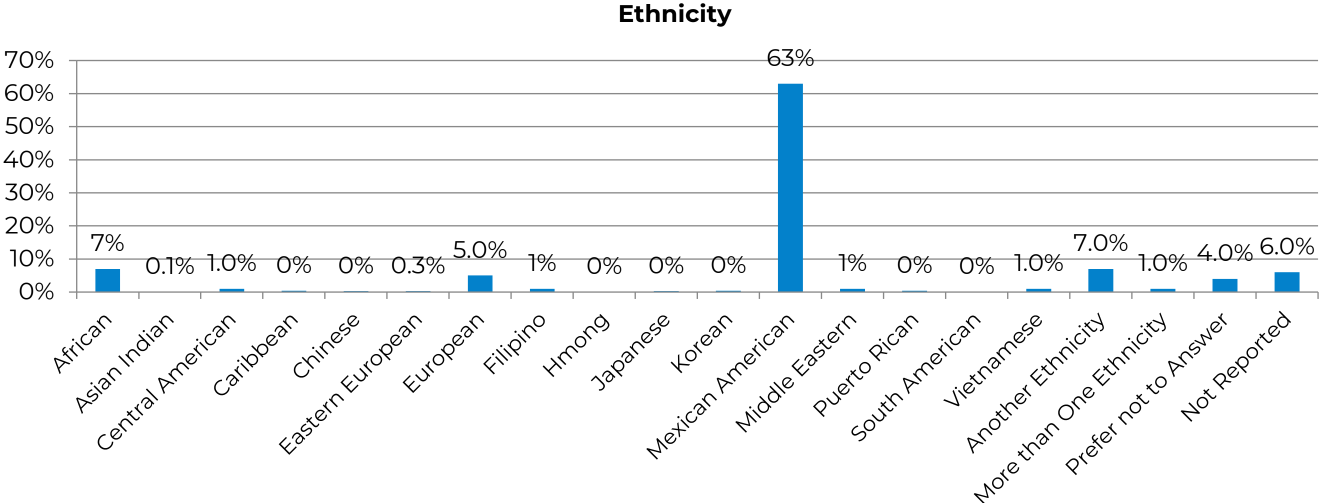


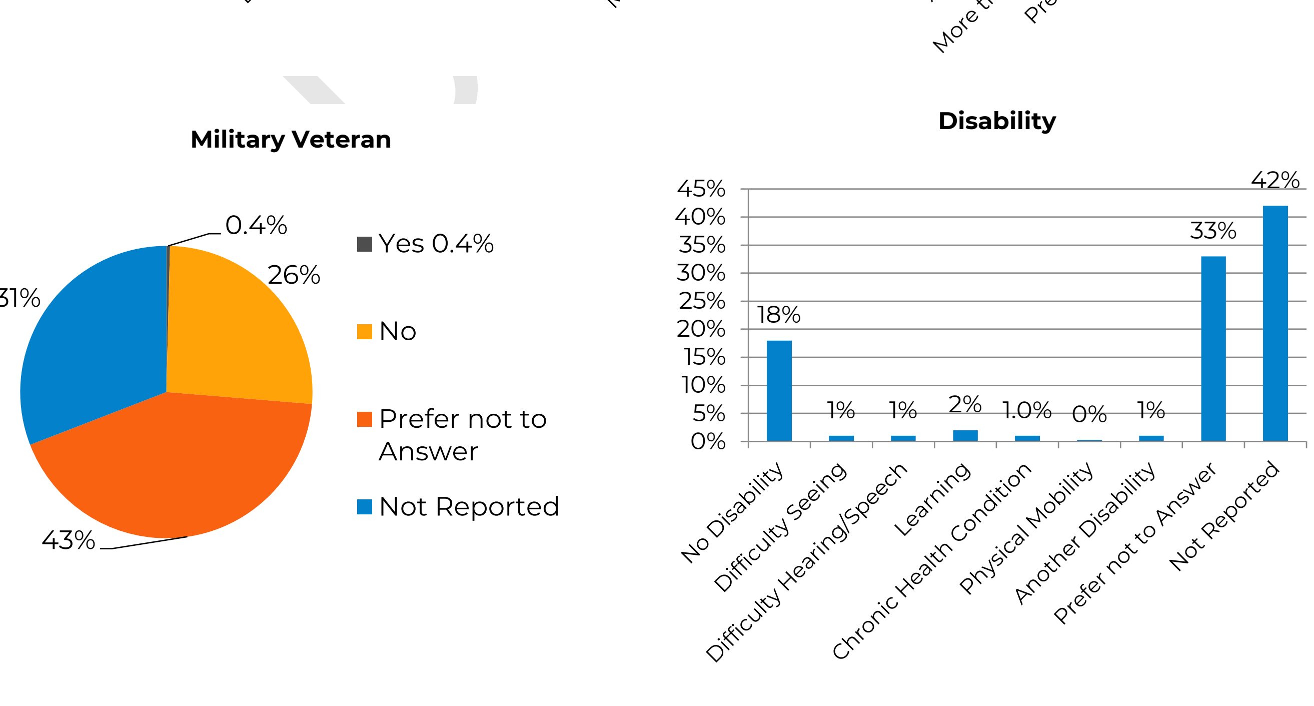






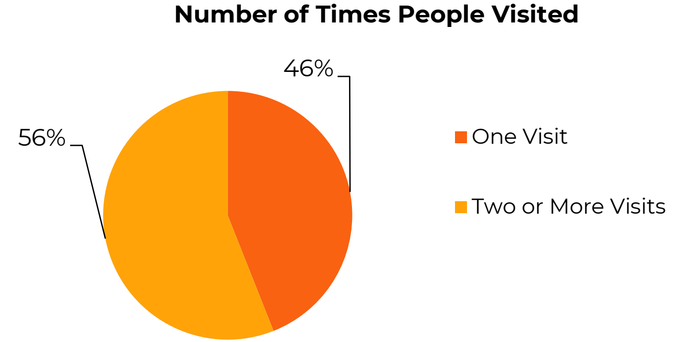

Race
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
0.1%
3%
9%
65%
9%
2%
0.3%
5%
2%
6%
American Indian
Asian
Black/African American
Hispanic
White
More than One Race
Native Hawaiian or other...
Another Race
Prefer not to Answer
Not Reported


Ethnicity
70%
60%
50%
40%
30%
20%
10%
0%
7%
0.1%
1.0%
0%
0%
0.3%
5.0%
1%
0%
0%
0%
63%
1%
0%
0%
1.0%
7.0%
1.0%
4.0%
6.0%
African
Asian Indian
Central American
Caribbean
Chinese
Eastern European
European
Filipino
Hmong
Japanese
Korean
Mexican American
Middle Eastern
Puerto Rican
South American
Vietnamese
Another Ethnicity
More than One Ethnicity
Prefer not to Answer
Not Reported


Military Veteran
0.4%
26%
31%
43%
Yes 0.4%
No
Prefer not to Answer
Not Reported
Disability
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
18%
1%
1%
2%
1.0%
0%
1%
33%
42%
No Disability
Difficulty Seeing
Difficulty Hearing/Speech
Learning
Chronic Health Condition
Physical Mobility
Another Disability
Prefer not to Answer
Not Reported

HOW WELL DID WE DO IT?

3,625
Number of Attendees at Wellness Center Events (Duplicated Individuals)



Group Name	Number of Times Group Was Held
Group – Senior Socialization	47
Group (Español) – Comadres y Compadres	50
TAY – Autism Empowerment	2
TAY – RealTalk	20
TAY – Anger Management	39
TAY – Cooking Class	8
TAY – DRA	33
TAY – Friendship Circle	6
TAY – Gaming Group	19
TAY – Karaoke	9
TAY – Literacy Alliance	9
TAY – Positive Painting	6
TAY – Pride	19
TAY – Sacred Heart	6
TAY – Socialization	4

TAY – Stress Me Not	34
TAY – TAY Leadership Committee	8
TAY – TCB	21
TAY – Together We Stand	43
TAY – Walking Group	24

Contacts by Type	Number of Times Contact was Made
TAY – Outing	19
TAY – PC Lab	207
TAY – Phone Call	1,423
TAY – Volunteering	4
TAY – YCES	3

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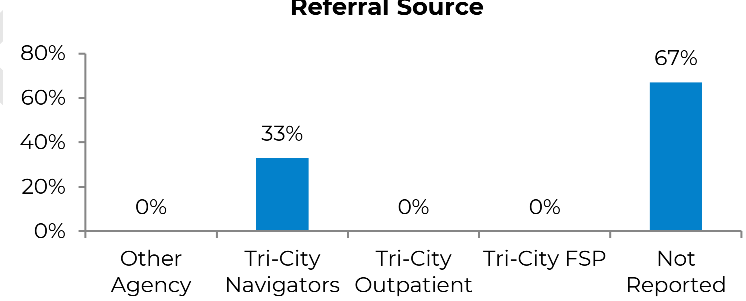
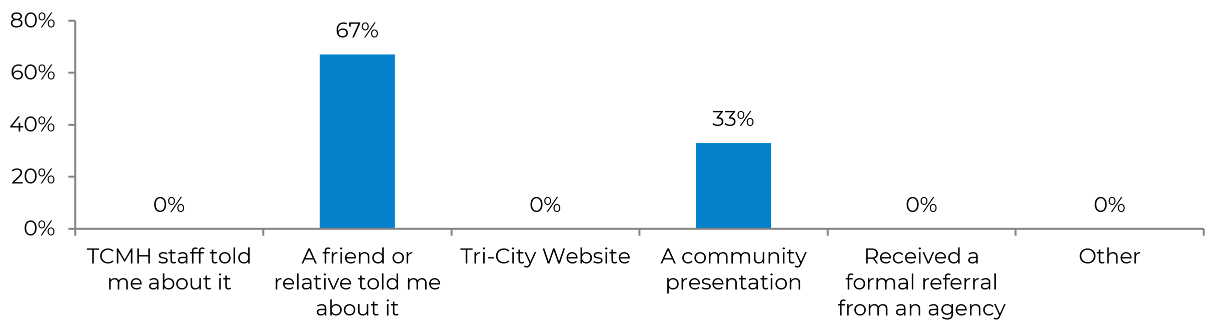
100%
Individuals Satisfied with Wellness Center Programs

Referral Source

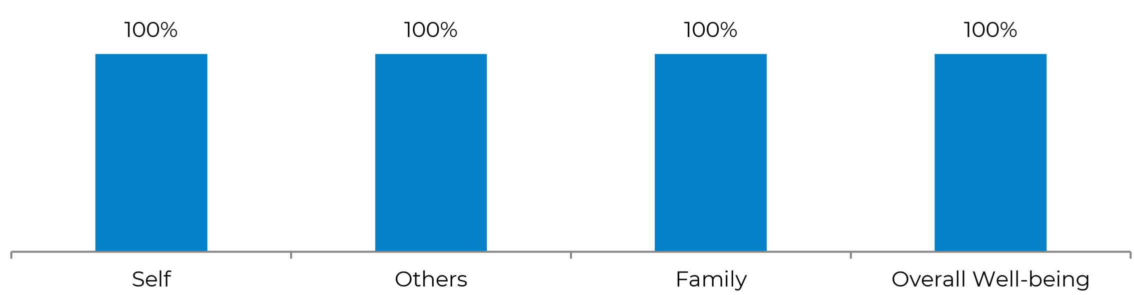


How Did You Learn About the Wellness Center Programs? (Choose All That Apply)



IS ANYONE BETTER OFF?

Percentage of people who report improved relationships with the following because of the help they receive from the Wellness Center Programs:

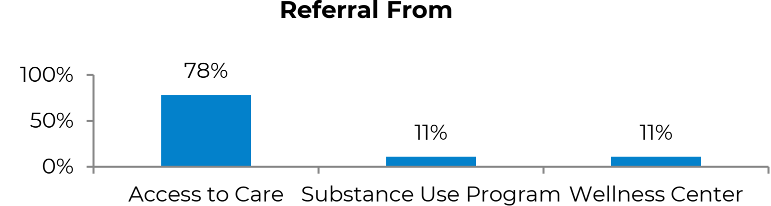


Number of Potential Responders	741
Setting in Which Responders were Engaged	Community, Wellness Center
Type of Responders Engaged	TAY, adults, seniors
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

9
MHSA Referrals to Wellness Center

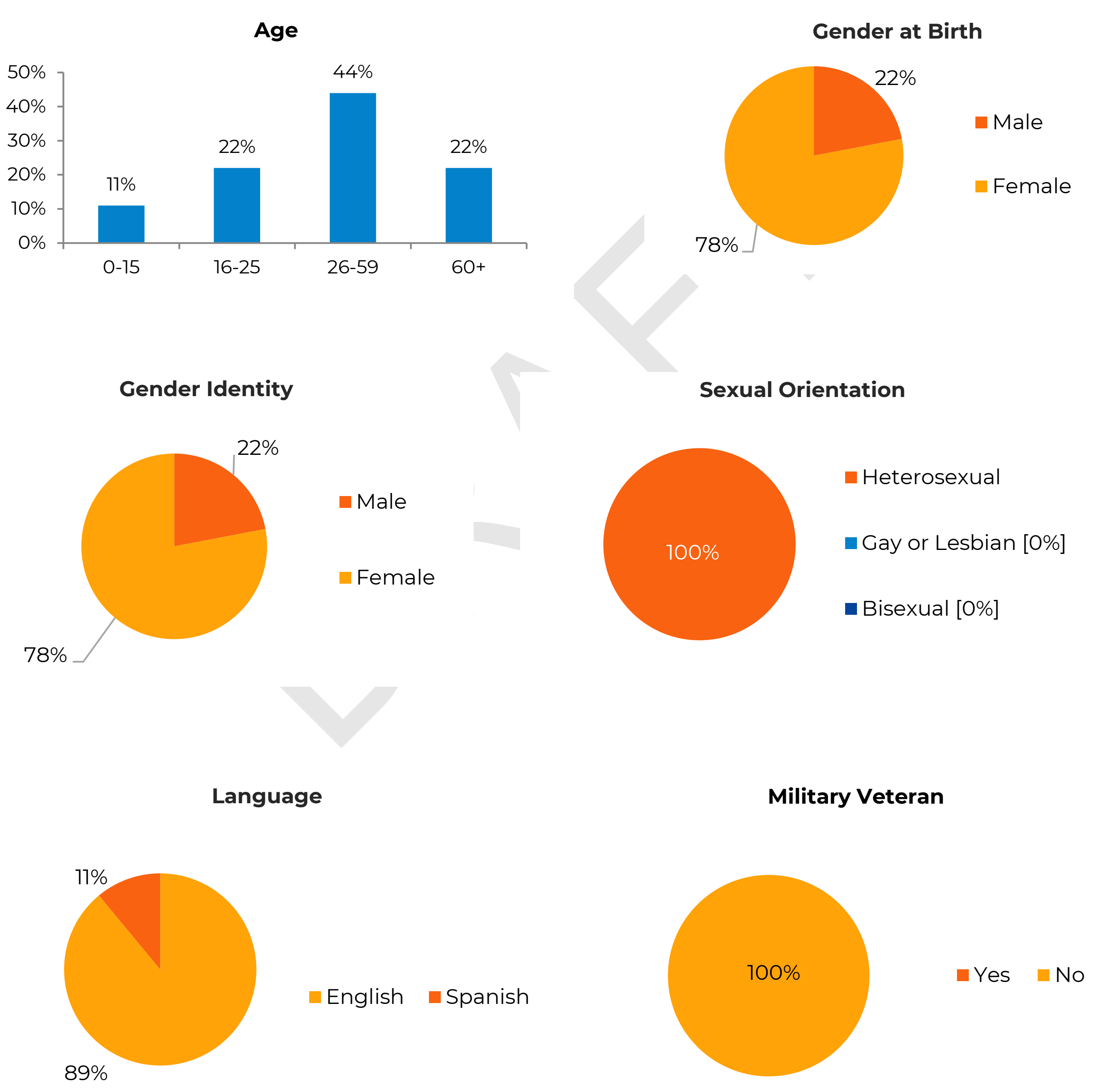
Referral From

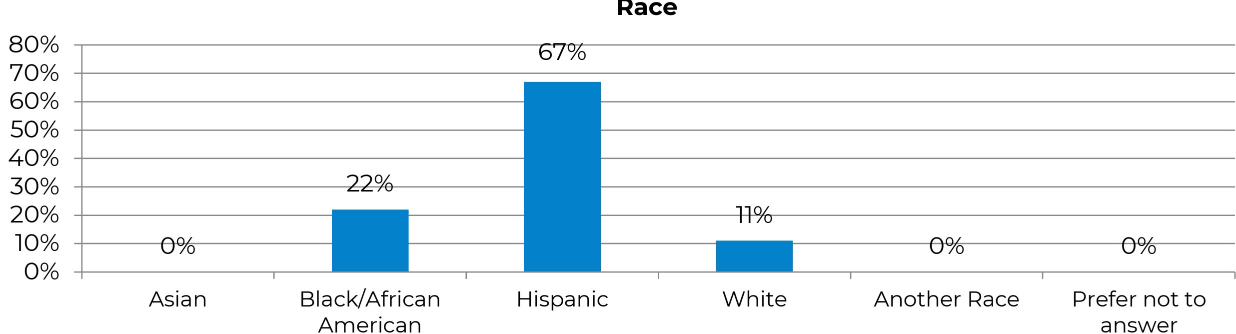


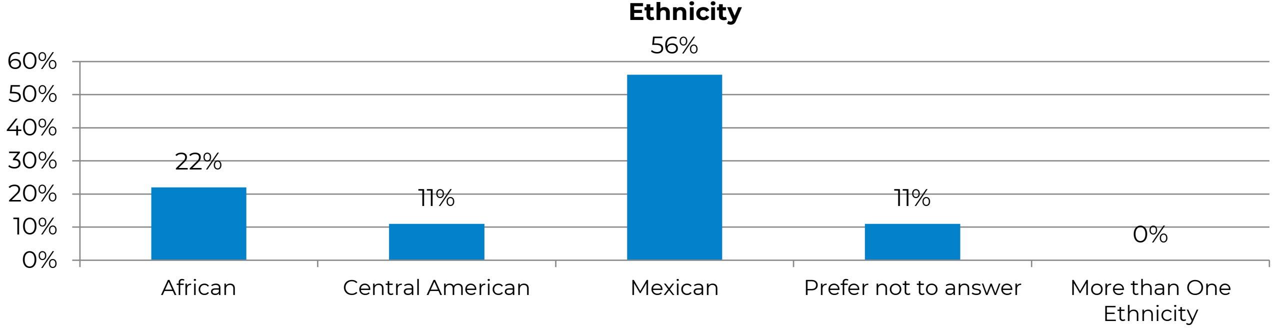
8 out of 9
Referrals Participated in Wellness Center Programs

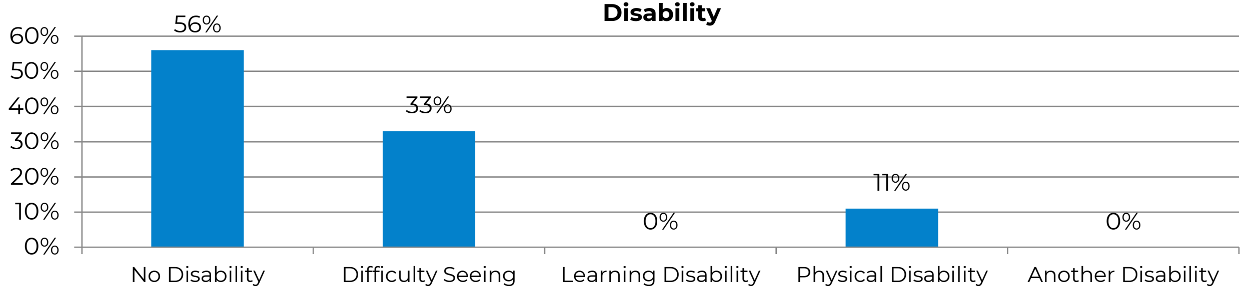
8 Days
Average Time Between Referrals and Participation in Wellness Center

PEI Demographics Based on MHSA Referrals




Race
80%
70%
60%
50%
40%
30%
20%
10%
0%
0%
22%
67%
11%
0%
0%
Asian
Black/African American
Hispanic
White
Another Race
Prefer not to answer


Ethnicity
60%
50%
40%
30%
20%
10%
0%
22%
11%
56%
11%
0%
African
Central American
Mexican
Prefer not to answer
More than One Ethnicity


Disability
60%
50%
40%
30%
20%
10%
0%
56%
33%
0%
11%
0%
No Disability
Difficulty Seeing
Learning Disability
Physical Disability
Another Disability

Family Wellbeing Program

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	___ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention	___ Prevention and Early Intervention		

Program Description

The Family Wellbeing program consists of a dynamic set of programing focused on addressing the needs of the family. Programming includes support groups, 1-1 support, and an array of culturally appropriate activities focused on wellness (e.g. exercise, cooking) and other interests that can attract family members and caregivers from vulnerable communities into peer-supported experiences.

Target Population

Family members and caregivers of people who struggle with mental illness from unserved and under-served communities.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	368	144	605	62	108
Cost Per Person	$71.00	$71.00	$71.00	$71.00	$71.00

Program Update

Prior to the COVID-19 outbreak, the Family Wellbeing (FW) program was focused on creating a new children's group, strengthening existing groups, expanding opportunities for community involvement, and partnering with new agencies in the community.

In September 2019, Family Wellbeing brought back a kid's group for ages 7-12 based on community feedback. Prior to COVID-19, the group averaged 5-7 participants weekly, and this number has remained steady since the pandemic, albeit now being hosted on a virtual platform.

Family Wellbeing also focused on strengthening existing groups, as a way to both bolster participation and attendance. As evidenced by holding a United Family Potluck for families. This event was well received with 34 participants, making up a total of 13 families, served that day.

During FY 2019-20, and prior to the outbreak of COVID-19, United Family also aimed to increase participant involvement in community events held by Tri-City. Two notable events where Family Wellbeing participants took an active role, were the Annual Tree Lighting event at the Wellness Center and the Pomona Christmas Parade in the month of December. During both events, participants from Family Wellbeing Karaoke Group were present to represent Tri-City while singing Holiday carols.

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Challenges and Solutions

Two challenges encountered for FWB staff include outreaching to new populations, and transportation issues. When receiving feedback from families in the community, staff found that transportation was a longstanding issue. Family Wellbeing also looked to access new cohorts by connecting with new community hubs that have emerged in the tri-city area.

In hopes of addressing these challenges, and prior to COVID-19, the Family Wellbeing program began hosting groups outside of the Wellness Center. Family Wellbeing had partnered with Pomona Wellness Community to host an Arts and Crafts group that was averaging 10 participants, and looking to begin hosting multiple other groups there as well. These efforts will continue once the pandemic restrictions are lifted.

COVID-19 Response

Following the outbreak of COVID 19, Family Wellbeing was impacted significantly. Due to changes in both staffing locations and the restrictions on providing in-person services, Family Wellbeing programing stopped completely and slowly began a re-building phase using a virtual platform. With this dramatic change in mind, FWB was charged with finding innovative ways to provide service. Options included the use of phones, email, and virtual platforms which for most families, was a viable method of communication. However, for some families, these options were limited based on lack of access. Community agency connections were somewhat easier to maintain.

A major challenge encountered was transitioning all FWB programing to a virtual platform, including Summer Camp, which was originally designed to be an in-person format. During the summer of 2020, Summer Camp was successfully transitioned to a virtually format. This popular program served 12 campers and their families. Campers were provided with a platform to use as well as supplies needed to complete activities, all delivered to their door using contactless delivery methods. Campers met virtually once a week, and maintained communication via phone and email. The feedback from the campers and parents was positive with families expressing gratitude for the opportunity to maintain some sense of normalcy during a difficult time. Seventy-five percent of participants were returning campers from previous sessions.

Cultural Approach

The Family Wellbeing program is available in both English and Spanish. Staff are bilingual and information brochures are available in multiple languages.

Another asset to the Family Wellbeing team is having staff who identify at LGBTQ+. These individuals attempt to address issues that can lead to barriers to seeking services as well stigma concerns. Also, FWB is meeting the community “where they are” by hosting groups at locations they are familiar with or current gathering.

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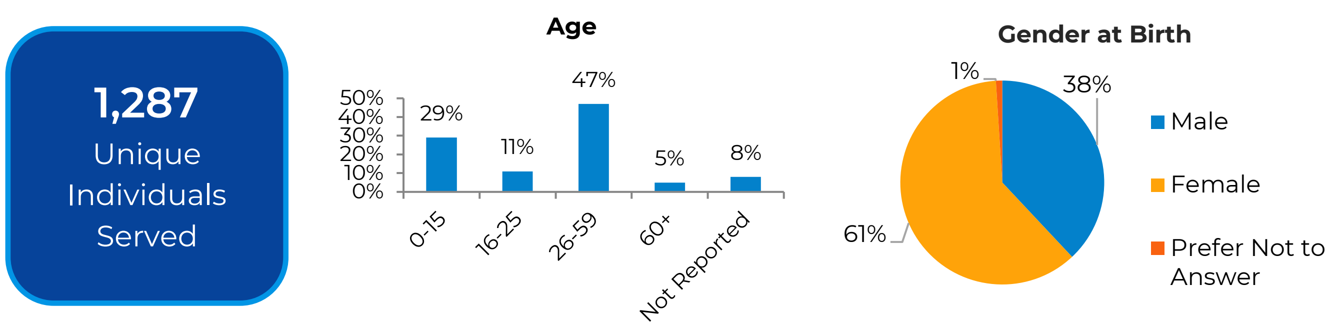
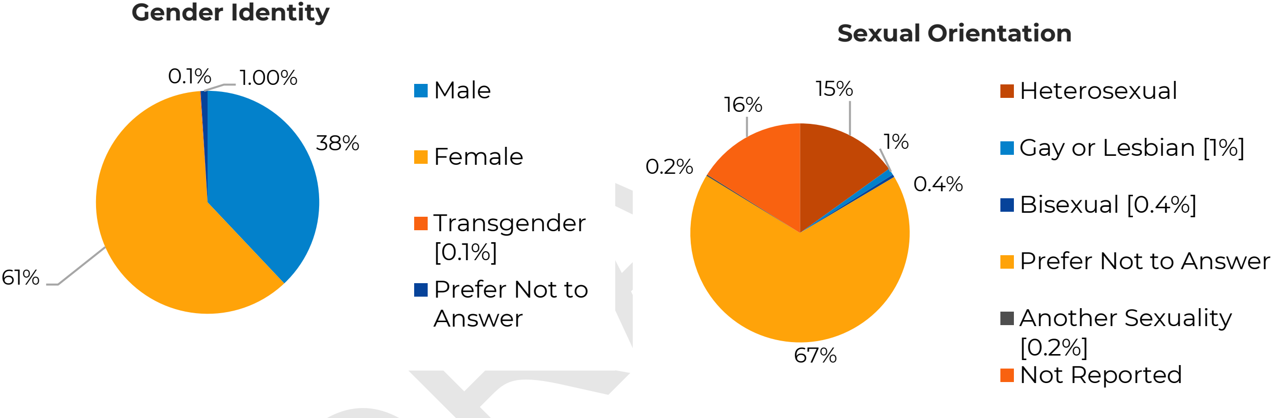
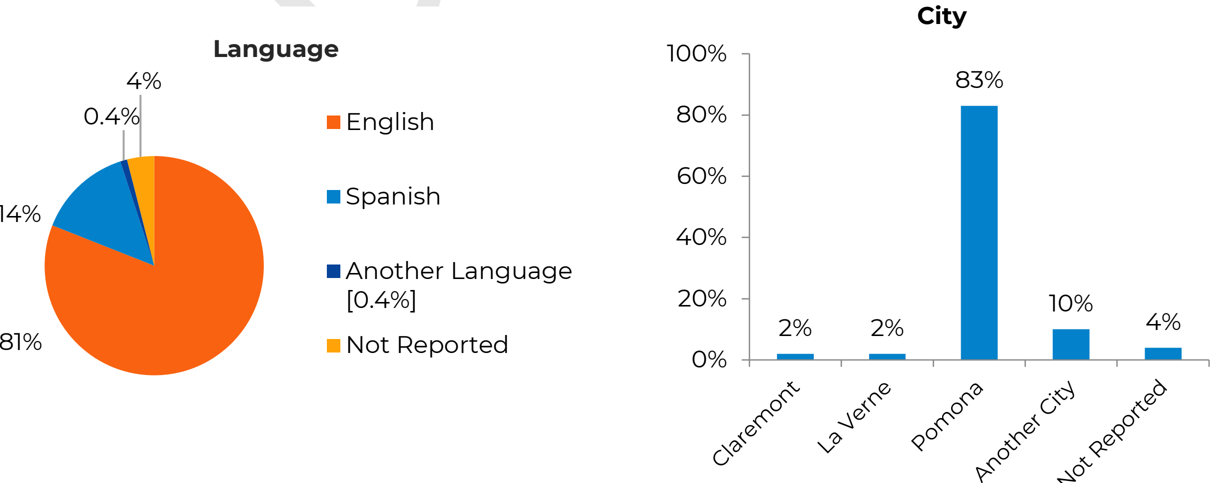
PROGRAM: Family Wellbeing Program

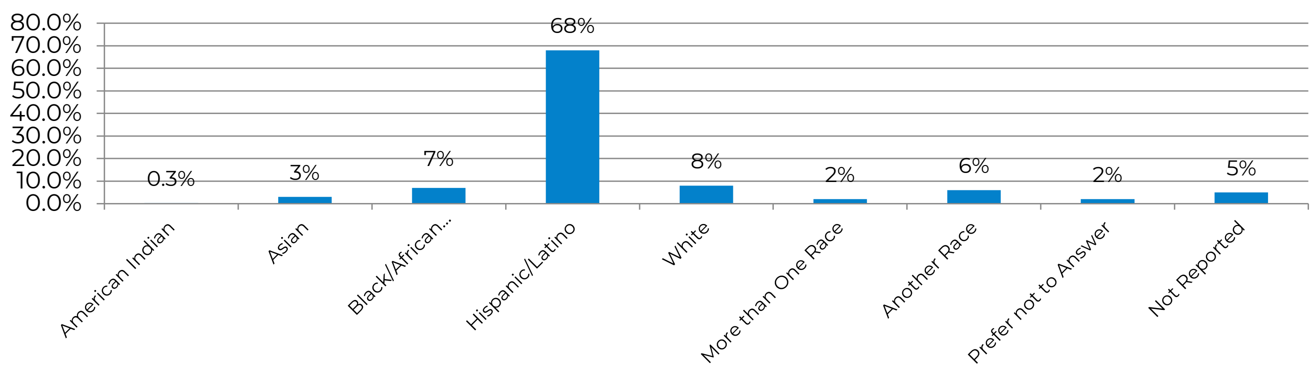
HOW MUCH DID WE DO?



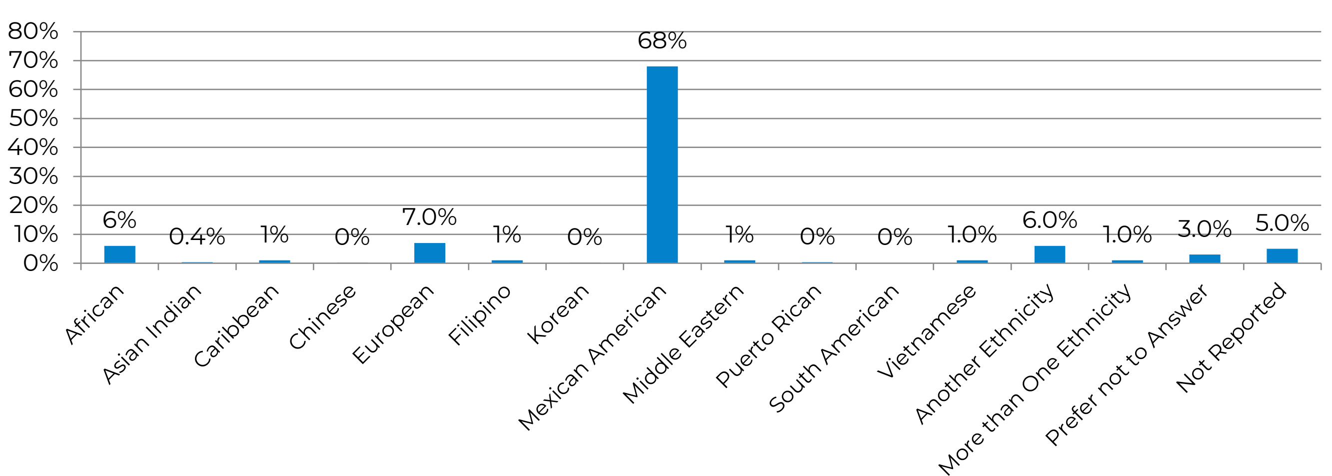




Race



Ethnicity



Military Veteran

16%

0.4%

18%

65%

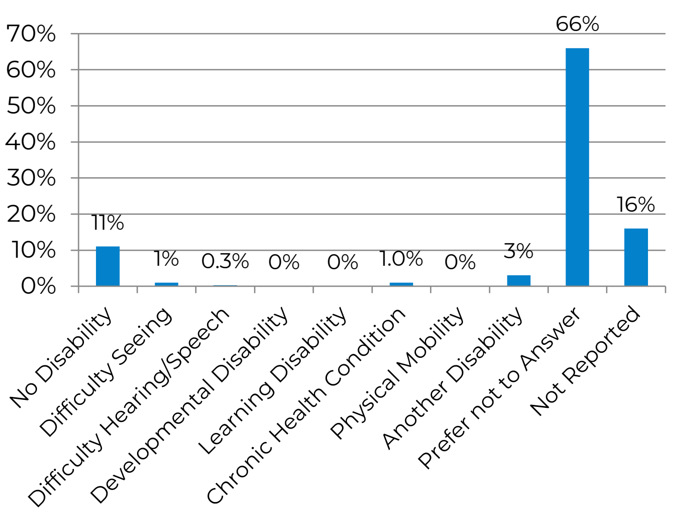
Yes [0.3%]

No

Prefer not to Answer

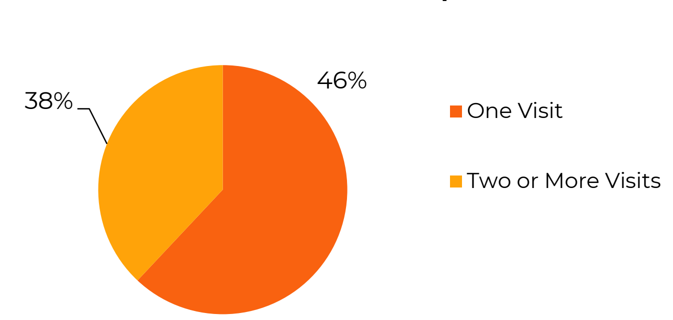
Not Reported

Disability



HOW WELL DID WE DO IT?

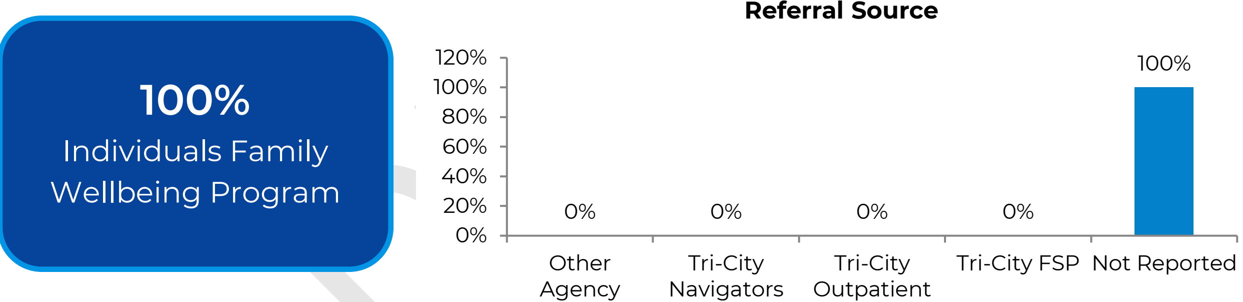
5,284
Number of Attendees at Family Wellbeing Events

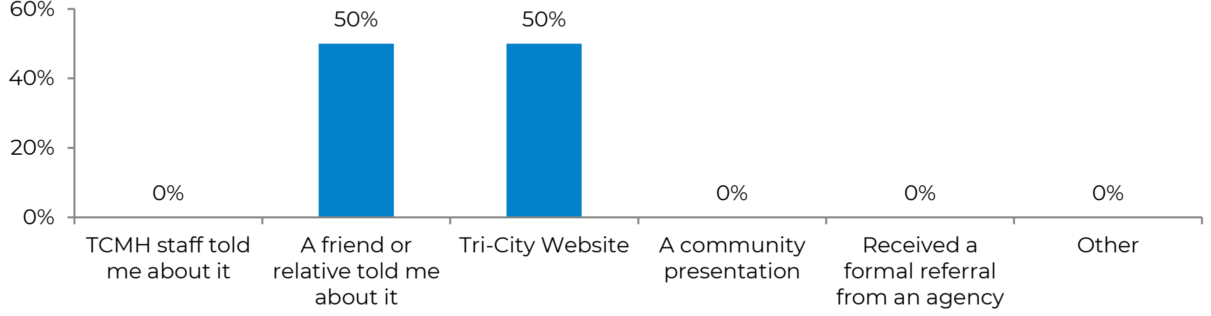


Group Name	Number of Times Group Was Held
FWS – Arts & Crafts	22
FWS – Attendance Letter	61
FWS – Bore No More	7
FWS – Cooking Class	2
FWS – Creative Writing	15
FWS – Grief & Loss	37
FWS – Kid's Hour	25
FWS – Limited to Limitless	43
FWS – Mommy & Me	24
FWS – Movie Night	34
FWS – Music	35
FWS – Sacred Heart	12
FWS – Spirituality	35
FWS – STEP Anger Management	1
FWS – Summer Camp	22
FWS – Teen Anger Management	25

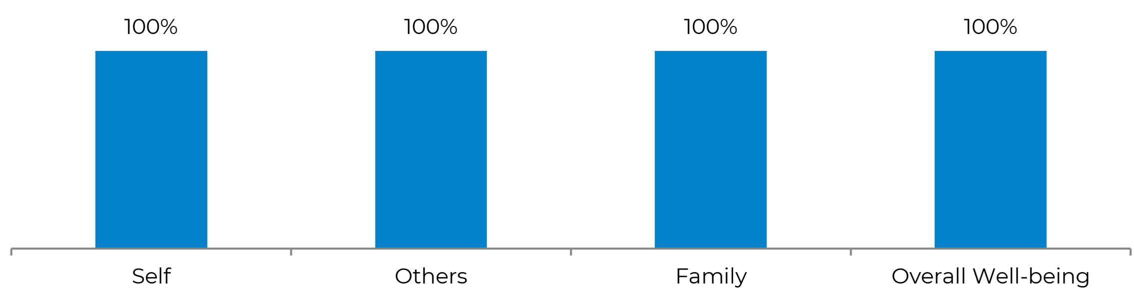
FWS – Teen Hour	37
FWS – United Family	34
FWS – Walking Adventure	36
FWS – Writing to Heal	31

Contacts by Type	Number of Times Contact was Made
FWS – Brief Check-in	527
FWS – One-on-One	99
FWS – Other	83
FWS – Phone Call	892



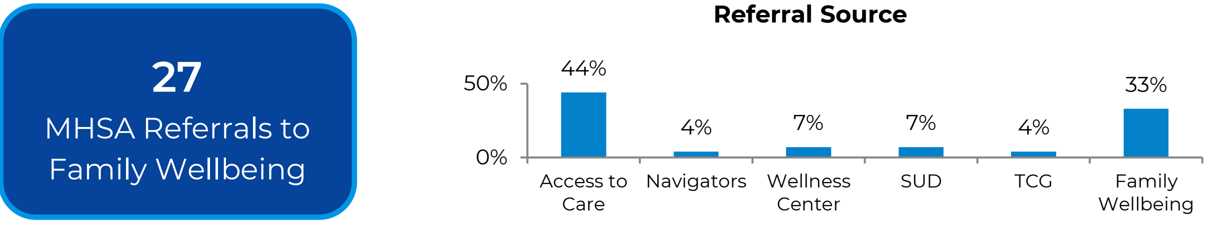


IS ANYONE BETTER OFF?



Number of Potential Responders	1,287
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Parents and children
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-age youth, older adults and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

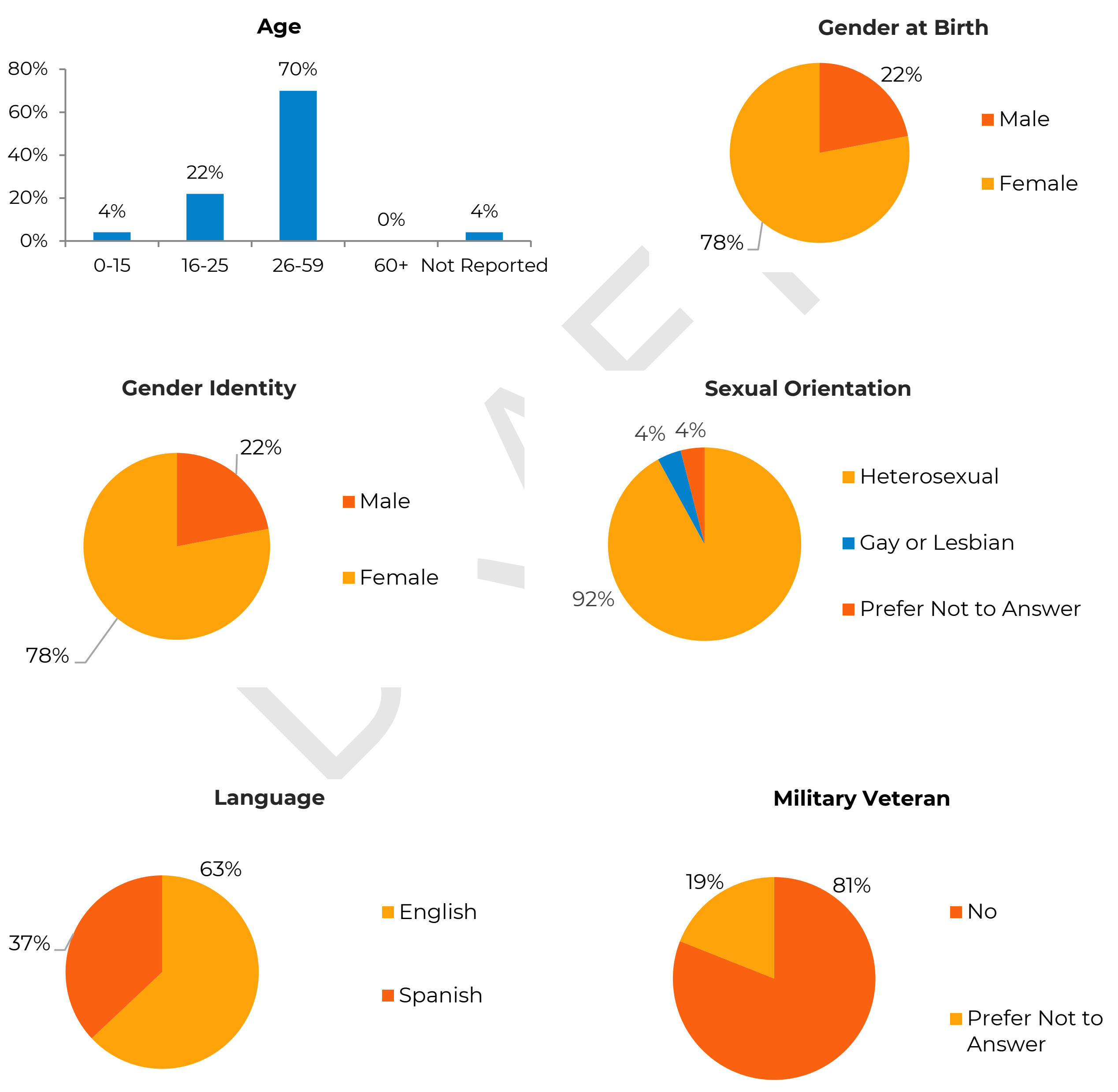
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

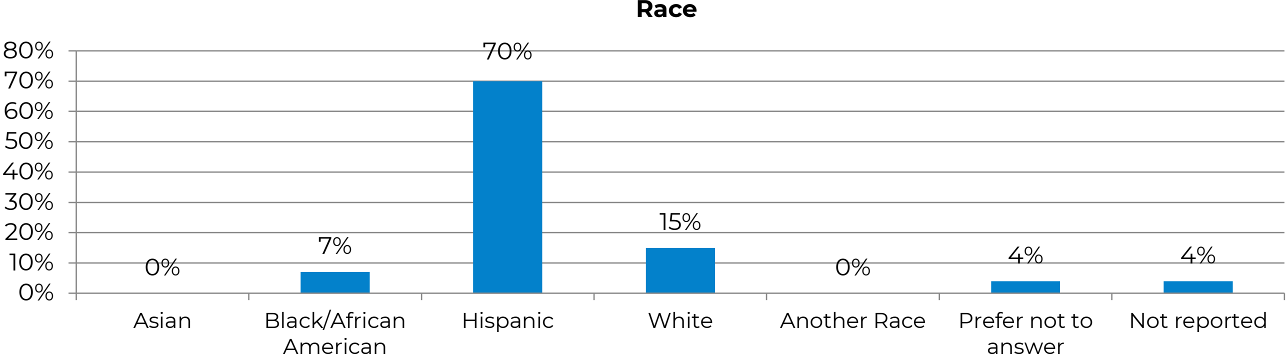


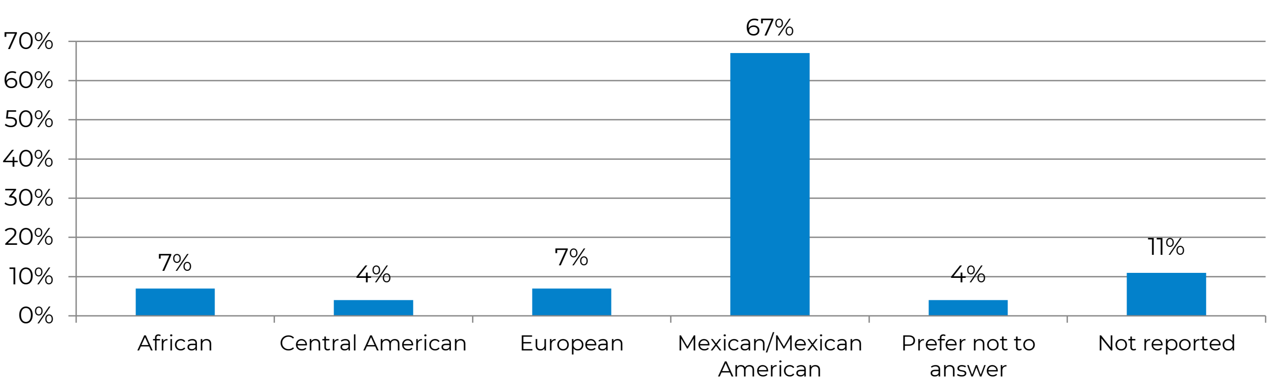
23 out of 27
Referrals Participated in Family Wellbeing Program

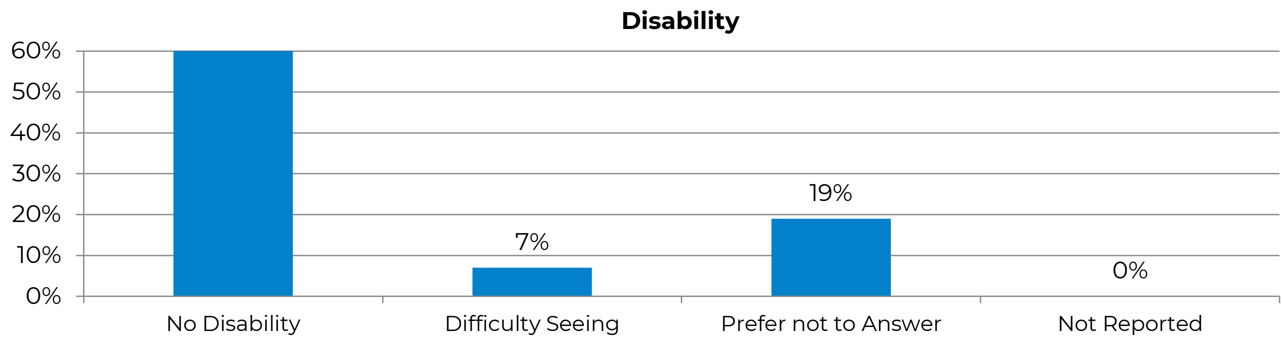
12 Days
Average Time Between Referrals and Participation in Family Wellbeing

PEI Demographics Based on MHSA Referrals




Race
80%
70%
60%
50%
40%
30%
20%
10%
0%
0%
7%
70%
15%
0%
4%
4%
Asian
Black/African American
Hispanic
White
Another Race
Prefer not to answer
Not reported


Ethnicity
70%
60%
50%
40%
30%
20%
10%
0%
7%
4%
7%
67%
4%
11%
African
Central American
European
Mexican/Mexican American
Prefer not to answer
Not reported


Disability
60%
50%
40%
30%
20%
10%
0%
7%
19%
0%
No Disability
Difficulty Seeing
Prefer not to Answer
Not Reported

NAMI: Ending the Silence

Status of Program:	_X_ New	___ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	___ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention		___ Prevention and Early Intervention	

Program Description

Ending the Silence is a community presentation offered by the National Alliance on Mental Illness (NAMI). This 50-minute program is designed to teach students, school staff and families to recognize the warning signs of mental health issues and what steps to take when they observe these symptoms in their students, friends or loved ones.

Target Population

Ending the Silence offers three separate presentations targeting; 1) middle and high school students; 2) teachers and school staff; and 3) adults with middle or high school youth.

Number of Trainings for FY 2019-20	8
Number of Attendees for FY 2019-20	346

Program Update

Prior to the COVID-19 outbreak, NAMI Pomona Valley (NPV) was on track to increase collaboration with local community partners and, thereby, increasing participation in their support and education programs. Additionally, NPV made plans to increase awareness among community stakeholders with an eye toward promoting the Ending the Silence (ETS) program, as well as support groups offered through the Community Services and Supports program. Notably, the Spanish language outreach efforts had increased.

Challenges and Solutions

Challenges with ETS continues to be logistical. As a school-based program, the mechanics of contacting schools, and confirming a commitment to host the training has proven to take an inordinate amount of time. Convincing school official of the value of this training, as well as scheduling the time for these presentations, continues to be an obstacle to implementing this training on a larger scale. In response to this, NPV has secured an intern who is dedicated to contact and coordinate with school officials in hopes of building a strong collaboration which will include this essential training.

COVID-19 Response

The Ending the Silence program was devastated by the COVID-19 outbreak insofar as the schools shut down eliminated the opportunity to provide the in-person ETS presentations. Although NPV

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attempted to transition the presentations to a virtual platform, these efforts were largely unsuccessful when the shutdown first happened as schools were grappling with more fundamental issues. As a result of the school shut down, getting a response from school personnel proved all but impossible. Therefore, presentations could not be arranged. However, efforts continue to try and improve the delivery of the ETS presentations and evaluation process using an online and web-based format.

Cultural Approach

NAMI is highly committed to cultural inclusion and offers the Ending the Silence program in both English and Spanish. In addition, efforts are made to recruit diverse populations as program leaders. All outreach and program materials are available in both English and Spanish. At this time, NAMI PV does not have a dedicated strategy to addressing barriers to the LGBTQ+ community who may be seeking services. Future efforts include distinct and consistent efforts to outreach to underserved and unserved groups and organizations, in the hopes of enhancing current practices in providing access to services.

PROGRAM: NAMI – Ending the Silence

HOW MUCH DID WE DO?

8
Presentations

346
Attendees

HOW WELL DID WE DO IT?

100%
Agreed or strongly agreed that the presentation increased their understanding of symptoms associated with mental health challenges

100%
Agreed or strongly agreed that the presentation will help them recognize early warning signs of mental health challenges

IS ANYONE BETTER OFF?

100%
Agreed or strongly agreed that the presentation provided them with new and useful resources

100%
Agreed or strongly agreed that the presentation helped them understand the impact of untreated mental health challenges

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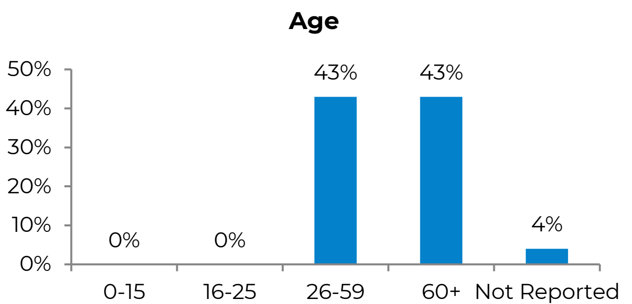
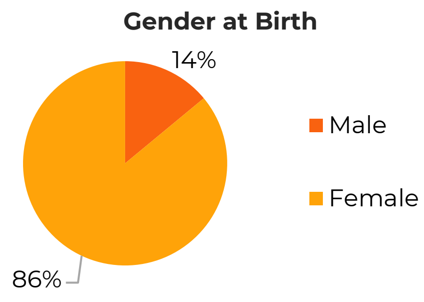
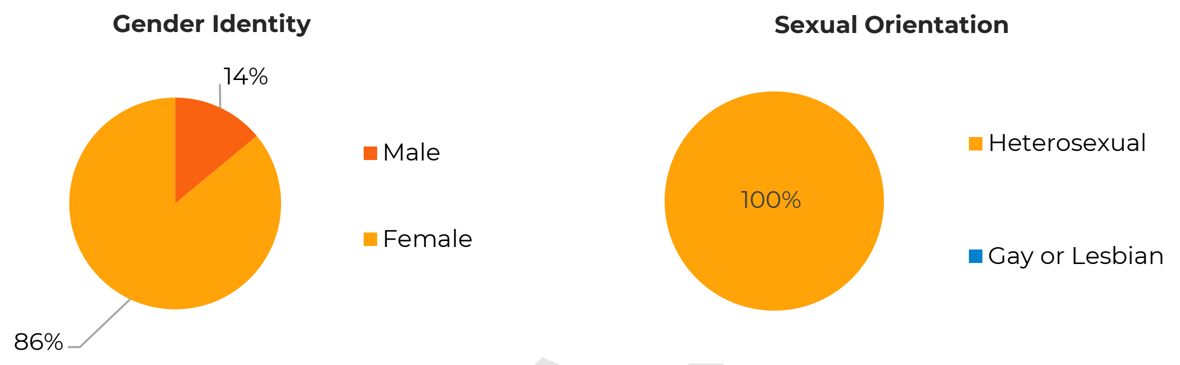
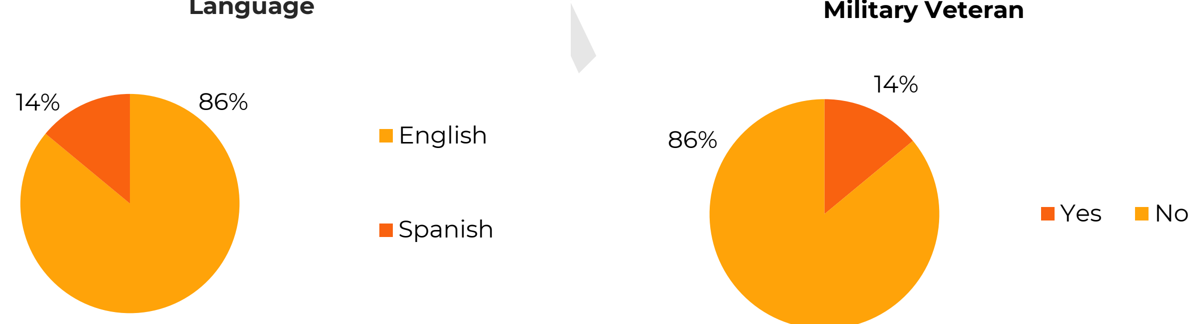
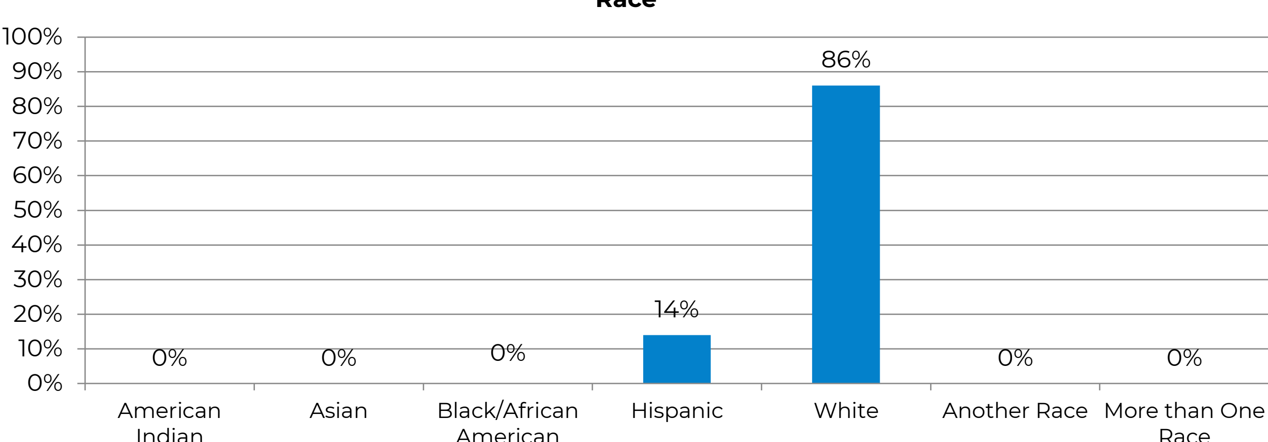
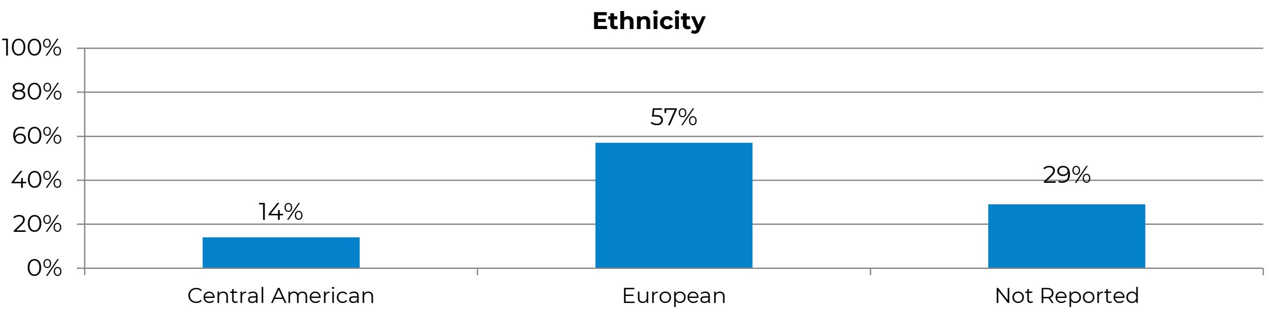

Age
50%
40%
30%
20%
10%
0%
0%
0%
43%
43%
4%
0-15
16-25
26-59
60+
Not Reported

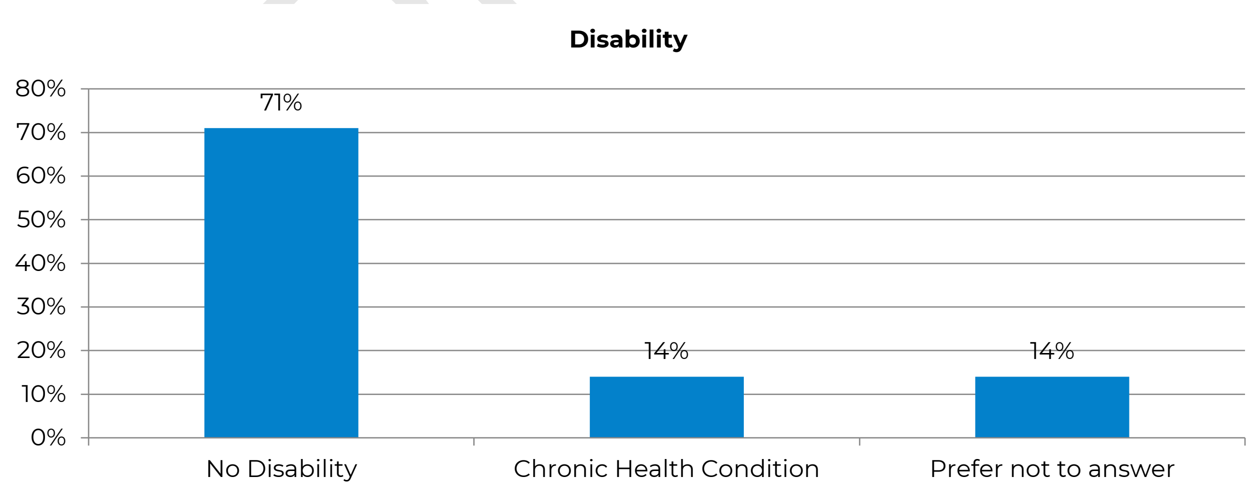

Gender at Birth
14%
86%
Male
Female


Gender Identity
14%
86%
Male
Female
Sexual Orientation
100%
Heterosexual
Gay or Lesbian


Language
14%
86%
English
Spanish
Military Veteran
14%
86%
Yes
No


Race
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0%
0%
0%
14%
86%
0%
0%
American Indian
Asian
Black/African American
Hispanic
White
Another Race
More than One Race


Ethnicity
100%
80%
60%
40%
20%
0%
14%
57%
29%
Central American
European
Not Reported


Disability
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
14%
14%
No Disability
Chronic Health Condition
Prefer not to answer

Number of Potential Responders	346
Setting in Which Responders were Engaged	Schools
Type of Responders Engaged	Teachers and school staff, middle and high school students, adults with middle or high school youth
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

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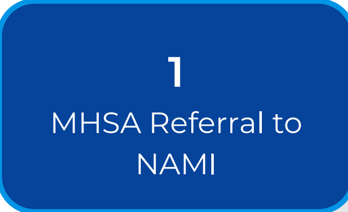
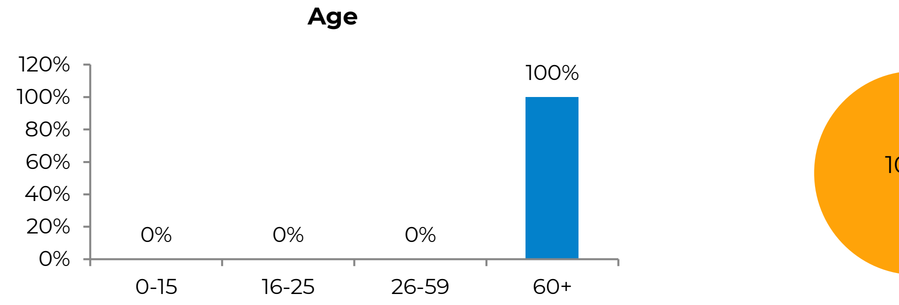
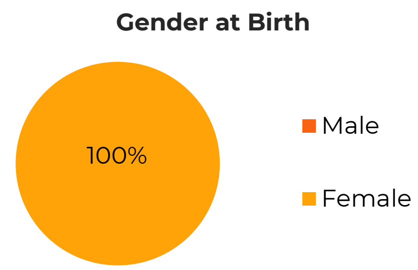
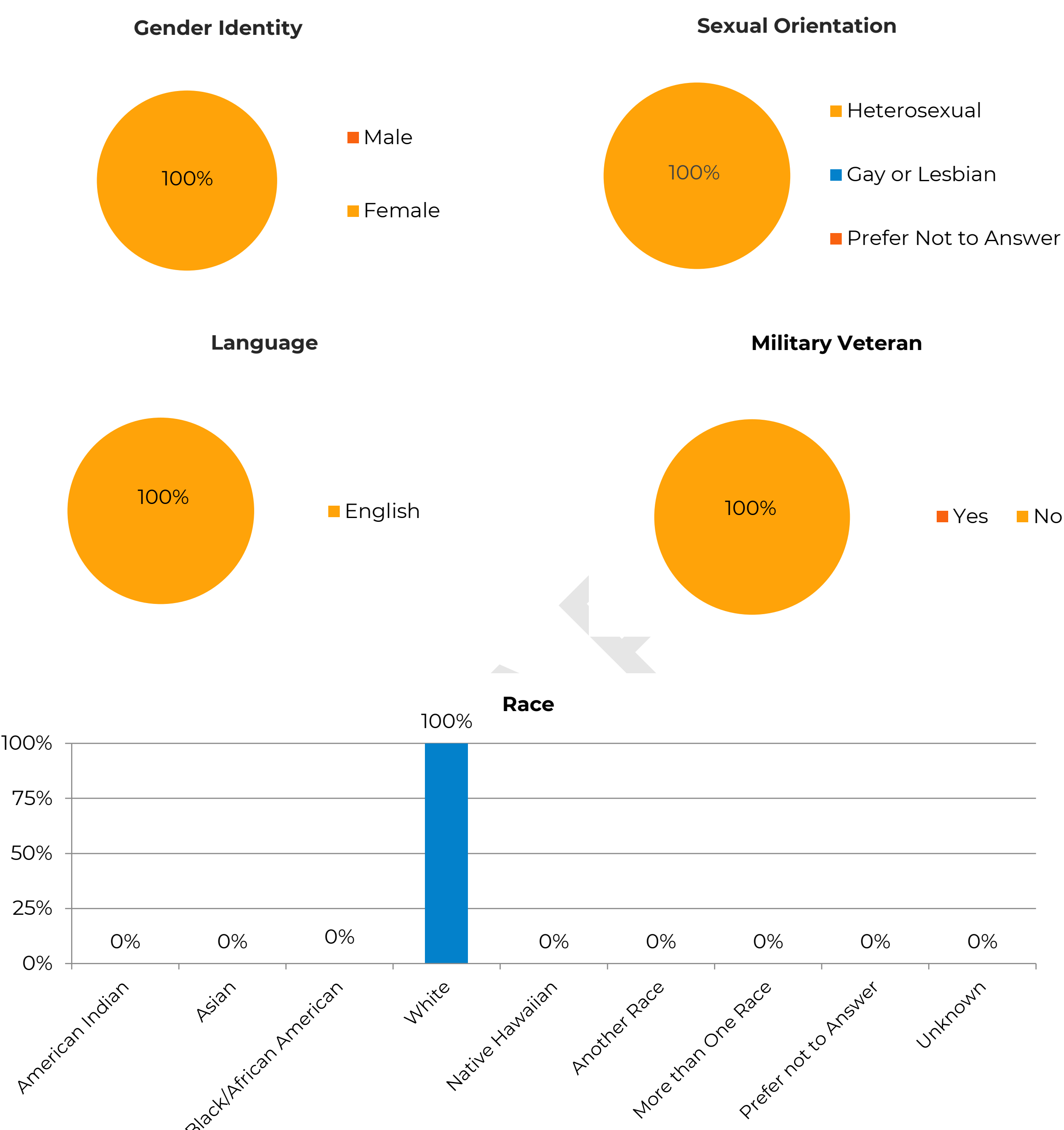
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

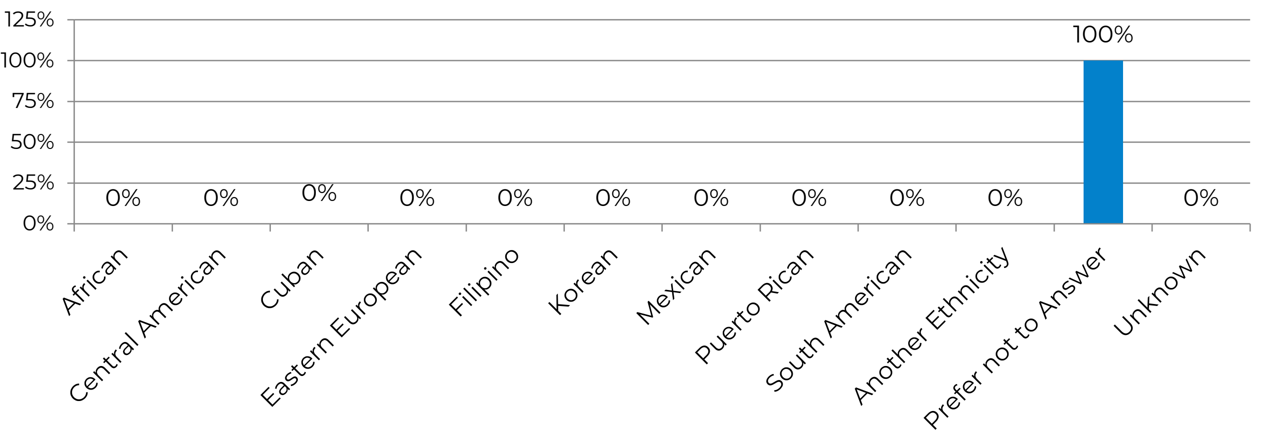


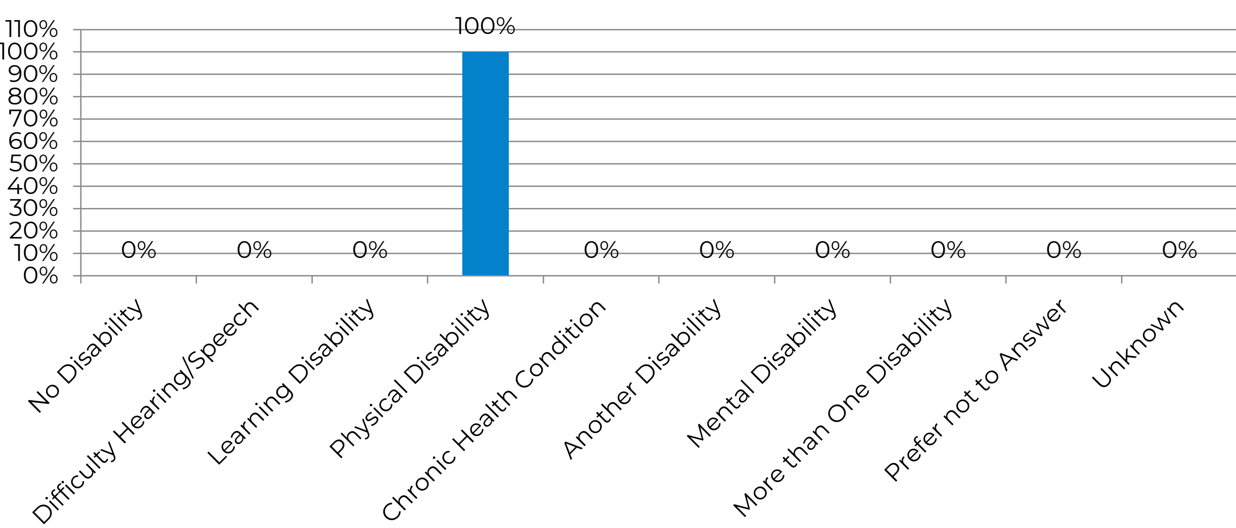
PEI Demographics Based on MHSA Referrals (n=1)






Gender Identity
100%
Male
Female
Sexual Orientation
100%
Heterosexual
Gay or Lesbian
Prefer Not to Answer
Language
100%
English
Military Veteran
100%
Yes
No
Race
100%
75%
50%
25%
0%
100%
0%
0%
0%
0%
0%
0%
0%
0%
American Indian
Asian
Black/African American
White
Native Hawaiian
Another Race
More than One Race
Prefer not to Answer
Unknown


Ethnicity
125%
100%
75%
50%
25%
0%
0%
0%
0%
0%
0%
0%
0%
0%
0%
0%
100%
0%
African
Central American
Cuban
Eastern European
Filipino
Korean
Mexican
Puerto Rican
South American
Another Ethnicity
Prefer not to Answer
Unknown


Disability
110%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0%
0%
0%
100%
0%
0%
0%
0%
0%
0%
No Disability
Difficulty Hearing/Speech
Learning Disability
Physical Disability
Chronic Health Condition
Another Disability
Mental Disability
More than One Disability
Prefer not to Answer
Unknown

Housing Stability Program

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	___ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention		___ Prevention and Early Intervention	

Program Description

Stable housing is a necessary foundation to be able to create wellbeing and support a person's mental health. Tri-City Housing staff work diligently with clients, mental health service providers, landlords, and property managers to secure housing placements, mediate conflicts, and strengthen relationships. The Housing Stability Program is a prevention program designed to help people with mental illness maintain their current housing or find more appropriate housing.

Target Population

Individuals experiencing mental illness who need support to maintain their current housing or find a more appropriate place of residence. Program staff members work with clients, mental health service providers, landlords, and property managers to secure housing placements, mediate conflicts, and strengthen relationships.

New Landlords Engaged	Landlord Luncheons Held	Attendees (Unique)	Repeat Attendees (Duplicates)
22	9	114	165

Program Update

In August of 2019, the Housing Stability Program (HSP) hosted the annual Housing Summit with the largest attendance for this event at 52 attendees. The event expanded from just providing regular update of the housing laws and regulations to guests such as the Los Angeles County Development Authority who presented their Homelessness Incentive Program which included a panel of previously homeless individuals, who shared their journey to being housed. The goal is to encourage owners to be more open to working with individuals using housing vouchers.

Challenges and Solutions

The HSP staff began offering the "Good Tenant Curriculum" to tenants residing at properties funded through MHSA. However, tenants at these sites did not appear motivated to attend the group despite a "graduation gift" that was promoted. There were only a few instances where the presenter encountered language barriers as the tenants spoke a language other than English or Spanish.

In response, HSP staff will review surveys from past attendees and revise the curriculum to cover topics and address questions from previous groups in hopes that this updated information will be applicable and of interest to these tenants.

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During FY 2019-20, the HSP added a new community group, Open Door. Through this group, staff are able to provide general housing listings created biweekly. This new, bi-weekly, group is a round table discussion for anyone that has questions regarding housing, with the purpose of clarifying any misconceptions of the availability of housing. It also provides an opportunity for community members to engage in conversations with each other to identify ways in which they have overcome housing obstacles.

COVID-19 Response

With the onset of the COVID 19 pandemic, the HSP staff quickly moved the Open Door Group to a virtual platform. In addition, the monthly landlord meetings were moved to a virtual platform as well. Community emails were sent referring individuals directly to the Housing Rights Center to offer support regarding housing rights and concerns.

Previously scheduled events, such as the first Housing Fair, inspired by job fairs held at the Wellness Center, were scheduled in compliance with state and federal restrictions. Outreach efforts were curtailed due to social distancing and a reduction with "in-person" meetings with landlords and property managers.

RingCentral, an online meeting platform, proved to be a valuable resource for staff when hosting groups, meetings, summits, and webinars. Trainings such as the Good Tenant Curriculum, were modified to be available for a call-in group format. Efforts are underway with community partners to add WIFI and computer stations so the Good Tenant Curriculum can be offered virtually as well.

Future efforts include working with Tri-City community trainers to expand the Mental Health First Aid trainings for property owners and landlords to help them when responding to difficult interactions with tenants. A new curriculum will be introduced in the future entitled Landlord Everyday Mental Health.

Housing staff will also begin hosting regular landlord housing forums to provide a virtual round table for landlords. Participants will be able to offer support to each other while identifying areas where resources and future education is needed.

Cultural Approach

Cultural inclusion is an important component to the Housing Stability Program. Five of the eight housing staff are bilingual in English and Spanish. Tri-City staff maintain strong alliances with various agencies throughout the county that serve diverse communities. Information and resources gleaned from these relationships are then provided to participants during the Landlord Luncheons.

Stigma regarding mental illness is also a concern and the Open Door group is structured to focus on individuals who are considered underserved, and offer support and resources as they express their experience with barriers or discriminations. Mental Health First Aid training is offered for landlords, owners, and property managers in order to help them better understand and be able to support tenants with mental health conditions.

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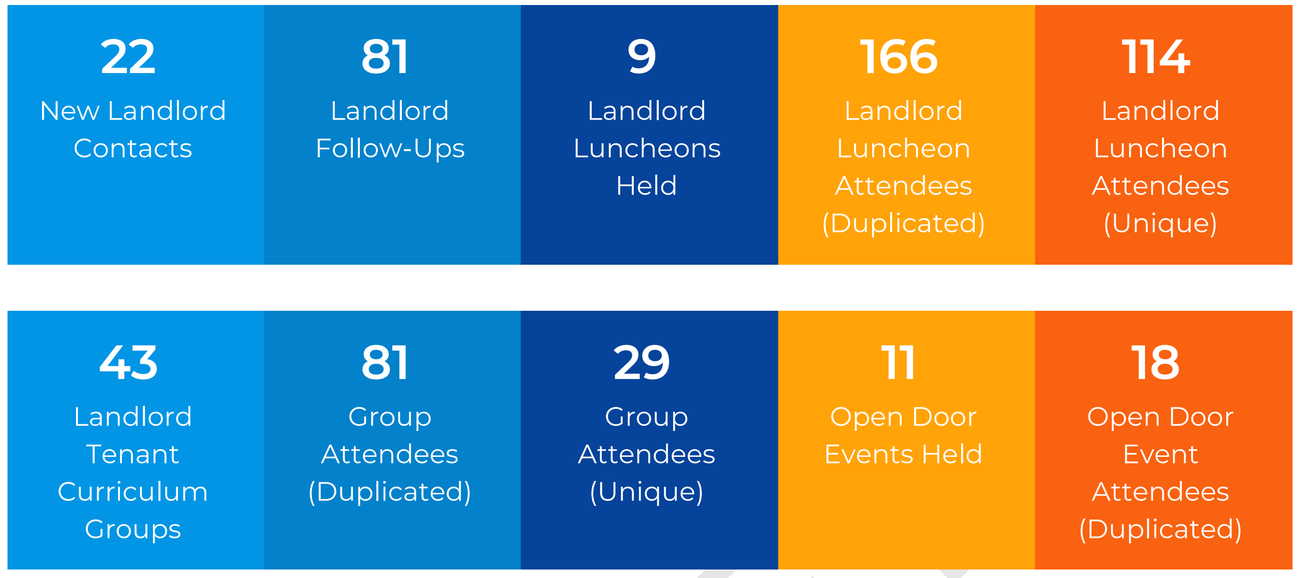
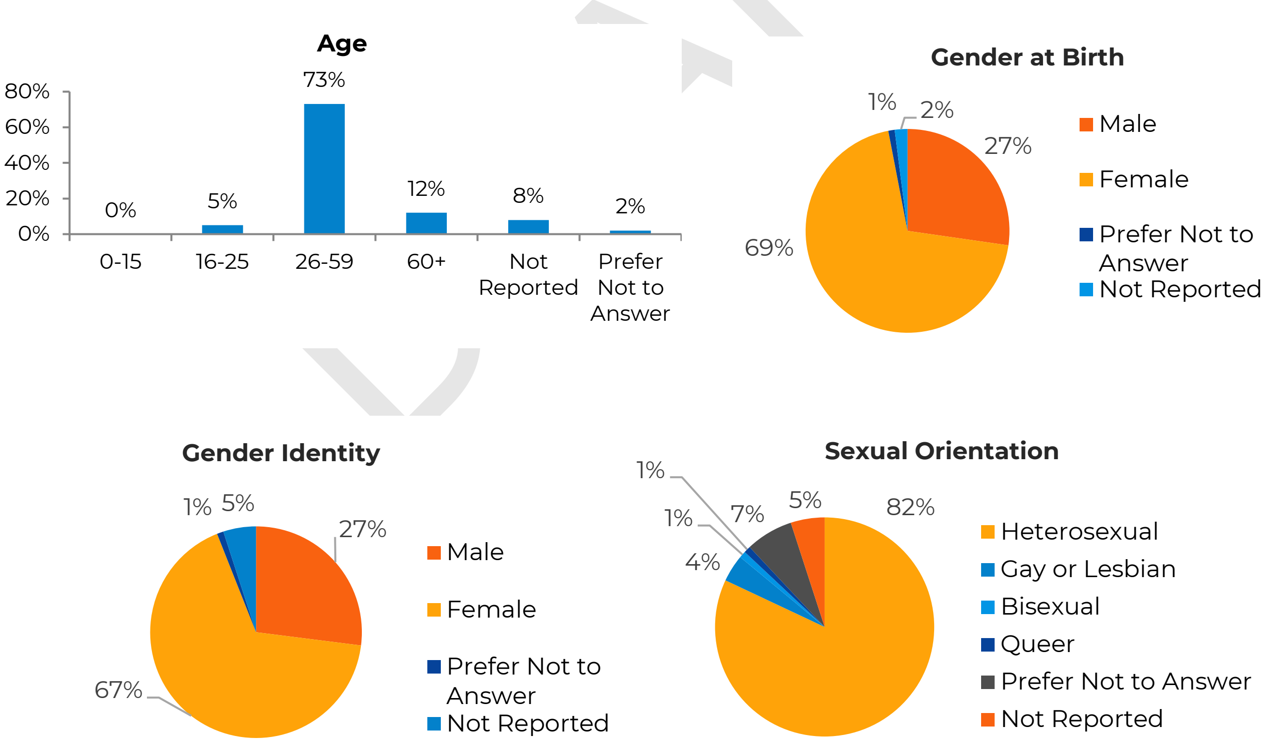
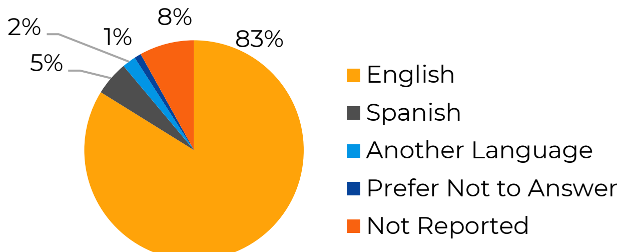
PROGRAM: Housing Stability Program (HSP)

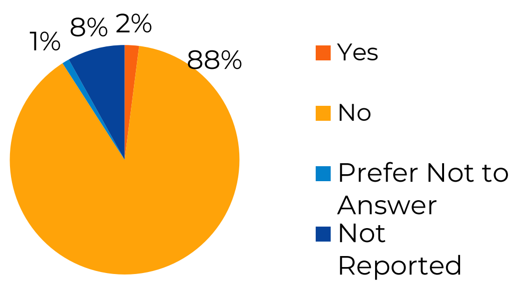
HOW MUCH DID WE DO?

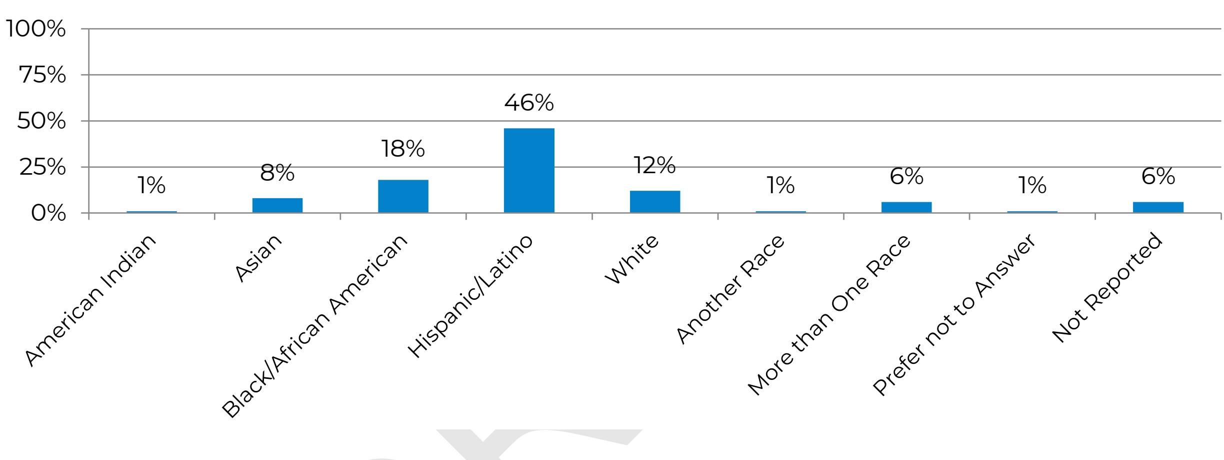


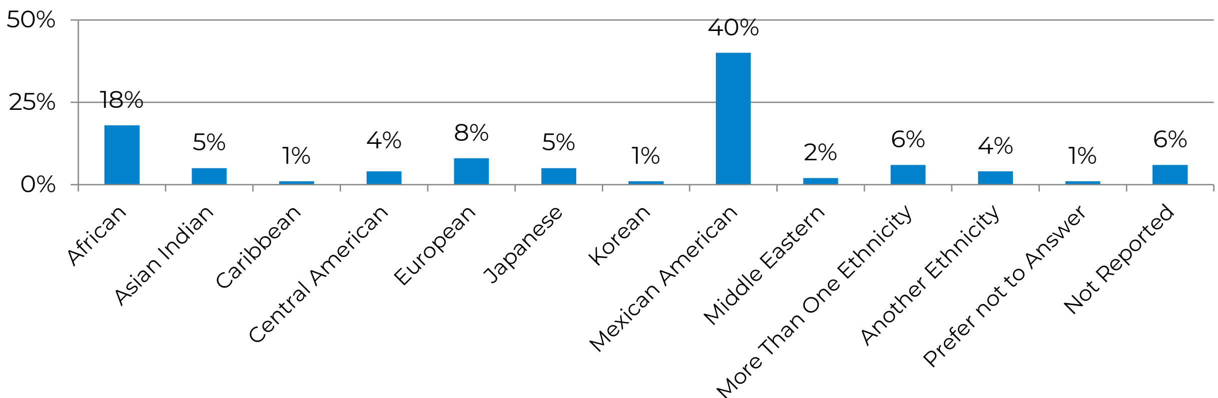
PEI Demographics, Including Housing Participants

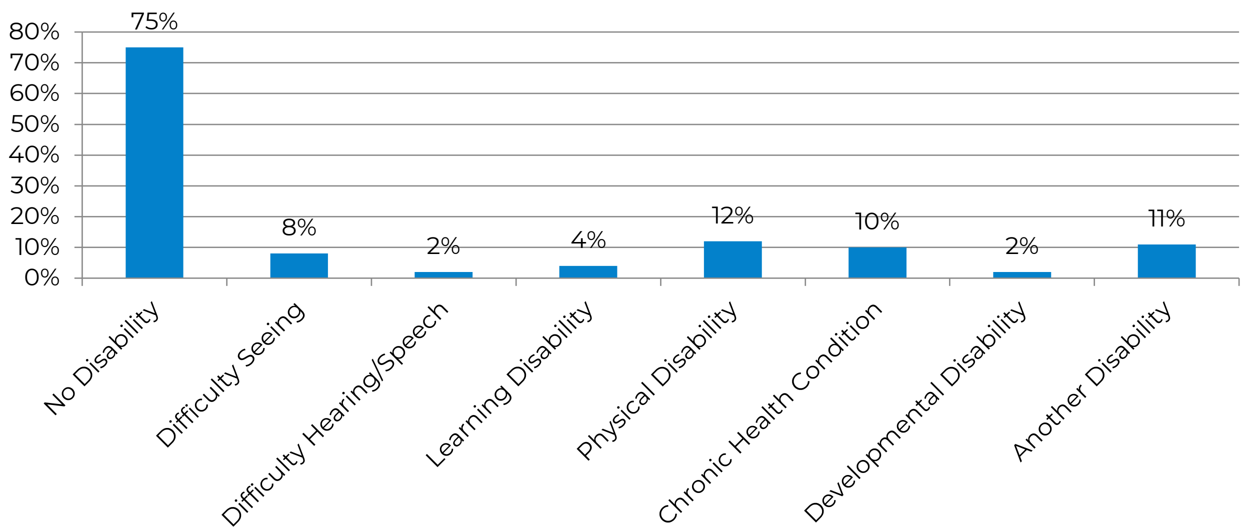



Language
2%
1%
8%
83%
5%
English
Spanish
Another Language
Prefer Not to Answer
Not Reported

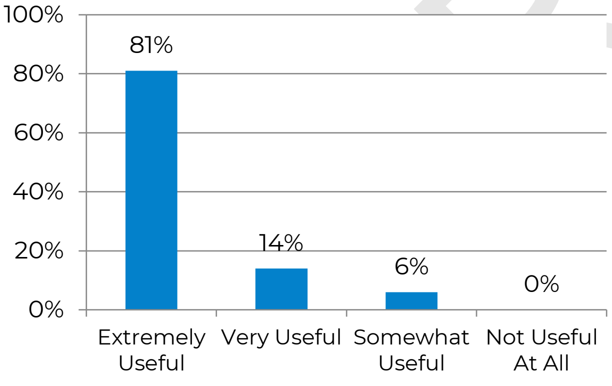

Military Veteran
1%
8%
2%
88%
Yes
No
Prefer Not to Answer
Not Reported

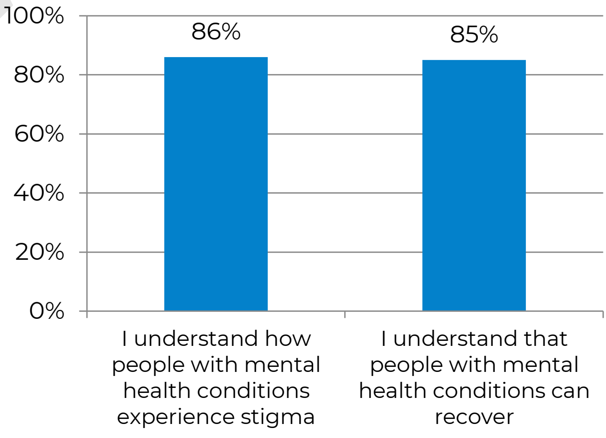

Race
100%
75%
50%
25%
0%
1%
8%
18%
46%
12%
1%
6%
1%
6%
American Indian
Asian
Black/African American
Hispanic/Latino
White
Another Race
More than One Race
Prefer not to Answer
Not Reported


Ethnicity
50%
25%
0%
18%
5%
1%
4%
8%
5%
1%
40%
2%
6%
4%
1%
6%
African
Asian Indian
Caribbean
Central American
European
Japanese
Korean
Mexican American
Middle Eastern
More Than One Ethnicity
Another Ethnicity
Prefer not to Answer
Not Reported



HOW WELL DID WE DO IT?





94%
Good Tenant Curriculum Participants Would Recommend This Curriculum to Others

93%
Good Tenant Curriculum Participants Reported the Presenter was Engaging and Approachable

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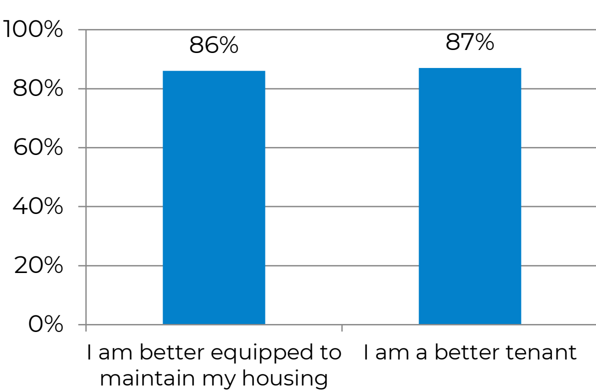
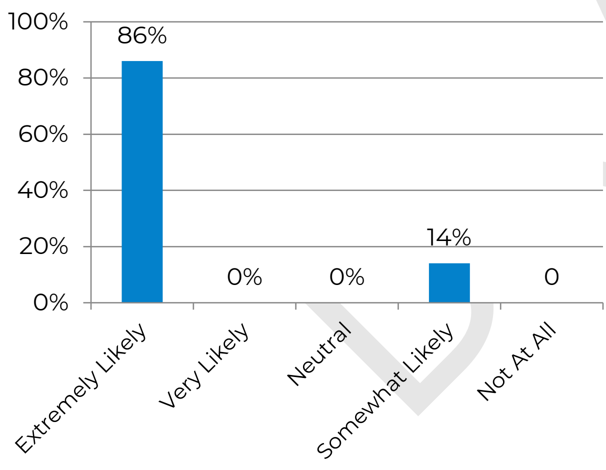
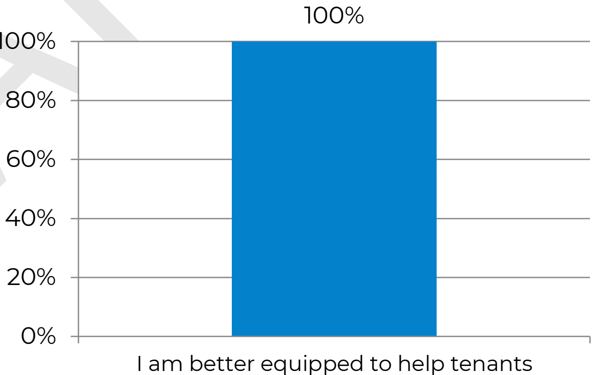
IS ANYONE BETTER OFF?



92%
Good Tenant Curriculum Participants Reported That Staff Helped Them Obtain the Information Needed to Accomplish Their Housing Goals





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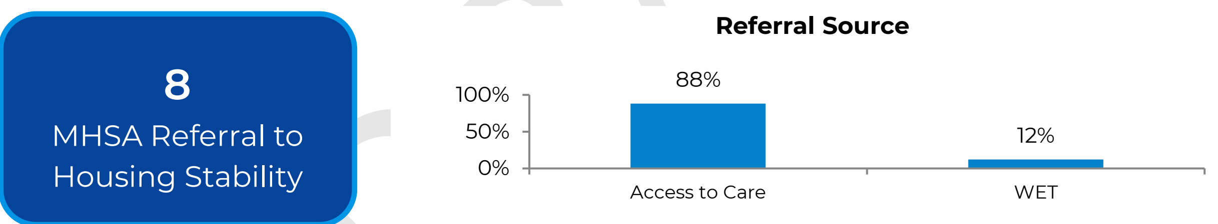
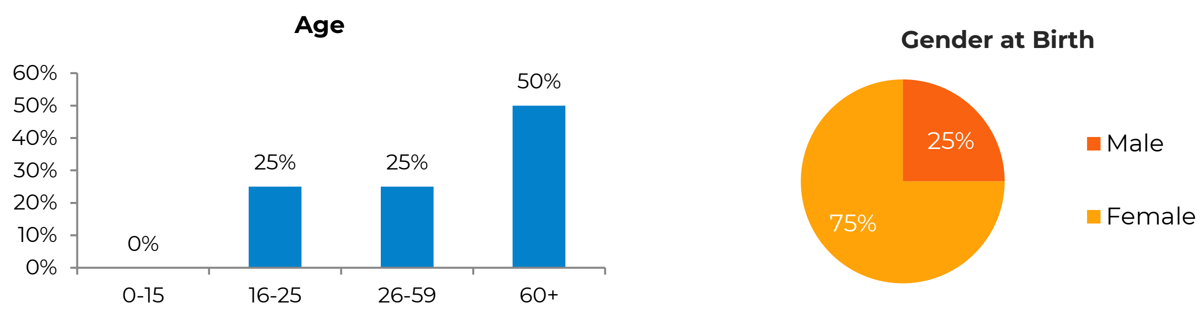
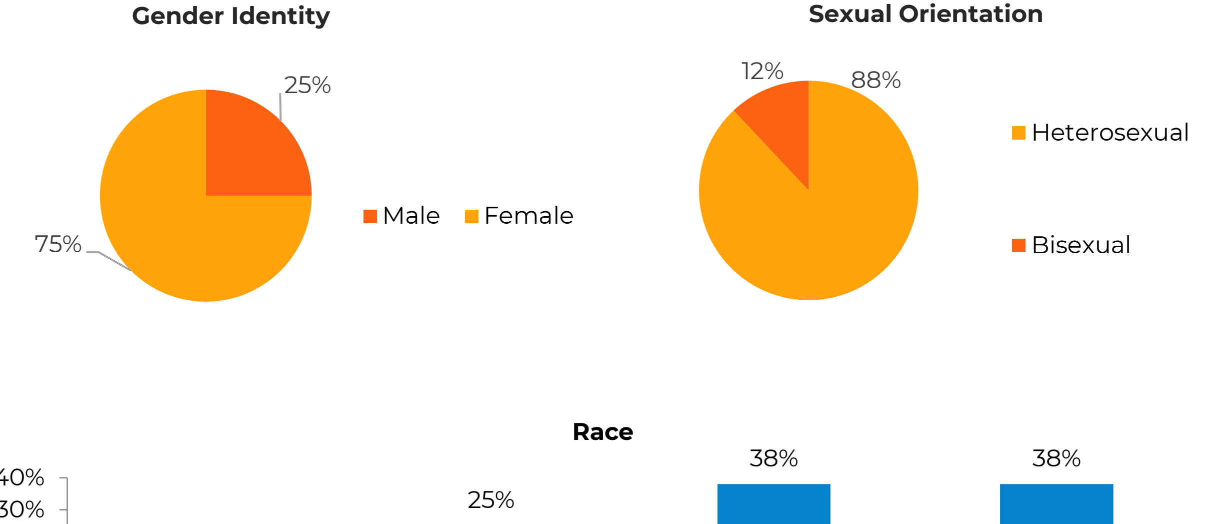
Number of Potential Responders	143
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Landlords and community members
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-age youth, older adults and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

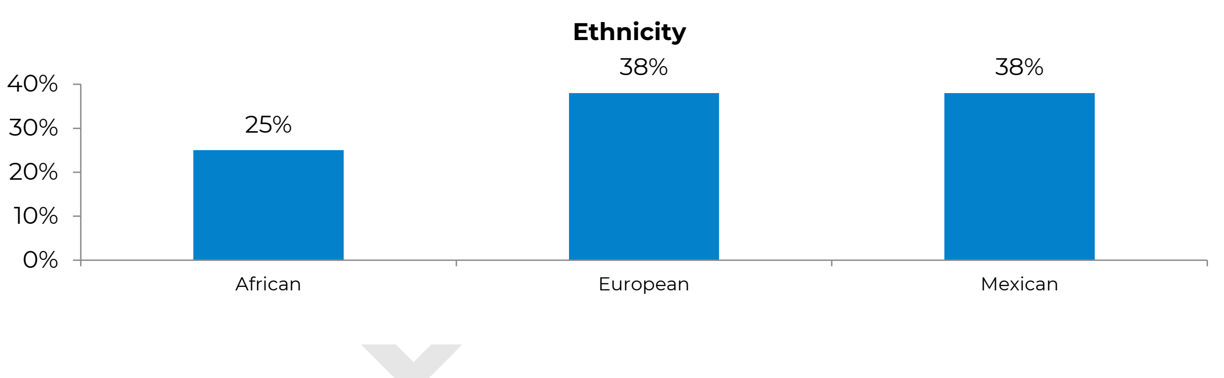
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

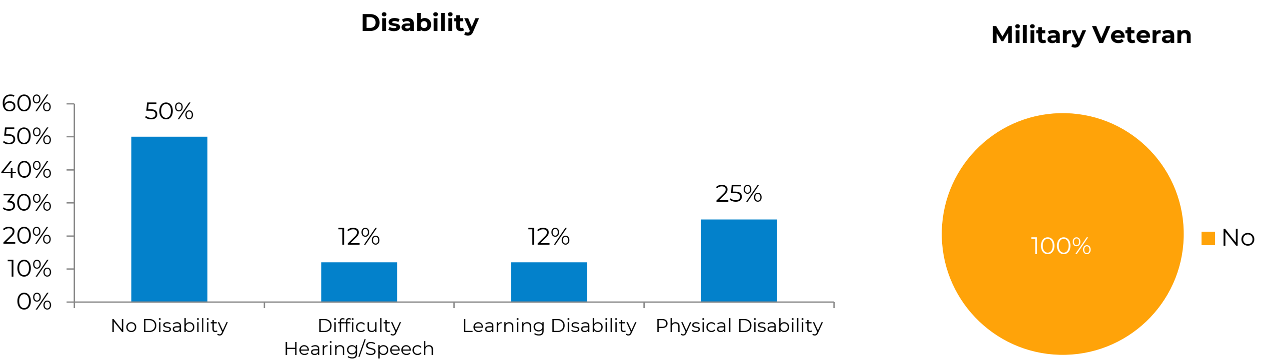


PEI Demographics Based on MHSA Referrals




Gender Identity
25%
75%
Male
Female
Sexual Orientation
12%
88%
Heterosexual
Bisexual
Race
40%
30%
20%
10%
0%
0%
25%
38%
38%
Asian
Black/African American
Hispanic/Latino
White


Ethnicity
40%
30%
20%
10%
0%
25%
38%
38%
African
European
Mexican


Disability
60%
50%
40%
30%
20%
10%
0%
50%
12%
12%
25%
No Disability
Difficulty Hearing/Speech
Learning Disability
Physical Disability
Military Veteran
100%
No

Therapeutic Community Gardening

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	___ Prevention	_X_ Early Intervention	___ Prevention and Early Intervention		

Program Description

The Therapeutic Community Gardening program helps participants decrease their isolation and experience mental health benefits through participation in horticulture/gardening activities and group therapy exercises.

Target Population

Unserved and underserved populations including adults, youth ages 16-25, families with children, older adults, and veterans.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	11	8	40	19	4
Cost Per Person	$3,316.00	$3,316.00	$3,316.00	$3,316.00	$3,316.00

Program Update

The Therapeutic Community Garden (TCG) program continues to be a popular option for community members and staff referrals. Community participation is a fundamental foundation for this program and staff are able to support this concept through hosting and participating in local events such as a resource fair at Cal Poly Pomona Veteran's Resource Center and Fall at the Farm hosted at the Pomona Fairplex. Additional events were sponsored by Tri-City and included the adult outpatient graduation ceremony, Wellness Center Tree Lighting Event, and Harvest Feast at Tri-City's Royalty location.

During FY 2019-20, TCG staff also hosted workshops at the Jocelyn Senior Center for older adults, Simon Middle School, and a monolingual group for parents in the Claremont Unified School Districts book club in the Therapeutic Community Garden. One of their most popular gatherings was a winter event help in the Garden which drew 55 attendees.

Challenges and Solutions

One of the challenges experienced by this team included a low turnout for groups located at various Tri- City housing locations. Transition age youth (TAY) continue to be a difficult population to engage, enroll and maintain in TCG groups.

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To increase future attendance in TAY groups, TCG staff will be collaborating with community partners who support this age specific group. These efforts include maintaining preexisting relationships with TAY organizations as well as hosting workshops and events that target this essential age group.

COVID-19 Response

TCG operations were impacted dramatically due to COVID 19. In March 2020, all groups were put on hold due to concerns with public and staff safety. The majority of services rendered through TCG were through groups prior to COVID 19; therefore, all direct services were put on hold. However, weekly wellness calls to TCG participants began and continue to this day.

Groups for TCG shifted to a virtual platform in July of 2020. TCG staff are currently utilizing social media platforms to provide information regarding the Garden to the public. Adapting to the virtual world of delivering services via telehealth presented many challenges. A few of those challenges included: adapting to and learning technology related to delivering services virtually; assisting TCG clients to download and learn technology to be able to log-in to virtual groups and making accommodations for individuals that were not comfortable receiving services through telehealth. Curriculum and program development, disseminating information to the public, and ensuring proper HIPAA (Health Insurance Portability and Accountability Act) and documentation guidelines were followed delayed the process of offering services virtually. At this time, TCG groups are now being conducted virtually.

Finally, TCG staff-initiated harvest drop-off/pick-ups of items from the garden to TCG participants and worked with local non-profit agency to offer donations of fruit.

Cultural Approach

The Therapeutic Community Garden is diligent is addressing barriers for underserved and unserved communities. Efforts include:

- Full time Spanish-speaking Mental Health Specialists and monolingual Spanish groups
- English and Spanish speaking adult and older adult groups
- Transitional Aged Youth, youth and family aged group
- Wellness Center group (indoors) for participants who are unable to be in the garden.
- Modifying TCG activities for individuals with learning impairments (as needed)
- Curriculum development includes discussions about diversity, culture and how differences between plants can benefit each other (companion planting and crop rotation)
- Participation in events that bring awareness to diversity and inclusion
- Attendance to trainings and webinars that focus on increasing cultural competency and awareness

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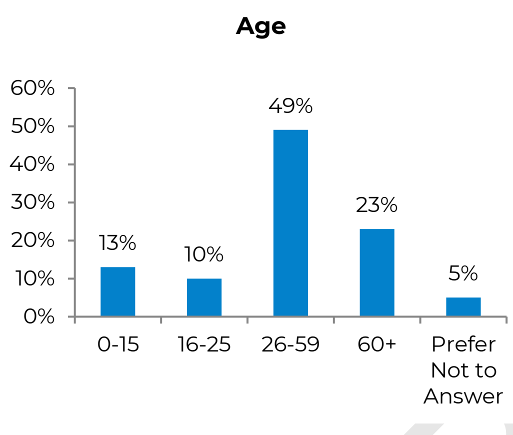
- A majority of program materials are available in Spanish (i.e. waivers, enrollment sheet, referral forms, questionnaires, flyers, labels for garden beds)

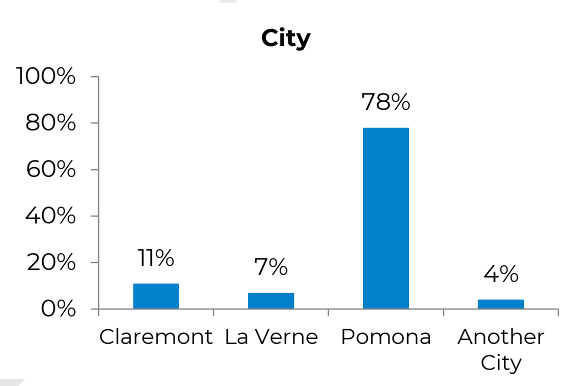
PROGRAM: Therapeutic Community Gardening (TCG)

HOW MUCH DID WE DO?

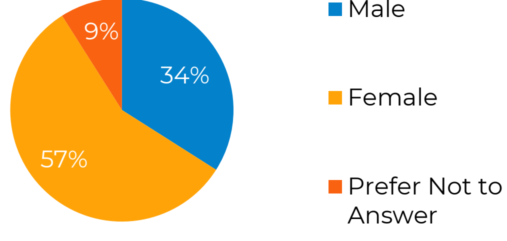
349 Days

Average Length of Time Individuals Enrolled in TCG

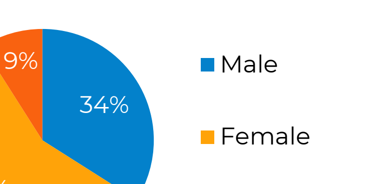


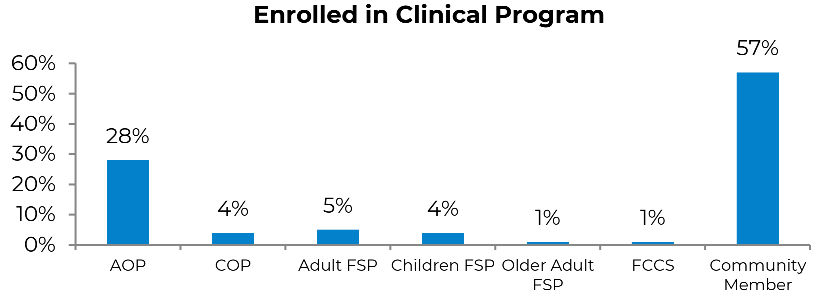


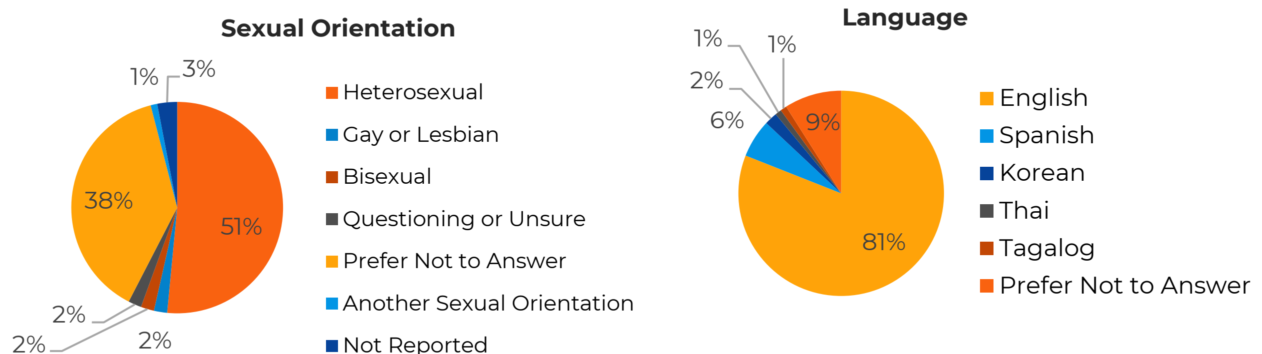
Gender Identity

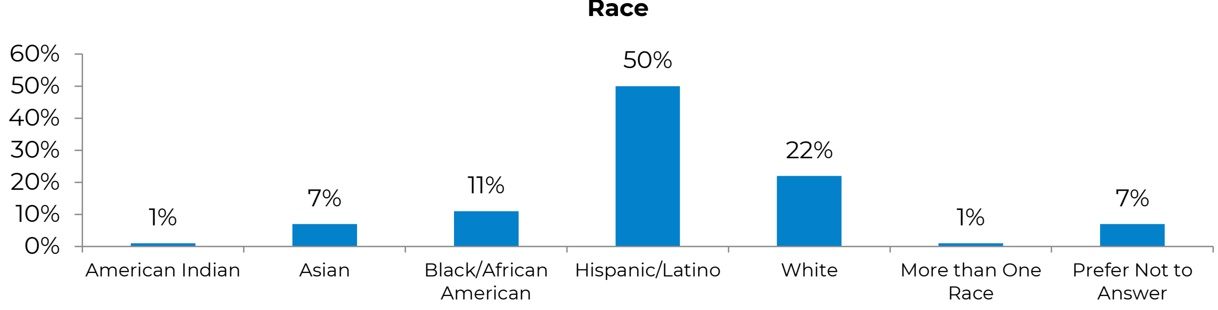


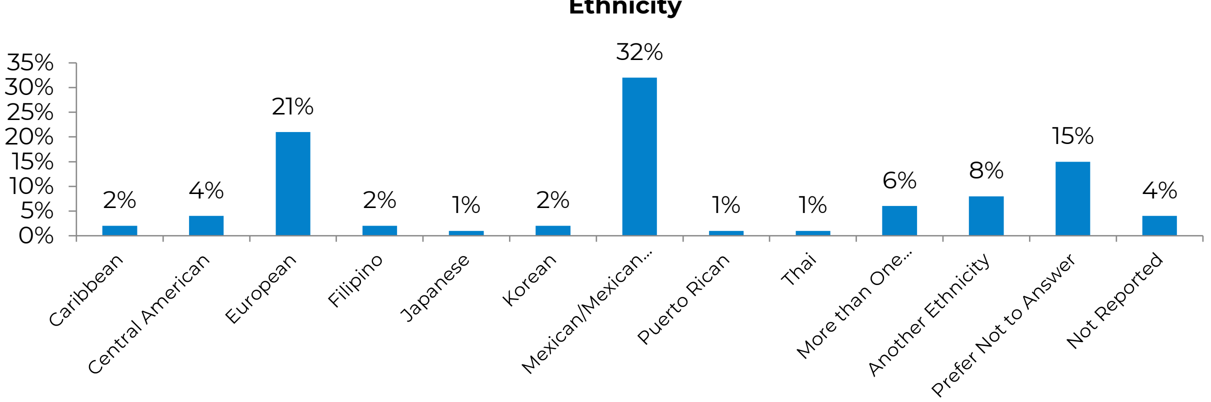
Gender at Birth

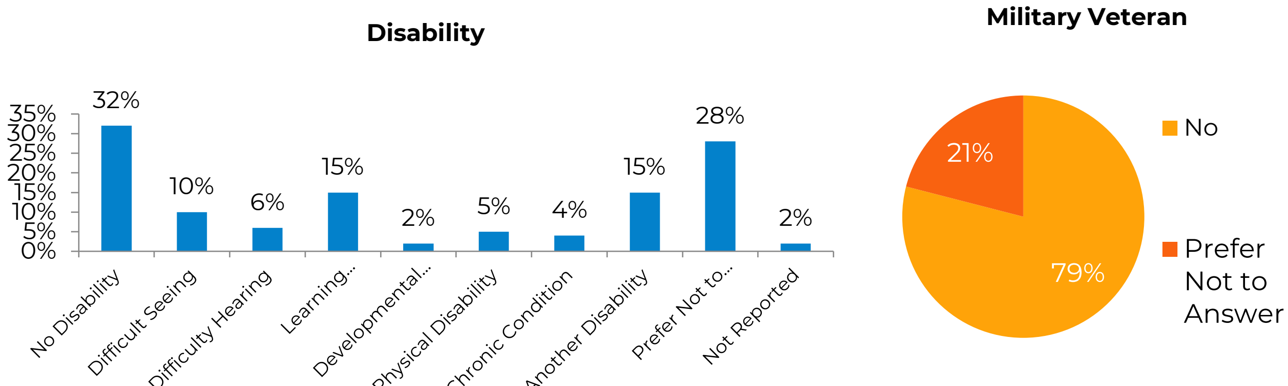




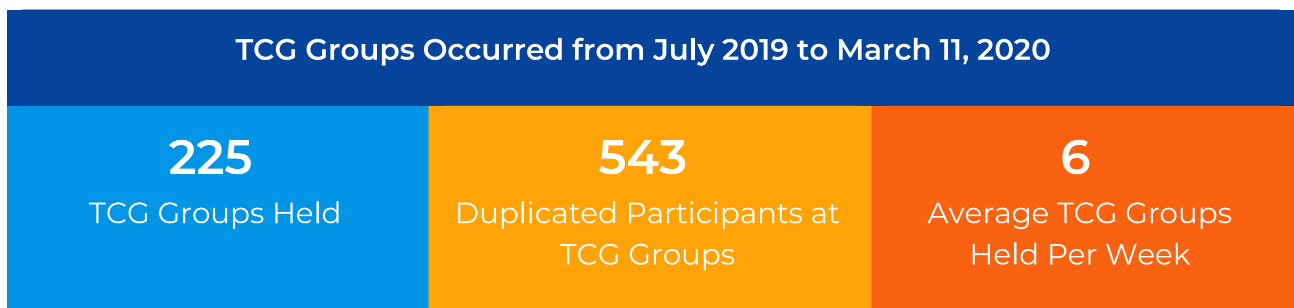

Sexual Orientation
1%
3%
38%
51%
2%
2%
2%
Heterosexual
Gay or Lesbian
Bisexual
Questioning or Unsure
Prefer Not to Answer
Another Sexual Orientation
Not Reported
Language
1%
1%
2%
6%
9%
81%
English
Spanish
Korean
Thai
Tagalog
Prefer Not to Answer

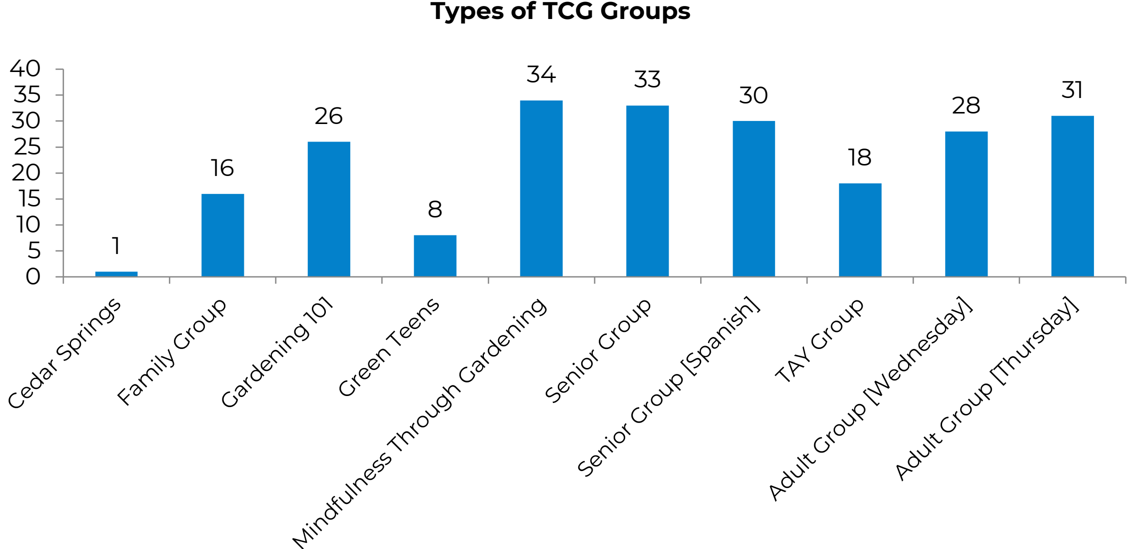

Race
60%
50%
40%
30%
20%
10%
0%
1%
7%
11%
50%
22%
1%
7%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More than One Race
Prefer Not to Answer

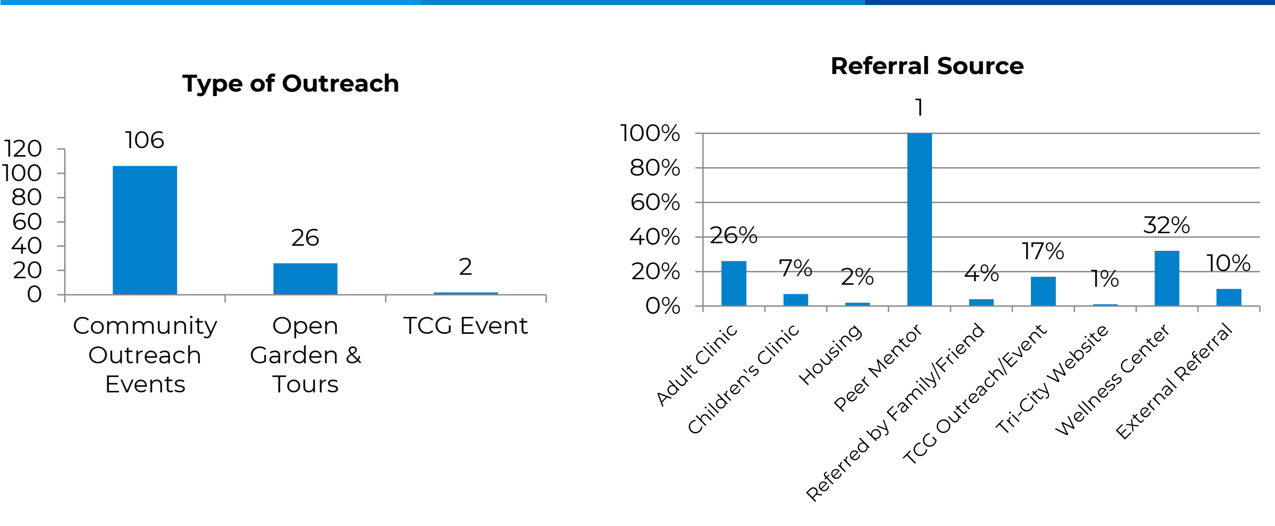

Ethnicity
35%
30%
25%
20%
15%
10%
5%
0%
2%
4%
21%
2%
1%
2%
32%
1%
1%
6%
8%
15%
4%
Caribbean
Central American
European
Filipino
Japanese
Korean
Mexican/Mexican...
Puerto Rican
Thai
More than One...
Another Ethnicity
Prefer Not to Answer
Not Reported


Disability
35%
30%
25%
20%
15%
10%
5%
0%
32%
10%
6%
15%
2%
5%
4%
15%
28%
2%
No Disability
Difficult Seeing
Difficulty Hearing
Learning...
Developmental...
Physical Disability
Chronic Condition
Another Disability
Prefer Not to...
Not Reported
Military Veteran
21%
79%
No
Prefer Not to Answer

HOW WELL DID WE DO IT?







IS ANYONE BETTER OFF?

100%	91%	96%	96%	86%
TCG Participants Enjoy Attending TCG Groups	TCG Participants Feel More Connected to Others [Peers, Family, etc.] Because of TCG Groups	TCG Participants Feel Their Symptoms Have Improved Because of Their Work at the Garden	TCG Participants Feel More Confident from the Skills Learned in TCG Groups	TCG Participants Have Better Communication with Others Because of TCG Groups

TCG Participant Feedback

"So glad I came to TCG, networked with other community members."

"I've learned more."

"I have always benefited. It is easier for me."

"I enjoy it. I want to plant new things."

"I have gained so much knowledge and experiences."

"I learned a lot of practical skills and I love the opportunity to socialize."

"I like TCG a lot!"

"Being here makes me feel comfortable and good."

"I'm here to keep learning the group talk strategies."

"I feel more positive in how I feel, Thank you for our case workers too!"

"Being active, the groups are great!"

"I'm calmer, more able to deal with life's challenges and how I was before I started coming."

"It calms me down."

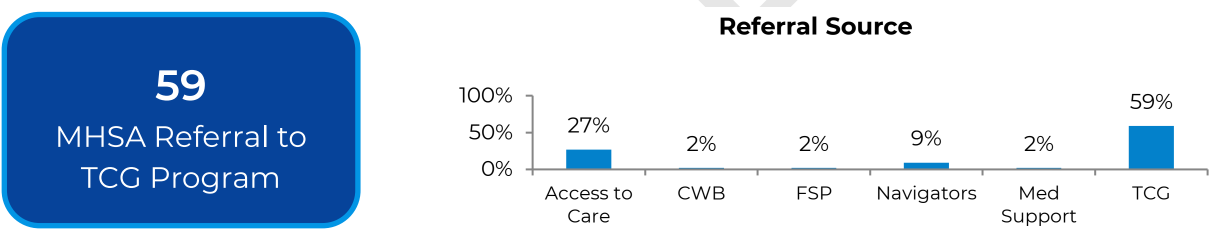
"Walking and working in the garden makes me feel good."

"I completely like learning about nature and garden."

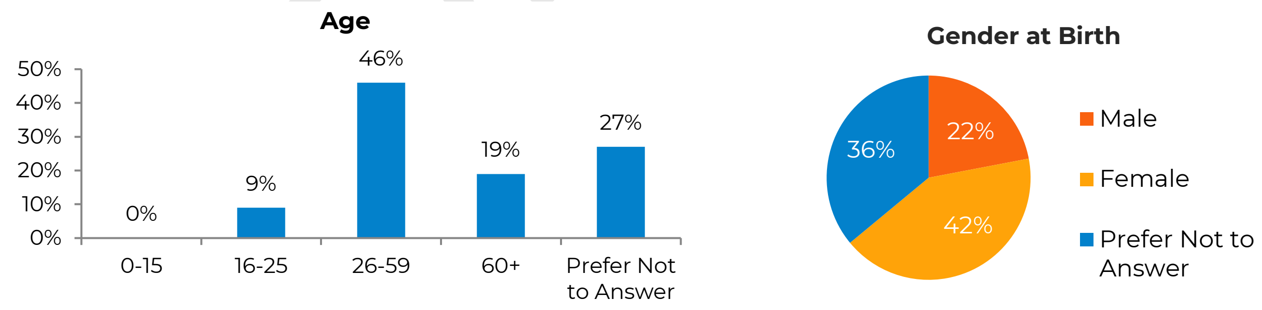
"I feel very happy, can't wait for Friday group!"

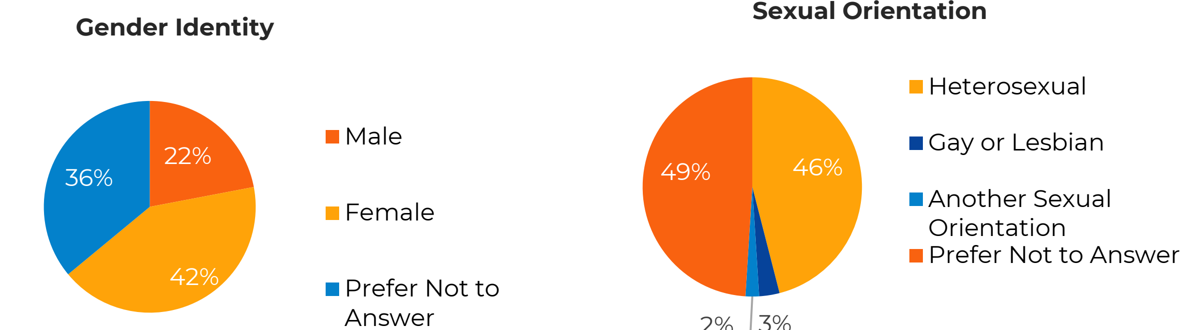
Number of Potential Responders	82
Setting in Which Responders were Engaged	Community, schools, health centers, workplace and outdoors
Type of Responders Engaged	TAY, teachers, LGBTQ+, families, religious leaders and those with lived experience
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

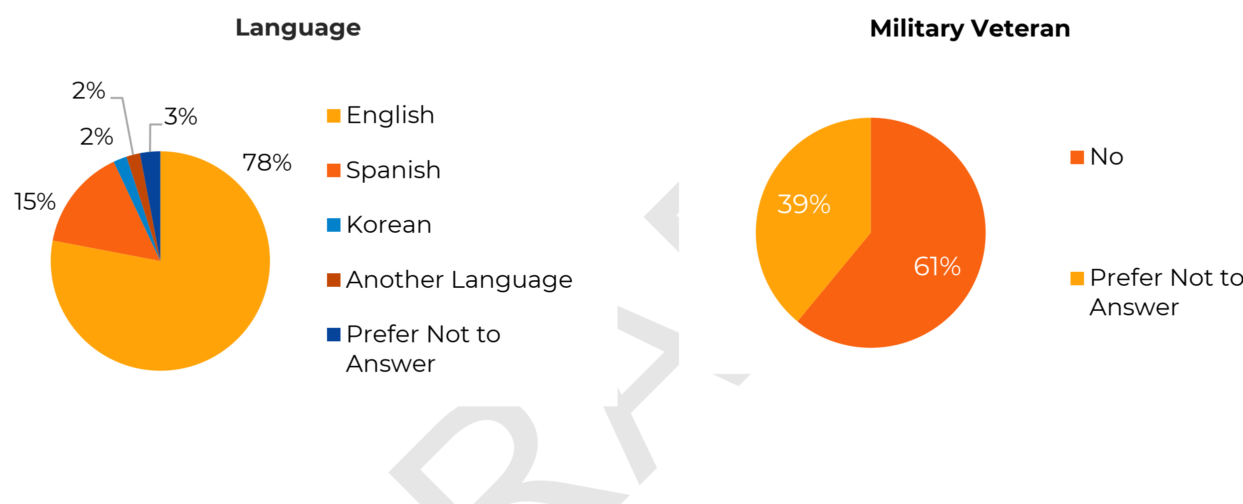
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

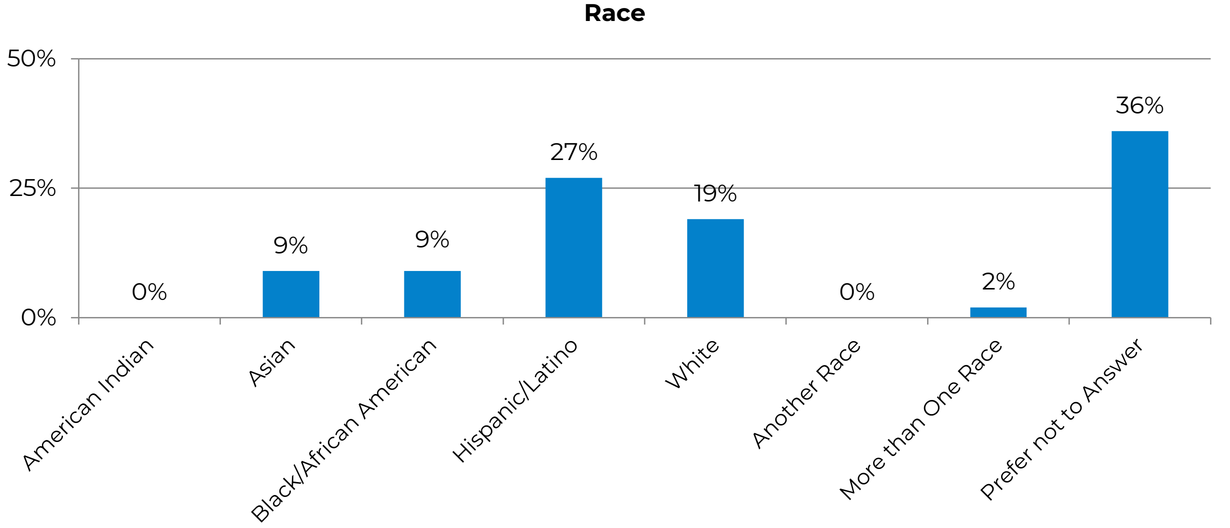


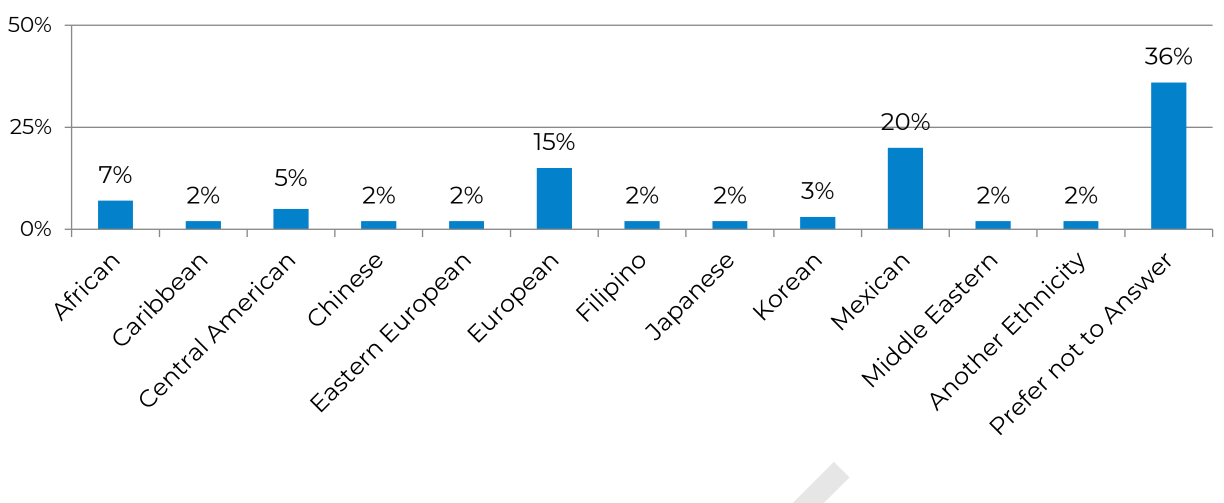
PEI Demographics Based on MHSA Referrals

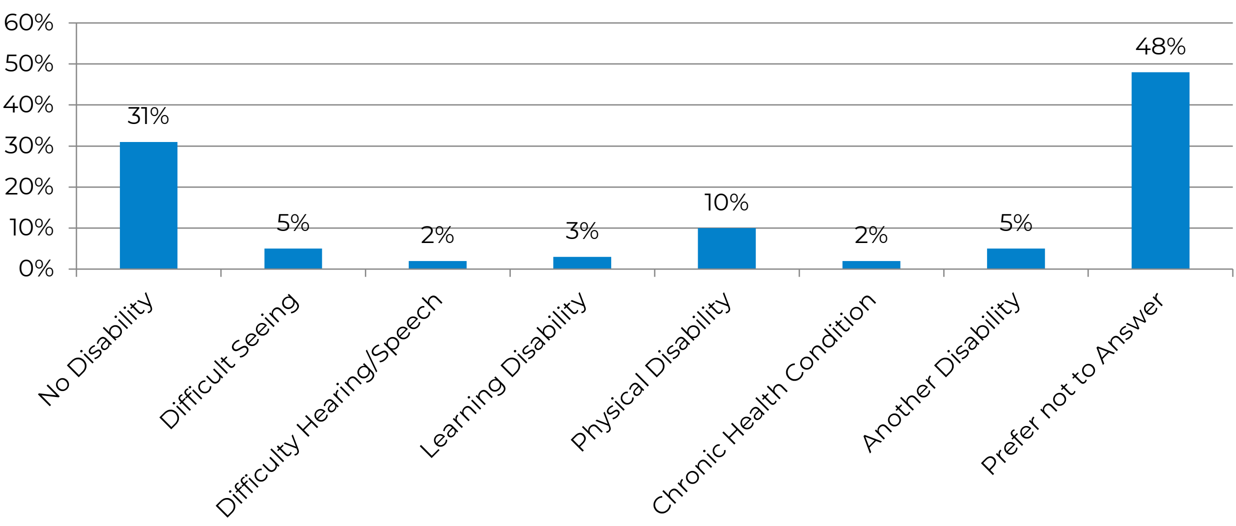



Gender Identity
22%
36%
42%
Male
Female
Prefer Not to Answer
Sexual Orientation
49%
46%
2%
3%
Heterosexual
Gay or Lesbian
Another Sexual Orientation
Prefer Not to Answer


Language
2%
3%
2%
78%
15%
English
Spanish
Korean
Another Language
Prefer Not to Answer
Military Veteran
39%
61%
No
Prefer Not to Answer


Race
50%
25%
0%
0%
9%
9%
27%
19%
0%
2%
36%
American Indian
Asian
Black/African American
Hispanic/Latino
White
Another Race
More than One Race
Prefer not to Answer


Ethnicity
50%
25%
0%
7%
2%
5%
2%
2%
15%
2%
2%
3%
20%
2%
2%
36%
African
Caribbean
Central American
Chinese
Eastern European
European
Filipino
Japanese
Korean
Mexican
Middle Eastern
Another Ethnicity
Prefer not to Answer


Disability
60%
50%
40%
30%
20%
10%
0%
31%
5%
2%
3%
10%
2%
5%
48%
No Disability
Difficult Seeing
Difficulty Hearing/Speech
Learning Disability
Physical Disability
Chronic Health Condition
Another Disability
Prefer not to Answer

Early Psychosis Program

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	___ 0-15	_X_ 16-25	___ 25-69	___ 60+	Other:
Type of Program:	___ Prevention	_X_ Early Intervention		___ Prevention and Early Intervention	

Program Description

Utilizing the PIER (Prevention, Intervention, Enforcement and Reentry) model, Tri-City staff host workshops and trainings for community members and school personnel focused on recognizing and addressing the earliest symptoms of mental illness. This evidence-based treatment option uses three key components- community outreach, assessment and treatment to reduce symptoms, improved function and decrease relapse. The goal for this program includes increasing awareness among community members in recognizing the signs and symptoms of early psychosis and how to connect individuals to services as well as to reduce the time of untreated psychosis and severe mental illness.

Target Population

Transition Age Youth (TAY) ages 16 to 25 who are experiencing psychosis and are not currently enrolled in mental health services.

Number of Workshops for FY 2019-20	7
Number of Attendees for FY 2019-20	75

Program Update

Beginning in July 2020, Tri-City staff implement the Portland Identification and Early Referral (PIER) model as the basis for their Early Psychosis Program (ESP). This model utilizes a team-based system of early detection and intervention in psychosis. This first year of implementation included the completion of the Memo of Understanding with PIER as well as the last of the hiring (occupational therapist) needed to complete the PEIR team.

Challenges and Solutions

Challenges for this program included making the shift from a research focus to an action/implementation focus. This included finalizing the hiring of staff and developing the phases of implementation including outreach and trainings. By establishing training dates early on with community partners, this ensured that outreach presentations were on their calendars in order to spread the word and increase referrals to the program.

COVID-19 Response

With the onset of COVID 19, the PIER trainings and training with UCLA, another adjunct program for staff, were delayed. Although these trainings were originally scheduled to begin in April/May of 2020

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and to be completed over the summer, the pandemic required the trainings to be modified to be presented via a virtual platform. This delay resulted in the PIER trainings being rescheduled to be completed by the second week of November 2020 and the UCLA training is now estimated to be completed by January 2021. The outreach portion of these trainings were also impacted as community partners also shifted their focus to addressing their own internal priorities which left little time for adjunct presentations or trainings.

In response to these challenges, Tri-City staff are working to adapt these new training practices to be conducted virtually with clients via telehealth. In addition, outreach efforts were also adapted to be conducted virtually via phone or webinars.

Cultural Approach

In addressing cultural inclusion, the ESP employs staff that are reflective of the community served and make it a practice to approach the work with cultural humility. Ongoing discussions of race, culture, and health disparities in department meetings, group and individual supervisions with staff, has proven to be effective in instilling this approach.

In addition, staff ensure that assessment and new PIER training material are available in other threshold languages, including Spanish. Flyers, assessments, and forms are available in Spanish and other languages as needed. Presentations on outreach are available in Spanish. The material is also presented in a manner that is easy to understand even if English is not their primary language.

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PROGRAM: Early Psychosis

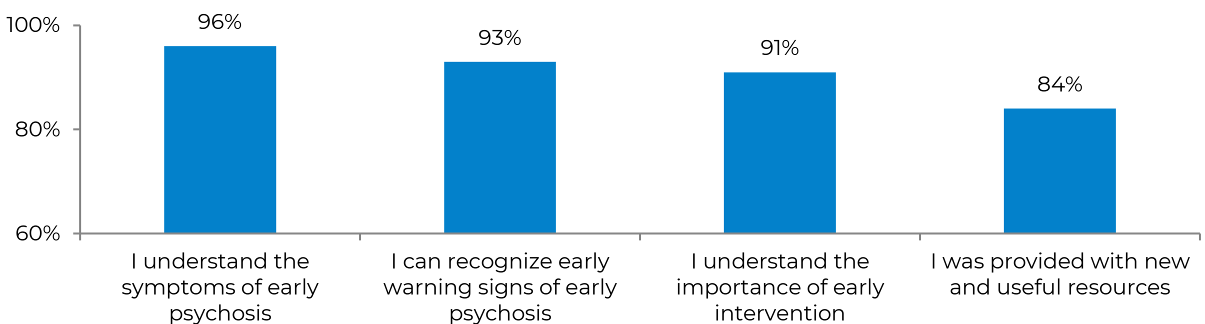
HOW MUCH DID WE DO?

7
Workshops Held

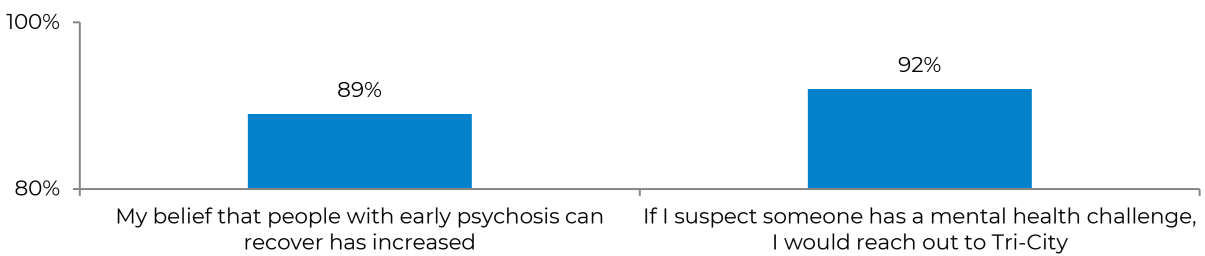
75
Participants

HOW WELL DID WE DO IT?

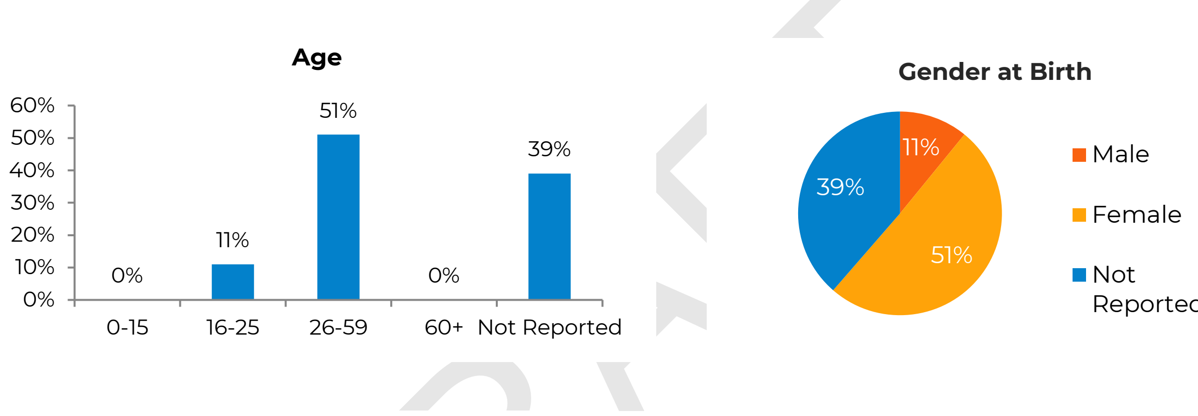
Percentage of participants who agree or strongly agree with the following statements:

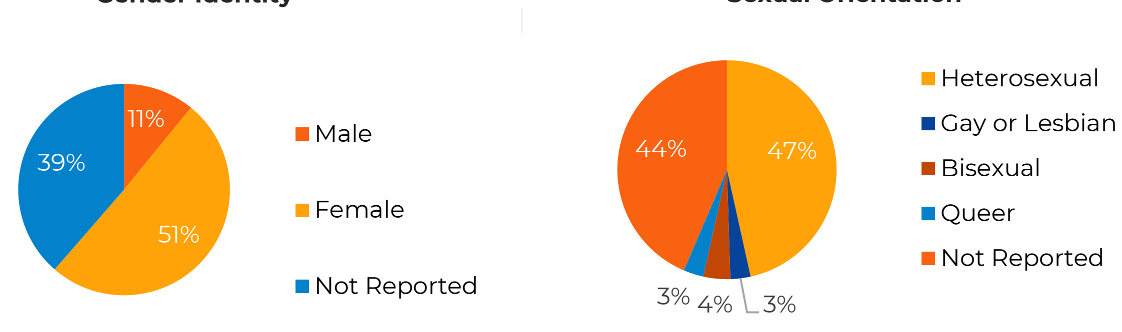


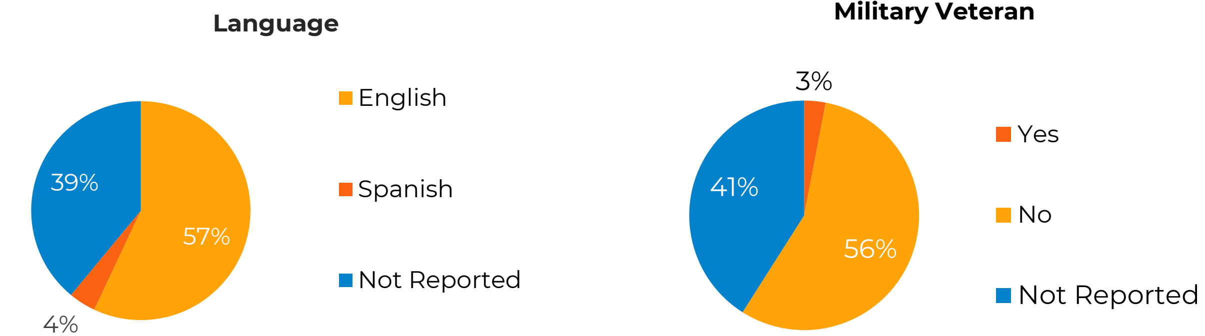
IS ANYONE BETTER OFF?

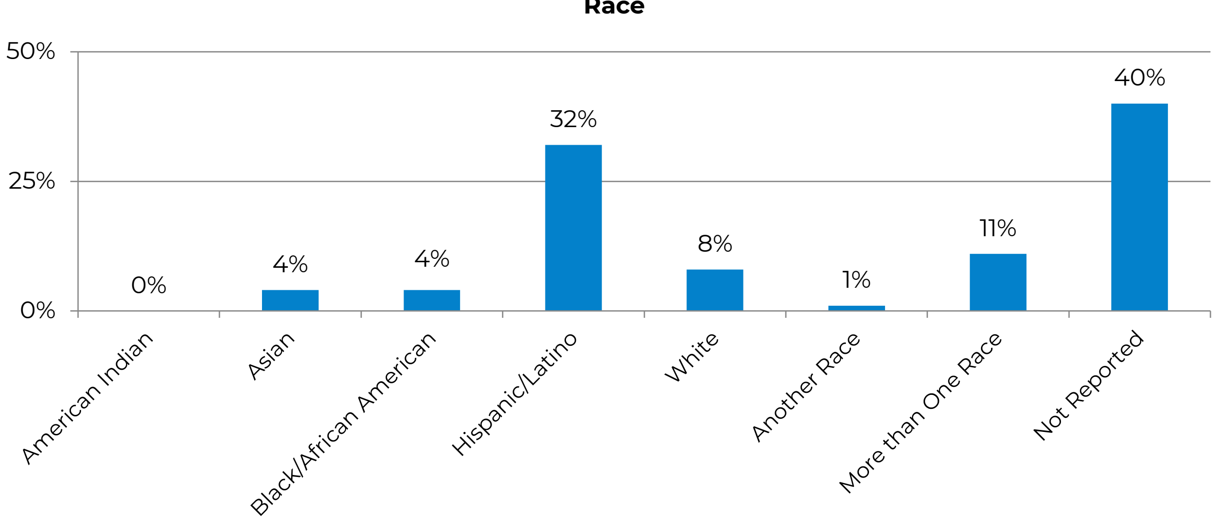


PEI Demographics





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0%
0%
4%
4%
32%
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1%
11%
40%
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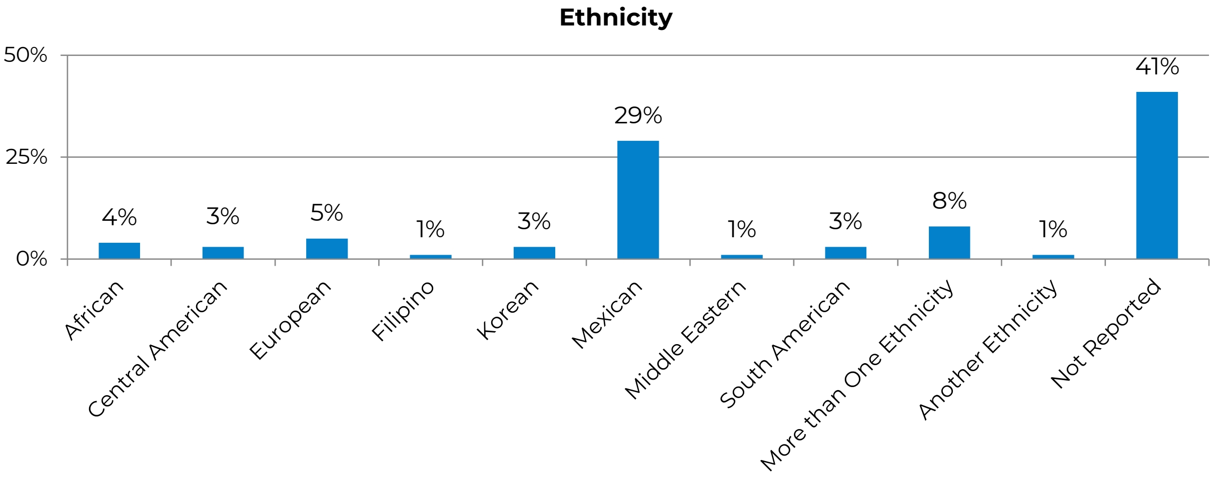
Asian
Black/African American
Hispanic/Latino
White
Another Race
More than One Race
Not Reported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1%
3%
29%
1%
3%
8%
1%
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European
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Korean
Mexican
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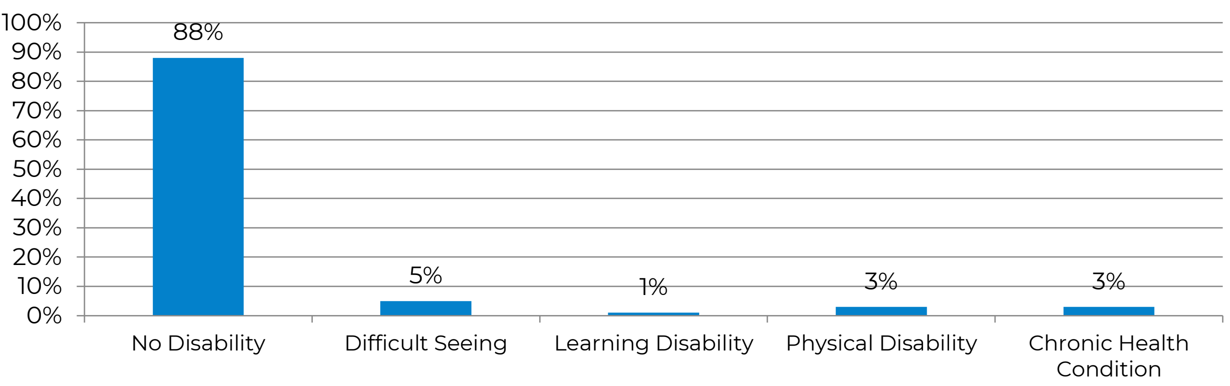
South American
More than One Ethnicity
Another Ethnicity
Not Reported


Disability
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
88%
5%
1%
3%
3%
No Disability
Difficult Seeing
Learning Disability
Physical Disability
Chronic Health Condition

Number of Potential Responders	75
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Community members
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-age youth, older adults and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

0
MHSA Referral to Early Psychosis

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Innovation (INN)

Help@Hand Tech Suite Project

Innovation consists of short-term projects, one to five years, that explore novel efforts to strengthen aspects of the mental health system.

Help@Hand Tech Suite Project

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	___ CSS	___ PEI	_X_ INN	___ WET	___: CFTN
Target Population:	___ 0-15	_X_ 16-25	___ 25-69	_X_ 60+	Other: Monolingual Speakers

Program Description

The primary purpose of this project is to increase access to mental health care by providing a non-traditional system for individuals who may be reluctant to access services through a more formal clinical setting. Through the use of computers, tablets and smartphones, community members will be able to access a suite of technology-based mental health services focused on prevention, early intervention, and family and social support with the intent to: decrease emergency care services; reduce psychiatric hospitalizations; and reduce the duration of untreated mental illness.

Help@Hand Tech Suite Project	
Projected Funding Amount	$1,674,700.00
Duration of INN Project	September 28, 2018 to June 30, 2021
Revised Project Dates	January 1, 2019 to January 1, 2024 Originally designed to be a three-year project, the Collaborative as a whole voted to extend the project to five years to allow adequate time to complete the implementation phase and learning goals for this project. No additional funds are requested or required at this time.

Target Population

- Transition age youth and college students (up to age 25) who are seeking peer support or who are interested in offering their support as trained peer listeners.
- Older adults (ages 60+) who lack transportation or are unable to access traditional services.
- Non-English speaking clients and community members who may be experiencing stigma and language barriers.

Program Update

Tri-City's initial concept of Help@Hand was to provide ways for clients to stay active in their personal wellness between appointments and for the greater community to have access to tools that promote mental wellbeing.

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Now that we are in the midst of a global pandemic that encourages physical distancing as a means prevention, the technology that will be used by Help@Hand becomes even more essential. Tri-City is aware that this pandemic can be triggering for some individuals and can also contribute to isolation. The goal is to be able to use the different technologies in the suite of applications to provide support in this “new normal”. There will be apps that clinicians can use with their clients in conjunction with individual treatment plans. There will also be apps to support those in isolation by providing a virtual community of connectedness.

The original Help@Hand/Tech Suite proposal highlighted the targeted groups of older adults, transition age youth, and monolingual Spanish speakers. It has now become clear that moving forward, this project will expand those target populations to encompass other populations that may also have been severely impacted by COVID-19.

During FY 2019-20, the Innovation Plan Coordinator position was filled following an extensive hiring search. In addition, local efforts include convening a focus group consisting of Wellness Advocates/Peers who were charged with reviewing potential applications for a future pilot program.

Milestones for FY 2019-20 include:

- A focus group comprised of Wellness Advocates, MHSA staff, and the IT consultant, participated in a product testing process.
- Through the collaboration, various wellness apps have made accessing their apps free for participating counties/agencies and Tri-City has been taking advantage of the opportunity by providing the resources to staff and clients.
- CalMHSA created Digital Mental Health Literacy training videos and Tri-City will be utilizing the videos for clients and community members on-boarding.
- Tri-City continued to send useful wellness app information to our staff for self-care (and some client resources).
- Tri-City Wellness Advocates started planning for a Community Connections webinar to teach our clients and community members how to be safe online. They will be using the skills and information they acquired during the train-the-trainer session of the February Help@Hand Peer Summit.

Challenges and Solutions

In September 2019, Tri-City hired a new Innovation program coordinator after having this position vacant for an extended period of time. However, this project continued to move forward in collaboration with other counties who are a part of the Tech Suite project. A focus group was convened to review a potential application, WYSA, for a pilot project. Although this process proved promising, the pilot project was delayed due to COVID-19.

COVID-19 Response

The major impact of COVID 19 was the stalling of workgroups that were envisioned for the pilot process. Revisions to this plan included moving into virtual meetings and creating innovative ways to continue the outreach to potential participants. One of these creative virtual outreach efforts

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included a community webinar hosted by Tri-City Wellness Advocates that focused on how to be safe online. Materials for this webinar were provided by Help@Hand, the Tech Suite Collaborative.

Cultural Approach

By providing an equally accessible way for individuals to access wellness, Help@Hand eliminates some of the traditional barriers to seeking service such as stigma, language and need for transportation. Additionally, as two of the primary populations designated for this project, there is a specific goal to create access and pay special attention to monolingual Spanish speakers and older adults.

Applications under consideration by Tri-City for this project will have the capacity for non-English language translation. In addition, training videos and outreach materials will be available in both English and Spanish to accommodate the primary populations residing in the Tri-City area.

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Tech Suite/Help@Hand Collaboration Update (Provided by CalMHSA)

FY 2019-20 Overview

Help@Hand is a statewide Collaborative project that began in 2018 with fourteen Counties and Cities leveraging interactive technology-based mental health solutions to help shape the future and improve accessibility and outcomes to connect people with care across the state. Technology has many benefits, but there are also many challenges and questions. The participating Cities/Counties are at the forefront of innovation to understand how technology is introduced and works, within the public behavioral health system of care. This means Help@Hand is not one project, but many projects across multiple Cities and Counties. The Collaborative offers the benefit of a shared learning experience that increases choices for Counties/Cities, accelerates learning, and adds in cost sharing. The focus of Help@Hand remains on pursuing a shared vision and common goals. Change at the scale of this project necessitates a robust readiness and change management approach. The project team has focused on building in activities to address these areas for both the project team and the community.

Impact

During FY 2019-20, the Help@Hand project had many successes and challenges. Some of the most notable impacts of the project during this time were work with the Peer community and the Cities' and Counties' exploration of mental health products to find those that best fit the needs of their stakeholder community.

Peers

Peers identified and raised the need for Digital Mental Health Literacy (DMHL) to empower California communities to make informed decisions about how they engage with technology. Listening sessions were held by the Peer and Community Engagement Manager to gather topics that would facilitate understanding and adoption of technology. There were 20 Digital Mental Health Literacy discovery sessions held in eleven different Counties with over 300 stakeholders from June – November 2019. These sessions led to the development of a DMHL video series, and a DMHL Curriculum that includes smaller coaching sessions (Q1-Q3 '19 & '20). Additionally, there were two Peer Summits held, in May and September 2019, to support Collaboration of Peer Leads from across the state for project learning, connection, and problem solving (Q1 2019). Monthly Peer Collaboration meetings were held to serve as a space for Peers to connect and share County/City project updates.

Technology Exploration

In early 2020, after the results of the Request for Statement of Qualifications (RFSQ) were released, the collaborative cities and counties began engaging their community stakeholders and conducting focus groups to explore new technologies available to the project and receive additional feedback on products that would be a good fit for their communities.

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Challenges and Solutions

There are many things to consider when integrating technology into existing systems of care. The Help@Hand Collaborative has addressed many challenges in this work. Some of the challenges experienced by the Collaborative during FY 19-20 include:

COVID-19 Response

The beginning of 2020 brought significant challenges to Help@Hand participating cities and counties due to the COVID-19 pandemic. Many Collaborative members' focus changed quickly in March 2020 as they were asked to respond to evolving pandemic response request and care needs in their local communities.

Rapid Response - The early months of the pandemic saw Cities and Counties challenged to understand how they could quickly leverage mental health technology to meet growing community needs. Help@Hand worked quickly to develop a streamlined approach that supported Cities and Counties in launching a technology to their respective communities in direct response to growing mental health needs related to quarantine and COVID-19. Each step of the technology selection, readiness and deployment process is essential. Therefore, the rapid response approach did not reduce or eliminate critical steps but streamlined them by working to establish common features and functionality with the vendors and reducing variation among Cities and Counties. This effort is ongoing.

See attached CalMHSA Support for City and County's MHSA Annual Report

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Workforce Education and Training (WET)

The WET efforts focus on strengthening and supporting existing staff and caregivers through trainings while focusing on attracting new staff and volunteers to ensure future mental health personnel.

Workforce Education and Training (WET)

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	___ CSS	___ PEI	___ INN	_X_ WET	____ CFTN
Target Population:	___ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:

Program Description

The Workforce Education and Training (WET) program is providing a learning environment for staff to take and facilitate trainings for their personal and professional development. Also, the program serves as a learning hub for students, peers and the community by providing service learning opportunities to gain experience in the mental health field.

Target Population

The population served is transition age youth (TAY) through older adults. The service-learner program is focused on high school and college students, peers, veterans, retirees and anyone who is interested in gaining experience in the mental health field.

Relias online courses completed by Tri-City staff for FY 2019-20	2,059
Number of Service-Learner hours logged for FY 2019-20	2,232
Number of Service-Learners hired by Tri-City staff for FY 2019-20	5

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Program Update

In keeping with Tri-City's commitment to ensuring staff are sufficiently trained and educated to meet the needs of our clients, the Workforce Education and Training (WET) program offered trainings both online and in-person. In total, during Fiscal year 2019-2020, staff, volunteers, and interns participated in 2,255 online courses covering a variety of topics. Additionally, prior to COVID-19 restrictions, several trainings were provided in- person.

Notably, all staff were required to attend trainings related to Trauma Informed Care. All clinical staff were required to attend the Trauma Resiliency Model Training, and non-clinical staff were required to attend the Community Resiliency Model. These trainings provide practical tools to support a person who is reacting to trauma, and offers Tri-City staff a common language to address this critical issue faced by so many of Tri-City's clients. Additional trainings include Mental Health First Aid, Adverse Childhood Experiences (ACEs), and Motivational Interviewing.

Through the Southern California Regional Partnership, Tri-City offered a series of Trauma Focused trainings conducted by Dr. Gabriela Grant. Specific topics included Trauma Foundations, The Neurobiology of Trauma, Trauma and Eating Disorders, and Trauma and Disasters.

During FY 2019-2020, Service Learners (volunteers) contributed 768.15 hours towards Tri-City Mental Health's workforce (excluding peer mentors and summer camp volunteers). The WET department, in partnership with Tri-City's Prevention and Early Intervention's Peer Mentor Program, and others,

launched the Peer 2 Career program; a comprehensive training plan to help volunteers, and participants with lived experience to be better prepared for a career in community mental health.

Challenges and Solutions

The WET Supervisor resigned his position in August 2019, and the position was filled in October 2019. This change lead to some revisions in processes and roles for this position. The Communications Coordinator and Director of MHSA and Ethnic Services performed the duties of this position during the period of recruitment which ensured continuity of services and a smooth transition for the new supervisor.

COVID-19 Response

WET program staff are currently working from home in accordance with company policy and state regulations. Staff meetings are conducted via Ring Central. Because of the restrictions on gatherings, in- person trainings have been eliminated and focus is now exclusively on online trainings. Conducting trainings virtually offers unique challenges that are difficult to overcome. Previously, trainings included components of group work, large and small discussions, hands-on activities, etc. Our virtual platforms have enabled Tri-City Mental Health to incorporate many of these experiences into virtual trainings. However, hands-on activities remain a challenge, and group discussions are presumably less impactful.

Most trainings that were previously held live, have been converted to a virtual platform, when possible. Some in-person trainings that are dictated by agencies outside of Tri-City, are unavailable at this time, and will resume once it is feasible.

The Service-Learner program was significantly reduced. Many service learners volunteer at Tri-City as part of college course requirements, but that requirement has been lifted by many local colleges. Service Learners that continue to volunteer are working remotely. However, service learners are utilized less frequently because of the need to prioritize the safety of everyone.

The WET program staff also manages Tri-City's social media accounts, including Facebook, Instagram, Twitter, and LinkedIn. This has grown to be one of the primary methods of interacting with the public, and renewed effort has been made to offer new and relevant content across all social media platforms.

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Cultural Approach

Tri-City's approach to social media images and content is meant to be inclusive of the diversity and culture reflective of our communities. Tri-City intentionally includes topics that appeal to a wide variety of experiences and present them in ways consistent with those differences.

Trainings for staff are often directly related to supporting clients that are diverse including supporting members of the LGBTQ+ communities.

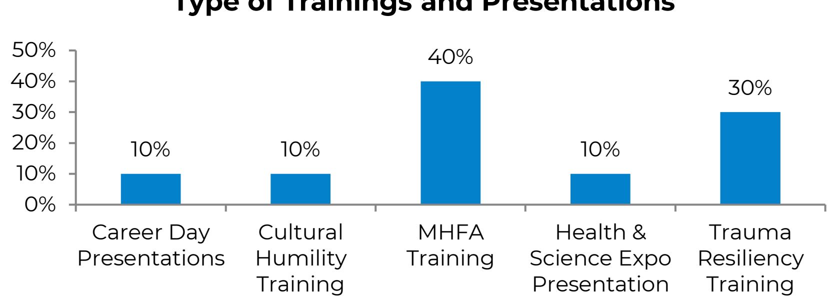
Both internal and external communications are offed in English and Spanish. Many Service-Learners are fluent in multiple languages and are able to include their cultural perspectives on the work they perform for Tri-City.

PROGRAM: Workforce Education and Training (WET)

HOW MUCH DID WE DO?

2,232	20	13
Service Learner Hours	Service Learner Applications	Clients Participated in the WISH Program

10
Trainings, Conferences and Educational Opportunities for Staff



HOW WELL DID WE DO IT?

21	5	2,255
Applicants Became Service Learners	Service Learners were Hired at Tri-City	Courses Completed by Staff Through the Relias Online Training

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Capital Facilities and Technological Needs (CFTN)

The CFTN plan focuses on improvements to facilities, infrastructure and technology of the local mental health system.

Capital Facilities and Technological Needs

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	___ CSS	___ PEI	___ INN	___ WET	_X_ CFTN
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:

Program Description

Capital Facilities and Technological Needs provides funding for building projects, improving the infrastructure of mental health providers, and increasing technological capacity to improve the delivery of mental health services.

In keeping with key goals of MHSA to modernize and transform the mental health service system, Tri-City's Capital Facilities and Technological Needs (CFTN) Plan launched two strategic phases:

1. Supporting and empowering mental health service recipients and providers by creating greater access to technology, and establishing a higher level of program monitoring and outcome analysis. The technology portion of this plan launched an integrated information system with increased and upgraded infrastructure and modernized administrative and clinical processes such as clinical charts and billing systems.
2. Providing suitable space to accommodate Tri-City's growing MHSA workforce. Tri-City purchased an existing building consisting of multiple staff offices, a conference room and oversized meeting space. This refurbished building now provides a permanent location for Tri-City's expanding MHSA staff as well as a convenient place for hosting community stakeholder meetings.

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Program Updates

On March 18, 2020, Tri-City Mental Health's Governing Board approved the expenditure of Capital Facilities and Technological Needs funds in the amount of $970,968.00 to make improvements for two TCMH locations. Although funding was already available in the CFTN Plan, as allocated by stakeholders in previous years, this project proposal outlines in greater detail how the funds will be spent.

Beginning with the MHSA building located at 2001 N. Garey Ave, Pomona, improvements will focus on upgrading the electrical infrastructure and will address the current outdated electrical system. In addition, this proposal will include redesigning and re-purposing existing meeting space to accommodate new offices to support the continued growth and expansion of MHSA personnel. The electrical upgrade and office space remodel located at 2001 N. Garey Ave, Pomona, 91767 is estimated to be in the amount of $509,208.00.

The second renovation will take place at the undeveloped garden located adjacent to the TCMH clinic at 2008 N. Garey Ave, Pomona. This garden will include concrete walkways, raised planting beds, complete ADA access, fencing, entry gate located on Garey Ave, benches, vegetable garden beds, planting, irrigation and shade pavilion with a sink and washing station and will also include a storage shed.

The capital improvements to the Therapeutic Community Garden located at 2008 N. Garey Ave., Pomona, 91767 is estimated to be in the amount of $461,760.00.

With the impact of the COVID –19 pandemic, the Facilities Department began looking at all office space, and updating floor plans, at each Tri-City site to ensure the 6 ft. social distancing requirement is enforced and to prepare for when staff return to work.

Cultural Competence Plan Update

Cultural Competence Plan Update

In July, 2010, Tri-City Mental Health developed a comprehensive Cultural Competence Plan based on criteria provided by the Office of Multicultural Services/Department of Mental Health. This plan provided TCMHA an opportunity to describe in great detail this agency's commitment to support the growth and development of racially and ethnically focused services with an emphasis on attempting to close the cultural disparity gap in mental health care offered within the three cities of Claremont, Pomona, and La Verne.

In December 2020, Tri-City prepared a Three-Year Cultural Competence Plan and thereby renewed its commitment to deliver quality and individualized care tailored to the social, cultural and linguistic needs of clients and community members residing within the catchment area. As a culturally proficient health care provider, Tri-City distinguishes itself as a leader in health care services focused on recovery with a person-centered approach.

Tri-City engaged with community members who contributed to the universal goals of reducing health care disparities and promote diversity within the agency and the community served. Through the development of active partnerships with advisory councils including the Cultural Inclusion and Diversity Committee (CIDC), the African American Family Wellness Advisory Council (AAFWAC), ¡Adelante! Latinx Wellness Advisory Council and the LGBTQ+ Advisory Council, Tri-City is able to address challenges related to accessing services including language barriers, health education and cultural differences in communication styles.

Tri-City Advisory Councils

The following advisory councils demonstrate Tri-City's new initiatives and focuses on leadership and delivery of culturally relevant services dedicated to the undisputable call for health care equity.

Cultural Inclusion and Diversity Committee (CIDC)

Tri-City Mental Health's (Tri-City) Cultural Inclusion and Diversity Committee (CIDC) is committed to the advancement of quality mental health services that are culturally compatible and respectful of the diverse healthcare beliefs of the people we serve. It is the mission of this Cultural Inclusion and Diversity Committee to guide and support the staff of Tri-City to ensure cultural and linguistically appropriate programs and services are available for community members residing in the cities of Claremont, Pomona and La Verne.

African American Family Wellness Advisory Council (AAFWAC)

The African American Family Wellness Advisory Council (AAFWAC) was established in December 2019. As a result, this advisory council and its goals are still in the early development stages. Its primary goal is to nurture hope and wellness within the African American community through mental health advocacy and treatment referral.

¡Adelante! Latinx Wellness Advisory Council

¡Adelante! Latinx Wellness Advisory Council was established in September 2020. As a result, this advisory council and its goals are still in the early development stages. Its primary goal is to instill

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hope and wellness by empowering community members within the Latinx community to advocate and share their experience, knowledge and feedback.

LGBTQ+ Wellness Advisory Council

The LGBTQ+ Wellness Advisory Council was established in September 2020. As a result, this advisory council and its goals are still in the early development stages. Its primary goal is to give a voice to LGBTQ+ communities by empowering members to advocate and share their experience, knowledge and feedback.

Asian American and Pacific Islander (AAPI) and Native Indigenous Communities

Asian American and Pacific Islanders (AAPI) and Native Indigenous communities have also been identified as unserved and underserved populations in the Tri-City service area. Over the next three years, the CIDC plans to outreach and engage with these communities to develop advisory councils, with the intention to empower members to advocate their community's mental health needs and bridge gaps in delivery and access to services.

Plan Update

As mental healthcare professionals, Tri-City is committed not only to developing strong clinical skills but to ensure each individual who represents this agency values diversity and is competent to understand and respond to cultural differences with each client. This commitment includes participation in cultural inclusive groups that contribute to the delivery of culturally and linguistically inclusive services.

Below is a list of activities/trainings/meetings which occurred during FY 2019-20.

Summary of Cultural Competence Activities During FY 2019-20		
Date	Name of Activity, Meeting or Training	Type of Activitity
07/11/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
07/25/2019	**Enhancing Cultural Humility** Jonathan Martines, PhD, CSUN	Staff Training
07/30/2019	Community Inclusion, Diversity and Wellness Fair	Community Event
08/05/2019	**Improving Behavioral Health for Latino Population** Webinar	Staff Training
08/15/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
09/04/2019	**Latinx Intersectionality: Strength, Power & Change** 2019 Latino Mental Health Conference California Endowment Center, Los Angeles	Staff Training
09/12/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting

09/18/2019	**Latino and Hispanic Heritage Celebration** Staff Video	Staff Activity for Community
10/02/2019	**Allies Ally Advocacy Training** Dr. D M Hunter	Staff Training
10/07/2019	**Family History Month Toolkit** E-Newsletter	Staff Education & Awareness
10/10/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
10/31/2019	**Tri-City Fall Harvest Festival** CIDC Cultural Booth	Community Event for Clients and Consumers
11/08/2019	**Honoring Our Veterans** Veterans Day Staff Video	Staff Education & Awareness
11/14/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
12/09/2019	**Overcoming the Holiday Blues** Self-Care E Newsletter for Staff and Clients	Staff and Community Education & Awareness
01/04/2020	January/February CIDC Staff Newsletter	Staff Education & Awareness
01/09/2020	Cultural Inclusion and Diversity Committee Meeting	Meeting
01/14/2020	CIDC Presentation Tri-City Mental Health Commission	Meeting
02/13/2020	Cultural Inclusion and Diversity Committee Meeting	Meeting
02/20/2020	**African American Heritage** Lunch & Learn	Staff Training & Education
03/26/2020	**COVID-19 Resource and Support Guide** Website Resource Page	Community Awareness
03/26/2020	**The Impact of COVID-19 on the LGBTQ+ Community** Webinar by the National Coalition LGBT Health	Staff Training
05/04/2020	**Working with Older Adults During COVID-19** City of Pomona, Neighborhood Services Department Presented by Tri-City Mental Health	Community Training
05/14/2020	Cultural Inclusion and Diversity Committee Meeting	Meeting
05/21/2020	**AAPI & Mental Health Infographic and Resources** Asian American and Pacific Islander (AAPI) Heritage Month	Staff Education & Awareness
05/21/2020	**Countering Stigma During May Mental Health Month** Advertorial in La Nueva Voz Pomona Newspaper	Community Awareness

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05/27/2020	**Lessons from the Past: Yellow Peril and COVID-19 Times Webinar** The Japanese American Citizens League, The Asian American Psychological Association, The South East Asian Resource Center, The National Council of Asian Pacific Americans, and The Heart Mountain Wyoming Foundation	Staff Education & Awareness
06/08/2020	**Maintaining Positive Emotions During Tough Times** Tri-City Mental Health Webinar Tri-City's African American Family Wellness Advisory Council (AAFWAC) with presenter, Dr. Gloria Morrow	Staff and Community Education & Awareness
06/11/2020	Cultural Inclusion and Diversity Committee Meeting	Meeting
06/24/2020	**The ABC's of LGBTQ+** Tri-City Mental Health Webinar	Staff and Community Education & Awareness
06/11/2020	**LGBTQ+ Mental Health Resources Newsletter** LGBTQ+ Pride Month	Staff Education & Awareness

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MHSA Expenditure Plan

MHSA Expenditure Plan

Cost Per Participant Summary

The services provided in Fiscal Year 2019-20 by age group, number of clients served, and average cost per person are summarized in the table below per the guidelines for this Annual Update:

Summary of MHSA Programs Serving Children, Including TAY			
Program Name	Type of Program	Unique Clients Served	Cost Per Person
Full Service Partnership (Child)	CSS	106	$11,913
Full Service Partnership (TAY)	CSS	147	$12,338
Community Navigators	CSS	229	$234**
Wellness Center	CSS	522	$727**
Supplemental Crisis Services	CSS	238	$636**
Family Wellbeing Program	Prevention	559	$71**
Peer Mentor Program (TAY Wellbeing)	Prevention and Early Intervention	541	$109
Therapeutic Community Gardening	Early Intervention	19	$3,316**

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Summary of MHSA Programs Serving Adults and Older Adults, Including TAY			
Program Name	Type of Program	Unique Clients Served	Cost Per Person
Full Service Partnership (TAY)	CSS	147	$12,338
Full Service Partnership (Adult)	CSS	317	$11,623
Full Service Partnership (Older Adult)	CSS	66	$8,232
Community Navigators	CSS	1,516	$234**
Wellness Center	CSS	1,615	$727**

Supplemental Crisis Services	CSS	1,093	$636**
Field Capable Clinical Services for Older Adults	CSS	26	$2,526
Family Wellbeing Program	Prevention	885	$71**
Peer Mentor Program (Older Adult Wellbeing)	Prevention and Early Intervention	1,053	$119
Therapeutic Community Gardening	Early Intervention	71	$3,316**

**** These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.**

In FY 2019-20, Tri-City served approximately 2,823 unduplicated clients who were enrolled in formal services. Tri-City currently has 190full-time and 20 part-time employees and an annual operating budget of 28.1 million dollars. Tri-City strives to reflect the diversity of its communities through it hiring, language spoken, and cultural competencies.

Regarding shortages in personnel, the most difficult to fill positions are Clinical Therapists and Clinical Supervisors. The most difficult to retain position is Clinical Therapist. Below is a list of current open positions.

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Position	Full-Time Equivalent (FTE)	Department
Accountant	1	Finance
Clinical Supervisor I	2	Child & Family Outpatient (COP)/ School-Based Team
Clinical Therapist I/II	3	Adult FSP
Clinical Therapist I/II	3	Adult Outpatient (AOP)
Clinical Therapist I/II	1	TAY FSP
Clinical Therapist I/II	2	Child & Family Outpatient (COP)
Clinical Therapist I/II	1	Child & Family Outpatient (COP) School Partnership Program (SPT)
Mental Health Specialist	3	Adult FSP
Community Navigator I/II	2	MHSA
Program Support Assistant II	1	Medical Records
Psychiatric Technician I/II/III	2	Crisis Support

FY 2021/22 Mental Health Services Act Annual Update
Funding Summary

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 4/9/21

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2021/22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	12,756,841	2,231,564	2,139,830	241,051	1,262,404	
2. Estimated New FY 2021/22 Funding	9,557,444	2,389,361	628,779			
3. Transfer in FY 2021/22[a/]	0	0	0	0	0	0
4. Access Local Prudent Reserve in FY 2021/22	0	0				0
5. Estimated Available Funding for FY 2021/22	22,314,285	4,620,925	2,768,609	241,051	1,262,404	
B. Estimated FY 2021/22 MHSA Expenditures	9,210,946	2,355,742	304,266	214,083	961,968	
G. Estimated FY 2021/22 Unspent Fund Balance	13,103,339	2,265,183	2,464,343	26,968	300,436	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2021	2,352,603
2. Contributions to the Local Prudent Reserve in FY 2021/22	16,604
3. Distributions from the Local Prudent Reserve in FY 2021/22	0
4. Estimated Local Prudent Reserve Balance on June 30, 2022	2,369,207

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2021/22 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 4/9/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. 1a-Child FSP	1,312,498	463,267	424,616		424,616	
2. 1b-TAY FSP	1,986,864	1,030,522	658,725		297,617	
3. 1c-Adult FSP	3,314,495	2,011,087	1,303,407			
4. 1d-Older Adult FSP	431,488	335,663	95,825			
Non-FSP Programs						
1. Community Navigators	477,822	477,822				
2. Wellness Center	1,273,080	1,273,080				
3. Supplemental Crisis Services	723,947	723,947				
4. Field Capable Clinical Services for Older Adults	111,392	111,392				
5. Permanent Supportive Housing	362,927	307,927				55,000
CSS Administration	3,035,119	2,476,239	432,695		126,184	
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Program Estimated Expenditures	13,029,631	9,210,946	2,915,268	0	848,417	55,000
FSP Programs as Percent of Total	76.5%					

FY 2021/22 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 4/9/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Family Wellbeing	95,261	95,261				
2. Older Adult Wellbeing (Peer Mentor)	79,313	79,313				
3. Transition-Age Youth Wellbeing (Peer Mentor)	74,641	74,641				
4. Community Capacity Building (Community Wellbeing, Stigma Reduction and Suicide Prevention, and Community Mental Health Training)	520,882	520,882				
5. NAMI Community Capacity Building Program (Ending the Silence)	35,500	35,500				
6. Housing Stability Program	206,875	206,875				
PEI Programs - Early Intervention						
7. Older Adult Wellbeing (Peer Mentor)	79,313	79,313				
8. Transition-Age Youth Wellbeing (Peer Mentor)	74,641	74,641				
9. Therapeutic Community Gardening	333,150	333,150				
10. Early Psychosis	207,399	207,399				
PEI Programs - Other						
11.	0	0				
12.	0	0				
13.	0	0				
PEI Administration	606,767	606,767				
PEI Assigned Funds	42,000	42,000				
Total PEI Program Estimated Expenditures	2,313,742	2,355,742	0	0	0	0

FY 2021/22 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 4/9/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Help @ Hand	304,266	304,266				
2.	0	0				
3.	0	0				
4.	0	0				
INN Administration	0	0				
Total INN Program Estimated Expenditures	304,266	304,266	0	0	0	0

FY 2021/22 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 4/9/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. A Systematic Approach to Learning and Improvement	109,934	109,934				
2. Engaging Volunteers and Future Employees	34,836	34,836				
WET Administration	69,313	69,313				
Total WET Program Estimated Expenditures	214,083	214,083	0	0	0	0

FY 2021/22 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 4/9/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Electrical Upgrade & Office Space Remodel	504,208	504,208				
2. Capital Improvements to Therapeutic Community Garden	457,760	457,760				
CFTN Programs - Technological Needs Projects						
3.	0	0				
4.	0	0				
5.	0	0				
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	961,968	961,968	0	0	0	0

Appendix

Prevention and Early Intervention Annual Report FY 2019-20

PREVENTION AND EARLY INTERVENTION ANNUAL REPORT JUNE 2021

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DRAFT

To: Mental Health Services Oversight and Accountability Commission

Subject: MHSA Three-Year Prevention and Early Intervention Evaluation Report

This report is prepared in compliance with California Code of Regulations, Title 9, Section 3560.010(2)(1), Prevention and Early Intervention Program and Evaluation Report.

Tri-City Mental Health Authority (TCMHA) was created in 1960 as a result of a Joint Powers Authority adopted by the cities of Claremont, La Verne, and Pomona. TCMHA and the city of Berkley are the only cities in California considered a "county" and serve as the mental health authority, although not the mental health plan, for a specific area.

Tri-City Mental Health engaged in a robust stakeholder and community planning process beginning in September of 2021. A total of three stakeholder meetings were held in addition to a stakeholder workgroup dedicated to the review of the PEI programs. During this time, participants received updates as well as the opportunity to provide feedback, make suggestions and recommend changes for consideration by Tri-City staff.

The following report is contained in Tri-City's Annual Update for FY 2021-22 and was posted for a 30-day public review and comment period from May 7, 2021 to June 8, 2021. The MHSA Public Hearing will be held on June 8, 2021 hosted by Tri-City's Mental Health Commission. At that time, the Mental Health Commission will recommend approval of the MHSA Annual Update for FY 2021-22. The Tri-City Governing Board will act on this recommendation and adopted the Annual Update for FY 2021-22 on June 16, 2021.

With this timeline in mind, we respectfully submit the following information, vetted through our community planning process, and pending approval by TCMHA's Governing Board.

Prevention and Early Intervention program information and data for FY 2019-20
Prevention and Early Intervention Regulation Data Reporting Status

Please feel free to contact me with any questions.

Regards,

Rimmi Hundal
Director of MHSA and Ethnic Services
Tri-City Mental Health Services
(909) 326-4626
rhundal@tricitymhs.org

DRAFT

Prevention and Early Intervention Programs

DRAFT

Community Capacity Building

Community Wellbeing Program

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	___ 25-69	___ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention		___ Prevention and Early Intervention	

<u>Program Description</u>

The program provides small grants up to $10,000 and technical assistance to help communities build their capacity to strengthen the wellbeing of their members and the community as a whole. The program focuses on providing support to communities at greater risk for mental illness.

<u>Target Population</u>

Local communities (defined as a group of individuals who rely on each other for support and can act together) who are interested in building their own capacity to strengthen the wellbeing of their members.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+
Number Served FY 2019-20	2,794	59	59	29

Program Update

The Community Wellbeing Grant program awarded 11 grants in FY 2019-20. These grantees represent 2,941 individuals and the following agencies and organizations: City of Pomona After School Recreation, Claremont Unified School District, Gente Organizada, Kennedy Austin Foundation, NAMI African American Parents, NAMI Padres Efectivos, Newcomers Access Center, Parkside Boys and Girls Club, Simons Middle School, STEM Club City of Knowledge and The Greener STEMs Club. Programs offered through this groups include afterschool learning activities, tutoring, gardening, parenting classes, support groups, public speaking skills, STEM clubs, that improved the wellbeing of their communities.

<u>Challenges and Solutions</u>

There were not significant challenges for this program in FY 2019-20. One notable change was the transition of the Community Capacity Organizer to another position. However, this position was quickly filled and the grant process continued seamlessly and with continued support.

DRAFT

COVID-19 Response

As with other MHSA programing, the Community Wellbeing Grant program was moved to a virtual platform with staff working remotely. Meetings that previously took place in person were now conducted through RingCentral.

Beginning with the onset of COVID 19, all grantees were required to make modifications to their projects. Participants identified how their communities were impacted by the pandemic and how these modifications would be implemented. All correspondence and communication were handled through RingCentral, phone calls and emails.

When preparing for the next round of grants, the CWB staff modified their application and interview process to comply with local, state and federal guidelines regarding COVID-19. This included conducting all application reviews and participant interviews via RingCentral. Future protocol for this program will continue as stated until the COVID 19 restrictions are lifted.

Cultural Approach

The Community Wellbeing Program collaborates with an array of grantees that provide services to the underserved and unserved communities. These grantees also network and collaborate with each other to continue to provide services to these communities. In addition, staff continue to outreach and network with local agencies who focus on providing services to the underserved and unserved communities.

In response to addressing barriers to service; grantees are notified via email of any upcoming Tri-City programs, services, webinars, community connections webinars, mental health trainings that address these barriers. Grantees are encouraged to spread the word within their communities so they can participate in any of these educational opportunities.

The Community Capacity Organizer for this program is bilingual and able to communicate effectively in both English and Spanish. In addition, all flyers, brochures, grant applications, and supporting documents are available in both English and Spanish.

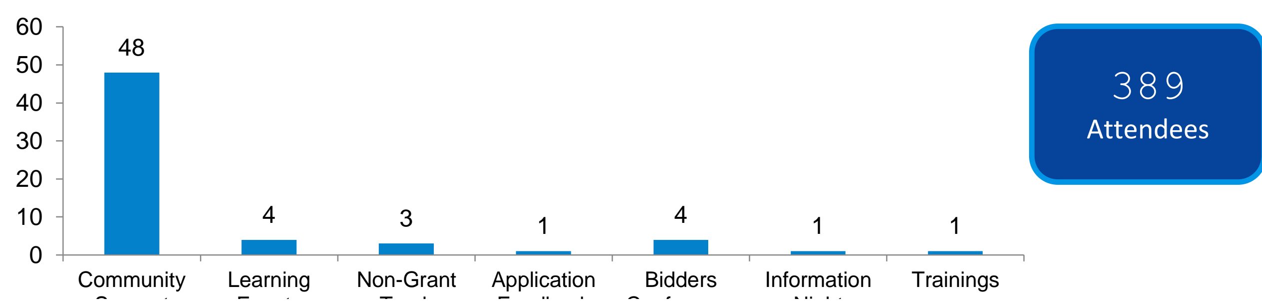
PROGRAM: Community Wellbeing Program (CWB)

HOW MUCH DID WE DO?

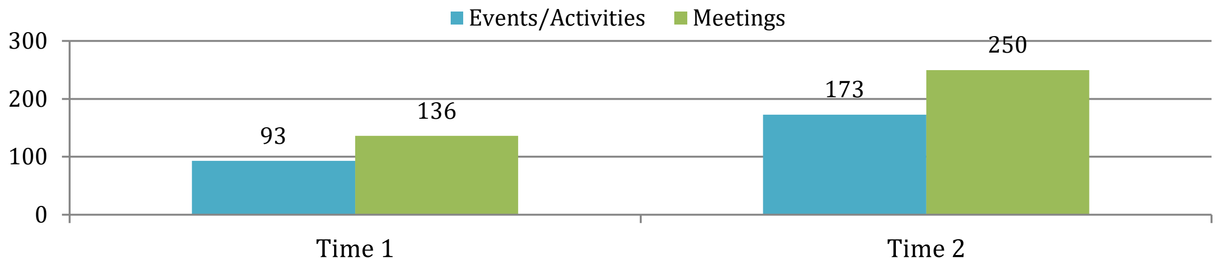
11 Community Grantees Chosen	2,941 Community Members Represented in 10 out of 11 Grantees	1,781 Number of People Who Benefited from Grantee Activities from 10 out of 11 Grantees

DRAFT

Number of Events Held by Community Capacity Organizer

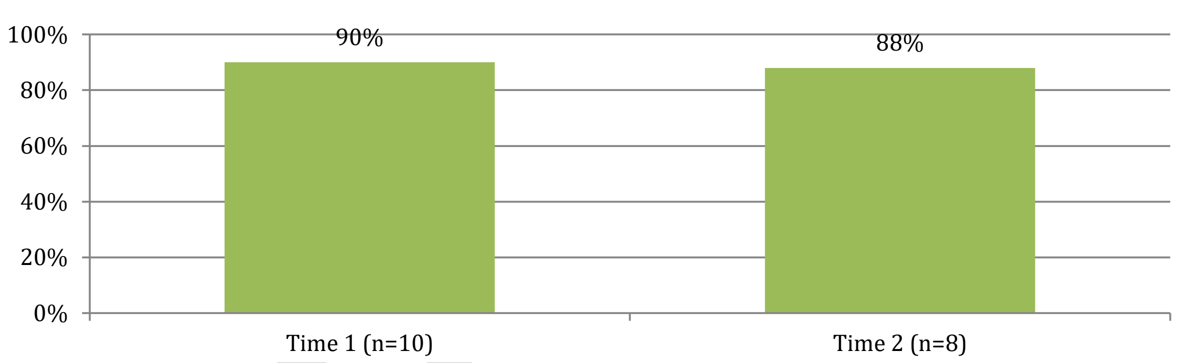


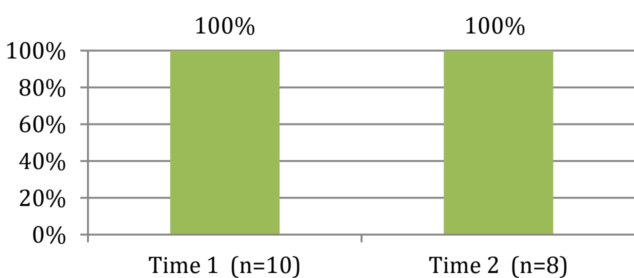
Number of Community Events/Activities and Meetings



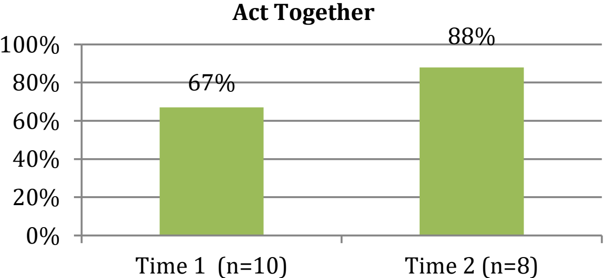
HOW WELL DID WE DO IT?

Percentage of Grantees who Report How Successful Their Community's Activities were:

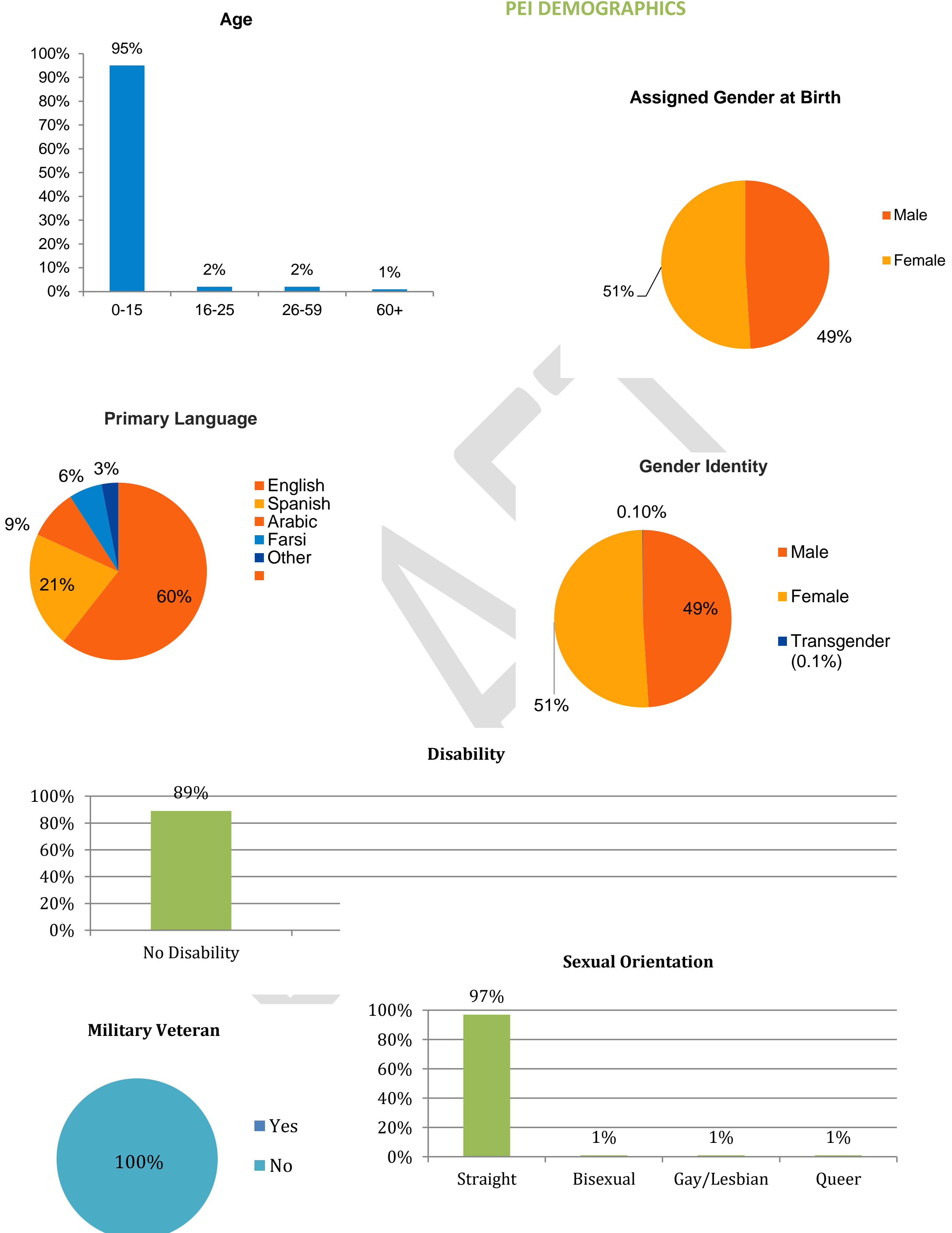


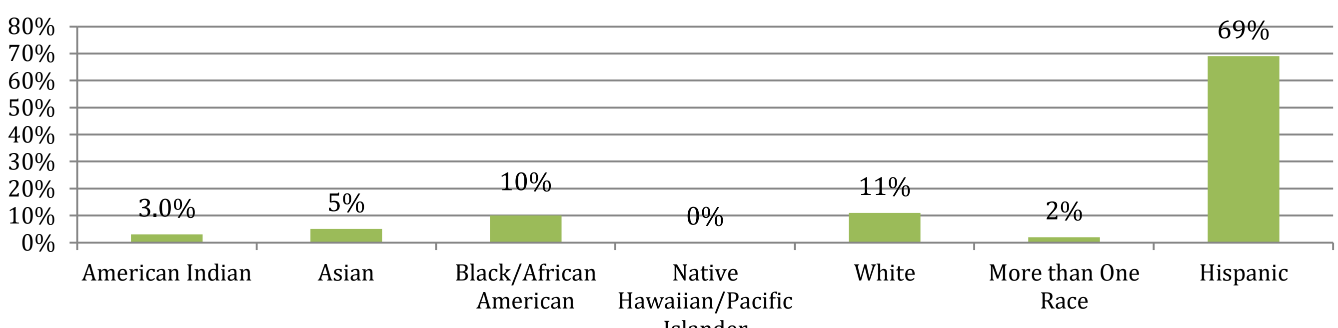


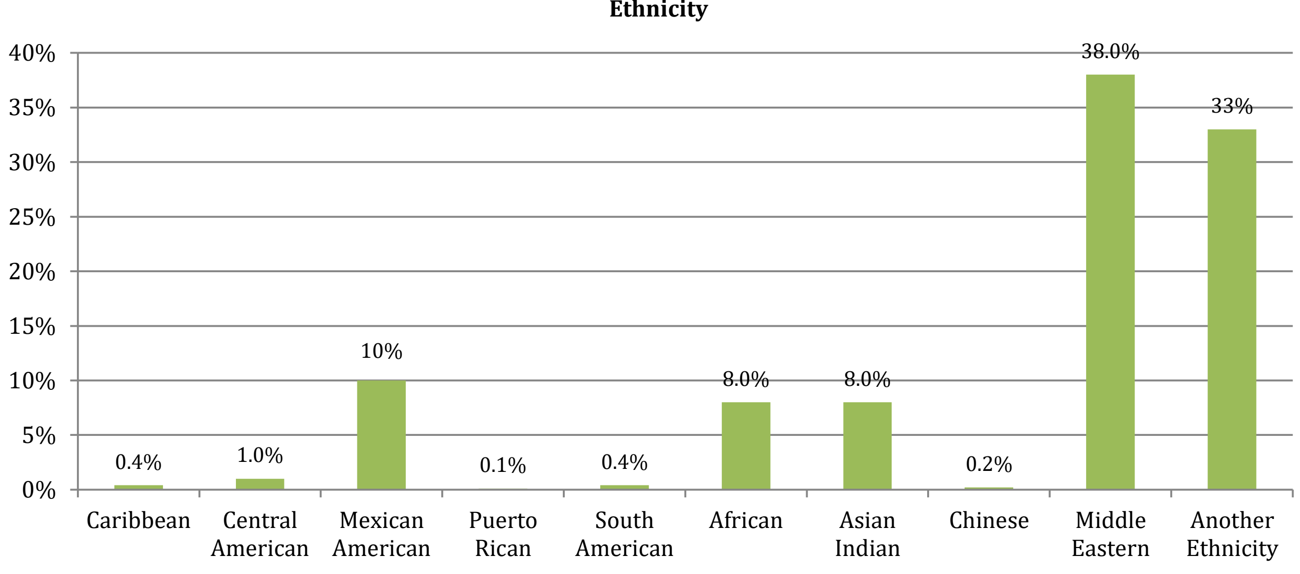
Percentage of Grantees Who Report Improvement in Their Ability to Effectively Act Together



PEI DEMOGRAPHICS



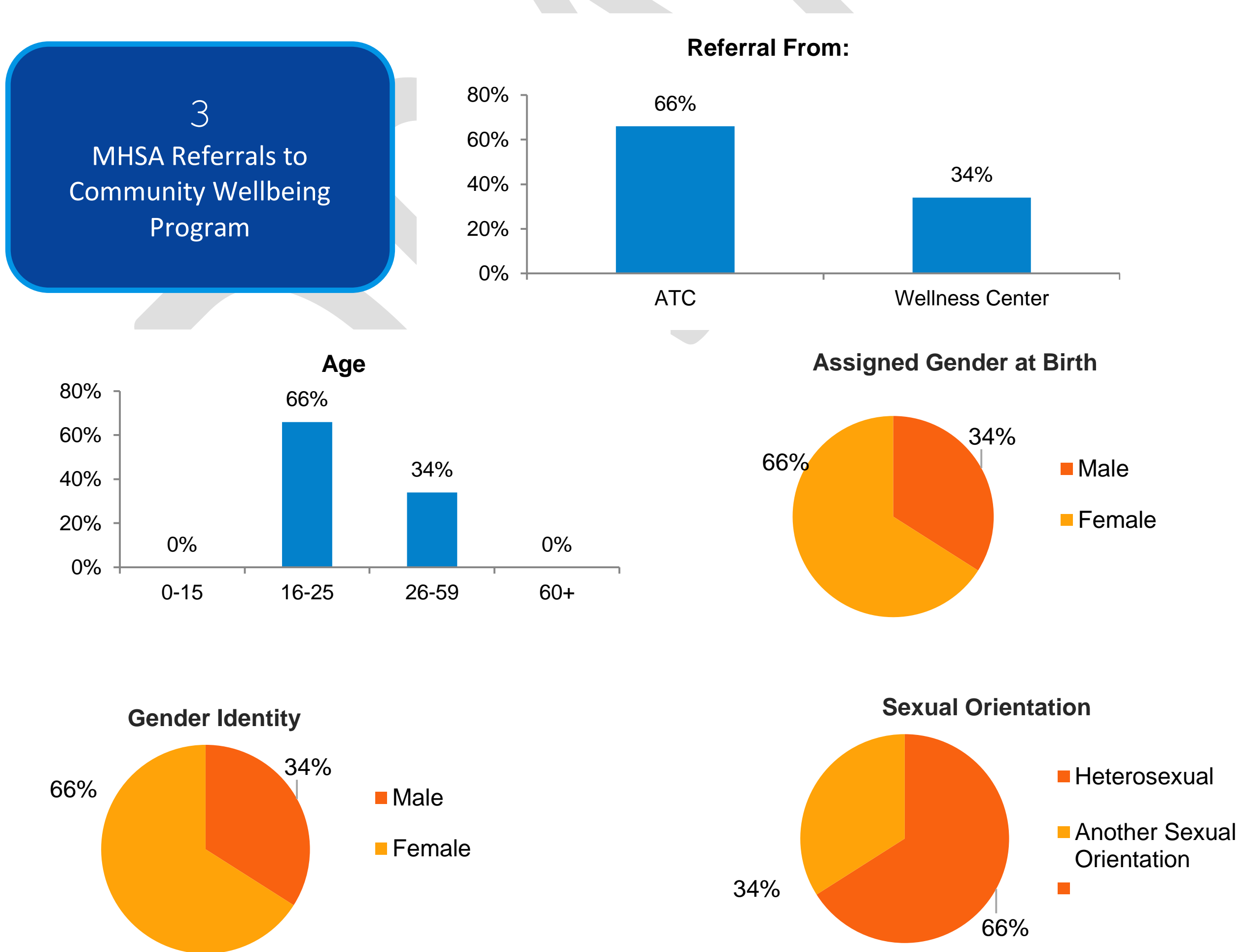

Race
80%
70%
60%
50%
40%
30%
20%
10%
0%
3.0%
5%
10%
0%
11%
2%
69%
American Indian
Asian
Black/African American
Native Hawaiian/Pacific Islander
White
More than One Race
Hispanic

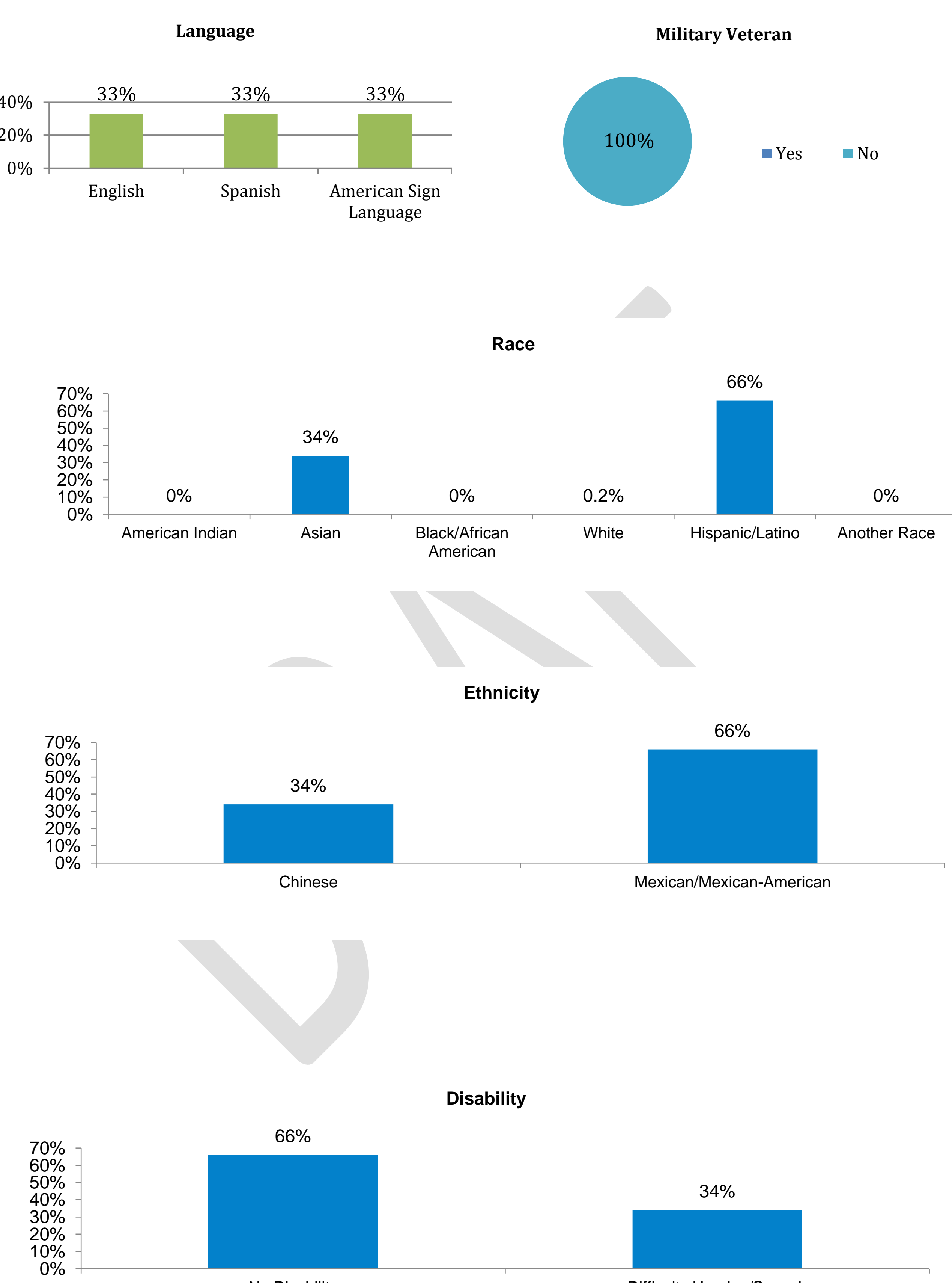

Ethnicity
40%
35%
30%
25%
20%
15%
10%
5%
0%
0.4%
1.0%
10%
0.1%
0.4%
8.0%
8.0%
0.2%
38.0%
33%
Caribbean
Central American
Mexican American
Puerto Rican
South American
African
Asian Indian
Chinese
Middle Eastern
Another Ethnicity

Number of Potential Responders	2,941
Setting in Which Responders were Engaged	Community, Schools, Health Centers, Workplace and Outdoors
Type of Responders Engaged	TAY, teachers, LGBTQ+, families, religious leaders, and those with lived experience
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

PEI Demographics Based on MHSA Referrals





Language
40%
20%
0%
33%
33%
33%
English
Spanish
American Sign Language
Military Veteran
100%
Yes
No
Race
70%
60%
50%
40%
30%
20%
10%
0%
0%
34%
0%
0.2%
66%
0%
American Indian
Asian
Black/African American
White
Hispanic/Latino
Another Race
Ethnicity
34%
66%
Chinese
Mexican/Mexican-American
Disability
66%
34%
No Disability
Difficulty Hearing/Speech

Community Mental Health Trainings

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	___ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention		___ Prevention and Early Intervention	

Program Description

Community Mental Health Trainers offer free group trainings including Mental Health First Aid (MHFA), Adverse Childhood Experiences [ACE], Community Resiliency Model [CRM], Motivational Interviewing [MI], and Everyday Mental Health [EMH] as well as workshops based on the Recovery Model, Non-Suicidal Self-Harm and parenting classes. Since the onset of COVID-19, these trainings are now offered virtually.

Target Population

Tri-City staff, community members, local schools and agencies who are interested in learning how to recognize the early warning signs of mental illness and appropriately intervene to provide support.

Community Mental Health Trainings FY 2019-20	54
Individuals Trained	940

Program Update

The Community Mental Health Trainings continue to be a popular program within the tri-city area. The extensive menu of training options, and the flexibility of Tri-City's staff in adapting trainings to their audiences, has allowed this program to expand the type of trainings offered.
In July 2019, Pomona Unified School District (PUSD) asked Tri-City to host a series of mental health and wellness workshops for PUSD summer students and exchange students from China. Claremont Graduate University's Social Work Program, in collaboration with Western Colleges' Nursing Program requested a series of Tri-City trainings on Adverse Childhood Experiences [ACE], Community Resiliency Model [CRM], Motivational Interviewing [MI], and Everyday Mental Health [EMH] to graduate students in each of their programs. Western University invited Tri-City to provide an ACES presentation to over 100 of their medical students from their Pomona campus and a satellite campus in Oregon virtually ACEs Aware Grant.

Challenges and Solutions

With this growing popularity, it became clear that a dedicated program staff/trainer was needed to oversee this essential program. A second challenge was the limited curriculum available in Spanish in addition to the lack of a bilingual trainers. These issues were addressed and resolved when this position was filled in July 2020.

DRAFT

COVID-19 Response

As with all MHSA programing, staff began working remotely with all communication conducted through RingCentral, email and/or by phone. Similar to staff, all communication with community partners were managed through phone/email.

As expected, all scheduled events, trainings, and programs had to be canceled due to physical/social distancing requirements without the ability to reschedule. Instead, communication focused on providing resources, information, updates, and virtual webinars regarding COVID-19.

COVID-19 significantly impacted the ability to immediately provide the same level of trainings as prior to the pandemic. Access to a virtual platform and the modification to the "in-person" trainings took time to execute. Many community partners did not have a virtual platform in place in order to receive the training virtually. In addition, the pandemic caused many community partners to shut down which limited communication for a significant period of time, including local school districts and colleges who were busy transitioning to a virtual learning environment with very little notice or preparation.

As of April 2020, all community trainings were offered virtually through the RingCentral Webinar platform. CMHT began providing weekly webinars on topics that were already a part of Tri-City's training series. Notification of these trainings were posted on Tri-City's webpage, social media accounts, and emails.

Cultural Approach

Prior to COVID-19, Community Mental Health trainers (CMHT) were able to address cultural barriers through in-person connections with under/unserved communities and by building relationships with organization that work, serve, and support these communities, by providing information, services, and trainings.

By working closely with Tri-City's Stigma Reduction Program, CMHTs share information on how to reduce stigma that impacts community partners from seeking, accessing, and utilizing services. By reaching out to organizations to set-up trainings, share information, and educate them on what mental illness/wellness is, it's impact, and accessible services, staff are able to share resources available to help prevent and support someone who's experiencing a mental health challenge.

Tri-City has hired a bilingual/Spanish full-time program staff to provide trainings in Spanish. Trainings and webinars will be available in English and Spanish in addition to marketing materials available in both languages as well.

PROGRAM: Community Mental Health Trainings (CMHT)

HOW MUCH DID WE DO?

940
Individuals Served

54
Community Mental Health Trainings

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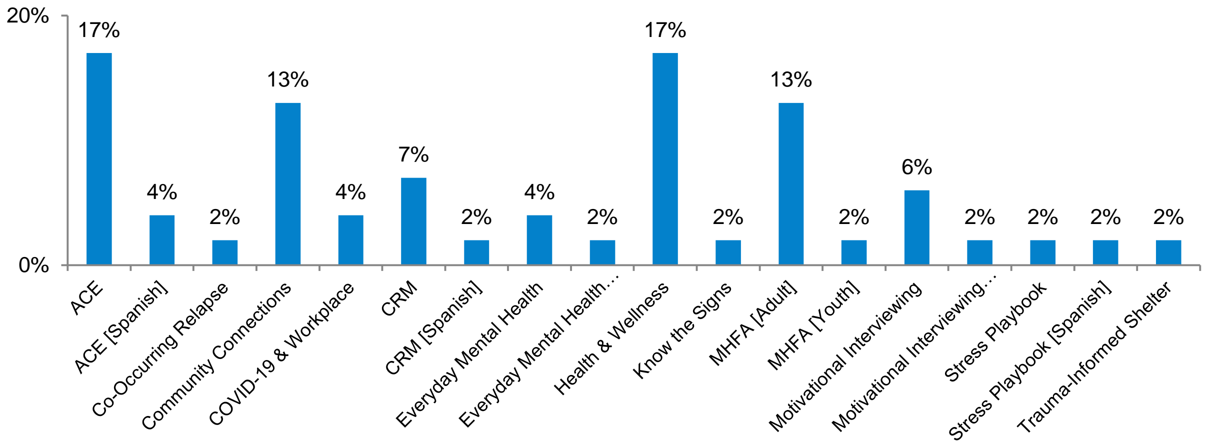
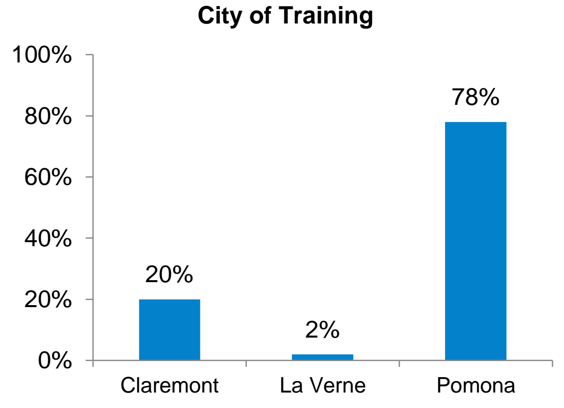
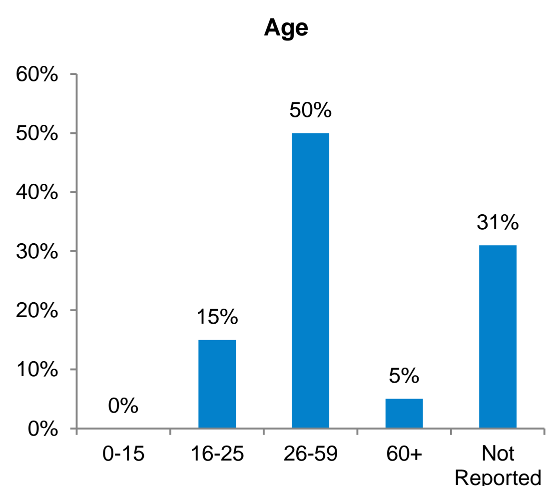
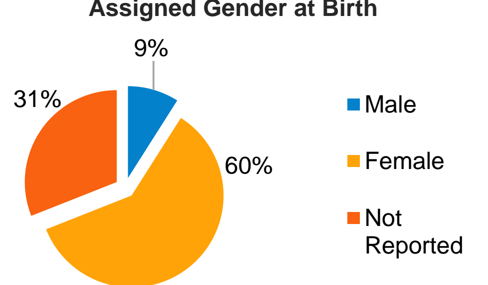
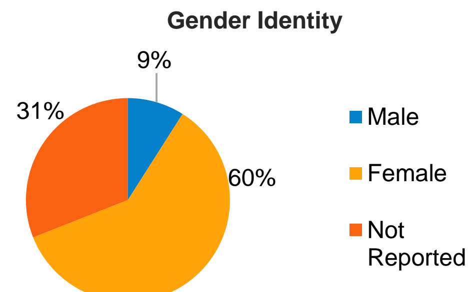
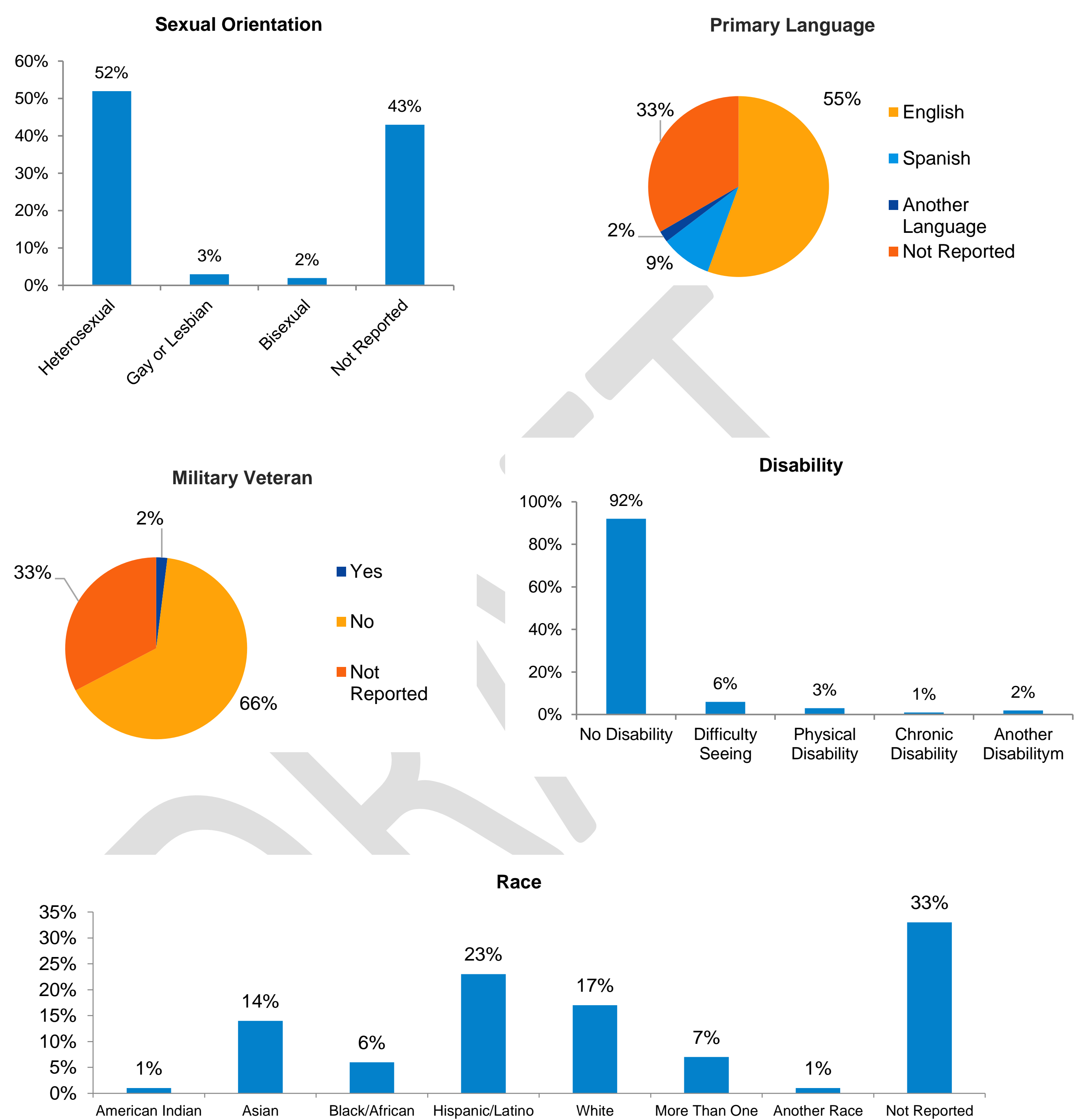

Community Mental Health Trainings
20%
0%
17%
4%
2%
13%
4%
7%
2%
4%
2%
17%
2%
13%
2%
6%
2%
2%
2%
2%
ACE
ACE [Spanish]
Co-Occurring Relapse
Community Connections
COVID-19 & Workplace
CRM
CRM [Spanish]
Everyday Mental Health
Everyday Mental Health…
Health & Wellness
Know the Signs
MHFA [Adult]
MHFA [Youth]
Motivational Interviewing
Motivational Interviewing…
Stress Playbook
Stress Playbook [Spanish]
Trauma-Informed Shelter


City of Training
100%
80%
60%
40%
20%
0%
20%
2%
78%
Claremont
La Verne
Pomona

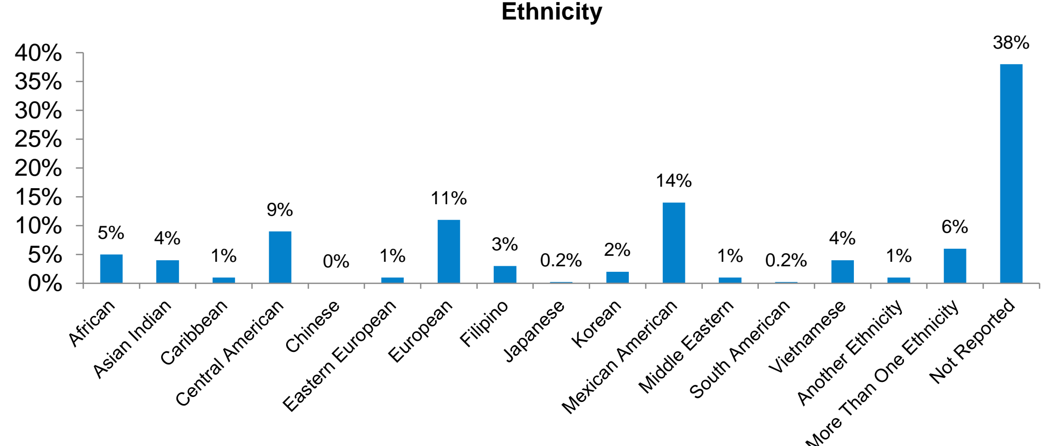

Age
60%
50%
40%
30%
20%
10%
0%
0%
15%
50%
5%
31%
0-15
16-25
26-59
60+
Not Reported


Assigned Gender at Birth
9%
31%
60%
Male
Female
Not Reported


Gender Identity
9%
31%
60%
Male
Female
Not Reported



Sexual Orientation
60%
50%
40%
30%
20%
10%
0%
52%
3%
2%
43%
Heterosexual
Gay or Lesbian
Bisexual
Not Reported
Primary Language
33%
55%
2%
9%
English
Spanish
Another Language
Not Reported
Military Veteran
2%
33%
66%
Yes
No
Not Reported
Disability
100%
80%
60%
40%
20%
0%
92%
6%
3%
1%
2%
No Disability
Difficulty Seeing
Physical Disability
Chronic Disability
Another Disabilitym
Race
35%
30%
25%
20%
15%
10%
5%
0%
1%
14%
6%
23%
17%
7%
1%
33%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More Than One Race
Another Race
Not Reported

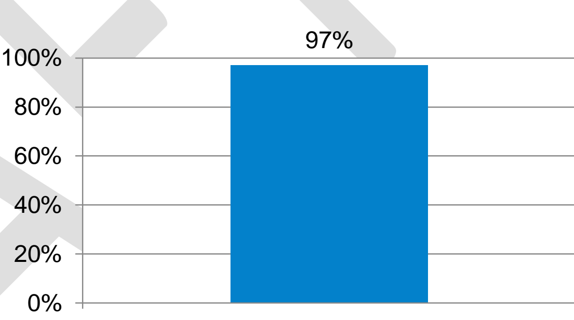


HOW WELL DID WE DO IT?

Percentage of participants who report the training was relevant to their day to day activities:

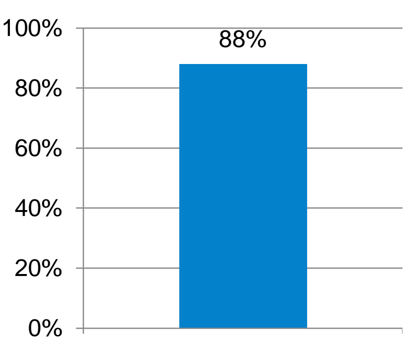
100%
80%
60%
40%
20%
0%
88%

Percentage of participants who rated the training session as good or excellent

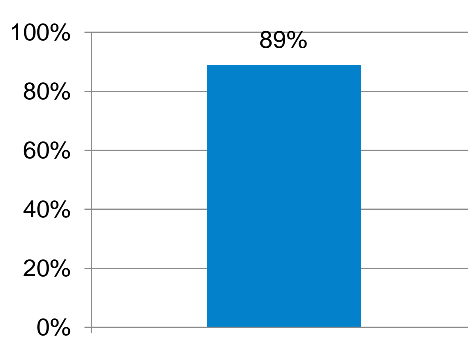


IS ANYONE BETTER OFF?

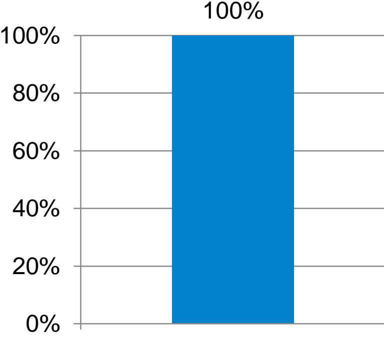
Percentage of participants who report feeling confident in using or applying the skills learned in the training:



Percentage of participants who report feeling more confident reaching out to someone who may be experiencing a mental health challenge or crisis



Percentage of participants who would recommend the training to others:

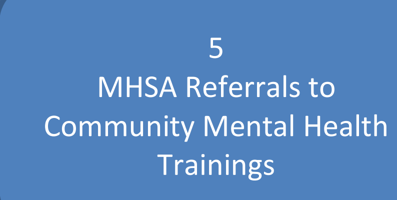


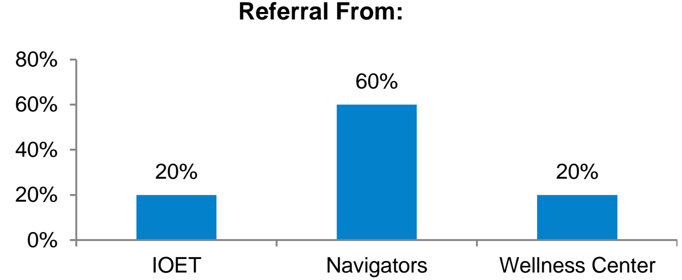
DRAFT

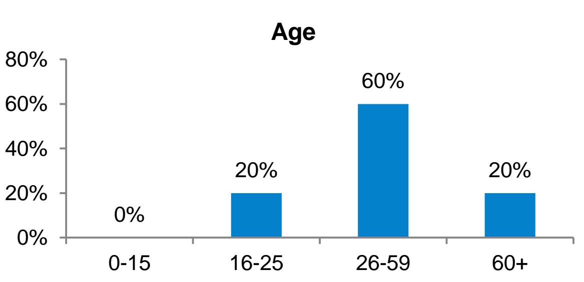
Number of Potential Responders	940
Setting in Which Responders were Engaged	Community, schools and colleges
Type of Responders Engaged	TAY, adults, seniors, landlords and students
Underserved Populations	Black/African American, Asian American/Pacific Islander, Hispanic/Latino, Native American, Refugee/Immigrant, Lesbian/Gay/Bisexual/Transgender/Questioning, Transition Age Youth, Older Adults, and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

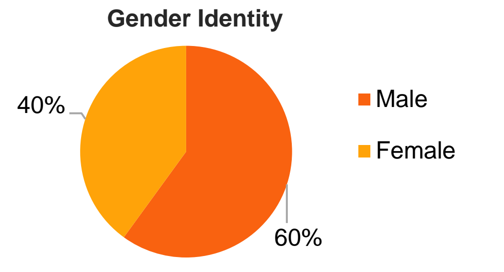
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

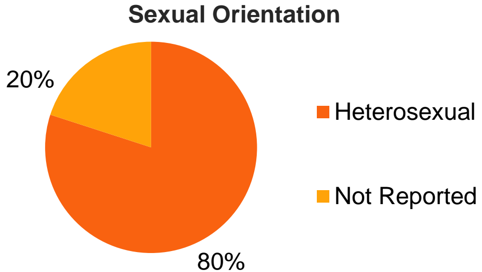
PEI Demographics Based on MHSA Referrals

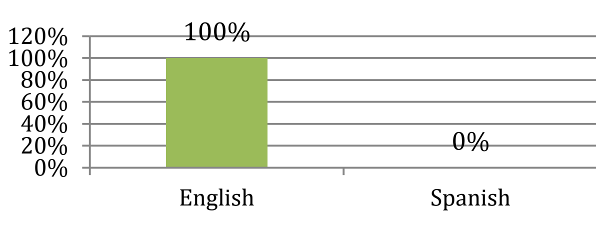


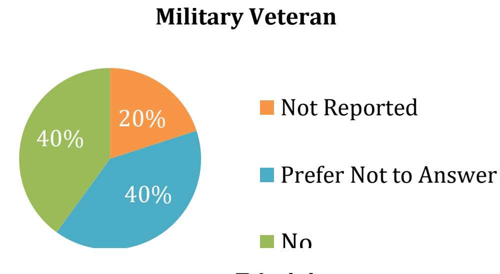


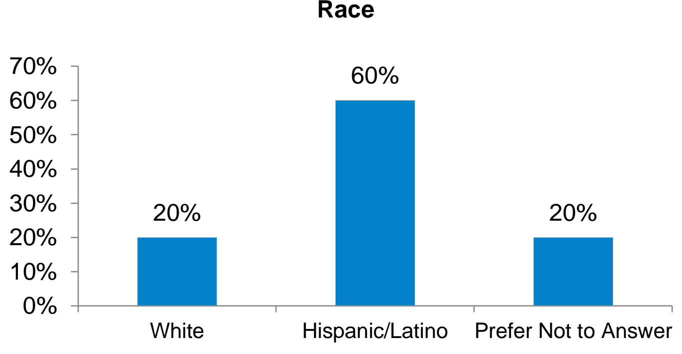


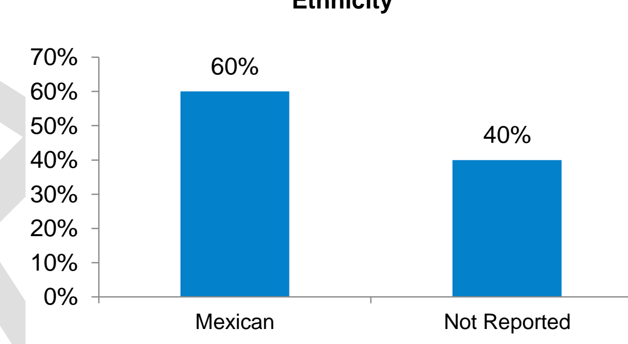

Gender Identity
40%
60%
Male
Female

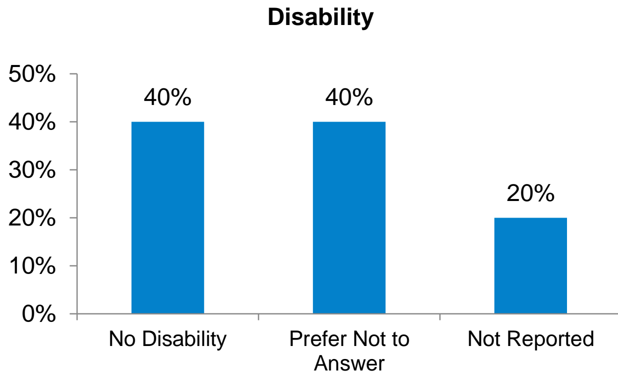

Sexual Orientation
20%
80%
Heterosexual
Not Reported


Language
120%
100%
80%
60%
40%
20%
0%
100%
0%
English
Spanish


Military Veteran
20%
40%
40%
Not Reported
Prefer Not to Answer


Race
70%
60%
50%
40%
30%
20%
10%
0%
20%
60%
20%
White
Hispanic/Latino
Prefer Not to Answer


Ethnicity
70%
60%
50%
40%
30%
20%
10%
0%
60%
40%
Mexican
Not Reported


Disability
50%
40%
30%
20%
10%
0%
40%
40%
20%
No Disability
Prefer Not to Answer
Not Reported

Stigma Reduction and Suicide Prevention

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention		___ Prevention and Early Intervention	

Program Description

Tri-City's stigma reduction effort is encompassed under Room4Everyone and includes a website focused on stigma reduction, along with several other components designed to empower individuals suffering with mental health challenges and awareness to the stigma related to mental illness. Suicide prevention efforts include offering the safeTALK alertness training which provides participants with the skills needed to recognize the signs of suicide in an individual and connect them quickly and safely with the appropriate resources and support services.

Target Population

Community members, agencies and organizations located in the Tri-City region (cities of Claremont, Pomona, and La Verne).

Number of Individuals Served FY 2019-20	206

Program Update

On September 10, 2019, a World Suicide Prevention Day event was hosted in collaboration with NAMI Pomona Valley. This public event screened the documentary "Suicide: The Ripple Effect', a feature length film which documents the suicide attempt of Kevin Hines, the impact of his suicide attempt on others, and his later work as a mental health advocate. We Connect, We Live, We Thrive was the theme of the event. It focused on screening the film, stories of suicide survivors and community partners who have opportunity for community members to connect and get involved right away.

The annual Creative Minds Art Gallery reception theme was 'Let's Celebrate'. Notable entries included a class project submitted by Claremont High School's photography class. This was a wonderful example of collaboration between Tri-City and local schools in raising awareness of the connection of mental health and the arts.

Challenges and Solutions

Challenges during this period included the fact that the curriculum used for suicide prevention, SAFETALK, continues to be only available in English. In addition, the training is four hours long and some participants feel this is too long. The topic of suicide can be very sensitive and challenging for participants to stay engaged for that extended period of time or feel comfortable asking questions.

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In response to these concerns, staff have started using Know the Signs, another suicide prevention training/presentation, which is available in Spanish, and can be presented by any staff member.

A second challenge focuses on the stigma reduction presentations which are delivered by a Courageous Minds speaker (person who identifies with lived experience). However, due to scheduling and personal responsibilities, it has been a challenge to maintain speakers to be a part of this program. Staff have connected with Tri-City clinicians and MHSA programs to identify potential clients/participants who would be a great fit for this speaker program.

COVID-19 Response

The impact of COVID 19 for this program primarily involved the cancellation of community events including Green Ribbon Week, a popular week-long series of events focusing on stigma reduction. Outreach efforts were also curtailed since local schools, agencies, and community-based sites were closing in response to the pandemic.

By utilizing RingCentral, a virtual platform, staff were able to offer webinars focusing on a wide-range of topics and promote virtual events, presentations and trainings. In consideration of the impact of individuals in the community being socially isolated, staff designed weekly session called Community Connections that highlighted a specific skill or topic each week and allowed attendees to participate virtually through their cameras and microphones.

Cultural Approach

Striving to offer and provide trainings, presentations and information to diverse communities and neighborhoods across all three cities is one way the stigma reduction program attempts to reach as many individuals as possible. Multi- language trainings are made possible through the collaboration of program staff and bilingual staff members who co-facilitate. When promoting events like art workshops and art reception, flyers are available in both English and Spanish.

The Stigma Reduction program works on reducing stigma by creating a safe space for presentations and trainings that are culturally sensitive and beneficial for all participants. The meaning of "Room4Everyone" expands beyond those with and without mental health conditions. It also refers to finding ways we are more alike than different, no matter what the differences are. Barriers experienced by the LGBTQ community are reduced by having materials that reflect the specifics of mental health on members of their community. Presentations and trainings dedicated to this important population touches on topics that are relevant and provides an opportunity for discussions, provide inclusion, and allow for questions from heterosexual and cisgender attendees to help increase their understanding.

PROGRAM: Stigma Reduction and Suicide Prevention
HOW MUCH DID WE DO? Stigma Reduction

15
Stigma Reduction Presentations

20
Courageous Minds Speakers Shared

DRAFT

Type of Stigma Reduction Presentations

Type	%
Stigma [Courageous Minds Speakers]	47%
Thriving	6%
Mindfulness	7%
Creative Journaling	6%
Co-Occuring Disorders	7%
Storytelling	6%
Personal Stories	6%
Faith & Recovery	6%
As a Therapist	6%

Presentations by City

City	%
Claremont	6%
La Verne	20%
Pomona	73%

1,656
Promotional Materials Distributed

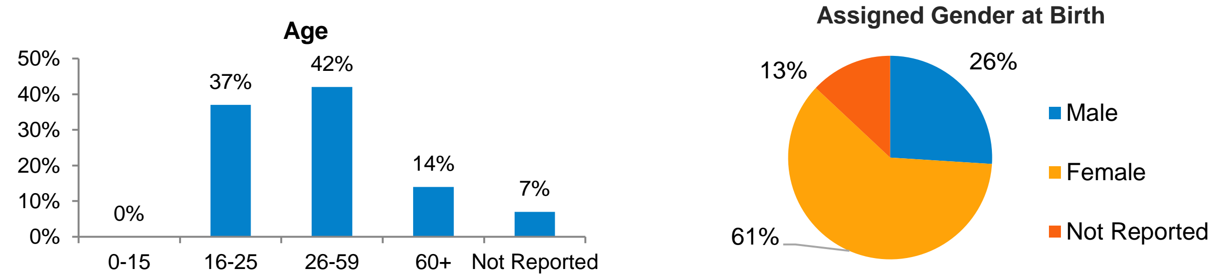
City of Promotional Materials

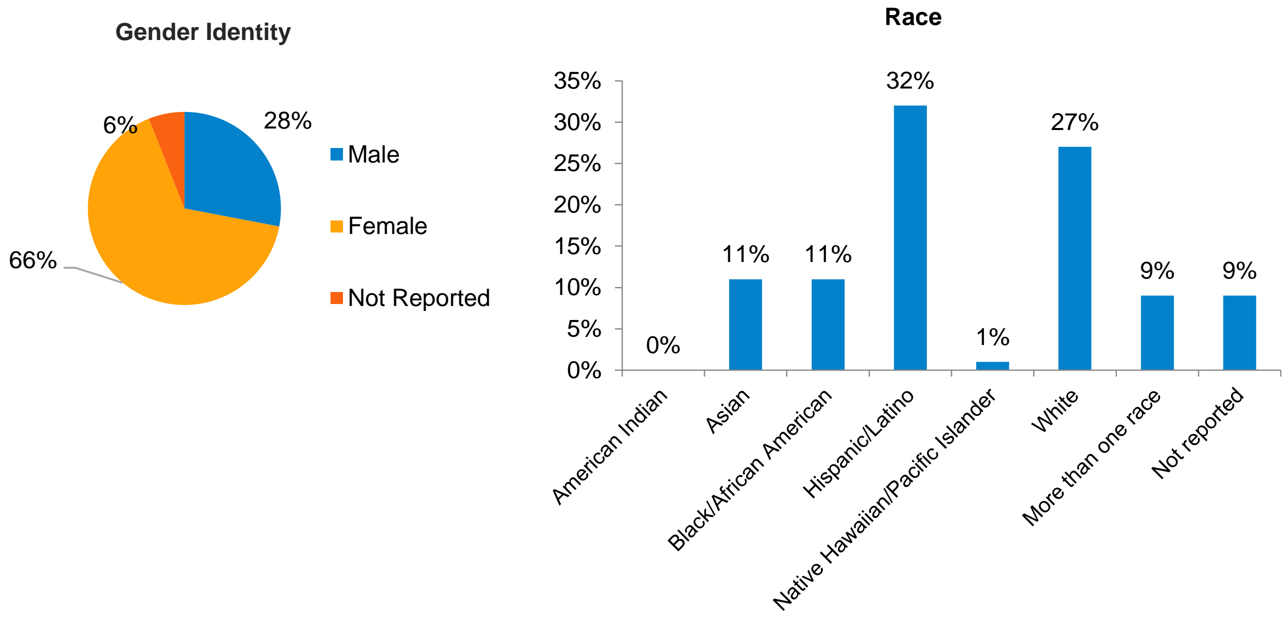
City	%
Claremont	6%
La Verne	22%
Pomona	67%
Other City	6%

Type of Distributed Promotional Materials

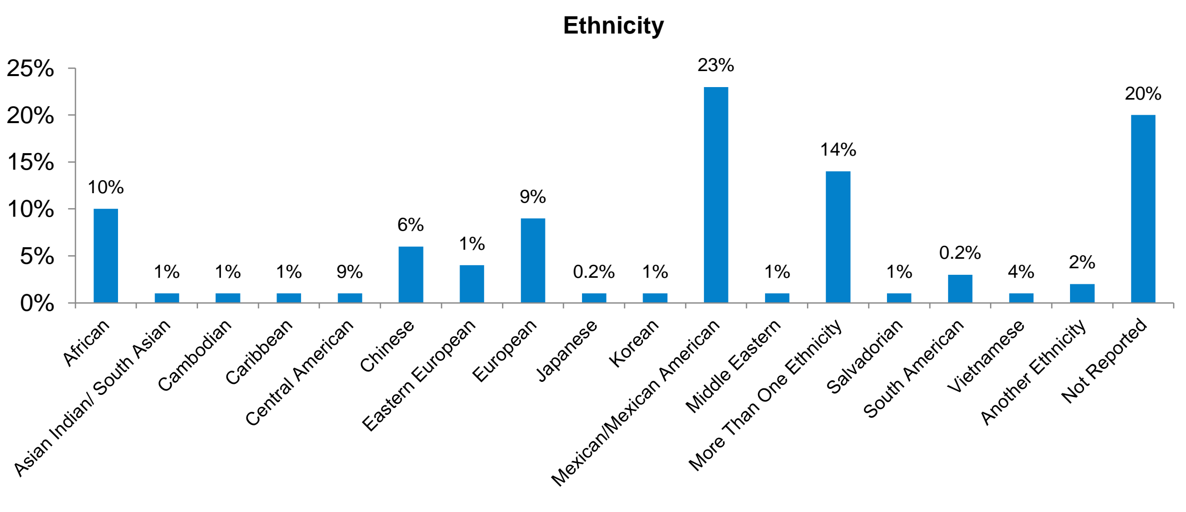
Type	Count
Flyers, Brochures, Posters	807
Green Ribbons, Bracelets, Buttons	849

Demographics Based on Participants Who Completed Stigma Reduction Surveys (n=117)

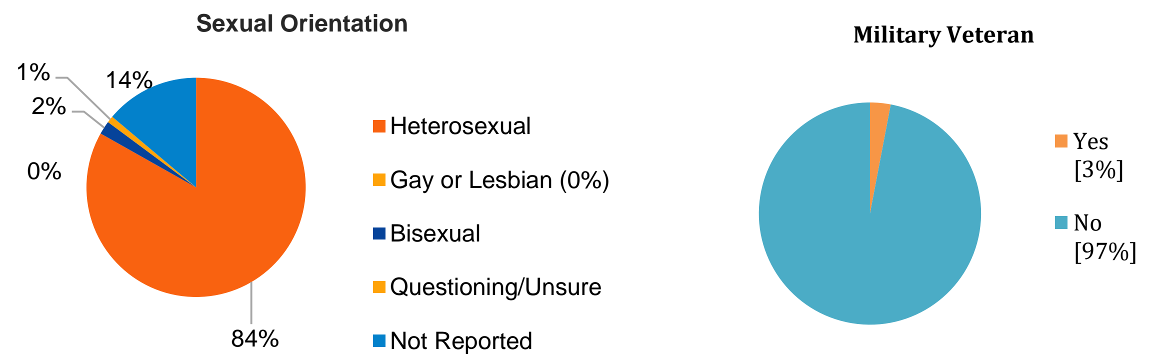




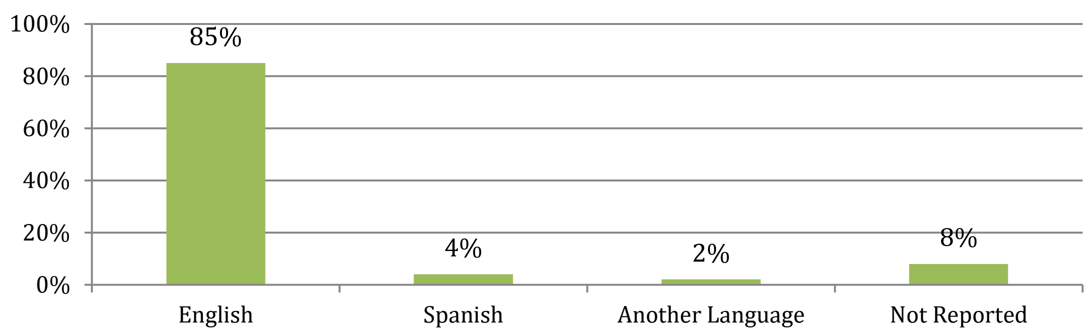
Gender Identity
6%
28%
66%
Male
Female
Not Reported
Race
35%
30%
25%
20%
15%
10%
5%
0%
0%
11%
11%
32%
1%
27%
9%
9%
American Indian
Asian
Black/African American
Hispanic/Latino
Native Hawaiian/Pacific Islander
White
More than one race
Not reported

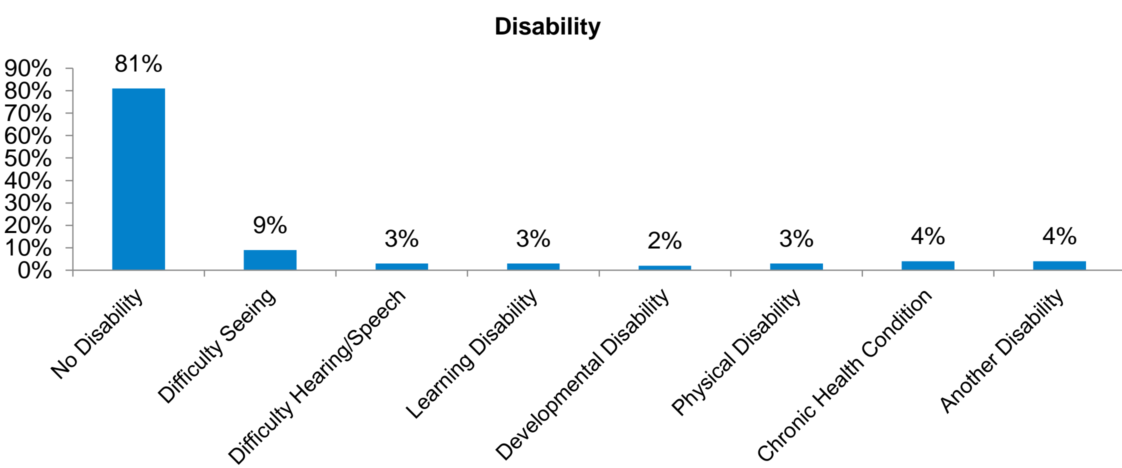


Ethnicity
25%
20%
15%
10%
5%
0%
10%
1%
1%
1%
9%
6%
1%
9%
0.2%
1%
23%
1%
14%
1%
0.2%
4%
2%
20%
African
Asian Indian/ South Asian
Cambodian
Caribbean
Central American
Chinese
Eastern European
European
Japanese
Korean
Mexican/Mexican American
Middle Eastern
More Than One Ethnicity
Salvadorian
South American
Vietnamese
Another Ethnicity
Not Reported

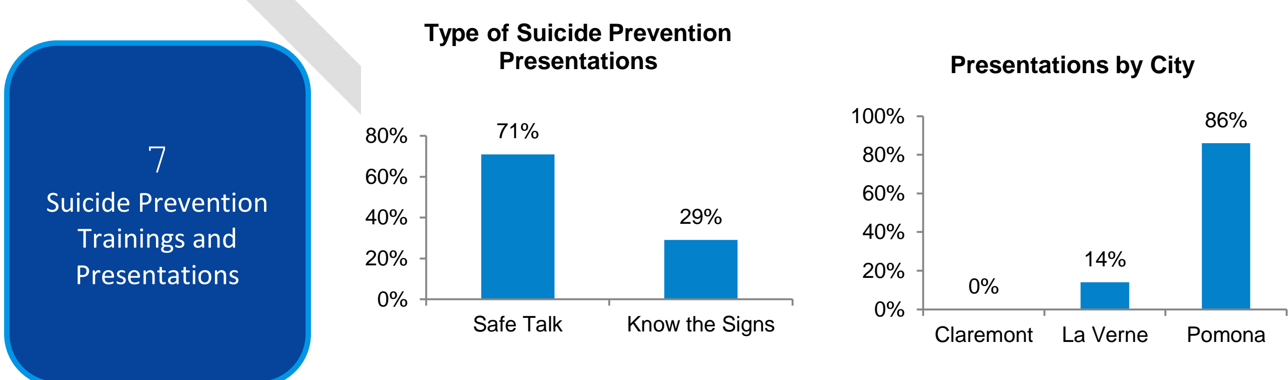


Sexual Orientation
1%
14%
2%
0%
84%
Heterosexual
Gay or Lesbian (0%)
Bisexual
Questioning/Unsure
Not Reported
Military Veteran
Yes
[3%]
No
[97%]

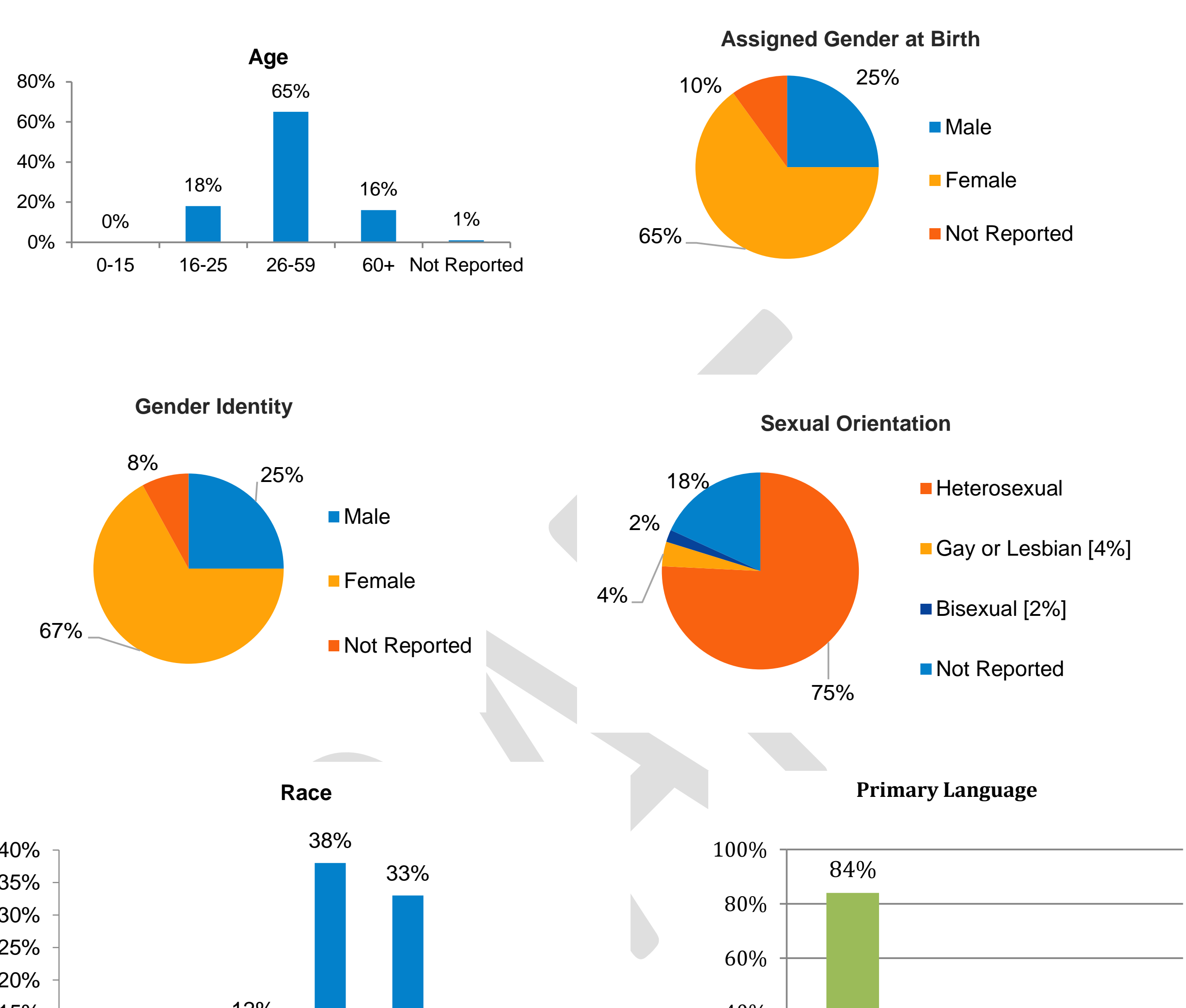


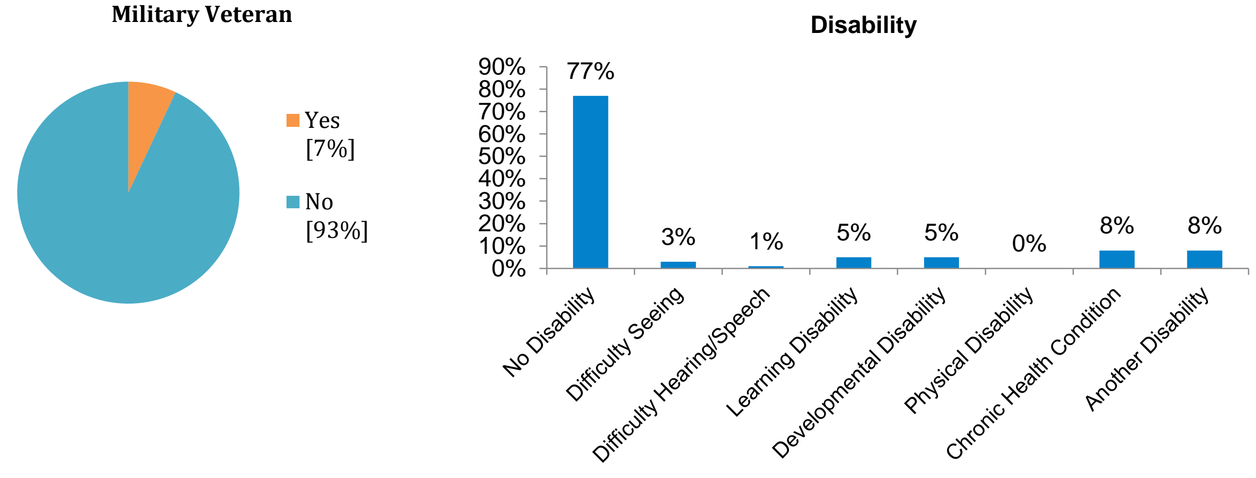


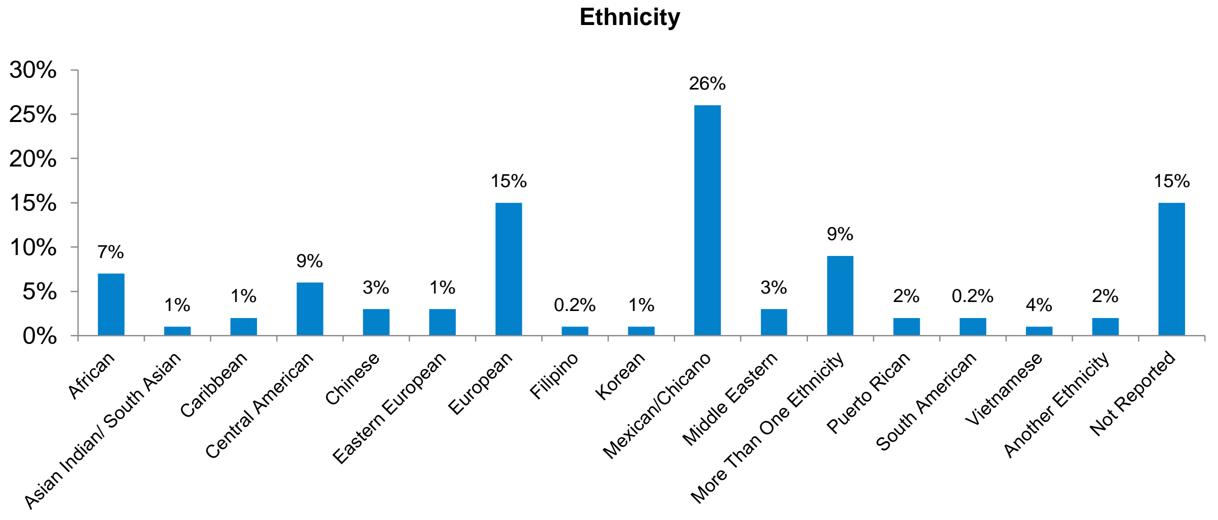
HOW MUCH DID WE DO? Suicide Prevention



Demographics Based on Participants Who Completed Safe Talk Surveys (n=89)

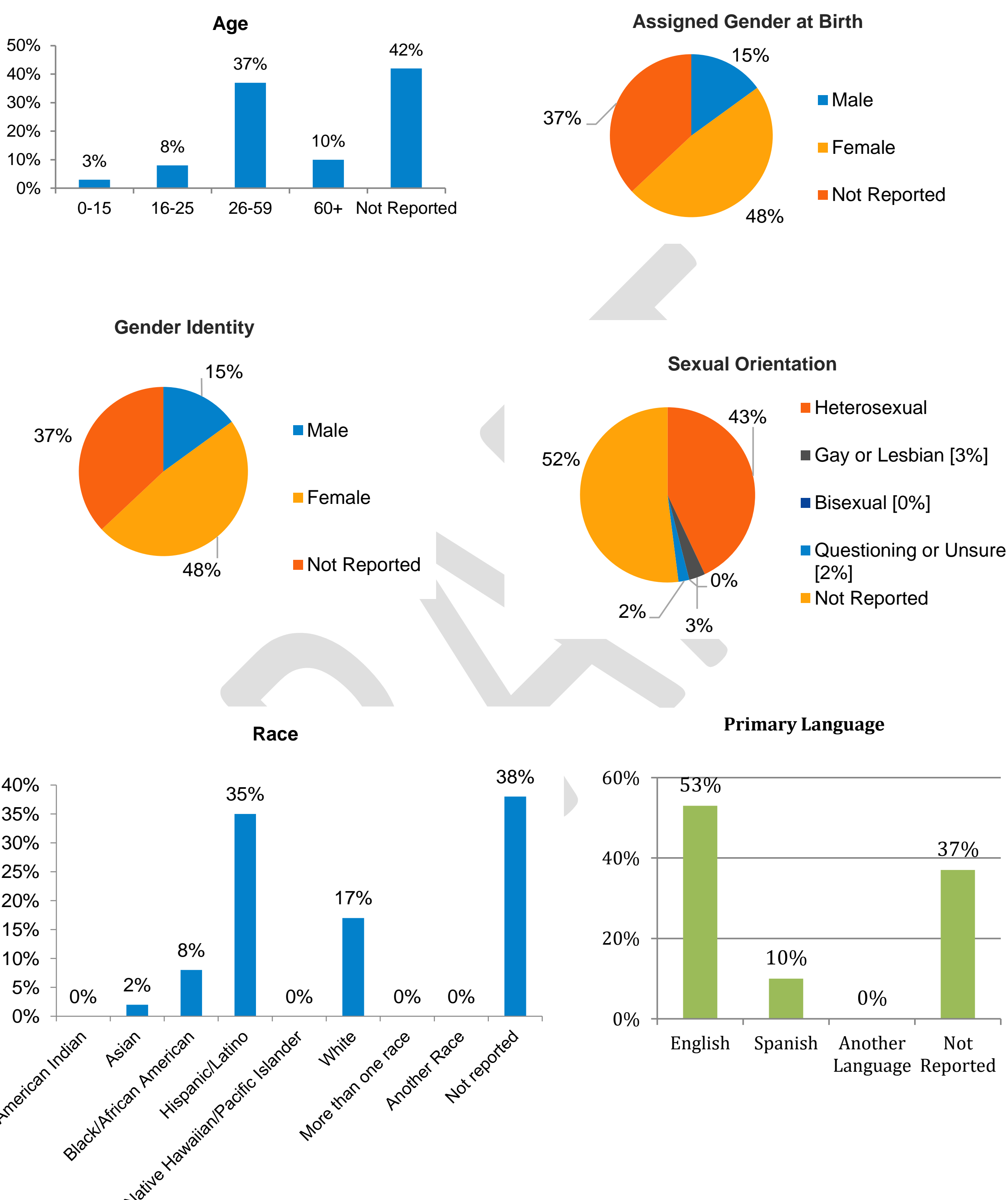


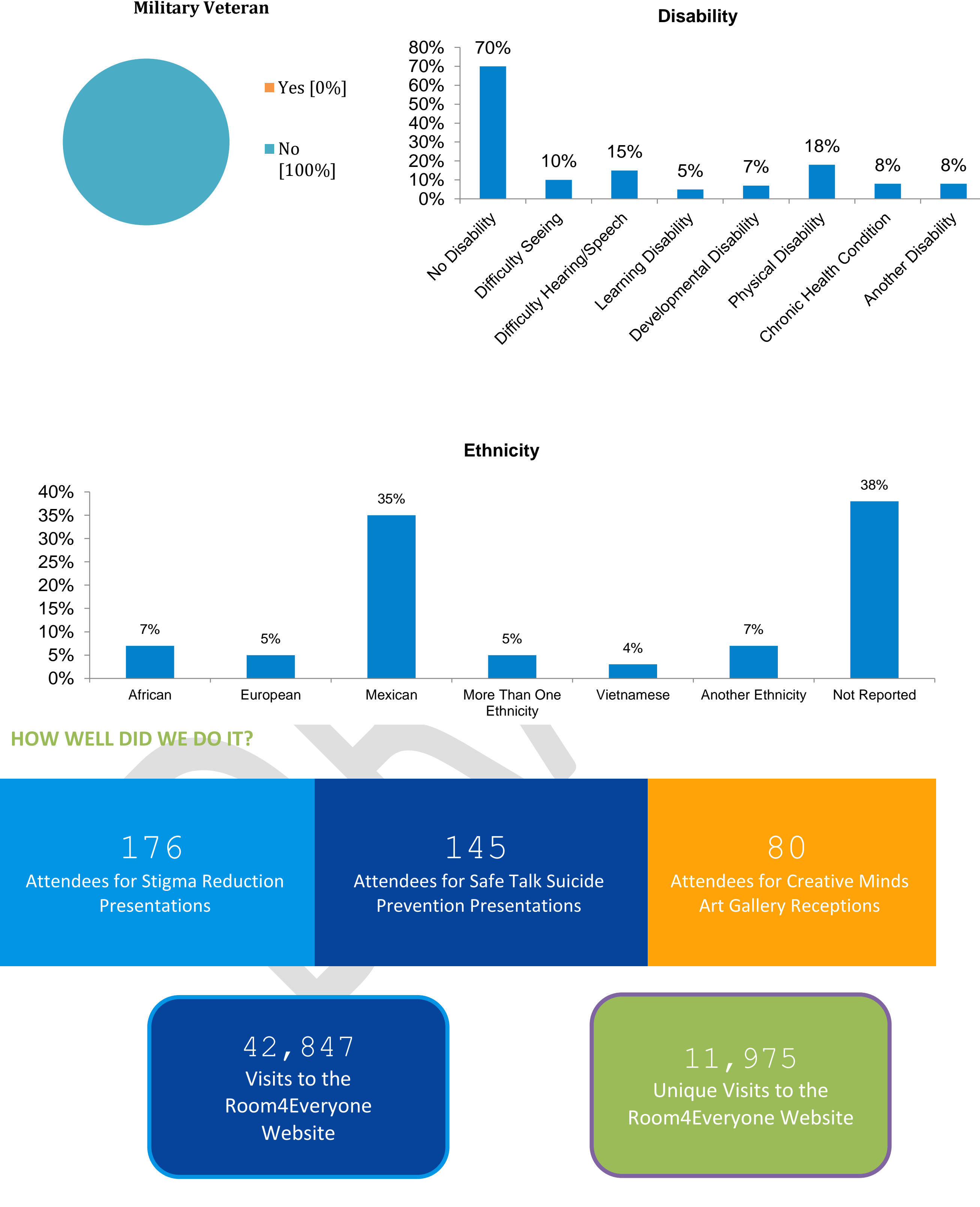




HOW MUCH DID WE DO? Creative Minds Art Gallery

Demographics Based on Participants Who Completed Art Workshop Surveys

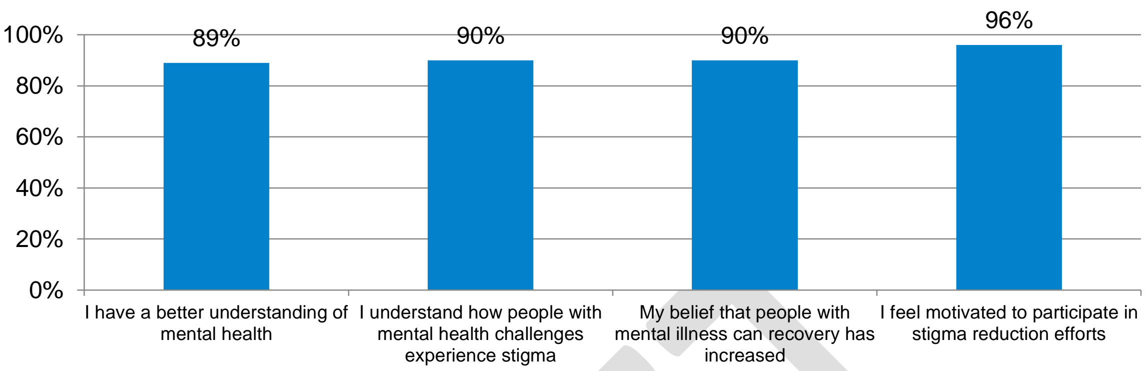




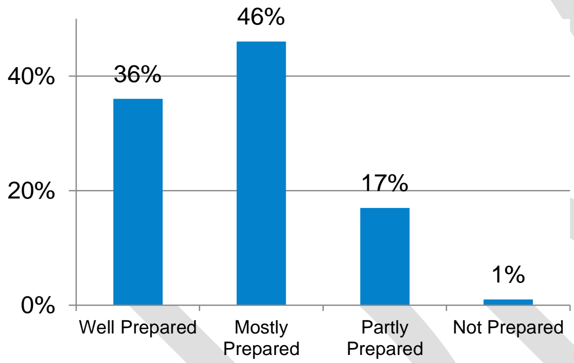
Website Hits Data from July 2019 to December 2019

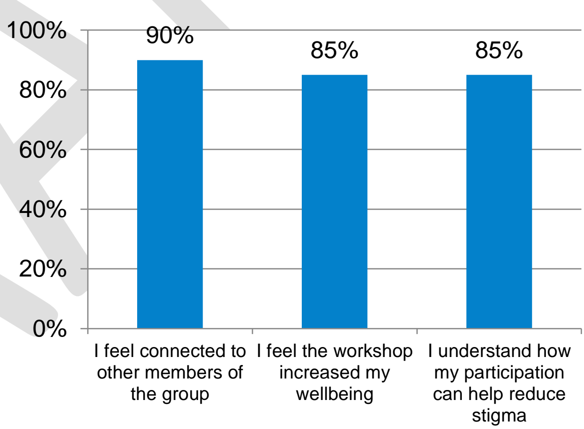
IS ANYONE BETTER OFF?

Stigma Reduction



Suicide Prevention





DRAFT

Number of Potential Responders	401
Setting in Which Responders were Engaged	Community, schools, colleges, health centers, workplace, shelters, online and outdoors
Type of Responders Engaged	TAY, adults, seniors, teachers, LGBTQ+, families, suicide attempters/survivors, religious leaders and those with lived experience
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

0
MHSA Referrals to Stigma Reduction or Suicide Prevention Programs

DRAFT

Older Adult and Transition Age Youth Wellbeing

Both the Older Adult Wellbeing and the Transition Age Youth Wellbeing programs are comprised of two projects: Peer mentoring and specialty groups/programing offered at the Wellness Center specific to TAY and older adults needs.

Peer Mentor and Wellness Center PEI Programs

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	___ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	___ Prevention	___ Early Intervention		_X_ Prevention and Early Intervention	

Program Description

Trained volunteers (peer mentors) from the tri-city area provide support to peers (mentees) who are in emotional distress. Peer mentors offer both individual and group support, and additional assistance through linkage to community resources that are both age and culturally matched to each individual mentee. Individuals attending the TAY and Older Adult programing located at the Wellness Center benefit from specialized support groups and activities targeting their specific needs.

Target Population

Transition Age Youth (TAY ages 18-25) and Older Adults (ages 60 and over)

Peer Mentor/Mentees

Age Groups	TAY 18-25	Adults 26-59	Older Adults 60+	Unknown
Mentors FY 2019-20	14	12	4	0
Mentees FY 2019-20	25	39	23	0
Groups FY 2019-20	0	29	20	286
Cost Per Person	$109	$119	$119	N/A

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Wellness Center (PEI TAY and Older Adults)					
Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	56	502	56	99	4
Cost Per Person	$727	$727	$727	$727	$727

Peer Mentor Program

Program Update

The Peer Mentor program continues to support both mentors (individuals providing the support) and mentees (individuals receiving the support). Peer Mentors focused on engaging individuals with lived experience who apply and then are trained to provide support to community members who are seeking a non- clinical level of care. These services are offered in English, Spanish, Vietnamese and Cantonese.

In FY 2019-20, this program sustained 30 dedicated and highly trained community mentors. Of these 30 mentors, 19 identified with lived experience who were able to provide an empathic level of support based on personal experience.

In addition to one-on-one sessions, this program offers support groups as well. Two of the critical populations supported through these groups include older adults and the LGBTQ+.

Challenges and Solutions

The number of mentors identifying themselves with lived experience continue to increase each year. This can be a significant benefit for mentees who are looking to connect with another peer. However, one of the challenges for staff has been to provide adequate and meaningful support for the needs of our mentors as well.

Additional challenges include engaging the homeless population and older adults. Over the next fiscal year, staff will continue to work on engaging these individuals through one-on-one support via telephone. Efforts will also include an increase focus on self-care and wellbeing to help mentors, specifically those who identify with lived experience, to ensure that they receive adequate support to help minimize/reduce any mental health symptoms.

COVID-19 Response

Since the outbreak of COVID-19, the Peer Mentor Program moved its service delivery to phone and virtual platforms. Historically, many mentors take a summer break and return in the fall. However, with the onset of COVID-19, several of the mentors continued to offer support throughout summer break due to the increased need since the onset of the pandemic. Trainings continued as well in order to provide the mentors with up-to-date COVID-19 information and how they can best support their mentees. The Peer Mentor wellbeing activities, normally held in person, were temporarily put on hold.

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However, staff began to brainstorm to create virtual wellness roundtables where the groups can continue to meet virtually.

As expected with the pandemic, there was an increase in referrals in a short period of time thereby increasing the number of mentees each mentor had on their case load. Since the majority of mentors who provide services to the community identify themselves with lived experience, group meetings and individual supervisions were also increased to provide extra support to these mentors as they continued to provide extra support to mentees.

Cultural Approach

Peer mentors identify with numerous local communities (African American, Asian, Latino, Bisexual, Gay, Native American, TAY, Older Adult and Physically disabled). The majority of the mentors are bilingual and provide services in English, Spanish, Tamil, Hindi, Malayalam, Korean, Cantonese. In addition, the PM program currently has mentors who identify in the LGBTQ+ community who provide input and feedback on how to engage with others in the community.

Peer Mentoring programing focus on providing serves to individuals with limited mobility, limited access to transportation, monolingual individuals, LGBTQ, homelessness, and transition age youth. Presentations also focus on the veteran population in addition to providing multiple wellbeing activities in the communities. In addition, the program provides bilingual and monolingual senior socialization groups at local parks and mental wellbeing activities at senior living locations where residents may experience limited mobility and lack of transportation.

Wellness Center Programs: Transition Age Youth and Older Adults

Transition age youth (TAY) and older adults are considered critical populations in need of support yet tend to be some of the most difficult to engage. Reasons include issues related to stigma and difficulty with transportation. In an effort to meet the needs of these individuals, the Wellness Center has created programs utilizing Prevention and Early Intervention (PEI) funding to create programing specific to the needs and interests of these, often considered, at-risk individuals.

Program Update

In an effort to build participation in the TAY programing, Wellness Center staff have focused their outreach efforts on collaborating with local service organizations who work with this age group. Prior to COVID-19, the Wellness Center saw a slight increase in the number of groups offered as well as the number of unique individuals who attended the Center. Although the COVID -19 pandemic has since impacted onsite groups, efforts continue to build a relationship with these community organizations which will allow for a smooth transition for TAY to come to the Wellness Center once the pandemic has abated.

The Wellness Center's older adult programing continues to struggle with engagement and attendance. Recognizing the unique needs of this population, the Center created a Mental Health Specialist position where this staff member is dedicated to engaging older adults throughout the community and developing age appropriate activities and support groups based on their needs.

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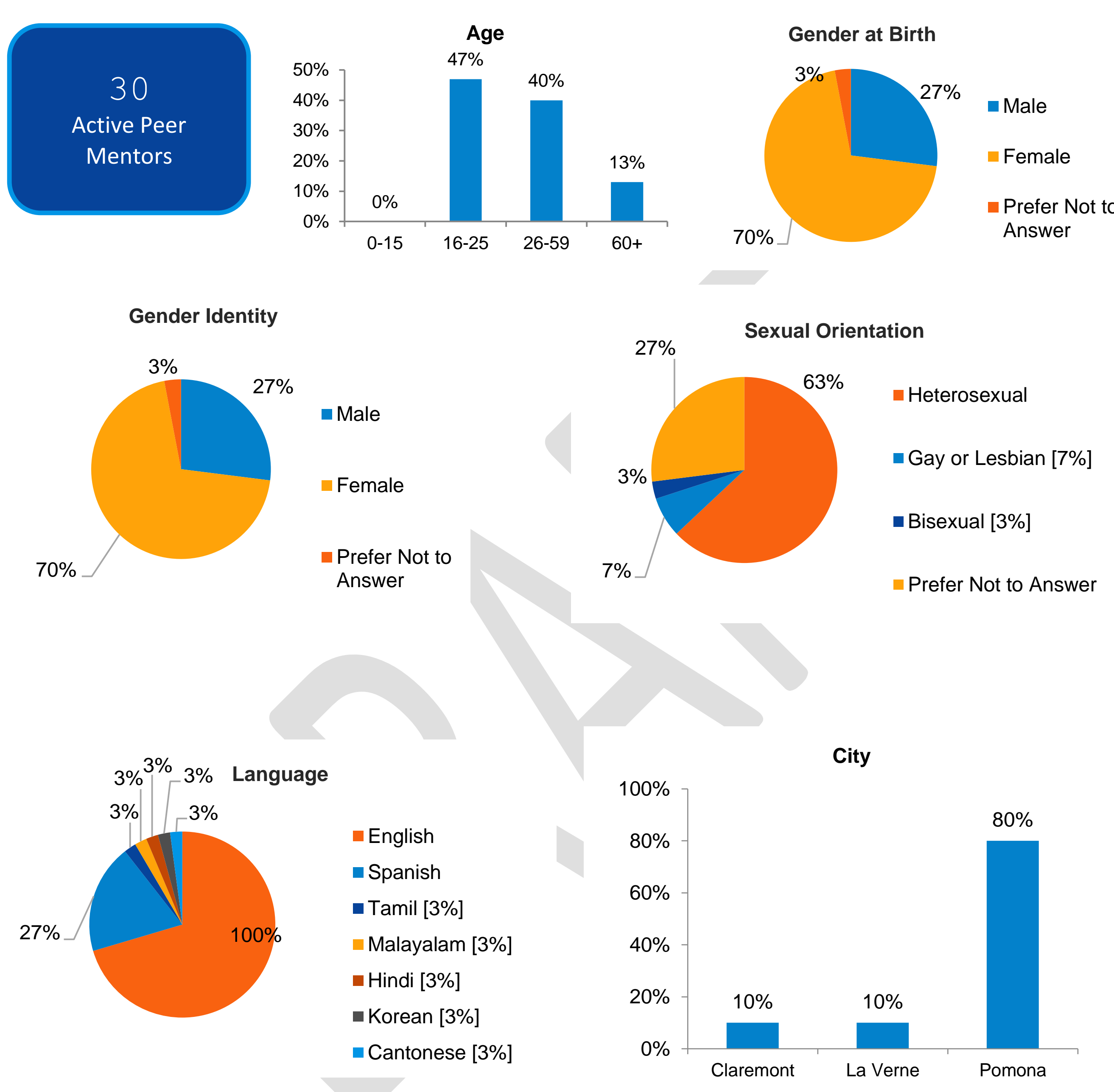
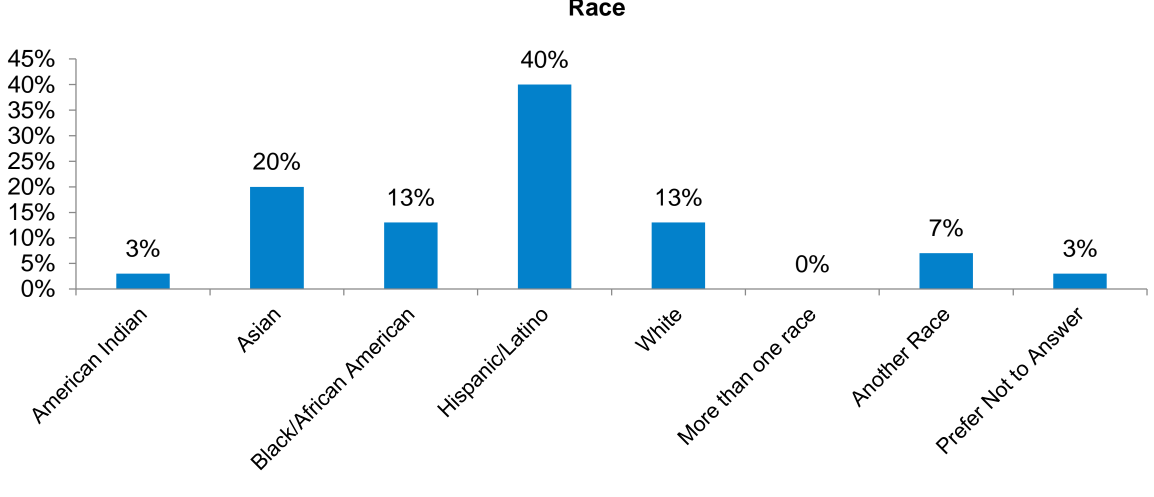
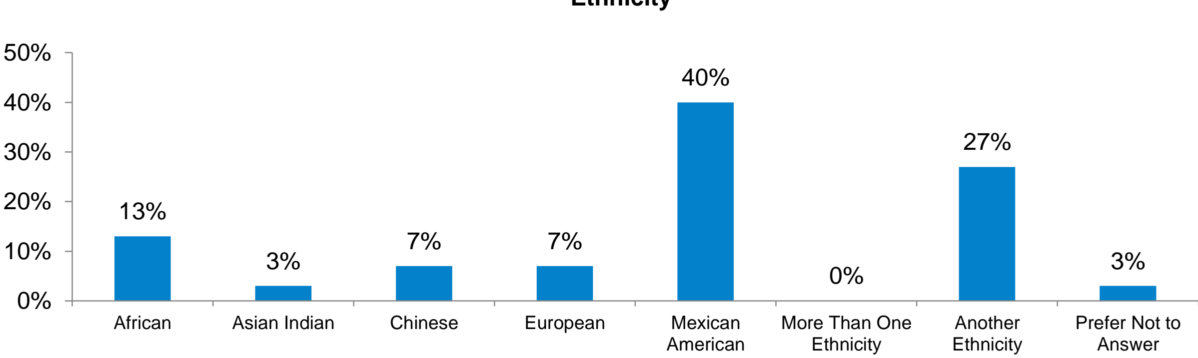
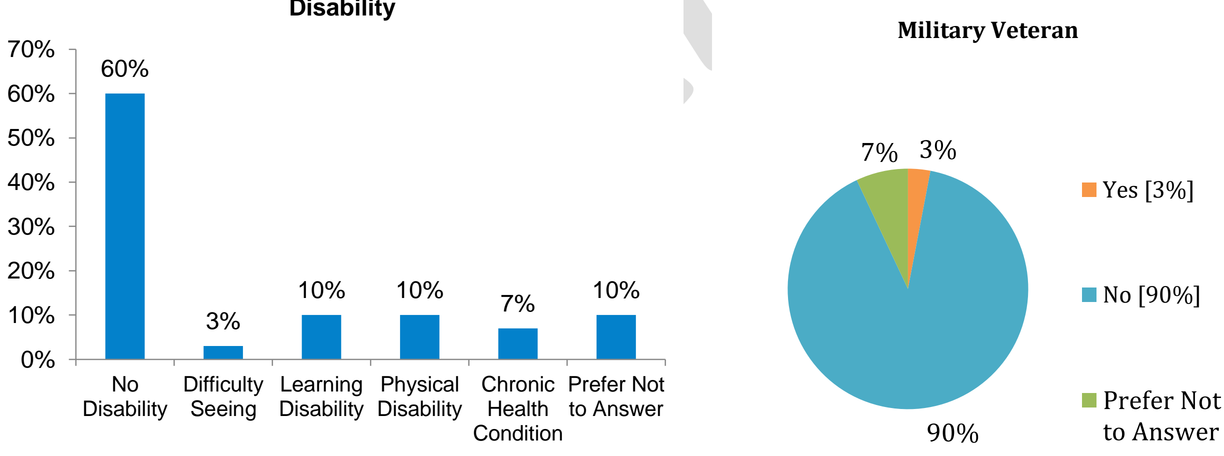
PROGRAM: Peer Mentoring
HOW MUCH DID WE DO?

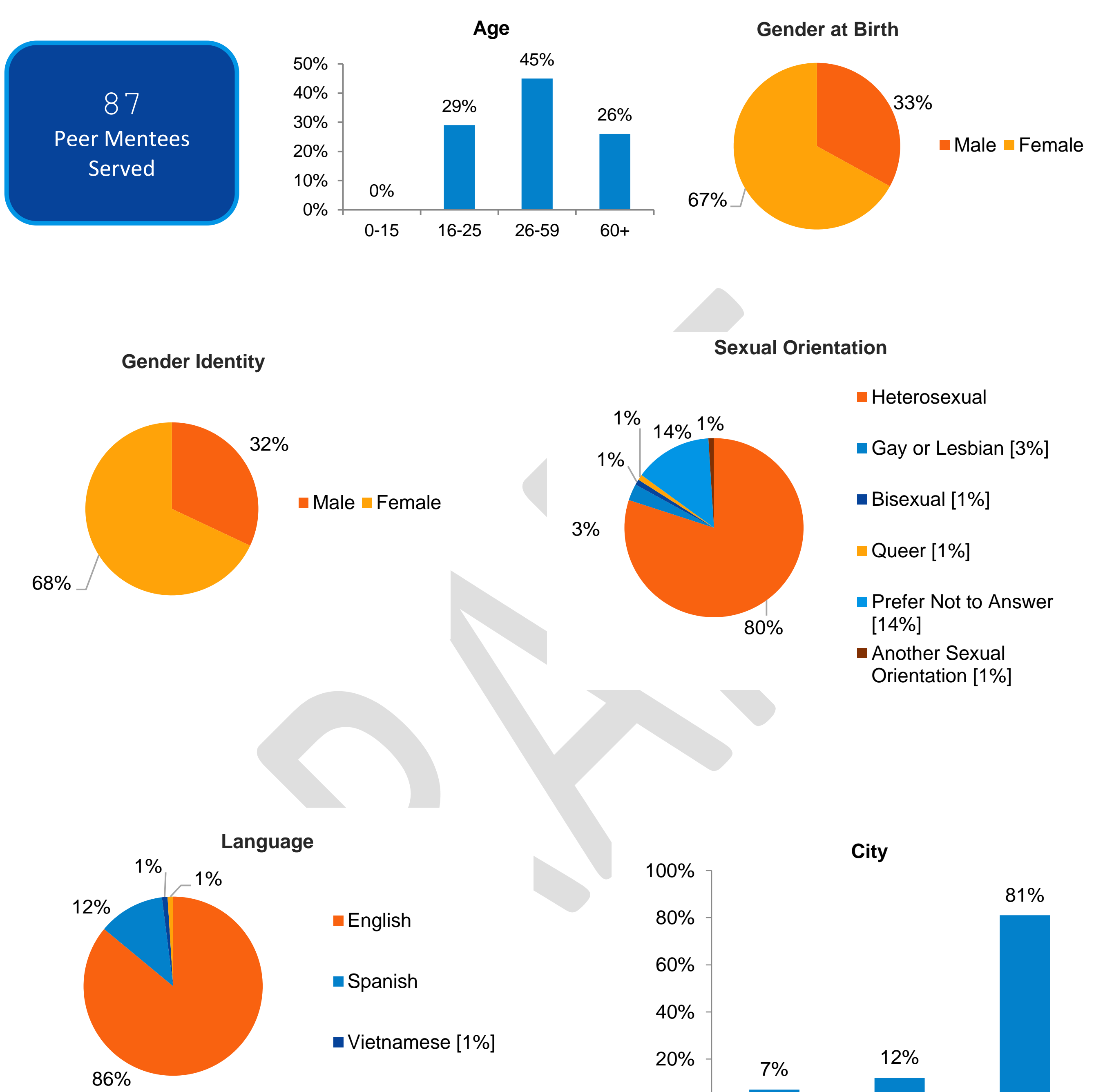



Race
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
3%
20%
13%
40%
13%
0%
7%
3%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More than one race
Another Race
Prefer Not to Answer


Ethnicity
50%
40%
30%
20%
10%
0%
13%
3%
7%
7%
40%
0%
27%
3%
African
Asian Indian
Chinese
European
Mexican American
More Than One Ethnicity
Another Ethnicity
Prefer Not to Answer


Disability
70%
60%
50%
40%
30%
20%
10%
0%
60%
3%
10%
10%
7%
10%
No Disability
Difficulty Seeing
Learning Disability
Physical Disability
Chronic Health Condition
Prefer Not to Answer
Military Veteran
7%
3%
90%
Yes [3%]
No [90%]
Prefer Not to Answer

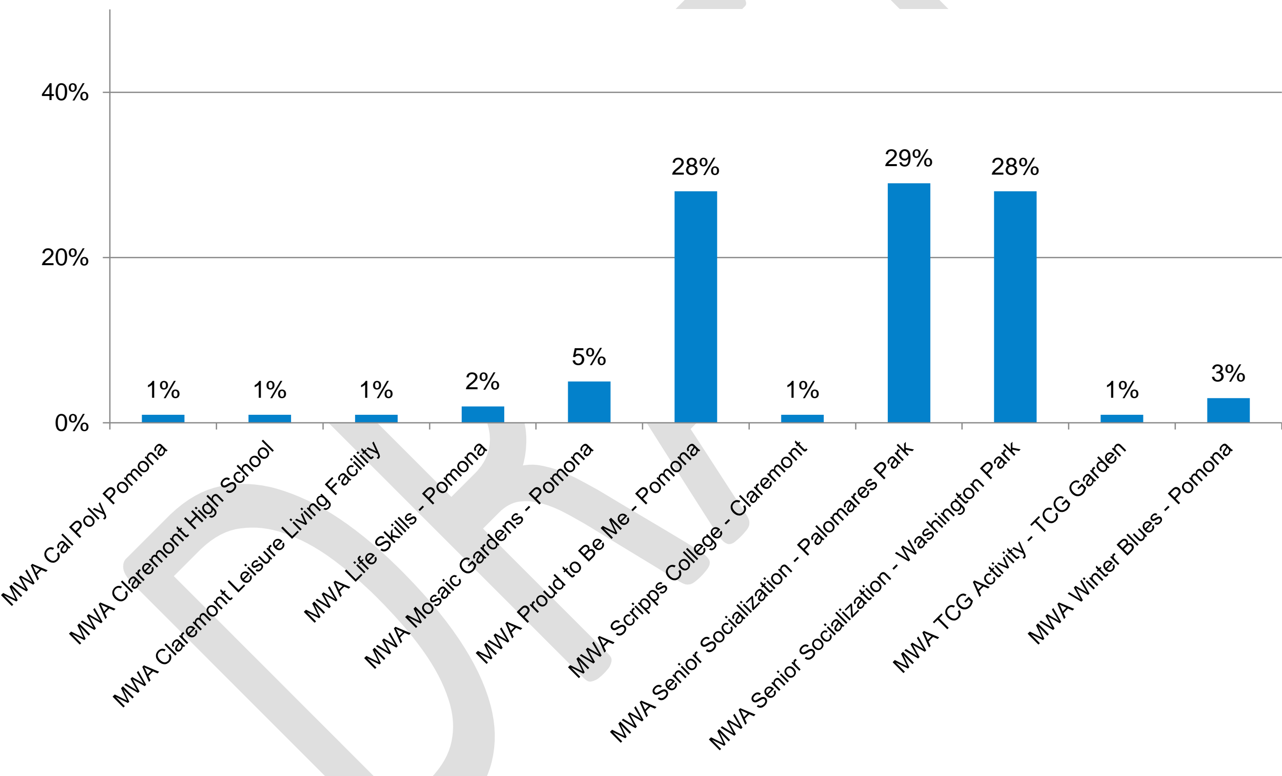
Peer Mentee Demographics



Mental Wellbeing Activities Occurred from July 2019 through March 2020

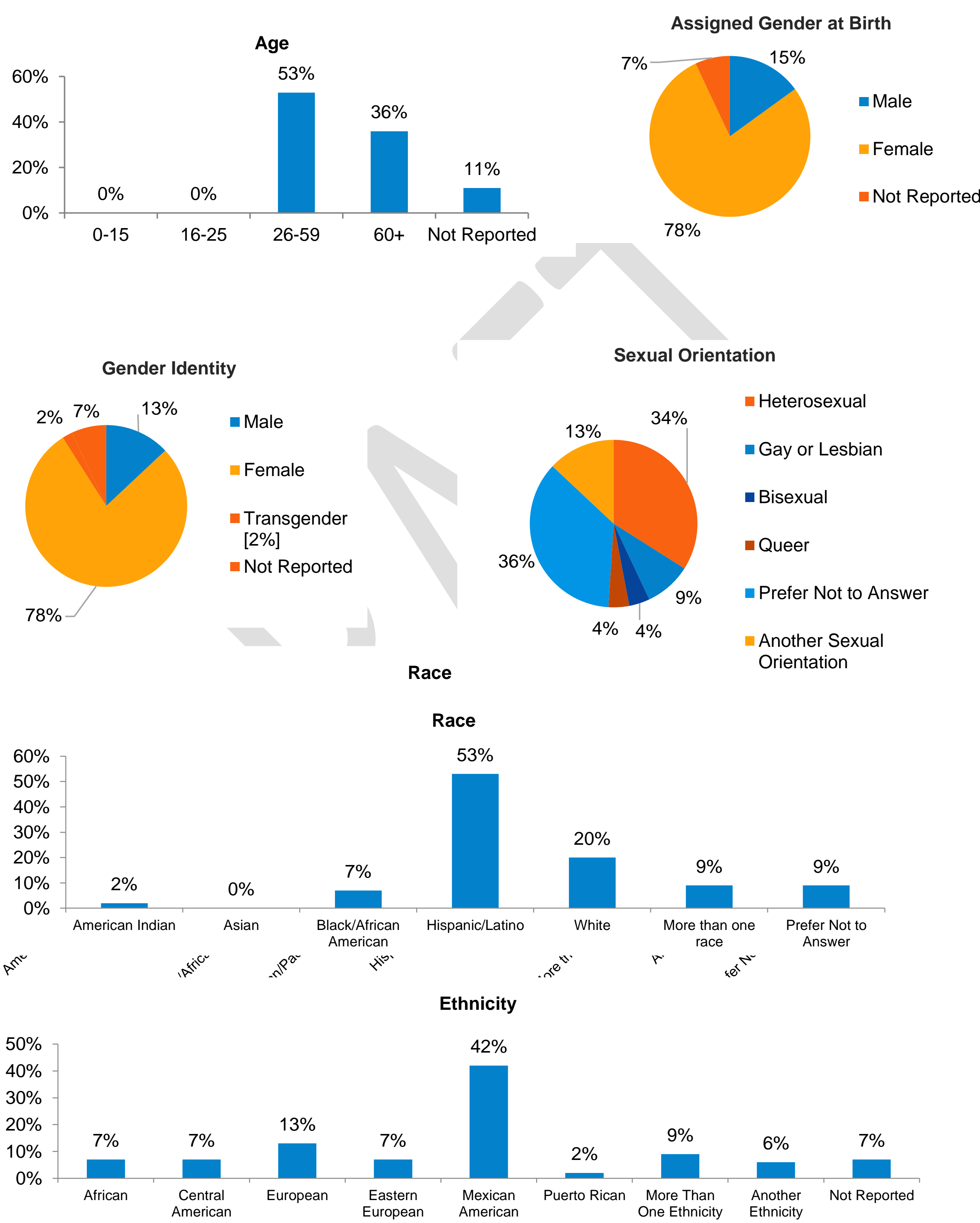
335
Unique Participants at Peer Mentor Mental Wellbeing Activities

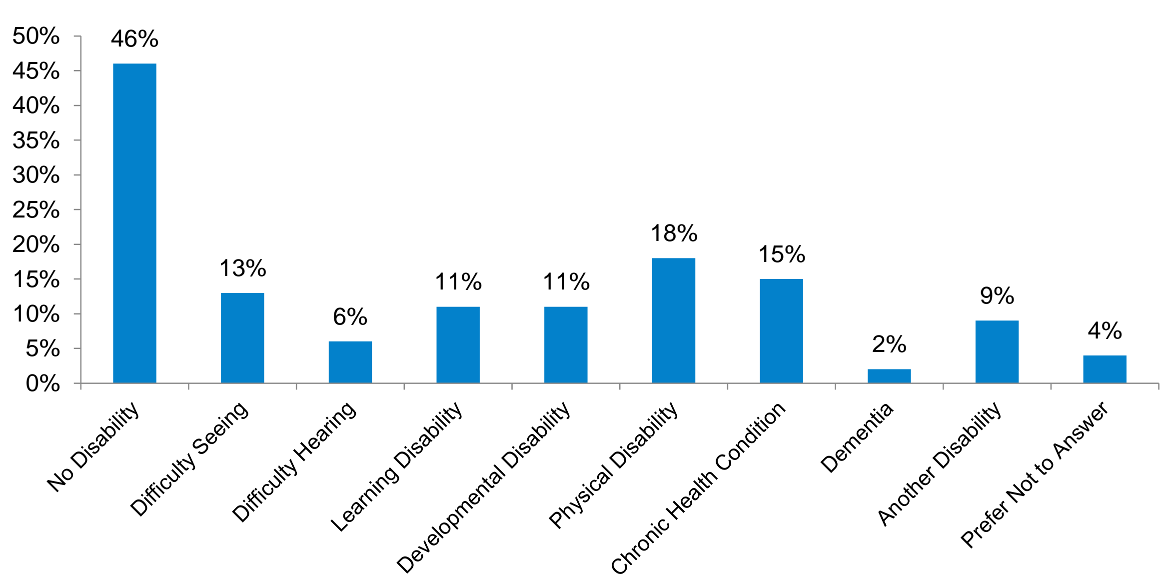
856
Duplicated Participants at Peer Mentor Mental Wellbeing Activities

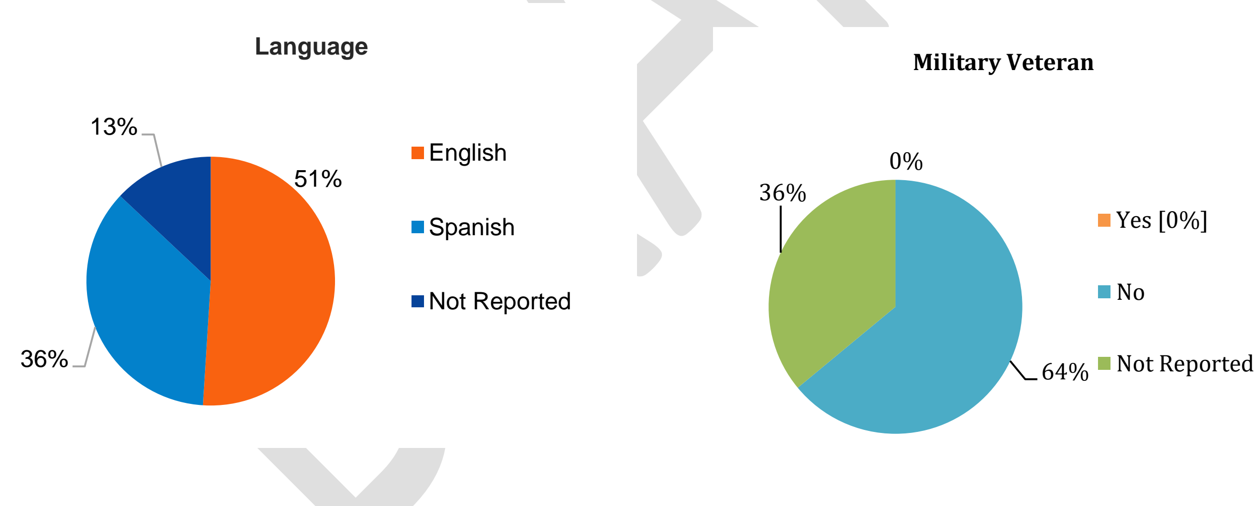


29
Peer Mentor Trainings

PEI Demographics Based on Mental Wellbeing Participants Who Completed Mental Wellbeing Mentor Surveys (n=55)




Disability
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
46%
13%
6%
11%
11%
18%
15%
2%
9%
4%
No Disability
Difficulty Seeing
Difficulty Hearing
Learning Disability
Developmental Disability
Physical Disability
Chronic Health Condition
Dementia
Another Disability
Prefer Not to Answer


Language
13%
51%
36%
English
Spanish
Not Reported
Military Veteran
0%
36%
64%
Yes [0%]
No
Not Reported

HOW WELL DID WE DO IT?

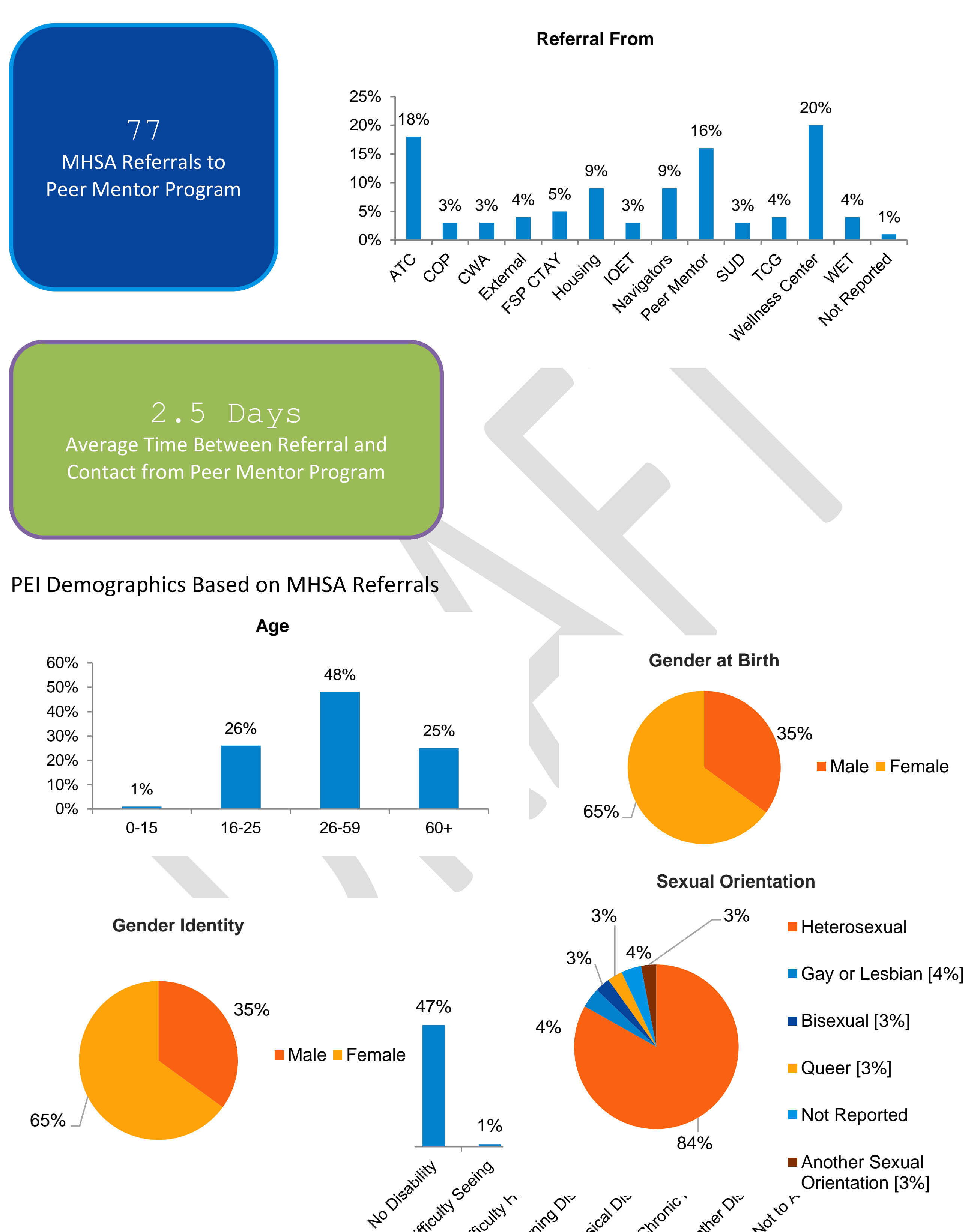
77% 59 out of 77 Referrals Became Mentees	100% Peer Mentees Reported Feeling Comfortable with Their Peer Mentor	1,419 Service Learner Hours Completed by Peer Mentors	96% Individuals Enjoy Participating in Peer Mentor Mental Wellbeing Activities	19 Peer Mentors Self-Identify with Lived Experience, 8 of those 19 Being New Peer Mentors

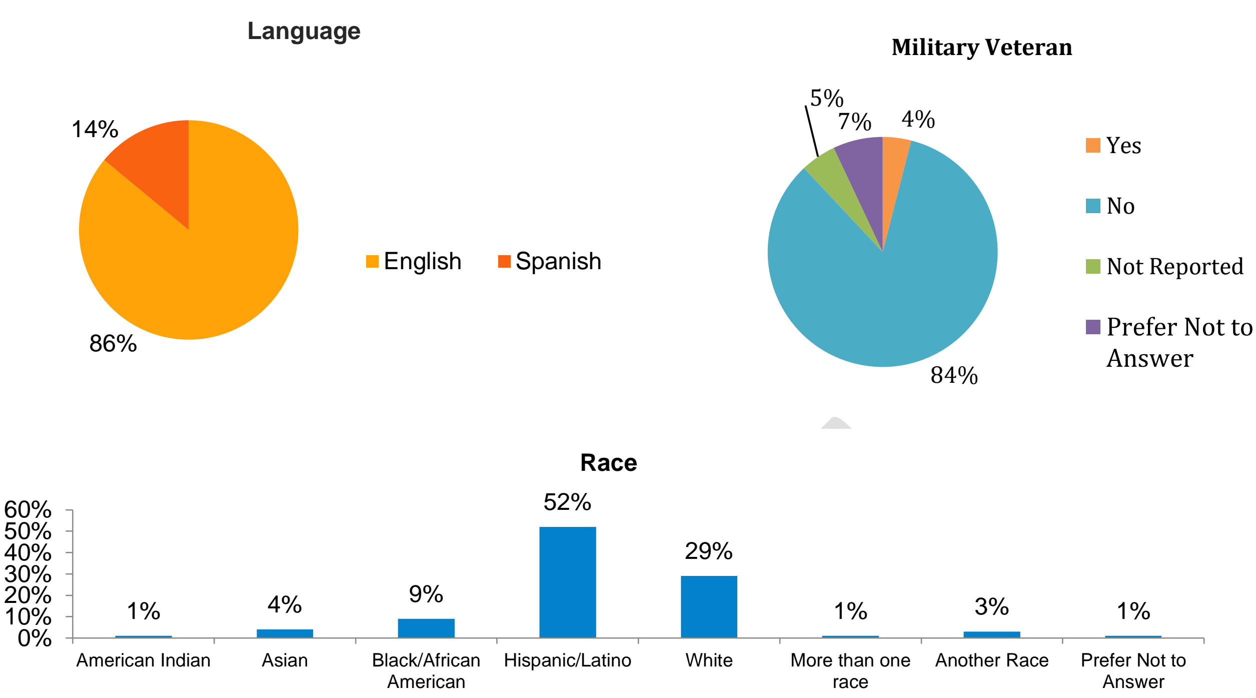
IS ANYONE BETTER OFF?

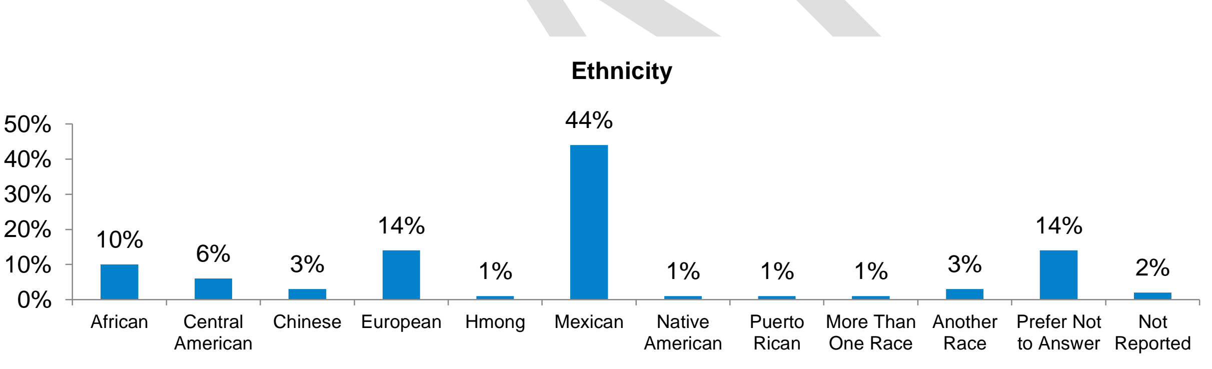
100% Peer Mentors Reported Becoming a Peer Mentor Has Made a Positive Impact in Their Lives	100% Peer Mentees Agreed Peer Mentors Provided Helpful Support in Their First Session	85% Individuals Feel More Confident from the Skills Learned in Peer Mentor Mental Wellbeing Activities

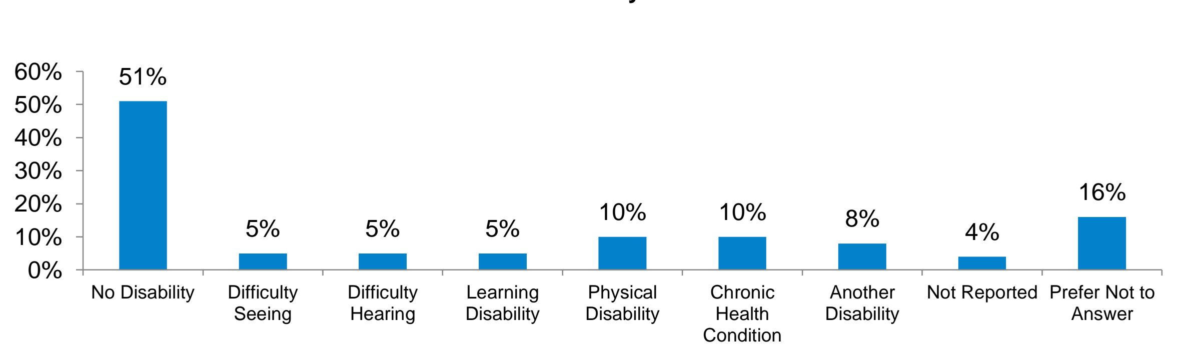
Number of Potential Responders	442
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	TAY, adults, seniors, and those with lived experience
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition age youth, older adults, and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:



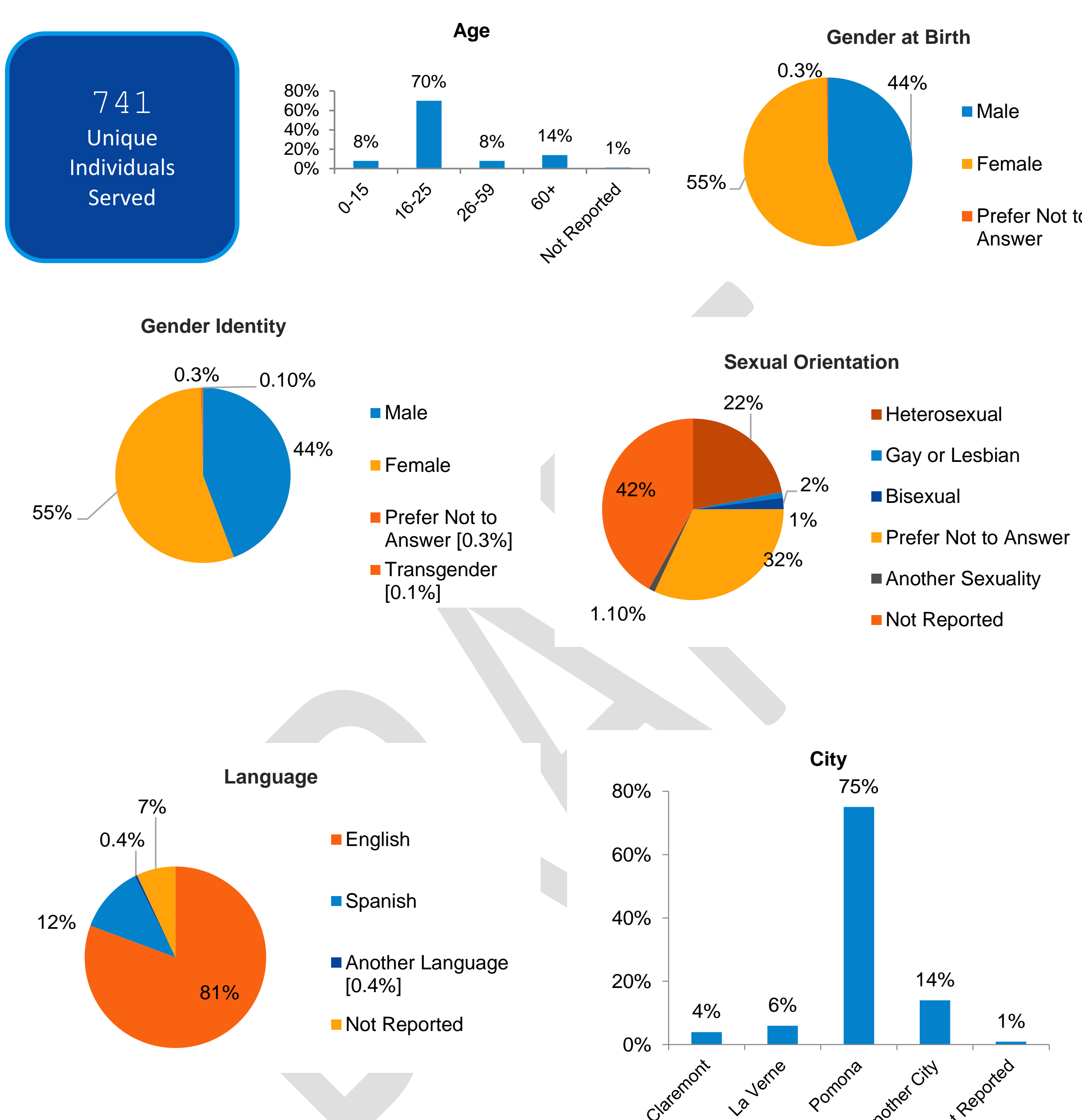

Language
14%
86%
English
Spanish
Military Veteran
5%
7%
4%
84%
Yes
No
Not Reported
Prefer Not to Answer
Race
60%
50%
40%
30%
20%
10%
0%
1%
4%
9%
52%
29%
1%
3%
1%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More than one race
Another Race
Prefer Not to Answer

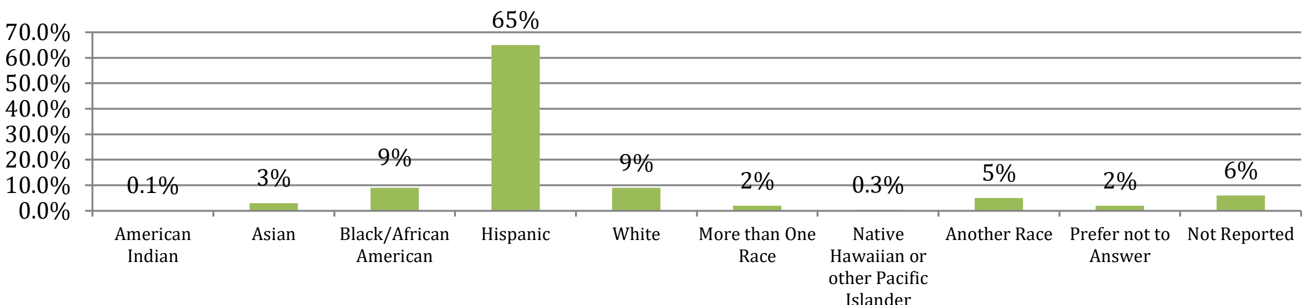

Ethnicity
50%
40%
30%
20%
10%
0%
10%
6%
3%
14%
1%
44%
1%
1%
1%
3%
14%
2%
African
Central American
Chinese
European
Hmong
Mexican
Native American
Puerto Rican
More Than One Race
Another Race
Prefer Not to Answer
Not Reported


Disability
60%
50%
40%
30%
20%
10%
0%
51%
5%
5%
5%
10%
10%
8%
4%
16%
No Disability
Difficulty Seeing
Difficulty Hearing
Learning Disability
Physical Disability
Chronic Health Condition
Another Disability
Not Reported
Prefer Not to Answer

PROGRAM: Wellness Center - PEI

HOW MUCH DID WE DO?





Ethnicity

70%
60%
50%
40%
30%
20%
10%
0%

7% African
0.1% Asian Indian
1.0% Central American
0% Caribbean
0% Chinese
0.3% Eastern European
5.0% European
1% Filipino
0% Hmong
0% Japanese
0% Korean
63% Mexican American
1% Middle Eastern
0% Puerto Rican
0% South American
1.0% Vietnamese
7.0% Another Ethnicity
1.0% More than One Ethnicity
4.0% Prefer not to Answer
6.0% Not Reported

Military Veteran

0.4%
26%
31%
43%
Yes 0.4%
No
Prefer not to Answer
Not Reported

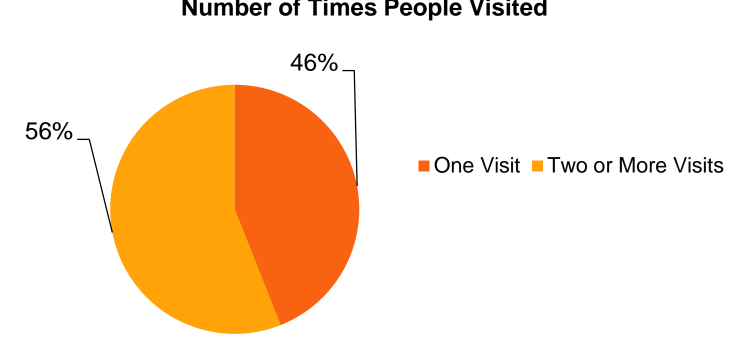
Disability

45%
40%
35%
30%
25%
20%
15%
10%
5%
0%

18% No Disability
1% Difficulty Seeing
1% Difficulty Hearing/Speech
2% Learning
1.0% Chronic Health Condition
0% Physical Mobility
1% Another Disability
33% Prefer not to Answer
42% Not Reported

HOW WELL DID WE DO IT?

3,625
Number of Attendees at Wellness Center Events (Duplicated Individuals)

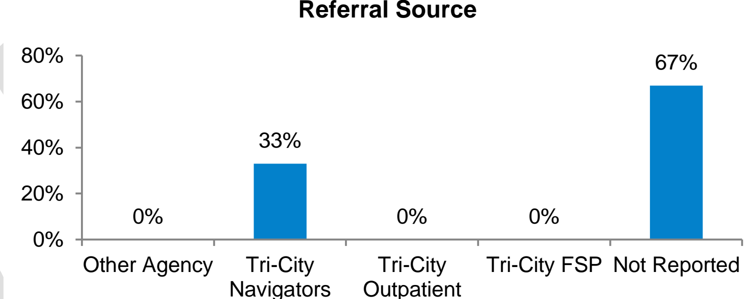


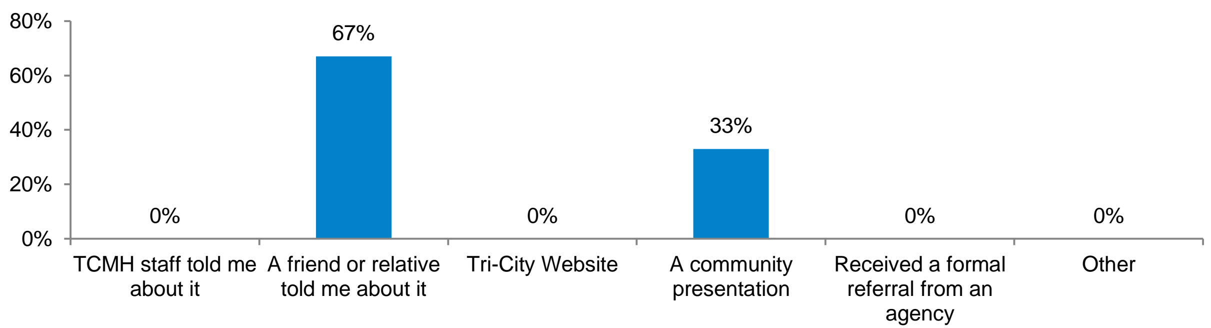
Group Name	Number of Times Group Was Held
Group – Senior Socialization	47
Group (Español) – Comadres y Compadres	50
TAY – Autism Empowerment	2
TAY – RealTalk	20
TAY – Anger Management	39
TAY – Cooking Class	8
TAY – DRA	33
TAY – Friendship Circle	6
TAY – Gaming Group	19
TAY – Karaoke	9
TAY – Literacy Alliance	9
TAY – Positive Painting	6
TAY – Pride	19
TAY – Sacred Heart	6
TAY – Socialization	4
TAY – Stress Me Not	34
TAY – TAY Leadership Committee	8
TAY – TCB	21

TAY – Together We Stand	43
TAY – Walking Group	24

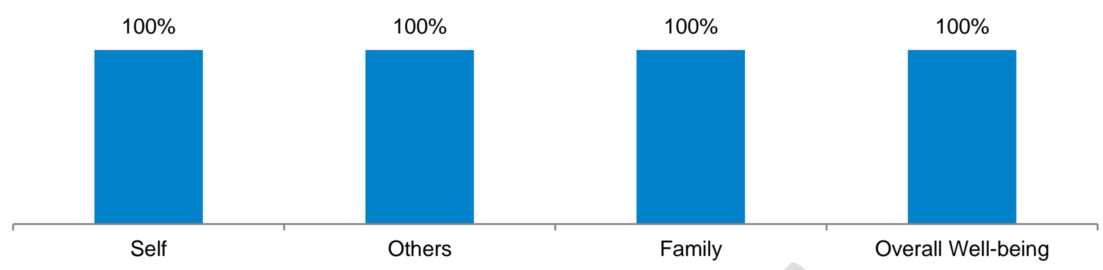
Contacts by Type	Number of Times Contact was Made
TAY – Outing	19
TAY – PC Lab	207
TAY – Phone Call	1,423
TAY – Volunteering	4
TAY – YCES	3

100%
Individuals Satisfied with Wellness Center Programs



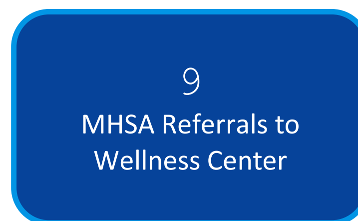


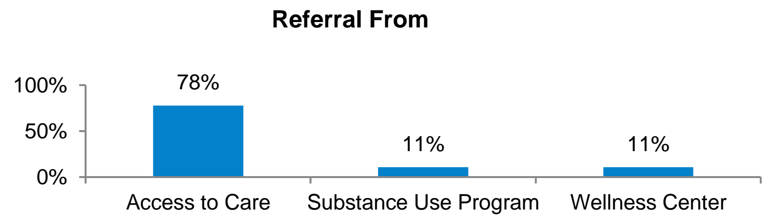
IS ANYONE BETTER OFF?



Number of Potential Responders	741
Setting in Which Responders were Engaged	Community, Wellness Center
Type of Responders Engaged	TAY, adults, seniors
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

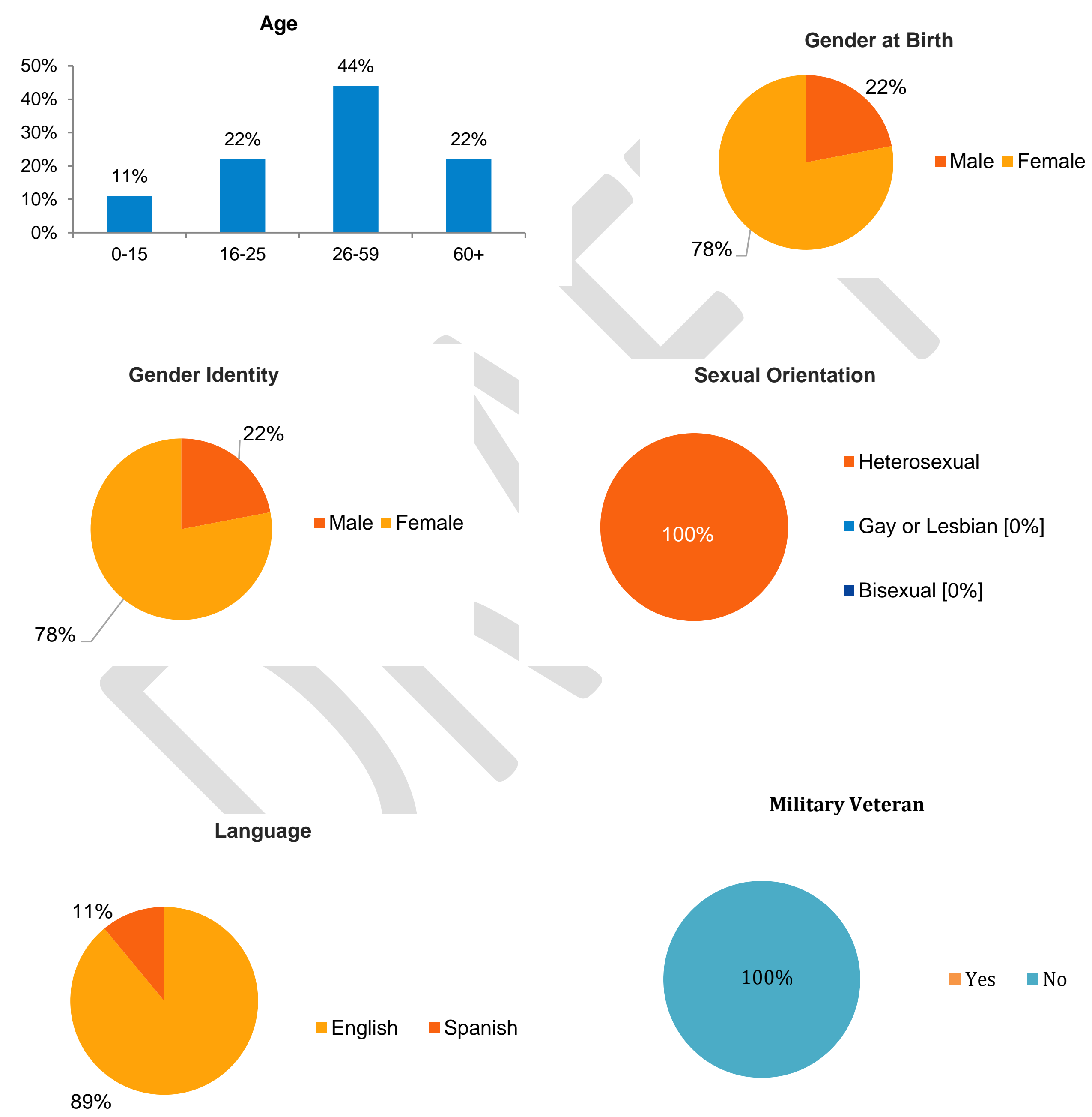


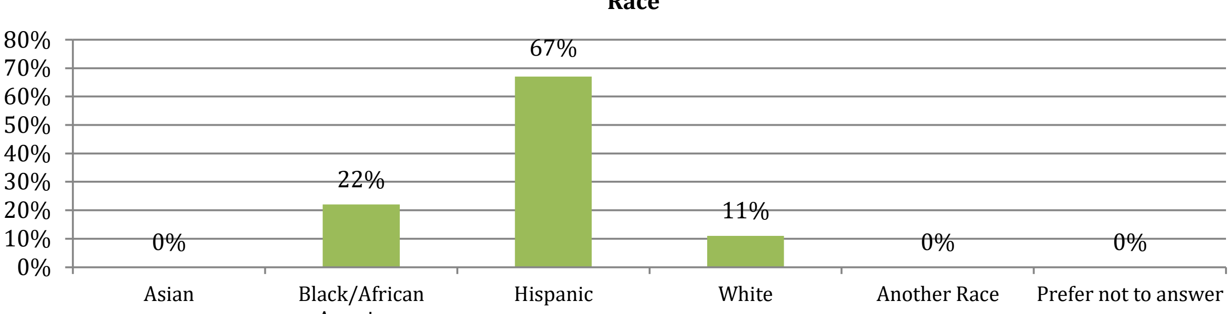


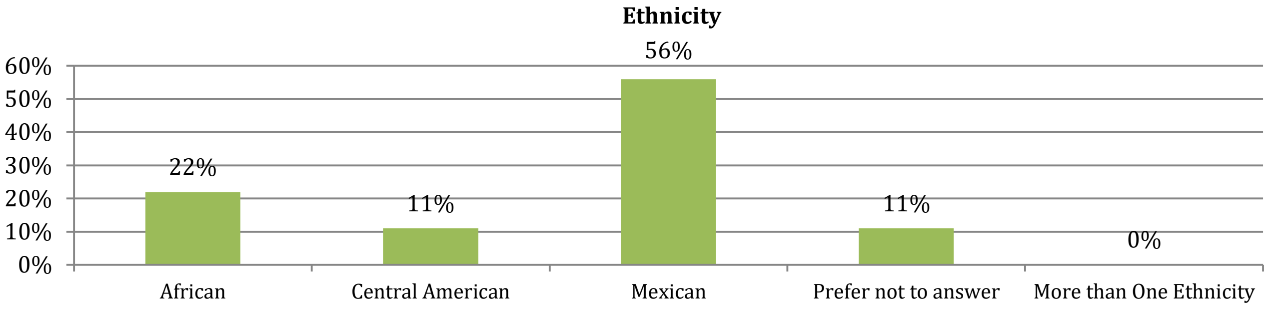
8 out of 9
Referrals Participated in Wellness Center Programs

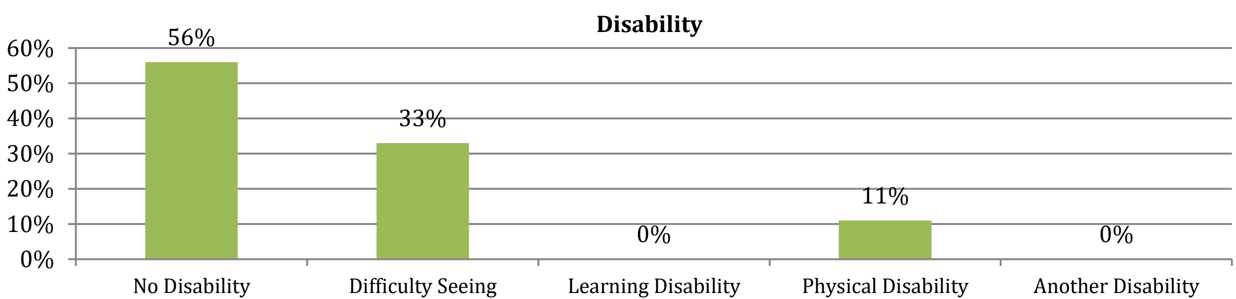
8 Days
Average Time Between Referrals and Participation in Wellness Center

PEI Demographics Based on MHSA Referrals




Race
80%
70%
60%
50%
40%
30%
20%
10%
0%
67%
22%
11%
0%
0%
0%
Asian
Black/African American
Hispanic
White
Another Race
Prefer not to answer


Ethnicity
60%
50%
40%
30%
20%
10%
0%
56%
22%
11%
11%
0%
African
Central American
Mexican
Prefer not to answer
More than One Ethnicity


Disability
60%
50%
40%
30%
20%
10%
0%
56%
33%
0%
11%
0%
No Disability
Difficulty Seeing
Learning Disability
Physical Disability
Another Disability

Family Wellbeing Program

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	___ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention	___ Prevention and Early Intervention		

Program Description

The Family Wellbeing program consists of a dynamic set of programing focused on addressing the needs of the family. Programming includes support groups, 1-1 support, and an array of culturally appropriate activities focused on wellness (e.g. exercise, cooking) and other interests that can attract family members and caregivers from vulnerable communities into peer-supported experiences.

Target Population

Family members and caregivers of people who struggle with mental illness from unserved and under-served communities.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	368	144	605	62	108
Cost Per Person	$71.00	$71.00	$71.00	$71.00	$71.00

Program Update

Prior to the COVID-19 outbreak, the Family Wellbeing (FW) program was focused on creating a new children's group, strengthening existing groups, expanding opportunities for community involvement, and partnering with new agencies in the community.

In September 2019, Family Wellbeing brought back a kid's group for ages 7-12 based on community feedback. Prior to COVID-19, the group averaged 5-7 participants weekly, and this number has remained steady since the pandemic, albeit now being hosted on a virtual platform.

Family Wellbeing also focused on strengthening existing groups, as a way to both bolster participation and attendance. As evidenced by holding a United Family Potluck for families. This event was well received with 34 participants, making up a total of 13 families, served that day.

During FY 2019-20, and prior to the outbreak of COVID-19, United Family also aimed to increase participant involvement in community events held by Tri-City. Two notable events where Family Wellbeing participants took an active role, were the Annual Tree Lighting event at the Wellness Center and the Pomona Christmas Parade in the month of December. During both events, participants from Family Wellbeing Karaoke Group were present to represent Tri-City while singing Holiday carols.

DRAFT

Challenges and Solutions

Two challenges encountered for FWB staff include outreaching to new populations, and transportation issues. When receiving feedback from families in the community, staff found that transportation was a longstanding issue. Family Wellbeing also looked to access new cohorts by connecting with new community hubs that have emerged in the tri-city area.

In hopes of addressing these challenges, and prior to COVID-19, the Family Wellbeing program began hosting groups outside of the Wellness Center. Family Wellbeing had partnered with Pomona Wellness Community to host an Arts and Crafts group that was averaging 10 participants, and looking to begin hosting multiple other groups there as well. These efforts will continue once the pandemic restrictions are lifted.

COVID-19 Response

Following the outbreak of COVID 19, Family Wellbeing was impacted significantly. Due to changes in both staffing locations and the restrictions on providing in-person services, Family Wellbeing programing stopped completely and slowly began a re-building phase using a virtual platform. With this dramatic change in mind, FWB was charged with finding innovative ways to provide service. Options included the use of phones, email, and virtual platforms which for most families, was a viable method of communication. However, for some families, these options were limited based on lack of access. Community agency connections were somewhat easier to maintain.

A major challenge encountered was transitioning all FWB programing to a virtual platform, including Summer Camp, which was originally designed to be an in-person format. During the summer of 2020, Summer Camp was successfully transitioned to a virtually format. This popular program served 12 campers and their families. Campers were provided with a platform to use as well as supplies needed to complete activities, all delivered to their door using contactless delivery methods. Campers met virtually once a week, and maintained communication via phone and email. The feedback from the campers and parents was positive with families expressing gratitude for the opportunity to maintain some sense of normalcy during a difficult time. Seventy-five percent of participants were returning campers from previous sessions.

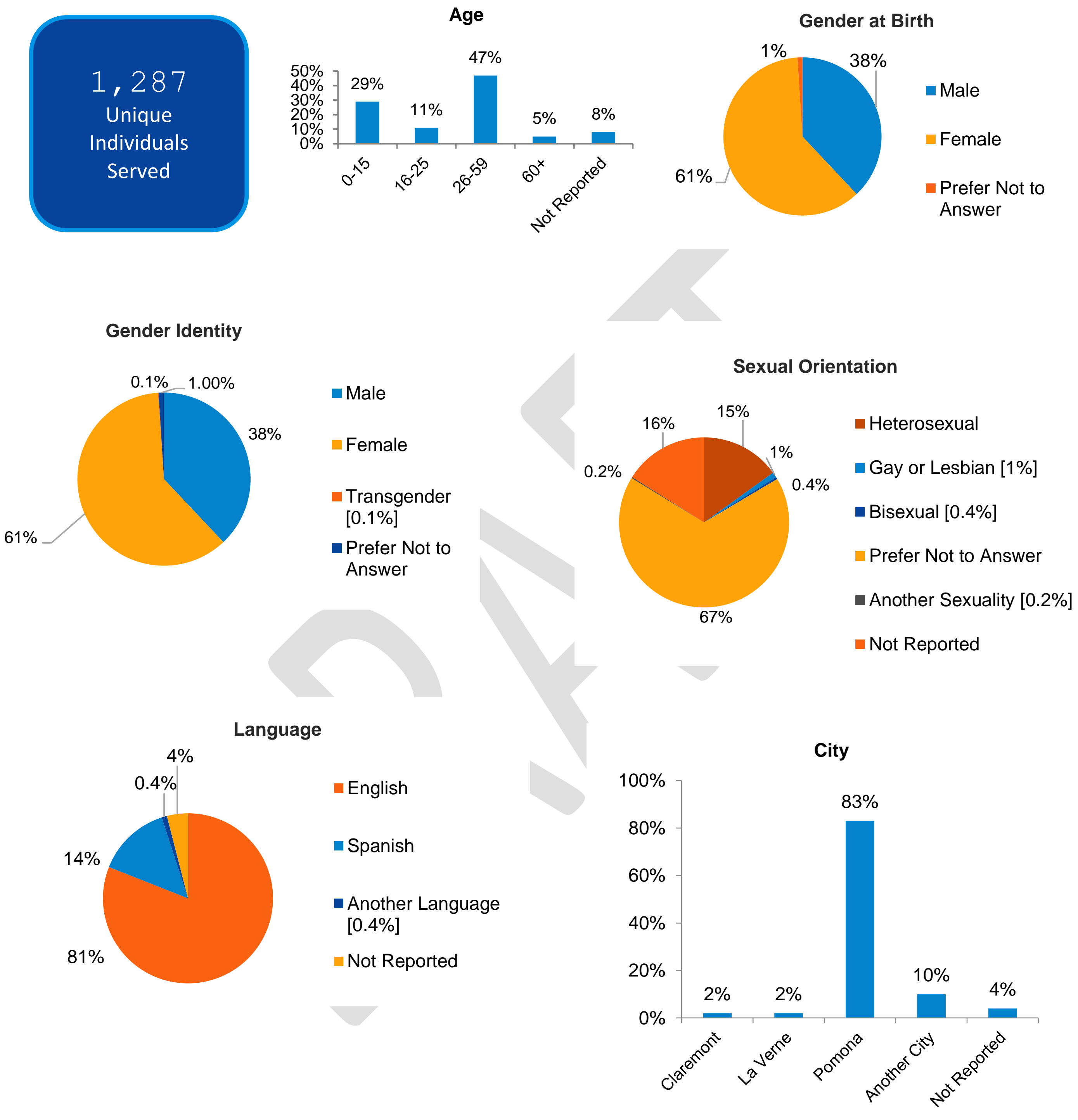
Cultural Approach

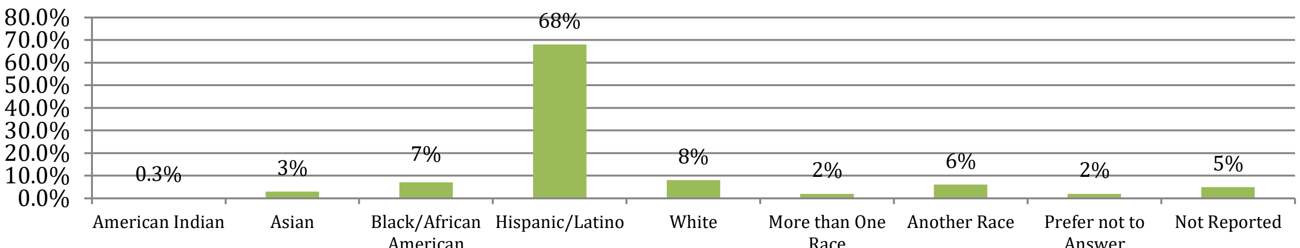
The Family Wellbeing program is available in both English and Spanish. Staff are bilingual and information brochures are available in multiple languages.

Another asset to the Family Wellbeing team is having staff who identify at LGBTQ+. These individuals attempt to address issues that can lead to barriers to seeking services as well stigma concerns. Also, FWB is meeting the community “where they are” by hosting groups at locations they are familiar with or current gathering.

DRAFT

PROGRAM: Family Wellbeing Program
HOW MUCH DID WE DO?





Ethnicity

80%
70%
60%
50%
40%
30%
20%
10%
0%

6% African
0.4% Asian Indian
1% Caribbean
0% Chinese
7.0% European
1% Filipino
0% Korean
68% Mexican American
1% Middle Eastern
0% Puerto Rican
0% South American
1.0% Vietnamese
6.0% Another Ethnicity
1.0% More than One Ethnicity
3.0% Prefer not to Answer
5.0% Not Reported

Military Veteran

0.4%
18%
65%
16%

Yes [0.3%]
No
Prefer not to Answer
Not Reported

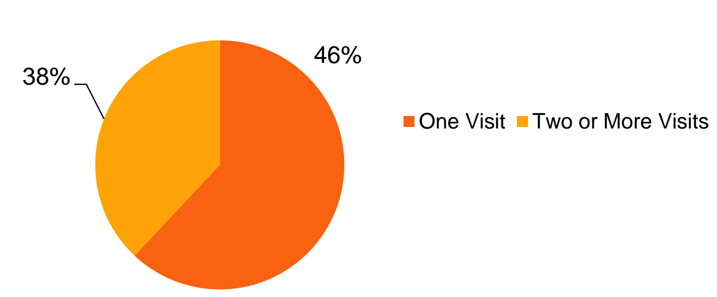
Disability

70%
60%
50%
40%
30%
20%
10%
0%

11% No Disability
1% Difficulty Seeing
0.3% Difficulty Hearing/Speech
0% Developmental Disability
0% Learning Disability
1.0% Chronic Health Condition
0% Physical Mobility
3% Another Disability
66% Prefer not to Answer
16% Not Reported

HOW WELL DID WE DO IT?

5,284
Number of Attendees at Family Wellbeing Events

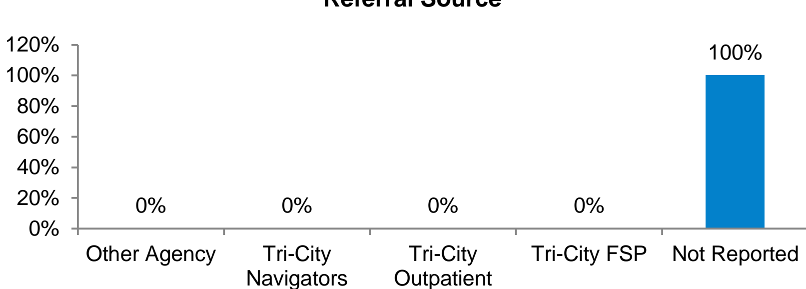


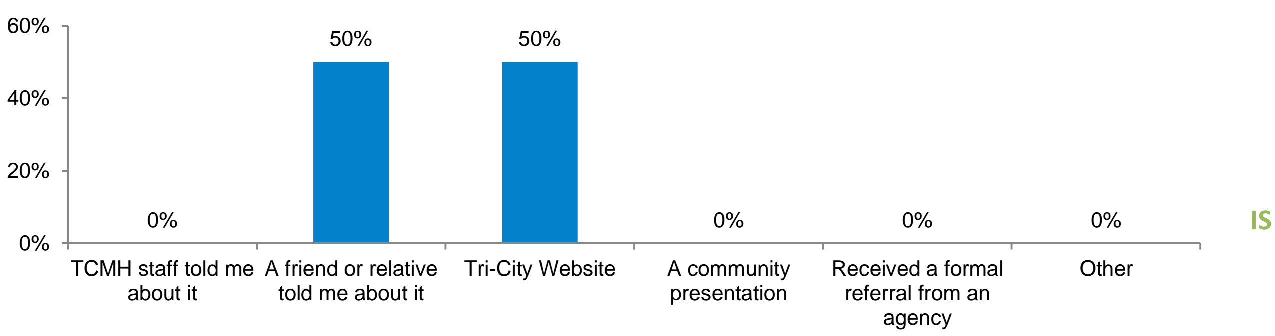
Group Name	Number of Times Group Was Held
FWS – Arts & Crafts	22
FWS – Attendance Letter	61
FWS – Bore No More	7
FWS – Cooking Class	2
FWS – Creative Writing	15
FWS – Grief & Loss	37
FWS – Kid's Hour	25
FWS – Limited to Limitless	43
FWS – Mommy & Me	24
FWS – Movie Night	34
FWS – Music	35
FWS – Sacred Heart	12
FWS – Spirituality	35
FWS – STEP Anger Management	1
FWS – Summer Camp	22
FWS – Teen Anger Management	25
FWS – Teen Hour	37

FWS – United Family	34
FWS – Walking Adventure	36
FWS – Writing to Heal	31

Contacts by Type	Number of Times Contact was Made
FWS – Brief Check-in	527
FWS – One-on-One	99
FWS – Other	83
FWS – Phone Call	892

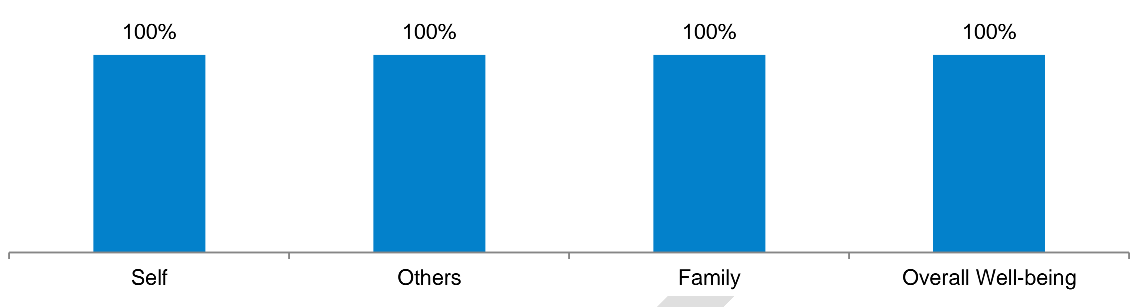
100%
Individuals Family Wellbeing Program





IS

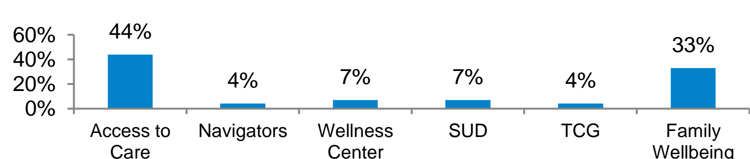
ANYONE BETTER OFF?



Number of Potential Responders	1,287
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Parents and children
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-age youth, older adults and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

27
MHSA Referrals to Family Wellbeing



23 out of 27
Referrals Participated in Family Wellbeing Program

12 Days
Average Time Between Referrals and Participation in Family Wellbeing

Age

Age	Percent
0-15	4%
16-25	22%
26-59	70%
60+	0%
Not Reported	4%

Gender at Birth

Male 22%
Female 78%

Gender Identity

Male 22%
Female 78%

Sexual Orientation

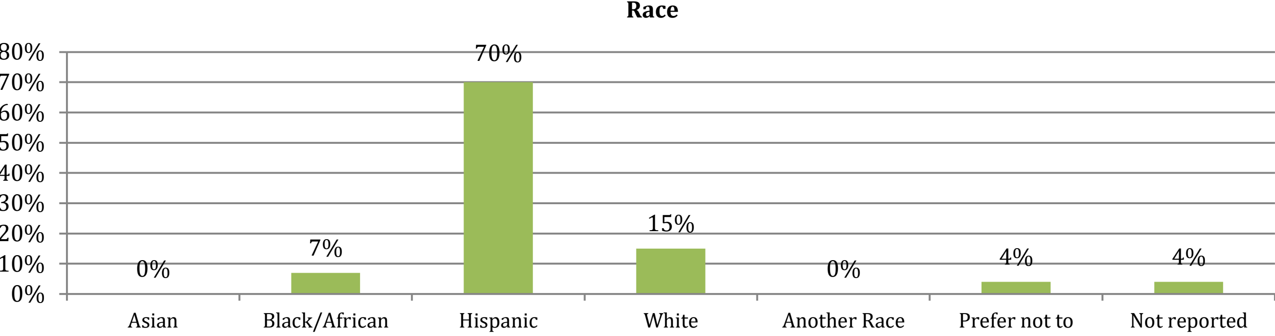
Heterosexual 92%
Gay or Lesbian 4%
Prefer Not to Answer 4%

Language

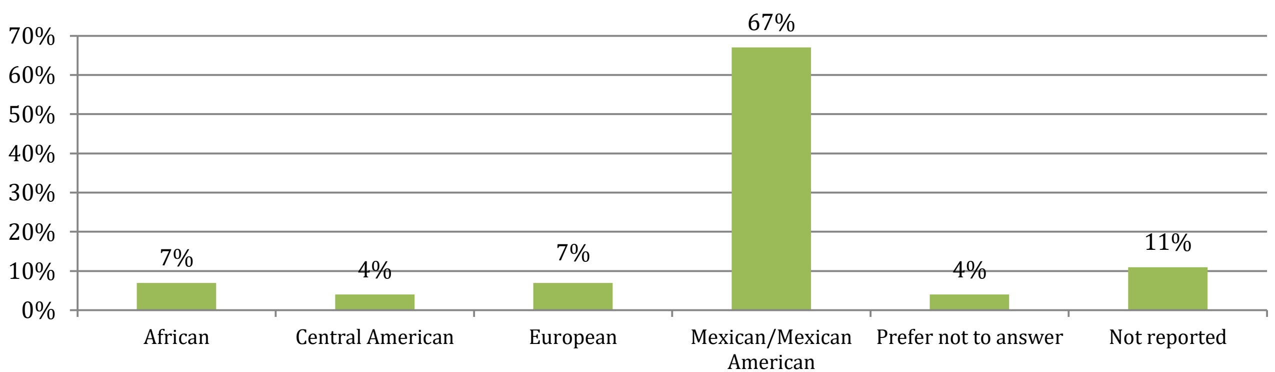
English 63%
Spanish 37%

Military Veteran

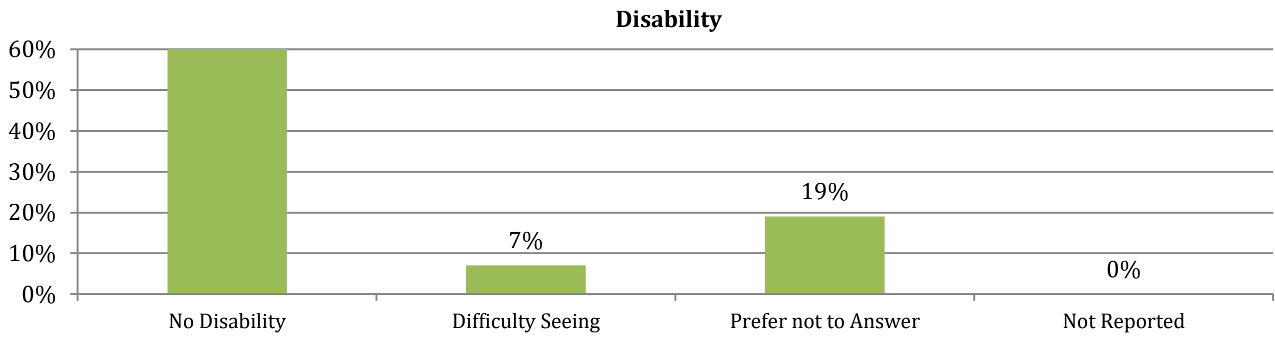
No 81%
Prefer Not to Answer 19%



Race
80%
70%
60%
50%
40%
30%
20%
10%
0%
0%
7%
70%
15%
0%
4%
4%
Asian
Black/African American
Hispanic
White
Another Race
Prefer not to answer
Not reported



Ethnicity
70%
60%
50%
40%
30%
20%
10%
0%
7%
4%
7%
67%
4%
11%
African
Central American
European
Mexican/Mexican American
Prefer not to answer
Not reported



Disability
60%
50%
40%
30%
20%
10%
0%
7%
19%
0%
No Disability
Difficulty Seeing
Prefer not to Answer
Not Reported

NAMI: Ending the Silence

Status of Program:	_X_ New	___ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	___ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention		___ Prevention and Early Intervention	

<u>Program Description</u>

Ending the Silence is a community presentation offered by the National Alliance on Mental Illness (NAMI). This 50-minute program is designed to teach students, school staff and families to recognize the warning signs of mental health issues and what steps to take when they observe these symptoms in their students, friends or loved ones.

<u>Target Population</u>

Ending the Silence offers three separate presentations targeting; 1) middle and high school students; 2) teachers and school staff; and 3) adults with middle or high school youth.

Number of Trainings for FY 2019-20	8
Number of Attendees for FY 2019-20	346

Program Update

Prior to the COVID-19 outbreak, NAMI Pomona Valley (NPV) was on track to increase collaboration with local community partners and, thereby, increasing participation in their support and education programs. Additionally, NPV made plans to increase awareness among community stakeholders with an eye toward promoting the Ending the Silence (ETS) program, as well as support groups offered through the Community Services and Supports program. Notably, the Spanish language outreach efforts had increased.

<u>Challenges and Solutions</u>

Challenges with ETS continues to be logistical. As a school-based program, the mechanics of contacting schools, and confirming a commitment to host the training has proven to take an inordinate amount of time. Convincing school official of the value of this training, as well as scheduling the time for these presentations, continues to be an obstacle to implementing this training on a larger scale. In response to this, NPV has secured an intern who is dedicated to contact and coordinate with school officials in hopes of building a strong collaboration which will include this essential training.

<u>COVID-19 Response</u>

The Ending the Silence program was devastated by the COVID-19 outbreak insofar as the schools shut down eliminated the opportunity to provide the in-person ETS presentations. Although NPV attempted to transition the presentations to a virtual platform, these efforts were largely unsuccessful when the shutdown first happened as schools were grappling with more fundamental issues. As a result of the school shut down, getting a response from school personnel proved all but impossible. Therefore,

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presentations could not be arranged. However, efforts continue to try and improve the delivery of the ETS presentations and evaluation process using an online and web- based format.

Cultural Approach

NAMI is highly committed to cultural inclusion and offers the Ending the Silence program in both English and Spanish. In addition, efforts are made to recruit diverse populations as program leaders. All outreach and program materials are available in both English and Spanish. At this time, NAMI PV does not have a dedicated strategy to addressing barriers to the LGBTQ+ community who may be seeking services. Future efforts include distinct and consistent efforts to outreach to underserved and unserved groups and organizations, in the hopes of enhancing current practices in providing access to services.

PROGRAM: NAMI – Ending the Silence

HOW MUCH DID WE DO?

8
Presentations

346
Attendees

HOW WELL DID WE DO IT?

100%
Agreed or strongly agreed that the presentation increased their understanding of symptoms associated with mental health challenges

100%
Agreed or strongly agreed that the presentation will help them recognize early warning signs of mental health challenges

IS ANYONE BETTER OFF?

100%
Agreed or strongly agreed that the presentation provided them with new and useful resources

100%
Agreed or strongly agreed that the presentation helped them understand the impact of untreated mental health challenges

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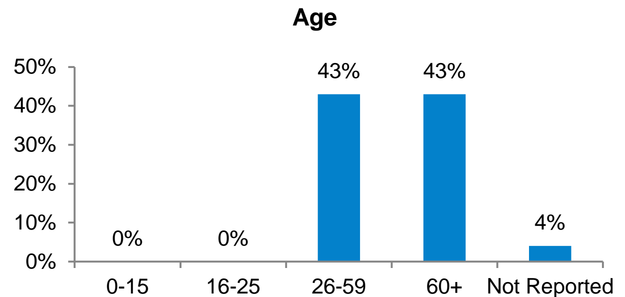
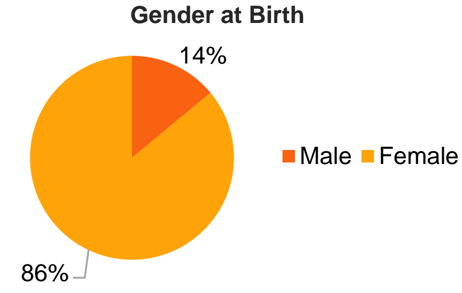
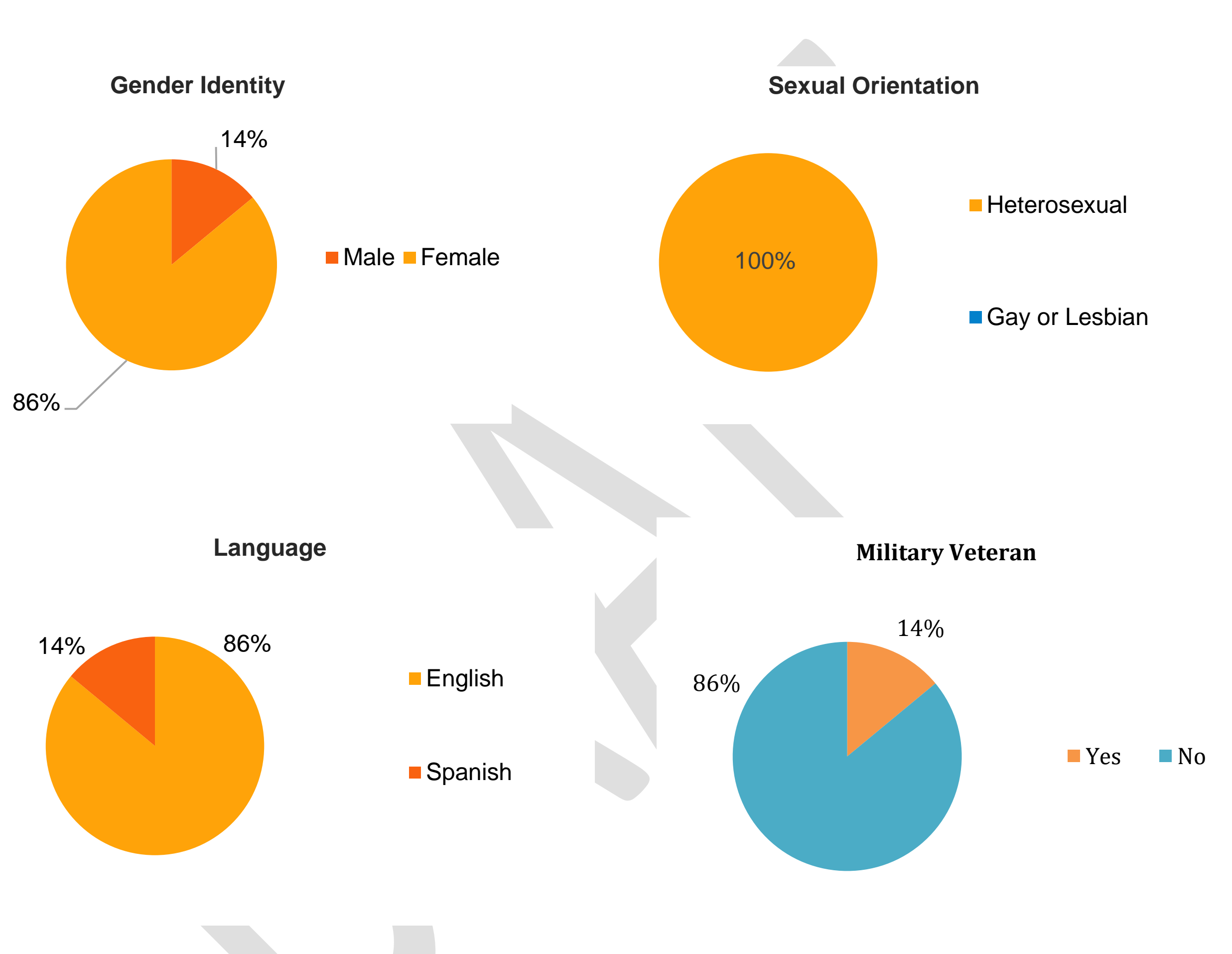
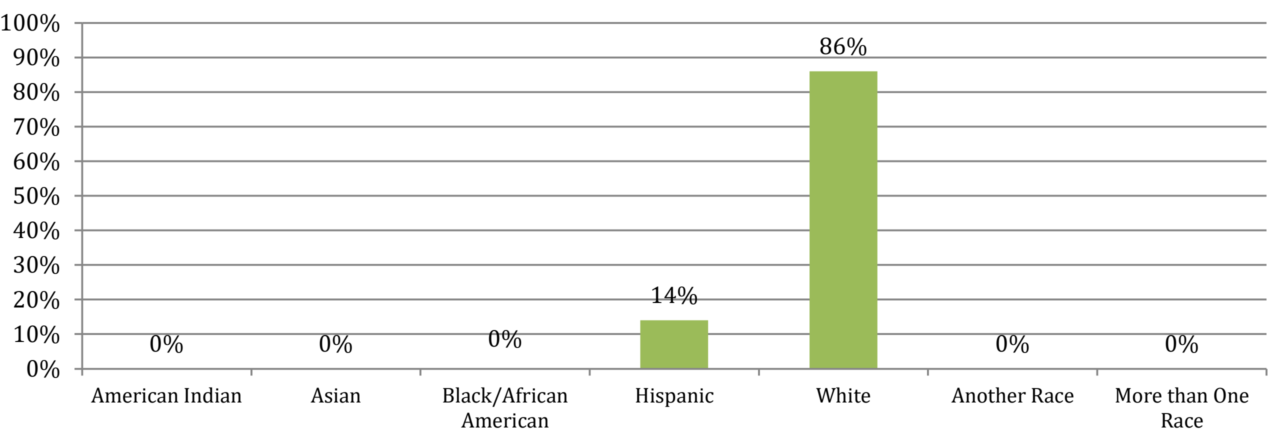

Age
50%
40%
30%
20%
10%
0%
0%
0%
43%
43%
4%
0-15
16-25
26-59
60+
Not Reported


Gender at Birth
14%
86%
Male
Female

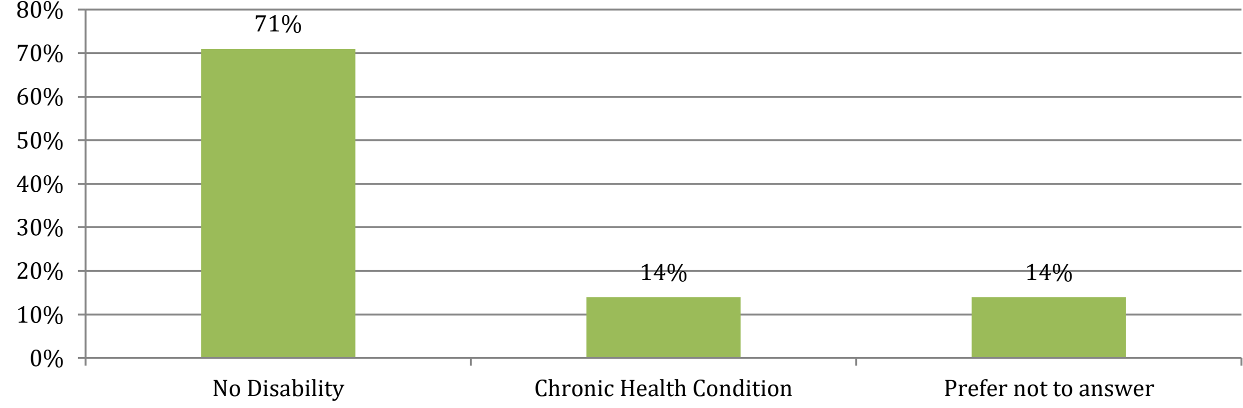

Gender Identity
14%
86%
Male
Female
Sexual Orientation
100%
Heterosexual
Gay or Lesbian
Language
14%
86%
English
Spanish
Military Veteran
14%
86%
Yes
No



Ethnicity

100%
80%
60%
40%
20%
0%

Central American	European	Not Reported
14%	57%	29%



Number of Potential Responders	346
Setting in Which Responders were Engaged	Schools
Type of Responders Engaged	Teachers and school staff, middle and high school students, adults with middle or high school youth
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

1
MHSA Referral to NAMI

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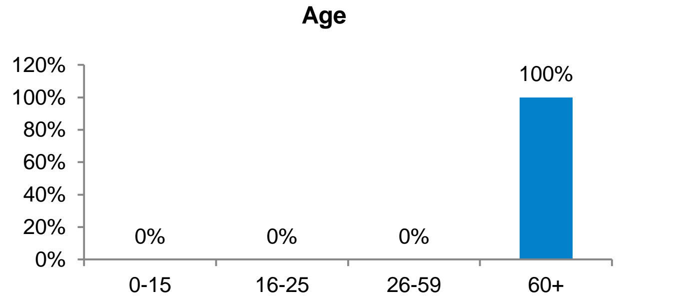
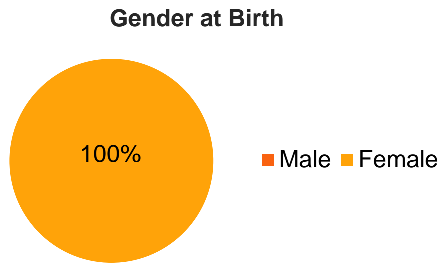
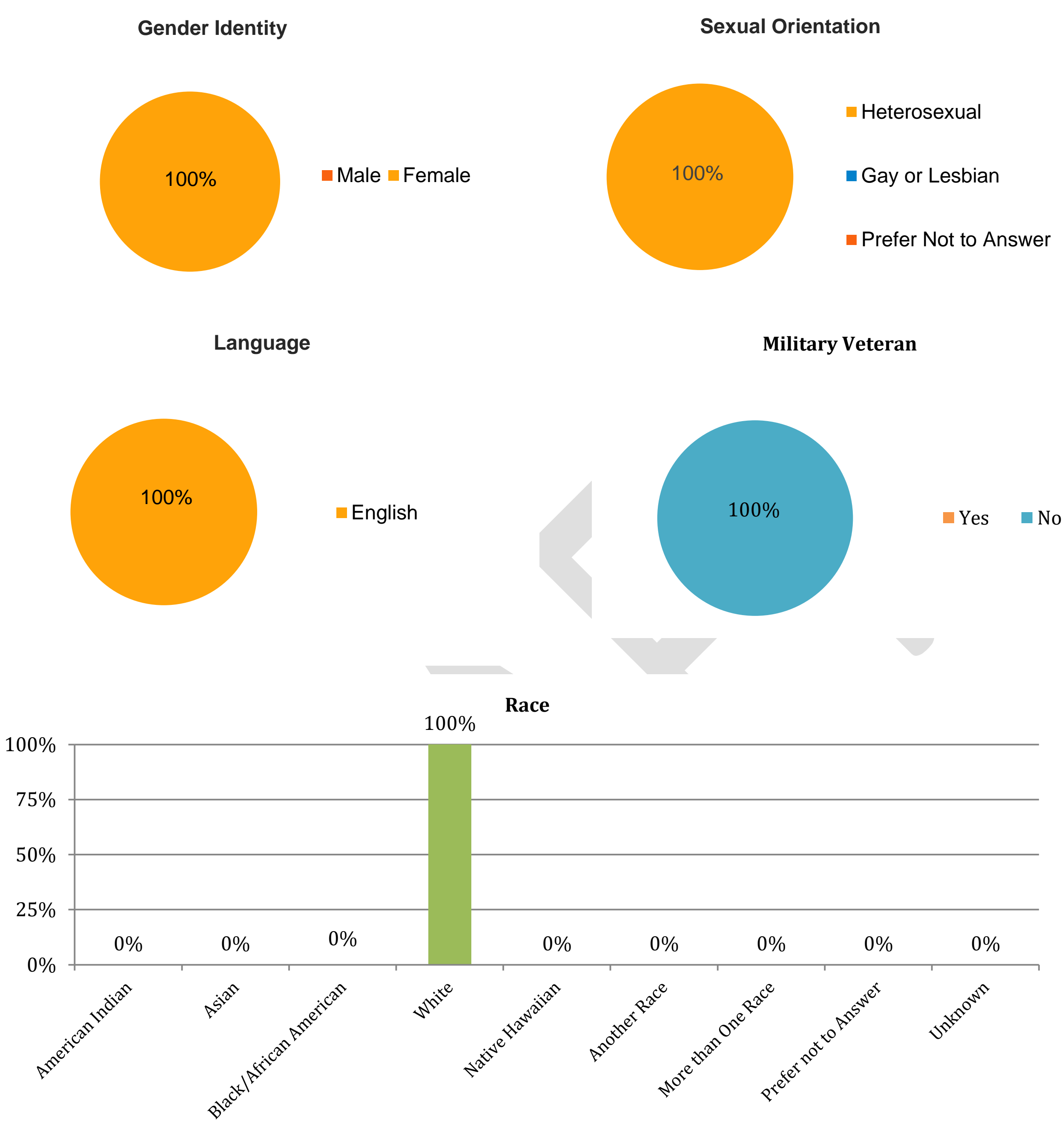
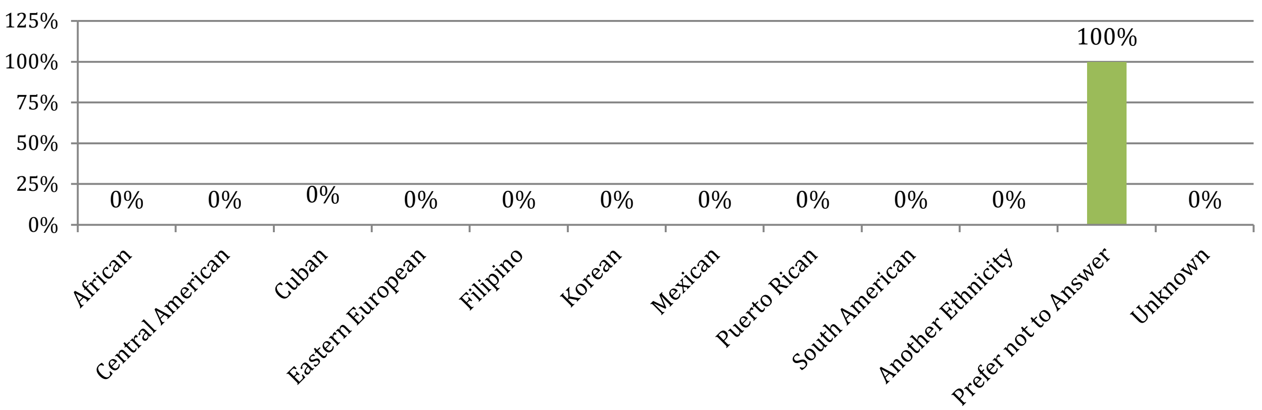
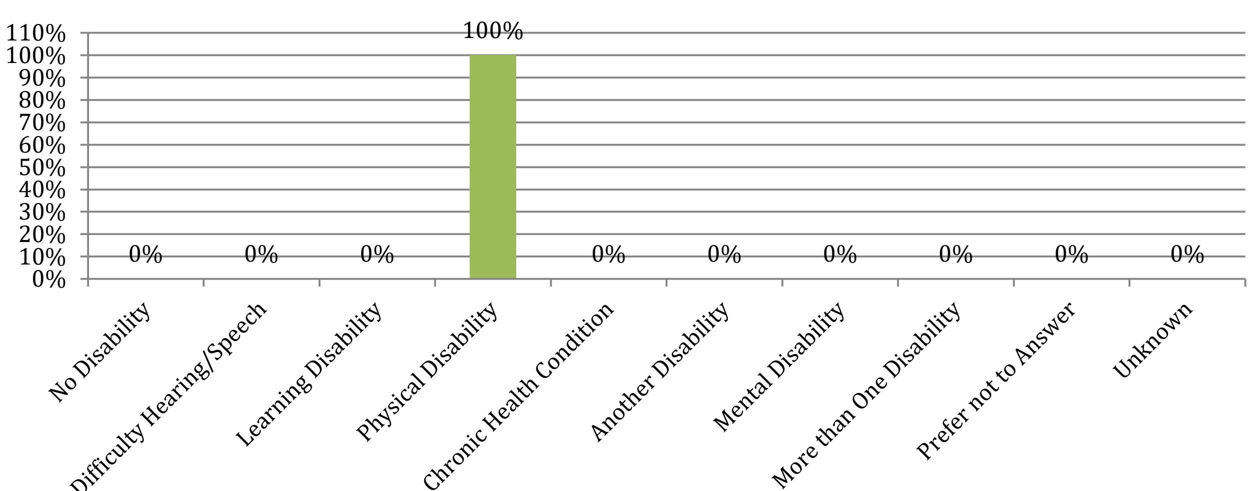
PEI Demographics Based on MHSA Referrals (n=1)






Gender Identity
100%
Male
Female
Sexual Orientation
100%
Heterosexual
Gay or Lesbian
Prefer Not to Answer
Language
100%
English
Military Veteran
100%
Yes
No
Race
100%
100%
75%
50%
25%
0%
0%
0%
0%
0%
0%
0%
0%
0%
American Indian
Asian
Black/African American
White
Native Hawaiian
Another Race
More than One Race
Prefer not to Answer
Unknown


Ethnicity
125%
100%
75%
50%
25%
0%
0%
0%
0%
0%
0%
0%
0%
0%
0%
0%
100%
0%
African
Central American
Cuban
Eastern European
Filipino
Korean
Mexican
Puerto Rican
South American
Another Ethnicity
Prefer not to Answer
Unknown


Disability
110%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0%
0%
0%
100%
0%
0%
0%
0%
0%
0%
No Disability
Difficulty Hearing/Speech
Learning Disability
Physical Disability
Chronic Health Condition
Another Disability
Mental Disability
More than One Disability
Prefer not to Answer
Unknown

Housing Stability Program

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	___ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention		___ Prevention and Early Intervention	

Program Description

Stable housing is a necessary foundation to be able to create wellbeing and support a person's mental health. Tri-City Housing staff work diligently with clients, mental health service providers, landlords, and property managers to secure housing placements, mediate conflicts, and strengthen relationships. The Housing Stability Program is a prevention program designed to help people with mental illness maintain their current housing or find more appropriate housing.

Target Population

Individuals experiencing mental illness who need support to maintain their current housing or find a more appropriate place of residence. Program staff members work with clients, mental health service providers, landlords, and property managers to secure housing placements, mediate conflicts, and strengthen relationships.

New Landlords Engaged	Landlord Luncheons Held	Attendees (Unique)	Repeat Attendees (Duplicates)
22	9	114	165

Program Update

In August of 2019, the Housing Stability Program (HSP) hosted the annual Housing Summit with the largest attendance for this event at 52 attendees. The event expanded from just providing regular update of the housing laws and regulations to guests such as the Los Angeles County Development Authority who presented their Homelessness Incentive Program which included a panel of previously homeless individuals, who shared their journey to being housed. The goal is to encourage owners to be more open to working with individuals using housing vouchers.

Challenges and Solutions

The HSP staff began offering the "Good Tenant Curriculum" to tenants residing at properties funded through MHSA. However, tenants at these sites did not appear motivated to attend the group despite a "graduation gift" that was promoted. There were only a few instances where the presenter encountered language barriers as the tenants spoke a language other than English or Spanish.

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In response, HSP staff will review surveys from past attendees and revise the curriculum to cover topics and address questions from previous groups in hopes that this updated information will be applicable and of interest to these tenants.

During FY 2019-20, the HSP added a new community group, Open Door. Through this group, staff are able to provide general housing listings created biweekly. This new, bi-weekly, group is a round table discussion for anyone that has questions regarding housing, with the purpose of clarifying any misconceptions of the availability of housing. It also provides an opportunity for community members to engage in conversations with each other to identify ways in which they have overcome housing obstacles.

COVID-19 Response

With the onset of the COVID 19 pandemic, the HSP staff quickly moved the Open Door Group to a virtual platform. In addition, the monthly landlord meetings were moved to a virtual platform as well. Community emails were sent referring individuals directly to the Housing Rights Center to offer support regarding housing rights and concerns.

Previously scheduled events, such as the first Housing Fair, inspired by job fairs held at the Wellness Center, were scheduled in compliance with state and federal restrictions. Outreach efforts were curtailed due to social distancing and a reduction with “in-person” meetings with landlords and property managers.

RingCentral, an online meeting platform, proved to be a valuable resource for staff when hosting groups, meetings, summits, and webinars. Trainings such as the Good Tenant Curriculum, were modified to be available for a call-in group format. Efforts are underway with community partners to add WIFI and computer stations so the Good Tenant Curriculum can be offered virtually as well.

Future efforts include working with Tri-City community trainers to expand the Mental Health First Aid trainings for property owners and landlords to help them when responding to difficult interactions with tenants. A new curriculum will be introduced in the future entitled Landlord Everyday Mental Health.
Housing staff will also begin hosting regular landlord housing forums to provide a virtual round table for landlords. Participants will be able to offer support to each other while identifying areas where resources and future education is needed.

Cultural Approach

Cultural inclusion is an important component to the Housing Stability Program. Five of the eight housing staff are bilingual in English and Spanish. Tri-City staff maintain strong alliances with various agencies throughout the county that serve diverse communities. Information and resources gleaned from these relationships are then provided to participants during the Landlord Luncheons.

Stigma regarding mental illness is also a concern and the Open Door group is structured to focus on individuals who are considered underserved, and offer support and resources as they express their experience with barriers or discriminations. Mental Health First Aid training is offered for landlords, owners, and property managers in order to help them better understand and be able to support tenants with mental health conditions.

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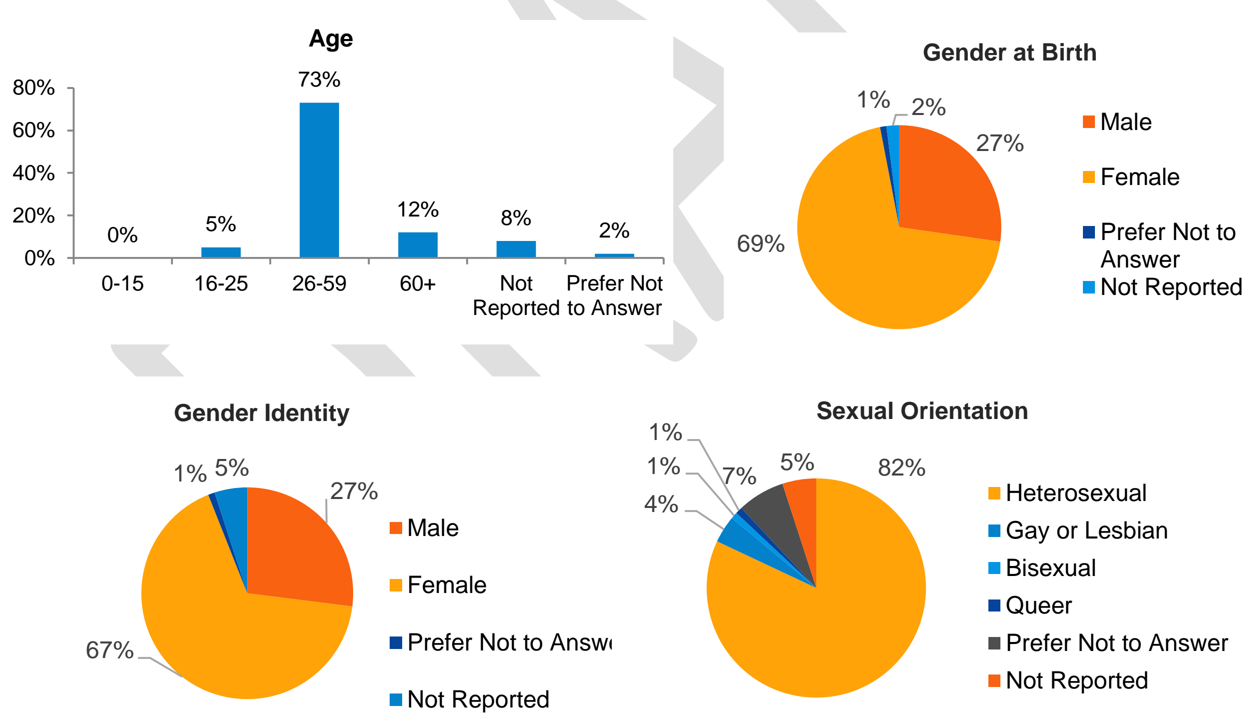
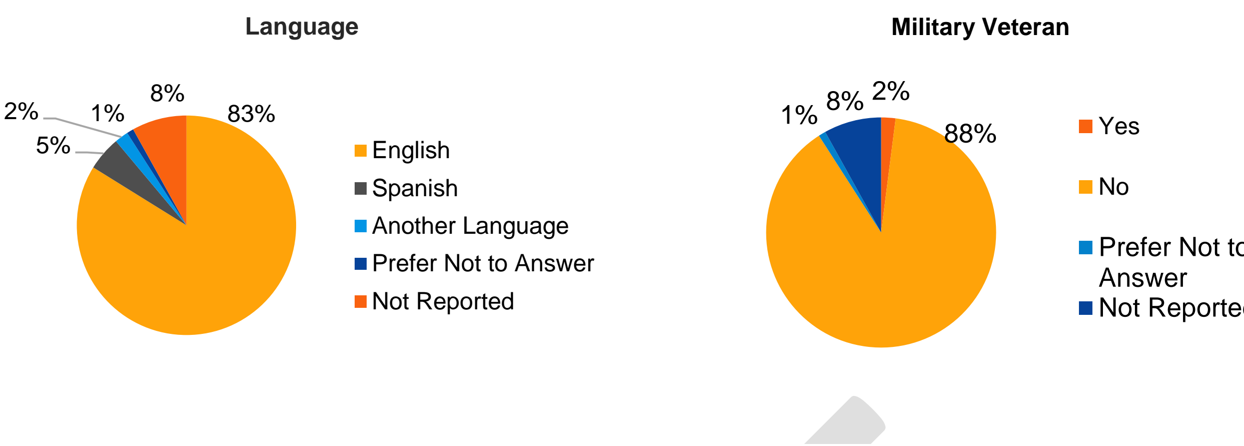
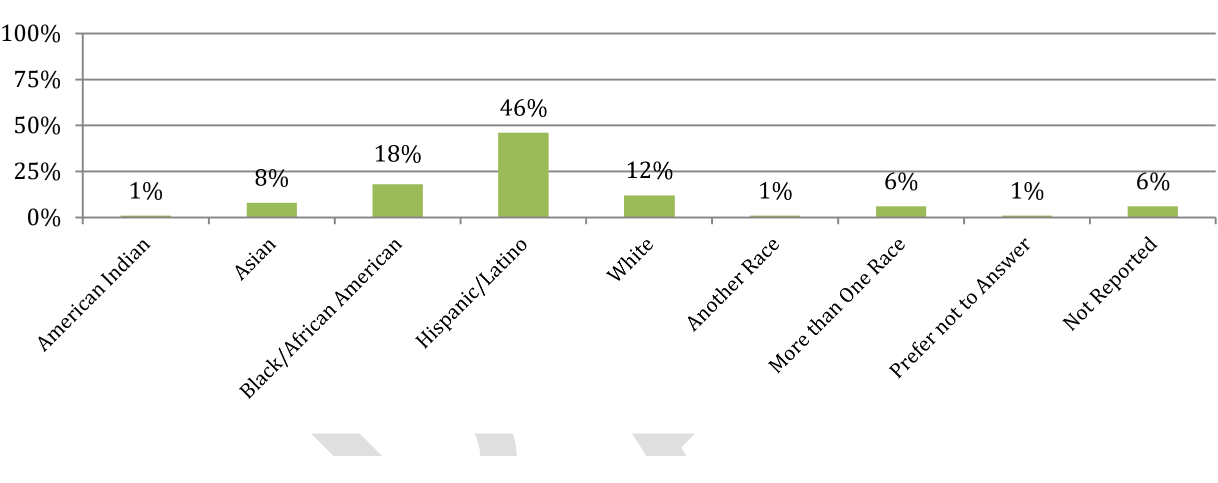
PROGRAM: Housing Stability Program (HSP)
HOW MUCH DID WE DO?

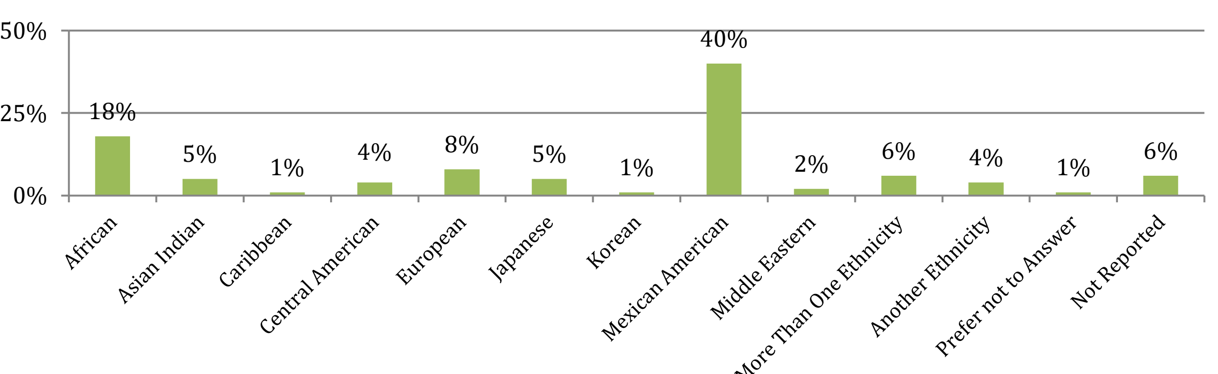
22 New Landlord Contacts	81 Landlord Follow-Ups	9 Landlord Luncheons Held	166 Landlord Luncheon Attendees (Duplicated)	114 Landlord Luncheon Attendees (Unique)
43 Landlord Tenant Curriculum Groups	81 Group Attendees (Duplicated)	29 Group Attendees (Unique)	11 Open Door Events Held	18 Open Door Event Attendees (Duplicated)

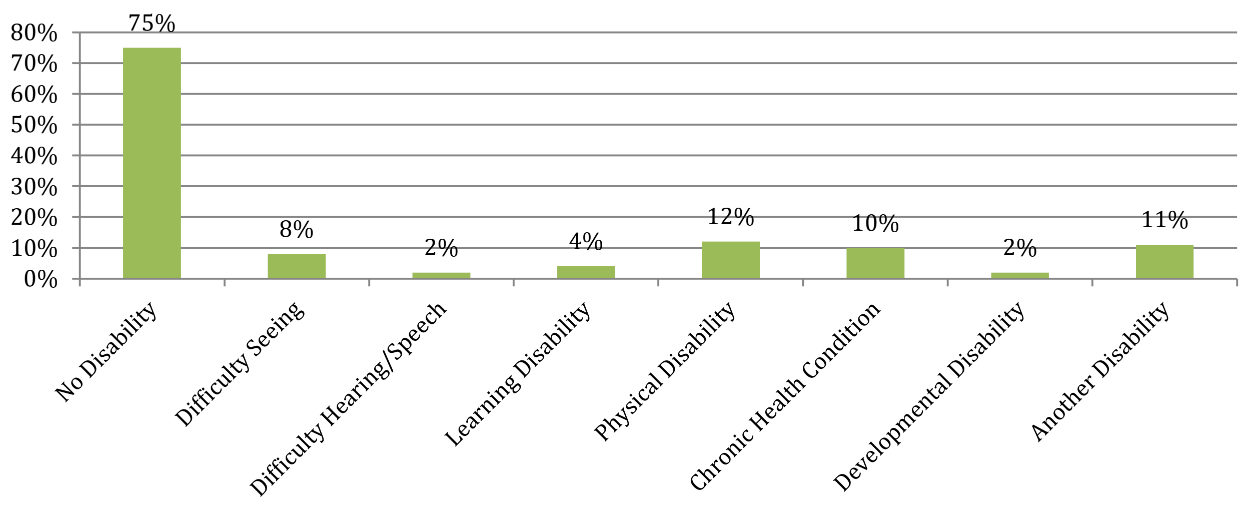
PEI Demographics, Including Housing Participants

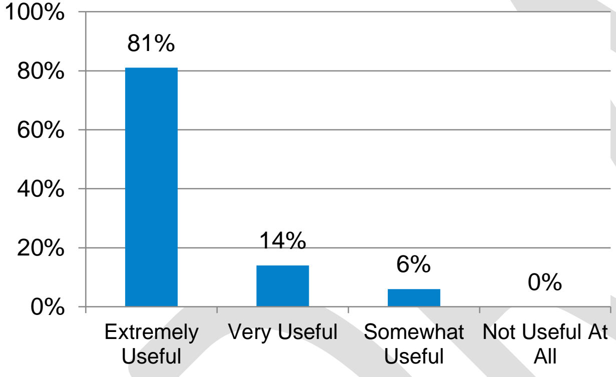


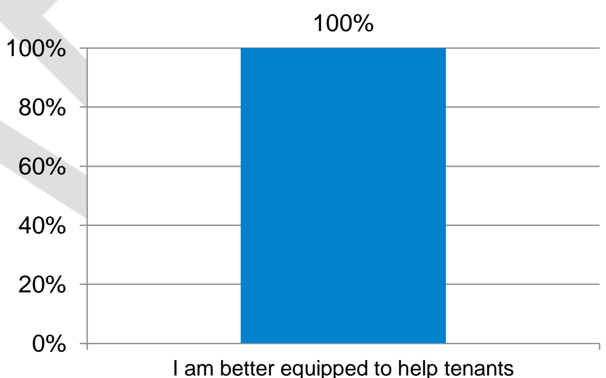

Language
2%
1%
8%
83%
5%
English
Spanish
Another Language
Prefer Not to Answer
Not Reported
Military Veteran
1%
8%
2%
88%
Yes
No
Prefer Not to Answer
Not Reported


Race
100%
75%
50%
25%
0%
1%
8%
18%
46%
12%
1%
6%
1%
6%
American Indian
Asian
Black/African American
Hispanic/Latino
White
Another Race
More than One Race
Prefer not to Answer
Not Reported


Ethnicity
50%
25%
0%
18%
5%
1%
4%
8%
5%
1%
40%
2%
6%
4%
1%
6%
African
Asian Indian
Caribbean
Central American
European
Japanese
Korean
Mexican American
Middle Eastern
More Than One Ethnicity
Another Ethnicity
Prefer not to Answer
Not Reported





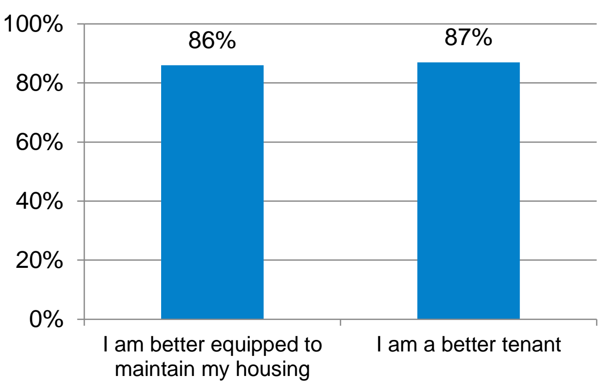


HOW WELL DID WE DO IT?

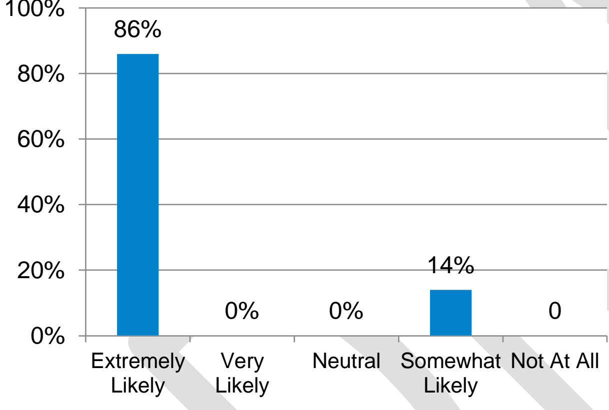
94%
Good Tenant Curriculum Participants Would Recommend This Curriculum to Others

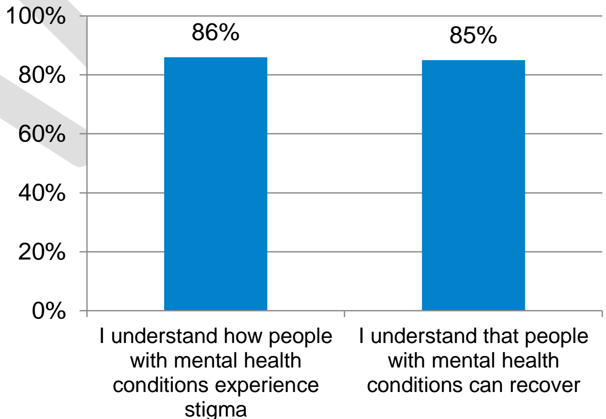
93%
Good Tenant Curriculum Participants Reported the Presenter was Engaging and Approachable

IS ANYONE BETTER OFF?



92%
Good Tenant Curriculum Participants Reported That Staff Helped Them Obtain the Information Needed to Accomplish Their Housing Goals

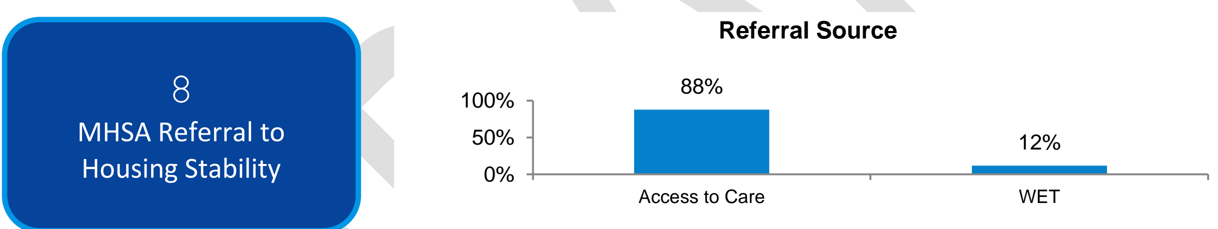




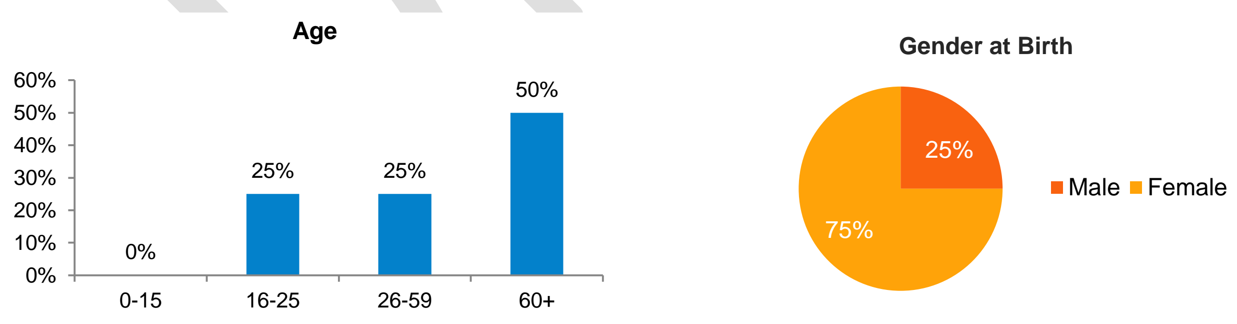
DRAFT

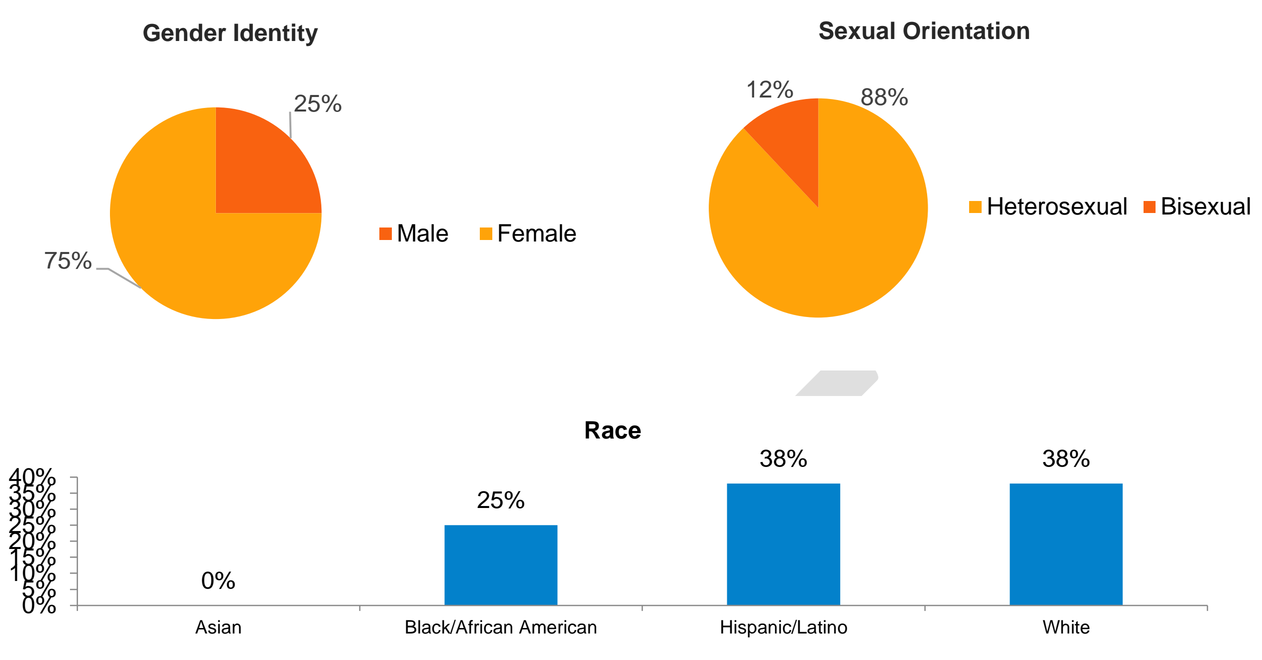
Number of Potential Responders	143
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Landlords and community members
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-age youth, older adults and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

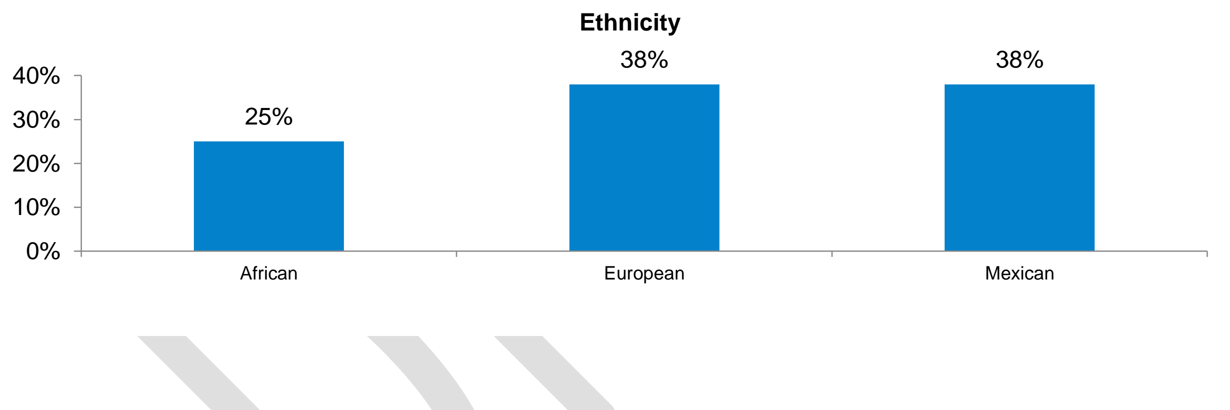
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

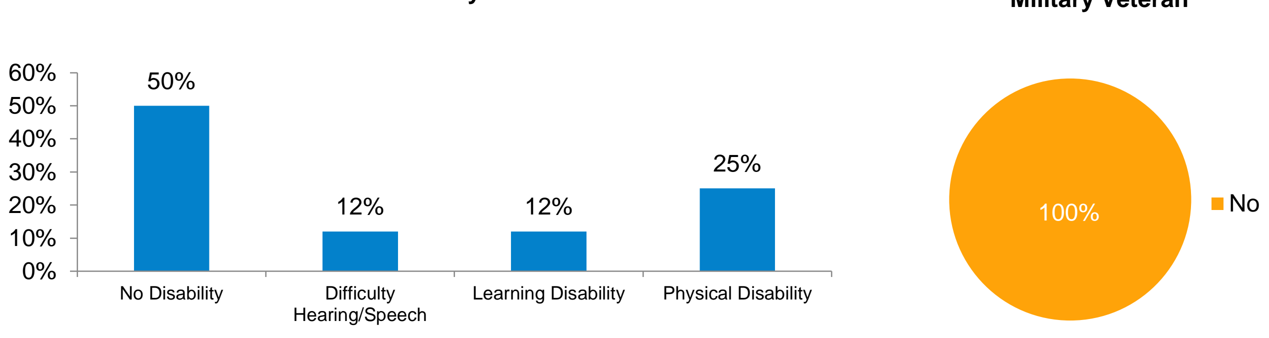


PEI Demographics Based on MHSA Referrals




Gender Identity
25%
75%
Male
Female
Sexual Orientation
12%
88%
Heterosexual
Bisexual
Race
0%
25%
38%
38%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Asian
Black/African American
Hispanic/Latino
White


Ethnicity
25%
38%
38%
40%
30%
20%
10%
0%
African
European
Mexican


Disability
50%
12%
12%
25%
60%
50%
40%
30%
20%
10%
0%
No Disability
Difficulty Hearing/Speech
Learning Disability
Physical Disability
Military Veteran
100%
No

Therapeutic Community Gardening

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	___ Prevention	_X_ Early Intervention		___ Prevention and Early Intervention	

Program Description

The Therapeutic Community Gardening program helps participants decrease their isolation and experience mental health benefits through participation in horticulture/gardening activities and group therapy exercises.

Target Population

Unserved and underserved populations including adults, youth ages 16-25, families with children, older adults, and veterans.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	11	8	40	19	4
Cost Per Person	$3,316.00	$3,316.00	$3,316.00	$3,316.00	$3,316.00

Program Update

The Therapeutic Community Garden (TCG) program continues to be a popular option for community members and staff referrals. Community participation is a fundamental foundation for this program and staff are able to support this concept through hosting and participating in local events such as a resource fair at Cal Poly Pomona Veteran's Resource Center and Fall at the Farm hosted at the Pomona Fairplex. Additional events were sponsored by Tri-City and included the adult outpatient graduation ceremony, Wellness Center Tree Lighting Event, and Harvest Feast at Tri-City's Royalty location.

During FY 2019-20, TCG staff also hosted workshops at the Jocelyn Senior Center for older adults, Simon Middle School, and a monolingual group for parents in the Claremont Unified School Districts book club in the Therapeutic Community Garden. One of their most popular gatherings was a winter event help in the Garden which drew 55 attendees.

Challenges and Solutions

One of the challenges experienced by this team included a low turnout for groups located at various Tri- City housing locations. Transition age youth (TAY) continue to be a difficult population to engage, enroll and maintain in TCG groups.

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To increase future attendance in TAY groups, TCG staff will be collaborating with community partners who support this age specific group. These efforts include maintaining preexisting relationships with TAY organizations as well as hosting workshops and events that target this essential age group.

COVID-19 Response

TCG operations were impacted dramatically due to COVID 19. In March 2020, all groups were put on hold due to concerns with public and staff safety. The majority of services rendered through TCG were through groups prior to COVID 19; therefore, all direct services were put on hold. However, weekly wellness calls to TCG participants began and continue to this day.

Groups for TCG shifted to a virtual platform in July of 2020. TCG staff are currently utilizing social media platforms to provide information regarding the Garden to the public. Adapting to the virtual world of delivering services via telehealth presented many challenges. A few of those challenges included: adapting to and learning technology related to delivering services virtually; assisting TCG clients to download and learn technology to be able to log-in to virtual groups and making accommodations for individuals that were not comfortable receiving services through telehealth.

Curriculum and program development, disseminating information to the public, and ensuring proper HIPAA (Health Insurance Portability and Accountability Act) and documentation guidelines were followed delayed the process of offering services virtually. At this time, TCG groups are now being conducted virtually.

Finally, TCG staff-initiated harvest drop-off/pick-ups of items from the garden to TCG participants and worked with local non-profit agency to offer donations of fruit.

Cultural Approach

The Therapeutic Community Garden is diligent is addressing barriers for underserved and unserved communities. Efforts include:

- Full time Spanish-speaking Mental Health Specialists and monolingual Spanish groups
- English and Spanish speaking adult and older adult groups
- Transitional Aged Youth, youth and family aged group
- Wellness Center group (indoors) for participants who are unable to be in the garden.
- Modifying TCG activities for individuals with learning impairments (as needed)
- Curriculum development includes discussions about diversity, culture and how differences between plants can benefit each other (companion planting and crop rotation)
- Participation in events that bring awareness to diversity and inclusion
- Attendance to trainings and webinars that focus on increasing cultural competency and awareness
- A majority of program materials are available in Spanish (i.e. waivers, enrollment sheet, referral forms, questionnaires, flyers, labels for garden beds)

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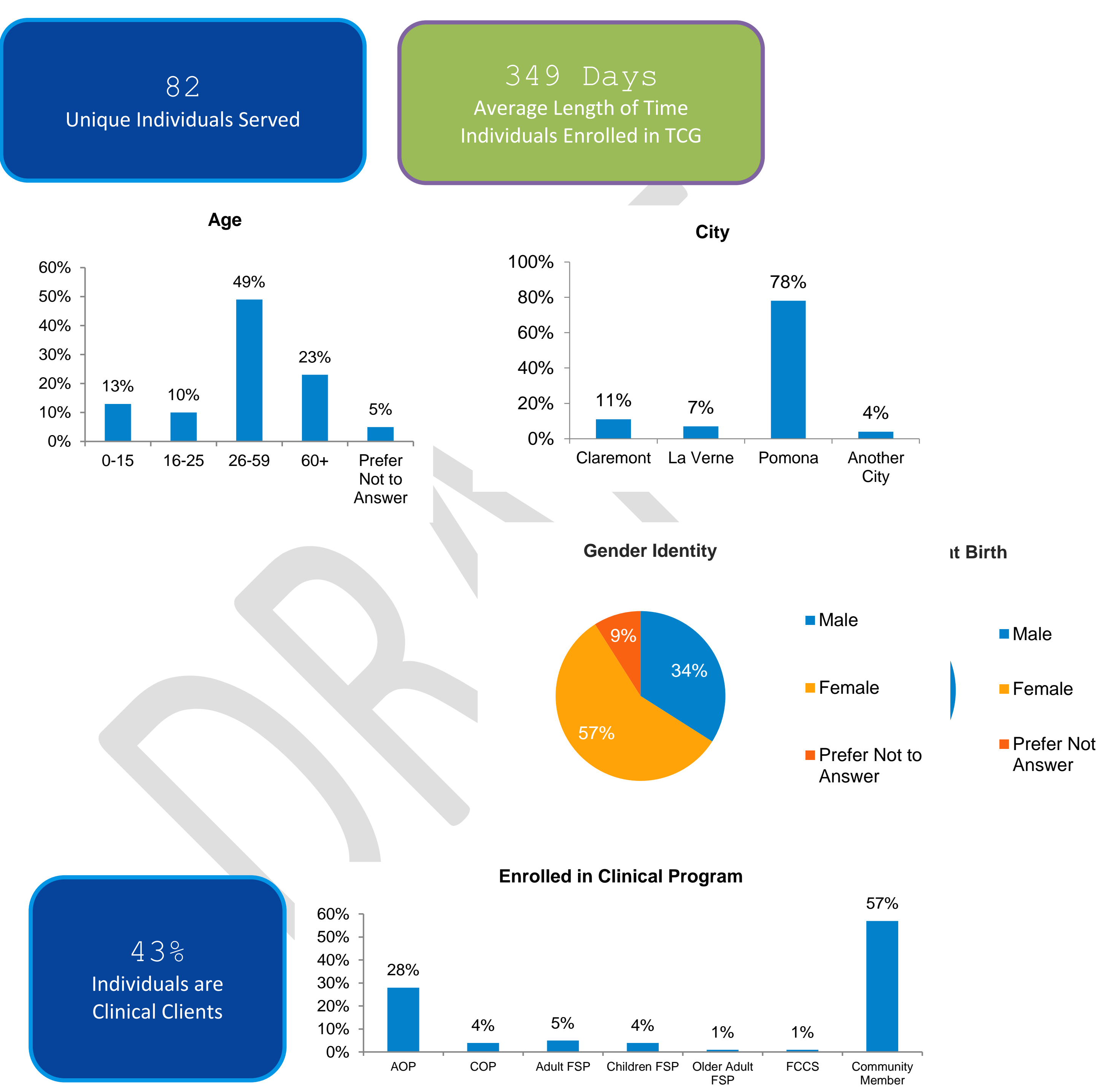
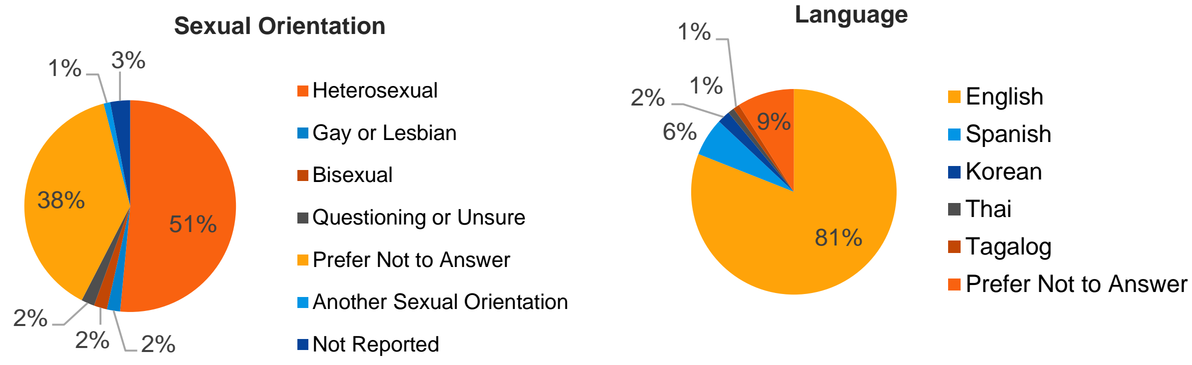
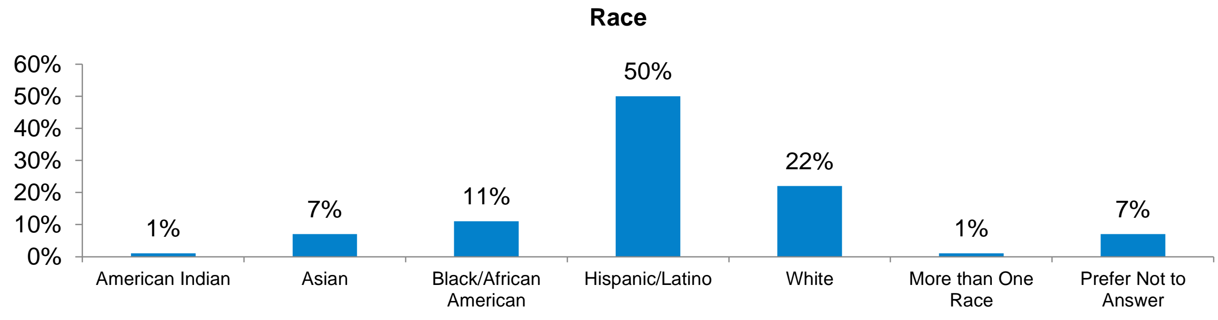
PROGRAM: Therapeutic Community Gardening (TCG)

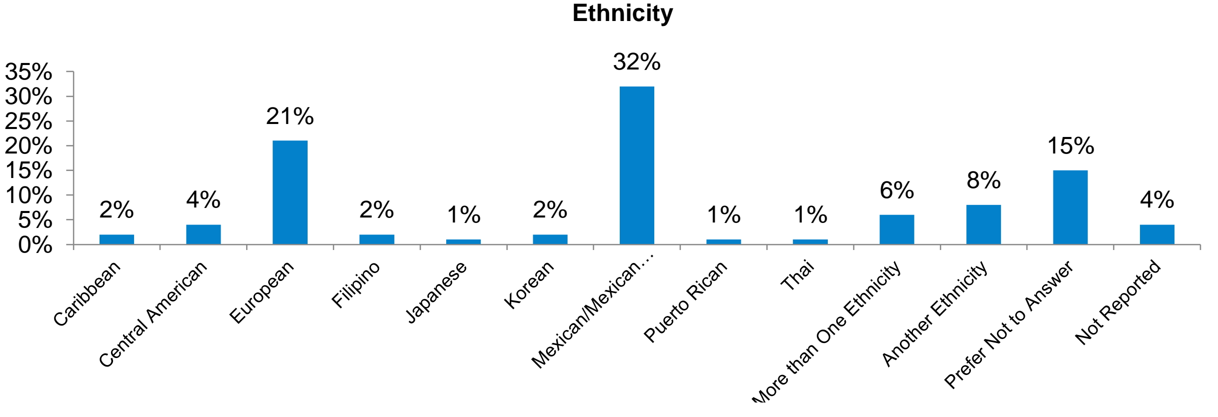
HOW MUCH DID WE DO?

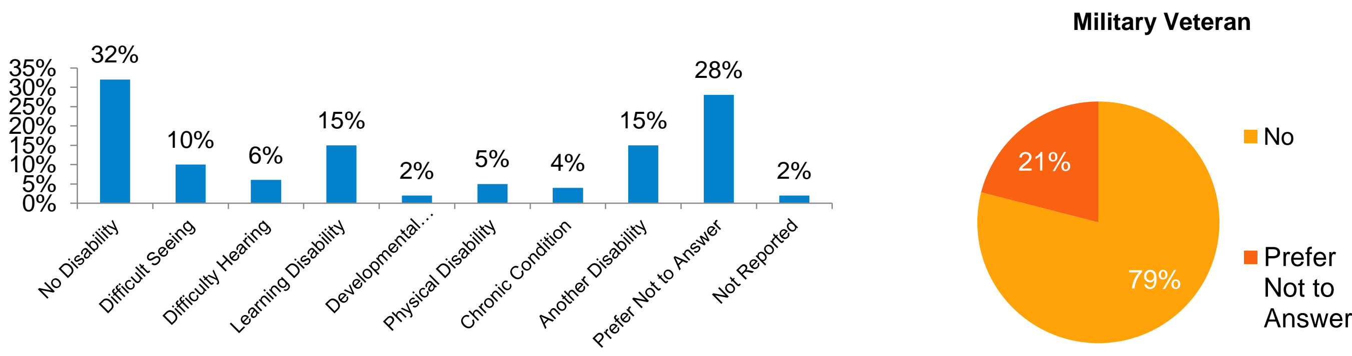


43%
Individuals are
Clinical Clients

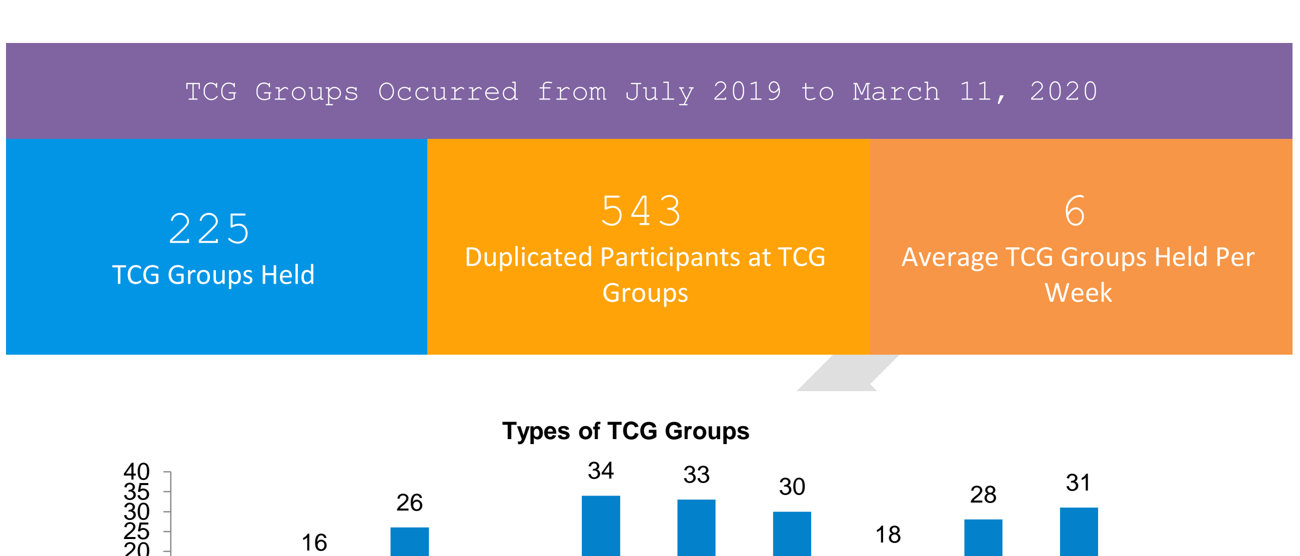

Sexual Orientation
51%
38%
1%
3%
2%
2%
2%
Heterosexual
Gay or Lesbian
Bisexual
Questioning or Unsure
Prefer Not to Answer
Another Sexual Orientation
Not Reported
Language
81%
9%
6%
2%
1%
1%
English
Spanish
Korean
Thai
Tagalog
Prefer Not to Answer

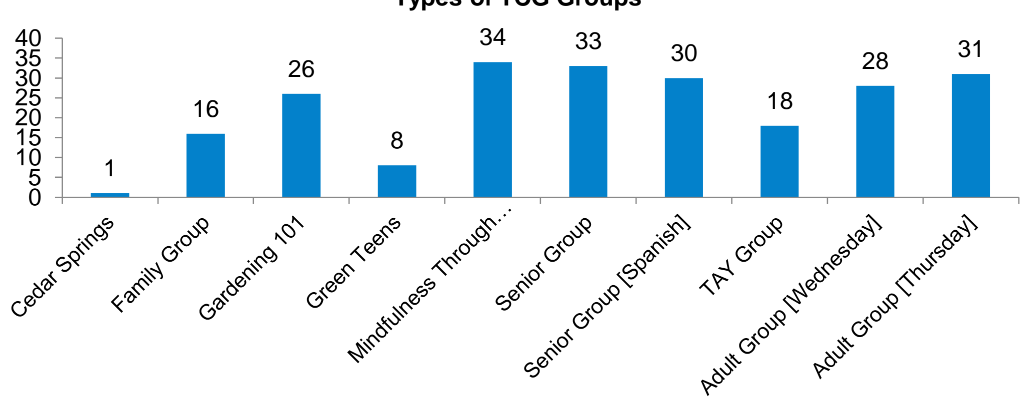

Race
60%
50%
40%
30%
20%
10%
0%
1%
7%
11%
50%
22%
1%
7%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More than One Race
Prefer Not to Answer


Ethnicity
35%
30%
25%
20%
15%
10%
5%
0%
2%
4%
21%
2%
1%
2%
32%
1%
1%
6%
8%
15%
4%
Caribbean
Central American
European
Filipino
Japanese
Korean
Mexican/Mexican…
Puerto Rican
Thai
More than One Ethnicity
Another Ethnicity
Prefer Not to Answer
Not Reported

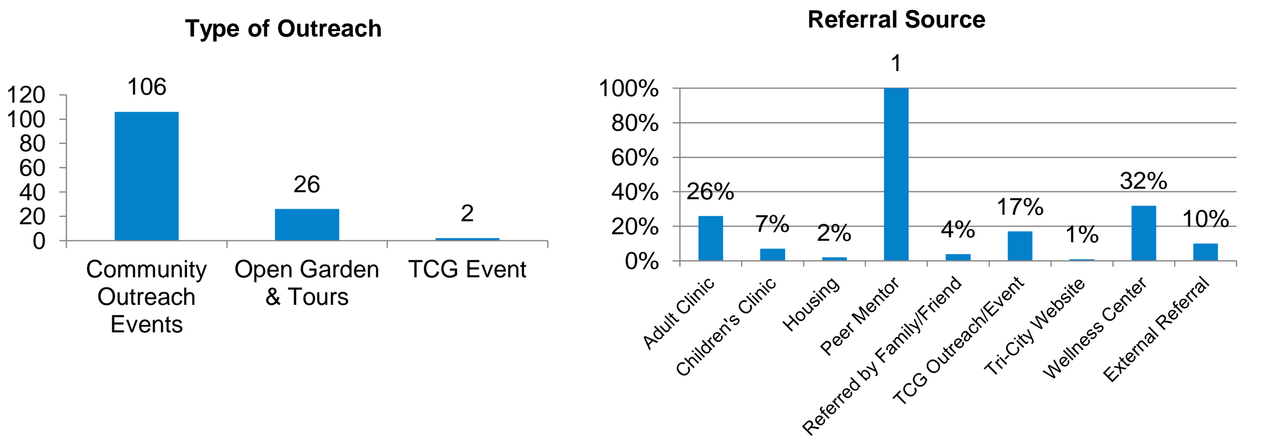

Disability
35%
30%
25%
20%
15%
10%
5%
0%
32%
10%
6%
15%
2%
5%
4%
15%
28%
2%
No Disability
Difficult Seeing
Difficulty Hearing
Learning Disability
Developmental…
Physical Disability
Chronic Condition
Another Disability
Prefer Not to Answer
Not Reported
Military Veteran
21%
79%
No
Prefer Not to Answer

HOW WELL DID WE DO IT?





275	134	1,402
Wellness Phone Calls Made to TCG Participants [March 2020 – June 2020]	Outreach Events	Individuals Engaged



IS ANYONE BETTER OFF?

100%	91%	96%	96%	86%
TCG Participants Enjoy Attending TCG Groups	TCG Participants Feel More Connected to Others [Peers, Family, etc.] Because of TCG Groups	TCG Participants Feel Their Symptoms Have Improved Because of Their Work at the Garden	TCG Participants Feel More Confident from the Skills Learned in TCG Groups	TCG Participants Have Better Communication with Others Because of TCG Groups

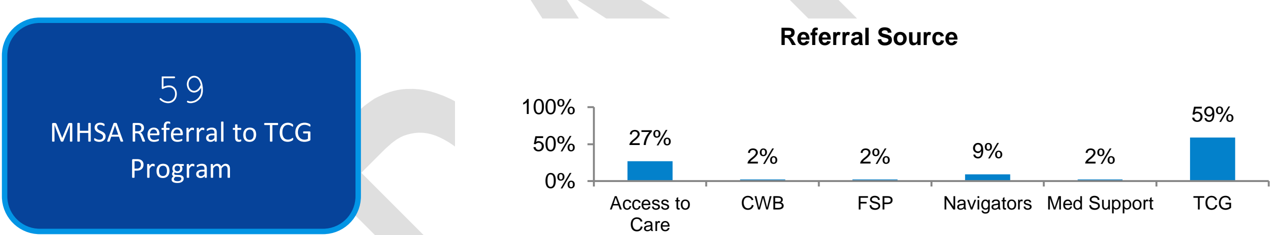
TCG Participant Feedback

"So glad I came to TCG, networked with other community members."
"I've learned more."
"I have always benefited. It is easier for me."
"I enjoy it. I want to plant new things."
"I have gained so much knowledge and experiences."
"I learned a lot of practical skills and I love the opportunity to socialize."
"I like TCG a lot!"
"Being here makes me feel comfortable and good."

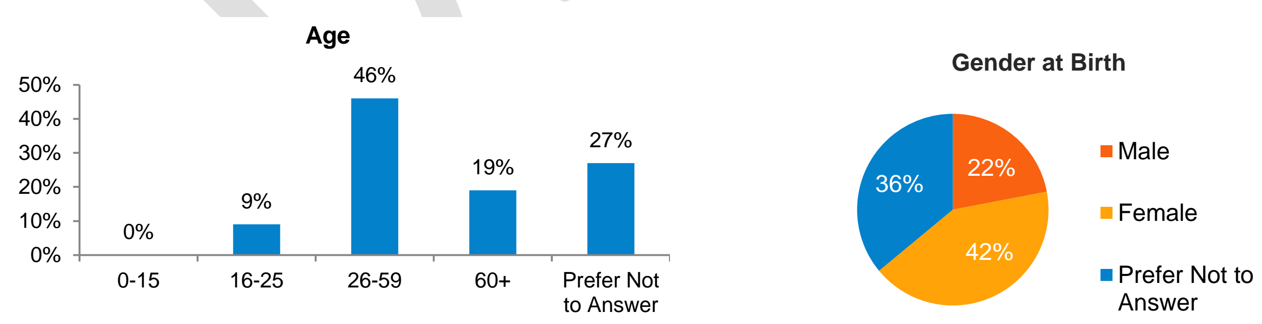
"I'm here to keep learning the group talk strategies."
"I feel more positive in how I feel, Thank you for our case workers too!"
"Being active, the groups are great!"
"I'm calmer, more able to deal with life's challenges and how I was before I started coming."
"It calms me down."
"Walking and working in the garden makes me feel good."
"I completely like learning about nature and garden."
"I feel very happy, can't wait for Friday group!"

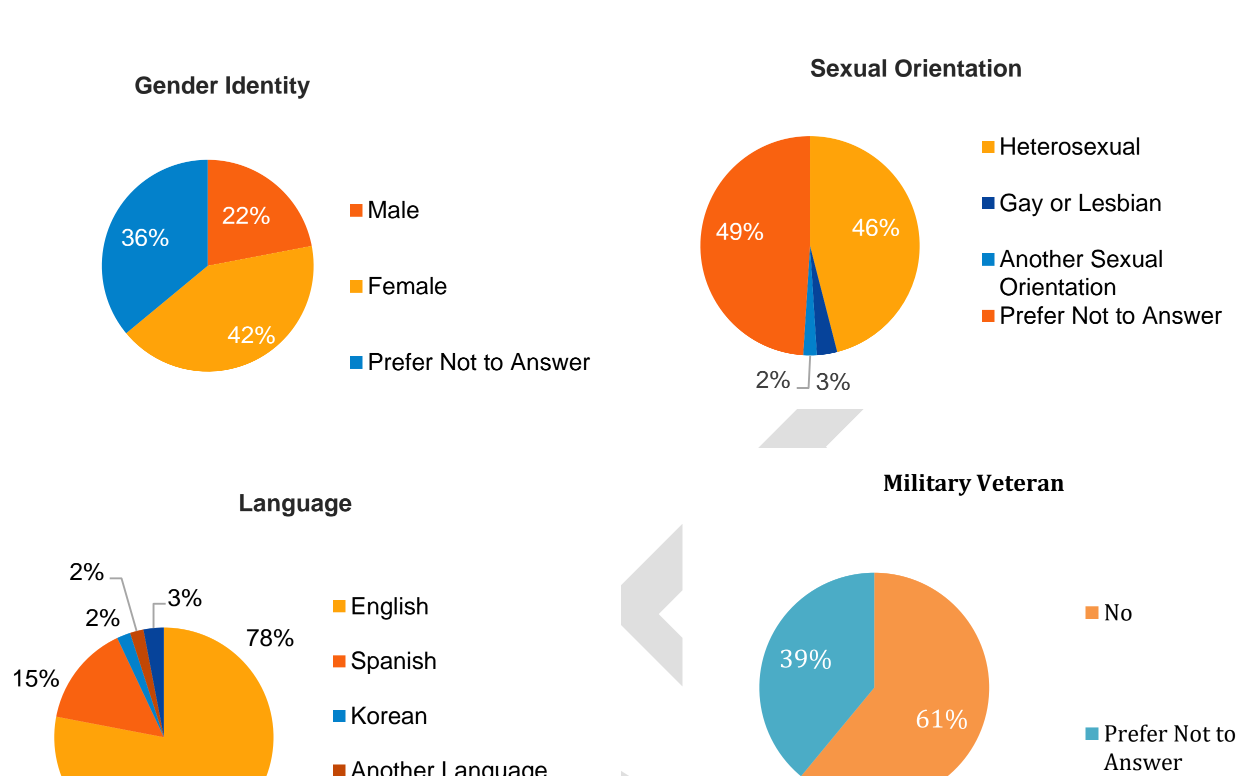
Number of Potential Responders	82
Setting in Which Responders were Engaged	Community, schools, health centers, workplace and outdoors
Type of Responders Engaged	TAY, teachers, LGBTQ+, families, religious leaders and those with lived experience
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

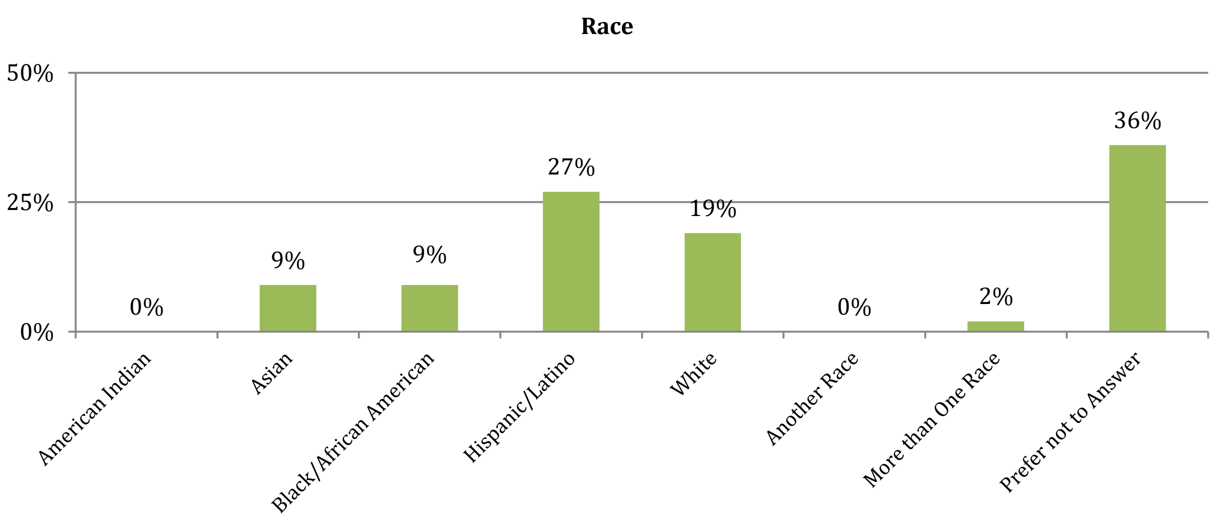
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

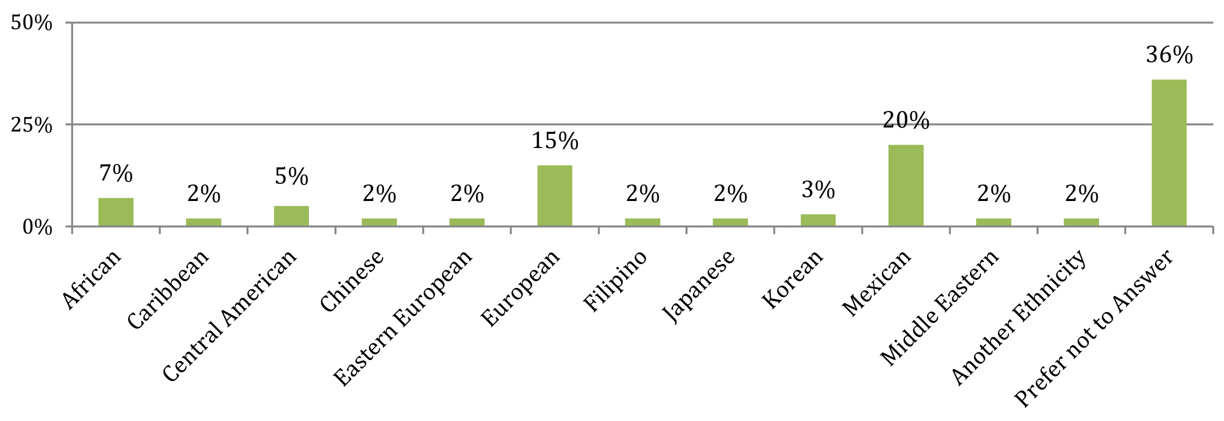


PEI Demographics Based on MHSA Referrals

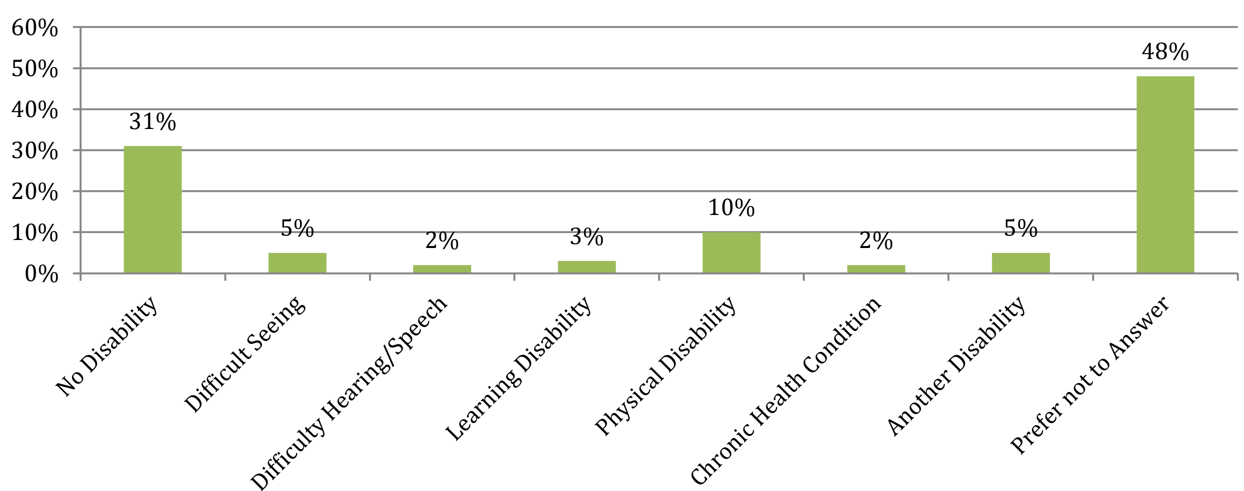



Gender Identity
22%
36%
42%
Male
Female
Prefer Not to Answer
Sexual Orientation
49%
46%
2%
3%
Heterosexual
Gay or Lesbian
Another Sexual Orientation
Prefer Not to Answer
Language
2%
2%
3%
15%
78%
English
Spanish
Korean
Another Language
Prefer Not to Answer
Military Veteran
39%
61%
No
Prefer Not to Answer


Race
50%
25%
0%
0%
9%
9%
27%
19%
0%
2%
36%
American Indian
Asian
Black/African American
Hispanic/Latino
White
Another Race
More than One Race
Prefer not to Answer



Ethnicity
50%
25%
0%
7%
2%
5%
2%
2%
15%
2%
2%
3%
20%
2%
2%
36%
African
Caribbean
Central American
Chinese
Eastern European
European
Filipino
Japanese
Korean
Mexican
Middle Eastern
Another Ethnicity
Prefer not to Answer



Disability
60%
50%
40%
30%
20%
10%
0%
31%
5%
2%
3%
10%
2%
5%
48%
No Disability
Difficult Seeing
Difficulty Hearing/Speech
Learning Disability
Physical Disability
Chronic Health Condition
Another Disability
Prefer not to Answer

Early Psychosis Program

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	___ 0-15	_X_ 16-25	___ 25-69	___ 60+	Other:
Type of Program:	___ Prevention	_X_ Early Intervention		___ Prevention and Early Intervention	

Program Description

Utilizing the PIER (Prevention, Intervention, Enforcement and Reentry) model, Tri-City staff host workshops and trainings for community members and school personnel focused on recognizing and addressing the earliest symptoms of mental illness. This evidence-based treatment option uses three key components- community outreach, assessment and treatment to reduce symptoms, improved function and decrease relapse. The goal for this program includes increasing awareness among community members in recognizing the signs and symptoms of early psychosis and how to connect individuals to services as well as to reduce the time of untreated psychosis and severe mental illness.

Target Population

Transition Age Youth (TAY) ages 16 to 25 who are experiencing psychosis and are not currently enrolled in mental health services.

Number of Workshops for FY 2019-20	7
Number of Attendees for FY 2019-20	75

Program Update

Beginning in July 2020, Tri-City staff implement the Portland Identification and Early Referral (PIER) model as the basis for their Early Psychosis Program (ESP). This model utilizes a team-based system of early detection and intervention in psychosis. This first year of implementation included the completion of the Memo of Understanding with PIER as well as the last of the hiring (occupational therapist) needed to complete the PEIR team.

Challenges and Solutions

Challenges for this program included making the shift from a research focus to an action/implementation focus. This included finalizing the hiring of staff and developing the phases of implementation including outreach and trainings. By establishing training dates early on with community partners, this ensured that outreach presentations were on their calendars in order to spread the word and increase referrals to the program.

COVID-19 Response

With the onset of COVID 19, the PIER trainings and training with UCLA, another adjunct program for staff, were delayed. Although these trainings were originally scheduled to begin in April/May of 2020

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and to be completed over the summer, the pandemic required the trainings to be modified to be presented via a virtual platform. This delay resulted in the PIER trainings being rescheduled to be completed by the second week of November 2020 and the UCLA training is now estimated to be completed by January 2021. The outreach portion of these trainings were also impacted as community partners also shifted their focus to addressing their own internal priorities which left little time for adjunct presentations or trainings.

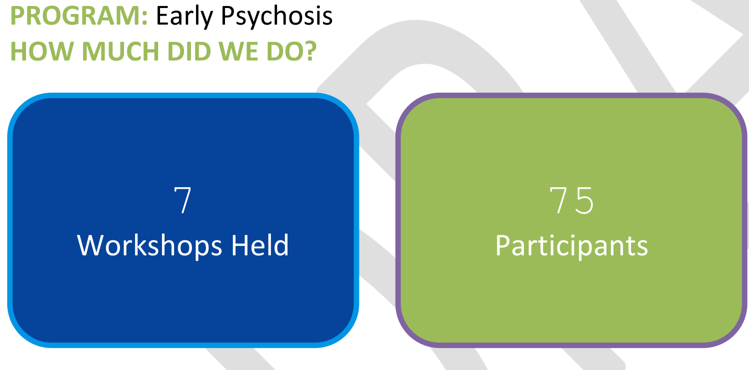
In response to these challenges, Tri-City staff are working to adapt these new training practices to be conducted virtually with clients via telehealth. In addition, outreach efforts were also adapted to be conducted virtually via phone or webinars.

Cultural Approach

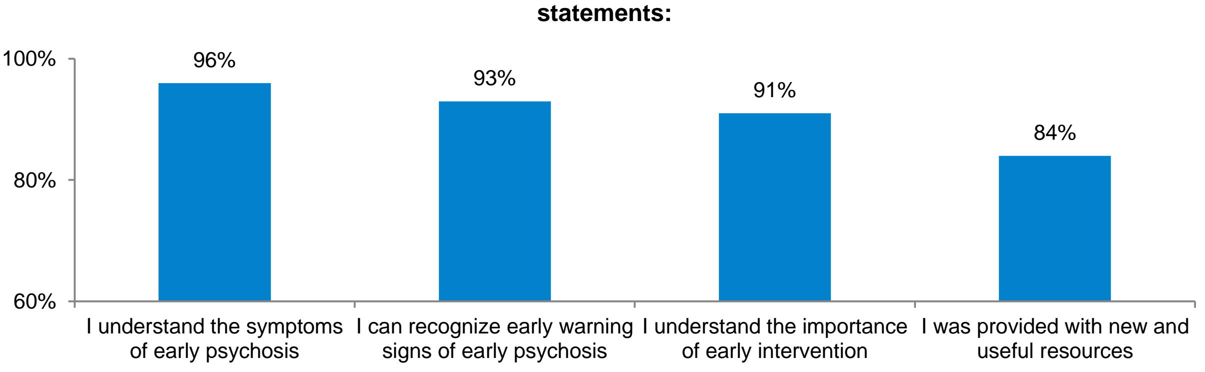
In addressing cultural inclusion, the ESP employs staff that are reflective of the community served and make it a practice to approach the work with cultural humility. Ongoing discussions of race, culture, and health disparities in department meetings, group and individual supervisions with staff, has proven to be effective in instilling this approach.

In addition, staff ensure that assessment and new PIER training material are available in other threshold languages, including Spanish. Flyers, assessments, and forms are available in Spanish and other languages as needed. Presentations on outreach are available in Spanish. The material is also presented in a manner that is easy to understand even if English is not their primary language.

PROGRAM: Early Psychosis
HOW MUCH DID WE DO?

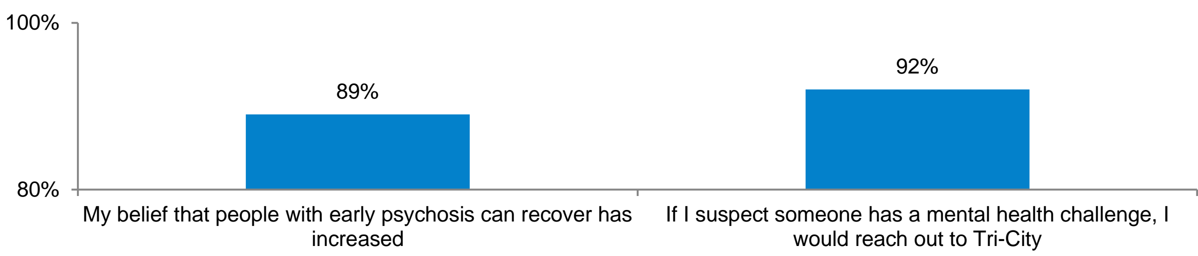


HOW WELL DID WE DO IT?



IS ANYONE BETTER OFF?

Percentage of participants who agree or strongly agree with the following statements:



PEI Demographics

Age

60%
50%
40%
30%
20%
10%
0%
0%
11%
51%
0%
39%
0-15
16-25
26-59
60+
Not Reported

Gender at Birth

39%
51%
Male
Female
Not Reported

Gender Identity

39%
51%
Male
Female
Not Reported

Sexual Orientation

44%
47%
3% 4%
3%
Heterosexual
Gay or Lesbian
Bisexual
Queer
Not Reported

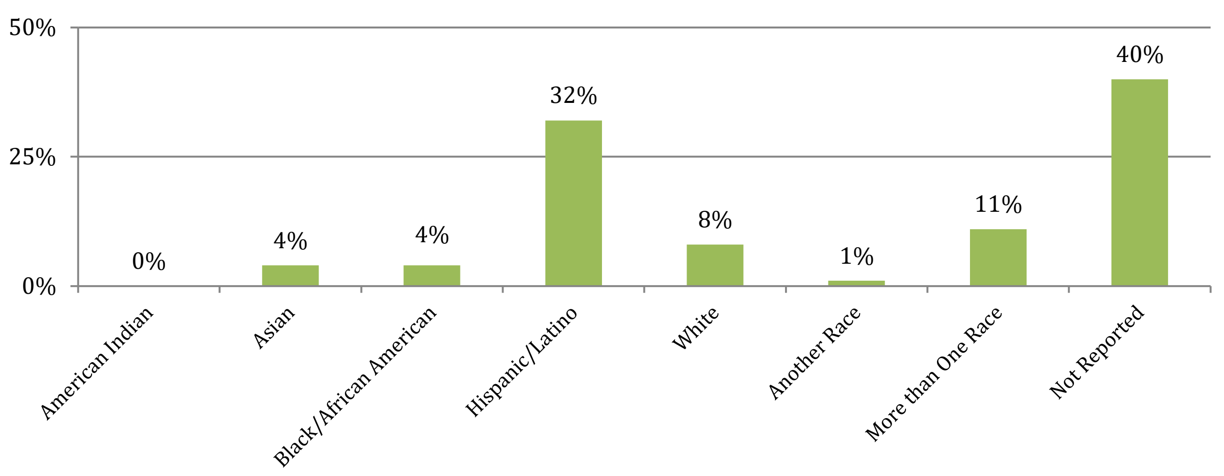
Language

39%
57%
4%
English
Spanish
Not Reported

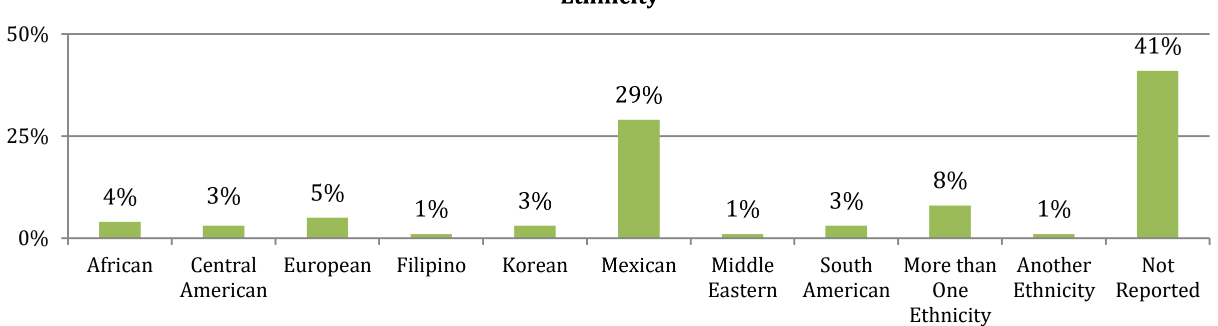
Military Veteran

3%
41%
56%
Yes
No
Not Reported

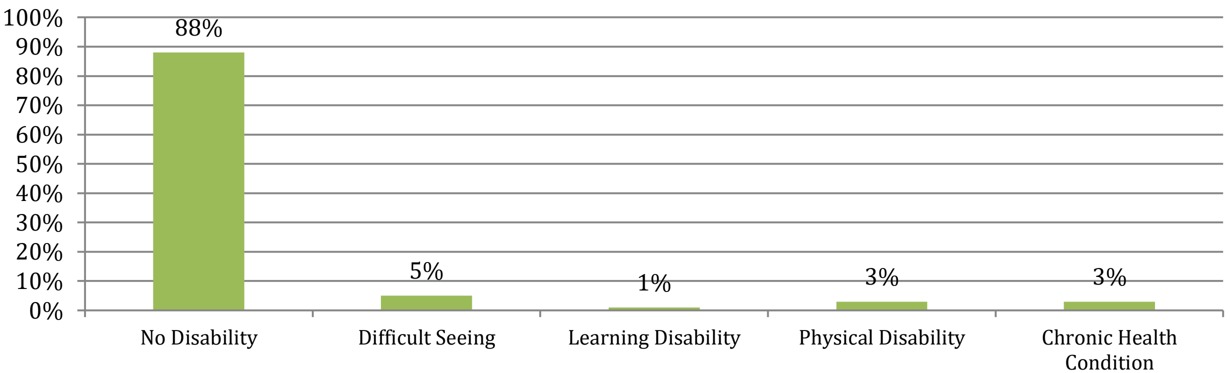
Race



Ethnicity



Disability



Number of Potential Responders	75
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Community members
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-age youth, older adults and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

0
MHSA Referral to Early Psychosis

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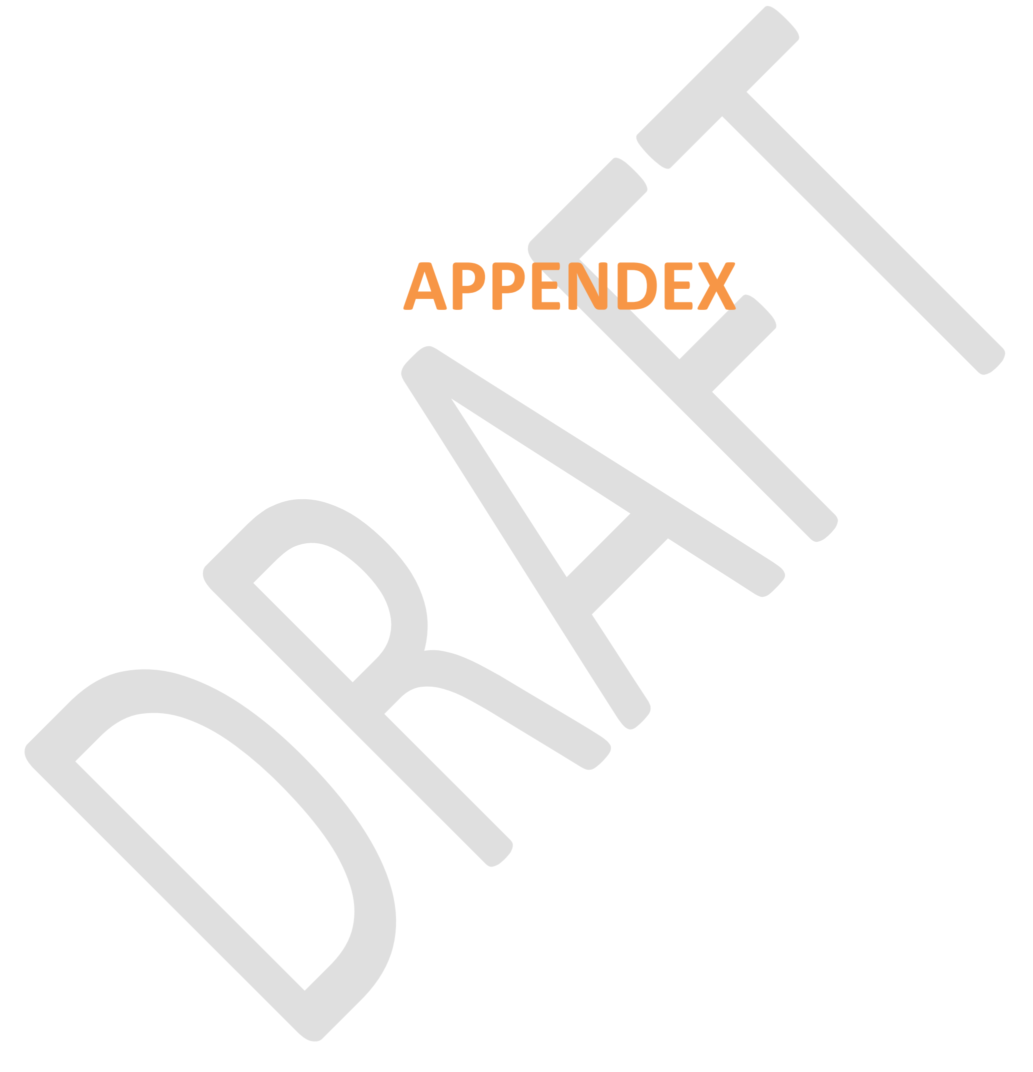
EXPENDITURE REPORTS

A	B	C	D	E	F	G	H
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention							
1.	Family Wellbeing	95,261	95,261				
2.	Older Adult Wellbeing (Peer Mentor)	79,313	79,313				
3.	Transition-Age Youth Wellbeing (Peer Mentor)	74,641	74,641				
4.	Community Capacity Building (Community Wellbei	520,882	520,882				
	Stigma Reduction and Suicide Prevention,						
	and Community Mental Health Training)						
5.	NAMI Community Capacity Building Program	35,500	35,500				
	(Ending the Silence)						
6.	Housing Stability Program	206,875	206,875				
PEI Programs - Early Intervention							
7.	Older Adult Wellbeing (Peer Mentor)	79,313	79,313				
8.	Transition-Age Youth Wellbeing (Peer Mentor)	74,641	74,641				
9.	Therapeutic Community Gardening	333,150	333,150				
10.	Early Psychosis	207,399	207,399				
PEI Programs - Other							
11.		0	0				
12.		0	0				
13.		0	0				
PEI Administration		606,767	606,767				
PEI Assigned Funds		42,000	42,000				
Total PEI Program Estimated Expenditures		2,313,742	2,355,742	0	0	0	0



APPENDEX

MHSA Regulations for Prevention and Early Intervention

"The County shall identify each Program funded with Prevention and Early Intervention funds as a Prevention Program, Early Intervention Program, Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Stigma and Discrimination Reduction Program, Suicide Prevention Program, Access and Linkage to Treatment Program, or Program to Improve Timely Access to Services for Underserved Populations".

Prevention and Early Intervention Regulations/July 1, 2018
(Title 9 California Code of Regulations, Division 1, Chapter 14 MHSA)

Per the Regulations stated above, Counties are required to identify each program funded under their Prevention and Early Intervention Plan by one or more of the following categories:

Prevention and Early Intervention Plan Required Categories/Programs

1. Prevention Program
   a. Housing Stability Program
   b. Therapeutic Community Gardening
2. Early Intervention Program
   a. Early Psychosis Program
   b. TAY and Older Adult Wellbeing (Peer Mentor Program)
   c. Therapeutic Community Gardening
3. Access and Linkage to Treatment Program
   a. Early Psychosis Program
   b. Family Wellbeing Program
   c. Housing Stability Program
   d. TAY and Older Adult Wellbeing (Peer Mentor Program)
   e. Therapeutic Community Gardening
   f. Wellness Center (TAY and Older Adults)
4. Stigma and Discrimination Reduction
   a. Community Mental Health Trainings
   b. Community Wellbeing Program
   c. Early Psychosis Program
   d. Family Wellbeing Program
   e. Housing Stability Program
   f. TAY and Older Adult Wellbeing (Peer Mentor Program)
   g. Therapeutic Community Gardening
   h. Wellness Center (TAY and Older Adults)
5. Outreach for Increasing Recognition for Early Signs of Mental Illness Program
   a. Community Mental Health Trainings
   b. Community Wellbeing Program
   c. Early Psychosis Program
   d. Family Wellbeing Program
   e. Housing Stability Program
   f. TAY and Older Adult Wellbeing (Peer Mentor Program)
   g. Therapeutic Community Gardening
   h. Wellness Center (TAY and Older Adults)
6. Suicide Prevention
   a. Stigma Reduction/Suicide Prevention
   b. NAMI: Ending the Silence
   c. TAY and Older Adult Wellbeing (Peer Mentor Program)

Innovation Annual Report
FY 2019-20

MHSA INNOVATION ANNUAL REPORT JUNE 2021

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To: Mental Health Services Oversight and Accountability Commission

Subject: Innovation Project

This report is prepared in compliance with California Code of Regulations, Title 9, Section 3580, Innovation Project Report.

Tri-City Mental Health Authority (TCMHA) was created in 1960 as a result of a Joint Powers Authority adopted by the cities of Claremont, La Verne, and Pomona. TCMHA and the city of Berkley are the only cities in California considered a "county" and serve as the mental health authority, although not the mental health plan, for a specific area.

Tri-City Mental Health engaged in a robust stakeholder and community planning process beginning in September of 2021. A total of three stakeholder meetings were held in addition to four stakeholder workgroup/focus groups dedicated to the review of this project as well as the testing of a new application for the pending pilot project, myStrength. During this time, participants received updates regarding the Help@Hand project as well as the opportunity to test the new application, myStrength, provide feedback, make suggestions and recommend changes for consideration by staff.

The following report is contained in Tri-City's Annual Update for FY 2021-22 and was posted for a 30-day public review and comment period from May 7, 2021 to June 8, 2021. The MHSA Public Hearing will be held on June 8, 2021 hosted by Tri-City's Mental Health Commission. At that time, the Mental Health Commission will recommend approval of the MHSA Annual Update for FY 2021-22. The Tri-City Governing Board will act on this recommendation and adopt the Annual Update for FY 2021-22 on June 16, 2021.

With this timeline in mind, we respectfully submit the following information, vetted through our community planning process, and pending approval by TCMHA's Governing Board.

- Innovation project information and data for FY 2019-20
- Expenditure report for INN program
- Innovation Technology Suite Status Report-CalMHSA

Community Stakeholder Meetings

9/30/2020
3/4/2021
4/8/2021

INN Workgroup/Focus Group

Help@Hand/Tech Suite:
1/21/2021
2/11/2021
2/16/2021
2/18/2021

Please feel free to contact me with any questions.
Regards,

Rimmi Hundal
Director of MHSA and Ethnic Services
Tri-City Mental Health Services
(909) 326-4626
rhundal@tricitymhs.org

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Innovation Project

Help@Hand

Originally named “Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions (Tech Suite)”

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Help@Hand Tech Suite Project

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	___ CSS	___ PEI	_X_ INN	___ WET	___: CFTN
Target Population:	___ 0-15	_X_ 16-25	___ 25-69	_X_ 60+	Other: Monolingual Speakers

Program Description

The primary purpose of this project is to increase access to mental health care by providing a non-traditional system for individuals who may be reluctant to access services through a more formal clinical setting. Through the use of computers, tablets and smartphones, community members will be able to access a suite of technology-based mental health services focused on prevention, early intervention, and family and social support with the intent to: decrease emergency care services; reduce psychiatric hospitalizations; and reduce the duration of untreated mental illness.

Help@Hand Tech Suite Project	
Projected Funding Amount	$1,674,700.00
Duration of INN Project	September 28, 2018 to June 30, 2021
Revised Project Dates	January 1, 2019 to January 1, 2024 Originally designed to be a three-year project, the Collaborative as a whole voted to extend the project to five years to allow adequate time to complete the implementation phase and learning goals for this project. No additional funds are requested or required at this time.

Target Population

- Transition age youth and college students (up to age 25) who are seeking peer support or who are interested in offering their support as trained peer listeners.
- Older adults (ages 60+) who lack transportation or are unable to access traditional services.
- Non-English speaking clients and community members who may be experiencing stigma and language barriers.

Program Update

Tri-City's initial concept of Help@Hand was to provide ways for clients to stay active in their personal wellness between appointments and for the greater community to have access to tools that promote mental wellbeing.

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Now that we are in the midst of a global pandemic that encourages physical distancing as a means prevention, the technology that will be used by Help@Hand becomes even more essential. Tri-City is aware that this pandemic can be triggering for some individuals and can also contribute to isolation. The goal is to be able to use the different technologies in the suite of applications to provide support in this "new normal". There will be apps that clinicians can use with their clients in conjunction with individual treatment plans. There will also be apps to support those in isolation by providing a virtual community of connectedness.

The original Help@Hand/Tech Suite proposal highlighted the targeted groups of older adults, transition age youth, and monolingual Spanish speakers. It has now become clear that moving forward, this project will expand those target populations to encompass other populations that may also have been severely impacted by COVID-19.

During FY 2019-20, the Innovation Plan Coordinator position was filled following an extensive hiring search. In addition, local efforts include convening a focus group consisting of Wellness Advocates/Peers who were charged with reviewing potential applications for a future pilot program.

Milestones for FY 2019-20 include:

- A focus group comprised of Wellness Advocates, MHSA staff, and the IT consultant, participated in a product testing process.
- Through the collaboration, various wellness apps have made accessing their apps free for participating counties/agencies and Tri-City has been taking advantage of the opportunity by providing the resources to staff and clients.
- CalMHSA created Digital Mental Health Literacy training videos and Tri-City will be utilizing the videos for clients and community members on-boarding.
- Tri-City continued to send useful wellness app information to our staff for self-care (and some client resources).
- Tri-City Wellness Advocates started planning for a Community Connections webinar to teach our clients and community members how to be safe online. They will be using the skills and information they acquired during the train-the-trainer session of the February Help@Hand Peer Summit.

<u>Challenges and Solutions</u>

In September 2019, Tri-City hired a new Innovation program coordinator after having this position vacant for an extended period of time. However, this project continued to move forward in collaboration with other counties who are a part of the Tech Suite project. A focus group was convened to review a potential application, WYSA, for a pilot project. Although this process proved promising, the pilot project was delayed due to COVID-19.

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COVID-19 Response

The major impact of COVID 19 was the stalling of workgroups that were envisioned for the pilot process. Revisions to this plan included moving into virtual meetings and creating innovative ways to continue the outreach to potential participants. One of these creative virtual outreach efforts included a community webinar hosted by Tri-City Wellness Advocates that focused on how to be safe online. Materials for this webinar were provided by Help@Hand, the Tech Suite Collaborative.

Cultural Approach

By providing an equally accessible way for individuals to access wellness, Help@Hand eliminates some of the traditional barriers to seeking service such as stigma, language and need for transportation. Additionally, as two of the primary populations designated for this project, there is a specific goal to create access and pay special attention to monolingual Spanish speakers and older adults.

Applications under consideration by Tri-City for this project will have the capacity for non-English language translation. In addition, training videos and outreach materials will be available in both English and Spanish to accommodate the primary populations residing in the Tri-City area.

Tech Suite/Help@Hand Collaboration Update
(Provided by CalMHSA)

FY 2019-20 Overview

Help@Hand is a statewide Collaborative project that began in 2018 with fourteen Counties and Cities leveraging interactive technology-based mental health solutions to help shape the future and improve accessibility and outcomes to connect people with care across the state. Technology has many benefits, but there are also many challenges and questions. The participating Cities/Counties are at the forefront of innovation to understand how technology is introduced and works, within the public behavioral health system of care. This means Help@Hand is not one project, but many projects across multiple Cities and Counties. The Collaborative offers the benefit of a shared learning experience that increases choices for Counties/Cities, accelerates learning, and adds in cost sharing. The focus of Help@Hand remains on pursuing a shared vision and common goals. Change at the scale of this project necessitates a robust readiness and change management approach. The project team has focused on building in activities to address these areas for both the project team and the community.

Impact

During FY 2019-20, the Help@Hand project had many successes and challenges. Some of the most notable impacts of the project during this time were work with the Peer community and the Cities' and Counties' exploration of mental health products to find those that best fit the needs of their stakeholder community.

Peers

Peers identified and raised the need for Digital Mental Health Literacy (DMHL) to empower California communities to make informed decisions about how they engage with technology. Listening sessions were held by the Peer and Community Engagement Manager to gather topics that would facilitate understanding and adoption of technology. There were 20 Digital Mental Health Literacy discovery sessions held in eleven different Counties with over 300 stakeholders

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from June – November 2019. These sessions led to the development of a DMHL video series, and a DMHL Curriculum that includes smaller coaching sessions (Q1-Q3 '19 & '20). Additionally, there were two Peer Summits held, in May and September 2019, to support Collaboration of Peer Leads from across the state for project learning, connection, and problem solving (Q1 2019). Monthly Peer Collaboration meetings were held to serve as a space for Peers to connect and share County/City project updates.

Technology Exploration

In early 2020, after the results of the Request for Statement of Qualifications (RFSQ) were released, the collaborative cities and counties began engaging their community stakeholders and conducting focus groups to explore new technologies available to the project and receive additional feedback on products that would be a good fit for their communities.

Challenges and Solutions

There are many things to consider when integrating technology into existing systems of care. The Help@Hand Collaborative has addressed many challenges in this work. Some of the challenges experienced by the Collaborative during FY 19-20 include:

COVID-19 Response

The beginning of 2020 brought significant challenges to Help@Hand participating cities and counties due to the COVID-19 pandemic. Many Collaborative members' focus changed quickly in March 2020 as they were asked to respond to evolving pandemic response request and care needs in their local communities.

Rapid Response - The early months of the pandemic saw Cities and Counties challenged to understand how they could quickly leverage mental health technology to meet growing community needs. Help@Hand worked quickly to develop a streamlined approach that supported Cities and Counties in launching a technology to their respective communities in direct response to growing mental health needs related to quarantine and COVID-19. Each step of the technology selection, readiness and deployment process is essential. Therefore, the rapid response approach did not reduce or eliminate critical steps but streamlined them by working to establish common features and functionality with the vendors and reducing variation among Cities and Counties. This effort is ongoing.

See attached CalMHSA Support for City and County's MHSA Annual Report

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INNOVATION EXPENDITURE REPORT

DRAFT

County:	TRI-CITY MENTAL HEALTH AUTHORITY					Date:	4/9/21
		Fiscal Year 2021/22					
		A	**B**	**C**	**D**	**E**	**F**
		Estimated Total Mental Health Expenditures	**Estimated INN Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
INN Programs							
1.	Help @ Hand	304,266	304,266				
2.		0	0				
3.		0	0				
4.		0	0				
INN Administration		0	0				
Total INN Program Estimated Expenditures		304,266	304,266	0	0	0	0

DRAFT

INNOVATION
TECHNOLOGY SUITE
STATUS REPORT

THE FOLLOWING STATUS REPORT WAS PREPARED BY THE CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (CALMHSA) FOR THE MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION (MHSOAC) AND PROVIDES A DETAILED OVERVIEW OF THE PROJECT FROM A COLLABORATIVE PERSPECTIVE.

DRAFT

CalMHSA Help#Hand Annual Report
FY 2019-20

Date: April 6, 2021

To: Help@Hand Collaborative Cities and Counties
From: CalMHSA
Re: CalMHSA Comments on Help@Hand Year 2 Annual Evaluation Report

Dear Help@Hand Cities and Counties,

CalMHSA is proud to support this multi-year innovation project in which 14 California Cities and Counties work together to explore mental health solutions through the use of technology. At publication of this report, the Help@Hand project has seen:

- Four product launches
- Stakeholder engagement through webinars, listening sessions, local input opportunities and focus groups
- Streamlined processes and rapid-response deployments to support communities during the COVID-19 pandemic

A key component of the project is evaluation, which results reports on a quarterly and annual basis. This annual report encompasses Year 2 (January 1, 2020 – December 31, 2020) of the Help@Hand evaluation and synthesizes evaluation findings across Cities/Counties.

The analysis and findings presented are those of the University of California, Irvine's (UCI) Help@Hand evaluation team. CalMHSA works collaboratively with UCI throughout the project and reviews the report for confidentiality, but neither CalMHSA, nor Cities/Counties are authors of the report.

How to Read This Report

Evaluation Reports are written with the Help@Hand Cities/Counties in mind as the target audience, however the project understands there are many other stakeholders who also have interest in these reports. Annual evaluation reports provide Help@Hand Cities/Counties with a larger perspective of the work in progress. Different from the quarterly evaluation reports, which are not intended to be exhaustive, the annual reports provide a more thorough view of the activities which took place throughout the year. Despite the comprehensive approach the annual report takes, readers should note the analysis and findings outlined in the report are still in summary and do not constitute all City/County, collaborative or project management activities completed during this evaluation period.

CalMHSA invites Help@Hand Cities/Counties to consider the following as they review the report:

- **Reflect** – Review and acknowledge the incredible work that has been done to date. Please take the time to recognize those on your teams, and in your communities, who have worked diligently to bring the project this far.
- **Learn** – One of the primary intentions of the Help@Hand innovation project is to learn. Learning includes both acknowledgement of successes and consideration of opportunities to improve. CalMHSA respects the openness and vulnerability of all project participants in embracing a learning mindset through which we explore and discover innovative solutions to improve our communities and save lives.
- **Respond** – Help@Hand project participants in particular should consider where and how to integrate the recommendations and learnings captured in this report. All audiences who have questions or wish to provide comments related to this report may email feedback to CalMHSA at helpathand@calmhsa.org and to UCI at dsorkin@uci.edu.

This report is a lengthy document in excess of 160 pages. To assist you in navigating, here is a preview of how the report is organized:

- Executive Summary (pages 5-6)
- Summary of Activities (pages 10-14)
- Recommendations (page 97)
- Spotlights (pages 14, 17, 21, 47, 61, 78,)
- Report Chapters are structured in the following format:
  - Key points for chapter
  - Overview and outline
  - Methods & Findings
  - Learnings

Preview of Activities in Year 3, Quarter 1

- Three additional product pilots and launches
- Monterey county RFP closed, scoring completed and intent to award notification made
- Recruitment for the Peer Program Coordinator role
- Completion of SharePoint redesign to facilitate communication and information sharing
- Facilitation of next collaborative Lessons Learned presentation
- Revised evaluation scope of work

Thank you for your interest in the learnings from Help@Hand. Questions or comments can be provided by contacting CalMHSA at helpathand@calmhsa.org and to UCI at dsorkin@uci.edu.

4/6/2020

Mental Health Services Act (MHSA) Innovation Technology Suite Evaluation

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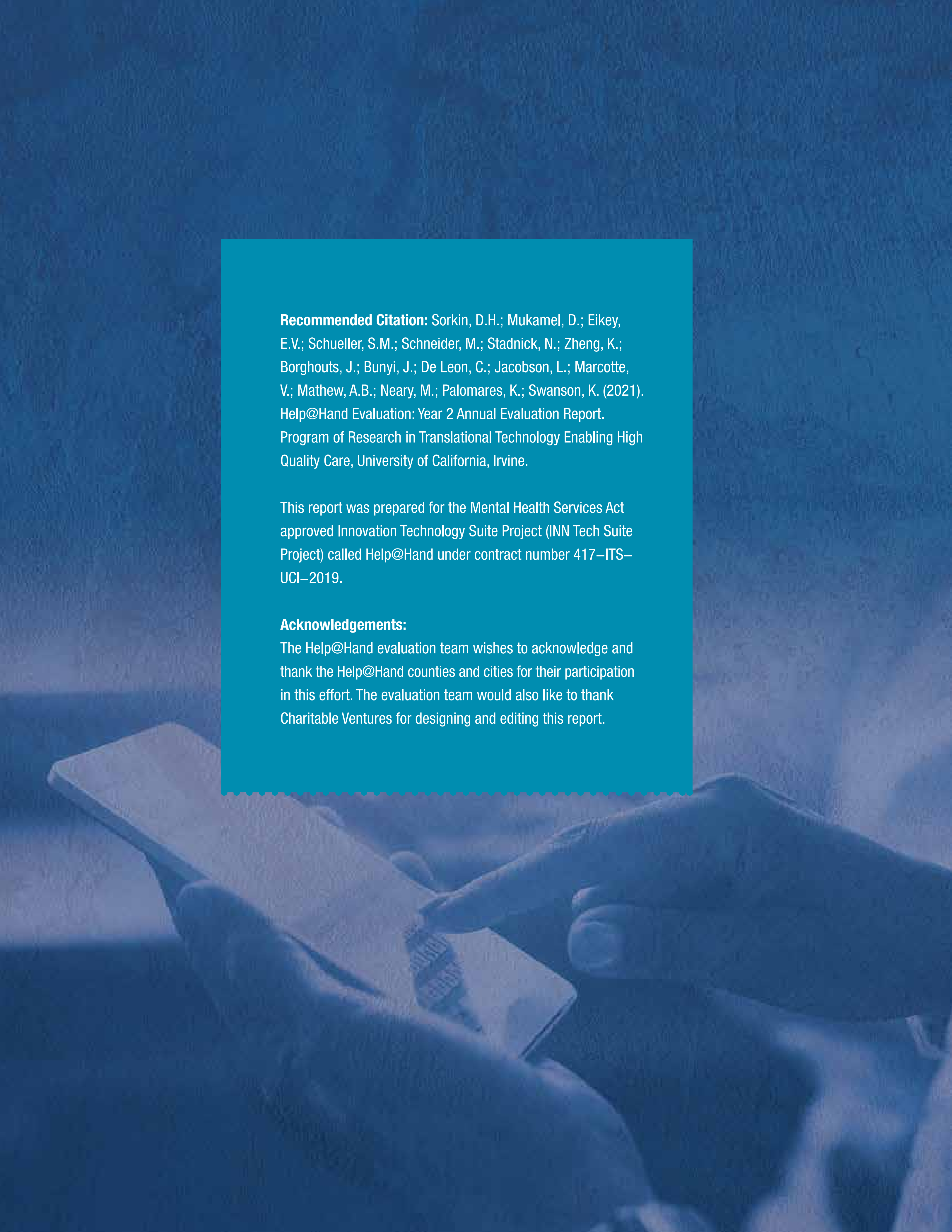
University of California, Irvine

Year 2 Annual Evaluation Report
January – December 2020
Submitted February 2021



Recommended Citation: Sorkin, D.H.; Mukamel, D.; Eikey, E.V.; Schueller, S.M.; Schneider, M.; Stadnick, N.; Zheng, K.; Borghouts, J.; Bunyi, J.; De Leon, C.; Jacobson, L.; Marcotte, V.; Mathew, A.B.; Neary, M.; Palomares, K.; Swanson, K. (2021). Help@Hand Evaluation: Year 2 Annual Evaluation Report. Program of Research in Translational Technology Enabling High Quality Care, University of California, Irvine.

This report was prepared for the Mental Health Services Act approved Innovation Technology Suite Project (INN Tech Suite Project) called Help@Hand under contract number 417–ITS–UCI–2019.

Acknowledgements:

The Help@Hand evaluation team wishes to acknowledge and thank the Help@Hand counties and cities for their participation in this effort. The evaluation team would also like to thank Charitable Ventures for designing and editing this report.

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INTRODUCTION

Year 2 of the Help@Hand project was marked by the same critical ruptures, social upheavals, and unprecedented challenges that have shaped 2020 for all of us, and have made the work of providing targeted and accessible digital mental health therapeutics newly profound for our communities.

The COVID-19 pandemic has revealed itself to be a generation-defining complex of interrelated crises—not only the public health emergency which is still overwhelming Help@Hand counties/cities, but also new crises of rampant unemployment, housing issues, and much more. Meanwhile, 2020 witnessed thousands of protests that have demanded an evolution of the conversation around systemic racism and its effects in communities of color. And through all of this, the year in politics culminated in the national election in November, with Joseph R. Biden Jr. and Kamala D. Harris, respectively, selected as the President and Vice President of the United States.

The past year had several challenges, but also gave way for communities to speak loudly and clearly about their needs, strengths, fears, and hopes. 2020 revealed all of these needs to be inextricably linked, and emphasized the collective toll on mental health. And yet, Year 2 of the Help@Hand program has afforded a vital opportunity to respond to community need with renewed dedication and community-driven effort.

Year 2 of the project was a year of careful community needs assessments, rigorous assessment of digital therapeutic technologies and market surveillance, thoughtful piloting and implementation phases, and vital shared learnings across the collaborative with an emphasis on even greater cross-unit collaboration moving forward. Critical insights into the needs and trends of different linguistic communities, age groups, and regions with respect to the use of digital and online mental health tools were gained. A high-level overview of Year 2 program and evaluation activities as well as learnings is provided below. As the program looks ahead to Year 3, it will continue to build upon the successes and learnings of this unparalleled, yet incredibly formative year.

HELP@HAND EVALUATION ACTIVITIES AND LEARNINGS

SYSTEM EVALUATION- MARKET SURVEILLANCE, ENVIRONMENTAL SCAN, AND COLLABORATIVE PROCESS EVALUATION

The Year 2 system evaluation focuses on evaluating system-related factors that may affect Help@Hand. It presents evaluation activities and learnings from the market surveillance, as well as the status of the environmental scan and the collaborative process evaluation. Findings include:

- User experience assessment suggests that many mental health apps offer interesting, engaging, and easy-to-use support. However, limited accessibility features indicate that not everyone can get on-demand support from these apps and may face barriers beyond ease of use.
- User experience, downloads, and engagement were higher for chatbot apps than for meditation or peer support apps.
- Digital phenotyping, an approved component of Help@Hand technologies, is not a widely available feature in publicly available mental health apps.
- Apps identified through Help@Hand's most recent Request for Statement of Qualification (RFSQ) tended to underperform in the marketplace in terms of number of downloads and number of monthly active users.

PEER EVALUATION

The evaluation of the Peer component carried out in Year 2 documents Peer activities, identifies successes and challenges to implementing the Peer component, and shares lessons learned across the Collaborative. Findings include:

- Peers are playing an active role in supporting the Help@Hand program across the Collaborative. There is enthusiasm overall for the contribution of the Peer component to the Help@Hand project.
- Digital educational materials can be delivered remotely to address digital literacy, in response to the in-person constraints brought about by COVID-19.
- Peers have been engaged in digital product testing throughout Year 2, and counties/cities plan to sustain this engagement into Year 3.
- Over time, more counties/cities are reporting successes with incorporating Peer input into Help@Hand decisions, but challenges to program implementation are being reported by an increasing number of counties/cities.

COUNTY/CITY TECHNOLOGY, USER EXPERIENCE, AND IMPLEMENTATION EVALUATION

In Year 2, the Help@Hand evaluation team conducted needs assessments to assure that technologies remain appealing and accessible to all users throughout the reach of the Collaborative. In particular, the needs of Los Angeles community college students and individuals within the Riverside County Deaf and Hard of Hearing Community were assessed, and plans for additional assessments with Orange County were initiated.

Marin, Riverside, San Francisco, and San Mateo Counties, as well as City of Berkeley and Tri-City explored different technologies with target populations to provide valuable feedback about how well or poorly specific technologies were received, which in turn will inform the pilot and implementation phase of selected technologies.

Meanwhile, Los Angeles, Marin, San Francisco, San Mateo, Santa Barbara, and Tehama Counties planned pilots to test potential technologies. A few of these pilots were paused or discontinued for various reasons. At the same time, Los Angeles and Orange Counties implemented technologies, with the intention of offering these technologies to a larger group of community members or using them for the remainder of the project.

In addition, the Help@Hand Collaborative developed a framework to rapidly launch technologies to respond to the needs of their communities during COVID-19. Riverside County developed and launched a peer-chat app called Take my Hand in 2020. San Francisco County is planning to partner with Riverside County on piloting this app as well in 2021. Another technology launched was Headspace, which Los Angeles and San Mateo Counties began offering to county residents in 2020. San Francisco plans to launch Headspace in their county in 2021.

Also, Monterey and Los Angeles Counties released a Request for Information and created a Request for Proposal as part of their development of a tool that screens and refers residents of Monterey County.

Finally, Kern and Modoc Counties completed their projects and transitioned off of Help@Hand. Exit interviews were conducted with both counties.

OUTCOMES EVALUATION AND DATA DASHBOARDS

The outcomes evaluation assesses Help@Hand's overall impact in the state of California. Key findings include:

- For both teens and adults, individuals with higher distress levels were more likely to have used online tools to connect with other individuals living with similar addiction or mental health conditions.

- California Health and Human Services (CHHS) and its Institutional Review Board (IRB) approved the Help@ Hand evaluation team request for data from vital statistics, which allowed the evaluation team to start analyzing data regarding suicides, and drug and alcohol overdoses. The analysis of the five-year baseline period from 2015 to 2019 revealed that the general rates of suicide and overdose are generally slightly higher in comparison counties than in Help@Hand counties.

RECOMMENDATIONS

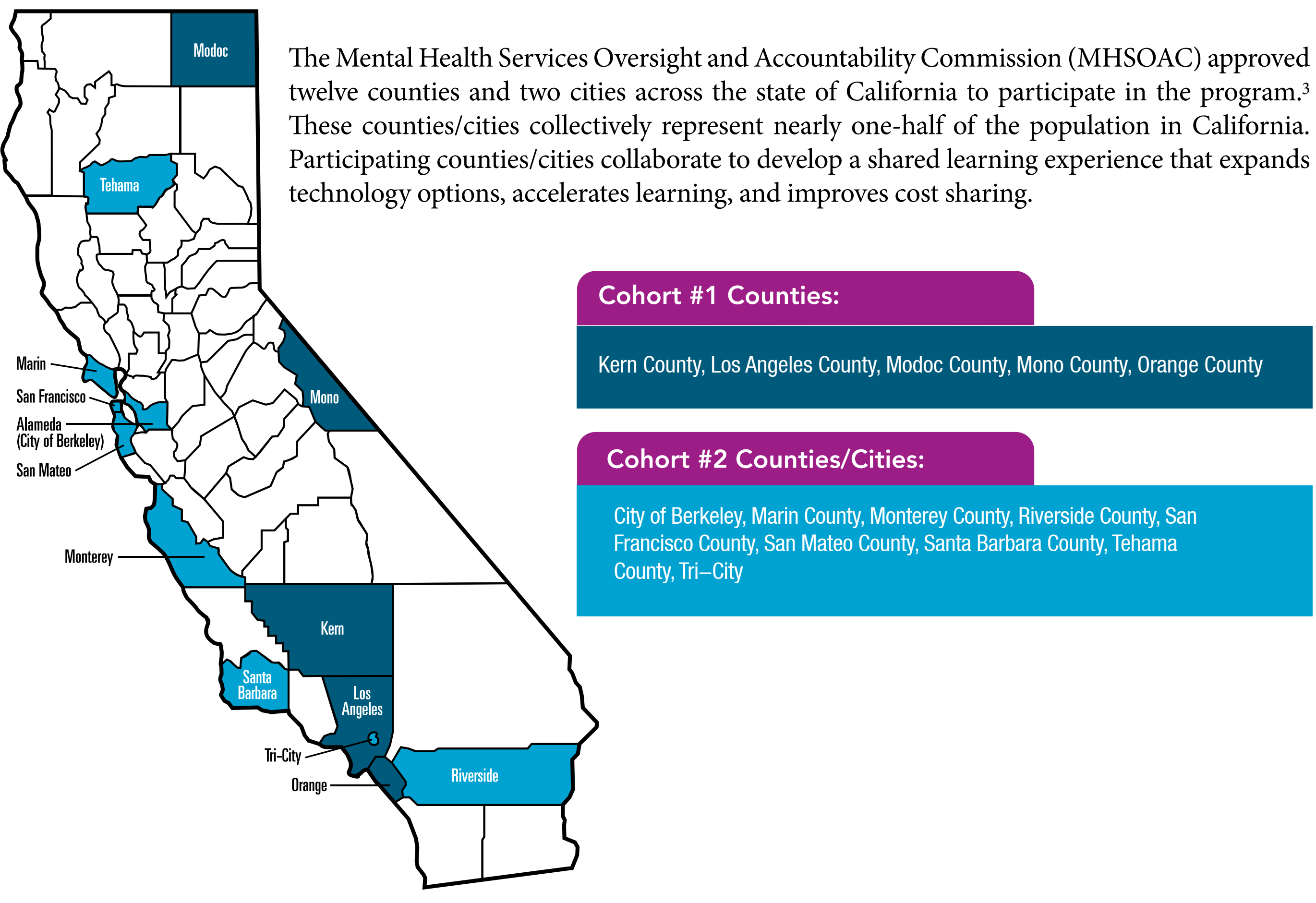
Recommendations based on evaluation learnings are provided on page 97 for the Help@Hand Collaborative and the individual Help@Hand counties/cities.

The Innovation Technology Suite (branded as Help@Hand in 2019) is a five-year[1] statewide demonstration funded by Prop 63 (now known as the Mental Health Services Act) and has a total budget of approximately $101 million. It is designed to bring a set (or "suite") of mental health digital therapeutic technologies into the public mental health system. The program intends to provide people across California with free access to high quality, digital mental health therapeutics. In addition, Help@Hand leads innovation efforts by integrating Peers[2] throughout the program.

The efforts of Help@Hand are guided by the following five shared objectives:

1. Detect and acknowledge mental health symptoms sooner;
2. Reduce stigma associated with mental illness by promoting mental wellness;
3. Increase access to the appropriate level of support and care;
4. Increase purpose, belonging, and social connectedness of individuals served;
5. Analyze and collect data to improve mental health needs assessment and service delivery.

[1] The project was originally designated as a 3-year effort.
[2] Help@Hand defines a Peer as a person who publicly self-identifies with having a personal lived experience of a mental health/co-occurring issue accompanied by the experience of recovery. A Peer has training to use that experience to support the people they serve.



The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved twelve counties and two cities across the state of California to participate in the program.[3] These counties/cities collectively represent nearly one-half of the population in California. Participating counties/cities collaborate to develop a shared learning experience that expands technology options, accelerates learning, and improves cost sharing.

Cohort #1 Counties:

Kern County, Los Angeles County, Modoc County, Mono County, Orange County

Cohort #2 Counties/Cities:

City of Berkeley, Marin County, Monterey County, Riverside County, San Francisco County, San Mateo County, Santa Barbara County, Tehama County, Tri–City

ABOUT THE EVALUATION

The University of California, Irvine (UCI) in partnership with the University of California, San Diego (UCSD) is conducting a comprehensive formative evaluation of Help@Hand. The formative evaluation observes and assesses the program as it happens in order to provide real-time feedback and learnings.

This evaluation report presents learnings from Year 2 (January-December 2020). The report is organized as follows:

- **Summary of Activities – Describes key activities and milestones accomplished during the period**
- **Evaluation – Reports activities and learnings on:**
  - System Evaluation
  - Peer Evaluation
  - County/City Technology, User Experience, and Implementation Evaluation
  - Outcomes Evaluation and Data Dashboards
- **Help@Hand Evaluation Advisory Board Recommendations – Presents recommendations based on learnings**

[3] Counties and cities can participate by submitting a proposal to the MHSOAC. Upon approval, counties and cities contract with CalMHSA, which serves as the administrative and fiscal intermediary for the program. Inyo County began participating in 2018, but later withdrew in 2018 due to insufficient internal resource capacity.

Word cloud generated by Tech Leads to describe 2020

QUARTER 1 (JAN-MAR 2020)

Oversight and Help@Hand Leadership

- Published semi–annual report and presented update to the MHOAC (Help@Hand Collaborative)
- Approved pilot evaluation plan (Help@Hand Leadership)
- Convened Roadmap workgroup and Linguistic and Cultural Adapta–tion workgroup (Help@Hand Leadership)
- Announced resignation of Peer and Community Engagement Man–ager (CalMHSA)
- Created business continuity plans in response to COVID–19 crisis (Help@Hand Collaborative)
- Examined feasibility of statewide rapid response to COVID–19 pandemic (Help@Hand Collaborative)

County/City Activities

- Began exploring technologies and/or pilot planning (Los Angeles, Riverside, San Mateo, Santa Barbara, Tri–City)
- Presented 2nd edition of app guide to several stakeholders and worked on 3rd edition (Kern)
- Prepared to launch Take my Hand, a county–developed peer chat website (Riverside)
- Continued planning screening and referral tool (Monterey)
- Continued planning for Mindstrong implementation (Orange)
- Convened Digital Mental Health Literacy Train–the–Trainer work–shop (Help@Hand Collaborative)

CRISIS

At the beginning of Year 2, the Help@Hand Collaborative made major strides to plan successful launches of technologies within their communities. Los Angeles, Riverside, San Mateo, and Santa Barbara Counties, as well as Tri-City, began planning pilots, which involved: exploring and vetting apps with staff, community members, and other stakeholders; meeting with vendors to learn more about their technologies; and engaging members of target populations with technology and the project through app guides, "AppyHours," and other outreach activities. Riverside County prepared to launch a pilot of their own peer chat website, Take my Hand. Meanwhile, Monterey and Orange Counties continued to plan their technology implementations. The project management team consulted experts and developed templates, tools, processes, and guidance to support these various planning endeavors. A description of some support can be found in the spotlight on page 14.

In addition, workgroups were convened to operationalize key strategic project priorities as well as address linguistic and cultural community needs. A Digital Mental Health Literacy (DMHL) train-the-trainer workshop was hosted by CalMHSA and held in Kern County with 30 Peers. The workshop provided training on a number of topics, including CalMHSA's digital mental health literacy curriculum and coaching sessions. CalMHSA also launched

- Held virtual Help@Hand Collaboration meeting (Help@Hand Collaborative)

Project Management

- Contracted with expert to provide clinical guidance for risk and liability (CalMHSA)
- Created and shared new vendor contract template and pilot proposal template (CalMHSA)
- Developed organizational change management tool, product matrix tool and Digital Behavioral Health Questionnaire (DBHQ) risk assessment tool (CalMHSA)
- Established pilot process and procurement process for county/city purchases (CalMHSA)
- Provided guidance for short code messaging and to operationalize Help@Hand branding (CalMHSA)
- Created interactive dashboard on project–related metrics
- Developed digital mental health literacy video series (CalMHSA)
- Launched HelpAtHandCa.org website (CalMHSA)
- Hosted webinar on Help@Hand for stakeholders and the general public (Help@Hand Collaborative)

QUARTER 2 (APR-JUN 2020)

Oversight and Help@Hand Leadership

- Approved 3 pilot proposals received from Los Angeles County (Help@Hand Leadership)
- Developed a rapid response option for counties/cities to deploy a rapid response solution in response to COVID–19 (Help@Hand Collaborative)
- Began recruiting for a new Peer and Community Engagement Manager (CalMHSA)
- Revisited project budget model, including evaluation scope of work (Help@Hand Collaborative)
- Approved and published grievance policy on Help@Hand website (Help@Hand Leadership)

County/CIty Activities

- Conducted college student needs assessment (Los Angeles, Help@Hand evaluation team)
- Explored technologies and/or planned pilots (Marin, Riverside, San Francisco, San Mateo, Santa Barbara, Tehama, Tri–City)
- Released Request for Information (RFI) to inform planning of screening and referral tool development (Monterey, Los Angeles)
- Began negotiating contract with MindLAMP to replace MindStrong for electronic diary card in Dialectical Behavior Therapy (DBT) program (Los Angeles)
- Launched Take my Hand COVID–19 Rapid Response (Riverside)
- Launched Headspace COVID–19 Rapid Response (Los Angeles)
- Began planning Headspace COVID–19 Rapid Response (San Mateo)
- Launched Mindstrong (Orange)

the Help@Hand website (HelpAtHandCa.org) and hosted a webinar to inform stakeholders and the general public about the Help@Hand program.

In March 2020, the program faced a major crisis with the arrival of the global COVID-19 pandemic and California's subsequent stay-at-home order. In response, CalMHSA actively worked with counties/cities to create business continuity plans and began to examine the feasibility of rapidly deploying technologies to immediately help communities during the COVID-19 pandemic. Several counties/cities quickly presented pilot proposals for Help@Hand Leadership approval in order to launch technologies to help communities. Others adapted planning activities for virtual formats. For example, Marin County and Tri-City began planning remote app exploration sessions with their target groups.

CALIBRATION

During quarter 2, the COVID-19 pandemic continued to impact the physical health, mental health, and economic security of individuals worldwide, and residents of the Help@Hand counties/cities were no exception. Meanwhile, the prevalence of systemic racism in the U.S. drew global attention, as high-profile cases of police violence erupted into an unprecedented series of sustained protests and civil unrest. While raising awareness and sparking dialogue on race and social justice issues, these highly traumatic public events also compounded the need for mental health and other much needed services in communities of color.

Several Help@Hand counties/cities worked tirelessly to explore technologies and plan technology pilots and implementations to meet community needs. In addition, the Help@Hand Leadership developed the Rapid COVID-19 Response framework in order to calibrate to the immediate needs of communities. The framework streamlined the process to launch technologies and allowed those counties/cities who were ready to deploy technologies to both target populations and the general public to quickly do so. Two counties– Los Angeles and Riverside – launched efforts via the framework. San Mateo County began to plan a launch of Headspace using the framework. While these counties pursued rapid response interventions, Orange County launched its Mindstrong implementation with psychiatric patients seen at UCI Health Psychiatry Services.

Meanwhile, many counties/cities paused activities while their local leadership assessed their organizational impacts amid the uncertainty brought about by the pandemic. These assessments helped inform how counties/

Project Management

- Developed Hybrid Pilot Implementation process (CalMHSA)
- Published product profiles to consolidate key information about RFSQ products and vendors (CalMHSA)
- Assessed current product certifications, licensures, and other accreditation of healthcare technology companies (CalMHSA)
- Developed Recommended Staff Expertise guidance and project onboarding materials for new Collaborative members (CalMHSA)
- Published Stakeholder Report on Help@Hand website (helpathand–ca.org)

QUARTER 3 (JUL-SEPT 2020)

Oversight and Help@Hand Leadership

- Onboarded new CalMHSA Executive Director (CalMHSA, Help@Hand Collaborative)
- Instituted new Help@Hand budget (Help@Hand Collaborative)
- Continued discussions on Help@Hand evaluation's scope of work (Help@Hand Leadership)
- Approved Tehama County's pilot proposal (Help@Hand Leadership)
- Approved funding for translation of six documents into Spanish (Help@Hand Leadership)

County/CIty Activities

- Began planning needs assessment with behavioral health clients (Orange, Help@Hand evaluation team)
- Explored technologies and/or planned pilots (Berkeley, Marin, Riv–erside, San Francisco, San Mateo, Tehama, Tri–City)
- Expanded implementation to allow more clinicians to refer patients to Mindstrong (Orange)
- Began developing Request for Proposal (RFP) development for screening and referral tool (Monterey, Los Angeles)
- Implemented Headspace using Rapid COVID–19 Response (Los Angeles, San Mateo)
- Assessed Take my Hand Rapid COVID–19 Response (Riverside)
- Announced pause in Help@Hand work until January 2021 (Tri–City)

Project Management

- Added county and city resources to the County Collaboration Center on SharePoint (CalMHSA)
- Began coordinating how to collect and share lessons learned with counties/cities (CalMHSA, Help@Hand evaluation team)
- Developed Digital Mental Health Literacy (DMHL) Planning Guide (CalMHSA)
- Adapted DMHL courses and supplemented Facilitator Guides for virtual delivery (CalMHSA)
- Developed video tutorial series on Zoom Features (CalMHSA)
- Worked on vendor contracts for Los Angeles, Orange, San Mateo, Tehama, Tri–City (CalMHSA)
- Designed Marketing Outreach Recommendations document (CalM–HSA)
- Updated Helpathandca.org website and Help@Hand project dash–board (CalMHSA)

cities could adapt and re-calibrate Help@Hand activities. For example, Santa Barbara County paused their technology pilot planning to focus on impact of COVID-19 within the agency. During this pause, Santa Barbara re-directed its efforts on developing a Peer Ambassador Program.

COLLABORATION

Collaboration was discussed at the leadership level in quarter 3. In July 2020, CalMHSA's Board and the Help@Hand Collaborative welcomed a new Executive Director, Amie Miller, PsyD. As part of her on-boarding, she met with each county/city in order to understand their projects and strengthen collaboration.

Project activities also reflected greater collaboration during the quarter. Each county/city gathered lessons learned from their technology planning and implementations, which they began to readily share with other counties/cities in the Help@Hand Collaborative. Cross-collaboration learnings were shared on several weekly Tech Lead calls. Painted Brain, who subcontracted with a number of Help@Hand counties/cities, also shared learnings from these collaborations (see spotlight on page 17). CalMHSA and the Help@Hand evaluation team began to strategize for how to better collect and share lessons learned with counties/cities. A central county collaboration center was also created on SharePoint to save local resources for other to use as well.

In addition to collaborative learnings, technology collaborations were explored. For example, Monterey County partnered with Los Angeles County on the development of a screening and referral tool. Both counties discussed expanding their collaboration on the tool to other counties/cities. Similarly, several counties/cities discussed potential technology collaborations with Take my Hand, Mindstrong, and Wysa.

Lastly, collaborative solutions were created to address common challenges. For example, the Collaborative approved a subcontract with a translation vendor to ensure linguistic and cultural appropriateness—a common challenge among all counties/cities (see spotlight on page 21). CalMHSA also created several guides and tutorials to address another common challenge, helping counties/cities provide outreach virtually, while looking into addressing contracting challenges with technology vendors.

CONTINUATION AND CHANGE

Significant changes occurred at the end of Year 2. Kern and Modoc Counties announced they completed their projects and met their project objectives. As such, they

QUARTER 4 (OCT-DEC 2020)

Oversight and Help@Hand Leadership

- Separated from the George Hills Company (CalMHSA)
- Approved Marin County's pilot proposal (Help@Hand Leadership)
- Announced project completion (Kern, Modoc)

County/CIty Activities

- Conducted Deaf and Hard of Hearing Community needs assessment (Riverside, Help@Hand evaluation team)
- Explored technologies and/or planned pilots (Berkeley, Marin, Riverside, San Francisco, San Mateo, Tehama, Tri–City)
- Began planning Headspace Rapid COVID–19 Response (San Fran–cisco)

Project Management

- Initiated thorough research on resources to help inform a county/city's approach to equitable device distribution (CalMHSA)
- Developed and shared a communication plan template to ac–company new project artifacts so that the purpose, goal(s), and objectives of each new item are clear and can be shared with the Collaborative (CalMHSA)
- Updated website based on initial feedback (CalMHSA)
- Translated and shared the Digital Mental Health Literacy curriculum from English to Spanish (CalMHSA)
- Shared insights on Terms of Service development (Riverside)

The noted list of activities is meant to describe programmatic highlights and does not necessarily reflect all effort across the various levels of the program.

would transition off Help@Hand. In addition, CalMHSA separated from George Hills, a firm who had provided CalMHSA administrative functions for several years. The separation involved some initial disruptions, such as issues with the projects website and SharePoint as well as CalMHSA's email and Zoom accounts.

At the same time though, counties/cities continued to make significant strides with their project planning, pilots, and implementations. For example, Marin County developed pilot plans, which were reviewed and approved by the Help@Hand Leadership. Additionally, some counties/cities also explored and planned new technology launches. A needs assessment was conducted with Riverside County's Deaf and Hard of Hearing Community. New technologies were also explored with Riverside County behavioral health clients.

Despite unexpected challenges in Year 2, the Help@Hand program has had many successes and learnings that poised them for continued progress in Year 3.

SPOTLIGHT
Foundational Knowledge

Authors: Kim Tarabetz, Help@Hand Organizational Change Mangement Manager; Erik Newland, Help@Hand Implementation and Product Consultant; Brittany Ganguly, Help@Hand Program Manager

The Help@Hand project seeks to build a complementary support system that offers a bridge to care, helps identify early signs of mental health changes, offers timely support, removes barriers, and seeks to include new avenues of care for communities not connected to conventional county services. In the implementation of emerging technologies in the behavioral health space, Help@Hand, through a collaborative of California cities and counties, hopes to enable this complementary support system. A primary component of the project is the identification and evaluation of feasibility to implement these technologies within the regional government structures.

In order to be successful, Help@Hand has identified the need to provide and support implementation of behavioral health applications through technology industry methodologies and standards, project management, and organizational change management (OCM).

TECHNOLOGY

Technical Basics

In supporting innovative technology applications representing the latest and greatest products, it is critical that collaborative partners and decision makers have the foundational knowledge of software system engineering, methodologies and best practices in order to make informed decisions.

Some of these practices include:

- Understanding of technology industry common vernacular and language
- An overview of the Software Development Lifecycle (SDLC) and the steps involved
- Agile and Waterfall software development methods
- The importance of testing, even with an off-the-shelf product, to verify the technology meets government regulations and standards, as well as consumer needs
- Roles and responsibilities in software development as the custodians and implementers of products

Expectations

Setting expectations and needs around the support infrastructure for technology applications and implementations is critical. The identification of partner vendors and purchasing of technology applications is not enough. Successful implementation and supporting consumer adoption requires a lot of work. This includes supporting administration and compliance with city, county, and state standards. Understanding and supporting the difficulty and complexity of technology in terms of the level of support required to make decisions, negotiate partnerships, make changes (e.g. translations, customizations with city and county specific information), and navigating local and state policies and standards.

Deploying a product that is successfully launched and used by the community requires cities and counties to find the right solution and take the right approach to meet the needs of their community. This includes understanding local risk tolerances, the number of changes to a product that is needed and weighing the pros and cons of finding that right solution.

Some of the Tactics Help@Hand Used:

- Overview of Agile Methods
- SDLC Panel Discussion
- Digital Behavioral Health Questionnaire
- Product Vendor Profiles
- Product Vendor Security Questionnaire
- Digital Mental Health Literacy
- Facilitating vendor and City/County planning discussions

CHANGE MANAGEMENT

What is Change Management

Organizational Change Management (OCM) is support for the people-aspect of change projects. Adoption of new technologies and supporting communities that may not be as familiar with innovative technology requires a great deal of effort to establish common goals, align expectations and keep stakeholder apprised of the project. While a significant level of effort, this level of engagement is essential to be a good partner to project stakeholders and the communities served, as well as to mitigate the risk of future hurdles that may arise when a stakeholder group is uninformed. At the collaborative and local levels, Help@Hand has identified and supported the need to draw from industry subject matter experts and integrate change management throughout the project.

Communication

Communication is vital to stakeholders and the communities that are being served by technology. The frequency of communication is often much greater than anticipated, both within the city and county internal networks and to community members. However, communication is not a 1-way channel. Feedback from the collaborative members on project expectations and where there may be a lack of clarity is crucial to refining communication approaches including channels and messages. In addition, feedback and engagement from the stakeholder community to inform technology product selection is equally vital in helping counties select a product that resonates with their communities.

Alignment

In all projects, but especially in a collaborative setting, alignment is a tremendous influence on how successfully the project moves forward. Simply put, alignment means project leaders and decision-makers have a unified perspective of what it means for the project to be successful and they work together to achieve that goal. On a complex and collaborative project, this becomes even more challenging partly due to the larger number of decision-makers and key stakeholders, including community stakeholders, Peers, oversight agencies, budget, risk, legal, and technology.

- Take time to build common goals & expectations and check back on them frequently
- Recognize internal partnerships (IT, Peers, Legal, Program)

- Recognize external partnerships (Collaborative members, Stakeholders, CBOs)
- Anticipate areas of concern or potential resistance by gathering regular feedback and proactively addressing areas of concern as they arise

Stakeholders

Identification and support of stakeholders to provide guidance and transparency in technology selection and evaluation is a necessity. This requires significant organizational change needs and communication strategies. As a public innovation project supporting the behavioral health community, Help@Hand has worked to increase stakeholder involvement through focus groups, regular status reporting and creating forums for open discussion. Stakeholder groups include Peers, community, government oversight and evaluation

Some of the Tactics Help@Hand Used:

- OCM Plans
- OCM Training
- OCM Coaching
- Lesson Learned
- Highlighted Examples from Other Counties
- Collaborative Roadmap
- Executive Alignment Workshop
- County Strategic Plan Template
- Stakeholder Webinar & Report
- Local Stakeholder Meetings
- Polling during tech lead calls

SPOTLIGHT

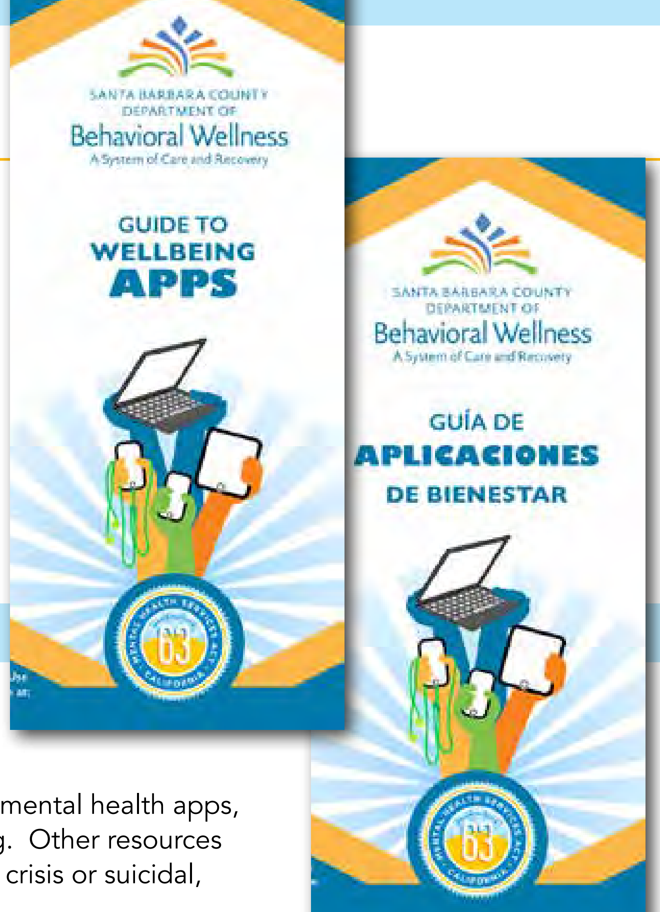
Painted Brain: Working with Multiple Counties to Address Digital Literacy

For Santa Barbara and San Mateo counties, digital literacy became a critical issue in Year 2 of the Help@Hand program. While efforts were being taken towards the implementation of the Help@Hand program, for both counties, it became increasingly clear that many in their communities did not know how to use a smartphone or tablet – let alone understand how to use an app that is on that device. With such a gap in understanding, both counties understood that raising digital literacy was key to the success of the program. Painted Brain, an organization with a history of teaching digital literacy in behavioral settings and with vulnerable populations, was separately contracted by both counties to address this gap. Painted Brain, according to Rayshell Chambers, Chief Operating Officer and one of the original founders,

Meets people where they are at. They understand the needs of communities of color and other disenfranchised communities and being able to develop the curriculum and other outreach and engagement strategies that are culturally responsive and linguistically appropriate to address the digital divide in isolated communities and counties across the state of California.

Santa Barbara

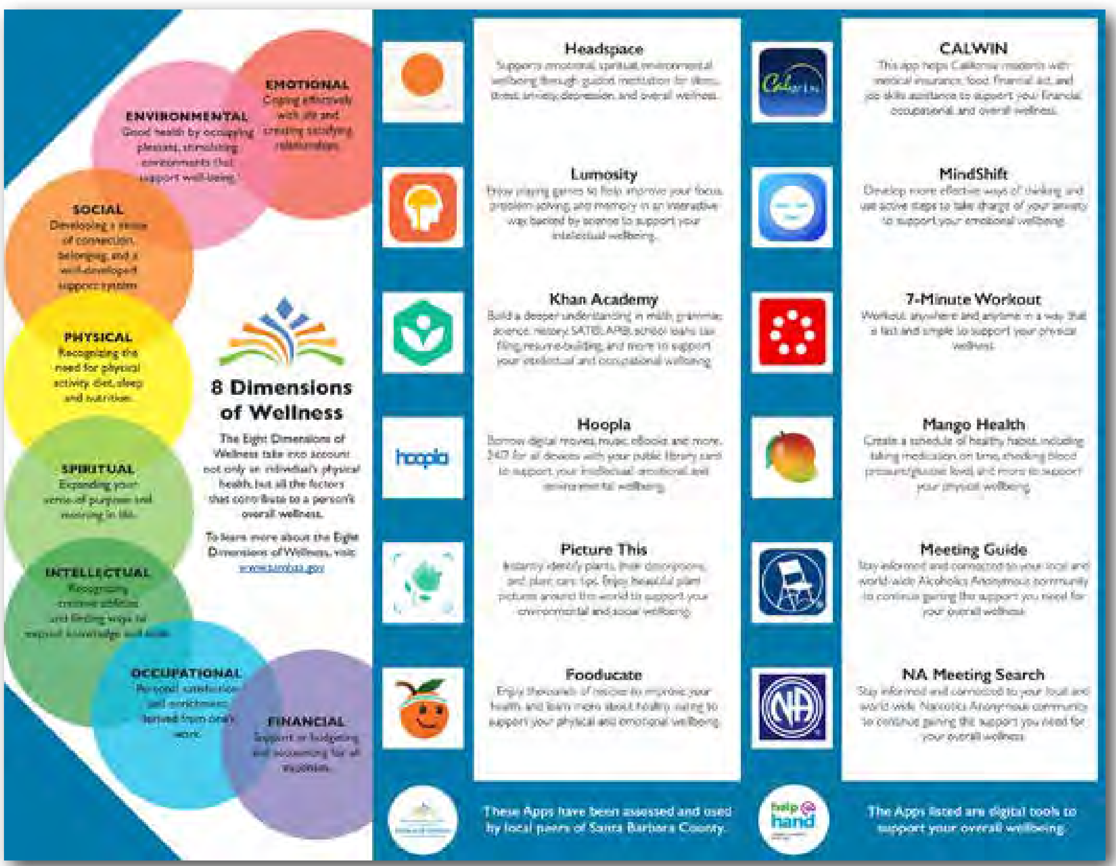
Painted Brain was contracted by Santa Barbara to integrate digital literacy into traditional mental health settings. To do this, Painted Brain provided four services – designing a brochure, training Santa Barbara's workforce, developing a digital literacy curriculum for the TAY community, and providing ongoing technical support, Appy Hours. The impact of these services has been substantial. Although in different formats, digital literacy support has been provided in Santa Barbara County to older adults, TAY, adults and youth leaving a hospital after a psychiatric hold, and Santa Barbara County's peer workforce.



Brochure

To support individuals with mental health issues, Painted Brain in collaboration with Santa Barbara created a brochure, Guide to Wellbeing Apps. Based on Painted Brain's assessment and evaluation of several mental health apps, this brochure lists 12 apps that support overall wellbeing. Other resources are also provided including contact information those in crisis or suicidal,

Lifeline, a 24-hour toll-free Access line, and a QR code to access Santa Barbara County's Mental Health, Alcohol & Substance Use Information, Referrals & Crisis Support website and information about the 8 Dimensions of Wellness. This brochure along with a smartphone are given to adults and youth getting out of hospitals on psychiatric holds.



Workforce Training

Painted Brain also trained the Santa Barbara County Department of Behavioral Wellness' peer workforce. The purpose of the training was twofold. The first goal of the training was to enhance the digital literacy skills of Santa Barbara County's peer workforce. The second goal of the training was for Peers to have the skills to support client's use of digital devices. In other words, the purpose of the training was for Peers to become proficient in the use of digital devices as well as learn how to support others in their use of mobile devices. To fulfill both goals, Painted Brain used a train-the-trainer model that fits the needs of the community members they serve. A digital health curriculum created by Painted Brain that covered such topics as setting up a gmail account, downloading an app, and using a phone camera provided the structure of the training. To assure that Peers would be able to support their specific community members, lessons were framed within the context and the community that Peers would be working in. Peers who completed the training became the first cohort of peer digital ambassadors – a new role created for the Help@Hand program. Equipped with digital understanding and the skills to teach others the same, the next step for peer digital ambassadors will be to use the curriculum to facilitate groups on digital wellness.

Appy Hours

Appy Hours is a regular opportunity for older adults in the Santa Barbara area to learn and optimize their mobile device knowledge. Specific topics, such as how to scan a QR reader and creating a YouTube account as well as opportunities for attendees to ask specific questions are given. Adapted from the in-person Appy Hours offered prior to covid, Appy Hours take place online via Zoom. Knowing the importance of making what can be a stressful topic fun, informative and engaging, Painted Brain includes games, polls, music, videos, and opportunities to win gift cards throughout the event.

Their efforts appear to be successful too. Chambers explained that Painted Brain has received positive feedback from those who attend the Appy Hours and from family members whose parent attends them too. As an example, Chambers shared that one family member described the impact of the Appy Hours on their mother as "transformational" and that it raised her "confidence".

TAY curriculum

Most recently, Painted Brain has been contracted by Santa Barbara County to create a digital health literacy curriculum for the TAY community. Still in the design phase, the focus of the curriculum will be digital wellness and recovery. It will cover the topics of recovery & resilience; online safety practices; and basic computer skills. Gaby Garcia, Program Analyst for Painted Brain explained that "each topic will focus on how technology can support TAY's overall wellness". To guide the development of the curriculum, Painted Brain, in collaboration with local colleges, is hosting listening sessions with TAY throughout the region. According to Chambers the listening sessions have been informative. Within the TAY community they've heard from TAY who "saw no purpose of basic digital literacy skills – like email set-up and email maintenance. Then, there were TAY at the community college that said we need this so bad". For the TAY who wanted to learn about digital literacy, they are interested in learning about email maintenance as well as using email for personal advocacy and professional use. The advantages Painted Brain gains from the listening sessions expand beyond using responses to develop the curriculum. It also is a unique opportunity for Painted Brain to share what they learned with Santa Barbara County colleagues.

San Mateo

Painted Brain's work with San Mateo began after the County had launched the distribution of mobile devices to community members. Having quickly mobilized the requisition and begun the delivery of smartphones or tablets to community members, San Mateo learned that the challenges to the effort were not logistics, instead it was the support that individuals were seeking from the peer workers who were delivering them. That is, peer workers were reporting that when they delivered the mobile devices, they were being asked questions about how to use the devices – how to turn it on, how to make phone calls, etc. While willing to help, Peers were not skilled at offering digital support. Recognizing that there was a need for digital literacy training within their community, San Mateo, who had heard about the positive work that Painted Brain was doing in other Counties, decided on a plan that would meet the needs of their workforce and the community they served. Like Santa Barbara, they chose to contract Painted Brain to train their workforce on digital literacy. With this training, Peers, in turn, would be able to use their newly acquired digital literacy skills to support the San Mateo community.

Workforce Training

Painted Brain chose to use a train-the-trainer model for the workforce training. As they did with the Santa Barbara peer workforce training, Painted Brain taught topics from their digital literacy curriculum including online security and privacy, introduction to digital peer navigation, email set-up and maintenance on a computer and a mobile device as well as telehealth. Importantly, the training was geared toward San Mateo County's needs. Painted Brain, first, identified community needs then during the training incorporated topics that the peer workforce had already encountered while distributing mobile devices. As Painted Brain staff member, Rashawn Morris, explained "I think the main thing is that we're trying to come from the perspective of what their Peers may need and what Peers themselves are going to need to train others". He also explained that "The whole time we are going through different training modalities to support people even wanting to be a part of this digital world".

Two trainings were completed by the end of 2020. The first was for the County peer workforce while the other was open to the workforces of the organizations that San Mateo has contracted with for the distribution of the mobile devices. Morris summarized training participants in the following quote "both times they've been very receptive to the information we are giving, and they have also been able to speak on their experience". Both trainings received positive feedback.

Next Steps

For 2021, San Mateo will continue using Painted Brain to offer digital literacy education to their community. Digital literacy education will be offered in three contexts. First, another set of workforce trainings will be offered to the organizations that are assisting with the distribution of the mobile devices. Second, an intermediate

level training on online platforms and facilitation methods will be provided for community organizations Last, Painted Brain will host online Tech Cafés to all San Mateo County community members.   This additional work has the potential to greatly impact the County. As explained by Chambers "We're hitting three sectors of their population. We're hitting internal peer workforce, their community-based organizations(their contractors) and we're hitting their communities".

Workforce Trainings

A total of 18 organizations have received mobile devices for their clients. with over 1,000 devices having been distributed. The need for digital literacy education has been noticeable by many in the workforce. To support workforces from all organizations, Painted Brain will replicate the Fall 2020 trainings. Two additional trainings will be offered. Chambers explained that the goal of the trainings is to "build their current workforce's capacity to understand digital literacy topics and be able to interact and work with clients around digital literacy topics".

Tech Cafés

With the peer workforce trained in digital literacy, San Mateo County Health learned that community members were routinely reaching out to them for technical support. Workforce trainings had focused on peer workers having the skills to support individuals in the first steps of using a mobile device. They weren't, however, supposed to become technical support. To address this need, Painted Brain will host Tech Cafés. Similar to the Appy Hours provided in Santa Barbara, Tech Cafés will cover various digital literacy topics, address questions, and engage attendees with games, polls, music and opportunities to win gift cards. Tech Cafes are offered community-wide.

Zoom Training

To support community-based organization providers who had shared during a townhall on race and equity that they too struggled with technology, apps and offering support services online, Painted Brain will develop and provide an online facilitation training. Still in development, Chambers explained that the training would "provide the opportunity for participants to learn the various aspects of the teleconferencing platforms as well as group facilitation techniques that supports individuals social and emotional well-being, behavioral health, physical health, and workforce development. Training will discuss the intersection between the need for: technical skills to conduct virtual groups and the employment of inclusive facilitation techniques that are grounded in anti-racist and equitable practices". The training is planned to be at an intermediate level. Examples of topic include using the chat box, creating community agreements, facilitation from a racial equitable lens, and encouraging participation.

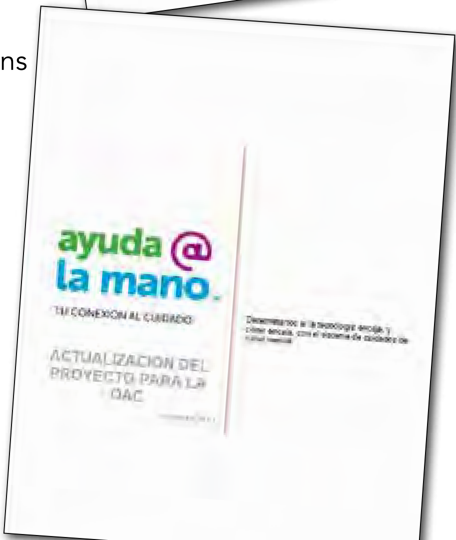
SPOTLIGHT
A Collaborative Driven Approach to Language Vendor Selection

Authors:
Lorena Campos, Associate Program Coordinator
Brittany Ganguly, Program Manager

Introduction

One of Help@Hand's principles for collaboration is to "Maintain accountability and transparency with all stakeholders." Included in this initiative is ensuring language access. Spanish is the most common threshold language across all the Collaborative Counties and Cities. So, in the Spring of 2020 during a Tech Lead Collaboration Meeting the members decided to solicit a vendor to translate major stakeholder update materials from English to Spanish.

CalMHSA supported collaborative members by providing recommendations for vendors to work with, developing the scope of work, and supporting the contract process to execute the translation work.



The Collaborative materials in this scope of work included the:

- Stakeholder Update Report (Q2 2020)
- Help@Hand Update to the MHSOAC (Q4 2019)
- Digital Mental Health Literacy (DMHL) Curriculum
- Digital Mental Health Literacy video series
- Help@Hand webpage

The overall process for this initiative included:

1. CalMHSA research cost and vendor qualifications for the scope of work
2. Get feedback from the Tech Leads/Collaborative on vendor selection
3. Collaborative vote for vendor approval

Informed decision making

Collaborative members shared their requirements to assess language translation vendors with the CalMHSA team during Tech Lead calls. These requirements informed CalMHSA's approach to solicit vendors and communicate the project needs with potential vendors.

Initially CalMHSA researched and provided three recommendations for vendors the collaborative could work with. Upon presenting this information during a Tech Lead call, collaborative members requested more information on the vendors, such as work samples, and shared additional requirements they were looking for vendors to fulfill. This prompted CalMHSA to receive additional vendor recommendations from the Cities and Counties and reach out to the vendors that better met the Collaborative's needs. Throughout the process Collaborative members were encouraged to voice any questions they had for the vendors to the CalMHSA team who consolidated these questions to communicate out to the prospective vendors.

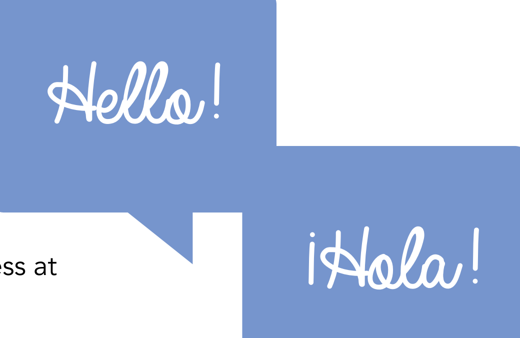
The Collaborative outlined the following requirements of vendors:

- Vendors provide their background experience and/or certification.
- Vendors have experience with behavioral health subject matter and vocabulary to trust that they would capture nuances in the language.
- Vendors provide samples of their work as part of the vendor selection process.
- That the translation process has a "back translation" step included.
  - This was specifically outlined as: Person A will translate the document, Person B will back translate the document, then A+B will confer.

After collecting this information from each vendor under consideration, CalMHSA compiled packets for Collaborative members to review.

These packets included:

- The vendors quote(s) for the outlined scope of work
- File(s) documenting the vendor's certification and/or background
- Up to 3 samples of the vendor's work.



The collaborative discussed the vendor selection and translation process at the following Tech Lead meetings:

- April 4, 2020 – Initial translation discussion with expectation setting
- May 19, 2020 – Scope of work outlined
- June 19, 2020 – Presentation of research and vendor recommendations
- July 14, 2020 – Update on vendor quotes and expertise and follow up discussion
- July 21, 2020 – Back translation process outlined
- August 18, 2020 – Presentation of three additional vendor recommendations
- August 25, 2020 – Reminder to Collaborative to send their rank order choices of the translation vendors

After the vendor option packets were shared with the collaborative, members voted in rank order for their top two vendor choices. These votes were collected by CalMHSA to tally. The results were shared with the Collaborative and confirmed during a Tech Lead Collaboration meeting announcement. Following the vendor selection choice by the collaborative, CalMHSA entered a contract with the vendor for the elected translation services.

Lessons Learned

Each county/city has their own local process for document translation, through the vendor selection process CalMHSA learned some cities/counties have more resources to translate their materials than others, resulting in different expectations for working with vendors. A few Collaborative members shared they typically outsource the work to translate materials to Spanish, but that they also build the "back translation" step into the process, while others use internal staffing resources to translate documents. Consensus showed that having Collaborative wide stakeholder materials translated with CalMHSA's support was the best way to uphold the project level principle of accountability and transparency.

A best practice recommendation from this process is to understand the city/county's process for the work before shortlisting potential vendors. This will help to ensure the vendor selections meet all collaborative members' minimum criteria. For example, the first three vendors CalMHSA shortlisted did not provide samples of their work. The collaborative provided feedback that receiving samples is a standard practice in their county and city processes prompting CalMHSA to find additional vendors that were willing to provide work samples. These additional vendors ultimately made it on the short list that the Collaborative chose from.

1 SYSTEM EVALUATION

Key Points

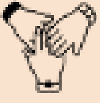
- User experience of apps reviewed in the market surveillance suggest that many mental health apps offer interesting, engaging, and easy-to-use support. However, limited accessibility features (e.g. languages, assistive technologies, and internet requirements) indicate that not everyone can get on-demand support from these apps and may face barriers beyond ease of use.
- User experience, downloads, and engagement were higher for chatbot apps than for meditation or peer support apps. This may mean that people are more likely to download and use apps with better user experiences.
- Digital phenotyping, an approved component of Help@Hand technologies, is not a widely available feature in publicly available mental health apps. Many digital phenotyping apps are still in the research and development phase.
- Apps identified through Help@Hand's most recent Request for Statement of Qualification (RFSQ) tended to underperform in the marketplace in terms of number of downloads and number of monthly active users.

OVERVIEW

This section focuses on evaluating system-related factors that may affect Help@Hand. It presents evaluation activities and learnings from the market surveillance, as well as the status of the environmental scan and the collaborative process evaluation.

The **market surveillance** is a review of apps within and outside of Help@Hand. In Year 2, three types of apps were reviewed (meditation, peer support, and chatbot apps) and assessed for their accessibility, user experience, and marketplace performance. In addition, the market surveillance includes a review of chatbot app features, digital phenotyping platforms, products from Help@Hand's recent Request for Statement of Qualification (RFSQ), and various learning briefs shared with the Help@Hand Collaborative in Year 2.

An **environmental scan** monitors public perceptions of mental health documented through key media events. It understands how international and local events (e.g. a celebrity opening up about their mental health struggles or a traumatic world event) may impact Help@Hand.



The **collaborative process evaluation** takes into consideration the processes, interactions, and collaboration across the Help@Hand counties/cities and stakeholder groups.

MARKET SURVEILLANCE

For the Help@Hand program, counties/cities must implement mental health technologies that meet the approved components shown in **Figure 1.1**. In Year 2, counties/cities considered three types of apps that met these criteria: meditation apps, chatbot apps, and peer support apps.

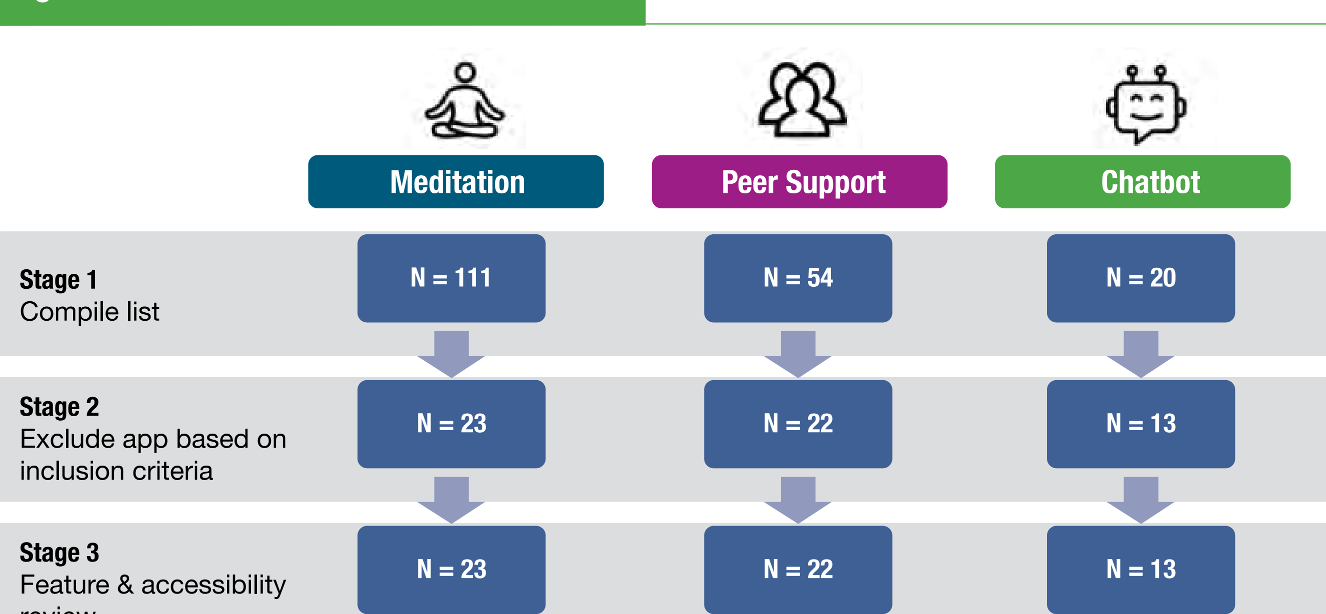
Figure 1.1. Approved Components of Help@Hand Technologies[4]

Peer Chat and Digital Therapeutics:	Virtual Evidence-Based Therapy Using an Avatar:	Digital Phenotyping:
Use techonology-based mental health solutions to intervene and offer support	Use an avatar or other technologies for self-care	Use passive data for early detection and intervention

[4] Definitions of required components are from the RFSQ Vetting Process and Scoring Tool Criteria.

These apps were reviewed in the market surveillance in order to help counties/cities understand what the apps can offer, how they are being used, and to provide evaluation benchmarks. **Figure 1.2** illustrates the review process for these three types of apps.

Figure 1.2. Market Surveillance Review Process



Market Surveillance Review Process

- Stage 1- The evaluation team compiled a broad list of apps for each review based on app store searches and the team's expertise in digital mental health.
- Stage 2- The team excluded apps not meeting the inclusion criteria.[5] Fewer criteria were applied to the chatbot list since there were only a few chatbots available in the app marketplace.
- Stage 3- The team downloaded and explored the apps to determine the presence or absence of various features, including accessibility features (e.g., language, internet access, and assistive technology).
- Stage 4- The evaluation team had experts and consumers review the user experience of apps using the Mobile App Rating Scale (MARS), a well-known, validated, and standardized tool that assesses the engagement, functionality, aesthetics, and information quality of health apps (Stoyanov et al, 2015).
- Stage 5- The team gathered marketplace data (e.g., the number of monthly active users and downloads for each apps over the past year) from Apptopia, a third-party analytics platform.[6]

[5] The inclusion criteria for meditation and peer chat apps were: 1) available on both iOS and Android; 2) updated within the last 12 months; and 3) has either meditation or peer support as its primary feature. The inclusion criteria for chatbot apps was that it had a chatbot component as it's primary feature. Because there were fewer chatbot apps available in the marketplace to begin with, fewer criteria were applied to narrow down the chatbot app list.

[6] Apptopia, Marketplace data was not available for every app because apps needed to rank within the top 1500 apps for iOS and within the top 200 apps for Google Play in order to have marketplace data available on Apptopia. This explains why the number of apps reviewed in stage 5 differed from stage 3 and 4. In addition, the number of apps differed between the stages because apps are frequently added and removed from the marketplace.

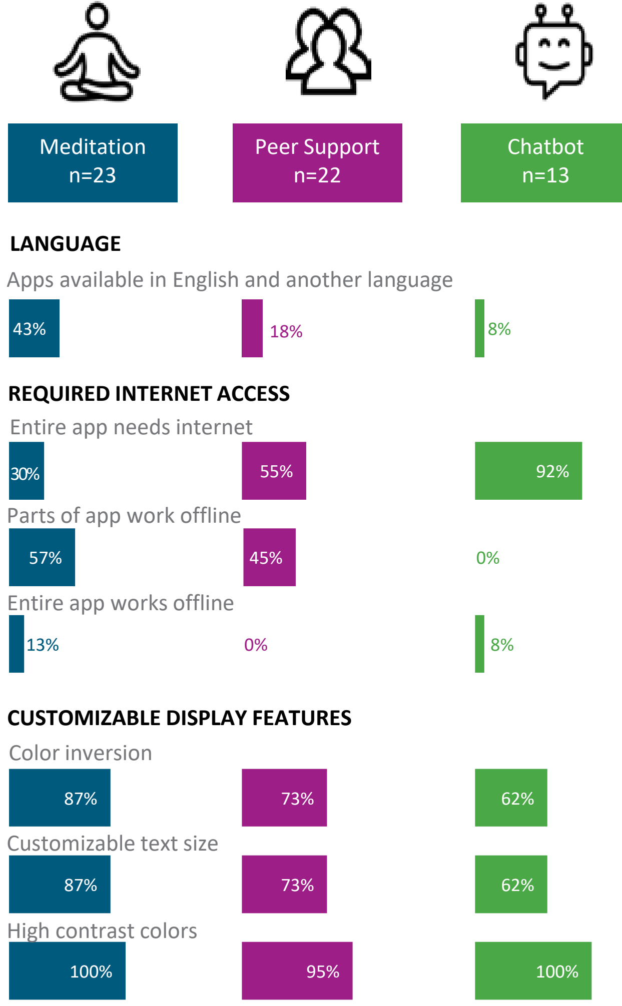
Accessibility, User Experience, and Marketplace Data Reviews:

ACCESSIBILITY

Accessibility means making apps easy to use for a broad range of people. If apps are only easy or possible to use for some people and not others, this can widen the gap in access to care. The accessibility of meditation, peer support, and chatbot apps was reviewed with respect to language, internet access, and customizable display features.

Figure 1.3 compares language availability, the need for internet connection for full or partial functionality, and customizable display features across all apps. Key learnings are presented below.

Figure 1.3. Accessibility Reviews of Meditation, Peer Support, and Chatbot Apps



App Accessibility Review - Key Points

Language: The majority of apps were available in English only. Note that even when different languages are available, this does not always mean that the app is culturally appropriate. It simply means that the text has been translated.

Required Internet Access: The majority of meditation, peer support, and chatbot apps reviewed need internet connectivity and could not be used without internet access. This can be a problem since some people may have inconsistent or limited internet access. Some meditation and peer support apps had parts that were available offline. For example, almost half (45%) of peer support apps had some content, such as assessments and journals available offline, but not the peer support forums or chatrooms themselves.

Customizable Display Features: For most apps, screen readers could only read some, but not all, of the app content. This means that users who need the text to be read aloud to them cannot use every part of the app. The ability to change text size, contrast, and colors can allow someone to read text on screen more easily.

USER EXPERIENCE REVIEWS

User experience means the overall experience one has when using an app. Questions to consider include:

- Is the app easy to use?
- Is the app interesting and fun to use?
- Is it interactive?
- Does the app work properly?
- How good does the app look?
- Is the content well-written and accurate?

User experience of mental health apps can be assessed through the Mobile App Ratings Scale (MARS; Stoyanov et al., 2015), which can be found in **Appendix B**. For each app reviewed in Year 2, two experts and one consumer used the MARS to assess the user experience of each app. Experts had extensive experience in user experience and mental health app reviews. Consumers were individuals who had lived experience with mental health challenges.

Figure 1.4 details both the expert and consumer scores for the chatbot apps reviewed. Note that while the MARS tool gives a total score out of 5.00, the developer of the tool states that a score of 4.00 can indicate high-quality apps. The majority of chatbot apps (77% expert rated, 62% consumer rated) scored higher than 4.00. **Appendix C** shows the expert and consumer user experience scores for meditation and peer support apps.

Figure 1.5 shows combined user experience scores across meditation, peer support, and chatbot apps to allow for comparisons. User experience was rated higher in chatbot apps than meditation and peer support apps. This suggests that chatbot apps have the best user experience. That said, there were fewer apps (N=13) in the chatbot group than the meditation and peer support group, so readers should be cautious when interpreting these results.

Figure 1.4. Expert and Consumer User Experience Reviews of Chatbot Apps

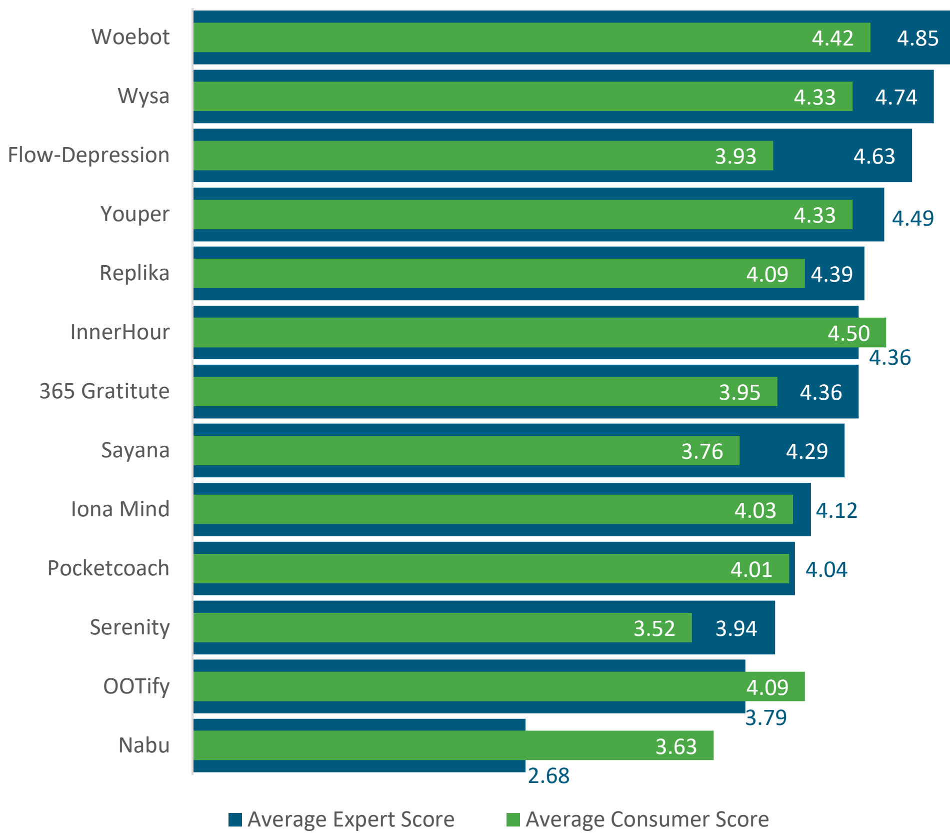
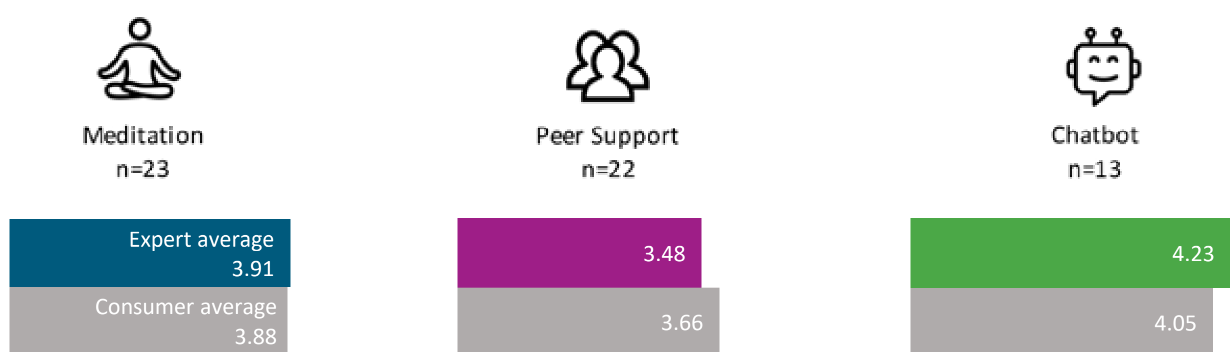


Figure 1.5. Average User Experience Reviews for Meditation, Peer Support, and Chatbot Apps



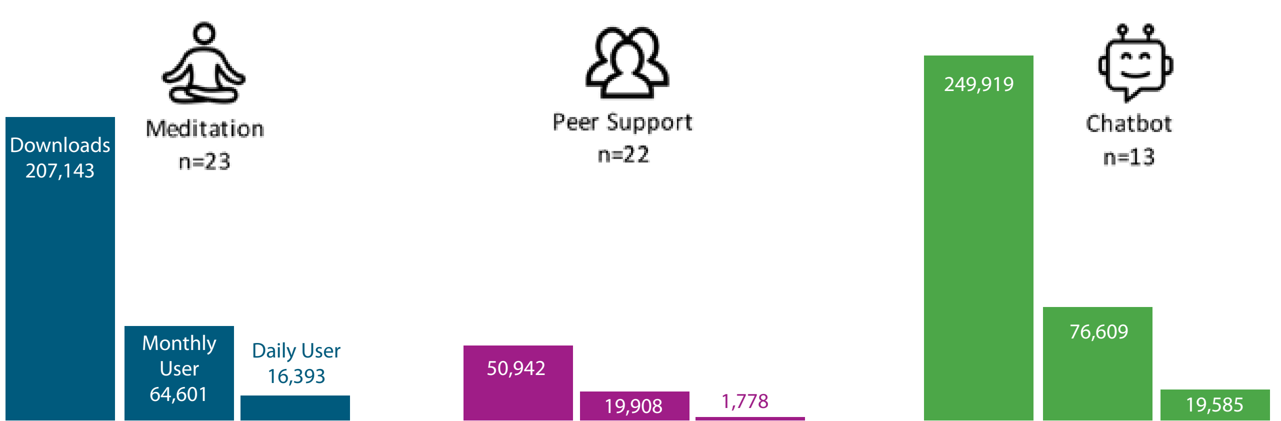
MARKETPLACE DATA REVIEW

Finally, marketplace data was reviewed to explore how people engage with and use these products. **Figure 1.6** compares the following metrics across meditation, peer support, and chatbot apps[7]:

- **Downloads:** The number of new users downloading the app for the first time.[8]
- **Monthly Active Users (MAU):** The number of users who opened the app at least once in a 30-day period
- **Daily Active Users (DAU):** The number of users who opened the app at least once in a day

Figure 1.6 shows that chatbot apps have higher median number of downloads and engagement (both MAU and DAU), compared to meditation and peer support apps. However, 1) there are fewer chatbot apps than meditation and peer support apps available in the marketplace, and 2) the highest performing apps in terms of downloads and engagement belong to the meditation category (Calm and Headspace). Meditation and peer support apps therefore have both very high and very low performing apps whereas chatbot apps tend to perform more consistently well.

Figure 1.6. Median Downloads, Monthly Users, and Daily Users of Meditation, Peer Support, and Chatbot Apps



[7] Ns noted in the figures represent the number of apps in each group with marketplace data available for both iOS and Android, which is why they are some differences between the Ns here and those reported elsewhere.

[8] If a user gets a new phone or re-downloads the app, it still counts as one download.

Feature Review: Chatbot Apps

What is a chatbot?
A chatbot is a software program designed to mimic a conversation with a human.

Meditation and peer support apps were reviewed in previous evaluation reports and can be found in **Appendix C**. This section provides a feature review of chatbot apps.

The goal of chatbots most often is not to make users think they are talking with a real person. Although they are sometimes called "virtual therapists," they are not a replacement for a therapist or other provider. Instead, chatbots may be helpful when used: 1) in addition to an existing professional care; 2) while someone waits for an appointment with a provider; and 3) to support overall wellness, rather than to treat mental health symptoms.

The evaluation team conducted a feature review of 13 chatbot apps as shown in **Table 1.1**. There are several key findings from the feature review of chatbots related to:

- **Chatbot Goals:** The primary purpose of chatbots may be to chat with the user about how they are feeling or to guide the user through the use of the app.
- **Response Options:** Interaction between a user and a chatbot varies from open-text to pre-set responses.
- **Chatbot Personalities:** Chatbot interface ranges from avatars with distinct "personalities" to simple text-based exchanges without an attached persona.
- **Crisis Response:** Chatbots varied drastically in their response to users indicating that they are experiencing a mental health crisis.

Table 1.1. Full Feature Reviews of Chatbot Apps

App name	Screen Reader Capabilities	Customizable Display Features	Internet required for use?	# Languages	Content for underserved groups	Features of chatbot			
	+++ All buttons spoken ++ Most buttons or features spoken + Some buttons or features spoken	A+ Text size T High contrast text ◐ Color inversion ▶ Animation reduction	(wifi) Yes (wifi crossed) No			Is the primary goal to a) **chat** with the user about how they are feeling, or b) to **guide** them through using the app?	Can users respond via a) **pre-set responses only** or b) **both** open text and pre-set responses?	What is the personality of the chatbot avatar (if any)?	How does the chatbot respond to mental health crisis?[9]
365 Gratitude	++	◐ ▶	Yes	1	None	Guide	Pre-set only	Animated alpaca named Joy	N/A
Flow	+	A+ T ◐ ▶	Yes	2	None	Guide	Both	No clear avatar	N/A
InnerHour	++	A+ T ◐	Yes	1	None	Guide	Pre-set only	No clear avatar	N/A
Iona Mind	+	◐ ▶	Yes	1	None	Chat	Both	No clear avatar	Words of comfort. States the app is not designed to handle crisis. Advises user to contact emergency services.
Nabu	++	A+ ◐ ▶	Yes	1	None	Guide	Pre-set only	Animated owl	N/A
Ootify	++	T ◐ ▶	Yes	1	None	Guide	Pre-set only	No clear avatar	N/A

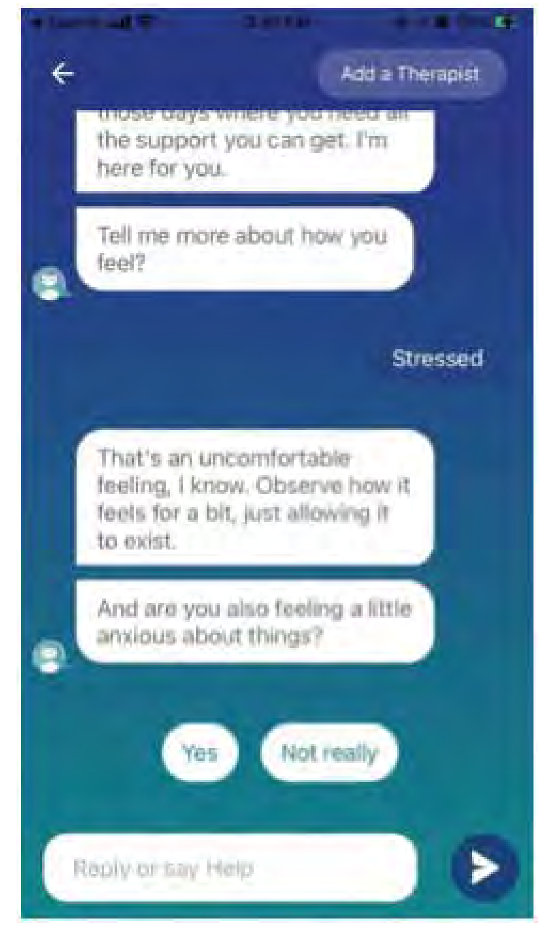
[9] N/A means that users were not able to say that they were in crisis. Therefore, the response is not applicable.

Pocketcoach	+	A+ T		1	None	Both	Both	No clear avatar	N/A
Replika	++	A+ T		1	None	Chat	Both	User can create/customize avatar	Crisis hotlines, offers tools to help manage panic attacks.
Sayana	+			1	None	Guide	Both	Human character	No crisis response
Serenity	++	A+ T		1	None	Chat	Both	Human character	Advises user to speak to "a human" in their life. Provides crisis hotline.
Woebot	+++	A+ T		1	None	Chat	Both	Animated robot	Words of comfort. States the app is not designed to handle crisis. Asks user's location and provides hotlines and text lines.
Wysa	+++	T		1	LGBTQ+ Community	Chat	Both	Animated penguin	Words of comfort, provides crisis line resources. SOS button also on home page with crisis resources.
Youper	+++	A+		1	None	Chat	Both	No clear avatar	Words of comfort. States the app is not designed to handle crisis. Asks user's location and provides hotlines and text lines.

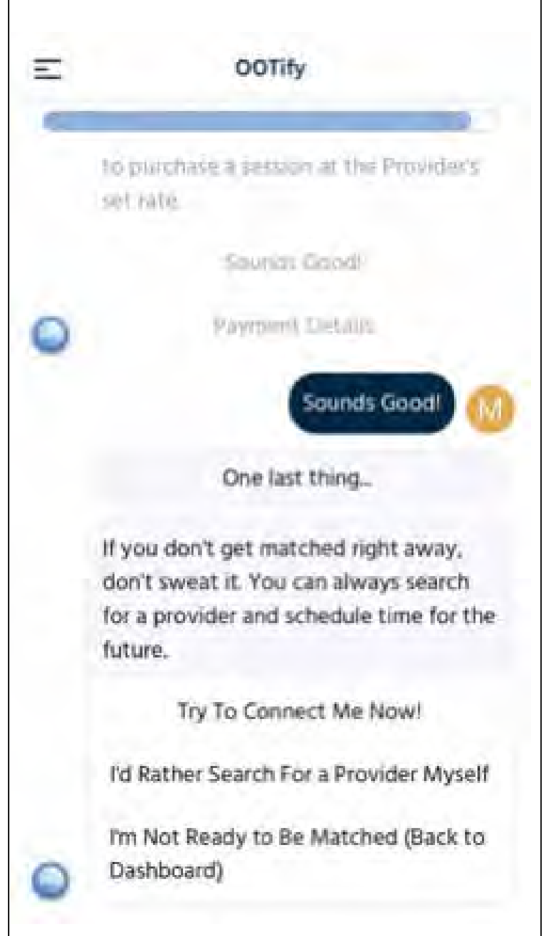
CHATBOT GOALS

Figure 1.7 shows that the goals of chatbots vary from one mental health app to another. About half (n=7) of the 13 chatbot apps reviewed aimed to chat with the user about how they are feeling. The other half (n=6) aimed to guide the user through the app and help them find resources within the app. Furthermore, some chatbots were only available in the app at certain times. For example, the chatbot in 365 Gratitude only appeared during first use to introduce the user to the app—it was not available during later sessions.

Figure 1.7. Sample Goals of Chatbot Apps



Interactive Example: Wysa
Goal is to talk through how the user is feeling

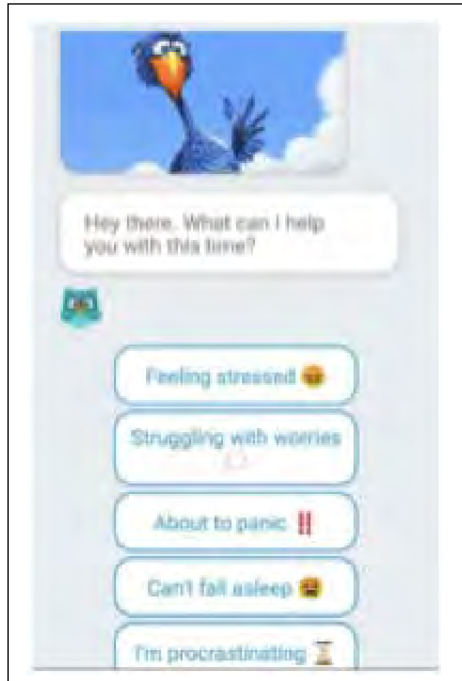


App Use Example: Ootify
Goal is to guide app use and match user with a provider

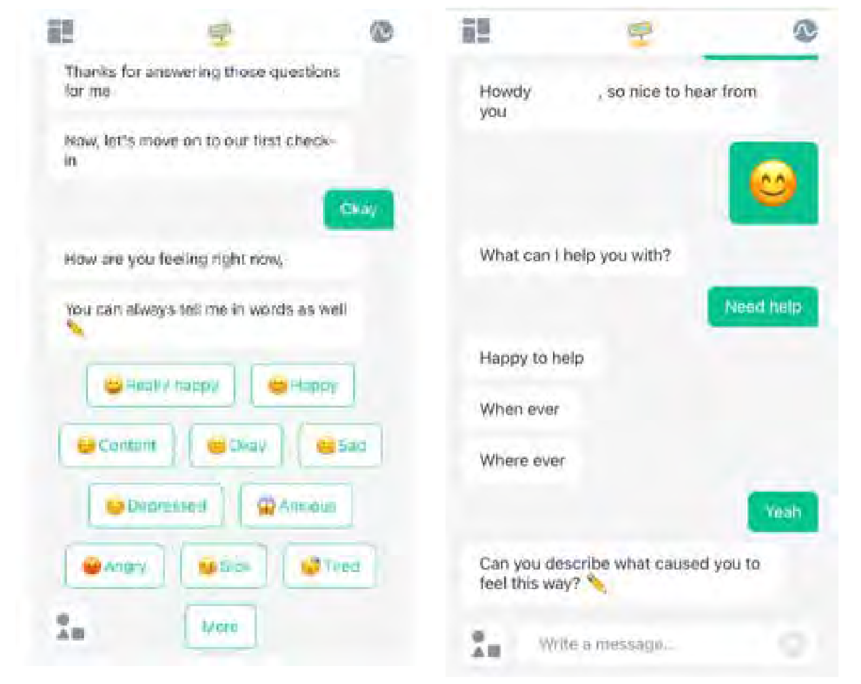
RESPONSE OPTIONS

Users may chat with the chatbot through pre-set responses or open-text responses. In a pre-set response model, users can only select options for response determined by the app. In an open-text response model, the user can type anything they like into the chat, as if they were sending a text message. Examples of both models are shown in **Figure 1.8**.

Figure 1.8. Sample Response Options of Chatbots Apps



Pre-Set Response Example: Nabu
Users choose from pre-set options only



Open-Text Response Example: Woebot
Users can use both open-text and pre-set response to chat

Of the apps reviewed, one-third (n=4) had only pre-set responses and two-thirds (n=9) had both open-text and pre-set options. A user cannot choose when they want to use a pre-set versus open-text response; the app determines that.

All apps whose primary goal was to chat with the user about their mental health allowed both open-text and pre-set options. While open text responses allow users to provide more personalized information and describe things in their own words, they may also pose challenges with monitoring. A chatbot may not necessarily know how to respond to an unlimited number of responses.

CHATBOT PERSONALITIES

Some chatbots have a distinct "personality" or avatar, while others are more simplistic and lack a clear avatar. Almost half (46%; n=6) of the apps reviewed had a distinct avatar personality, and 54% (n=7) did not. **Figure 1.9** provides examples of these chatbot styles.

Figure 1.9. Sample Personalities in Chatbot Apps

Avatar Example: 365 Gratitude
Chatbot is a cute alpaca named Joy

Non-Avatar Example: Youper
Chatbot does not have a clear or distinct personality

CRISIS RESPONSE

When talking to a chatbot, a user may disclose that they are in a mental health crisis and need immediate support. Research has shown that people view a conversation with a virtual therapist as more anonymous than a conversation with a human. They may then be more likely to disclose or describe something that they may not discuss with a human due to stigma (Lucas et al., 2017). Since users may disclose a mental health crisis to a chatbot, the evaluation team reviewed how each chatbot app responds to a crisis in order to help determine if the app responds sensitively and appropriately.

Not every app allowed a user an option to say that they were in crisis because some apps only allow for pre-set responses. Users were unable to say that they were in crisis through pre-set responses in 46% of the apps reviewed (n = 6). When users could say they were in crisis, one app did not acknowledge this or respond, and appeared to glitch. Of the apps that did respond, the most common response to crisis was providing hotline numbers where the user could get support. Details of crisis responses are in the last column of **Table 1.1**.

Review of Digital Phenotyping Platforms

Digital phenotyping platforms were also reviewed in Year 2. Digital phenotyping, one of the approved components of Help@Hand technologies, passively collects data to predict or monitor mental health and wellness. Passive data is collected "in the background," rather than being actively input into a device by a user (although users should always give permission for this data to be collected). Digital phenotyping models propose that how users interact with their devices can tell as much about their mental states as what they enter into their devices.

In Year 1, the market surveillance identified digital phenotyping platforms through app store searches and app descriptions. Mindstrong was the only platform found, since many digital phenotyping platforms were under development and not yet available on the app stores for download.[10] In Year 2, the evaluation team broadened the search to also include digital phenotyping platforms identified through expertise and knowledge of the digital mental health space, the published literature, and review papers and lists of digital phenotyping platforms in mental health. This resulted in a list of 11 digital phenotyping platforms. While this review was not meant to be exhaustive, it intended to identify some emerging digital phenotyping products and illustrate some of the variation in digital phenotyping platforms and available features.

Each platform was reviewed for the presence or absence of various features related to: 1) passive data collection (e.g., sensor-based data collection); 2) active data collection (e.g., surveys, cognitive tests, and voice recordings); and 3) types of interventions associated with the platform. **Table 1.2** displays the full information for each platform.

Table 1.2. Features of Digital Phenotyping Platforms

		Passive Data Collection Features						Active Data Collection				
	Operating System	Location Features	Interaction Features	Communi–cation Features	Movement Features	Physiology Features	Other Features	Surveys	Cognitive Tasks	Voice Recordings	Interventions	Intended for Research Purposes Only
Aware	Android, iOS	•	•	•	•		•	•			Tracking	•
BiAffect	iOS		•		•		•	•	•		No intervention	•
BeiWe	Android, iOS	•		•	•		•	•			No intervention	•
EARS	Android, iOS	•	•		•		•	•		•	No intervention	•
inSTIL	Android, iOS	•		•	•		•	•	•	•	No intervention	•
MindLAMP	Android, iOS	•		•	•			•	•		Mindfulness, Education tracking, interactive modules	
Mindstrong	Android, iOS	•	•	•				•			Linkage to care provider	
Monsenso	Android, iOS			•	•			•			Tracking	
MoodTriggers	Android	•		•	•	•	•	•			Tracking	•
MoviSensXS	Android				•	•	•	•			Triggered Interventions	•
Sensus	Android, iOS	•		•	•	•	•	•			No intervention	•

[10] This might be because they do not have a business-to-consumer model or are intended mostly for research purposes.

PASSIVE DATA COLLECTION

Six types of passive data collected via digital phenotyping platforms were identified:

Location Features	*Location Features* included Global Positioning System (GPS), or specific locations from other databases, such as Google Places location types. Location data was collected by 9 of 11 platforms (82%).
Interaction Features	*Interaction Features* refer to the way a person uses or interacts with their phone and include keystrokes, time and length of messages, typing movement, phone swipes, etc. Interaction data was collected by 4 of 11 platforms (36%).
Communication Features	*Communication Features* included call and text logs that provide information such as number, timing, and length of phone calls and text messages, and social media. Communication data was collected by 8 of 11 platforms (73%).
Movement Features	*Movement Features* included accelerometer data, step counts, exercise data, and metabolic equivalent of task. Movement data was collected by 10 of 11 platforms (91%).
Physiology Features	*Physiology Features* included galvanic skin response, heart rate, and heart rate variability. Physiological data was collected by 3 of 11 platforms (27%).
Other Features	*Other Features* included battery life, weather data, ambient light, facial expressions in "selfie" photos, and BlueTooth sensors triggers. Data from other features was collected by 8 of 11 platforms (73%).

ACTIVE DATA COLLECTION

Three types of active data collected via digital phenotyping platforms were identified:

Surveys	*Surveys* included both standard assessments and customizable assessments. Surveys could either be available for users to complete as desired, at fixed intervals, or triggered by passive data. Survey data was collected by 11 of 11 platforms (100%).
Cognitive Tasks	*Cognitive Tasks* are those that require a person to actively process information in order to assess cognitive processes, such as memory, attention, or learning. Data from cognitive tasks was collected by 3 of 11 platforms (27%).
Voice Recordings	*Voice Recordings* allowed users to record information through speech. Voice recording data was collected by 2 of 11 platforms (18%).

INTERVENTIONS

The digital phenotyping platforms reviewed included various interventions. About half of the platforms (n=6, 54%) included some form of intervention.

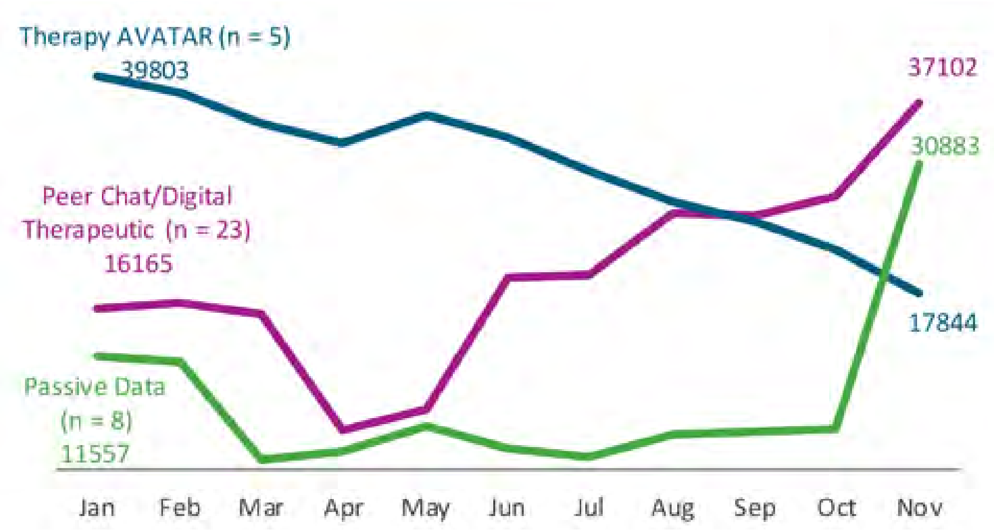
- **Tracking:** Tracking symptoms, mood, behaviors, and medication was most common.
- **Linkage to care provider:** Only *Mindstrong* included direct linkage to care providers, but *MindLAMP* could potentially facilitate this with a provider dashboard.
- **Triggered interventions:** *MoviSensXS* offered triggered interventions, or what are known as "ecological momentary interventions." These interventions could be triggered by different actions, including answers in a questionnaire or information from the sensor-based data collection. Interventions could take the form of text, audio, or video, but the content of these interventions would have to be created by the team deploying *MoviSensXS*.
- **Other:** *MindLAMP* included intervention modules such as mindfulness and psychoeducation. It also provided a dashboard that allows for information received by the *MindLAMP* platform to integrate with care providers.

Marketplace Data Review of Help@Hand RFSQ-Approved Apps

In addition to reviewing apps in the broader marketplace, the market surveillance reviewed apps in the Help@ Hand Request For Statement of Qualifications (RFSQ).[11] The Help@Hand RFSQ-approved apps only included apps that met the project's required components: peer chat/digital therapeutics (N=75), therapy avatars (N=75), and digital phenotyping (N=41), where Ns represent the number of apps approved for inclusion in each category.

Figures 1.10 and 1.11 show the changes in downloads and monthly active users (MAU) across 2020 by component for each Help@Hand approved app where data is available (e.g., Ns in the graphs show the number of apps with marketplace data is available). Additional marketplace data is in **Appendix D**[12]. Although there is a general increasing trend for peer chat/digital therapeutic apps and decreasing trend for therapy avatar apps, significant variation exist in the month-to-month levels. Changes observed in downloads or use of the Help@Hand RFSQ-approved apps might be due to general changes in downloads and use in the broader app marketplace. Counties/cities should keep this in consideration when viewing app data obtained from vendors.

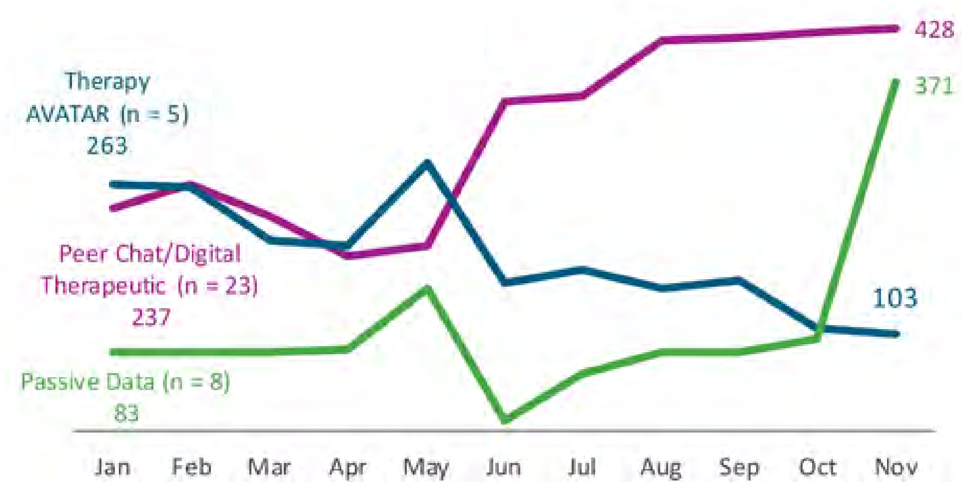
Figure 1.10. Median Downloads of Help@Hand RFSQ Apps in 2020



[11] Help@Hand released an RFSQ to vendors in September 2019 in response to a need for expanding the technology offerings within the project.

[12] Marketplace data was not available for every app in the RFSQ, because apps needed to rank within the top 1500 apps for iOS and within the top 200 apps for Google Play in order to have marketplace data available on Apptopia.

Figure 1.11. Median Monthly Active Users of Help@Hand RFSQ Apps in 2020



It is also worth noting the scale of downloads and monthly active users for the Help@Hand RFSQ apps versus the broader marketplace. The median download for Help@Hand RFSQ apps tended to be between 100-500 per month, whereas the meditation, peer support, and chatbot apps in the broader marketplace were approximately 17,000, 4,000, and 21,000 downloads per month, respectively. Similarly, the monthly active users for Help@Hand RFSQ apps were in the 10,000 to 40,000 range, and meditation, peer support, and chatbot apps in the broader marketplace were in the 20,000 to 76,000 range. As such, Help@Hand RFSQ-approved apps tended to be less downloaded and less used than the average app of similar categories in the marketplace. The maturity of products submitted to the Help@Hand RFSQ is a concern for their viability in the Help@Hand project.

Market Surveillance Learning Briefs

Learning briefs examining other aspects of the app marketplace were developed in Year 2 and can be found in **Appendix E**. These brief include.

- **Free Apps with COVID-19 Content Brief** reviews 10 free apps with COVID-19 content that could support the community during the pandemic.
- **Selected Mental Health App Performance during COVID-19 Brief** examines marketplace performance data of selected apps identified since the onset of COVID-19.
- **Mental Health Apps Provided or Recommended by Insurance Plans in California Brief** identifies mental health apps available for the community by major insurance companies in California.
- **myStrength and Apps Similar to myStrength Brief** summarizes features and research on RFSQ-approved apps that are similar to myStrength.

Learnings from the Market Surveillance

Learnings from reviews of apps considered by counties/cities and apps outside of Help@Hand found:

- **Language:** Many of these apps are not suitable for counties/cities targeting non-English speaking populations since they do not provide resources in languages other than English.
- **Internet Access:** Most apps need to be connected to the internet to work. People with limited access to the internet, such as geographically isolated populations or those with limited data plans, will not be able to get on-demand mental health support from these apps.
- **Assistive Technology:** Most apps allow the user to customize content display to some degree (e.g., a user could increase the text size to better view the content). However, if users need a screen reader to read content aloud to them, this was not widely available.
- **User Experience:** Chatbots had higher user experience scores than meditation and peer support apps from both experts and consumers.
- **Marketplace Data Review:** Marketplace data showed that peer support apps were far less popular than meditation or chatbot apps. They were downloaded less and had fewer monthly and daily active users. This suggests that people may be more likely to engage with meditation or chatbot apps.
- **Purpose of Chatbots:** Although an app may say that it provides a mental health chatbot, some apps simply guided the user through the app rather than providing mental health support or chatting with the user about how they are feeling. Chatbot apps also may not always respond appropriately when a user says that they are in crisis.
- **Digital Phenotyping Platforms:** Digital phenotyping platforms can collect a range of passive data but are more limited in the range of active data collection modes. Most digital phenotyping platforms are intended for research and assessment purposes with limited opportunities for clinical intervention.
    - **Passive Data:** The most common passive data features are location, communication, and movement.
    - **Active Data:** The most common active data collection method is surveys.
    - **Availability:** Most of the digital phenotyping platforms reviewed were available on both Android and iOS.
- **Help@Hand RFSQ-Approved Apps:** Marketplace data of the RFSQ app show considerable monthly changes in downloads and use. Comparisons between RFSQ apps with number of downloads and monthly active users from products in similar categories in the marketplace generally show fewer downloads and less use of RFSQ products.

ENVIRONMENTAL SCAN

An environmental scan monitors public perceptions of mental health documented through key media events. News stories based on keywords related to Help@Hand were collected, but analysis of these stories has not started due to limited staffing to support the environmental scan. This activity was on hold in Year 2.

COLLABORATIVE PROCESS EVALUATION

Help@Hand is also influenced by the processes, interactions, and collaboration across the Help@Hand counties/cities and stakeholder groups. The collaborative process evaluation examines how these factors affect Help@Hand at the system and organizational level.

The evaluation team developed an interview guide and survey for the collaborative process evaluation in Year 1 and updated the interview guide in Year 2 to reflect project changes. However, the Collaborative requested a pause on conducting interviews and surveys since October 2019. There are plans to re-launch the collaborative process evaluation in Year 3.

2 PEER EVALUATION

Key Points

- Peers play an active role in supporting the Help@Hand program across the Collaborative. There is overall enthusiasm for the contribution of the Peer component to Help@Hand.
- In response to the COVID-19 pandemic and the halting of in-person outreach activities, counties/cities created educational materials that could be delivered virtually to address digital literacy.
- Peers engaged in digital product testing throughout Year 2, and counties/cities plan to sustain this engagement into Year 3.
- Counties/cities reported a number of successes and challenges related to the Peer component of Help@Hand. Over time, more counties/cities reported successes with incorporating Peer input into Help@Hand decisions. However, challenges to program implementation were reported by an increasing number of counties/cities.

OVERVIEW

The evaluation of the Peer component of Help@Hand documents Peer activities, identifies successes and challenges to implementing the Peer component, and shares lessons learned across the Collaborative.

PEER EVALUATION

Surveys were developed from interviews conducted in quarters 1 and 2.[13] Surveys in quarter 3 (n=15) were completed by 14 Peers and 1 Tech Lead (from a county/city without a Peer Lead), while surveys in quarter 4 (n=13) were completed by 10 Peer Leads, 1 Tech Lead, and 2 Peer/Tech Leads.[14]

Figure 2.1 shows Peer evaluation activities conducted in each quarter of Year 2. **Appendix F** includes learning briefs summarizing findings from the quarter 2 interviews and quarter 3 surveys.

Figure 2.1. Peer Evaluation Interviews and Surveys Conducted in Year 2

Peer Activities in Year 2

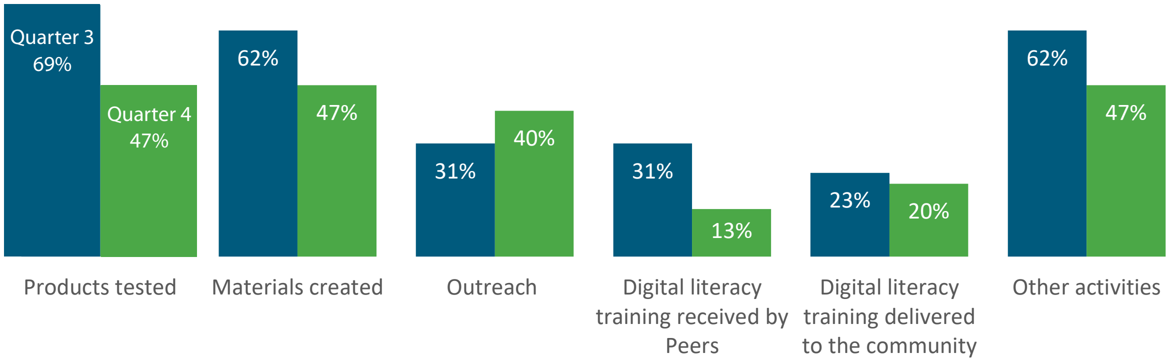
Surveys asked about the activities that Help@Hand Peers engaged in within counties/cities during quarter 3 and quarter 4. **Figure 2.2** shows the survey results.

- **Product Testing and Material Creation.** The most common Peer activities in both quarters were testing products (e.g., potential digital mental health apps) and creating materials (e.g., developing educational presentations related to digital literacy) for target populations. Owing to social distancing mandates issued toward the end of quarter 1, collaboration among the Peers during quarters 3 and 4 occurred virtually and the materials developed were primarily intended for distribution through digital platforms. Using these platforms helped Peers learn new skills that would prepare them to carry out outreach virtually.

[13] Quarter 1 interviews (n=11) included ten Help@Hand Peer Leads and the Help@Hand Peer and Community Engagement Manager. Quarter 2 interviews (n=13) included 11 Peer Leads and two Tech Lead (from counties without a Peer Lead).
[14] Follow-up interviews were conducted in quarter 3 to elicit details on survey responses and were not conducted in quarter 4 due to the winter holiday.

- **"Other" Activities.** Peers were engaged in a variety of "other" activities during quarter 4. These included: 1) implementing the Mindstrong and Headspace apps; 2) becoming proficient in using virtual communication platforms; and 3) working with the Help@Hand evaluation team to refine surveys and focus group guides.

Figure 2.2. Peer Activities Reported in Peer Evaluation Surveys

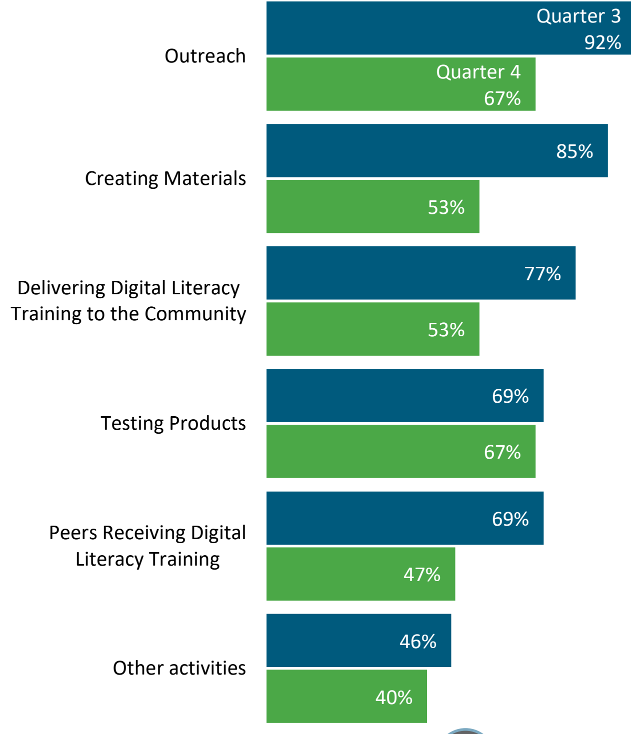


Planned Peer Activities

Surveys and interviews also asked about planned Peer activities for the following quarter. **Figure 2.3** shows the survey results. Together with the interviews, surveys reveal:

- **Changes in planned activities.** Outreach, creating materials, and delivering digital literacy training to the community were the most frequently identified planned Peer activities in the quarter 3 survey. Plans for all three of these activities were reduced in the quarter 4 survey, though over half of the respondents still indicated that these activities were planned. Plans to test products remained steady over both quarters at about two-thirds of respondents.
- **Optimism.** Interviews conducted in quarter 3 conveyed a general optimism about shifting from preparing for digital mental health literacy outreach and into implementing outreach in 2021.

Figure 2.3. Planned Peer Activities Reported in Peer Evaluation Surveys



Successes

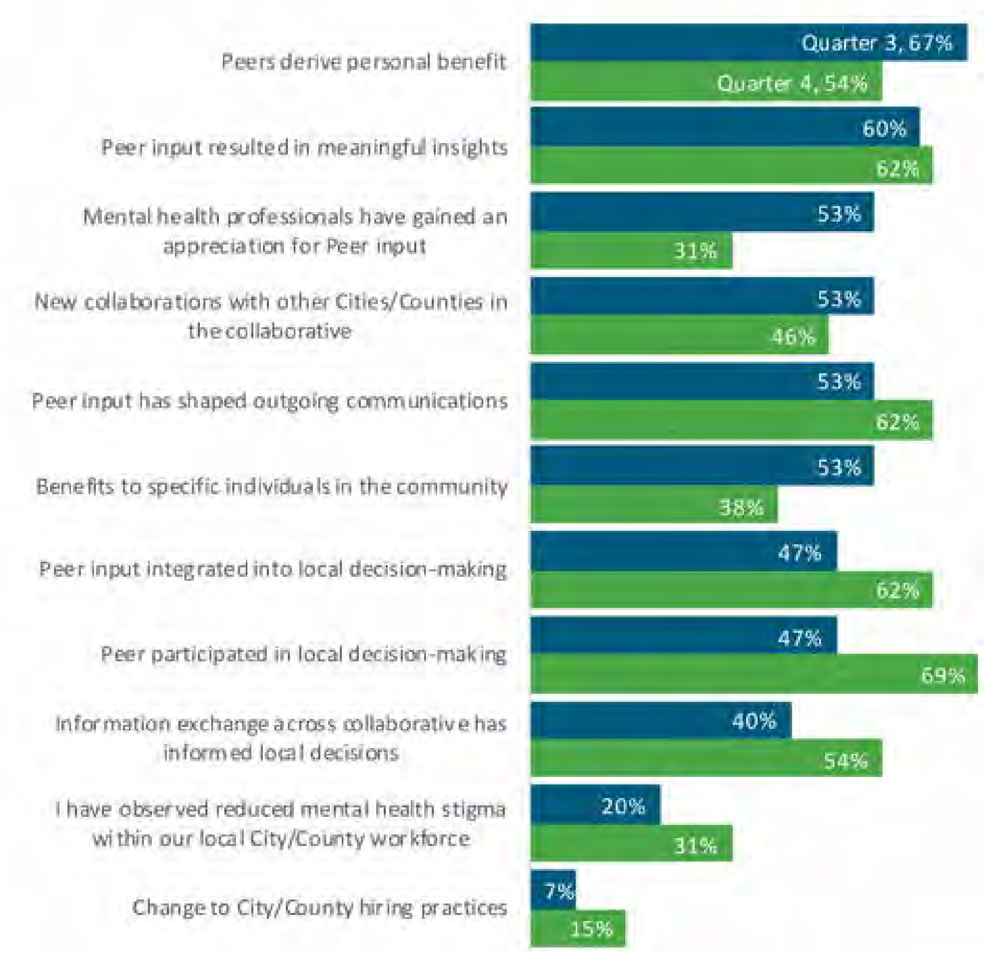
Early interviews (those conducted in quarters 1 and 2) found the following Peer successes:

- **Active Peer Engagement.** Peers were actively engaged in supporting Help@Hand by vetting potential technologies, developing digital literacy education materials, conducting outreach to the community, and delivering digital literacy workshops. In addition, Peers represented their counties/cities on Peer Leadership calls and participated in the digital mental health literacy (DMHL) train-the-trainer event held by CalMHSA.
- **Peers as Contributors and Collaborators.** Peers were recognized by Help@Hand as experts and partners in program development and delivery, which had a perceived impact on mental health stigma reduction within county organizations. Peer Leads attributed the reduced stigma both to the appreciation accorded to Peers by Help@Hand physicians and therapists, as well as the openness and transparency surrounding mental health issues that characterized the work between Peers and their colleagues. For Peers, openly addressing their mental health issues was a novel experience, which they felt brought about a cultural shift in the workplace, as colleagues responded with understanding and acceptance about mental health needs.
- **New Peer-related Personnel Policies.** Efforts to overcome hiring challenges led to changes in personnel policies in some counties/cities, such as creating a new job classification for peer employees.

Figure 2.4 shows successes identified in surveys from quarters 3 and 4. Interviews and surveys showed:

- **Quarter 3 Successes.** More than half of survey respondents noted the following successes since the beginning of the Help@Hand program:
  - o Peer input was integrated into local decision-making.
  - o Peer input yielded meaningful insights, such as focusing attention on the logistical issues of technology implementation (e.g., how much data would a cell phone plan need to use a given technology).
  - o Peer input shaped outgoing communication, resulting in more effective messaging that was tailored for the intended audience.
  - o New collaborations emerged across counties/cities, which was noted as unusual within the state since cross-county sharing is rare.
  - o Help@Hand yielded benefits to specific individuals in the community. This includes the delivery of mental health services through telehealth, which was facilitated by digital literacy training given to the community by Peers. Another example is San Mateo and Youth Leadership Institute's anthology project, which is described in the **spotlight** on page 47.
  - o Mental health professionals gained an appreciation for Peer input, which resulted in a reduction in the stigma around mental health within the county workforce. Peer Leads reported that this reduction in workplace stigma was a personal benefit for the Help@Hand Peers.
  - o Peers derived personal benefit, including both gainful employment and a forum for discussing their mental health.
- **Changes in Successes from Quarter 3 to Quarter 4.** There was an increase in the proportion of counties/cities reporting that Peers were participating in local decision-making and that Peer input was integrated into local decision-making in the quarter 4 survey. There was also an increase in the proportion of respondents who indicated that information exchange across the Collaborative had informed local decisions.

Figure 2.4. Successes Reported in Peer Evaluation Surveys



DMHL Train-the-Trainer Workshop Attendees

Challenges

Early interviews found challenges with:

- **Recruiting, hiring, and retaining Peers.** It was challenging to recruit Peers who possessed the right constellation of skills and abilities for supporting Help@Hand (e.g., digital literacy, proficiency in a language other than English). Hiring has been complicated by county/city human resource policies that make some Peers ineligible. Attrition among the Peers was related to individuals being promoted, being in time-limited appointments, or being unable to meet the demands of the position over time.
- **Community outreach.** There was limited digital literacy among both the Peers and the members of the target populations. There were also challenges with meeting community needs. These challenges included: not having enough bilingual staff to reach non-English speaking communities; difficulty finding the right place and time to engage transition-age youth (TAY); and transportation and technology barriers for older adults and isolated communities.
- **Communication within and across counties/cities.** The departure of the Peer and Community Engagement Manager in March 2020 exacerbated delays in the flow of information across the Collaborative and highlighted limited information sharing mechanisms.
- **Decision-making and roles/responsibilities.** Interviews in the early part of Year 2 revealed that Peers were not completely integrated into decision-making processes within and across counties/cities during the start-up phases of Help@Hand. Also, there was a lack of clarity across the collaborative in terms of roles and responsibilities, causing Peers to be uncertain as to the decision-making processes.

- **COVID-19.** In quarter 1, counties/cities planned to mobilize outreach and digital literacy campaigns by hosting in-person “Appy Hours” and distributing paper DMHL materials. Plans also included disseminating information about digital mental health resources within the Peer workforce and to communities. Since COVID-19 restrictions hindered these plans, counties/cities generally responded by focusing their Peer efforts on technology testing and material development, much of it intended for virtual dissemination. The wide range of innovative responses illustrated the resilience of the Peer Leads in finding ways to continue to add value to the Help@Hand Collaborative and influence local decision-making through Peer input.

Figure 2.5 shows challenges identified in the latter half of Year 2. Surveys from quarters 3 and 4, as well as interviews from quarter 3, found:

- **Unclear Decision-Making Processes.** Lack of clarity regarding decision-making processes across the Collaborative was reported by about 40% of respondents in both surveys.
- **Challenges with hiring and internal information sharing (Quarter 3).** Difficulty with hiring and internal information sharing emerged as the most common challenges experienced by counties/cities since the beginning of Help@Hand in the quarter 3 survey. It is interesting to note that these challenges were reported by fewer counties/cities in the quarter 4 surveys.
    - o **Difficulties in recruiting and hiring Peers.** There was difficulty in recruitment and hiring efforts due to employment structures (e.g., human resources and hiring policies) and personnel turnover.
    - o **Insufficient flow of information within the county/city.** Two structural factors emerged as major contributing factors: 1) the use of subcontractors to carry out the Peer component, which added levels of authority and delayed transmission of information; and 2) the dual program management structure involving both Peer Leads and Tech Leads, which was viewed as creating silos of information that were not conducive to knowledge-sharing.

Figure 2.5. Challenges Reported in Peer Evaluation Surveys

Learnings from the Peer Evaluation

Interviews and surveys about the Peer component of Help@Hand reveal learnings on:

- **Product Testing and Material Creation.** Common Peer activities in Year 2 included testing potential technologies and creating outreach materials, particularly for virtual dissemination. Peer Leads expressed general optimism about implementing digital mental health literacy outreach in 2021.
- **Peer Successes.** There were several Peer successes in Year 2. These include:
  - o **Local Decision-Making and Peer Input.** Peers were participating in local decision-making and their input was integrated in decision-making processes. Peer input offered meaningful insights for technology implementation and outgoing communication. It was also appreciated by mental health professionals and reduced mental health stigma within the county workforce.
  - o **Collaborations across counties/cities.** This was a particularly noteworthy success since cross-county sharing is rare within the state. Information-sharing across the Collaborative helped inform some local decisions.
  - o **Benefits for community members and Peers themselves.** Peers were involved in activities that helped the community. For example, Peers provided digital literacy trainings that helped community members access telehealth. In addition, Peers benefited from gainful employment and a forum for discussing their own mental health.
- **Peer Challenges and Opportunities.** Overall, interviews and surveys at the end of Year 2 revealed both enthusiasm and appreciation for the added value that Peers brought to the Help@Hand Collaborative. This was tempered, however, by frustration with the slow pace of technology implementations and the continued gap in the leadership structure resulting from the unfilled Peer and Community Engagement Manager position. Still, counties/cities appeared to engage an entrepreneurial spirit, especially in response to the challenges of the COVID-19 pandemic, and began to establish cross-collaborations to accelerate learnings.

SPOTLIGHT
Anthology

Once the pandemic began, Youth Leadership Institute San Mateo (YLI) like other community organizations found themselves in need of novel ways to connect with the youth they served. Their shift to zoom meetings proved to be inaccessible for some and inadequate for others. Indeed, YLI's, Help@Hand Peer Leader, Adam Wilson, who was interviewed for this Spotlight, stated *We saw early on that having conversations and being on zoom, that not everyone was equipped to do it or wants to do it.* YLI, then, sought additional ways for young people to have a dialogue or outlet to deal with the pandemic. Inspired by one employee's recent experience with collecting stories from local community members, in partnership with San Mateo County Behavioral Health and Recovery Services, YLI created the anthology project.

Artist: Marcela Cordova

An anthology is a collection of selected literary pieces or passages or works of art or music (Merriam-Webster, n.d.). Anthologies can be centered around a certain theme, genre, culture, nation, or time period. With that in mind, the Youth Leadership Institute (YLI) San Mateo anthology project sought to gather a collection of writings, art, videos, etc. by individuals in San Mateo County. All pieces would center around the theme of mental health.

Specifically, in hopes of changing the narrative around mental health, the anthology project aimed to provide San Mateo County community members with an opportunity to express their experiences with mental health, emotional wellbeing, and COVID-19. The plan was to have individuals submit pieces that, together, would be turned into a collection of works. The anthology would highlight the mental health experiences of all people of San Mateo County especially transition-aged youth (15-25 years old). To break down stigmas around mental health as well as provide a space where the community could openly share their thoughts, and feelings about mental health, YLI planned to publish the anthology on their website. The project would, also, be used to inform the direction and implementation of the Help@Hand program. For instance, Wilson suggested it may inform YLI about what features the apps we're looking at for Help@Hand might need to include based on the themes we're seeing in the pieces.

Initially, YLI planned to invite only the youth that they worked with. It quickly shifted, however, to a community-wide project when YLI partnered with San Mateo County Behavioral Health and Recovery Services. This partnership expanded their reach to all adults – TAY through older adults. Likewise, to reflect the diversity of the community, YLI reached out to agencies and organizations that worked with such communities as Latinx, LGBTQ, and youth with mental health issues. They also made sure to include organizations in different economic areas and located throughout the county. Three organizations were subcontracted to assist with outreach and engagement for the anthology project.

Outreach began with a call for submissions. In it, individuals were invited to submit pieces using any medium and format that they chose. Suggestions included poetry, mini-autobiographies, audio and video, interviews, and artwork. Although it was not necessary to use them, four prompts were provided to inspire and guide the work.

Prompts included describing experiences with mental health, stigma around mental health, treatment for mental health and the impact of COVID-19 on mental health and emotional wellbeing. All prompts also included the role that technology had on one's mental health. Definitions were provided for the terms mental health, stigma, and technology too. Submissions could be in any language and everyone who submitted one or more pieces received a stipend. If YLI published a piece, that individual would receive an additional sum too.

As submissions were received, YLI was in awe of the depth of each piece. Using collage, prose, poetry, videos, and art created from various mediums, individuals described such feelings as isolation, loneliness, confinement, recovery, and self-affinity. Thus far, pieces from over 50 individuals between the ages of 15 -30 years-old and written in English or Spanish have been submitted. Wilson was unsure of the total number of pieces received because many individuals submitted several pieces.

Artist: Kai Doran

One challenge they faced was reaching older adults. Outreach efforts included texting, creating flyers, printing them, and personally distributing flyers to the community they worked with. Staff also tried slipping flyers under doors in older adult communities as well as emailing and calling them. Although these efforts were effective for younger adults, they were ineffective with older adults.

Nonetheless, the project grew to be larger and more time-consuming than expected. With a steady flow of pieces being submitted, YLI decided to start posting individual pieces on their Instagram. This, however, was more labor intensive than expected. Or, as Wilson stated, the capacity to meaningfully engage with all pieces is challenging. For instance, YLI needed to determine whether creators wanted to be anonymous. Also, because Instagram is a visual platform, pieces such as stories and poems that were text only needed to be designed in a visually appealing manner. Additionally, YLI staff chose hashtags and wrote captions for each piece; all of which needed to be approved by the creator before posting. Aware that they had followers who were Spanish-speaking, YLI also had captions written in both English and Spanish. As Wilson shared There's a lot of steps you want to take to assure that the youth's voice is being authentic and that it's also being anonymous if that's what they want.

Artist: Marcela Cordova

Unexpectedly, another benefit surfaced. Youth and parents shared that it positively impacted themselves and their families. Some parents shared that this was the first they were able to learn about their child's feelings about mental health and/or COVID-19. Wilson explained It has opened up some young people and their families to conversations that they might not have had. Secondly, for some young artists, having their work posted on Instagram was the first time they'd had a piece published. Indeed, Wilson stated that we had one young person submit five paintings and we've published a few of those. They've had a good amount of engagement and click throughs. That's been exciting to be able to give them a platform to show off their skills. Moreover, Wilson explained that the project gave youth an opportunity to express themselves in a way that they might not be able to do in their home, with their friends, or at school.

As stated above, submissions were to be used as way to learn about the mental health needs of the San Mateo Community. As of now, with submissions slowing down, the next steps for YLI include identifying the common themes in the anthology which will be used to inform what features the app should include and if there are specific mental health needs within their community. Wilson explained that we've seen some themes like isolation, depression and needing more mental health services. They haven't, however, been able to sit down and say what the biggest themes coming out of it are. YLI is also planning to include organizations that subcontracted with them in the Help@Hand pilot as well as create a space on their website to post the anthology.

Reference

(Merriam-Webster. (n.d.) Anthology. In Merriam-Webster.com dictionary. Retrieved January 22, 2021, from https://www.learnersdictionary.com/definition/anthology)

3 COUNTY/CITY TECHNOLOGY, USER EXPERIENCE, AND IMPLEMENTATION EVALUATION

Key Points

- Los Angeles and Riverside Counites conducted needs assessments with community college students and members of Riverside County's Deaf and Hard of Hearing Community, respectively. Orange County is planning a needs assessment of its clients. Needs assessments gather detailed information on perceptions of mental health among the target population, use of technology to support mental health, and resources desired to support mental health.
- Marin, Riverside, San Francisco, and San Mateo Counties, as well as City of Berkeley and Tri-City explored different technologies with target populations to select which technology to pilot or implement.
- Los Angeles, Marin, San Mateo, Santa Barbara, and Tehama Counties as well as Tri-City planned pilots that would test potential technologies with their target population on a small scale. Some pilots were paused or discontinued for various reasons.
- Los Angeles and Orange Counties implemented technologies, with the intention of scaling these across their target population or using them for the remainder of the project. Evaluation interviews and surveys with leadership, providers, and users were conducted in Year 2.
- Riverside County developed and launched a peer-chat app called Take my Hand in 2020, and San Francisco is planning to partner with Riverside on piloting this app as well in 2021.
- Los Angeles and San Mateo Counties began offering county residents Headspace in Year 2 in order address mental health needs in communities, particularly those impacted by COVID-19. San Francisco began planning their Headspace launch for 2021.
- Monterey and Los Angeles Counties released a Request for Information and created a Request for Proposal as part of their development of a tool that screens and refers consumers.
- Kern and Modoc Counties completed their projects and transitioned off of Help@Hand. Exit interviews were conducted with both counties.

OVERVIEW

This section presents county/city activities as of the end of Year 2, which are summarized in **Table 3.1**.

The progress made toward needs assessments, technology explorations and selections, pilot, and implementation phases is further detailed in this section. The COVID-19 Rapid Response, development of a Request for Information (RFI) and Request for Proposal (RFP), and project completion by some counties are also described.

Table 3.1. Overview of County/City Efforts at the End of Year 2

County/City	Activity	Target Audience(s)	Technology	Current Status
City of Berkeley	• Technology Exploration and Selection	• General population • Transitional age youth (TAY) • Isolated older adults	• Headspace • myStrength	• Active– planning underway
Kern	• Project Completion	• N/A	• N/A	• Completed
Los Angeles	• Needs Assessment	• Community college students	• N/A	• Completed
Los Angeles	• Pilot Planning	• Older Adults • Isolated populations at higher risk of serious complications from COVID–19 • Adult cognitive behavioral health clients • Individuals seeking Peer Resource Center support	• Uniper • CredibleMind • Headspace (pilot)	• Inactive– planned but not executed and no longer in progress
Los Angeles	• Implementation	• Dialectical behavior therapy (DBT) clients	• Mindstrong/ MindLAMP	• Active– transitioning from Mindstrong to MindLAMP
Los Angeles	• Rapid COVID–19 Re–sponse	• Los Angeles County residents	• Headspace	• Active– implementation underway
Marin	• Technology Exploration and Selection (complet–ed) • Pilot Planning	• Older (isolated) adults	• myStrength • Uniper	• Active– pilot planning under–way
Modoc	• Project Completion	• N/A	• N/A	• Active– participation in Help@Hand concludes April 2021
Mono	• Technology Exploration and Selection	• N/A	• Considering Headspace or myStrength	• Inactive– Will become active Spring 2021
Monterey	• Request for Information (RFI) (completed) • Request for Proposal	• Monterey County residents	• Screening and referral tool	• Active– planning underway
Orange	• Needs Assessment	• Behavioral Health Services clients • Parents of Behavioral Health Services clients	• N/A	• Active– planning underway
Orange	• Implementation	• Eligible clients at UCI Health Psychiatry Services	• Mindstrong	• Active– implementation underway

County/City	Activity	Target Audience(s)	Technology	Current Status
Riverside	• Needs Assessment	• Deaf and Hard of Hearing Community	• N/A	• Active– completed and planning expansion underway
Riverside	• Technology Exploration and Selection	• Full Service Partnership (FSP) consumers	• A4I or Focus	• Completed
Riverside	• Rapid COVID–19 Re–sponse	• Riverside County residents	• Take my Hand	• Active– implementation underway
San Francisco	• Technology Exploration and Selection	• TAY • Transgender youth and adults	• Take My Hand	• Completed
San Francisco	• Rapid COVID–19 Re–sponse	• San Francisco County resi–dents	• Headspace	• Active– planning underway
San Mateo	• Technology Exploration and Selection (complet–ed) • Pilot Planning	• Older adults • TAY	• Wysa	• Active– pilot planning un–derway
San Mateo	• Rapid COVID–19 Re–sponse	• San Mateo County residents	• Headspace	• Active– implementation underway
Santa Barbara	• Pilot Planning	• Clients recently discharged from inpatient psychiatric care • Geographically isolated individuals • TAY	• Headspace	• Paused
Tehama	• Pilot Planning	• Persons who are Homeless or at risk of Homelessness • Isolated Individuals • Tehama County Health Ser–vices Agency – Behavioral Health Consumers	• myStrength	• Active– planning underway
Tri-City	• Technology Exploration and Selection	• TAY • Older adults • Monolingual Spanish speakers	• Headspace • myStrength • Mindstrong	• Active– planning underway
Tri-City	• Pilot Planning	• TAY engaged at Tri–City's Wellness Center	• Wysa	• Inactive– planned but not executed

NEEDS ASSESSMENT (LOS ANGELES, ORANGE, RIVERSIDE)

In Year 2, needs assessments were conducted, planned, and expanded to engage members of target Help@Hand audiences regarding their mental health needs and their thoughts on how technology can help meet those needs. Specifically, Los Angeles, Orange, and Riverside Counties worked with the evaluation team to develop, conduct, and/or analyze data from their local needs assessments. These needs assessments identified: 1) current mental health needs and beliefs of the target population; 2) current apps, technologies, and resources used in the community; 3) factors likely to influence uptake of technologies; 4) initial measures of outcomes, such as stigma and social connectedness, and mental health literacy; and/or 5) insights for county/city recruitment strategies.

Los Angeles

Completed needs assessment

Los Angeles County partnered with El Camino College (a community college in Los Angeles County) and the Help@Hand evaluation team to conduct a needs assessment with students at El Camino College. A needs assessment survey was distributed electronically to a random sample[15] of 5,000 students from April 16 – June 30, 2020. A total of 500 participants completed the survey.[16]

Results from the needs assessment were shared with the Collaborative in past Help@Hand evaluation reports. A learning brief and comprehensive report were created and shared with Los Angeles County and El Camino College.

Orange

Planning needs assessment

Orange County began to use telehealth to deliver county behavioral health services during COVID-19. Anecdotally, some transitional aged youth (TAY) clients expressed a preference for in-person appointments. Orange County and the Help@Hand evaluation team tailored the needs assessment to learn: 1) whether all behavioral health clients had this preference; 2) what challenges clients may face in using telehealth services; and 3) what factors may contribute to dissatisfaction with telehealth services.

Two versions of the survey were created: one for clients over the age of 13, and another for parents or guardians of clients under the age of 13. The surveys were updated based on findings from a clinician telehealth study conducted by the county. The surveys are expected to be implemented in 2021.

Riverside

Expanding needs assessment

Riverside County partnered with the Center on Deafness Inland Empire (CODIE) and the Help@Hand evaluation team to conduct a needs assessment of the Deaf and Hard of Hearing Community. In September 2020, a focus group and survey were conducted with community advocates who identified as members of the Deaf and Hard of Hearing Community and were members of CODIE. Eleven people were invited to participate in the focus group and survey. Ten people participated in the focus group and nine people completed the survey.[17] Findings were shared in a learning brief with Riverside County and presented for the Collaborative in the quarter 3 report.

Results cannot be generalized to the larger Riverside Deaf and Hard of Hearing Community because of the small sample of the focus group and survey. As such, plans to expand the needs assessment survey to the larger Riverside Deaf and Hard of Hearing Community are underway. The survey is also anticipated to be implemented in 2021.

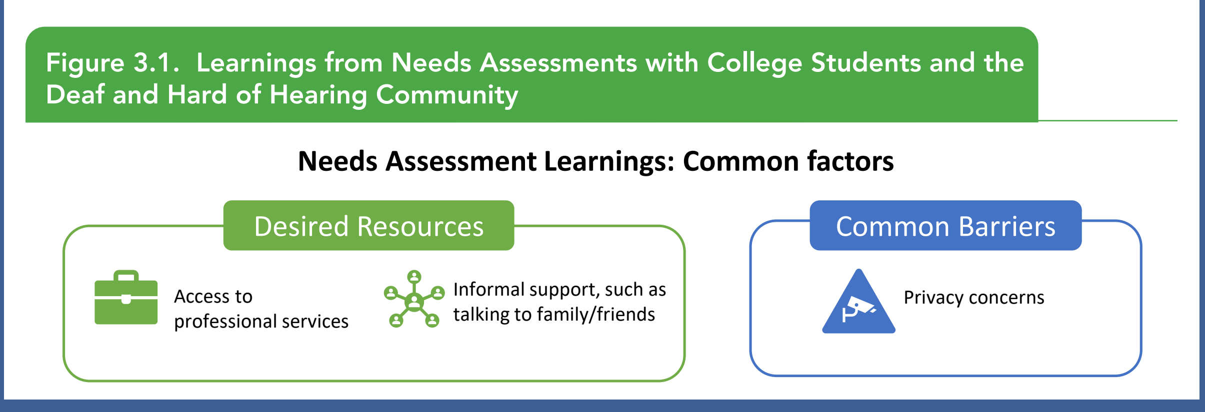
[15] Sampling was done proportionate to gender and race for California community colleges.
[16] Participants received a $10 Amazon gift card for completing the survey.
[17] Focus group participants received a $30 Amazon gift card, and survey participants received a $10 Amazon gift card.

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: NEEDS ASSESSMENT (LOS ANGELES, RIVERSIDE)

While needs assessments are valuable for understanding the unique characteristics of a particular population, looking across needs assessments may also lead to broader insights. **Figure 3.1** shows common learnings from needs assessments with community college students in Los Angeles County and the Deaf and Hard of Hearing Community in Riverside County.

In particular, both target audiences expressed an interest in accessing professional services and informal support. Counties/cities should consider if their specific target audiences is also interested in such access and think about how technologies may support these needs. Privacy also emerged as a potential barrier for both community college students and the Deaf and Hard of Hearing Community who participated in the needs assessment. Ranging widely, privacy concerns included worries about vendors sharing personal data with third parties, potential data breaches, and being identified in peer chat apps. Counties/cities should consider privacy as a potential barrier in adopting and using mental health technologies for target populations.

Figure 3.1. Learnings from Needs Assessments with College Students and the Deaf and Hard of Hearing Community



TECHNOLOGY EXPLORATION AND SELECTION (BERKELEY, MARIN, RIVERSIDE, SAN FRANCISCO, SAN MATEO, TRI-CITY)

Technology exploration allows target audience members or those familiar with the target audience to explore technologies and give initial feedback on whether the technology fits the target audience. Those technologies that fit may be selected to pilot and/or implement with the target audience. In 2020, Marin, Riverside, San Francisco, and San Mateo Counties, as well as City of Berkeley and Tri-City, engaged in technology exploration and selection[18].

City of Berkeley

Exploring technologies

City of Berkeley reviewed four apps (Headspace, myStrength, HeyPeers, and Uniper) that may fit their TAY, isolated older adult, and general populations. In the wake of recent nationwide political upheaval surrounding the topic of racial justice, the city intends to make additional efforts to reach communities of color, including African American, Latinx, and Asian Pacific Islanders. City of Berkeley staff and Peers reviewed each app and determined myStrength and/or Headspace as likely technologies to implement, due especially to their widespread use with large numbers of people in various populations.[19] Staff will further review myStrength and Headspace in 2021.

[18] Mono County will conduct technology explorations in Spring 2021.

[19] Although a pilot was initially considered, City of Berkeley decided to proceed with a COVID-19 Rapid Response implementation.

Marin

Completed technology exploration and selection

Marin County examined myStrength and Uniper with its older adult population. With support from CalMHSA and the Help@Hand evaluation team, the county developed processes and tools to support virtual technology exploration that complied with COVID-19 social distancing requirements. Twelve older adults and community members explored myStrength and Uniper over seven days and then participated in focus groups and surveys.[20] Findings were shared in a learning brief with Marin County and in the quarter 3 Help@Hand evaluation report for the Collaborative.

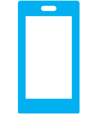
Riverside

Completed technology exploration and selection

In addition to conducting a needs assessment with the Deaf and Hard of Hearing Community (described above) and launching their own platform – Take my Hand (described below), Riverside County reviewed other apps to pilot with their various target populations.[21] Based on their review, Riverside County determined A4i and/or Focus may meet the needs of those in their Full Service Partnership (FSP) program, an intensive program offering mental health and support services for those experiencing and/or at-risk for institutionalization, homelessness, incarceration, or psychiatric in-patient services.

A total of 24 county clinic participants, including some FSP consumers, participated in focus groups and a survey. Eleven were aged 16-25 years and twelve were aged 26+ years.[22] Findings were shared in a learning brief with Riverside County. Key findings include:

Key Findings from Technology Exploration with FSP Consumers

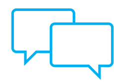


APP PREFERENCE

TAY participants seemed to show a preference for A4i, whereas adult participants were more split and acknowledged that both technologies had useful features.

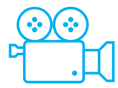
CONNECTION WITH OTHERS

Participants valued being able to connect with others, both with a care team and other users.



IMPROVED COMMUNICATION

Participants liked being able to communicate with their care team and share information with A4i, but there were some concerns around what would happen if messages do not receive a reply.



VIDEO AND TEXT

Different modalities to view information, such as video and text, were viewed positively.

PRIVACY CONCERNS

Participants reported possible privacy concerns from others seeing technology notifications on their phone, and expressed the need for users to trust the app in order to share information with others within it.

San Francisco

Completed technology exploration and selection

At the beginning of 2020, San Francisco considered piloting Headspace with county staff. Toward the end of 2020, San Francisco decided to implement Headspace to anyone who lives or works in San Francisco County. San Francisco later used CalMHSA's Request for Statement of Qualification (RFSQ) product matrix[23] to review potential peer-chat apps for county residents, particularly transgender and TAY communities. The county considered 11 apps: HeyPeers, Ouchie, Pre Registry, SageSurfer, Sharpen Minds, Sober Grid, Support Groups Central, Supportiv, Uniper, Wysa, and Take my Hand (described below). Based on careful review and discussions, the county is considering to work with Riverside County to pilot Take my Hand in 2021.

[20] Participants received a gift card for their participation.
[21] Riverside County's priority target populations include: TAY; Deaf and Hard of Hearing; visually impaired; males aged 45+ years; high-risk populations (e.g., those who are re-entry, enrolled in the FSP Program, or with an eating disorder); Mid-County & Desert populations; adults aged 65+ years; and ethnic, cultural and LGBTQ+ communities.
[22] Participants received a gift basket for their participation.
[23] The RFSQ product matrix was created by CalMHSA to help counties/cities review the 93 RFSQ apps. The matrix has three components: (1) Ability to filter apps based on specific features; (2) Product profiles to compare across apps; and (3) Glossary of terms.

San Mateo

Completed technology exploration and selection

Figure 3.2 depicts the potential apps that San Mateo County primarily considered for its target audiences. For its technology exploration and selection, San Mateo County recruited older adults and TAY to engage with and review each app. They were then invited to complete a survey and discuss their experiences in focus groups.

Figure 3.2. Target Audiences and Technologies Considered for San Mateo County's Technology Exploration and Selection

TAY. Five TAY spent up to 6 hours exploring Headspace, myStrength, and Wysa. They then participated in both surveys and focus groups. Findings were shared in a learning brief with San Mateo County. Key findings include:

Key Findings from Technology Exploration with TAY

APP PREFERENCE

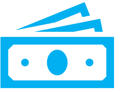
Participants seemed to show a preference for Headspace and Wysa over myStrength in terms of navigation, cultural sensitivity, meeting needs, and visual look.

NAVIGATION

It was important to easily navigate through the app to be able to engage with content. myStrength was perceived to be harder to navigate compared to the other two technologies due to the large amount of material, which was not organized in a user-friendly and aesthetically-pleasing manner.

CULTURAL SENSITIVITY

myStrength was perceived to be less culturally sensitive relative to Headspace and Wysa. Headspace had a relatively high rating and included content involving racial groups. Wysa also had a relatively high rating, though a participant acknowledged room for improvement.



RESOURCES REQUIRED

Most participants felt they had appropriate devices to access these technologies. However, it not only mattered whether participants had the resources required to use the app, but also to engage in various activities suggested by the app (e.g., cost of using therapist, need for equipment for workouts).

VISUAL LOOK AND VARIETY OF CONTENT

Participants were more engaged if they thought the app was visually pleasing, and a large variety of content prompted users to engage with the app.

Older Adults. Eight older adults spent 1-6 hours exploring myStrength and Wysa.[24] Seven of these older adults participated in surveys and six participated in a focus group. Findings were shared in a learning brief with San Mateo County and in the quarter 3 Help@Hand evaluation report for the Collaborative.

[24] Uniper was not explored because test accounts were not available.

Tri-City
Exploring technologies

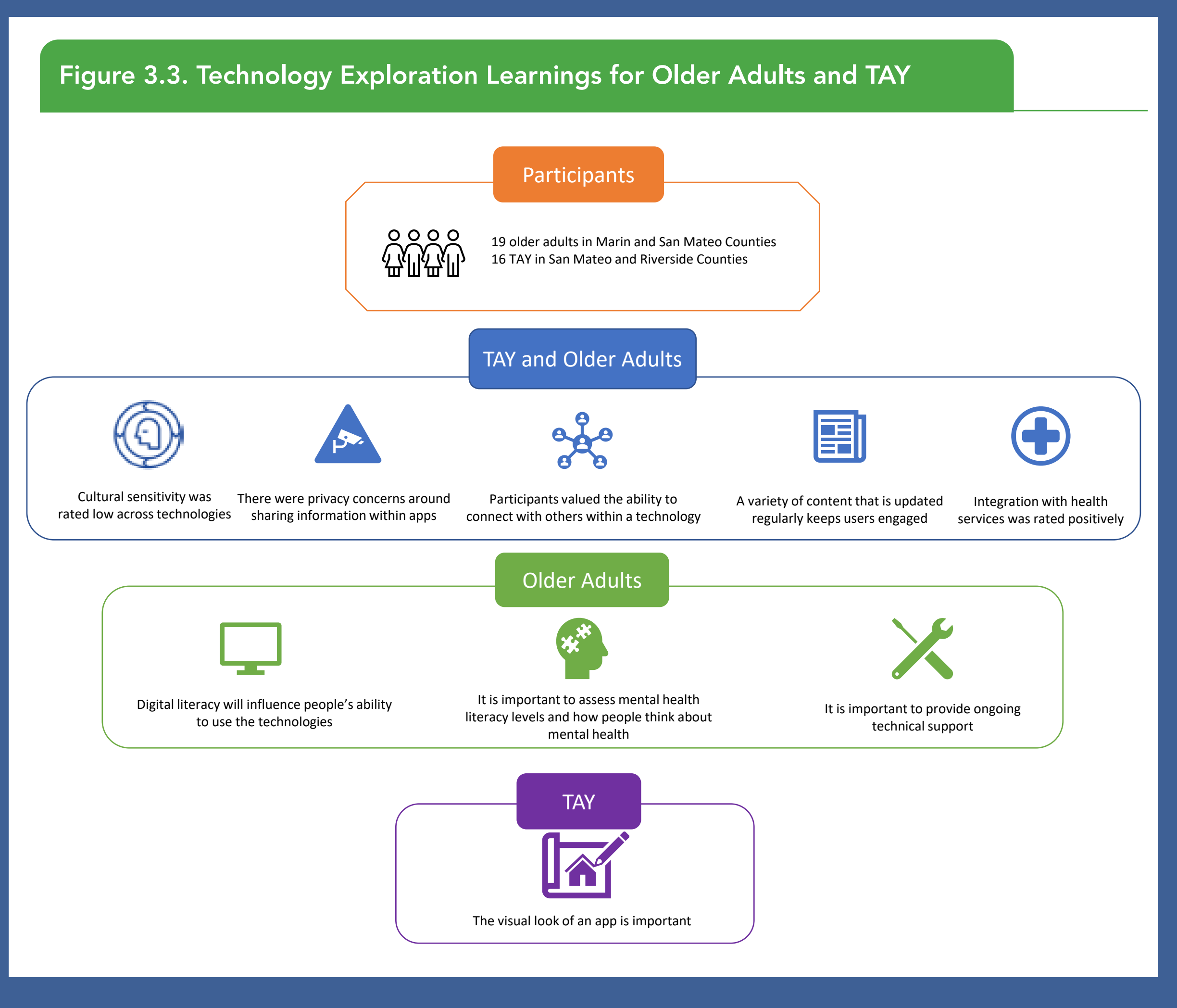
In late 2020, Tri-City began to shift from planning a pilot with Wysa to exploring Headspace and myStrength. Tri-City is also interested in a possible collaboration with Orange County to implement Mindstrong. In early 2021, Tri-City will conduct focus groups with Tri-City's clinical staff, Peers, and community members in order to determine which technologies best fit the needs and scope of their older adult, TAY, and monolingual Spanish-speaking populations.

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: TECHNOLOGY EXPLORATION AND SELECTION (MARIN, RIVERSIDE, SAN MATEO)

Marin, Riverside, and San Mateo Counties worked with target audience members to explore technologies and provide feedback that would help select appropriate technologies to pilot and/or implement. Learnings from common target audiences (e.g., older adults and TAY) and technologies (e.g., myStrength) are presented below to help other counties/cities considering these audiences or technologies.

Figure 3.3 presents learnings from technology explorations with older adults and TAY in Marin, Riverside, and San Mateo Counties. Counties/cities across the Collaborative, particularly those targeting TAY or older adults, should consider these learnings when selecting technologies for their pilots or implementations.

Figure 3.3. Technology Exploration Learnings for Older Adults and TAY



myStrength was the only technology explored in multiple counties. **Figure 3.4** shows learnings from technology exploration with myStrength in Marin and San Mateo Counties. Participants enjoyed the variety of content that myStrength offers, such as information about mental health and the ability to track mood and sleep. However, they reported privacy concerns due to sharing demographic information within the app. These findings may be valuable to counties/cities planning to implement myStrength.

Figure 3.4. Technology Exploration Learnings for myStrength

myStrength

Privacy concerns due to sharing demographic information

Wide variety of content keeps users engaged

19 older adults and 5 TAY in Marin and San Mateo Counties explored myStrength

PILOT (LOS ANGELES, MARIN, SAN MATEO, SANTA BARBARA, TEHAMA, TRI-CITY)

Los Angeles, Marin, San Mateo, Santa Barbara, and Tehama Counties as well as Tri-City planned pilots that would test potential technologies with their target population on a small scale. Pilots help to answer:

1) Should a county/city continue on a larger scale with the technology for their target population?
2) If a county/city continues with the technology, what can help inform a successful scale-up?
3) What learnings from the pilot can help other Help@Hand counties/cities?

Los Angeles

Pilot planned, but not executed

In March 2020, Los Angeles County presented three pilot proposals to Help@Hand Leadership for approval: Uniper for older adults; CredibleMind for isolated populations at higher risk of serious complications from COVID-19; and Headspace for adult cognitive behavioral health (CBT) clients and individuals seeking Peer Resource Center support. In April 2020, the three pilot proposals were approved, but Los Angeles County paused pilot launches in order to focus on their Headspace Rapid COVID-19 Response. In July 2020, the County decided not to move forward with these three pilots.

Marin

Planning pilot

Based on findings from their technology exploration of Uniper and myStrength with older adults and community members, Marin County's Advisory Committee decided to pilot both myStrength and Uniper with isolated older adults. The county worked with CalMHSA and the Help@Hand evaluation team to plan its pilots. In December 2020, Marin County presented its myStrength pilot to the Help@Hand Leadership and received approval to move forward.[25]

For their myStrength pilot, Marin County plans to recruit 30 English- and Spanish-speaking isolated older adults to engage with the technology. Tech4Life, a contractor hired by Marin County, will provide digital literacy training to all participants before engaging with myStrength. Marin County also secured a partnership with the Telehealth Equity Project, which will provide nurse interns to help recruit isolated older adults, offer them technical assistance, and conduct evaluation surveys. In addition to surveys with users, the evaluation will involve interviews with

[25] Marin County's pilot planning for Uniper is on hold until spring 2021 due to challenges planning two simultaneous pilots. In addition, Uniper was still finalizing the Spanish version of the app, which was a high priority for Marin County, whereas myStrength was ready to go.

users as well as surveys and interviews with the nurse interns (as shown in **Table 3.2**). The evaluation may also include interviews with the Marin County's Tech Lead and Peer. Marin plans to launch their pilot in early 2021.

Table 3.2. Evaluation Activities for Marin and Tehama Counties' Pilots

Evaluation Activity	Marin County	Tehama County
User Surveys	√ once before digital literacy training once after digital literacy training once at the end of the pilot	√ once at the beginning and once at the end of the pilot
User interviews	√ once 4–weeks after the pilot start	√ once 4–weeks after the pilot start and once at the end of the pilot
User Focus Groups		√ once 3 months after the pilot start and once 5 months after the pilot start
Staff Surveys	√ once at the end of the pilot	√ once no sooner than 2 months after the start of the pilot
Staff Interviews	√ once at the end of the pilot	√ once at the end of the pilot

San Mateo
Planning pilot

After reviewing technology exploration findings with older adults and TAY, San Mateo County selected to pilot Wysa with their older adult and TAY. Both target populations viewed Wysa as more culturally competent compared to the other technologies explored. San Mateo County also appreciated Wysa's flexibility to make changes to the app and add county-specific resources. A contract between Wysa and CalMHSA is expected in early 2021. San Mateo will also work with CalMHSA and the Help@Hand evaluation team to develop a pilot proposal.

Santa Barbara
Pilot planned, but not executed

In early 2020, Santa Barbara County collected input from community members and began planning to pilot Headspace with their target populations (e.g., TAY in colleges and universities; certain isolated adult clients; and adults discharged from psychiatric hospitals or who received crisis services). In May 2020, Santa Barbara County paused its pilot planning in order to focus on the impact of COVID-19 within the agency. Given feedback from community members that they needed digital literacy training and access to devices before launching an app, the county then shifted its efforts to developing and implementing their Digital Wellness Ambassador program. The program utilizes Peers to support those transitioning from inpatient to outpatient psychiatric care by sharing information on mental health resources and assisting with navigation to outpatient referrals. Santa Barbara County also partnered with other agencies to improve digital literacy among their target population. They subcontracted with Painted Brain to engage TAY in "listening sessions" that allows the county to hear from TAY about their mental health and technology needs. They also worked with a local community-based organization to host Appy Hours and plan digital literacy trainings for isolated older adults.

Tehama
Planning pilot

Tehama County initially considered piloting Happify, but Happify notified Help@Hand that they were not taking on new clients due to COVID-19. At that point, based on input and evaluation of other apps by their staff and Peers, Tehama decided to move forward with piloting myStrength. Target populations for the pilot include persons

who are Homeless or at risk of Homelessness, isolated individuals, and Tehama County Health Services Agency – Behavioral Health (TCHSA-BH) consumers. Their pilot will include Peer staff and wellness advocates recruiting and engaging 30 participants (10 from each target population) via a one-on-one approach.

In September 2020, Tehama County presented their pilot proposal to the Help@Hand Leadership and received approval to move forward. The county anticipates to finalize their contract with myStrength and launch their pilot in early 2021. **Table 3.2** summarizes how the pilot will be evaluated. The **spotlight** on page 61 highlights how Tehama County Peers helped shape and inform the pilot evaluation.

Tri-City

Pilot planned, but not executed

At the beginning of 2020, Tri-City decided to pilot Wysa with TAY engaged at Tri-City's Wellness Center based on insights from their wellness advocates. They actively worked with CalMHSA and the Help@Hand evaluation team to negotiate a contract with Wysa and plan their pilot. However, Tri-City paused their pilot planning in August 2020 due to personnel turnover and staff capacity concerns. In late 2020, Tri-City decided to no longer pursue a pilot with Wysa. Although Wysa met the needs of Tri-City's TAY population, it did not meet the needs of its other target populations (e.g., it would not work with their monolingual Spanish-speaking population). Thus, Tri-City shifted to exploring other technologies (as described above).

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: PILOT (LOS ANGELES, MARIN, SAN MATEO, SANTA BARBARA, TEHAMA, TRI-CITY)

Los Angeles, Marin, San Mateo, Santa Barbara, and Tehama Counties as well as Tri-City planned different pilots to test potential technologies in Year 2. Key learnings from planning these pilots include:

- Structuring pilots: Pilots may be structured differently depending on the technology and target audience. For example, some target audiences may benefit from digital literacy and individualized support as part of a pilot. On the other hand, some technologies may be used on devices that target audiences are more familiar with, and may require less individualized support.
- New recruitment and engagement challenges: COVID-19 created new challenges for recruiting and engaging target audience members in pilots. Digital literacy levels influenced target audience members' ability to engage in remote data collection and redeem incentives distributed electronically. Careful planning and consideration was needed to address these challenges.
- Community-based partnerships: Partnering with organizations that serve the target audience can provide vital support with recruitment and staffing. For example, Marin County's partnership with the Telehealth Equity Project created a referral stream for their myStrength pilot and provided nurse interns to offer support.
- Easy to understand materials can support decision-making: Materials that use very little jargon helped people understand core concepts and make informed, insightful decisions. For example, materials with little jargon helped people easily understand statistics and inform decisions for the evaluation.
- Understand vendor data: It was important to know what data vendors were able to provide and whether vendors were open to taking new clients early in the pilot planning process.
- Involve Peers in evaluation: Peers offered valuable input when selecting appropriate evaluation items. Evaluation efforts must always find a balance between what is scientifically valid and what is feasible – a partnered Peer-driven approach was an effective strategy for striking this balance.

SPOTLIGHT
Engaging Peers in the Evaluation: A Model for Measurement

In the winter of 2019, the Help@Hand program completed the important work of defining and selecting the measurement constructs to assess mental health stigma.

A panel of five community Peers, individuals with lived experience and/or family member experience, and six academics with expertise in developing stigma measures was convened. The panel came to consensus on the dimensions of stigma that were important to measure as part of Help@Hand, specifically the following three areas:

1) **Internalized stigma:** one's own stigma toward their mental health condition;

2) **Resilience:** one's hope and positive attitude toward living with or recovering from one's mental health condition; and

3) **Mental health treatment stigma:** one's stigma toward seeking treatment for one's mental health condition.

The result of the effort was to identify 28 questions to be incorporated in the Help@Hand evaluation:

Background:

There are many measures of mental health stigma that focus on the broad perspectives of the stigmatizer versus the perspectives of the stigmatized. A community participatory approach was adopted in late 2019 to select the guiding instruments for the Help@Hand program. The effort ensured that the instruments:

1) were sensitive to the type of impact expected of Help@Hand apps;

2) met the stigma dimensions of interest of counties/cities; and

3) were scientifically valid.

DOMAIN / SCALE		SUBSCALE	ITEMS
Internalized Stigma	ISMI	Alienation	I feel out of place in the world because I have a mental illness Having a mental illness has spoiled my life People without mental illness could not possibly understand me I am embarrassed or ashamed that I have a mental illness I am disappointed in myself for having a mental illness I feel inferior to others who don't have a mental illness
		Social Withdrawal	I don't talk about myself much because I don't want to burden others with my mental illness I don't socialize as much as I used to because my mental illness might make me look or behave 'weird' Negative stereotypes about mental illness keep me isolated from the 'normal' World Stay away from social situations in order to protect my family or friends from embarrassment Being around people who don't have a mental illness makes me feel out of place or inadequate I avoid getting close to people who don't have a metal illness to avoid rejection
Resilience	RAS-R	Willingness to ask for help	I know when to ask for help I am willing to ask for help I ask for help when I need
		Not dominated by symptoms	Coping with my mental illness is no longer the main focus of my life My symptoms interfere less and less with my life My symptoms seem to be a problem for shorter periods of time each time they occur
Mental Health Treatment Stigma	SSOSH		I would feel inadequate if I went to a therapist for psychological help My self-confidence would NOT be threatened if I sought professional help Seeking psychological help would make me feel less intelligent My self-esteem would increase if I talked to a therapist My view of myself would not change just because I made the choice to see a therapist It would make me feel inferior to ask a therapist for help I would feel okay about myself if I made the choice to see professional help If I went to a therapist, I would be less satisfied with myself My self-confidence would remain the same if I sought professional help for a problem I could not solve I would feel worse about myself if I could not solve my own problems

Tehama County, in their pilot launch of myStrength, included the reduction of mental health stigma as an anticipated primary outcome of their technology implementation. The Tehama team turned to the work of tailoring their survey instruments to include items to measure mental health stigma in order to capture changes.

Led by Travis Lyon, Mental Health Services Act Coordinator, Behavioral Health, and in partnership with Ron Culver, Northern Valley Catholic Social Service (NVCSS) Supervisor, Tehama County Peer Programs, and a team of participating Peers, a workgroup was developed. This workgroup identified and commented on the limitations of the provided items that had been identified in the prior year.

Two primary limitations of the recommended survey items were identified by the workgroup. The first limitation was the overall length of the recommended items. Given the demographic questions that Tehama planned to include, surveys needed to be kept short to ensure that they could be reasonably completed. The second limitation was the lack of inclusivity and potential offensive wording of some of the items in the scales. For example, the surveys items were developed and guided by evidence-based practices to maximize the reliability and validity of the survey instruments. The Peers, however, were uncomfortable with some of the wording choices. Including questions with words like looking “weird” or “having one’s life spoiled” were noted as potentially being stigmatizing themselves.

> *The reason the Peers and I wanted to include all three areas of internalized stigma, resilience, and mental health treatment seeking stigma is because they all go hand in hand. Internalized stigma, the belief that there is “something wrong with me,” can lead to not seeking treatment; “there is something wrong with me because I need help,” which in turn makes it very difficult to foster any sense of resilience, making it exceedingly challenging to break the cycle.*
>
> – **Ron Culver**, *Northern Valley Catholic Social Service (NVCSS) Supervisor, Tehama County Peer Programs*

With guidance from the Help@Hand evaluation team, the Peer workgroup sought to understand and respond to these limitations. Three areas were explored by the workgroup:

1. Which stigma topics/constructs, if any, were important to include in their evaluation?

   a) Internalized Stigma (subtopics: Alienation, Social Withdrawal)

   b) Resilience (subtopics: willingness to ask for help; not dominated by symptoms)

   c) Mental Health Treatment Seeking Stigma

2. How many questions did they want to include in their survey? What was feasible and appropriate when considering respondent burden?

3. What wording options seemed best for promoting cultural competency and inclusiveness?

The next step involved selecting the specific items to be used for each area of inquiry. To facilitate the discussion, the evaluation team shared data collected as part of the Help@Hand evaluation around survey wording and measurement with the Tehama workgroup. The workgroup reviewed the scree plot analysis for each construct to see how many unique groups of questions were present in each scale.

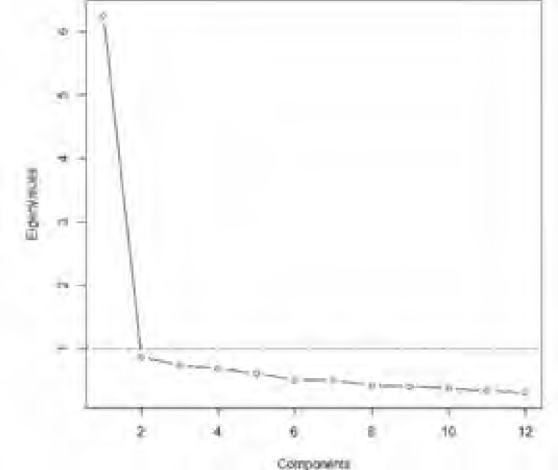


Figure 1: Scree plot for the 12 items of the ISMI section

Figure 1 shows the scree plot for the 12-items that are part of the ISMI scale. A scree plot displays how much variation each component captures from the data. The general rule, when using a scree plot, is to drop the components after the one starting the elbow. As shown in the figure, the scree plot indicated that there was one significant cluster (or group of items) and perhaps a second less meaningful cluster.

The workgroup then walked through different ways to consider the influence of each individual item on the total scale – or the item total correlation. For example, this was done by creating a total score for each scale, and then correlating each item’s score with the total score (at the participant level).

Table 1 shows an example of Item I12 (which came from the social withdrawal subscale), which had the highest item total correlation with the ISMI scale (0.79), and that all the items had a relatively high total correlation (r >.5).

Table 1

7.1 The ISMI items

- I1: I feel out of place in the world because I have a mental illness.
- I2: Having a mental illness has spoiled my life.
- I3: People without mental illness could not possibly understand me.
- I4: I am embarrassed or ashamed that I have a mental illness.
- I5: I am disappointed in myself for having a mental illness.
- I6: I feel inferior to others who don't have a mental illness.
- I7: I don't talk about myself much because I don't want to burden others with my mental illness.
- I8: My mental illness might makes me look or behave "weird".
- I9: Negative stereotypes about mental illness keep me isolated from the 'normal' world.
- I10: I stay away from social situations in order to protect my family or friends from embarrassment.
- I11: Being around people who don't have a mental illness makes me feel out of place or inadequate.
- I12: I avoid getting close to people who don't have mental illness to avoid rejection.

Ranks	California dataset		Other States dataset	
	Item and category	Correlation with the ISMI total score	Item and Category	Correlation with the ISMI total score
1	I12(Social Withdrawal)	0.79	I12(Social Withdrawal)	0.80
2	I9 (Social Withdrawal)	0.77	I11 (Social Withdrawal)	0.77
3	I11(Social Withdrawal)	0.76	I9(Social Withdrawal)	0.77
4	I10(Social Withdrawal)	0.76	I10(Social Withdrawal)	0.76
5	I6 (Alienation)	0.76	I8 (Social Withdrawal)	0.74
6	I8 (Social Withdrawal)	0.75	I6 (Alienation)	0.74
7	I4 (Alienation)	0.73	I5 (Alienation)	0.74
8	I2 (Alienation)	0.73	I4 (Alienation)	0.72
9	I5 (Alienation)	0.71	I2 (Alienation)	0.70
10	I1 (Alienation)	0.68	I1 (Alienation)	0.67
11	I7 (Social Withdrawal)	0.62	I7 (Social Withdrawal)	0.64
12	I3 (Alienation)	0.60	I3 (Alienation)	0.59

In addition to considering the psychometric properties of each item, the Peer Workgroup also balanced their item selection by considering the language used in each item.

The final selection of items included the following:

Original Item Wording (Peer Selected)

1. Internalized Stigma (ISMI)
   A. Alienation
      1) I4: I am embarrassed or ashamed that I have a mental illness.
      2) I6: I feel inferior to others who don't have a mental illness.
      3) I2: Having a mental illness has spoiled my life.
   B. Social Withdrawal

1) I7: I don't talk about myself much because I don't want to burden others with my mental illness.
2) I11: Being around people who don't have a mental illness makes me feel out of place or inadequate.
3) I12: I avoid getting close to people who don't have mental illness to avoid rejection.

2. Resilience (RAS-R) - Willingness to ask for help and not dominated by symptoms
    1) R1: I know when to ask for help.
    2) R5: My symptoms interfere less and less with my life.
    3) R6: My symptoms seem to be a problem for shorter periods of time each time they occur.
3. Mental Health Treatment Stigma (SSOSH) - Self-Perception concerning Treatment
    1) S2: My self-confidence would NOT be threatened if I sought professional help.
    2) S4: My self-esteem would increase if I talked to a therapist.
    3) S9: My self-confidence would remain the same if I sought professional help for a problem I could not solve.

Peer Driven Item Reduction and Wording

1. Internalized Stigma (ISMI)
    A. Alienation
        1) I4: I am embarrassed or ashamed that I have mental health challenges.
        2) I6: I feel inferior to others who don't have mental health challenges.
        3) I2: Having mental health challenges has spoiled my life.
    B. Social Withdrawal
        1) I7: I don't talk about myself much because I don't want to burden others with my mental health challenges.
        2) I11: Being around people who don't have mental health challenges makes me feel out of place or inadequate.
        3) I12: I avoid getting close to people who don't have mental health challenges to avoid rejection.
2. Resilience (RAS-R) - Willingness to ask for help and not dominated by symptoms
    4) R1: I know when to ask for help.
    1) R5: My symptoms interfere less and less with my life.
    2) R6: My symptoms seem to be a problem for shorter periods of time each time they occur.
3. Mental Health Treatment Stigma (SSOSH) - Self-Perception concerning Treatment
    1) S2: My self-confidence would NOT be threatened if I sought professional help.
    2) S4: My self-esteem would increase if I talked to a therapist.
    3) S9: My self-confidence would remain the same if I sought professional help for a problem I could not solve.

In sum, there are several learnings that came out of this process:

- Including Peers in the decision-making process around measurement in evaluation is critical for selecting appropriate evaluation items.
- Developing the necessary understanding to make such decisions takes time.
- The availability of data gathered as part of the Help@Hand evaluation was critical for using a data-driven approach for shortening the survey instruments.
- When presented with materials that are explained using minimal jargon, it is possible for people with limited training in statistics to understand the core issues and be able to make informed and insightful decisions.
- Evaluation efforts must always find a balance between what is scientifically valid and what is feasible – a partnered Peer-driven approach is an effective strategy for striking this balance.

> *I believe it was an extremely worthwhile process. It was great to see how the Peers and the UCI team were willing to learn from each other, and how open the creative space was that allowed for a rich and meaningful dialogue. A genuinely enjoyable experience!*
>
> – **Ron Culver**, *Northern Valley Catholic Social Service (NVCSS) Supervisor, Tehama County Peer Programs*

The evaluation team wishes to extend a thanks to Travis for creating the time and space to do this work. We also wish to extend a special thanks to Ron and the Peers for so generously sharing their viewpoints and being open to learning about scale construction and item selection.

IMPLEMENTATION (LOS ANGELES, ORANGE)

An implementation is the launch of a single product with the focus on the county/city scaling it across their target population or using it for the remainder of the Help@Hand project. Los Angeles and Orange Counties implemented Mindstrong in different ways.

Los Angeles
Implementing

In 2020, Los Angeles County decided to discontinue the use of Mindstrong DBT diary cards, which are tools used as part of Dialectical Behavioral Therapy (DBT) to track symptoms and coping skills (Linehan, 1993), at their Harbor-UCLA DBT clinic. The decision was made for two reasons: 1) Mindstrong changed its business model to only support the full Mindstrong Care product line (not the DBT diary cards); and 2) Los Angeles County wanted a product that they could manage "in-house" in order to easily make customizations that meet client and county needs, such as having more active assessments. Los Angeles County also decided to work with MindLAMP to provide diary cards for their clients. A contract with MindLAMP was executed in October 2020 and the teams began transitioning patients from Mindstrong to MindLAMP into the new year.

COUNTY LEADERSHIP AND PROVIDER INTERVIEWS

The Help@Hand evaluation team interviewed Los Angeles County's leadership (n=2) and providers who used Mindstrong with their clients (n=2) in order to identify lessons learned and recommendations for counties/cities planning to or currently implementing Mindstrong. Interviewees identified **lessons learned**, including:

- **Lack of communication on client use:** Mindstrong was perceived as "a black box" in that providers had limited knowledge of client use (e.g., they did not know what information or services clients were offered, or which clients engaged with Mindstrong unless clients directly informed the providers). This was a significant challenge that helped inform the decision to discontinue Mindstrong.
- **Confusion on biomarker features:** Leadership, providers, and clients did not fully understand Mindstrong's biomarker function. This also informed the decision to discontinue Mindstrong.
- **Better alignment with county services:** LA County wanted a technology that they could use as part of the clinical services they offer. LA County was especially interested in alignment with other initiatives such as expansion of DBT across LA County. Examples of the features they thought would be beneficial to their clinical services include more directly incorporating the DBT diary card and providing real-time assessments, such as client self-report questionnaires.
- **Issues with accessing Mindstrong:** Use of Mindstrong's DBT diary card required consistent access to a smart phone or computer. Clients who did not have consistent access were unable to use Mindstrong.

Recommendations based on these lessons learned include:

- **Start planning implementation of Mindstrong early:** Early and ongoing planning with clinics and implementation settings is essential for collaborative problem-solving. Expected implementation challenges include smartphone and computer access, which should be anticipated early.
- **Request Mindstrong trainings:** For those counties/cities proceeding with Mindstrong implementations, Mindstrong can provide specific trainings to providers and other stakeholders within counties/cities on: 1) where to find information about client use and progress (e.g., what clients are doing in their sessions, what resources are offered to clients, and what progress clients are making in their recovery); 2) the biomarker feature and how Mindstrong is using biomarker data; and 3) how to discuss the use and value of biomarkers to clients.

Orange County
Implementing

Orange County launched Mindstrong at UCI Health Psychiatry Services in May 2020. The launch began with only two providers referring eligible clients to Mindstrong Care, but later included an additional 22 resident providers

referring eligible clients. After clients are offered a referral, Orange County's Peers connect with clients to answer questions and gain the consent of clients interested in participating. Mindstrong only contacts those clients interested in participating.

RESIDENT PROVIDER SURVEYS AND INTERVIEWS

In December 2020, 16 resident providers involved in the implementation completed a survey and four participated in interviews. The survey and interview aimed to identify early learnings from the initial few months of implementation, and also elicit strategies to improve the implementation. Findings included:

Survey Findings	Providers had positive impressions of Mindstrong including high acceptability, feasibility, and appropriateness. Providers felt that they had the necessary training, knowledge, resources, support, and leadership necessary to use Mindstrong. Providers felt that it would be important to have additional clarification on different aspects of the Mindstrong product and its care support to better understand who might be most appropriate to use it and why it could be useful to that client.
Interview Findings	Providers had a positive impression of Mindstrong, especially given potential for technology–delivered care during COVID–19. Some barriers identified were onboarding procedures (i.e., blocked numbers, research study framing), clinical and front desk staff having limited knowledge of the Mindstrong implementation, and a lower Mindstrong adoption rate among clients. Additional training could help support better familiarity with the Mindstrong platform. Additional incentives could be provided for referring clients to Mindstrong.

CLIENT SURVEYS AND INTERVIEWS

In addition to resident providers, adopters (e.g., clients who use Mindstrong) will be invited to complete surveys[26] and interviews on a regular basis to understand their experience with Mindstrong and to inform learnings and recommendations for the implementation. Non-adopters (e.g., clients referred to Mindstrong, but opt not to participate) will be asked to complete one survey and one interview to understand what factors influenced their decision to not use Mindstrong, and to further inform client outreach improvements.

All client surveys and interview guides were vetted by Orange County's Tech Leads and Peers as well as UCI Health Psychiatry Services' clinical champion. The evaluation team began surveying adopters and non-adopters in November 2020. Surveys will continue in 2021.

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: IMPLEMENTATION (LOS ANGELES, ORANGE)

Learnings were identified from Los Angeles and Orange County's implementation of Mindstrong. The experience with Mindstrong in both counties, however, varied.

Los Angeles Implementation

Interviews with Los Angeles County on their Mindstrong implementation identified several lessons learned.

- Lack of communication on client use: Mindstrong was perceived as "a black box" in that providers had limited knowledge of client use (e.g., they did not know what information or services clients were offered, or which clients engaged with Mindstrong unless clients directly informed the providers).

[26] Most surveys are collected via phone in order to ensure as much relevant data is gathered in real time.

- Confusion on biomarker features: Mindstrong's biomarker function is not clear to the general consumer or their provider.
- Need for better alignment with county services: Los Angeles County wanted a technology that could be used as part of their clinical services they offer. Features that could not be incorporated with Mindstrong were more directly incorporating the DBT diary card and providing real-time assessments, such as client self-report questionnaires.
- Issues accessing Mindstrong: The use of the Mindstrong DBT diary card feature required consistent access to a smart phone or computer. Clients who did not have consistent access were unable to use Mindstrong.

Orange County Implementation

The implementation in Orange County of Mindstrong has focused on a wide-scale roll-out with full use of the Mindstrong product. Interviews conducted in Orange County identified several lessons learned:

- Positive impressions of Mindstrong: Providers had positive impressions of Mindstrong including high acceptability, feasibility, and appropriateness.
- Support and readiness for implementation: Providers felt that they had the necessary training, knowledge, resources, support, and leadership necessary to use Mindstrong.
- Areas for additional information: Providers felt that it would be important to have additional clarification on different aspects of the Mindstrong product and its care support to better understand who might be most appropriate to use it and why it could be useful to that client.
- Identification of early barriers: Some barriers identified were onboarding procedures (i.e., blocked numbers, research study framing), and clinical and front desk staff having limited knowledge of the Mindstrong implementation.

COVID-19 RAPID RESPONSE (LOS ANGELES, RIVERSIDE, SAN FRANCISCO, SAN MATEO)

The impact of COVID-19 required counties/cities to respond in new ways in order to rapidly support their communities. The Help@Hand project management team acknowledged this and developed the COVID-19 Rapid Response framework, which accelerates the process for counties/cities to implement technologies among community members—particularly those most disproportionately affected by COVID-19. In 2020, Riverside County used the framework to launch Take my Hand, while Los Angeles, San Francisco, and San Mateo used it to launch Headspace.

Riverside

Implementing Take my Hand

In April 2020, Riverside County developed and launched a peer-chat app called Take my Hand. Peer Support Specialists operated chats and on-call clinicians were available to support individuals whose chats indicated they were in crisis. **Figure 3.5** shows initial peer chat data collected by Riverside County. All figures were presented by Riverside County in their report summarizing Take my Hand's testing phase between April 17 - June 30, 2020.

Figure 3.5 includes:

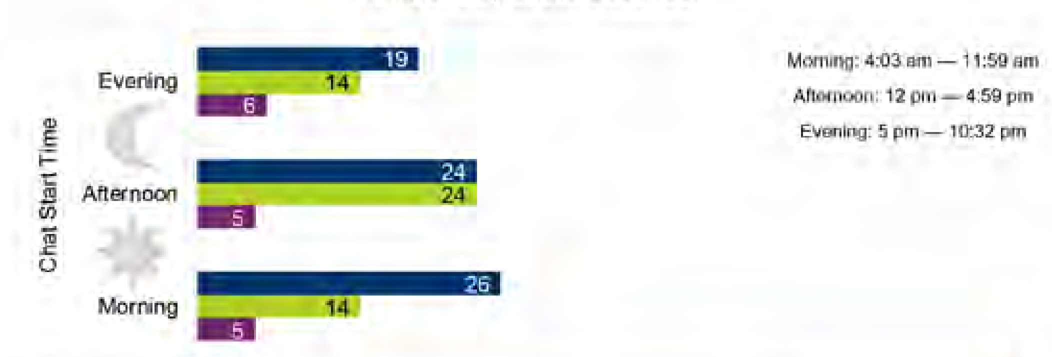
- **Chat frequencies:** Riverside County received 137 chats during the testing phase.
- **Time of day chats occured:** Chats occurred more commonly in the evening than the early morning or afternoon.

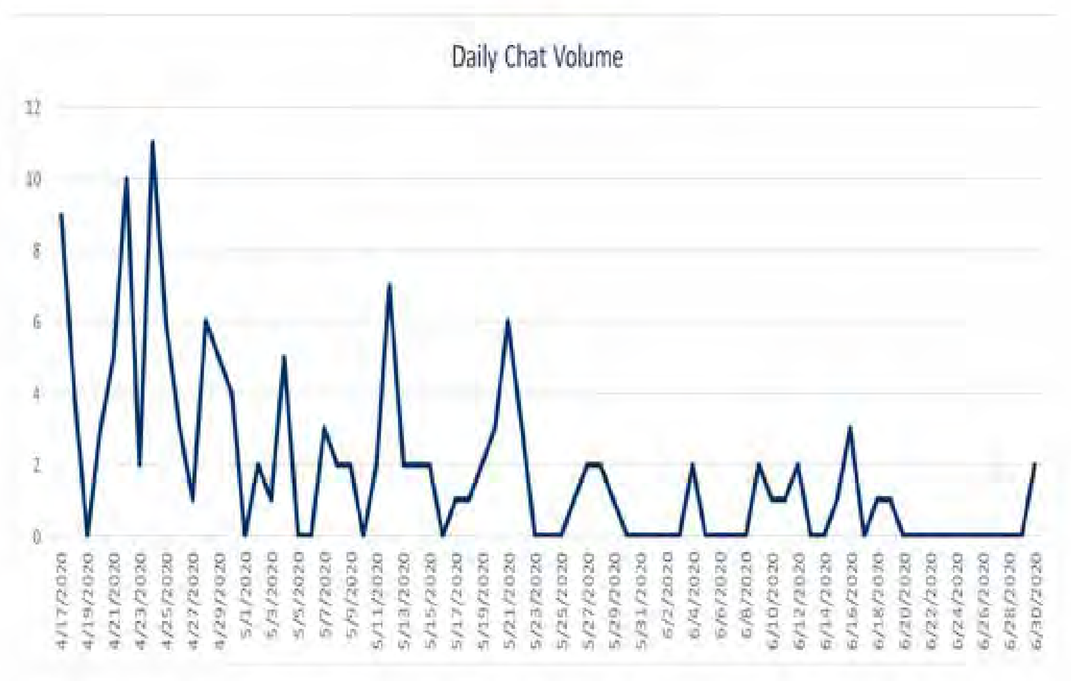
- **Daily chat volume:** Chat volume fluctuated. Most chats occurred early in the testing phase, but the overall volume was fairly low. One reason was due to limited advertising of Take my Hand in order to ensure enough staff capacity to respond to chat requests in the testing phase.
- **Average and sum of all chat duration:** The average chat duration was about 25 minutes.
- **Tags used during chats:**

  "Tags" flagged important topics arising in the chats, and helped Peers and clinicians assist consumers appropriately by informing them of the consumer's needs. Common tags are shown in the figure.
- **Customer demographic characteristic.** Gender, age, race/ethnicity, zip code, and other characteristics were collected.

Figure 3.5. Peer Chat Data Presented by Riverside County During Take my Hand Testing Phase

*One Spanish visitor, first timer


Time of Day Chats Occurred:
Morning: 4:03 am — 11:59 am
Afternoon: 12 pm — 4:59 pm
Evening: 5 pm — 10:32 pm
Chat Start Time
Evening
19
14
6
Afternoon
24
24
5
Morning
26
14
5
Total Chats
69
52
16
0 10 20 30 40 50 60 70
Month: April
Month: May
Month: June


Daily Chat Volume
0 2 4 6 8 10 12
4/17/2020 4/19/2020 4/21/2020 4/23/2020 4/25/2020 4/27/2020 4/29/2020 5/1/2020 5/3/2020 5/5/2020 5/7/2020 5/9/2020 5/11/2020 5/13/2020 5/15/2020 5/17/2020 5/19/2020 5/21/2020 5/23/2020 5/25/2020 5/27/2020 5/29/2020 5/31/2020 6/2/2020 6/4/2020 6/6/2020 6/8/2020 6/10/2020 6/12/2020 6/14/2020 6/16/2020 6/18/2020 6/20/2020 6/22/2020 6/24/2020 6/26/2020 6/28/2020 6/30/2020

Average Chat Duration (n=137):

25.05 min.

(min: 21s, max: 2hr. 40min.)

Average Waiting Time for a Peer to Pick-up a Chat:

31.01s

(min: 4s, max: 12min.)

Average Time for Consumer to Reply in the Chat:

67.73s

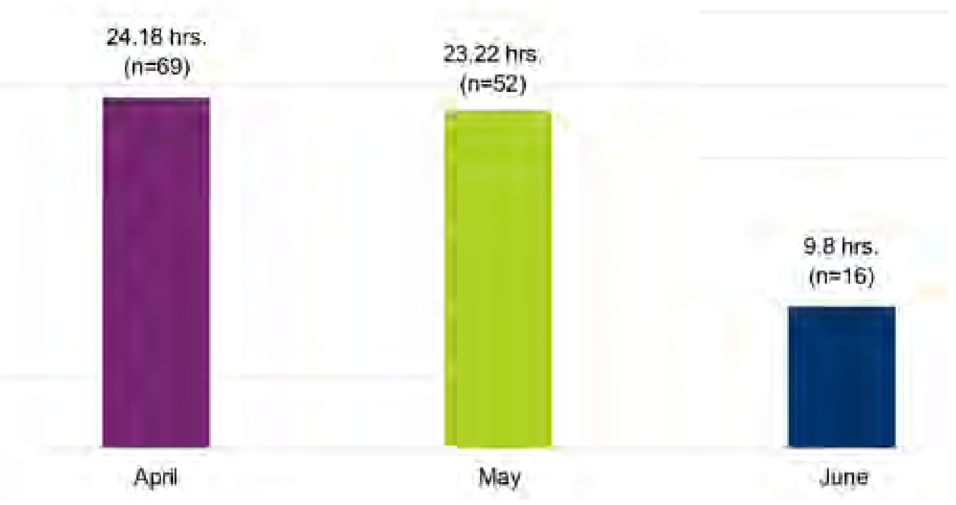
(min: 7s, max: 4.3min.)

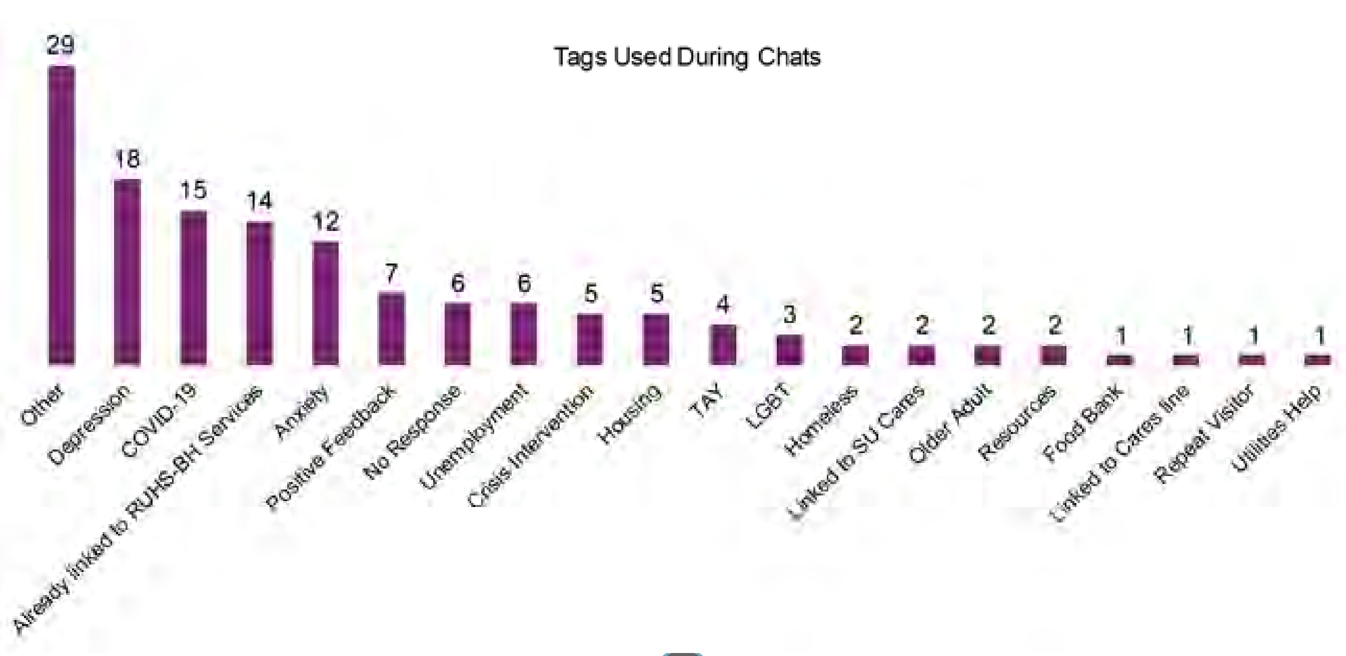
Crisis Transfers
Average Chat Duration (n=8):

35.03 min.

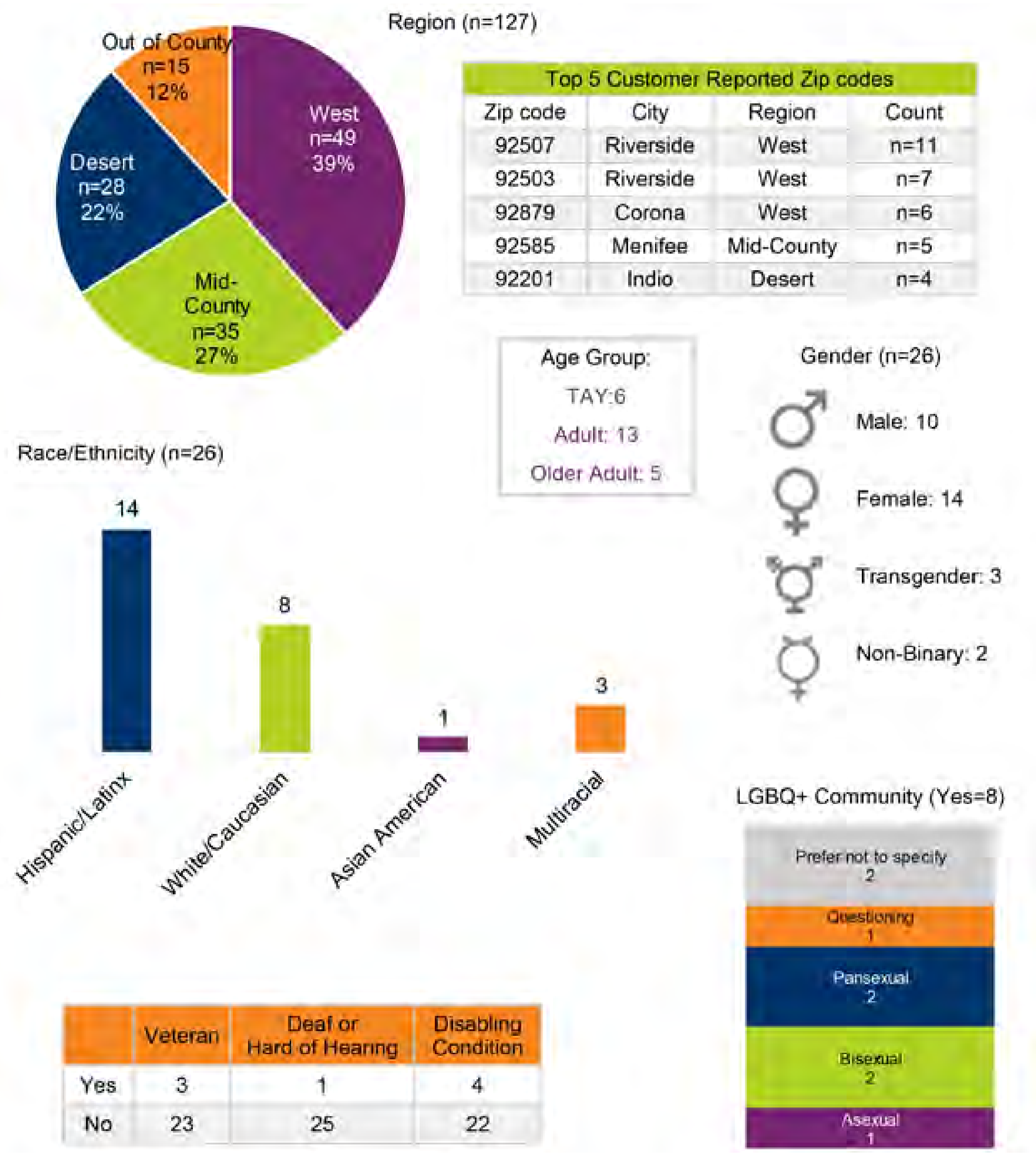
(min: 3min, max: 1hr. 57min.)

Sum of All Chat Durations per Month (n=137)



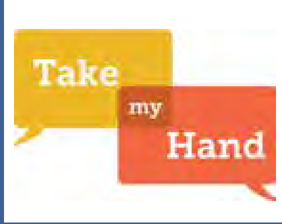


Demographic Characteristics



Top 5 Customer Reported Zip codes			
Zip code	City	Region	Count
92507	Riverside	West	n=11
92503	Riverside	West	n=7
92879	Corona	West	n=6
92585	Menifee	Mid-County	n=5
92201	Indio	Desert	n=4

	Veteran	Deaf or Hard of Hearing	Disabling Condition
Yes	3	1	4
No	23	25	22



Riverside County developed Take my Hand as a web-based live chat application that provides one-on-one support from a credentialed Peer Support Specialist. It was initially developed for the Help@Hand project but was rapidly deployed as additional support to the community after the 211 and 911 crisis call centers became overwhelmed following the COVID-19 pandemic. Take my Hand entered it's public testing phase April 17th, 2020 to June 30th, 2020. Take my Hand was offered 24/7 to the Riverside community and utilized Riverside University Health System-Behavioral Health's (RUHS-BH) Peer workforce, in addition to clinical therapists in the event of a crisis situation. An evaluation plan was developed for Take my Hand's trial phase.

Information was synthesized from the rapid deployment of Take my Hand led by RUHS-BH and their Peer team for the purposes of the formative evaluation (see Appendix G). This includes identifying lessons learned and providing recommendations from the Help@Hand evaluation team. Sources of data used for this synthesis included: 1) "RUHS-BH Take my Hand Live Peer Chat COVID-19 Rapid Deployment-Test Phase Report" developed by the Help@Hand Team in Riverside County; 2) "Take My Hand Test Phase Report" developed by Riverside County's local evaluators; and 3) Riverside County meeting notes from the Help@Hand evaluation team. This synthesis may provide generalizable insights as to how other counties/cities might successfully implement and sustain Take my Hand and/or apply learnings from Riverside's experience to their own implementations of other technologies.

Los Angeles, San Francisco, San Mateo
Planning and/or implementing Headspace

Los Angeles County used the COVID-19 Rapid Response framework to launch free Headspace subscriptions for all county residents in April 2020. San Mateo Headspace is available to all county residents. The San Mateo team chose to focus their outreach on a small, targeted audience first. They will begin a broader outreach in 2021. Meanwhile, San Francisco County plans to provide free Headspace subscriptions to all county residents in 2021.

HEADSPACE IN LOS ANGELES AND SAN MATEO COUNTIES

Below is data from the Headspace roll-out in Los Angeles and San Mateo Counties. Data includes monthly active users, monthly engagement rate, and engagement by content type.[30]

METRIC	DEFINITION
Monthly Active Users (MAU)	Number of enrolled Headspace members who have engaged with at least 1 piece of content in Headspace in a given month
Monthly Engagement Rate	Percent of total enrolled Headspace members who have engaged with at least 1 piece of content in Headspace in a given month (e.g., number of members who have engaged in a given month / total number of enrolled members)
Engagement by Content Type	The number of users engaging with each section in the app (e.g. focus, med–itation, sleep, etc.)

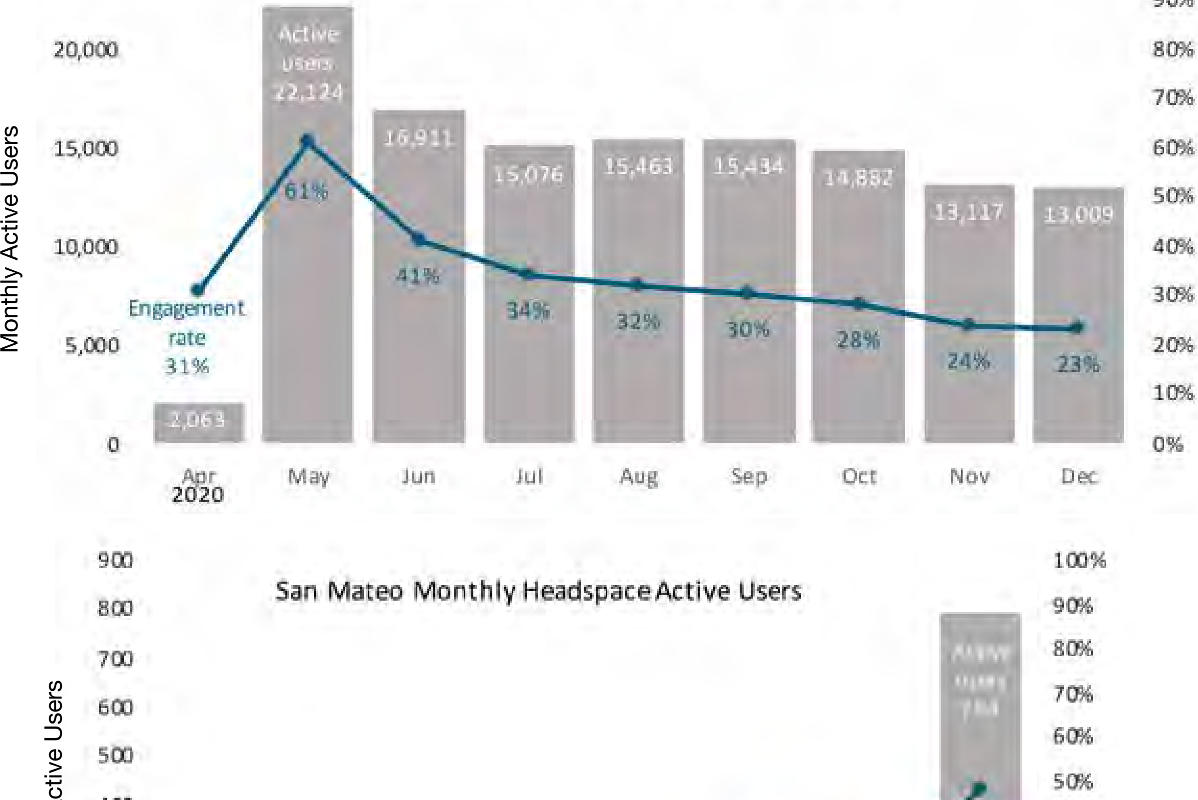
[30] Data was from the Headspace Enrollment Report for Los Angeles and San Mateo Counties. This report is available on each counties' Headspace dashboard.

Monthly Active Users and Monthly Engagement Rate

Figure 3.6 shows monthly active users and monthly engagement rate change from month-to-month, which is typical. This may be due to a number of reasons, including: marketing/advertising from the county and/or Headspace, current events, the time of the year, and more. For example, Netflix released a series on Headspace that may cue people to use the app after watching the show, or make them less likely to use the app and watch the show instead. Note that there are considerable differences between the monthly active users in Los Angeles County compared to San Mateo County because Los Angeles County made Headspace available to the entire county, while San Mateo conducted outreach to a small, targeted population.

The figure also shows that overall users in Los Angeles and San Mateo Counties may have an initial burst of interest in the technology and then later lose interest and be less engaged. These declines in use and engagement over time are common. In fact, use and engagement of Headspace by users across the United States declines over time. Studies have corroborated this pattern and found that nearly 1 in 4 people abandon apps after only one use (Perez, 2016). This suggests that the first few days of use may be when someone is a "motivated audience" and most interested in using a technology, and it is therefore critical for counties/cities to support and encourage people to use the app within the first few days of access.

Figure 3.6. Monthly Active Users for Los Angeles and San Mateo Headspace



Engagement by Content Type

Metrics such as monthly active users do not tell the full story. Engagement data within the app is crucial to understanding what people are using, and potentially benefiting from, in the app. This information might be useful to drive marketing and messaging. For example, the figures below show the types of content people are most engaged with in Los Angeles and San Mateo Counties.

In Los Angeles County, Headspace's meditation content was most popular from May-August 2020. Content related to sleep then became more popular beginning in September 2020.

Figure 3.7. Los Angeles Headspace – Engagement by Content Type

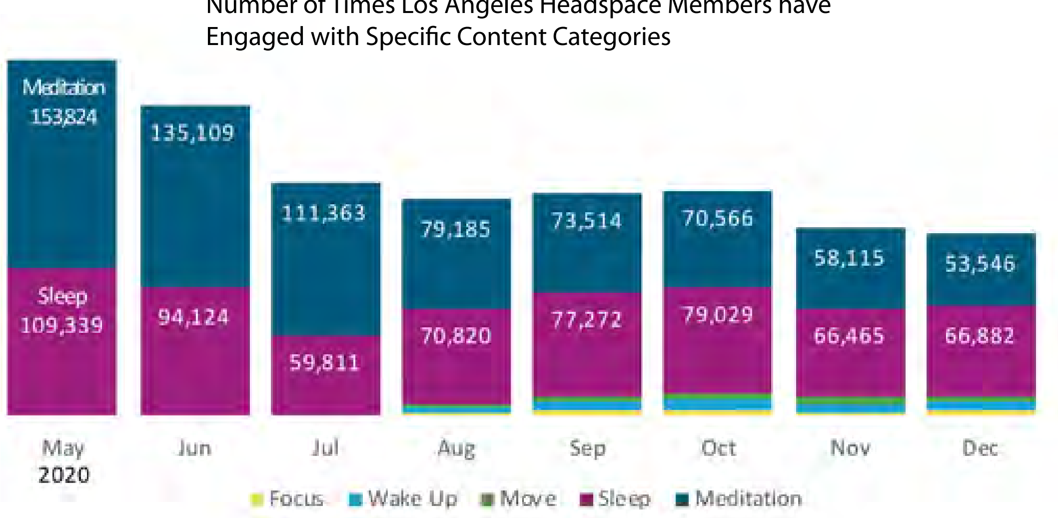
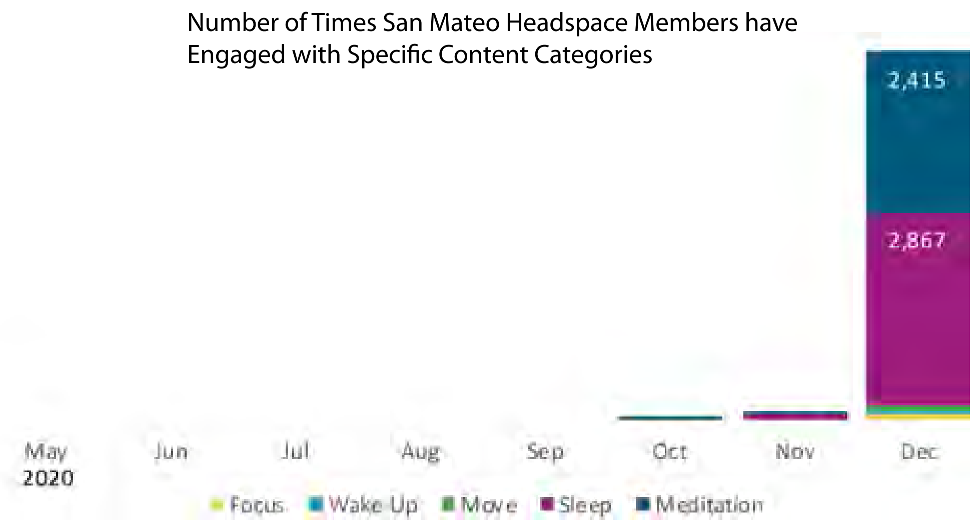


Figure 3.8. San Mateo Headspace – Engagement by Content Type



LEARNINGS FOR THE HELP@HAND COLLABORATIVE: COVID-19 RAPID RESPONSE (LOS ANGELES, RIVERSIDE, SAN FRANCISCO, SAN MATEO)

Various lessons were learned from Los Angeles, Riverside, San Francisco, and San Mateo Counties who used a framework developed by Help@Hand's project management team to accelerate the process of implementing technologies in communities. Riverside County implemented their Take my Hand platform, whereas the other counties implemented Headspace.

Riverside County's Take my Hand

- Importance of a live virtual platform: Riverside County identified a public health need to find a safe alternative to alleviate the growing strain being placed on 911 and 211 crisis call centers at the onset of the COVID-19 pandemic. Offering a support service via a live virtual platform may expand accessibility, support, and mental health services to those within and outside of Riverside County's behavioral health system.
- Training needs: Training varied across Peer Support Specialists, which highlighted the need to identify and define core competencies required for Peer Operators.
- Effective resources: Resources on the Take my Hand platform with Helpline information and "canned responses" to connect users with crisis-related resources were effective ways to help clients until a warm hand-off with clinical staff could be made.

Headspace Rapid Response

- Initial user engagement: The first few days after a client downloads an app may be the most likely time for them to become engaged with the app. Thus, it is critical for counties/cities to support and encourage people to use the app within the first few days of access.
- Value of app-level, county-specific data: App-level, county-specific data provided by app developers can help increase project learnings (for example, data on Headspace Engagement in Los Angeles and San Mateo), and is more valuable to evaluative efforts than looking at marketplace trends overall.

RFI AND RFP DEVELOPMENT (MONTEREY, LOS ANGELES)

Monterey County plans to develop a tool for all county residents that screens for various behavioral health issues and refers users to care. In early 2020, Monterey County developed and released a Request for Information (RFI) that gathered feedback from the vendor community on matters related to the development of the tool. Based on the RFI results, Monterey County developed a Request for Proposals (RFP) to solicit proposals from vendors interested in developing the app. The RFP will be released in 2021. This effort was done in partnership with Los Angeles County. The **spotlight** on page 81 shares more information about Monterey County's RFI and RFP process.

PROJECT COMPLETION (KERN, MODOC)

In 2020, Kern and Modoc Counties announced they completed their projects and would transition off Help@Hand. Exit interviews were conducted with each county's project lead (e.g., Tech Lead) to:

1. **Evaluate their experiences** as part of Help@Hand.
2. **Document lessons learned** from these experiences.
3. **Gather recommendations** for other counties and cities in Help@Hand.

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: PROJECT COMPLETION (KERN, MODOC)

Exit interviews with Kern and Modoc Counties identified collaborative accomplishments from their Help@Hand experience, including:

- New collaborations: Counties/Cities forged new partnerships with each other as a result of the Help@Hand program. For example:
  - Kern County was the first to curate an app guide—a list of apps that may benefit its community. Kern collaborated with other counties/cities to adapt and distribute the app guide for various communities.
  - Through opportunities such as Kern County's Peer Summit, Peers strengthened relationships with and learned from Peers in other counties/cities.
- Awareness of mental health resources and needs: Overall, the Tech Leads observed increased awareness of mental health resources and of the need for tailored, innovative, and easy to access mental health services.
- Importance of Peers: The Help@Hand program highlighted the significant value and contributions of Peers, identifying and providing opportunities to increase Peer visibility and in activities led by counties/cities. Modoc and Kern Counties also identified lessons learned:
- Peer training and supervision: Peers are an important workforce within Help@Hand; however, Kern and Modoc Counties struggled to provide sufficient Peer training and supervision that would allow Peers to consistently contribute their skills to needed areas of the project.
- Private (vendor) and public (county/city) misalignment: County Tech Leads perceived a misalignment of project goals between private (vendor) and public (county/city) entities. For example, counties/cities prioritize ensuring access to services for those most at need, but vendors prioritize growing their market potential. Also, vendors are generally more experienced in developing novel service delivery methods than in working within existing service systems. This tension has brought about challenges with developing and interpreting contracts between vendors and counties/cities.
- Balancing implementation needs: Challenges persisted in counties balancing the necessary resources for implementing within their counties and completing required deliverables for Collaborative-wide project management. These challenges were often perceived to slow progress in implementation and create administrative burden, especially among smaller counties/cities with fewer resources.

Recommendations based on these lessons learned include:

- Facilitate more cross-collaborations: CalMHSA could offer flexible use of supplemental funds to counties/ cities in order to develop and support cross-collaborative subprojects within Help@ Hand that may extend beyond technology implementations. CalMHSA may offer operational and project management support for these subprojects.
- Facilitate "communities of practice": CalMHSA would be instrumental in facilitating the communities of practice due to their unique role as the project manager of the overall Help@Hand project. CalMHSA would not be expected to lead the communities of practice, but to provide the structure in which they could be facilitated. CalMHSA is able to facilitate these communities of practice because they have knowledge of each county/city's interests and where shared interests might lie.

  CalMHSA could facilitate communities of practice or affinity networks within the Help@Hand project to: 1) increase collaborative problem-solving through sharing of resources, experiences, tools, and best practices; 2) increase support to Peers and capitalize on strengthening Peer relations across counties/cities; and 3) speed translation of learnings into practice. Communities of practice may include:
  - Subgroups focused on specific technologies (e.g., Headspace or myStrength) and/or populations (e.g., TAY or isolated older adults). These topics arise in different meetings, but not enough time is available for them. The subgroups would convene in a way that allows time for in-depth learning.
  - Regular topical meetings or interactive web tools that allow for easy sharing and access to resources or plans, which could be particularly beneficial to Peers.[31]
  - Subject matter experts train or facilitate on topics of interest, such as a presentation or case study about a successful implementation of myStrength, along with lessons learned.
- Hire staff to support the Peer component of Help@Hand: Given the need for Peer training and supervision resources, CalMHSA should accelerate efforts to fill the position of Peer Engagement and Community Manager and supplement this position with a second Peer for administrative support, Peer support, and continuity in the event of personnel turnover.

[31] An example of an online community practice would be the Implementation Science Coordination, Consultation & Collaboration Initiative for HIV/AIDS research, which provides various resources for project planning and implementation in their resource hub: https://isc3i.isgmh.northwestern.edu/resource-hub/

SPOTLIGHT
Monterey County's Model for Building a Web-Based Screening Tool

Mental health screenings are often the first step in getting help. However, Monterey County identified an important need faced by many county behavioral health systems -- walk-in clinics and other behavioral health services surpassed the county's capacity to screen clients and refer them to appropriate care and services. In response, Monterey County chose to focus their Help@Hand efforts toward creating a web-based screening tool that would screen for various behavioral health issues and refer people to care.

Wes Schweikhard, Monterey County's Tech Lead, referred to the tool as a *"way to minimize the time spent between someone experiencing symptoms and accessing services. We hope this will be a powerful tool that the public can use without any prior experience with mental health issues or services, providing them with useful information regarding their (or someone else's) symptoms and connect them to care. We also hope this will prove to be an aid to our clinical environments by providing a meaningful and accurate precursory assessment, which may allow for more clinical staff time to be devoted to therapy services."*

The goal is for the web-based screening tool to be available to all residents from Monterey County, Los Angeles County, and potential other participating California municipalities. This tool is not intended to provide a clinical diagnosis, but rather to guide a person through a series of questions with the purpose of helping them to understand potential symptoms, to give educational information, and to provide an option for referrals to available support resources. Furthermore, those who receive a referral will have their assessment results made available to appropriate care resources in order to expedite intake processes.

Request for Information
Help@Hand Screening Tool Project

MONTEREY COUNTY
BEHAVIORAL HEALTH

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.

Request for Proposal
Help@Hand Screening Tool Project

MONTEREY COUNTY
BEHAVIORAL HEALTH

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.

Request for Information (RFI) and Request for Proposal (RFP)

As noted in their approved MHSA Innovation Plan Proposal, the tool will be developed around the following core criteria:

Tool to be Developed around Following Core Criteria

- Being able to screen for a broad range of disorders, from low-risk with mild need to severe with urgent need.
- Being easily accessible for use by community-based providers to help individuals acquire treatment.
- Maintaining confidentially standards.
- Interfacing with MCBH's Avatar electronic health record system to provide more seamless transitions into care.
- Working fluently in Spanish.
- Build upon current evidence-based screening tools with proven validity, and utilize item response theory to minimize the number of questions involved in the assessment.

Monterey County decided to custom build this screening tool, rather than procure and adapt another product. This decision was largely based on a noted absence in the marketplace of a product that offered both a robust assessment functionality and also delivered referrals within the local county environment. Given that Monterey County had no prior experience developing a technology product, they joined the Help@Hand Collaborative to leverage the resources of the project, particularly CalMHSA's procurement processes and expertise in the technology space.

As part of the Collaborative, Monterey County has received extensive support and guidance from CalMHSA and formed a partnership with Los Angeles County Department of Mental Health. To start the work, Monterey County and CalMHSA initially began to develop a Request for Proposal (RFP) to design and build the tool. However, several questions arose while developing the RFP, such as: What are the required vendor qualifications? What does it actually take to develop an app? and, How much should this cost?

Given the number of outstanding questions that needed to be answered prior to selecting a vendor, CalMHSA and Monterey County made an incremental decision to release a Request for Information (RFI) prior to developing the final RFP. Wes described the RFI as a "rough draft" of the county's vision and needs, meant to solicit responses from vendors with information on the vendors' potential approach. In particular, the RFI was designed to help Monterey County gather information that will be used to define the scope of their product by filling in important details that were previously missing, like the market rate to develop the app and technical approaches. Vendors also raised important questions about the county's current technology infrastructure and data storage requirements, highlighting the need to include the county's information technology team on this project.

The RFI was released on 04/20/20 and concluded on 05/29/20, there were 17 respondents. This foundational work was important as it generated a number of key learnings:

1. **Confirmed the feasibility of the general approach.** The quality and quantity of the received responses provided evidence of feasibility that the technology vendor community could submit proposals based on the identified requirements within the proposed budget framework.

2. **Indicated that the clinical and technical requirements of the tool could be addressed by a single vendor.** Prior to the RFI, there was some thought that two or more vendors might be needed to address the design requirements separately of the technical requirements. Responses to the RFI clearly suggested that this work could be accomplished by a single vendor, thus simplifying the overall process.

3. **Informed licensing.** Technology vendors raised the issue of the complex licensing requirements that might burden counties/cities when trying to make changes to the product and/or raise concerns around ownership of the product in the future. As a result of the RFI, Monterey County identified the need to own the product in partnership with CalMHSA and Los Angeles County.

4. **Highlighted the value of using the RFI mechanism to test assumptions around technology requirements.**

Monterey County is anticipating that building a digital mental health product will require a team with diverse skillsets with technical and clinical backgrounds. Wes, who has a background in data management and analytics, has been the primary Monterey County employee working on Help@Hand. Jon Drake, the Assistance Bureau Chief of MCBH, has joined the project in recent months to provide additional guidance and support with his extensive procurement experience. It is anticipated that additional county staff, specifically clinical and IT subject-matter experts, will become engaged once development of the tool begins.

Wes Schweikhard, Monterey County's Tech Lead

Wes recommended that other counties considering a similar route ***"have robust discussions, buy-in, and participation with clinical, IT and peer representatives in your county early on, to identify the specific goals, consumer experience and integrations your tech project will have. This will help articulate your scope in more tangible terms and also help set realistic expectations regarding staff involvement, to ultimately make the RFP and implementation processes go more smoothly."***

Monterey County, Los Angeles County, and CalMHSA are pleased to announce that the RFP was released on January 8, 2021.

Learnings from the Technology, User Experience, and Implementation Evaluation

The Help@Hand evaluation team worked closely with the Help@Hand Collaborative to support several counties/cities' activities this year. Key learnings include:

- **Engagement Challenges.** Several counties/cities have noted the challenges of engaging with stakeholders remotely given COVID-19 and stakeholders' digital literacy levels, which will influence their ability to engage in a remote process. Additional planning, follow-up with participants, and organization/structure, as well as leveraging partnerships to reach community members, may be needed.
- **Needs Assessment.** As noted by the counties/cities, it is important to engage community stakeholders throughout the project. A needs assessment is one opportunity to engage stakeholders and gather feedback early in the process to better match users' needs with potential technologies.
    - o Through needs assessments with two target audiences—community college students in Los Angeles County and members of the Deaf and Hard of Hearing Community in Riverside County—both accessing professional services and informal support resources for managing their own mental health emerged as desired resources.
- **Technology Exploration and Selection.** Technology explorations in Marin, San Mateo, and Riverside Counties revealed similarities across target audiences in terms of perceptions of technologies.
    - o Both older adults and TAY emphasized the importance of cultural competency in technologies, the value of being able to connect with others within the technologies, the potential of integrating technologies with health services, and the usefulness of a variety of content that is updated regularly.
    - o Consistently across both needs assessments and technology explorations, privacy concerns—in terms of what information is collected and how it is used—has been discussed as a potential barrier to using technologies to support mental health.
    - o Differences across target audiences also emerged through technology explorations in Marin, San Mateo, and Riverside Counties. For older adults, digital literacy, how mental health is perceived, and on-going technical support are key; whereas, for TAY, the visual aesthetic of the technology is an important factor that would influence use.
    - o Through technology explorations of myStrength in Marin and San Mateo Counties, participants consistently reported the variety of content within myStrength positively, but had some concerns about the demographic information that users are required to share within the app in order to use it.
- **Los Angeles Implementation.** It should be noted that the Mindstrong implementation in Los Angeles was limited to a small number of clients with limited access to the full product. As such, interviews with Los Angeles County on their Mindstrong implementation identified several lessons learned.
    - o **Lack of communication on client use:** Mindstrong was perceived as "a black box" in that providers had limited knowledge of client use (e.g., they did not know what information or services clients were offered, or which clients engaged with Mindstrong unless clients directly informed the providers).
    - o **Confusion on biomarker features:** Mindstrong's biomarker function is not clear to the general consumer or their provider.
    - o **The need for better alignment with county services:** Los Angeles County wanted a technology that could be used as part of their clinical services they offer. Features that could not be incorporated with Mindstrong were more directly incorporating the DBT diary card and providing real-time assessments, such as client self-report questionnaires.
    - o **Issues accessing Mindstrong:** The use of the Mindstrong DBT diary card feature required consistent access to a smart phone or computer. Clients who did not have consistent access were unable to use Mindstrong.

- **Orange County Implementation.** The implementation in Orange County of Mindstrong has focused on a wide-scale roll-out with full use of the Mindstrong product. Interviews conducted in Orange County with provides identified several lessons learned:
  - o **Positive impressions of Mindstrong**. Providers had positive impressions of Mindstrong including high acceptability, feasibility, and appropriateness.
  - o **Support and readiness for implementation.** Providers felt that they had the necessary training, knowledge, resources, support, and leadership necessary to use Mindstrong.
  - o **Areas for additional information:** Providers felt that it would be important to have additional clarification on different aspects of the Mindstrong product and its care support to better understand who might be most appropriate to use it and why it could be useful to that client.
  - o **Identification of early barriers:** Some barriers identified were onboarding procedures (i.e., blocked numbers, research study framing), and clinical and front desk staff having limited knowledge of the Mindstrong implementation.
- **COVID-19 Rapid Response.** Various lessons were learned across different Counties implementing technologies as a rapid response to COVID-19 (i.e., Riverside, Los Angeles, San Francisco, and San Mateo).

  Riverside-Take my Hand for COVID-19
  - o Riverside County identified a public health need to find a safe alternative to alleviate the growing strain being placed on 911 and 211 crisis call centers at the onset of the COVID-19 pandemic. Offering a support service via a live virtual platform may expand accessibility, support, and mental health services to those within and outside of Riverside County's behavioral health system.
  - o Depth of nature and training varied across Peer Support Programs, thus recognizing a need to identify and define core competencies required for Peer Operators.
  - o Accessing resources (on the Take my Hand platform) with Helpline information available and using "canned responses" around connecting the user with crisis-related resources was an effective alternative until a warm hand off with clinical staff could be made.

  Headspace Rapid Response for COVID-19
  - o The first few days after a client downloads an app may be the most likely time for them to become engaged with the app. Thus, it is critical for counties/cities to support and encourage people to use the app within the first few days of access.
  - o App-level, county-specific data provided by app developers can help increase project learnings (for example, data on Headspace Engagement in Los Angeles and San Mateo), and is more valuable to evaluative efforts than looking at marketplace trends overall.
- **Project Completion.** As part of Kern and Modoc County's experience completing the Help@Hand project, various lessons were learned.
  - o **Peer training and supervision:** Peers are an important workforce within Help@Hand; however, Kern and Modoc Counties struggled to provide sufficient Peer training and supervision that would allow Peers to consistently contribute their skills to needed areas of the project.
  - o **Private (vendor) and public (county/city) misalignment:** County Tech Leads perceived a misalignment of project goals between private (vendor) and public (county/city) entities. For example, counties/cities prioritize ensuring access to services for those most at need, but vendors prioritize growing their market potential. Also, vendors are generally more experienced in developing novel service delivery methods than in working within existing service systems. This tension has brought about challenges with developing and interpreting contracts between vendors and counties/cities.
  - o **Balancing implementation needs:** Challenges persisted in counties balancing the necessary resources for implementing within their counties and completing required deliverables for Collaborative-wide project management. These challenges were often perceived to slow progress in implementation and create administrative burden, especially among smaller counties/cities with fewer resources.

4 OUTCOMES EVALUATION AND DATA DASHBOARDS

Key Points

- The evaluation team worked with experts to identify mental health stigma measures. A report that describes and recommends different mental health stigma measures to be included in the Help@Hand evaluation was developed in Year 2.
- The California Health Interview Survey (CHIS) included questions specifically tailored for the Help@Hand program on the use of online mental health resources. An important finding was both teens and adults with high distress levels compared to those with lower distress levels were more likely to have used online tools to connect with others with similar mental health or alcohol/drug concerns.
- Statewide vital statistics data on suicides and drug and alcohol overdoses in California between 2015-2019 were analyzed. Prior to launching technologies in Help@Hand counties, general rates of suicide and overdose are slightly higher in non-Help@Hand counties (those California counties not participating in Help@Hand) than in Help@Hand counties.

OVERVIEW

This section focuses on evaluating the impact of Help@Hand at a statewide level. It presents the following activities and learnings:

- **Outcomes Evaluation**
    - o Measuring Mental Health Stigma
    - o Data from Different Sources
    - o Learnings from the Outcome Evaluation
- **Data Dashboards**

OUTCOMES EVALUATION

The outcomes evaluation assesses Help@Hand's impact in California related to its five shared learning objectives:

Detect and acknowledge mental health symptoms sooner;

Reduce stigma associated with mental illness by promoting mental wellness;

Increase access to the appropriate level of support and care;

Increase purpose, belonging, and social connectedness of individuals served;

Analyze and collect data to improve mental health needs assessment and service delivery.

Measuring Mental Health Stigma

The evaluation team was able to identify measures for each of the learning objectives, except mental health stigma. In Year 1, the Help@Hand evaluation team performed a literature search of stigma measures and identified a large number of measures (over 400). A community participatory approach was used to ensure that the stigma measures used for this program: 1) capture the type of impact expected of Help@Hand technologies to be implemented; 2) meet the dimensions of stigma of interest to the participating Help@Hand counties/cities; and 3) are scientifically valid.

In Year 1, a panel of five Peers and individuals with lived experience and/or family member experience, as well as six academics with expertise in developing stigma measures, was convened. A report that described the process of identifying and recommending mental health stigma measures to be included in the Help@Hand evaluation was developed in Year 2.

Data from Diverse Sources

Counties/cities and technology vendors collected important data that can help reveal the full impact of Help@Hand in communities and in the state. This work included discussing how to access data from county/city and technology vendor systems.

In addition, the Help@Hand evaluation team worked with stakeholders to collect data from the California Health Interview Survey (CHIS) and California Health and Human Services (CHHS).

CHIS

CHIS is the largest state health survey in the nation. It asks questions on a wide range of health topics to a random sample of teens and adults throughout the state of California. In addition to collecting data from CHIS' routinely asked survey, the Help@Hand evaluation team and CalMHSA worked with CHIS to include additional questions related to Help@Hand. **Appendix H** includes these additional questions.

CHIS fielded their survey with the additional questions from September 2019-December 2019 for adult surveys and from September 2019-January 2020 for teen surveys. Data from the CHIS survey provided insights on the use of mental health technologies in California.[32] Overall, Help@Hand counties and non-Help@Hand counties had similar trends. **Appendix I** includes a table of the following data for specific counties.

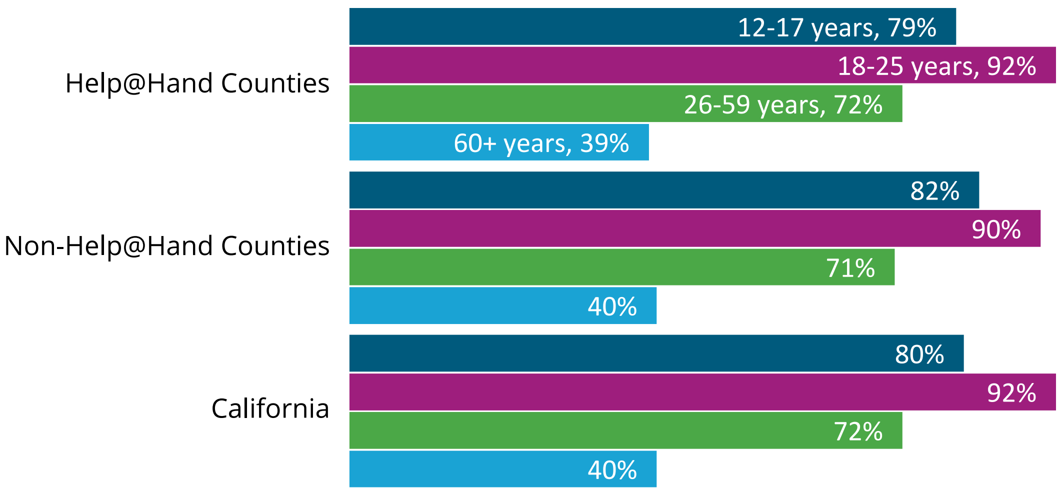
Age

Figure 4.1 shows the percent of people who use the internet and social media almost constantly or many times a day by age group for the Help@Hand counties, the comparison counties, and the State of California. The highest levels of use were among those age 18-25, followed by those age 12-17, and 26-59. People over the age of 60 had the lowest rates of intensive daily use; however, nearly 40% reported accessing the internet constantly or many times per day.

[32] The teen analytical sample was restricted to individuals between the ages of 12 to 17 and included 847 participants. The adult analytical sample was restricted to individuals of age 18 and older and included 22,160 individuals.

Figure 4.1. Internet and Social Media Use by Age

Participants who on a daily basis use the internet almost constantly or many times a day



Participants who on a daily basis use a computer or mobile device for social media almost constantly or many times a day

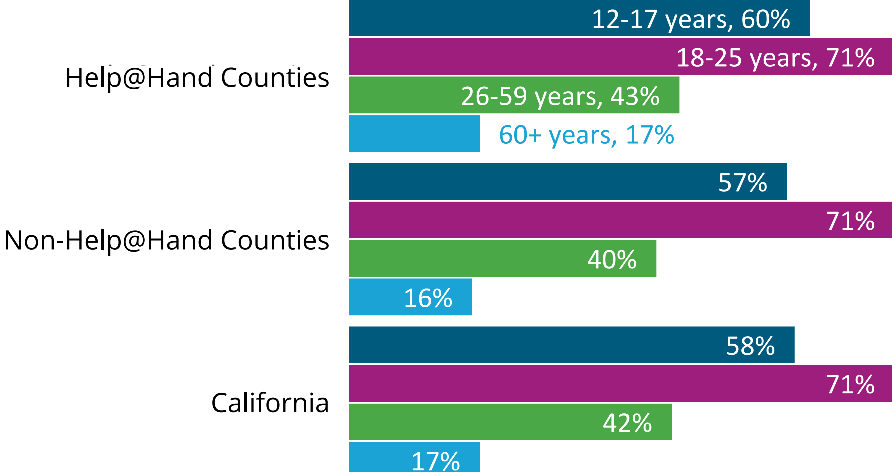
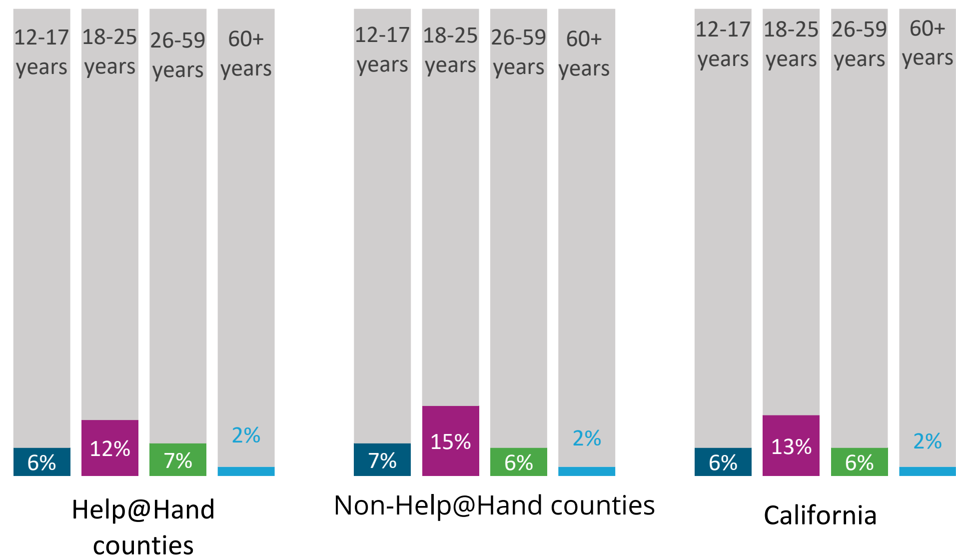
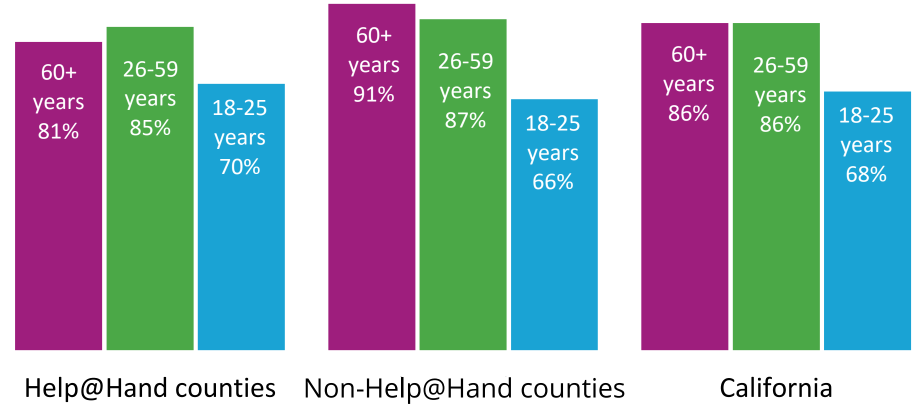


Figure 4.2 shows that 18-25 year olds (13% of them for all counties in California) also reported using online tools for mental health or addiction support more than other age groups in the past year. However, the individuals from age groups 26-59 and 60+ years found these tools more useful than the 18-25 year olds. This may suggest that TAY may be more likely to use online tools. Interestingly, there were generally high levels of usefulness among all people who tried these products, suggesting that understanding the various factors that impede access may be a fruitful area for exploration.

Figure 4.2. Use of Online Tools by Age

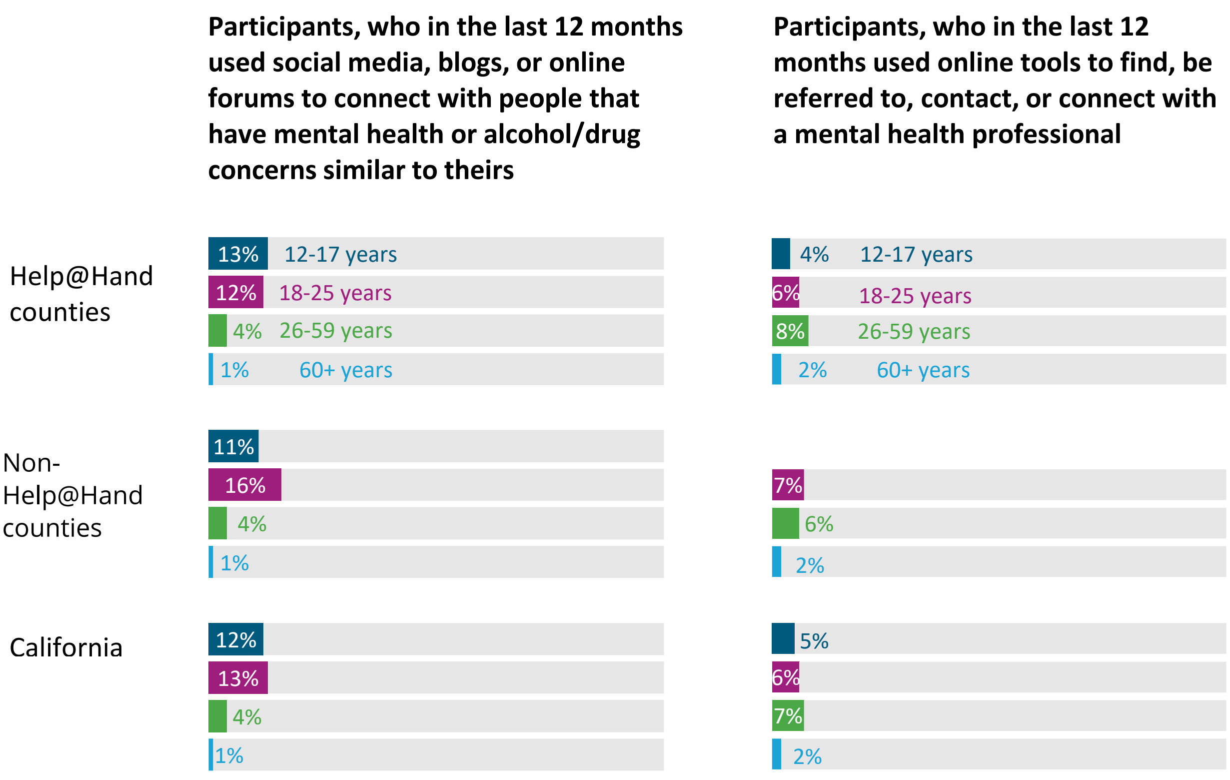




As shown in **Figure 4.3**, less than 15% of individuals surveyed used social media, blogs, and/or other online tools to connect with people with similar mental health or alcohol/drug concerns and/or connect with a professional. Taken with the findings from **Figure 4.2** above, perhaps people might be more likely to use an online tool to address their emotional needs, rather than using tools to connect to others.

Distress Level

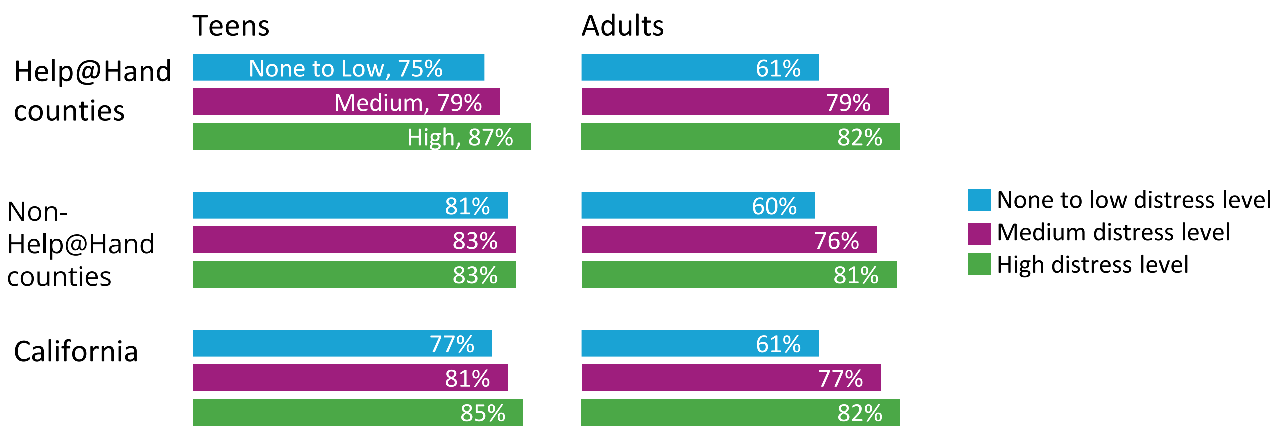
Figure 4.3. Use of Online Tools to Connect with Others by Age



Similar data was analyzed for teens and adults by distress level. For teens, the use of the internet and social media is relatively high for all distress levels (as shown in **Figure 4.4**). For adults, however, there are more notable differences in internet and social media use depending on the distress level. In particular, adults who have no to low distress levels use the internet and social media much less than adults with medium or high distress levels.

Figure 4.4. Internet and Social Media Use by Distress Level

Participants who on a daily basis use the internet almost regularly or constantly



Participants who on a daily basis use a computer or mobile device for social media almost regularly or constantly

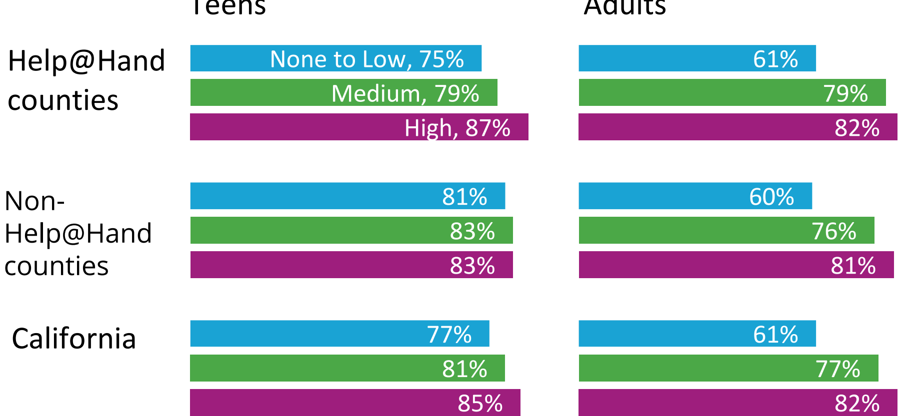
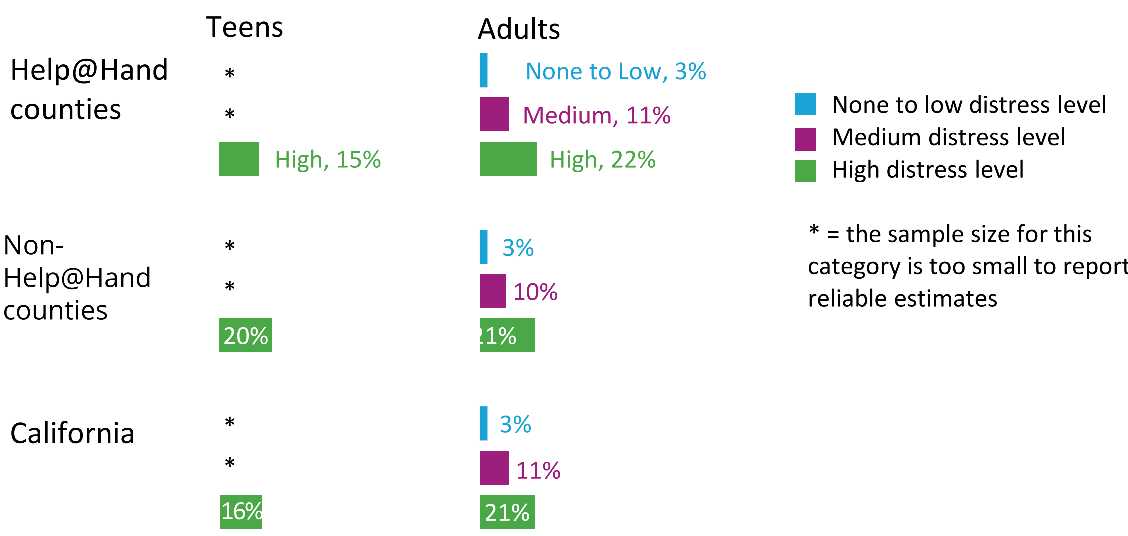


Figure 4.5 shows the percentage of adults that reported using online tools for mental health or alcohol/drug support in the past year increased significantly as the distress level increased. When asked about how useful the online support tools were, adults with high levels of distress reported the lowest levels of usefulness. This suggests that online tools may be more useful among people will low to medium distress levels. There is limited information available for teens due to the small number of participants and the very targeted subject of this survey.

Figure 4.5. Use of Online Tools by Distress Level

Participants who in the past 12 months tried to get help from an online tool for problems with their mental health, emotions, nerves, or use of alcohol or drugs



Adults who rated the online tool they used as somewhat or very useful

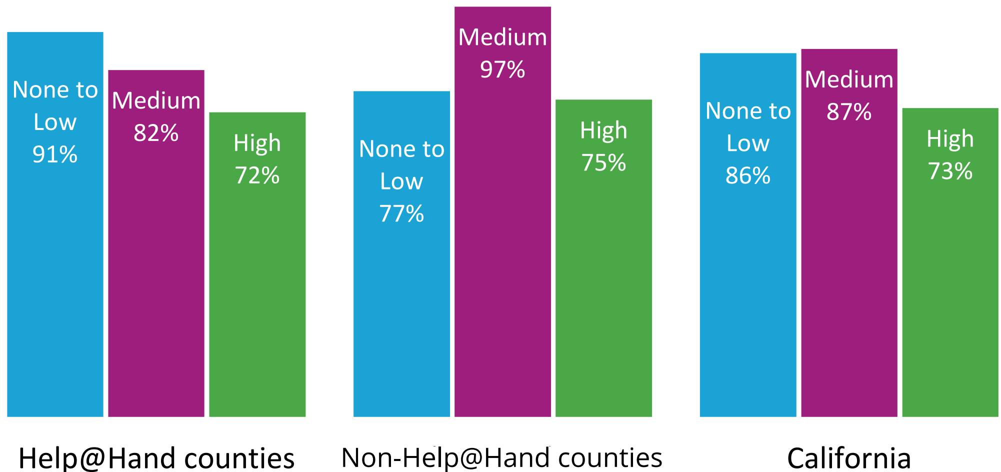
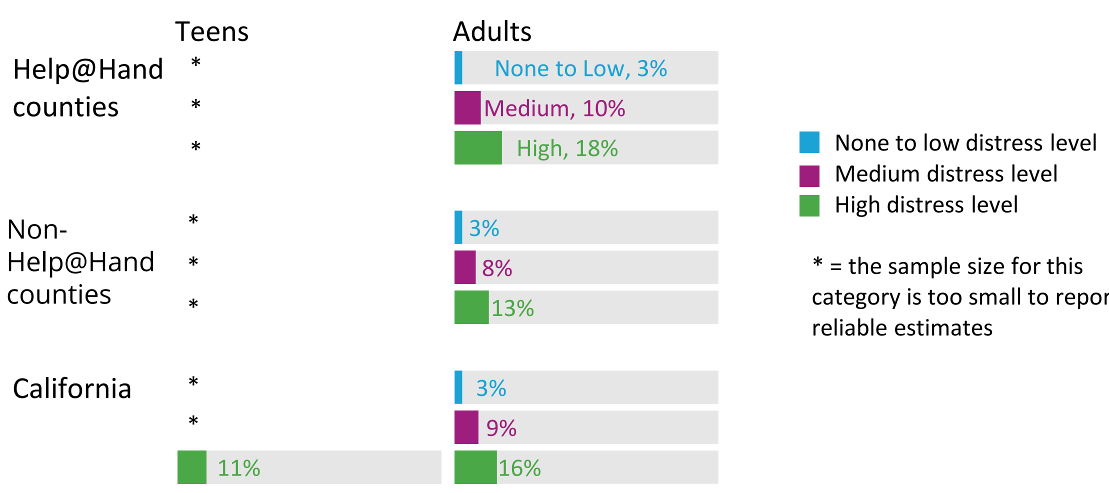


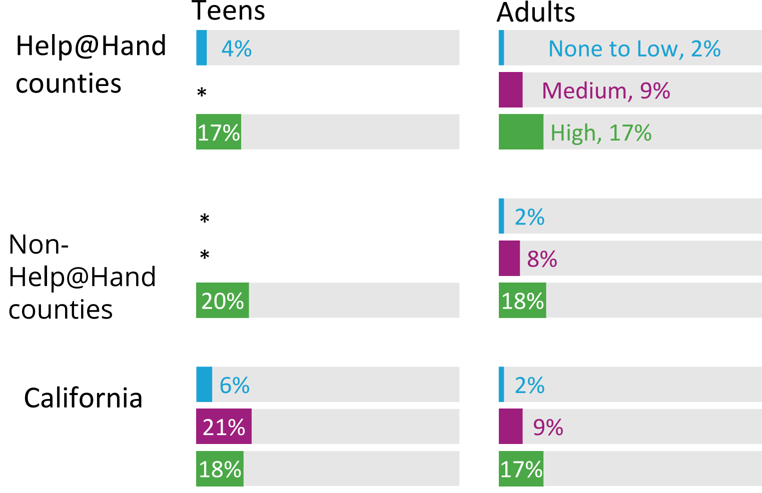
Figure 4.6 reveals that both teens and adults with higher distress levels were more likely to have used social media, blogs, or online forums to connect with people with similar mental health or alcohol/drug concerns: statewide, 18% of teens with high distress and 17% of adults with high distress. The same pattern was observed for adults who used online tools to connect with a mental health professional: 16% of adults with high distress, compared to 3% of adults with no to low distress. Due to the small number of teen participants and the nature of the survey, data is limited for some variables.

Figure 4.6. Use of Online Tools to Connect with Others by Distress Levels

Participants, who in the last 12 months used online tools to find, be referred to, contact, or connect with a mental health professional



Participants, who in the last 12 months used social media, blogs, or online forums to connect with people that have mental health or alcohol/drug concerns similar to theirs



VITAL STATISTICS

CHHS and its IRB approved the Help@Hand evaluation team to analyze: 1) Office of Statewide Health Planning and Development (OSHPD) inpatient and emergency department data; and 2) vital statistics. Analysis of inpatient, emergency department, and vital statistics data can compare access to care, access to appropriate levels of care, and outcomes across Help@Hand counties/cities. It can also draw comparisons with non-Help@Hand counties.

The following is a presentation of suicides and overdoses in California from vital statistics data between 2015-2019. Suicide and drug and alcohol overdoses claim thousands of lives each year in California. Underlying causes that lead to these deaths include depression, loneliness, bullying, histories of mental illness, and post-traumatic stress disorder (PTSD). This data serves to inform the Help@Hand counties/cities about the prevalence of deaths due to these causes in their respective area relative to the rest of the state.

It also establishes a baseline. The Help@Hand program aims to address such deaths by improving access to mental health resources and reducing mental health stigma. As a result, suicides and drug and alcohol overdoses may decrease as counties/cities participating in Help@Hand implement mental health technologies in the years to come.[33]

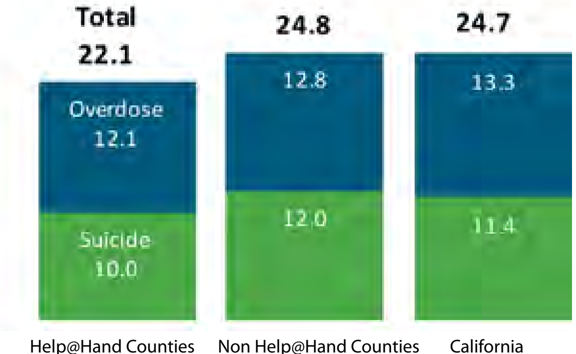
Because it is difficult to establish in cases of overdose whether death was accidental or intentional, determination of final cause of death as suicide by medical examiners is imprecise and varies substantially across counties. Therefore, the analysis considered a lower bound, defined as those reported by the medical examiners as suicides, and an upper bound, defined as those reported as suicide plus those reported as overdose.[34]

General Trends

Figure 4.7 shows that the average annual suicide rate between 2015-2019 was 11.4 deaths per 100,000 residents, and the annual average overdose rate was 13.3 in California. These averages were slightly smaller for the Help@ Hand counties than for non-Help@Hand counties. For Help@Hand counties, the average annual suicide rate and overdose rate were 10.0 and 12.2 per 100,000 Californians, respectively. For non-Help@Hand counties, the average annual suicide rate and overdose rate were 12.0 and 12.8 per 100,000 Californians, respectively.

It is important to keep in mind that these rates are for the period prior to the implementation of mental health apps in the Help@Hand counties/cities. As Help@Hand implements technologies in future years, the analysis of this data may reflect differences in the baseline rates of Help@Hand and non-Help@Hand counties as a result.

Figure 4.7. Suicide and Overdose Death Rates per 100,000 Residents



Gender

As shown in **Figure 4.8,** men are at a substantially higher risk for suicide and overdose than women. Men in California had an average annual suicide rate of 17.8 deaths per 100,000 residents and an average annual overdose rate of 18.9 per 100,000 residents.

[33] Data was aggregated to the county level and merged with population data from the United States Census Bureau to calculate population based rates for each year and for population subgroups. The annual rates were averaged over the 5-year period (e.g., 2015-2019)and are shown per 100,000 residents.

[34] Because it is difficult to establish in cases of overdose whether death was accidental or intentional, determination of final cause of death as suicide by medical examiners is imprecise and varies substantially across counties. Therefore, the analysis considered a lower bound, defined as those reported by the medical examiners as suicides, and an upper bound, defined as those reported as suicide plus those reported as overdose. Death with a final cause of suicide have ICD-10 codes X60-X84. Deaths with a final cause of overdose by drugs or alcohol have ICD-10 codes of X40-X45 (accidental poisoning) and Y10-Y15 (poisoning with undetermined intent).

Figure 4.8. Suicide and Overdose Death Rates per 100,000 Residents by Gender

Male Total 33.3
Overdose 17.8
Suicide 15.5
Female Total 11.2
Overdose 6.6
Suicide 4.6
Help@Hand counties

Male Total 33.3
Overdose 17.7
Suicide 18.6
Female Total 13.4
Overdose 8
Suicide 5.4
Non-Help@Hand counties

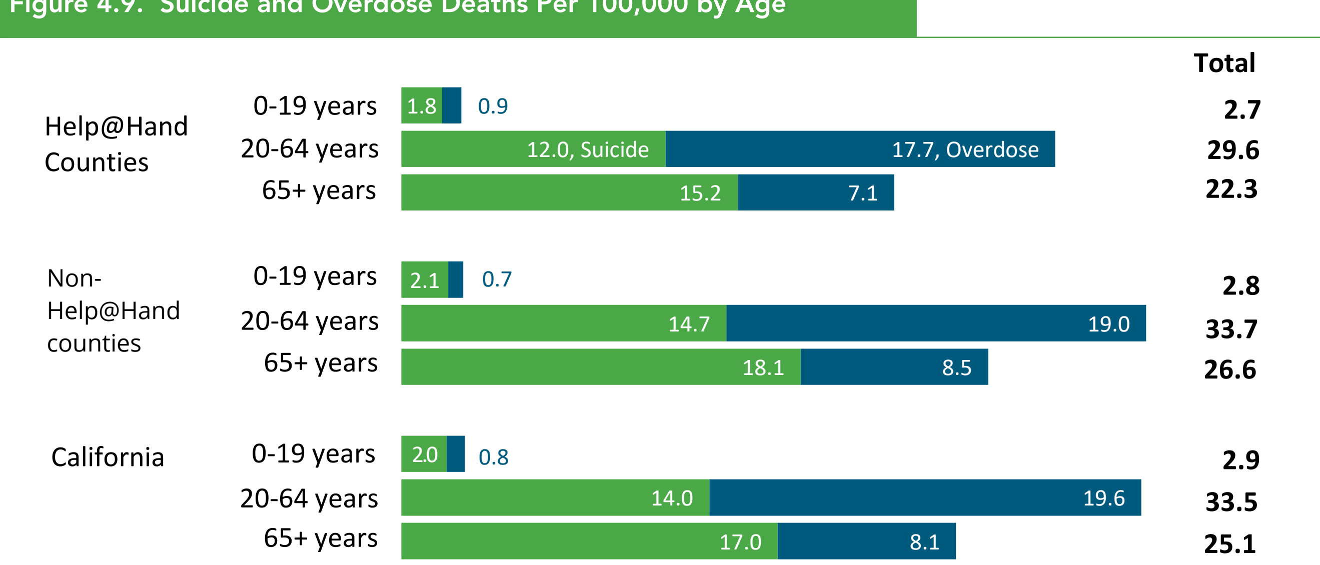
Male Total 36.7
Overdose 18.9
Suicide 17.8
Female Total 12.9
Overdose 7.7
Suicide 5.2
California

Age

Figure 4.9 shows that the age group in California with the highest rate of suicides was 65 and over, with an average annual rate of suicide of 17.0 deaths per 100,000 residents. The group with the second highest rate was the 20-64 year olds. In terms of drug and alcohol overdoses, 20-64 year olds had the highest rates by far.

Although deaths by overdose had small differences between counties, there were larger differences between counties for suicide. In particular, adults 65 and over had an average annual suicide rate in Help@Hand counties of 15.3 deaths per 100,000 residents, compared to 19.0 in non-Help@Hand counties.

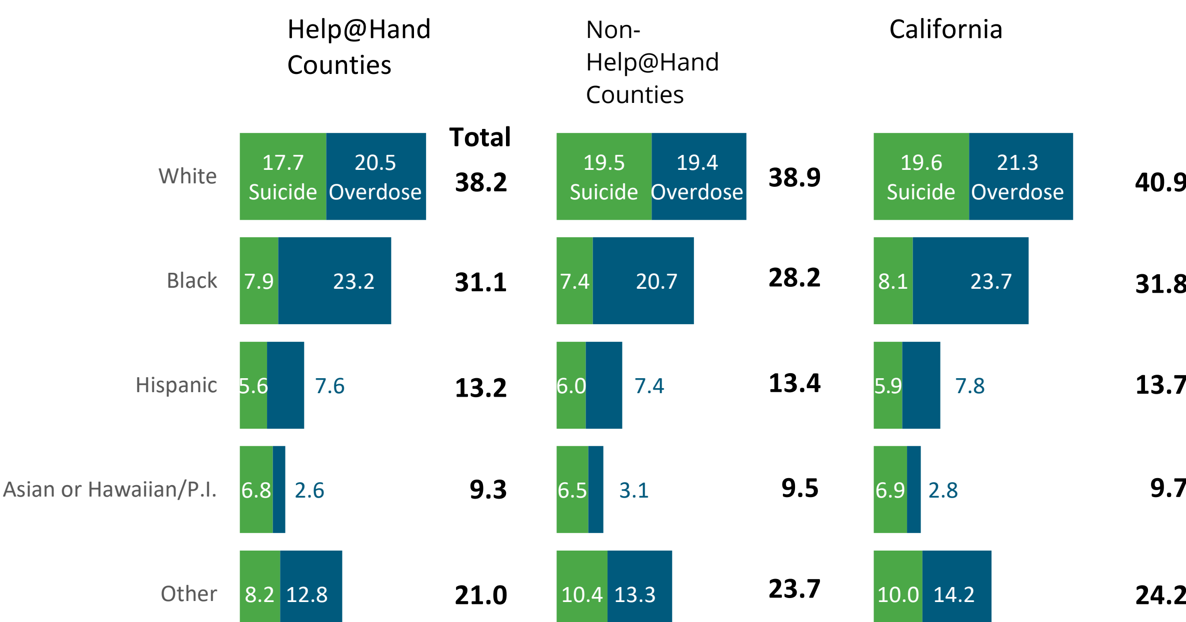
Figure 4.9. Suicide and Overdose Deaths Per 100,000 by Age



Race

Non-Hispanic Whites had the highest suicide rate, but non-Hispanic Blacks or African-Americans had the highest overdose rate in California during the period (as shown in **Figure 4.10**). Non-Hispanic Whites also had high rates of overdose. Overall, the suicide and overdose rates by race were generally similar in the Help@Hand counties and the non-Help@Hand counties.

Figure 4.10. Suicide and Overdose Deaths Per 100,000 by Race



Learnings from the Outcomes Evaluation

The Help@Hand evaluation team examined statewide data and learned:

- **Recent CHIS data shows:**
  - o **Technology Use by Age.** People of all ages used the internet many times a day or almost constantly, which means that they could access online support when needed. However, few people reported using online tools, particularly to connect with others.
  - o **Technology Use by Distress Level.** Both teens and adults with high distress reported using social media, blogs, or online forums to connect with people with similar mental health or alcohol/drug concerns.
- **Vital statistics data from California between 2015-2019 reveals trends in suicide and drug and alcohol overdose:**
  - o **Suicide and Overdose Trends.** Suicide and drug and alcohol overdoses rates in California are shown between 2015 and 2019. Help@Hand counties may want to consider technologies specifically targeting high risk communities.
  - o **Demographics of Suicide and Overdose Trends.** Men had a higher risk of suicide and overdose than women. Older adults over 65 years had higher rates of suicide, while younger adults between 20-64 years had higher rates of overdose.

DATA DASHBOARDS

Orange County and the Help@Hand evaluation team planned to pilot decision support dashboards that would be shared with other counties/cities. This work is paused to allow Orange County to focus on other project priorities and activities.

5 HELP@HAND EVALUATION ADVISORY BOARD

The Help@Hand evaluation received guidance and consultation from a team of state-wide experts and representatives across a broad spectrum of fields, stakeholder groups, and target populations. In particular, the Help@Hand Evaluation Advisory Board ensured that the evaluation:

- Considered key target audiences and addressed county/city-level variability
- Included measures of both process outcomes (implementation) and behavioral/health status outcomes (changes in participants) relevant to Help@Hand's goals
- Used methods appropriate to the project, especially with respect to scope and data collection
- Served as a vehicle for program improvement and program accountability that informed potential replication of the project
- Aligned with promising best practices, and
- Contributed to the existing knowledge base.

In Year 2, the Board met in three virtual meetings, during which the evaluation team provided updates on the Help@Hand evaluation and elicited the Board's feedback and guidance.

The Evaluation Advisory Board is comprised of a diverse group and includes:

- Experts with experience in mental health and/or technology evaluation
- Experts with experience in implementation science and evaluation
- Philanthropic and/or non-profit representatives
- Community mental health advocates
- County/City-level Help@Hand leaders
- Individuals with lived experience of a mental health/co-occurring issue accompanied by the experience of recovery, and
- Mental Health Services Oversight and Accountability Commission representatives

Help@Hand Evaluation Advisory Board Members

- Chair, Sergio Aguilar-Gaxiola, MD, PhD
  Director, UC Davis Center for Reducing Health Disparities
  Professor of Clinical Internal Medicine, UC Davis
- Ron Culver, BA[35]
  Supervisor II Tehama County Peer and Workforce Programs, Northern Valley Catholic Social Service
- Alex Elliott, MSW[36]
  Psychiatric Social Worker, Los Angeles County Department of Mental Health
- Doris Estremera, MPH
  Mental Health Services Act (MHSA) Manager, San Mateo County Health - Behavioral Health & Recovery Services
- Sharon Ishikawa, PhD
  MHSA Coordinator, Orange County Health Care Agency – Behavioral Health Services
- Karen D. Lincoln, PhD, MSW
  Associate Professor, School of Social Work, University of Southern California
  Director, USC Hartford Center of Excellence in Geriatric Social Work
- Brian S. Mittman, PhD
  Research Scientist, Health Services Research and Implementation Science, Kaiser Permanente Southern California
- Maria Martha Moreno, MS
  Administrative Services Manager, Riverside University Health System- Behavioral Health
- Keris Myrick, MS, MBA
  Co-Director, Mental Health Strategic Impact Initiative (S2i)
- Theresa Nguyen, LCSW
  Chief Program Officer and Vice President of Research and Innovation, Mental Health America
- David W. Oslin, MD
  Chief of Behavioral Health, Professor of Psychiatry, University of Pennsylvania
- Lawrence A. Palinkas, PhD
  Professor of Social Work, Anthropology and Preventive Medicine, University of Southern California
- Brian R. Sala, PhD
  Deputy Director, Evaluation and Program Operations, Mental Health Services Oversight and Accountability Commission
- Danielle A. Schlosser, PhD
  Lead Clinical Scientist, Mental Health, Verily
  Assistant Professor of Psychiatry, Department of Psychiatry, UCSF
- Brandon Staglin, MS
  President, One Mind
- Lindsay Walter, JD
  Deputy Director Admin and Operations, MHSA Chief – Santa Barbara County Department of Behavioral Wellness

[35] Joined the Help@Hand Evaluation Advisory Board in December 2020
[36] Joined the Help@Hand Evaluation Advisory Board in December 2020

Recommendations have been shared in each of the Year 2 quarter reports. Recommendations for the Help@Hand Collaborative have been consolidated, and in some cases repeated here, with learnings presented in this report according to the diverse themes reflected in the project. These recommendations are not meant to be interpreted as exhaustive or complete, but rather reflect knowledge that has been gleaned from some of the major opportunities and challenges of the past year. Furthermore, learnings and recommendations from the Evaluation Advisory Board are also reflected in themes below.

As such, the Help@Hand evaluation team recommends the following for the overall Help@Hand Collaborative and the individual Help@Hand counties/cities.

RECOMMENDATIONS FOR THE HELP@HAND COLLABORATIVE

CONTINUE TO BUILD A COLLABORATIVE AND COOPERATIVE CULTURE THAT FOSTERS RELATIONSHIPS, TRUST, AND RESPECT ACROSS THE COLLABORATIVE:

- **Facilitate more cross-collaborations:** Counties/cities are integrating Collaborative feedback into the work that they do (e.g., Santa Barbara utilizing Riverside's Poster; Kern widely sharing app guide; Los Angeles' recommendations around resources for LifeLine phones). The Help@Hand project management team may want to consider offering flexible use of supplemental funds to counties/cities in order to develop and support cross-collaborative subprojects within Help@Hand that may extend beyond technology implementations. The Help@Hand project management team may offer operational and project management support for these subprojects.
- **Facilitate "communities of practice":** CalMHSA would be instrumental in facilitating the communities of practice due to their unique role as the project manager of the overall Help@Hand project. CalMHSA would not be expected to lead the communities of practice, but to provide the structure in which they could be facilitated. CalMHSA is able to facilitate these communities of practice because they have knowledge of each county/city's interests and where shared interests might lie. CalMHSA could facilitate affinity networks, or communities of practice,[37,38] within the Help@Hand project to: 1) increase collaborative problem-solving through sharing of resources, experiences, tools, and best practices; 2) increase support to Peers and capitalize on strengthening Peer relations across counties/cities; and 3) speed translation of learnings into practice. Communities of practice may include:
    - Subgroups focused on specific technologies (e.g., Headspace or myStrength) and/or populations (e.g., TAY or isolated older adults). These topics arise in different meetings, but not enough time is available for them. The subgroups would convene in a way that allows time for in-depth learning.
    - Regular topical meetings or interactive web tools that allow for easy sharing and access to recourses or plans (which could be particularly beneficial to Peers).
    - Subject matter experts providing trainings or facilitation on topics of interest, such as a presentation or case study about a successful implementation of myStrength, along with lessons learned.
- **Facilitate use of SharePoint as a resource.** SharePoint improvements are appreciated by the Collaborative. Locating and accessing information (e.g. navigation) continues to be a challenge. Consider creating a workgroup to develop a model for organization that would be intuitive and useful for counties/cities staff accessing the site.

[37] Communities of practice are groups of people who have a similar and strong interest for a specific topic. They engage in joint activities/discussions, help each other, and share information (Centers for Disease Control and Prevention, 2019). Free resources may be found at: https://www.cdc.gov/phcommunities/resourcekit/resources.html

[38] An example of an online community practice would be the Implementation Science Coordination, Consultation & Collaboration Initiative for HIV/AIDS research, which provides various resources for project planning and implementation in their resource hub: https://isc3i.isgmh.northwestern.edu/resource-hub/

CONTINUE TO REFINE AND STREAMLINE PROJECT PROCESSES:

- **Leverage streamlined processes.** Urgency around responding to the COVID-19 pandemic compelled processes to streamline and quickly problem-solve barriers. Identifying and leveraging these streamlined processes will be important for future implementations. The COVID-rapid response technology implementation was a great example of a streamlined process.
- **Adapt project management support and documentation materials** (e.g. implementation meeting agendas or OCM plan templates) with an effort to simplify and make more efficient. These materials will be useful and important for future technology implementations both within Help@Hand and across other similar projects undertaken within counties/cities.
- **Continue to understand and document what information counties/cities value and need from the Technology vendor when selecting technologies.** For example, information about a product's available languages continues to be a common request. The 2019-2020 RFSQ process, Monterey RFI/RFP, and recent contract negotiations, for example, may offer important insights into county/city specific needs and requirements vis-à-vis general customer needs.

CONTINUE TO MEANINGFULLY ENGAGE PEERS IN HELP@HAND'S GOVERNANCE, PLANNING, IMPLEMENTATION, AND EVALUATION:

- **Hire staff to support the Peer component of Help@Hand.** Given the need for Peer training and supervision resources, CalMHSA should accelerate efforts to fill the position of Peer Engagement and Community Manager and supplement this position with a second Peer for administrative support, Peer support, and continuity in the event of personnel turnover.
- **Hire and retain qualified Peers.** Consider creating a workgroup to address barriers and facilitators that have emerged in the Help@Hand project for hiring and retaining qualified Peers (e.g. Human resources (HR)) policies around prior criminal records; need for ongoing support for Peers in recovery; HR limits on type of employment (e.g. extra work); Career pathways for success; High turnover).
- **Facilitate the development of formal pathways for increasing Peer engagement.** Counties/cities can incorporate Peers at different levels of the project (e.g., marketing, social media, video production). Counties/cities should consider how best to include Peers and what additional training can be useful to supporting the Peer workforce. See additional recommendations above pertaining to Communities of Practice.
- **Include Peers in the decision-making process around measurement in evaluation.** When presented with materials that are explained using minimal jargon, it is possible for people with limited training in statistics to understand the core issues and be able to make informed and insightful decisions. However, these efforts often require additional time and resources to support. Nonetheless, evaluation efforts must always find a balance between what is scientifically valid and what is feasible--a partnered Peer-driven approach is an effective strategy for striking this balance.

CONTINUE TO INTEGRATE DIGITAL MENTAL HEALTH LITERACY (DHML) TRAINING INTO COUNTY/CITY IMPLEMENTATIONS:

- **Analyze available data.** DMHL resources, consisting of 10 videos as well as an Instructor led curriculum which includes the 'Managing your digital presence curriculum' and 'Cyberbullying Curriculum', has been made available on the https://helpathandca.org/dmhl/ website. Use data available from website analytics and surveys to understand frequency of current use of materials and satisfaction with content. This information will be important for planning efforts around further dissemination.
- **Consider planned expansions and/or efforts to disseminate DMHL videos.** Consider a strategy to expand the use of the DMHL curriculum across the Collaborative – perhaps include link to site in marketing efforts. Providing much needed digital mental health literacy training to appropriate target populations may improve uptake of technology implementations.
- **Consider integration into tech implementations.** Consider additional efforts to integrate DMHL program in county/city pilot projects and implementations.

CONTINUE TO WORK TO STRUCTURE THE RELATIONSHIP BETWEEN TECHNOLOGY VENDORS AND COUNTIES/CITIES IN WAYS THAT PROMOTE A WIN-WIN FOR THE PRIVATE-PUBLIC PARTNERSHIP:

- **Incorporate data collection and sharing plans when contracting with technology vendors.** Because the availability of marketplace data via a third-party analytics platform changes over a relatively short period of time, it is crucial for vendors to directly provide these metrics. Detailed data provided directly from the app developer will yield more consistently available data points to help understand product performance. This data will also allow counties/cities to determine the real-world engagement and effectiveness of the apps and help achieve learning objectives. The Collaborative should negotiate contracts on behalf of counties/cities that ensure the apps provide detailed, individual-level data, including data on adoption, engagement, abandonment, and outcomes.
- **Understand the available resources offered by the vendor.** Consider using the following questions as a guide. These questions are not intended to be comprehensive, but rather used to facilitate a guided conversation:
  - o *Marketing:* What marketing materials are available and have been used to support adoption of product and maintenance of use over time? Who are the target audiences for these materials? Describe any efforts to test the efficacy/usefulness of potential marketing approaches?
  - o *Implementation:* Describe some of the settings for which the product has been successfully implemented? What has been some of the most successful implementation contexts (including target audiences)?
  - o *Data Availability:* Will data be shared at individual level or the aggregate? Identified or de-identified? Is the vendor willing to provide a data dictionary for data to be shared with the county/city? How are data constructs operationalized (including what is the denominator that is used)?
  - o *Dashboard Construction:* How often will data on the dashboard be refreshed? Will archival data be made available? Will the data be exportable?
- **Consider ownership issues, intellectual property, and/or licensing of products when deciding how best to move forward with custom builds.** There are important implications of these early decisions for future customizations of the product and expansions of the product to other markets.

CONTINUE ADOPTING A PERSON-CENTERED APPROACH, MATCHING THE NEEDS OF DIVERSE TARGET AUDIENCE MEMBERS TO APPROPRIATE AVAILABLE TECHNOLOGIES:

- **Consider language and culture.** Assess how the language and content of potential technologies fits the needs of diverse target audience members. Making a technology available to diverse ethnic, language, or cultural groups involves more than just translation.
- **Develop set of questions to assess cultural competency of the technology itself.** Data collection with technology consumers found that cultural competency is important across target audiences. Counties/cities have echoed the need for culturally competent technologies, but technologies explored have been rated low in cultural competency. Developing a set of questions to assess cultural competency of a technology itself early on, as well as evaluate to what extent vendors are able to meet counties/cities' needs regarding cultural competency for a particular target audience.
- **Consider assistive technologies:** Many technology products do not have sufficient assistive technologies. General-use apps which are available on the app stores are unlikely to be a good fit for people with disabilities. Discuss as a Collaborative how to vet potential technologies to meet such criteria. Discuss with chosen vendors their capabilities and capacity to expand accessibility features. Speak with members of the target group to understand what assistive technologies are most relevant across the Collaborative. Discuss as a Collaborative how to vet potential technologies to meet such criteria and discuss with chosen vendors their accessibility capabilities.

INCLUDE IMPORTANT STAKEHOLDERS FOR CONDUCTING CULTURAL TAILORING AND DISSEMINATION:

- **Include Peers and stakeholders in dissemination efforts.** Efforts are currently underway to translate materials for dissemination to key target audiences. As recommended as part of best practices, consider including

Peers and stakeholders in all dissemination efforts to ensure appropriate translation, cultural tailoring, and dissemination of documents and products.

- **Consider the materials to be selected for translation and dissemination.** There are a number of strategies for success, including selecting a medium for dissemination that suits the message (e.g. consider use of video or infographic). Identify the audience and tailor the message – it is important not to overlook the intended audience and consider specifically tailoring each message to that audience.

CONTINUE CONVERSATIONS AND PLANNING AROUND THE EQUITABLE DISTRIBUTION OF DEVICES:

- **Consider forming a Collaborative level workgroup to develop a recommendation or guideline, rather than a prescription.** Counties/cities are seeking a lot of guidance around equitable distribution of devices. Most counties/cities don't have guidelines for providing equitable distribution of technologies. There are concerns around making the program truly equitable, while balancing limited budgets, concerns around how the devices will be used, and liability.
- **Recognize a one size fits all model may not work.** Counties/cities might want to try different methods of distribution (e.g., loan, free devices, etc.) based on specific population needs. It is important for counties/cities to consider what the criteria are for those who will be receiving devices from county/city-specific programs.
- **Consider use of existing or prior programs to model distribution methods after and/or to leverage available resources** (e.g., state of California's distribution of Chromebooks for education, library device loan models, etc.). As noted during Tech Lead (9/8/2020), California Broadband and Digital Literacy office has work that might intersect with or support work being done by the Help@Hand project. California Broadband and Digital Literacy office work focuses on providing broadband internet access (not devices) to stakeholders across California.

RECOMMENDATIONS FOR INDIVIDUAL HELP@HAND COUNTIES/CITIES

Recommendations for individual Help@Hand counties/cities also come from across the quarter reports, as well as include learnings and recommendations from this report.

LOCAL IMPLEMENTATION:

- **Define goals and learning objectives for each technology implementation early in the process**. Participants rate the usefulness of technologies differently, depending on what goals a technology is expected to meet. Counties/cities should clearly define their goals and learning objectives to select and evaluate a technology.
- **Customize implementations for local context.** Implementations will be more likely to succeed when counties/cities deeply understand the problem or need they are trying to solve or address locally - both from the data and input from the community and from understanding the existing work and coalitions that may be working on similar issues.
- **Develop structured processes for eliciting stakeholder engagement.** Counties/cities who wish to engage community members throughout the project should develop structured plans for stakeholder engagement , find and leverage meaningful partnerships to reach and engage stakeholders, especially when utilizing remote processes during COVID-19. Counties/cities have found that working with local agencies that serve their target population can help with outreach and marketing for the project.
- **Remember the 5 key takeaways when engaging people (e.g. in a focus group):**
  1) Establish a win-win-win; show benefits to potential participants.
  2) "Your ego is not your amigo"[39]; research team should be humble and know that they might not be the only expert in what is being studied.
  3) Be intentional / know target audience for recruitment.

[39] Direct quote shared by one of the Help@Hand counties/cities on Tech Lead Call, 11/17/2020.

4) Luck is the residue of hard work – there is a lot of work that must go into the planning of any effort to engage stakeholders and community members.

5) One-size does not fit all when it comes to interventions and when it comes to research and/or evaluation.

- **Understand the underlying needs of your target audiences.** Needs assessments can provide important insights in the mental health needs of a target population. If counties/cities do not have a detailed understanding of their target audience yet, a needs assessment is recommended to uncover needs that can inform technology selection. In addition, these needs may inform strategies for marketing and outreach that is appropriate for the target population.
- **Understand and address barriers to accessing digital technologies.** As many apps do not function offline, work with county/city informational technology to explore potential options, consider workflow integration, and discuss client's internet access to find suitable workarounds. For example, if an app only has downloadable content, where can the client go to download the content? Digital literacy training and resources can also help users better understand connectivity to WiFi and internet data to avoid unexpected charges.
- **Recognize and plan for the challenge of working remotely.** Providing remote technical support is more challenging than in-person support. When gathering feedback remotely, counties/cities should be prepared to provide additional support and set aside time to collect target audience feedback.
- **Consider how the communication of informed consent and/or terms of services facilitates transparency among your counties/cities' consumers.** Because privacy concerns were a commonly identified barrier to technology use, maintaining communication and transparency on how app data is collected, stored, and used can help mitigate privacy concerns. As noted by counties/cities, an informed consent process that communicates a technology's terms and conditions in lay terms can also help technology users understand how their information will be used.
- **Test crisis response within apps.** Many of the apps reviewed did not include a crisis response. Counties/cities are encouraged to test crisis responses within the app to ensure that they meet expectations and respond appropriately. A crisis response plan outside of the app is also essential. If apps do not provide a crisis response, ensure that clients are aware of this and know who they should contact if they are in crisis.
- **Engage leadership and identify local champions.** Having strong leadership and champions can be crucial to seeing the project move forward. Resilience and stamina are keys to sustaining the project. Also, be sure to identify partners who are ready to be involved and participatory in the process -- "It takes a village."
- **Align terms.** It is important to ensure a shared understanding of commonly used terms for involved parties. For example, make sure that the technology vendor, participating clinics, county/city, and any other involved partners have a shared understanding of the definition of "Serious Mental Illness (SMI)". Counties/cities, vendors, and clinicians make not use this term in the same way.
- **Marketing efforts and materials must be on-going to promote continued uptake of products.** Recruitment of consumers and/or clinicians/ and/or other stakeholders must be viewed as being continuous -- not a one-time event if counties/cities want to see sustained growth in technology uptake.
- **Aim to recruit users in pilot efforts that reflect the target population.** Users can perceive the usefulness of technologies differently when they consider a technology for themselves, versus when considering it for a particular population. For the exploration phase, counties/cities should aim to recruit participants that are as representative as possible of the target audience.

PRODUCT FIT AND ENGAGEMENT:

- **Compare the features of similar products (e.g. myStrength, SilverCloud) during the app selection process.** Many of the products reviewed during the RFSQ process have features that overlap, but have important differences that make some apps a better fit for a particular target audience than other apps.
- **Consider products that connect people together.** Counties/cities should consider whether or not technologies allow users to connect with others, whether professional services or informal support, to receive mental

health support, and to what extent their target audience(s) would like to utilize these types of features, as this was valued by multiple target audiences in both needs assessments and technology explorations.

- **Consider products that connect people to existing systems of care.** Because participants also valued when technologies were integrated into existing systems of care, counties/cities should work with vendors to understand how a technology may work within existing health services but also to what extent the vendor is willing to add customization for connections to local resources and support to be embedded within the technology.
- **Engage early to enhance uptake.** The first few days after a client downloads an app may be the most likely time for them to become engaged with the app. Considering what other active approaches to enhance uptake and engagement may help people use the app within the first few days. For example, if they have technical difficulties or other questions during their first use, is there someone they can reach out to or a resource they can visit to help resolve them?
- **Continually check in with consumers who use a product over time.** Technology explorations indicated that participants valued having a variety of content that is consistently updated. In order to understand user engagement, counties/cities should consider not only capturing users' early impressions of a technology, but also checking in at later time points to evaluate whether the content meets users' long-term needs. Counties/cities can also engage with the vendors to determine if and how often content is updated.

CLINICAL INTEGRATION:

- **Create materials to help provide more training and orientation to residents and other clinic staff.** Perhaps the vendor has materials that are already available that could be disseminated. However, consider if these require adaptations and tailoring for appropriate groups.
- **Support early clinical champions.** Focusing support on "early adopters" might be more beneficial than changing the views of less enthusiastic providers.
- **Address barriers early and share with clinic staff changes made to address their concerns.** Generally, when a product is first introduced into a system, there is an overall positive view of the product. Addressing barriers to implementation early is important to supporting and sustaining early enthusiasm and excitement.

DATA USE:

- **Use data to continuously learn, adapt, and improve.** Design implementation and evaluation plans concurrently to support the collection of important data necessary for informing programmatic decisions.
- **Initiate vendor calls earlier in planning process to allow for better alignment with program and evaluation planning.**

DISSEMINATION AND SUSTAINABILITY:

- **Leverage local resources.** When marketing county/city efforts, it can be useful to work with other divisions within the department (e.g., TAY groups, Substance Use/Addiction recovery, Cultural Competency) to not only reach a wider audience but also to assist with messaging. Relatedly, it is useful to collaborate with local mental health organizations.
- **Be deliberate in where and how you market.** When marketing on digital media/online, it is important to consider the pros and cons of each platform as well as which audiences visit which social media platforms.
- **Start preparing for project end right now.** Consider the vision for what your county/city actually wants to achieve during the remaining time in the Help@Hand program, balancing Help@Hand objectives with project feasibility.
- **Develop long term roadmap.** Developing a long-term roadmap is a critical tool for ensuring sustainability for the programs counties/cities are building. Having a project plan align with a long-term roadmap also provides the opportunity to get input and buy-in from program staff and external stakeholders. Consider the opportunities for counties/cities to build sustainable infrastructures and roadmaps to support long-term technology integrations.

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APPENDIX A: COUNTY/CITY PROGRAM INFORMATION

Each Help@Hand county/city completed the following tables describing their program information, accomplishments, lessons learned, and recommendations.

City of Berkeley	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Andrea Bates	• Kirsten White • Karen Klatt	• Kirsten White • Karen Klatt	• Kirsten White • Karen Klatt
Implementation Site	• TBD	• TBD	• TBD	• TBD
Team Composition	• Tech Lead, Behavioral Health Director, MHSA Coordinator, Peer, Project Coordinator	• Steven, BH Director • Karen, MHSA Coordinator • Jaime, Peer Lead • Kirsten, RDA Consultant • Nicole, RDA Consultant	• Steven, BH Director • Karen, MHSA Coordinator • Jaime, Peer Lead • Kirsten, RDA Consultant • Nicole, RDA Consultant • Jeff Buell, Clinical Coordinator	• Steven, BH Director • Karen, MHSA Coordinator • Jaime, Peer Lead • Kirsten, RDA Consultant • Nicole, RDA Consultant • Jeff Buell, Clinical Coordinator
Target Audience	• TBD	• TAY; isolated seniors; communities of color, including African Americans, Latina, etc.; general population of Berkeley	• TAY; isolated seniors; communities of color, including African Americans, Latinx, and API community members; general population of Berkeley	• TAY; isolated seniors; communities of color, including African Americans, Latinx, and API community members; general population of Berkeley
Products in Use/Planned	• TBD	• Under review	• Selection in progress	• Berkeley staff completing validation of Headspace and myStrength
Implementation Approach	• TBD	• TBD	• TBD	• Rapid Response
Other Unique Qualities (of target audience, implementation, or other program aspect)	• TBD	• Prefer to engage minority-owned vendors	• Prefer to engage minority-owned vendors	• Following a review of the vendors qualified through the RSFQ process, no vendor was clearly minority-owned and no product was made specifically for BIPOC consumers.
Milestones	• Not applicable	• Peer Lead allocated to project • Local consultants contracted and onboarded to support app selection and developed plans for implementation	• The City Mental Health Team Partners are engaged in the App Technology selection	• Products selected for exploration (Headspace, myStrength) • Internal staff validation to prepare for product launch underway • Developing Peer engagement plans
Lessons Learned	• Regular brainstorm and Q&A opportunities, particularly Tech Lead Collaboration meetings, with fellow Help@Hand jurisdictions are valuable for supporting such a dynamic project implementation process • A shared understanding of project objectives is key • Objectives should be revisited with stakeholders on an ongoing basis			
Recommendations	• Regularly reteach and reinforce expectations regarding the required implementation documentation, both as a best practice and also to support counties/cities experiencing staff turnover or project pauses; • Consider offering support to connect smaller cohorts of similarly-sized/similarly-resourced jurisdictions on a quarterly or biannual basis, as progress of a very large county might be presented as a watershed project milestone but very inappropriate for a small jurisdiction to aspire to; • Increase transparency of product take-up (and perhaps other metrics) across pilots. It would be helpful to have better access to this data across pilots in order to inform realistic goal-setting at the local level.			

Kern County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Lamar K. Brandysky, LMFT	• Lamar K. Brandysky, LMFT	• Lamar K. Brandysky, LMFT	• Lamar K. Brandysky, LMFT
Implementation Site	• Self-Empowerment Team	• Self-Empowerment Team	• Self-Empowerment Team	• N/A
Team Composition	• Project Lead, Peer Lead, 2 Peers, PIO, Marketing Associate	• Project Lead, Peer Lead, 1 Peer, PIO, Marketing Associate	• Project Lead, Peer Lead, 1 Peer, PIO, Marketing Associate	• N/A
Target Audience	• Clients with serious mental illness • Kern County Residents	• Clients with serious mental illness • Kern County Residents	• Clients with serious mental illness • Kern County Residents	• N/A
Products in Use/Planned	• App guide, 2nd Edition – English and Spanish versions • App guide, 3rd Edition (planned)	• App guide, 2nd Edition – English and Spanish versions • App guide, 3rd Edition (planned)	• App guide, 2nd Edition – English and Spanish versions • App guide, 3rd Edition (planned)	• N/A
Implementation Approach	• Wide distribution of the app guide	• Wide distribution of the app guide	• Wide distribution of the app guide	• N/A
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Offer clinician education on app guide (planned) • Support other Help@Hand Counties/Cities (Mono, Modoc, and Santa Barbara) develop their own tailored app guide • Adapt app guide for Nevada, Fresno, San Bernardino, and Inyo Counties to publish their own app guide	• Offered clinician education on app guide (planned) • Supported other Help@Hand Counties/Cities (Mono, Modoc, and Santa Barbara) develop their own tailored app guide • Adapted app guide for Nevada, Fresno, San Bernardino, and Inyo Counties to publish their own app Guide	• The state-wide medical emergency declared by the governor has resulted in a pause on all Help@ Hand activities	• N/A
Milestones	• Published the 2nd Edition of *"The Peers' Guide to Behavioral Health Apps"* app guide in English and Spanish • Created a version of the app guide for Modoc, Mono, and Santa Barbara Counties that included content modifications and printing set-up • Prepared and Implemented a four-hour Peer Workshop on empowerment training for Kern BHRS and contract-ed Peers • Empowered Peers though the app guide development and dissemination • Prepared and hosted two-day digital mental health literacy training for Help@Hand Peers • Presented app guide to County Board of Supervisors in January • Presented to the Kern BHRS Management and to the Kern BHRS contract CEOs • Started systemic distribution to other Kern County agencies	• The state-wide medical emergency declared by the governor has resulted in a pause on all Help@ Hand activities.		• Kern County has completed their participation in the Help@Hand project.
Lessons Learned	• The proposed apps need to be thoroughly vetted prior to piloting with clients. A prime role of County mental health is to assure the provision of safe products to their vulnerable population. • Digital literacy takes one-on-one coaching which is time consuming and labor intensive. • Consumers benefit from basic digital literacy training. • Collaborating with fellow counties is fruitful and productive. • Working with County agencies requires an abundance of patience and perseverance. • It is vital that the peer employees not only have lived experience, but that they will have progressed sufficiently in their recovery that they feel free to share details of their journey. This sharing of surviving and thriving in their recovery is a prime issue to benefit our consumers and members.			
Recommendations	• Focus on producing a product. Time and energy can be spent on process and procedures with no resulting product			

Los Angeles County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Katherine Steinberg, MPP, MBA • Alex Elliott, MSW • Ivy Levin, LCSW	• Katherine Steinberg, MPP, MBA – Reassigned mid May 2020 • Alex Elliott, MSW – Served as a liaison for Painted Brain/ Peer contributions	• Alex Elliott, MSW- Served as a liaison for Painted Brain/Peer contributions	• Alex Elliott, MSW- Served as member of Evaluation State-Wide Advisory Board
Implementation Site	• Harbor UCLA DBT program • Peer Resource Center (planned) • Geriatric Evaluation Networks Encompassing Services Intervention Services (GENESIS) outpatient program for older adults (projected for pilot) • Telecare Los Angeles Older Adults (LAOA) Full Service Partnership (FSP) program (projected for pilot)	• Harbor UCLA DBT program • Peer Resource Center (planned) All pilots were placed on hold due to COVID	• Harbor UCLA DBT program • Peer Resource Center (planned) All pilots were placed on hold due to COVID	• Harbor UCLA DBT program • LAC DMH DBT Programs • LAC DMH will be moving forward with contracting with Prevail for a full LA community roll out to commence February 2021.
Team Composition	• Program Lead/Project Manager, Chief Medical Officer (Executive Sponsor), Behavioral Health Director, 2 Tech Leads, Chief Information Officer, IT Project POC, Chief of Peer Services, Evaluation Lead, Privacy SME, IT Security SME, Harbor UCLA Clinical Champion, Public Information Officer	• Program Lead/Project Manager, Chief Medical Officer (Executive Sponsor), Behavioral Health Director, 2 Tech Leads, Chief Information Officer, IT Project POC, Chief of Peer Services, Evaluation Lead, Privacy SME, IT Security SME, Harbor UCLA Clinical Champion, Public Information Officer	• Program Lead/Project Manager, Chief Medical Officer (Executive Sponsor), Behavioral Health Director, Chief Information Officer, IT Project POC, Chief of Peer Services, Evaluation Lead, Privacy SME, IT Security SME, Harbor UCLA Clinical Champion, Public Information Officer, Additional DMH staff/SMEs, as needed	All other pilots were placed on hold due to COVID • MindLAMP: Chief Information Officer, IT Project POC, Harbor UCLA Clinical Champions, DBT Project Liaison, Evaluation Advisory Board Member
Target Audience	• Transitional age youth and college students • County employees • Complex needs individuals (i.e., those with multiple and repeated hospitalizations) • Individuals and family members uncomfortable accessing community mental health services seeking de-stigmatized care and supports for well-being • Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting	• All Los Angeles County residents in need of support due to COVID • County employees • Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting	• All Los Angeles County residents in need of support due to COVID • County employees • Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting	• All Los Angeles County residents in need of support due to COVID • County employees • Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting
Products in Use/Planned	• Headspace (planned) • Modified Mindstrong Health App • CredibleMind (projected for pilot) • Uniper (projected for pilot) • MindLAMP (projected for pilot)	• Headspace for COVID-19 response made available • Modified Mindstrong Health App	• Headspace for COVID-19 response continued • Began transition from Mindstrong Health App to MindLAMP (diary cards)	• Headspace for COVID-19 response continued • Continued transition from Mindstrong Health App to MindLAMP (diary cards)
Implementation Approach	• Headspace for current DBT clients (possible COVID-19 response) • Headspace for individuals visiting the DMH Peer Resource Center • CredibleMind for isolated populations at higher risk for more serious complications from COVID-19 • Uniper for current DMH clients in the GENESIS outpatient program for older adults • Uniper for current older adult clients with internet access enrolled in the Telecare Los Angeles Older Adults (LAOA) Full Service Partnership (FSP) program • MindLAMP for clients in Harbor UCLA DBT program	• Headspace for COVID-19 response made available to all county residents • MindLAMP for clients in Harbor UCLA DBT program • Headspace for individuals visiting the DMH Peer Resource Center	• Headspace for COVID-19 response, available for all LA County residents • MindLAMP for clients in DBT programs in LA County, in development	• Headspace for COVID-19 response, available for all LA County residents • MindLAMP for clients in DBT programs in LA County, in development

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Los Angeles County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Other Unique Qualities (of target audience, implementation, or other program aspect)	• LAC DMH is exploring how to use apps and platforms that have already gone through internal review to meet the increased needs of those impacted by COVID-19 (COVID-19 response)	• Rapid deployment, without pilot process, of Headspace to meet the increased needs of the community due to COVID-19 • Streamlined all DMH communications to ensure community is aware of resources available	• Transition in progress to use MindLAMP to meet the increased needs of clients receiving DBT • MindLAMP is a unique open source solution • MindLAMP is developing a Digital Diary Card for LACDMH • DMH is developing the technical infrastructure to host MindLAMP within LACDMH's IT ecosystem via Microsoft Azure	• Transition in progress to use MindLAMP to meet the increased needs of clients receiving DBT • MindLAMP is a unique open source solution • MindLAMP is developing a Digital Diary Card for LACDMH • MindLAMP is translated into Spanish • DMH is developing the technical infrastructure to host MindLAMP within LACDMH's IT ecosystem via Microsoft Azure
Milestones	• Continued development and refinement of pilot proposal documents • Coordinated calls between vendors, LAC IT security, LAC program leads, and CalMHSA to get questions answered • Began evaluation planning and proposal refinement with UCI and CalMHSA • Learning collaborative at PRC: Discussion for the Development of a Guide to Wellbeing app guide • Development of Painted Brain App Evaluation Matrix • Finalized Guide to Wellbeing app guide and shared with the Help@Hand Collaborative • Gathered free resources offered in response to COVID-19 and shared with the Help@Hand Collaborative • Created a dynamic QR code for app guide • Presented pilot plans to Help@Hand leadership group (all pilots approved by Collaborative) • Development of Digital Health Literacy Modules by Painted Brain and associated DMH review • Headspace presentation at Countywide Supervisors Forum • Headspace on-site meeting: Getting started with Headspace with Tom Freeman, Engagement Manager • Development of request for information (RFI) Screening Tool w/ Monterey County • Participated in Help@Hand Language/Monolingual Working Group • Clinical Peer Review Presentation for the Quality, Outcomes and Training Division: Resources to help Deaf, Hard of Hearing, Blind and Physically Disabled Populations access and use Assistive Technology • Updated Help@Hand LA Charter and committee structure • Collaborated with UCI to develop the Community College students digital mental health baseline needs assessment	• The Leadership Committee reviewed and approved three pilot proposals from LA County on April 9th, 2020 • Headspace Plus subscription made available to all Los Angeles County residents as part of COVID rapid response in early May • Updated Peer-developed Digital Mental Health Literacy Modules to adapt for virtual training sessions • Engaged in the development of specific modules of digital health literacy curriculum and training to include telehealth etiquette and use of selected DMH telehealth platform (Vsee) by Peers • Held Digital Mental Health Literacy virtual trainings for Service extenders, Community Health Workers, and Peers champion • Translated Guide to Wellbeing app guide to Spanish and disseminated to the Help@Hand Collaborative • Various outreach and communication efforts to increase awareness and engagement with Headspace and the Guide to Wellbeing Apps • LACDMH LE provider completed interview on Apps to Support Wellbeing at Compton Pride	• Held Digital Mental Health Literacy virtual trainings for Service extenders, Community Health Workers, and Peers champion. Virtual trainings included Telehealth connection and support training for the peer champions • Held office hours to provide support and technical assistance for Service extenders, Community Health Workers, Peer Resource Center staff, and Peer champions • Presentation at 8/20 Peer Lead Collaboration meeting: Painted Brain: Peer roles in Telehealth	
Lessons Learned				
Recommendations				

Marin County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Chandrika Zager, LCSW MPH • Lorraine Wilson, MSW	• Chandrika Zager, LCSW MPH • Lorraine Wilson, MSW	• Chandrika Zager, LCSW MPH	• Chandrika Zager, LCSW MPH • Lorraine Wilson, MSW
Implementation Site	• Not applicable	• Not applicable	• Not applicable – working through partner CBOs	• Not applicable – working through partner CBOs
Team Composition	• Behavioral Health Director, Peer, MHSA Coordinator, Tech Lead	• Behavioral Health Director, Peer, MHSA Coordinator, Tech Lead	• Behavioral Health Director, MHSA Coordinator, Tech Lead, Peer Lead	• Behavioral Health Director, MHSA Coordinator, Tech Lead, Peer Lead
Target Audience	• Older Adults (particularly those who are isolated)	• Older Adults (particularly those who are isolated)	• Older Adults (particularly those who are isolated)	• Older Adults (particularly those who are isolated)
Products in Use/Planned	• Uniper (Testing) • myStrength (Testing) • Happify (Testing) • Wysa (Testing)	• Uniper • myStrength	• Uniper • myStrength	• myStrength
Implementation Approach	• TBD	• TBD	• In development	• Coordinated partnership with Telehealth Nurse Interns – blend of home visiting and virtual support
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Builds an intergenerational component (planned) • Obtain stakeholder feedback through online venues (COVID-19 response); will require both group and individual coaching and a much more drawn out process	• Virtual Focus Groups (200 hours, 12 participants) • All data gathered remotely – Zoom, Doodle, Online Surveys, DocuSign	• Concurrent dual pilots planned • Piloting both apps with monolingual Spanish-speaking population	• Piloting myStrength with English and monolingual Spanish-speaking population. Digital literacy is a major focus of the pre-pilot launch.
Milestones	• Business Advisory Committee established and will hold first meeting 4/16 • Identified two groups of stakeholder testers (congregation of older adults and peers) • Request for proposal issued to identify a trainer experienced with older adults to assist with digital literacy training • Recruitment is underway to hire a Peer for the project	• Advisory Committee met 4 times and helped recruit focus group members, outline outreach plan, and shared additional considerations for local evaluation • Tech4Life hired – contractor experienced in remote coaching in use of tech for older adults • Peer recruitment – Anticipated start mid-late August	• Peer Lead hired and onboarded • Dual pilot proposal approved by compliance, county counsel, and IT	• Telehealth Equity Partnership formalized which bring in university nurse interns to provide intergenerational in-home and virtual support • Training plans for partners developed and digital literacy curriculum and training formalized • Pilot preparation completed and approved • Intern training manual developed • Established online system for enrolling community members through CBOs
Lessons Learned	• Increasing digital literacy during a pandemic with a target population where more than 50% do not have devices and many require internet requires a significant investment of staff resources and logistical coordination to overcome. IT direct tech support would have dramatically enhanced efficiency of Help@Hand staff, allowing them to focus on program logistics rather than technical aspects of the project, such as configuring devices and establishing G-mail accounts. • Establishing tech accounts on behalf of participants requires careful consideration and legal agreements that would be enhanced/ simplified with coordinated tech support – Google Work Space • County systems are not accustomed to flexibly responding to technology needs of residents – how do we design systems from an equity lens when it involves purchasing equipment for residents or supporting internet? Payment systems don't align with program needs. • Partnerships are key to add capacity needed to reach isolated populations • Outreach for individuals who are isolated and monolingual speakers require targeted strategies – finding the partners who know where they are in the community; for Spanish Speaking population, despite multiple outreach strategies, the only one that led to participants enrolling were through Promotores who are out talking to people (YouTube, texts with IHSS and other strategies did not yield results). For English Speakers, 2 CBOs identified all participants in a very short period of time. Knowing the target audience was critical. • Defining "Isolation" is a complex concept to define in a pandemic and cultural considerations need to be considered • Use of University interns to work in small County is key to providing a labor force to engage isolate populations where Peer workforce is part time – if population had tech experience, project would be tremendously simplified (majority of resource intensity is onboarding participants to tech so that they can use an app/device) • Balancing varying system requirements of multiple partners is time intensive (e.g., onboarding interns, compliance, legal, training). Being clear on where decision making resides up front is important. • Collaborating across multiple agencies (7 County Departments-- IT, Compliance, HR Volunteer Coord., County Counsel, Aging and Adult Services, BHRS, Fiscal; two CBOs- Tech4Life and West Marin Senior Services; Two Universities, CalMHSA and UCI as well as Promotores requires lots of planning, coordination and communication; deadlines need to factor in the needs of multiple partners and approval processes. • Multiple legal agreements were required to onboard participants, involving remote acceptance of Google Terms and Privacy Policies, Help@Hand Participation Agreements and Device Use Agreements, all of which needed combinations of IT, Compliance and County Counsel approval. • Using data to find out where your population resides (Census and other key agencies like IHSS was key).			

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Marin County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Lessons Learned	• The field of digital behavioral health appears to not have experience responding in depth to issues of language and culture. Products are rolled out to Spanish Speakers are lacking in some critical areas. • Flexibility and creativity of research team were instrumental in influencing project design and in supporting data gathering for populations that are unable to access technology on the front -end. • New limitations of Spanish functionality of myStrength identified (no privacy practices or terms of service in Spanish) • Logistics of reaching older adults in Covid are complex – how to get sign off on release of information for those with no digital literacy? • Reaching the Spanish Speaking population requires more individualized approach – traditional flyers are not enough; one-on-one communication and outreach is necessary • County system not experienced/designed to administratively do things like pay for internet (limited-term for pilot) Processes need to be memorialized. • Only two nurse interns speak Spanish, leaving staffing challenges to work with those participants who need assistance in Spanish			
Recommendations	• Since additional IT support is necessary, establishing a technical support agreement with HHS IT and/or budgeting for and bringing on contracted IT support would help to accommodate project support needs. • Design future project timelines and goals to align better with staffing structure.			

Modoc County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Rhonda Bandy, PhD	• Rhonda Bandy, PhD	• Rhonda Bandy, PhD	• Rhonda Bandy, PhD
Implementation Site	• Modoc County Behavioral Health (MCBH)	• Modoc County Behavioral Health (MCBH)	• Modoc County Behavioral Health (MCBH)	• Modoc County Behavioral Health (MCBH)
Team Composition	• MCBH Branch Director, MCBH MHSA Coordinator, Behavioral Health Specialist	• MCBH Branch Director, MCBH MHSA Coordinator, Behavioral Health Specialist	• MCBH Branch Director, MCBH MHSA Coordinator, Behavioral Health Specialist, Peers, Health Services IT	• MCBH Branch Director, MCBH MHSA Coordinator, Behavioral Health Specialist, Peers, Health Services IT
Target Audience	• Current clients • County residents	• Current clients • County residents	• Current clients • County residents	• Current clients • County residents
Products in Use/Planned	• DBT Diary Cards from Mindstrong (tentative) • Apps vetted by other Counties that Modoc chooses off the bench (planned)	• Apps vetted by other Counties that Modoc chooses off the bench (planned)	• Waiting for apps vetted by other Counties that Modoc will choose off the bench • Appy Hours training is beginning to be translated into Spanish by local peer due to process taking too long through H@H administrative coordination. If the translation arrives before we are finished, we'll be happy to use it, especially since we are paying money through the collaborative for the translation	• None
Implementation Approach	• None until apps available on bench • Starting up Appy Hours for Digital Literacy Training in preparation for app implementation	• None until apps available on bench • Appy Hours for Digital Literacy Training on hold due to COVID-19 in preparation for app implementation	• None, stakeholders expressing impatience • Appy Hours for Digital Literacy Training on hold due to COVID-19	• None
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Phones not offered until apps are implemented	• Phones not offered until apps are implemented	• None	• None
Milestones	• Developed Appy Hours	• None this quarter due to COVID-19	• None, can't move forward until all paperwork is completed by other counties and approved by CalMHSA and H@H Leadership	• Gave notice to exit from H@H April 7, 2021.
Lessons Learned	• Stakeholder's patience has limits, especially when they view an INN as an expensive endeavor and are not seeing any tangible benefits.			
Recommendations	• Unencumber the app pilot processes so change can happen. Address leadership issues at CalMHSA. Finalize contracts around budgetary items, such as evaluation, etc.			

Mono County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Amanda Greenberg, MPH • Stephany Valadez	• Amanda Greenberg, MPH • Stephany Valadez	• Amanda Greenberg, MPH • Stephany Valadez	• Amanda Greenberg, MPH • Stephany Valadez
Implementation Site	• TBD	• TBD	• TBD	• TBD
Team Composition	• Behavioral Health Program Manager, Behavioral Health Services Coordinator	• Behavioral Health Program Manager, Behavioral Health Services Coordinator	• Behavioral Health Program Manager, Behavioral Health Services Coordinator	• Behavioral Health Program Manager, Behavioral Health Services Coordinator
Target Audience	• Individuals in remote, isolated areas of the County who have less access to social support and mental health services • Students attending Cerro Coso Community College in Mammoth Lakes	• Individuals in remote, isolated areas of the County who have less access to social support and mental health services • Students attending Cerro Coso Community College in Mammoth Lakes	• Individuals in remote, isolated areas of the County who have less access to social support and mental health services • Students attending Cerro Coso Community College in Mammoth Lakes	• Individuals in remote, isolated areas of the County who have less access to social support and mental health services • Students attending Cerro Coso Community College in Mammoth Lakes
Products in Use/Planned	• TBD (awaiting larger County/City pilots to be completed)	• TBD (awaiting larger county/city pilots to be completed)	• TBD (awaiting larger county/city pilots to be completed)	• TBD (awaiting larger county/city pilots to be completed)
Implementation Approach	• TBD (awaiting larger County/City pilots to be completed)	• TBD (awaiting larger county/city pilots to be completed)	• TBD (awaiting larger county/city pilots to be completed)	• TBD – considering "ready-made", out of the box, implementation specific products
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Mono County is very small, remote and rural, so we will have some challenges around implementation in our outlying areas	• Mono County is very small, remote and rural, so we will have some challenges around implementation in our outlying areas	• Mono County is very small, remote and rural, so we will have some challenges around implementation in our outlying areas	• Mono County is very small, remote and rural, so we will have some challenges around implementation in our outlying areas
Milestones	• Awaiting pilots	• Awaiting pilots	• Awaiting pilots • Peer Lead assigned to Project	• Awaiting pilots
Lessons Learned	• As a small county, MCBH asks staff to wear many different hats. One of the lessons learned from being part of this collaborative and other Innovation projects is that MCBH needs to ensure that staff assigned to lead certain projects have the capacity to do so. If they do not, then MCBH needs to consider what other staffing/consultants may be needed to take the project forward			
Recommendations	• We appreciate the move toward "ready made" apps.			

Monterey County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Wesley Schweikhard	• Same as Q1	• Same as Q1	• Same as Q1
Implementation Site	• Family Member / Friend of an Individual that Experiences a Mental Health Disorder • Individual entering Mental Health Clinic • Community Service Provider conducting outreach activities	• Same as Q1	• Same as Q1	• Same as Q1
Team Composition	• Behavioral Health Director, Tech Lead, Subject Matter Experts (Legal, IT)	• Same as Q1	• New Interim Behavioral Health Director (Lucero Robles)	• Jon Drake, Asst Bureau Chief assisting with procurement process
Target Audience	• Adults • Monolingual Spanish adults	• Same as Q1	• Same as Q1	• Same as Q1
Products in Use/Planned	• Custom build behavioral health screening tool (planned)	• Same as Q1	• Same as Q1	• Same as Q1
Implementation Approach	• Not Applicable	• Not applicable; Focus is on custom development vendor procurement	• Not applicable; Focus is on custom development vendor procurement	• Not applicable; Focus is on custom development vendor procurement
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Developing a custom build product instead of an existing product	• Same as Q1	• Same as Q1	• Same as Q1
Milestones	• Developed and release Request for Information (RFI) requesting feedback from vendor community on development of peer chat screening tool • Began to analyze RFI results	• Completed analysis of RFI results • Began to develop Request for Proposals (RFP), which was informed by RFI results • Began recruiting RFP review panel to include peers/stakeholders, clinical experts, and technology experts	• Same as Q2. RFP release stalled as CalMHSA identifies new county partners to join project. Additional steps also need to be taken to clarify roles and responsibilities of the county, CalMHSA, and vendors during the design/build and implementation phases of the project.	• RFP Released!
Lessons Learned	• County behavioral health staff are generally not familiar with development of technology products. Could have used education on the iterative process from the onset, as the county lacks staff support to monitor/approve the breadth and frequency of deliverables involved.			
Recommendations				

Orange County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT
Implementation Site	• UCI Medical Center • OC Community Colleges (initial communications begun to explore interest and feasibility of being implementation sites)	• UCI Medical Center • Community Colleges implementation delayed • Re-started conversations with County-operated programs (PACT, esp. CYBH) about MS implementation	• UCI Medical Center • Continued conversations with County-operated programs (Adult Mental Health) about feasibility of MS implementation • Explored opportunities for MS expansion	• UCI Medical Center • Determined County-operated programs (Adult Mental Health) may not be feasible at this time • Re-started internal discussions about feasibility of MS implementation in Community Colleges • Explored opportunities for MS expansion
Team Composition	• Peer Lead, 2 Peers, Compliance, PIO, AQIS, Cambria (3.5 FTE) to support Mindstrong Launch	• Peer Lead, 2 Peers, Compliance, PIO, AQIS, Cambria (2.5 FTE) to support Mindstrong Launch; 2 HCA INN Staff to support Informed Consent process; re-initiation of discussions with County managers to determine interest in MS (modified model) for their programs	• Peer Lead, 2 Peers, Compliance, Cambria (2.5 FTE) to support Mindstrong implementation; 2 HCA INN Staff to support Informed Consent process • Engaged new vendor, Charitable Ventures for marketing collateral and website	• Peer Lead, 2 Peers, Compliance, Cambria (2.5 FTE) to support Mindstrong implementation; 2 HCA INN Staff to support Informed Consent process, Charitable Ventures to support marketing collateral and website updates
Target Audience	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder • Anxiety disorders, substance use disorders or other co-occurring diagnoses are ok • May have a history of psychiatric hospitalization and/or 1+ crisis evaluations within last 12 months • Device eligibility: owns a smartphone with unlimited data, talk and text • May be expanded depending on research on Lifeline phones and Mindstrong data usage	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder • Anxiety disorders, substance use disorders or other co-occurring diagnoses are ok • May have a history of psychiatric hospitalization and/or 1+ crisis evaluations within last 12 months • Device eligibility: owns a smartphone with unlimited data, talk and text • May be expanded depending on research on Lifeline phones and Mindstrong data usage	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder • Co-occurring anxiety disorders, substance use disorders or other secondary diagnoses are ok as long as a qualifying diagnosis is present • Use of a smartphone (Android 6/iOS 11 or newer) • Internet access: Wi-Fi at home, work, school and/or cellular data plan • Primary user of their smartphone device • Does not currently have a psychotherapist Exclusion Criteria: • Consistent attendance at scheduled psychotherapy sessions provided by a licensed MFT/LCSW/LPCC or intern, or license-waivered clinician • Client only receiving non-clinical ancillary supports (i.e., case management, peer support, housing support, etc.) is **NOT** excluded from this program May be expanded depending on research on Lifeline phones and Mindstrong data usage	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder, Post Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD) • Co-occurring anxiety disorders, substance use disorders or other secondary diagnoses are ok as long as a qualifying diagnosis is present • Use of a smartphone (Android 6/iOS 11 or newer) • Internet access: Wi-Fi at home, work, school and/or cellular data plan • Primary user of their smartphone device Exclusion Criteria: • Does not currently have a psychotherapist • Consistent attendance at scheduled psychotherapy sessions provided by a licensed MFT/LCSW/LPCC or intern, or license-waivered clinician • Client only receiving non-clinical ancillary supports (i.e., case management, peer support, housing support, etc.) is NOT excluded from this program Mindstrong is continuing to explore the expansion of qualifying diagnoses
Products in Use/Planned	• Mindstrong Crisis Prevention Services (Planned)	• Mindstrong Crisis Prevention Services (In Use as part of soft launch)	• Mindstrong Crisis Prevention Services (In Use as part of soft launch)	• Mindstrong Health
Implementation Approach	• Mindstrong (Not in use yet)	• Mindstrong launched May 14, 2020	• Expanded Mindstrong referring providers at UCI Medical Outpatient Psychiatry to include residents • Revisited Mindstrong eligibility criteria to ensure appropriate referrals (i.e., clarified qualifying diagnoses; defined psychotherapist/psychotherapy)	• Started discussions on how to move to a broader marketing approach rather than a case by case referral • Developed digital consent videos to automate HCA informed consent process

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Orange County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
			• Updated HCA Informed Consent document to address Apple/Android privacy alerts • Continued discussions on clarity of continuity of care • Increased emphasis on sustainability planning • UCI Evaluation initiated interviews with referring providers and shared results recommendations with HCA • Several provider recommendations were implemented to improve and streamline the referral process • Established necessary activities to allow Peers to conduct outreach to complete consumer informed consent (smartphone, BAA's, secure emails, FTP site) • Conducted provider training to support full deployment to UCI Psychiatry • OC Peer developed Mindstrong consumer information sheet	• Created an eligibility and referral guide to help providers with referral process • Created physical outreach materials (postcard) to be used when referring providers want to share Mindstrong information with consumers • UCI Evaluation conducted interviews with referring providers and consumers to gather their feedback and perspectives on the referral process and to identify potential areas for improvement • Increased Peer involvement through participation in tech lead calls and development of outreach materials (brochures, flyers, MS video, FAQs)
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Serving individuals regardless of insurance type/status • Creating plan to pilot/test Lifeline phones • Extensive conversations and iterative refinement around informed consent process involving project team, compliance, Peers, UCI Medical, Mindstrong and video production company; including digitization of consent form and creating companion video/audio	• Proposal for Mobile Innovation and Lifeline Testing going through community planning	• Continuous assessment and adjustment of the rapid deployment response	• Evaluated referral flow and numbers and adjusted the process for improvements • Started discussions on feasibility of expanding Mindstrong to different target populations and programs
Milestones	Mindstrong: • Tentative pilot launch at UCI Medical Center in Spring 2020 (depending on impact of COVID-19 public health emergency response) • Implementation planning for Community Colleges, with preliminary soft pilot launch in Fall 2020 (possibly sooner in response to increased need for telehealth support due to impact of COVID-19 on school closures)	• Launched Mindstrong with UCI Medical Outpatient Psychiatry on 5/14/2020 • As of June 30, 2020 (end of Q2) UCI MC/Psychiatry referral statistics indicate: o 2 Referring providers o 16 consumers referred o 10 completed Mindstrong enrollments o 4 consumers could not be contacted by HCA-INN to complete Informed consent. o 2 consumers in-process	• Fully launched at UCI Psychiatry on 9/16/2020 • Streamlined Mindstrong training referral process using an Epic referral order • Contracted with marketing vendor (through CalMHSA) to convert informed consent into video format, convert trifold brochures into webpages and update OC Help@Hand webpages • Referral Statistics provided below table	• Trained Peers in referral/consent process • Began process for converting informed consent into digital format
Lessons Learned	• Communication with vendors, checking in to ensure information, terminology, messaging, and shared vision is accurate and determine appropriate data sharing is transparent • Risk, liability, legal counsel, and crisis response protocols are critical elements to the project and must remain an ongoing priority throughout implementation • Consumers and providers need easy access to County-specific and Help@Hand project information to learn about the product and what to expect • Identify and maintain strategies for effective, transparent communication and decision-making throughout implementation			
Recommendations	• Collaborate and prepare early with key stakeholders to support alignment in approaches, definitions, terminology, etc. and continuously revisit throughout implementation or when considering program expansion • Involve various subject matter experts (compliance, legal, fiscal, contracts, etc.) to support all stages of project implementation • Develop a streamlined process for training providers and project staff about the product to support consistency in communication about the product and with eligible consumers • Maintain ongoing and transparent communication between all project partners • Determine data access and ownership prior to execution of contracts • Actively engage Peers in all project activities • Maintain adaptable strategies and workplans; anticipate shifts and be flexible and prepared for changes • To the extent possible, maintain consistency in project staff for historical knowledge and continuity • Utilize parallel workstreams to more efficiently accomplish project activities			

Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	Maria Martha Moreno, MS CIS	Maria Martha Moreno, MS CIS	Maria Martha Moreno, MS CIS	Maria Martha Moreno, MS CIS
Implementation Site	• Transitional Age Youth Drop-In Centers (in Mid-County, Desert and Western Regions)	• Riverside County Community, Transitional Age Youth Drop-In Centers (in Mid-County, Desert and Western Regions)	• TakemyHand Live Peer Chat: Riverside County Community Transitional Age Youth (TAY) Drop-In Centers (in Mid-County, Desert and Western Regions), Deaf and Hard of Hearing • A4i or FOCUS: TAY, Adult and Older Adult SMI/ FSP Focus Participants from Western, Desert and Mid-County • Custom App or Existing App (TBD): Deaf and Hard of Hearing.	• TakemyHand Live Peer Chat: Riverside County Community Transitional Age Youth (TAY) Drop-In Centers (in Mid-County, Desert and Western Regions), Deaf and Hard of Hearing • A4i or FOCUS: TAY, Adult and Older Adult SMI/ FSP Focus Participants from Western, Desert and Mid-County • Custom App or Existing App (TBD): Deaf and Hard of Hearing. CODIE Representative team
Team Composition	• Peer Manager, Senior Peer, Peers, Clinical Supervisor, CODIE Representative, crisis intervention Clinicians, Application Developer, Technology Lead	• Peer Manager, Senior Peer, Peers, CODIE Representative, crisis intervention Clinicians, Application Developer, Technology Lead	**Leadership** Mathew Chang, Director Amy McCann, Assistant Director Brandon Jacobs, Deputy Director Research & Quality David Schoelen, MHSA Administrator **IT** Tura Morice, Chief Information Officer Jimmy Tran, Chief Information Security Officer Robert Watson, IT System Administrator **Compliance Officer** Ashley Trevino-Kwong, Compliance Officer **Senior Public Information Specialist** Thomas Peterson **Consumer Affairs Manager** Shannon McCleerey-Hooper **Senior Peer:** Pamela Norton **Peers:** Dakota Brown, Melissa Vasquez, Peter Kiriakos, Rhonda Taiwo, Carmela Gonzalez-Soto. **Social Media:** Dylan Colt Robert Youssef **Senior Clinical Therapist II** Amenze Ogbebor - In recruitment process Evaluation: Suzanna Juarez-Williamson, Supervisor Christy Mota, Research Specialist II.	**Leadership** Mathew Chang, Director Amy McCann, Assistant Director Brandon Jacobs, Deputy Director Research & Quality David Schoelen, MHSA Administrator **IT** Tura Morice, Chief Information Officer Jimmy Tran, Chief Information Security Officer Robert Watson, IT System Administrator **Compliance Officer** Ashley Trevino-Kwong, Compliance Officer **Senior Public Information Specialist** Thomas Peterson **Consumer Affairs Manager** Shannon McCleerey-Hooper **Senior Peer:** Pamela Norton **Peers:** Dakota Brown, Melissa Vasquez, Peter Kiriakos, Rhonda Taiwo, Carmela Gonzalez-Soto. **Social Media:** Dylan Colt Robert Youssef **Senior Clinical Therapist II** Amenze Ogbebor - In recruitment process Evaluation: Suzanna Juarez-Williamson, Supervisor Christy Mota, Research Specialist II.

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Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
			Application Developer: Rick Wright **Administrative Svc Analyst:** Ursula Lewis **CODIE Representatives:** Gloria Moriarty Lisa Price **Cultural Competency** Tonica Robinson, Manager Consulting Cultural Outreach & Education Workforce	**Application Developer:** Rick Wright **Administrative Svc Analyst:** Ursula Lewis **CODIE Representatives:** Gloria Moriarty Lisa Price **Cultural Competency** Tonica Robinson, Manager Consulting Cultural Outreach & Education Workforce
Target Audience	• Higher Risk Populations (i.e., first onset, re-entry, FSP consumers, eating disorders, suicide prevention) • Traditionally Underserved Communities (i.e., Hispanic/Latino, American Indian, African American, Asian-Pacific Islander, LGBTQ, deaf and hard of hearing) • Geographic service barriers to rural and frontier communities • Hearing and visually impaired communities	**Early Detection:** TAY Suicide Prevention: Men over the age of 45, Adults over the age of 65, TAY **Improve Outcomes for High Risk Populations:** Re-entry Consumers, FSP Consumers, Eating Disorder Consumers **Improve Service Access to Underserved Communities and for Rural Regions:** Deaf and Hard of Hearing, Visually Impaired, Mid-County & Desert Regions, Ethnic Cultural & LGBT communities.	**Early Detection:** TAY ***Suicide Prevention:*** Men over the age of 45, Adults over the age of 65, TAY Improve Outcomes for High Risk Populations: Re-entry Consumers, FSP Consumers, Eating Disorder Consumers ***Improve Service Access to Underserved Communities and for Rural Regions:*** Deaf and Hard of Hearing, Visually Impaired, Mid-County & Desert Regions, Ethnic Cultural & LGBT communities.	**Early Detection:** TAY ***Suicide Prevention:*** Men over the age of 45, Adults over the age of 65, TAY Improve Outcomes for High Risk Populations: Re-entry Consumers, FSP Consumers, Eating Disorder Consumers ***Improve Service Access to Underserved Communities and for Rural Regions:*** Deaf and Hard of Hearing, Visually Impaired, Mid-County & Desert Regions, Ethnic Cultural & LGBT communities.
Products in Use/Planned	• Take My Hand Peer Chat	TakemyHand Peer Chat, A4i, Focus, SageSurfer ManTherapy, FEEL Wearable, custom development for the Deaf and Hard of Hearing community.	TakemyHand Peer Chat, A4i, Focus, Custom development or existing app for the Deaf and Hard of Hearing community, SageSurfer ManTherapy, FEEL Wearable.	TakemyHand Peer Chat, A4i, Custom development or existing app for the Deaf and Hard of Hearing community, SageSurfer ManTherapy, FEEL Wearable, myStrength.
Implementation Approach	• The Take My Hand site will be live during set hours and managed by trained/certified Peer Operators (COVID-19 response)	• Takemyhand Peer chat is available to the Riverside community and promoted within the department via county emails, committees, social media, newsletters, etc. • Currently planning for focus groups with stakeholders, recruitment of consumers in app pilot selection process with three different Full-Service Partnership clinics (Desert, West and Mid-County regions).	• Takemyhand Peer chat is available to the Riverside community and promoted within the department via county emails, committees, social media, newsletters, etc. • Currently planning for focus groups with stakeholders, to guide the selection of additional apps for piloting. The stakeholders are under recruitment among consumers in three different Full-Service Partnership programs (Desert, West and Mid-County regions) and may include youth at the TAY centers.	• Takemyhand Peer chat is available to the Riverside community and promoted within the department via county emails, committees, social media, newsletters, etc. • Pilot A4i - Consumers in Full-Service Partnership programs (Desert, West and Mid-County regions) • Phase 1 Takemyhand Peer chat Transitional Age Youth. • DMHL – Painted Brain, Senior Peer Support Specialists and regional ambassadors' department-wide.
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Piloting own in-house product • Make Peers available on the app 24/7 (Planned) • The peer chat is based on the peer model and people will communicate with a real person; not Artificial Intelligence • Chat is anonymous and does not collect and/or store PII or PHI	Outreach and Education/Training provided by Peer Manager, Senior Peer, Peers, Supervising CT and Tech Lead. Regular collaboration feedback/updates to stakeholders committees/Meetings: Adult System of Care Committee, Behavioral Health Commission, Housing Committee, Cultural Competency Reducing Disparities, Committee, Older Adults System of Care Committee, Riverside Resilience	Outreach and Education/Training provided by Peer Manager, Senior Peer, Peers, Tech Lead. Regular collaboration feedback/updates to stakeholders Committees/Meetings: • FSP Committee – Melissa, Dakota, Martha • Adult System of Care Committee – Melissa • Behavioral Health Commission – Martha, Pamela, Melissa • Center on Deafness Inland Empire – Dakota	Outreach and Education/Training provided by Peer Manager, Senior Peer, Peers, Tech Lead. Regular collaboration feedback/updates to stakeholders Committees/Meetings: • FSP Committee – Melissa, Dakota, Martha • Adult System of Care Committee – Melissa • Behavioral Health Commission – Martha, Pamela, Melissa • Center on Deafness Inland Empire – Dakota

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Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
		community, TAY Collaborative– Desert, Mid, and Western, IEHP **Plan to collaborate:** Children's Committee meetings Criminal Justice Committee Desert Regional Board Eating Disorder Collaborative Inland Empire Kindness Campaign Mid County Regional Board Model Deaf Community Committee NAMI San Jacinto Promotores Asian American Task Force LGBT PEI Specialized Ethnic Community Initiatives programs	• Children's Committee – Melissa • Cultural Competency Reducing Disparities Committee – Martha, Pamela Melissa • Desert Regional Board meetings – Dakota • Eating Disorder Collaborative meetings – Dakota • Legislative Committee – Melissa • Mid County Regional Board meetings – Melissa • Model Deaf Community Committee – Dakota, Pamela, Martha, Shannon • NAMI San Jacinto meetings – Martha • Older Adults System of Care Committee – Dakota • TAY Collaborative meetings: Desert, Mid, and Western – Melissa, Dakota • Housing Committee – Dakota • Veterans Committee – Dakota • Riverside Resilience community meetings – TBD • May is Mental Health Month Fairs- Western & Mid County – TBD • Criminal Justice Committee – TBD • Inland Empire Kindness Campaign meetings – TBD	• Children's Committee – Melissa • Cultural Competency Reducing Disparities Committee – Martha, Pamela Melissa • Desert Regional Board meetings – Dakota • Eating Disorder Collaborative meetings – Dakota • Legislative Committee – Melissa • Mid County Regional Board meetings – Melissa • Model Deaf Community Committee – Dakota, Pamela, Martha, Shannon • NAMI San Jacinto meetings – Martha • Older Adults System of Care Committee – Dakota • TAY Collaborative meetings: Desert, Mid, and Western – Melissa, Dakota • Housing Committee – Dakota • Veterans Committee – Dakota • Riverside Resilience community meetings – TBD • May is Mental Health Month Fairs- Western & Mid County – TBD • Criminal Justice Committee – TBD • Inland Empire Kindness Campaign meetings – TBD
Milestones	**Compliance:** • Terms of Service – Approved by Riverside Help@Hand team (Technical lead, Clinical lead, Peer lead, Senior Peer, Evaluation Supervisor), HIPAA Compliance Officer and County Counsel • Chat engine software (LiveChatInc) approved by County IT, Department IT, HIPAA Compliance Officer, and Executive Team **Technical:** • Completed chat platform • Accomplished user testing for prototype on two different occasions and feedback was provided • Developed app to be able to identify a crisis situation and transfer chat to CT (a professional with specialized training) • Defined and set useful chat tags for reporting purposes (in various operators groups) • Made site searchable by Google • Made Live Chat Security HIPAA-compliant by disabling the ability to email a chat transcript, the ability to send files (Peer Opera- tor/Visitors), hiding chat history from visitors, inactivity timeouts, etc. • Made Operator passwords are managed by Take my Hand site administrators • Made authentication via LiveChat (no IP restriction) • Chat routing manual (visitors are picked from the queue) • Useful Links on Take my Hand website (i.e., Resources, Terms of Service)	**Technical:** • Defined and set useful chat tags for reporting purposes (in various Peer Operators groups) • Made TMH website searchable by Google • Management of Peer Operator user accounts and passwords • Authentication via LiveChat (no IP restriction) • Configuration of chat routing manual (visitors are picked from the queue) • Multiple Changes in Pre-Post, crisis and 1st time visitors (English/Spanish) Chat online surveys • Peer Operators TMH groups (Riverside, Riverside Crisis, Riverside 1st time visitors, Riverside Spanish, Riverside Spanish 1st time visitors) setup and configuration • April 27 through May 27, 2020- Website Visits 94,861, Unique TMH Website Visitors: 2,867 • June 5th through July 5th - Website Visits 63,355, Unique TMH Website Visitors: 2,963. • Website Metrics – need to license the software to be able to report on entire testing period. • Identified technical functionality to tag "trolls", inappropriate language chat users, and ability to ban users via the Ban User button • Complexity of the data files Structure of chats statistics files • Create and post Cookie Policy ((English/Spanish) • Notice of Privacy Practices (posted) • Frequently Asked questions webpage • Images management	**Pilot Needs Assessment Planning/Implementation Activities:** Deaf and Hard of Hearing Needs Assessment session 1 completed. Deaf and Hard of Hearing Community Survey planning initiated. **Personnel:** • Peer Recruitment - 3 new Peer trainees - Completed • Sr. CT Recruitment - 1 - Completed **Technical:** • TakemyHand Website Content Management system (FAQs, Resources, widgets, etc.) – WIP • TakemyHand Sandbox website/Chat engine. Successful tested video, language translator, chatbot and rich language chat content • TechSuite Electronic Health Records new service codes for staff time accounting **Marketing:** TakemyHand Promotional videos • TakemyHand Quick Info: https://www.youtube.com/watch?v=kweG5pZBndA • Dakota: https://www.youtube.com/watch?v=TJD-j4YuoKM&feature=youtu.be • Melissa: https://www.youtube.com/watch?v=Hq-jf8sHaYq8&feature=youtu.be	**Target Area:** Improve Service Access to Underserved Communities Population: Deaf and Hard of Hearing • Focus Group - CODIE Members • Needs Community Assessment Survey • Contract Justification Completed with Sorenson for Services (Adaptation of the 10 DMHL Videos, Curriculum, Community Survey, TMH Peer Operator training, TMH Terms of Service) • Deaf and Hard of Hearing (Focus Group) Needs Assessment Learning Update Report (UCI) **Technology**: • Mobile Devices/Kiosks - Contract Justification Completed • Procurement of 400 devices (100 iPads, 100 iPhones, 100 Galaxy Tab A, 100 Android Phones) - completed • IT Services and Support - Contract Justification Completed • SOW Jaguar Computer Systems -Reviewed/Completed • Contract IT Services & Support -Jaguar - Initiated • GIM - Kiosk procurement Process- 32 small kiosks, 7 (55") Large kiosks - Initiated • Kiosk Uses/Features Summary **Take my Hand Peer Chat** **Target Area:** Improve Service Access to Underserved Communities

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Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
	• Website content is 90 percent complete in English • Website loads testing reports (test 3 response times TakeMyHand.com, test 3 transaction throughout TakeMyHand.com) • Creating website content in Spanish (in process) • Cookie Policy (in process) **Training:** • Developed training materials for Peer Operators (Peer Operator training checklist, training for COVID-19, facilitator's manual for COVID-19, Peer Operator, training PPT script only, print-up manual for Peer Operator COVID-19). This includes a module on strategies to deal with "trolls", inappropriate language and situational challenges from malicious participants. • Scenario role-plays and a brainstorming solution session is included • Provided protocols for risk assessment and crisis protocols (Risk assessment, Questions-to-Assess-Suicide-Risk Handout, Essential Workers Support Line Protocol and Procedure) • Consumer resources; Riverside Free App guides (English/Spanish), County Resources (Resources Quick Link on Take my Hand website). • Quick list of crisis phone numbers, MS Teams, email, phone, etc. for internal communications among chat operators • Chat coverage work schedules • Identified protocols for tagging "trolls", inappropriate language chat users, and ability to ban users via the Ban User button • Canned responses • Established work hours • Developed strategy to deal with trolls and visitors using inappropriate language by banning them • Developed pre chat survey, post chat survey, post crisis chat survey, and first time visitors post chat survey **Marketing:** • Done by word of mouth, via a banner on the department website, and video presentation of product on departments' Facebook, YouTube page, etc. • Have internal department and stakeholders' newsletter (in process) **Evaluation:** • Developed internal evaluation plan (Evaluation Plan Tech Suite; Surveys (User Survey – post chat survey for participants in English/Spanish, After X number of chats – User Survey (Usability) in English/Spanish, Peer User Operator Survey, Clinician Operator Survey, Innovation Demographics in English/Spanish)	• Website design, development and content management took place as we implemented the test phase. • Website Spanish translations and design of the TakemyHand was implemented three weeks into the testing phase • Define useful Links on Take my Hand website (i.e., Resources, FAQs, Privacy Practices, Terms of Service, About Us, etc.) • Manage website content (English/Spanish) • Design of dynamic widgets (English/Spanish) • Design of content management website tool • TMH Website Load Testing Reports -Response times/Transaction throughout • TMH Capacity Framing –Full scale testing- scales automatically based on volume, performance improved to 1,000 entries requests per second. • 2-Tiers – Chat features in LiveChat engine –AWS/Web hosted Whois. • ELMR setup/training: special population /scheduling calendar site, service codes, staff member hours and exceptions • Export of chat data files: Total chats, Peer Operators Performance, chat duration, chat rating, chat availability, chat engagement, chat response time, missed chats, tags usage, chat waiting time, chat abandonment, pre and post chat surveys for all groups (English/Spanish, 1st time visitors, & crisis) **Marketing:** • All Hands on Deck Newsletters • ChatVox Weekly Bulletin for Operators • TakemyHand One Page Conversation Handouts for Clinics/Consumers • YouTube TakemyHand Promotional videos o Shannon McCleerey-Hooper: https://youtu.be/UZXfnqoX-2E o Shannon McCleerey-Hooper: https://youtu.be/tb9ilc26oPg o Maria Martha Moreno: https://youtu.be/9Ht94xAPNdc o Pamela Norton: https://losangeles.cbslocal.com/video/program/1430/4540496-web-site-provides-mental-health-support/ **Training:** Training Materials were adjusted/improved as the needed. **Peer Operators:** • One-on-One Virtual Peer Chat: A Training Manual for Peer Operators	• Alex: https://www.youtube.com/watch?v=G5e0MnRJLxs&feature=youtu.be **Training Materials:** TakemyHand Peer Chat • Getting up to speed on Rise & Storyline (trainings) and training Peers in other departments • Brainstorming out-of-the-box engagement strategies and "how to make recovery irresistible" • Create & deliver Storyline TakemyHand A.I. Waiting Room presentation "Waiting for a Peer Chat Operator: The Consumer Experience" • Update promotional materials to reflect new, shorter, TakemyHand Operator Hours • Resources Materials (Peter) *Deaf and Hard of Hearing* • Create & deliver Storyline Deaf/HOH app presentation, "Gloria Possibilities" • Resources Information Gathering (Carmela) *Digital Mental Health Literacy* • Digital FootPrints: https://360.articulate.com/review/content/d9535ce9-49c6-4c67-a07d-17ea85f8cca7/review • Adapting DMHL to virtual presentation (part 1 approaching completion; part 2 will be next quarter) • Create QR Code narrated PowerPoint module for DMHL *Other Training* • Testing out the Focus & A4i apps via test accounts • Continuing to crawl the internet for new MH apps and setting up test accounts with likely candidates • Update Free app guide to delete Freemium apps and insert new free ones, like "UCLA Mindful" • A4i vs. FOCUS in preparation for focus group PowerPoint presentation: https://rise.articulate.com/share/lddMB6DGaUkNb0E69oH9gTB3Z-kF5ZB3K#/lessons/t7aUhQftE6UKROMRfiZX-g9y_W__Wwf1S **Peer Manager Report finalized and shared.** The report shares the key players, the steps taken and the lessons learned as Riverside University Health System-Behavioral Health (RUHS-BH) worked to rapidly deploy the test phase of the first, ever, live, one-on-one Peer Support web-based chat platform, in response to the COVID-19 pandemic. **EVALUATION:** *Evaluation of TakemyHand testing phase report finalized and shared.*	**Population:** Deaf and Hard of Hearing, Mid-County & Desert Regions, Ethnic Cultural and LGBT • Take my Hand Peer Chat Operation 8 am to 5 pm Monday through Friday • Fulfilled and Implemented Crisis CT Role for Take my Hand • Resources Document List • Take my Hand Peer Operator Online USER GUIDE • Take my Hand INFOGRAPHICS • Take my Hand INFOGRAPHICS - LGBT • Take my Hand WIREFRAME • Take my Hand Security Questions (TMH Website & LIVECHAT Inc.) • Initiated TMH Service Mark (Trademark process) - Initiated process • Peer Operator Training completed for 4 new Peer Support Specialists/One Clinical Therapist • TechSuite Electronic Health Records new service codes for staff time accounting.- add new as needed • IEHP County Programs Liaison I Behavioral Health and Care Management Department- Arlene Ferrer • Take my Hand Newsletter No. 3 December 2020 • Convo Take My Hand flier - English • Convo Take My Hand flier - Spanish • RUHS Social Media - Facebook/Instagram • Peer Staff Development (ongoing) • Coping skills Resource Binder per Topic (WIP) • Articulate tool training to create presentations • Searchable spreadsheet for our resource list (WIP) • Identified need to create fuller Peer/CT Operator Training for TMH. (WIP) • Identified need to train Peer Team regarding emotional response and effective communication in text (WIP) • Help@Hand Learning Brief Riverside County Take My Hand **A4i/FOCUS** **Target Area:** Improve Outcomes for High Risk Populations. **Population:** FSP Consumers" A4i and FOCUS -Four Focus Groups (FSP, TAY, Adult, Older Adult) - 22 consumer participants • Tested & Explored A4i and FOCUS apps • Focus Group -fliers • Focus Group Recruitment Activities • Apps Focus Groups Presentation - Distributed and presented Executive Team/Managers/Supervisors • A4i vs FOCUS Articulate online presentation • Recruit and Assist with Focus Group Registration Process

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Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
		• Creating a Conversation: Addressing Distress in Peer Support • Open-ended Questions Quick Reference Handout • TMH Facilitator's Manual for Peer Ops COVID • TMH Peer Operator CheckList • Crisis Clinical Staff • Crisis SoC Protocols - Community Response Triage TMH • Essential Workers Support Line Protocol and Procedure TMH **Peer Manager Report:** The report will share the key players, the steps taken and the lessons learned as Riverside University Health System-Behavioral Health (RUHS-BH) worked to rapidly deploy the test phase of the first, ever, live, one-on-one Peer Support web-based chat platform, in response to the COVID-19 pandemic. **Evaluation:** A multi-tiered approach to examine various level of functionality, user experience and impact. The testing phase evaluation will focus on the following goals: 1). Test product acceptance and usability with real chat participants; 2). Gather information on Chat participant experience; 3). Gather information on Peer and CT Operator's Experience and Training • Chat Statistics • Total chats, • Peer Operators Performance • Chat duration • Chat rating • Chat availability • Chat engagement • Chat response time • Missed chats • Tags usage • Chat waiting time • Chat abandonment • Chat Surveys: pre and post chat surveys (English, Spanish, 1st time visitors, & crisis) • Peer Operators Interviews	A multi-tiered approach to examine various levels of functionality, user experience and impact. The testing phase evaluation focused on the following goals: 1). Test product acceptance and usability with real chat participants; 2). Gather information on Chat participant experience; 3). Gather information on Peer and CT Operator's Experience and Training • Chat Statistics: Total chats; Peer Operators Performance; Chat duration; Chat rating; Chat availability; Chat engagement; Chat response time; Missed chats; Tags usage; Chat waiting time; Chat abandonment • Chat Surveys: Region of County, zip code, acceptance of Terms of Service, post chat satisfaction survey, and demographics collection from first time visitors. • Testing phase report also included qualitative data from UCI focused interviews with peer chat operators • Deaf and Hard of Hearing (DHH) Needs Assessment began including a focus group and survey with community advocates. A broader DHH community survey is under development in collaboration with a lead DHH community advocate, UCI and County Evaluation staff. • Recruitment began for stakeholders to participate in focus groups to assist with app selection for piloting • Draft materials for app selection focus groups were developed including participation agreement, demographics, and tech use survey and focus group questions. Focus Groups Materials • A4i vs. FOCUS • PowerPoint presentation under development to use in focus group presentations to stakeholders • Demographics and tech use survey developed for focus group participants, focus questions for A4i and FOCUS app developed	• A4i vs FOCUS Power Point Presentation • Facilitate Focus Group • Design of Focus Group Registration Google Form • Tracking of final list of Focus Group Participants • Configure 4 iPad Devices to loan to focus group participants • Focus Groups gift baskets for participants - completed • Help@Hand Learning Brief_Riverside County APP Exploration Report (A4i and FOCUS) - Focus Groups (FSP, TAY, Adult, Older Adult) • Data Analysis on Education Level for current FSP TAY Consumers **Digital Mental Health Literacy Training** • Completed Section 1 of DMHL Self-Guided Online Platform version • Started -Section 1 of DMHL facilitator-guided online platform **Reduce stigma associated with mental illness by promoting mental wellness Educate/Outreach/Reduce Stigma/Partnership/ Resources** • Operation Uplift - Medical Center - offering the Take my Hand Peer Chat Resource • LGBT Medical Center -offering the Take my Hand Peer Chat Resource • Suicide Prevention Coalition • Cultural Competency Reducing Disparities Committee • FSP Committee • Behavioral Health Commission • Eating Disorder Collaborative • Tested & Explored free Apps • Riverside Free app guide - English • Riverside Free app guide -Spanish • Rural Communities (Facebook live panel to learn about approaches to reach rural communities in California) • Map -Unincorporated Riverside Communities • Attempted contact and build rapport in order to incorporate Model Deaf Community Committee's perspective in DHoH survey for a fuller community view. • Collecting app information (Android & iOS) from the team to maintain information on free-freemium apps to keep Free App guide up-to-date. • Exploring free to freemium apps (during downtown time)

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<table>
<tr><th>Riverside County</th><th>Quarter 1
(Jan–Mar 2020)</th><th>Quarter 2
(Apr – Jun 2020)</th><th>Quarter 3
(Jul – Sept 2020)</th><th>Quarter 4
(Oct – Dec 2020)</th></tr>
<tr><td>Lessons Learned</td><td colspan="4">• Focus Groups
• How did you recruit participants for your focus groups, and what were your strategies to communicate with them? You Voice Counts Fliers, and A4i/Focus PowerPoint Presentations during managers and Quality Improvement Committee meetings, emails to the executive team, department Peer Workforce, Managers and Clinic Supervisors were sent to announce and get help with stakeholders' recruitment.
• What worked well in terms of communicating? Meetings and A4i and Focus Video presentations.
• What did not work well? Short timeline in recruiting stakeholders' participants, an extended timeline can allow for verbal promotion via telephone with clinic supervisors and clinic staff meetings.
• What would you do differently next time? Extend the recruitment timeline and better preparation for the logistics in general (presentation, devices, support staff, incentives, etc.)
• What were your goals and were they clearly defined going into these focus groups? The goal was for stakeholders to share their thoughts about the two app features (A4i and FOCUS). Main theme was around "Do they find the app feature helpful" and "Does it not interest you at all?"
• Did the focus group achieve those? Yes. Findings are in the Help@Hand Learning Brief_Riverside County APP Exploration.v5 (UCI Report).
• If they did, what worked well? Our Peer team participated in providing feedback on the content of the presentation as to ensure recovery language is in use throughout the presentation, survey and one-on-one communication. Peer team was very proactive in working with the focus participant one-on-one to assist with the completion of the pre-focus group survey and in explaining the participation consent. Email and test reminders were sent to participants a day prior and on the day of the focus group. This was key to ensure participants remember their focus group event. In addition, we had a good number of TAY participants that were well informed about existing wellness apps and they were already using some of these apps.

• TakemyHand Live Peer Chat
• Identified need to create fuller Peer/CT Operator Training for TMH.
• Identified need to train Peer Team regarding emotional response and effective communication in text.
• Coping skills Resource Binder per Topic.
• Closing the gap of available mental health Peers for the DHoH population -"Building Peer Leaders" Peer Support Training to a few Gloria-identified CODIE members. Coordinate with CODIE (Gloria) to develop a Peer Training Plan.

• Deaf and Hard of Hearing
• Findings from the first stakeholders meeting were very useful and are a baseline to start drafting user case stories.
• To be able to gather more stakeholder representation data, there is the need to implement a DHoH Community needs assessment survey distributed along with an ASL video adaptation featured with Deaf talent that is representative of the Riverside demographic breakdown.</td></tr>
<tr><td>Recommendations</td><td colspan="4">• Next steps:

• Target Area: Improve Service Access to Underserved Communities
• Population: Deaf and Hard of Hearing"
• Work with Sorenson for the adaptation of the DHoH Community Needs Assessment Survey
• Deaf & Hard of Hearing App (custom or existing app) -Continue with identifying needs
• "Building Peer Leaders" Peer Support Training to a few Gloria-identified CODIE members. Coordinate with CODIE (Gloria) to develop a Peer Training Plan.
• Facilitator's Guide and Student Workbook in preparation to meet with Gloria to discuss the materials, and how we augment them for the DMHL learning.
• Coordinate with CODIE (Gloria) to TakemyHand Peer Operators Training Plan -after hired/contracted.
• Global transformational advocacy

• Technology
• Deliver devices
• Kiosks distribution/install process
• Draft policy and procedures for sanitizing the kiosk
• Draft policy and procedures for addressing vandalism on kiosks
• Research Text to Speech Apps for our Blind Community

• Take my Hand Peer Chat
• Target Area: Improve Service Access to Underserved Communities
• Population: Deaf and Hard of Hearing, Mid-County & Desert Regions, Ethnic Cultural and LGBT"
• Take my Hand Peer Chat Terms of Service VIDEO (English/Spanish)
• Take my Hand Peer Chat Terms of Service VIDEO (Deaf and Hard of Hearing) -Sorenson
• LGBT Take my Hand Riverside Spotlight Report
• Peer Staff Development (Ongoing)
• Addition of Family Advocate services on TakemyHand Website
• Take my Hand Chat Language Translator
• Take my Hand Video functionality (DHoH)
• TakemyHand Grievance/ End-User Experience feedback form available independently from automated survey after chat close.
• Chatbot Functionality for visitors in the queue - (HIPPA compliance)</td></tr>
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Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Recommendations	• TakemyHand Mobile app version • Contract RTA/Metrolink - Take my Hand - marketing skin for buses -digital advertising • Service Mark • URL link to California Consumer Privacy Act • IIS Server set up - to store chats data - get approval • Word cloud chat analysis • Dashboard reports configuration • Video stories webpage - marketing/ • Link to Help@Hand website • Automate chat data exports for evaluation • TMH changes/improvements based on stakeholder feedback • Create TakemyHand Product Profile - for Pilot Proposal? • TakemyHand vetting process from other counties - San Francisco • Secure timeline for pilot phase (Riverside Only) - do we need to have a Pilot? • Secure timeline for pilot phase (additional Counties – added in after initial Riverside pilot)- San Francisco • TakemyHand Landing Page- Other Counties - San Francisco county • Coping skills Resource Binder per Topic (WIP) • Articulate tool training to create presentations (ongoing) • Searchable spreadsheet for our resource list (WIP) • Identified need to create fuller Peer/CT Operator Training for TMH. (WIP) • Identified need to train Peer Team regarding emotional response and effective communication in text (WIP) • Press Release - marketing • **A4i** • **Target Area:** Improve Outcomes for High Risk Populations • **Population:** FSP Consumers" • Aim to start A4i App Pilot during this Quarter • Pilot Proposal (see CalMHSA Template) • User Agreement - Consumer - review by county counsel -compliance officer • Informed Consent -Consumer - review by county counsel -compliance officer • Evaluation Planning • App customizations • Trainings • **Marketing** • Digital Mental Health Literacy Training • Start DMHL training with peers who are going in to the hospitals to engage consumers. • Start normalizing DMHL and telehealth services, as well as introduce free wellness applications as a tool for self-support as they transition services. • Started -Section 1 of DMHL facilitator-guided online platform • Painted Brain contract to assist with DMHL training throughout the Department • **Reduce stigma associated with mental illness by promoting mental wellness** • **Educate/Outreach/Reduce Stigma/Partnership/Resources** • Riverside free app guide 123 Approval Process • Work with the Peer Support Specialists doing Navigation to get them primed for the opportunity to do that kind of introduction of apps. FSP Peers/consumers. • Model Deaf Community Committee (MDCC)- (promote community survey, DMHL videos, etc.) • Establish our consulting cultural outreach workforce to reach out to targeted populations about Help@Hand, education, resources and reduction of Mental Health Stigma. (SOW) • Riverside Help@Hand Story Map - prioritize and support Activities in Rural Areas • **Quarter 2 (Apr-May-Jun)** • myStrength • Target Area: LGBT, FSP, Older Adults, TAY, • Population: • Select Apps for other Pilots • Focus Groups: SageSurfer, ManTherapy, FEEL Wearable • **Quarter 3 (Jul-Aug-Sep)** • Distribution of devices acquired through government program.			

Santa Barbara County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Lindsay Walter, JD- MHSA • Maria Arteaga, JD- Peer & Ethnic Services • Vanessa Ramos- Help@Hand Project Manager	• Lindsay Walter, JD- MHSA • Maria Arteaga, JD- Peer & Ethnic Services • Vanessa Ramos- Help@Hand Project Manager	• Lindsay Walter, JD- MHSA • Maria Arteaga, JD- Peer & Ethnic Services • Vanessa Ramos- Help@Hand Project Manager	• Lindsay Walter, JD- MHSA • Maria Arteaga, JD- Peer & Ethnic Services • Vanessa Ramos- Help@Hand Project Manager
Implementation Site	• TBD	• On-line for Q2	• TBD	• TBD
Team Composition	• MHSA Chief, Department Peer and Equity Services Manager, Assistant Director, County IT staff, Project Manager, Division Chief of IT, MHSA Coordinator, Regional Tech Ambassadors, Tech-Testers	• Assistant Director; Ethnic Services and Peer Manager; MHSA Chief; Health Care Coordinator- Tech/ Peer lead; IT; Help@ Hand peer team; Project Contractor	• Assistant Director; Peer and Ethnic Services Manager; MHSA Chief; Health Care Coordinator- Tech/Peer lead; Help@ Hand peer team; Project Contractor- Painted Brain	• Assistant Director; Peer and Ethnic Services Manager; MHSA Chief; Health Care Coordinator- Tech/Peer lead; Help@ Hand peer team; Project Contractor- Painted Brain
Target Audience	• Individuals age 16 and over living in geographically isolated communities of diverse backgrounds • Transitional aged youth who are students at colleges and universities • Adults discharged from psychiatric hospitals and/or recipients of crisis services	• Individuals age 16 and over living in geographically isolated communities of diverse backgrounds • Transitional aged youth who are students at colleges and universities • Adults discharged from psychiatric hospitals and/or recipients of crisis services	• Individuals age 18 and over living in geographically isolated communities of diverse backgrounds • Transitional aged youth who are students at colleges and universities- 18 and older • Adults discharged from psychiatric hospitals and/or recipients of crisis services	• Individuals age 18 and over living in geographically isolated communities of diverse backgrounds • Transitional aged youth who are students at colleges and universities- 18 and older • Adults discharged from psychiatric hospitals and/or recipients of crisis services
Products in Use/Planned	• Headspace (planned) • Digital Literacy - Needs and Responses from Stakeholder Sessions (planned) • Digital Mental Health Literacy Course from CalMHSA (planned)	• Digital Wellness Ambassadors curriculum- combined digital literacy (Help@Hand/Painted Brain/ CalMHSA) • Zoom platform • App guide-mobile application in the brochure	• Digital Wellness Ambassadors curriculum- combined digital literacy (Help@Hand/Painted Brain/ CalMHSA) • Zoom platform • Outreach materials created by local Help@Hand team • Mindfulness sessions with Dr. Brock Travis	• Zoom platform • App guides • Appy Hour Templates • Peer Support Group PPTs • Headspace
Implementation Approach	• Headspace with up to 45 people which will include Dept. Clinical Staff/IT Staff/Peer Staff/Tech Testers within each target population/CBO that work with target populations/ MHSA Chief/Peer and Equity Manager/Help@Hand Project Manager/if hired by then Help@Hand Project Outreach Coordinator	• Combine digital literacy to create Digital Wellness Ambassadors materials • Disseminate by providing literacy curriculum throughout clinics; community centers; community-based organizations; adult housing; recovery learning centers; on-line; tbd • Share and provide linkage to low cost laptops/ phone and WIFI	• Combine digital literacy to create Digital Wellness Ambassadors materials • Disseminate by providing literacy curriculum throughout clinics; community centers; community-based organizations; adult housing; recovery learning centers; on-line; TBD • Share and provide linkage to low-cost laptops/ phone and WiFi	• Increase access to technology devices through sharing acquisition resources • Increase digital literacy through hosting Appy Hours throughout the county through collaboration with community partners • Create normalcy in using wellness apps to support mental wellness such as Headspace through peer led support groups
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Foster diversity within target populations including Spanish/Mixteco speakers and individuals from communities marginalized including LGBTQ+ • Goals for the pilot include adoption of digital wellness tools within the target populations, reduce isolation and loneliness within target populations, reduce negative life events among members of each target population, implementation of digital literacy and men- tal health literacy facilitated through peer employment opportunities and measuring the success of wellness through employment	• Peer driven curriculum is created to meet specific needs of peer community within SB target populations • COVID highlighted the need for technology access within target populations; project will begin to explore low cost laptop within target populations; • The group coordinated a digital Mental Health COVID-19 Campaign to compliment the May Mental Health Awareness including daily motivations and resources for all MH Staff, daily peer groups for community and disclosed peers, and targeted age groups by postcard mailings and chalk art. This was then extended by local peer support partners coordinating zoom daily peer groups whose monthly calendar is sent out digitally by our PIO.	• Digital Wellness Ambassador's will provide warm hand off through engaging BWELL Adult Recipients of Crisis Services/Discharged from PHF in peer-led digital literacy groups at the PHF; connecting clients to Lifeline cell phone; providing warm hand offs after the client discharges while awaiting outpatient services • Digital Wellness Ambassadors will work with Painted Brain to engage TAY enrolled in colleges/ universities in hosting Appy Hours Sessions to build Digital Wellness and Digital Empowerment Toolboxes • Digital Wellness Ambassadors will work with Promotoras community to enhance digital literacy for use with mental health education as created by the local promotoras	• Digital Wellness Ambassador engage BeWell Adult Recipients of Crisis Services/Discharged from PHF in peer-led digital literacy groups at the PHF; share resources to the Lifeline cell phone program; provide introduction to the clinic peers who may be working with clients after discharge from the PHF • Digital Wellness Ambassadors will work with Painted Brain to engage TAY enrolled in colleges/ universities in developing curriculum supporting using digital tools to support mental wellness • Digital Wellness Ambassadors will work with community to enhance digital literacy of current county application available such as Octopus- the benefits platform created by Social Services
Milestones	• Employment of peers	• Help@Hand peers are now hired through county	• Digital Wellness Ambassadors are working on the	• Help@Hand is facilitating peer-led groups at the

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Santa Barbara County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
	• Engagement with peer agencies • Development of strategies for upcoming pilot • Solidified the need for Digital Literacy and Digital Mental Health Literacy throughout the community • Explored digital wellness tools within the Psychiatric Health Facility connecting to the ongoing Wellness and Recovery Peer-run groups • Identified the need for target population of baseline data	extra-help vs temp agency • Contracted with Painted Brain • Began on-line learning collaboratives with painted brain and Help@Hand peers	creation of the Digital Wellness Handbook where the Digital Wellness Ambassador role is defined and supported through the development of peer-run groups; agendas to be led at the PHF and throughout the target populations including MHSA Housing and Senior Facilities • A guide to Zoom basics is being formulated to ensure that clients at the PHF understand the basics to connecting to tele-health via Zoom platform • Project Manager/Healthcare Coordinator is working through OCM Plan with implementation team • Monthly Action Items are being documented to ensure project's continued progress- see attached	in-patient Psychiatric Health Facility • More than 50 community members have received digital literacy training • Help@Hand project is highlighted quarterly in the Consumer and Family Member Newsletter • Community stakeholders are given updates monthly at different department hosting action team meetings • Help@Hand is working with local research and evaluation team on a Process Improvement Project approved by EQRO that measures the success of clients discharged from the PHF and client's first appointment • Help@Hand has gained community feedback through presentations given at BeWell Action Team meetings and with community-based organizations
Lessons Learned	• Lessons learned- The realization regarding the digital divide that exist within the community. Basic technology needs must be addressed prior to the adaptation of digital tools intended to support mental health needs. The three basic needs we learned about are: 1. Lack of access to digital technology tools 2. Lack of access to WIFI; internet; data plans 3. Lack of digital literacy such as how to download an app, how to update an app for best practices surrounding security • An additional lesson learned we discovered is the resiliency of mental health consumers in Santa Barbara County. For example, Help@Hand project hosted over 100 support groups on ZOOM and several Appy Hours with contracted vendor Painted Brain. The community rallied together and worked amongst each other to help one another learn how to use the call-in feature on ZOOM. Little by little the comfortability of using the ZOOM platform lessoned. Help@Hand collaborated with a local Lifeline vendor to provide smartphones to local community members that qualified. Once the qualifying consumers received phones, consumers then worked with local community-based organization to learn about digital basics.			
Recommendations	• Recommendations are: 1) a robust stakeholder feedback at the beginning of project implementation to continue to better understand and meet the basic needs of the community 2) to respect and honor the learnings found. For example, CalMHSA's Peer Manager visited several counties and met with community stakeholders to better learn about the community needs. The information that was gathered was that the community needed phones, WIFI and to increase digital literacy. Unfortunately, the project was already moving ahead with selection of mobile apps which left a fragmented system of who had access to digital technology, understanding of digital tools and who did not. If the project would have visited counties before beginning the process of the application selection there may have been better programming or focus in connecting consumers with technology devices, WIFI and increasing digital literacy. 3) to utilize peer staff from different counties to support the development and vet the language of materials being created for the larger project such as the website, stakeholder reports etc. This may help the project ensure that the project is peer-led as it was intended.			

San Francisco County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Teresa Yu, LMFT	• Teresa Yu, LMFT	• Teresa Yu, LMFT • Meaghan O'Brien, MA	• Teresa Yu, LMFT • Meaghan O'Brien, MA
Implementation Site	• TBD	• TBD	• TBD- currently narrowed down 9 apps (using Product Matrix developed by Help@Hand). Plan to have 10 apps to review and narrow down if Riverside's Peer Chat becomes available for the collaborative to use	• Headspace SOW approved for 10,000 licenses for Jan 1- Dec 1. • Have identified Take my Hand as the app of preference for TAY and Trans-Identified Adults.
Team Composition	• MHSA Director, Peer, MHSA Coordinator, Tech Lead, 2 Finance	• MHSA Interim Director (Tech Lead), Peer/MHSA Peer Services Manager, Finance, BHS • Consultant, Staff and Director from MHASF	• MHSA Interim Director (Tech Lead), Peer/MHSA Peer Services Manager, Finance, BHS • Consultant, Staff and Director from MHASF	• MHSA Interim Director (Tech Lead), Peer/MHSA Peer Services Manager, Finance, BHS Consultant, Staff and Director from MHASF. MHSA Director, SOCs, MHSA Peer Services Manager.
Target Audience	• TBD	• TBD	• App being researched: Community and Mental Health Consumers/family members with a specific focus on TAY and Trans-identified individuals • Headspace: MHA SF clients, mental health system clients • including SRO residents	• App being researched: Community and Mental Health Consumers/family members with a specific focus on TAY and Trans-identified individuals • Headspace: MHA SF clients, mental health system clients including SRO residents and Children, Youth and Families Department.
Products in Use/Planned	• TBD (waiting on approved apps by the Collaborative) • Headspace (the City/County of SF is exploring to possibly pilot for staff. This would add to the populations included in this project	• TBD (waiting on approved apps by the Collaborative and conducting app exploration)	• 9 apps have been narrowed down for continued app exploration • Headspace: 10,000 licenses planned to be added to MHA SF contract for this fiscal year	• Take my Hand • Headspace: 10,000 licenses planned to be added to MHA SF contract for this fiscal year
Implementation Approach	• TBD	• TBD	• TBD	
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Interested in Peer Chat apps available to all, but with a focus on the Transgender and Transitional Age Youth communities	• Interested in Peer Chat apps available to all, but with a focus on the Transgender and Transitional Age Youth communities	• Interested in Peer Chat apps available to all, but with a focus on the Transgender and Transitional Age Youth Communities (TAY) • Peers are concerned with PHI/data consumption while using app	• Exploring Headspace use with CYF (Children, Youth and Families) who are wanting to integrate it with clinical services
Milestones	• Started the City/County's collaboration with Mental Health Association of San Francisco	• Mental Health Association (MHA) has started to participate in Tech Lead and Implementation calls. They are conducting app exploration.	• Establishing a biweekly meeting between SF DPH and MHA SF • MHA SF hiring a Programs Coordinator to heavily support project (10/1 start date) • Developed a Product Matrix of apps that fit SF city/county needs, completed Needs Assessment • Exploring Headspace for SF city/county consumers	• Working on a hiring plan to hire two Peer Navigators to support Programs Coordinator at MHASF • Developing 12-part Digital Literacy Education training series for SF residents to begin 2/2021 • Moving forward with Headspace implementation with SF city and county
Lessons Learned	• Frequent and regular communication between County and CBO and adequate staffing devoted to the project has been key • More involved County/CBO collaboration than other Innovation projects due to complexity and changes with projects • Getting all parties together and more communication: such as between City Attorney and CalMHSA helped ensure clarity with complex County BOS/contracting process			
Recommendations	• Communication and collaboration: see above and also meeting with other counties who are implementing similar projects is very helpful for planning and learning about best practices for implementation			

San Mateo County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Doris Estremera, MPH	• Doris Estremera, MPH	• Doris Estremera, MPH	• Doris Estremera, MPH
Implementation Site	• Peninsula Family Service (PFS) • Youth Leadership Institute (YLI)		• Community-based agencies, BHRS clinics, online	• Community-based agencies, BHRS clinics, online
Team Composition	• MHSA Coordinator, Peer Specialist/Peer Support, Contracted Agencies: 1)Youth Leadership Institute (TAY Contractor): Peer Lead/ Program Coordinator, Bilin-gual-bicultural TAY Peer Lead (Spanish), 2) Peninsula Family Services (PFS): Peer Lead/Program Coordi-nator, bilingual-bicultural Peer (Spanish/Chinese)	• MHSA Coordinator, Peer Specialist/Peer Support, Contracted Agencies: 1) Youth Leadership Institute (TAY Contractor): Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish), 2) Peninsula Family Services (PFS): Peer Lead/ Program Coordi- nator, bilingual-bicultural Peer (Spanish/ Chinese)	• MHSA Coordinator • Office of Consumer and Family Affairs: Peer Specialist/Peer Support • Contracted Agencies: 1. Youth Leadership Institute (TAY Contractor): Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish) 2. Peninsula Family Service (Older Adult Contractor): Peer Lead/ Program Coordinator, bilingual-bicul-tural Peer (Spanish/ Chinese) 3. California Clubhouse and Heart and Soul: Help@ Hand Peer Ambassadors	• MHSA Coordinator • Office of Consumer and Family Affairs: Peer Spe-cialist/Peer Support • Contracted Agencies: 1. Youth Leadership Institute (TAY Contractor): Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish) 2. Peninsula Family Service (Older Adult Contractor): Peer Lead/ Program Coordinator, .5FTE bilingual-bi-cultural Peer (Spanish) 3. California Clubhouse and Heart and Soul: Help@ Hand Peer Ambassadors 4. Painted Brain: Peers providing digital mental health literacy train-the-trainer for peers and "tech hours" for community at large
Target Audience	• Transitional age youth • Older adults	• Transitional age youth • Older adults	• Transitional age youth (TAY) • Older adults	• Transitional age youth (TAY) • Older adults
Products in Use/Planned	• Happify with older adults (planned) • Remente with transitional age youth (planned)	• Headspace for COVID rapid response, plan to release August/ September 2020 • Selecting new products, considering: o Unipercare, myStrength, Wysa for older adults o Headspace, myStrength, Wysa for transitional age youth	• Headspace for COVID Rapid Response released September 2020 • Selecting new products for pilot, considering: o myStrength, Wysa for older adults o Headspace, myStrength, Wysa for TAY • Painted Brain digital mental health training for peers	• Headspace for COVID Rapid Response released September 2020 • Older Adults and TAY selected Wysa for pilot to launch in February/March 2021
Implementation Approach	• Remente for transitional age youth, YLI Peer Leads and youth ambassadors plan, promote and support the use of the app • Happify for older adults, PFS Peer Leads and older adult ambassadors plan, promote and support use of the app	• Phase 1 – Help@Hand Peer Ambassadors from YLI, PFS and Advisory Committee to promote and support use of all apps (Headspace and addi-tional selections). Peer ambassadors supporting outreach and engagement efforts through appy hours, direct community outreach and additional strategies to be developed. • Phase 2 – California Clubhouse and Heart and Soul (peer-led organizations) Peer Ambassadors to support integration of apps into Behavioral Health and Recovery Services. Strategies to be developed.	• Help@Hand Advisory Committee of local stakeholders continues to meet monthly and provides feedback on appropriate technology to meet the needs of older adults and transition-age youth, consults on the strategies for outreach and engagement, informs project evaluation, supports recruitment of older adults and youth to participate in the exploration and pilot phase of app selection, and serve as ambassadors of Help@Hand • Phase 1 – Help@Hand Peer Ambassadors from YLI, PFS and Advisory Committee promote and support use of all apps (Headspace and additional selections). Peer Ambassadors support outreach and engagement efforts through 'Appy Hours,' recruitment of participants in selection of apps and digital mental health literacy • Phase 2 – California Clubhouse and Heart and Soul (peer-led organizations) and BHRS Peer Ambassadors will support integration of apps into Behavioral Health and Recovery Services including	• Help@Hand Advisory Committee of local stake-holders continues to meet monthly and provides feedback on appropriate technology to meet the needs of older adults and transition-age youth, consults on the strategies for outreach and engagement, informs project evaluation, supports recruitment of older adults and youth to participate in the exploration and pilot phase of app selection, and serve as ambassadors of Help@Hand • Phase 1 – Help@Hand Peer Ambassadors from YLI, PFS and Advisory Committee promote and support use of all apps (Headspace and additional selec-tions). Peer Ambassadors support outreach and engagement efforts through 'Get Appy' workshops, recruitment of participants in selection of apps and digital mental health literacy. o Further marketing and outreach plans for Headspace response under development. o Pilot proposal for Wysa app under development • Phase 2 –BHRS Peer Ambassadors will support integration of apps into Behavioral Health and

Continued on next page

San Mateo County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
			digital mental health training of clients by peers • Painted Brain is supporting a train-the-trainer for peers and clients will receive devices (cell phone/ tablets) along with digital mental health supports. • Further marketing and outreach plans for Headspace response under development	Recovery Services including digital mental health training of clients by peers o Painted Brain is supporting a train-the-trainer for peers and clients will receive devices (cell phone/ tablets) along with digital mental health supports.
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Help@Hand Advisory Committee of local stakeholders meet monthly since inception (provides feedback on technology features, enhancements and customization to meet the needs of older adults and transition age youth, consults on the strategies for outreach and engagement, informs project evaluation questions and outcomes)	• Using T-Mobile Gov L1 Plan to procure devices for clients. • Using Headspace as a broader response to the San Mateo County community at-large to support for one-year due to COVID	• Leveraged $408,000 of MHSA and CARES Act funding to procure additional federally subsidized devices for clients to use for both Help@Hand and broader telehealth and recovery-oriented services for clients • Using Headspace as a broader response to the San Mateo County community at-large to support for one year due to COVID	• Contracted with Painted Brain to support additional “tech hours” for both Help@Hand implementation and broader racial equity actions due to COVID shelter-in-place • Leveraged $408,000 of MHSA and CARES Act funding to procure additional federally subsidized devices for clients to use for both Help@Hand and broader telehealth and recovery-oriented services for clients • Using Headspace as a broader response to the San Mateo County community at-large to support for one year due to COVID
Milestones	• Conducted focus groups with older adults and youth to learn needs and select the most appropriate apps • Focus groups to support development of digital mental health literacy curriculum • Hosted NorCal Peer Summit • PFS hosting AppyHours, engaging older adults in using technology • YLI developed a Help@Hand specific Youth Advisory Group • Advisory Committee received training on app exploration process to provide more in-depth input on selected apps • Ambassadors and peers participated in Digital Mental Health Literacy Train-the-trainer	• PFS shifted to over-the-phone and online Appy-Hours to continue engaging older adults in using technology. • YLI kicked off online Youth Advisory Group • Successfully procured and distributed 40 free phones to clients and tablets for peer workers to support during COVID • In negotiations with Headspace to provide access to the app for one-year to San Mateo County residents as a response to COVID • Re-started app selection process due to Happify unavailability during COVID and youth needs shifting now that interactions are primarily online. • Worked with UCI to tailor the app selection survey and make it available online	• Engaged 20+ BHRS and community-based agencies’ Peer Partners and Family Partners in the distribution of phones to clients, which will include digital mental health literacy training for the clients • Contracted with Painted Brain to provide digital mental health literacy train-the-trainer for Peer/ Family Partners • Launched Headspace access for one-year to San Mateo County residents as a response to COVID	• Selected apps • Expanded “tech hours” to community at large and partnering community-based agency staff • Partnering with other counties on Headspace license sharing, evaluation and marketing
Lessons Learned	• Addressing the digital divide by providing digital literacy supports are needed prior to engagement in any behavioral health technology solution and at various levels including; peer support workers, behavioral health staff across the network of providers, community and clients. • Having explicit communication with stakeholders of “non-negotiables” should be part of the selection of an app. For example, including cultural and language vetting as part of the early focus groups to inform selection of an app.			
Recommendations	• Implement an advisory committee of stakeholders early in the process to vet, consult with, create buy-in and provide direction • Include evaluation lens as part of project planning and process development for all aspects of the project including procurement, selection, piloting and implementation • Include devices and digital literacy as part of the overall solution; including train-the-trainer for peer support workers, and various opportunities for ongoing digital literacy support for clients (“tech hours”) and providers (intermediate tech training, e.g. equitable facilitation of groups, telehealth, etc.) • Include opportunities for collaboration with other Help@Hand Counties while honoring local diversity and needs			

Tehama County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Michelle Brousseau • Avery Vilche	• Travis Lyon • Avery Vilche	• Travis Lyon • Avery Vilche	• Travis Lyon • Avery Vilche
Implementation Site	• TBD	• Tehama County	• Tehama County	• Tehama County
Team Composition	• MHSA Coordinator, Tech Leads, Peer, Behavioral Health Director, Staff	• Behavioral Health Director, MHSA Coordinator, Tech Leads, Peer Supervisor, Staff, Peer Advocates	• Behavioral Health Director, MHSA Coordinator, Clinician, Case Manager, 2 Health Educators, Peer Supervisor, 2 Peer Advocates, Health Services Analyst	• Behavioral Health Director, MHSA Coordinator, Clinician, Case Manager, 2 Health Educators, Peer Supervisor, 2 Peer Advocates, Health Services Analyst
Target Audience	• TBD	• Persons who are Homeless or at risk of Homelessness, Geographically Isolated Adults, and TCHSA-BH Consumers	• Persons who are Homeless or at risk of Homelessness • Isolated Individuals • Tehama County Health Services Agency – Behavioral Health (TCHSA-BH) Consumers	• Persons who are Homeless or at risk of Homelessness • Isolated Individuals • Tehama County Health Services Agency – Behavioral Health (TCHSA-BH) Consumers
Products in Use/Planned	• TBD	• myStrength	• myStrength	• myStrength
Implementation Approach	• TBD	• Pilot with 30 people (10 from each Target Audience), Track Progress	• Pilot with 30 people (10 from each Target Audience), Track Progress	• Pilot with 30 people (10 from each Target Audience), Track Progress
Other Unique Qualities (of target audience, implementation, or other program aspect)	• TBD	• TBD	• Using a one-on-one individualized approach with participants linked to Peer Staff and Wellness Advocates	• Using a one-on-one individualized approach with participants linked to Peer Staff and Wellness Advocates
Milestones	• Not applicable	• Not applicable	• Pilot Proposal received budget approval from Collaborative Leadership • Organizational change management (OCM) Plan completed and initiated • Evaluation Plan completed • Vendor Engagement Plan completed	• Evaluation instruments completed • Statement of Work drafted
Lessons Learned	• Time required for processes and approvals • Project requires dedicated resources • OCM is as important as the technology • Strong ad hoc communication between implementation meetings facilitates progress			
Recommendations				

Tri-City	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Toni Robinson • Dana Barford	• Toni Robinson • Dana Barford	• Dana Barford	• Amanda Colt • Dana Barford
Implementation Site	• Transitional Age Youth Wellness Center	• Tri-City Wellness Center	• Tri-City Wellness Center	• Virtual due to COVID-19
Team Composition	• MHSA Coordinator, MHSA Manager, Peer Lead, MHSA Director	• MHSA Manager, MHSA Coordinator, Wellness Advocate Supervisor, Wellness Advocates, Wellness Center Supervisor, Clinicians, MHSA Director, Clinical Director	• MHSA Manager, MHSA Coordinator, Wellness Advocate Supervisor, Wellness Advocates, Wellness Center Supervisor, Clinicians, MHSA Director, Clinical Director	• MHSA Manager, MHSA-Inn Program Coordinator, MHSA Director, Cambria Consultant, Painted Brain Peer Consultant
Target Audience	• Transitional age youth • Older adults • Monolingual Spanish speakers	• For the potential pilot, our target audience has been updated to include: TAY; Older adults; Wellness advocates (peers); FSP clients being monitored by their clinicians	• For the potential pilot, our target audience has been updated to include: TAY; Older adults; Wellness advocates (peers); FSP clients being monitored by their clinicians	• For Implementation, our target populations will be TAY, Older adults, and Monolingual Spanish Speakers
Products in Use/Planned	• Wysa with transitional age youth	• Wysa	• Wysa	• Mindstrong collaboration with Orange County • Headspace or myStrength with CalMHSA
Implementation Approach	• Have a small focus group for pilot to obtain valuable feedback on a biweekly basis	• Twenty users will be recruited to use Wysa for 3 months and will participate in 7 focus groups held biweekly to evaluate Wysa's usability and effectiveness.	• Due to the loss of key staff, the pilot project and related focus groups were placed on temporary hold. However, Tri-City continues to actively participate in all other aspects and activities of this project and the Collaborative	• Due to COVID-19 and turnover of Program Coordinators we have continued to participate in all activities of the collaborative, but implementation of project has been delayed • Currently in discussion with Orange County to join them in the implementation of Mindstrong • Working with CalMHSA to implement either HeadSpace or myStrength with our target populations
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Having input from a focus group of peers to select the app to be piloted	• A group of 4 clinicians will also be recruited to determine the feasibility and appropriateness of using Wysa in support of the services they provide.	• Due to COVID-19, the 4 clinicians originally anticipated to determine the feasibility and appropriateness of using Wysa were not available to support this project due to the increased need for client services. The goal is to reevaluate this component in January 2021	• We will be holding a workgroup in January to present to them our ideas for moving forward with Mindstrong and either Headspace or myStrength
Milestones	• Focus group selected the app for pilot	April • A focus group comprised of Wellness Advocates, MHSA staff, and the IT consultant, participated in a product testing of the Wysa application • Product testing resulted in Tri-City moving forward with the app, with adjustments to the emergency contact function May • Wysa agreed to making adjustments to the emergency contact function of the app • CalMHSA began contract negotiations with Wysa • Tri-City started drafting the pilot proposal • Through the collaboration, various wellness apps have made accessing their apps free for participating counties/agencies and Tri-City has been taking advantage of the opportunity by providing the resources to staff and clients	August • Innovation Coordinator/Tech Lead left Tri-City in August. As a result, the Wysa pilot project was placed on temporary hold until a replacement is hired • Tri-City continues to actively participate in all other aspects and activities of this project and the Collaborative	December • Hired new Innovation Program Coordinator • Speaking with Orange County to possibly collaborate with them in order to implement Mindstrong in Tri-City • In discussion with CalMHSA about implementing either HeadSpace or myStrength with our Target Populations

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Tri-City	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
		• CalMHSA created Digital Mental Health Literacy training videos and Tri-City will be utilizing the videos for clients and community members • Tri-City met with UCI to develop an evaluation plan for the pilot process June • CalMHSA and Wysa reached an agreement in contract negotiations and Tri-City was given the green light to move forward with the pilot proposal and pilot evaluation plan • Tri-City continued to send useful wellness app information to our staff for self-care (and some client resources) • Tri-City Wellness Advocates started planning for a Community Connections webinar to teach our clients and community members how to be safe online. They will be using the skills and information they acquired during the train-the-trainer session of the February Help@Hand Peer Summit • Tri-City was trained to use Smartsheet for project management		
Lessons Learned	• We learned that we did not have the adequate internal staff to support implementation of project. We are reaching out to Painted Brain and Cambria to assist with support during implementation of future projects in order to ensure we can have a successful launch.			
Recommendations	• Collaborate with Orange County to take over some of their licenses for Mindstrong in order to roll out Mindstrong to our Target Populations. Work with CalMHSA to implement either Headspace or myStrength.			

Mobile Application Rating Scale (MARS)

App Quality Ratings

The Rating scale assesses app quality on four dimensions. All items are rated on a 5-point scale from “1.Inadequate” to “5.Excellent”. Circle the number that most accurately represents the quality of the app component you are rating. Please use the descriptors provided for each response category.

SECTION A

Engagement – fun, interesting, customisable, interactive (e.g. sends alerts, messages, reminders, feedback, enables sharing), well-targeted to audience

1. **Entertainment: Is the app fun/entertaining to use? Does it use any strategies to increase engagement through entertainment (e.g. through gamification)?**

   1 Dull, not fun or entertaining at all
   2 Mostly boring
   3 OK, fun enough to entertain user for a brief time (< 5 minutes)
   4 Moderately fun and entertaining, would entertain user for some time (5-10 minutes total)
   5 Highly entertaining and fun, would stimulate repeat use

2. **Interest: Is the app interesting to use? Does it use any strategies to increase engagement by presenting its content in an interesting way?**

   1 Not interesting at all
   2 Mostly uninteresting
   3 OK, neither interesting nor uninteresting; would engage user for a brief time (< 5 minutes)
   4 Moderately interesting; would engage user for some time (5-10 minutes total)
   5 Very interesting, would engage user in repeat use

3. **Customisation: Does it provide/retain all necessary settings/preferences for apps features (e.g. sound, content, notifications, etc.)?**

   1 Does not allow any customisation or requires setting to be input every time
   2 Allows insufficient customisation limiting functions
   3 Allows basic customisation to function adequately
   4 Allows numerous options for customisation
   5 Allows complete tailoring to the individual’s characteristics/preferences, retains all settings

4. **Interactivity: Does it allow user input, provide feedback, contain prompts (reminders, sharing options, notifications, etc.)? Note: these functions need to be customisable and not overwhelming in order to be perfect.**

   1 No interactive features and/or no response to user interaction
   2 Insufficient interactivity, or feedback, or user input options, limiting functions
   3 Basic interactive features to function adequately
   4 Offers a variety of interactive features/feedback/user input options
   5 Very high level of responsiveness through interactive features/feedback/user input options

5. **Target group: Is the app content (visual information, language, design) appropriate for your target audience?**

   1 Completely inappropriate/unclear/confusing
   2 Mostly inappropriate/unclear/confusing
   3 Acceptable but not targeted. May be inappropriate/unclear/confusing
   4 Well-targeted, with negligible issues
   5 Perfectly targeted, no issues found

A. Engagement mean score = ____________

SECTION B

Functionality – app functioning, easy to learn, navigation, flow logic, and gestural design of app

6. Performance: How accurately/fast do the app features (functions) and components (buttons/menus) work?

1 App is broken; no/insufficient/inaccurate response (e.g. crashes/bugs/broken features, etc.)
2 Some functions work, but lagging or contains major technical problems
3 App works overall. Some technical problems need fixing/Slow at times
4 Mostly functional with minor/negligible problems
5 Perfect/timely response; no technical bugs found/contains a 'loading time left' indicator

7. Ease of use: How easy is it to learn how to use the app; how clear are the menu labels/icons and instructions?

1 No/limited instructions; menu labels/icons are confusing; complicated
2 Useable after a lot of time/effort
3 Useable after some time/effort
4 Easy to learn how to use the app (or has clear instructions)
5 Able to use app immediately; intuitive; simple

8. Navigation: Is moving between screens logical/accurate/appropriate/ uninterrupted; are all necessary screen links present?

1 Different sections within the app seem logically disconnected and random/confusing/navigation is difficult
2 Usable after a lot of time/effort
3 Usable after some time/effort
4 Easy to use or missing a negligible link
5 Perfectly logical, easy, clear and intuitive screen flow throughout, or offers shortcuts

9. Gestural design: Are interactions (taps/swipes/pinches/scrolls) consistent and intuitive across all components/screens?

1 Completely inconsistent/confusing
2 Often inconsistent/confusing
3 OK with some inconsistencies/confusing elements
4 Mostly consistent/intuitive with negligible problems
5 Perfectly consistent and intuitive

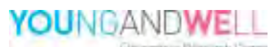
B. Functionality mean score = ___________

SECTION C

Aesthetics – graphic design, overall visual appeal, colour scheme, and stylistic consistency

10. Layout: Is arrangement and size of buttons/icons/menus/content on the screen appropriate or zoomable if needed?

1 Very bad design, cluttered, some options impossible to select/locate/see/read device display not optimised
2 Bad design, random, unclear, some options difficult to select/locate/see/read
3 Satisfactory, few problems with selecting/locating/seeing/reading items or with minor screen-size problems
4 Mostly clear, able to select/locate/see/read items
5 Professional, simple, clear, orderly, logically organised, device display optimised. Every design component has a purpose



11. Graphics: How high is the quality/resolution of graphics used for buttons/icons/menus/content?

1 Graphics appear amateur, very poor visual design - disproportionate, completely stylistically inconsistent
2 Low quality/low resolution graphics; low quality visual design – disproportionate, stylistically inconsistent
3 Moderate quality graphics and visual design (generally consistent in style)
4 High quality/resolution graphics and visual design – mostly proportionate, stylistically consistent
5 Very high quality/resolution graphics and visual design - proportionate, stylistically consistent throughout

12. Visual appeal: How good does the app look?

1 No visual appeal, unpleasant to look at, poorly designed, clashing/mismatched colours
2 Little visual appeal – poorly designed, bad use of colour, visually boring
3 Some visual appeal – average, neither pleasant, nor unpleasant
4 High level of visual appeal – seamless graphics – consistent and professionally designed
5 As above + very attractive, memorable, stands out; use of colour enhances app features/menus

C. Aesthetics mean score = ______________

SECTION D

Information – Contains high quality information (e.g. text, feedback, measures, references) from a credible source. Select N/A if the app component is irrelevant.

13. Accuracy of app description (in app store): Does app contain what is described?

1 Misleading. App does not contain the described components/functions. Or has no description
2 Inaccurate. App contains very few of the described components/functions
3 OK. App contains some of the described components/functions
4 Accurate. App contains most of the described components/functions
5 Highly accurate description of the app components/functions

14. Goals: Does app have specific, measurable and achievable goals (specified in app store description or within the app itself)?

N/A Description does not list goals, or app goals are irrelevant to research goal (e.g. using a game for educational purposes)
1 App has no chance of achieving its stated goals
2 Description lists some goals, but app has very little chance of achieving them
3 OK. App has clear goals, which may be achievable.
4 App has clearly specified goals, which are measurable and achievable
5 App has specific and measurable goals, which are highly likely to be achieved

15. Quality of information: Is app content correct, well written, and relevant to the goal/topic of the app?

N/A There is no information within the app
1 Irrelevant/inappropriate/incoherent/incorrect
2 Poor. Barely relevant/appropriate/coherent/may be incorrect
3 Moderately relevant/appropriate/coherent/and appears correct
4 Relevant/appropriate/coherent/correct
5 Highly relevant, appropriate, coherent, and correct

16. **Quantity of information: Is the extent coverage within the scope of the app; and comprehensive but concise?**

    N/A There is no information within the app
    1 Minimal or overwhelming
    2 Insufficient or possibly overwhelming
    3 OK but not comprehensive or concise
    4 Offers a broad range of information, has some gaps or unnecessary detail; or has no links to more information and resources
    5 Comprehensive and concise; contains links to more information and resources

17. **Visual information: Is visual explanation of concepts – through charts/graphs/images/videos, etc. – clear, logical, correct?**

    N/A There is no visual information within the app (e.g. it only contains audio, or text)
    1 Completely unclear/confusing/wrong or necessary but missing
    2 Mostly unclear/confusing/wrong
    3 OK but often unclear/confusing/wrong
    4 Mostly clear/logical/correct with negligible issues
    5 Perfectly clear/logical/correct

18. **Credibility: Does the app come from a legitimate source (specified in app store description or within the app itself)?**

    1 Source identified but legitimacy/trustworthiness of source is questionable (e.g. commercial business with vested interest)
    2 Appears to come from a legitimate source, but it cannot be verified (e.g. has no webpage)
    3 Developed by small NGO/institution (hospital/centre, etc.) /specialised commercial business, funding body
    4 Developed by government, university or as above but larger in scale
    5 Developed using nationally competitive government or research funding (e.g. Australian Research Council, NHMRC)

19. **Evidence base: Has the app been trialled/tested; must be verified by evidence (in published scientific literature)?**

    N/A The app has not been trialled/tested
    1 The evidence suggests the app does not work
    2 App has been trialled (e.g., acceptability, usability, satisfaction ratings) and has partially positive outcomes in studies that are not randomised controlled trials (RCTs), or there is little or no contradictory evidence.
    3 App has been trialled (e.g., acceptability, usability, satisfaction ratings) and has positive outcomes in studies that are not RCTs, and there is no contradictory evidence.
    4 App has been trialled and outcome tested in 1-2 RCTs indicating positive results
    5 App has been trialled and outcome tested in $\geq$ 3 high quality RCTs indicating positive results

D. Information mean score = ____________ *

* Exclude questions rated as "N/A" from the mean score calculation.

App subjective quality

SECTION E

20. Would you recommend this app to people who might benefit from it?

1	**Not at all**	I would not recommend this app to anyone
2		There are very few people I would recommend this app to
3	**Maybe**	There are several people whom I would recommend it to
4		There are many people I would recommend this app to
5	**Definitely**	I would recommend this app to everyone

21. How many times do you think you would use this app in the next 12 months if it was relevant to you?

1 **None**
2 1-2
3 3-10
4 10-50
5 >50

22. Would you pay for this app?

1 No
3 Maybe
5 Yes

23. What is your overall star rating of the app?

1	★	One of the worst apps I've used
2	★★	
3	★★★	Average
4	★★★★	
5	★★★★★	One of the best apps I've used

Scoring

App quality scores for

SECTION

A: Engagement Mean Score = ___________________________

B: Functionality Mean Score = ___________________________

C: Aesthetics Mean Score = ___________________________

D: Information Mean Score = ____________________________

App quality mean Score = ___________________________

App subjective quality Score = _________________________

App-specific

These added items can be adjusted and used to assess the perceived impact of the app on the user's knowledge, attitudes, intentions to change as well as the likelihood of actual change in the target health behaviour.

SECTION F

1. **Awareness: This app is likely to increase awareness of the importance of addressing [insert target health behaviour]**

Strongly disagree				Strongly Agree
1	2	3	4	5

2. **Knowledge: This app is likely to increase knowledge/understanding of [insert target health behaviour]**

Strongly disagree				Strongly Agree
1	2	3	4	5

3. **Attitudes: This app is likely to change attitudes toward improving [insert target health behaviour]**

Strongly disagree				Strongly Agree
1	2	3	4	5

4. **Intention to change: This app is likely to increase intentions/motivation to address [insert target health behaviour]**

Strongly disagree				Strongly Agree
1	2	3	4	5

5. **Help seeking: Use of this app is likely to encourage further help seeking for [insert target health behaviour] (if it's required)**

Strongly disagree				Strongly Agree
1	2	3	4	5

6. **Behaviour change: Use of this app is likely increase/decrease [insert target health behaviour]**

Strongly disagree				Strongly Agree
1	2	3	4	5

Selected Feature and User Experience Reviews of Meditation Apps

App name	Screen Reader Capabilities	Customizable Display Features	Offline Availability	Number of Languages Available in App	Content for Selected Target Groups	Peer connection in-app	User Experience Score (Max: 5)	
	+++ All buttons spoken ++ Most buttons or features spoken, some exceptions + Some buttons or features spoken, many exceptions	A+ Text size T High contrast text ◑ Color inversion ▶ Animation reduction	Internet needed Offline Access Offline access, paid version only Downloadable content Downloadable content, paid version only				Expert	Consumer
10% Happier	+	Text size, High contrast text, Color inversion	Downloadable content	1	None	No	4.57	4.39
Aura	+	Text size, High contrast text, Color inversion	Downloadable content	1	None	Yes	4.52	4.65
Black Lotus	++	Text size, High contrast text, Color inversion	Downloadable content	2	None	Yes	4.19	3.82
Breathe	+	Text size, High contrast text, Color inversion, Animation reduction	Internet needed	1	"Dealing with injustice" content in paid version	No	4.76	4.00
Buddhify	+	High contrast text, Color inversion	Offline Access	1	None	Yes	4.25	2.99
Calm	+++	Text size, High contrast text, Color inversion, Animation reduction	Downloadable content	8	None	No	4.69	4.11
Headspace	++	Text size, High contrast text, Color inversion, Animation reduction	Downloadable content	5	None	Yes	4.95	5.00
HelloMind	+	Text size, High contrast text, Color inversion, Animation reduction	Internet needed	1	None	No	3.67	4.09
Humm.ly	+	Text size, Color inversion	Internet needed	1	None	No	4.11	3.80
Insight Timer	+	Text size, High contrast text, Color inversion	Downloadable content, paid version only	35+	None	Yes	4.38	4.39
Liberate Meditation	++	Text size, Color inversion	Internet needed	1	Black, Indigenous, and POC community	No	3.23	3.21
21-Day Meditation Experience	++	Text size, High contrast text, Color inversion	Offline Access	1	None	No	3.61	3.83
Meditopia	++	High contrast text, Color inversion	Downloadable content, paid version only	9	None	No	4.77	3.98
Mind the Bump	++	Text size, High contrast text, Color inversion	Internet needed	1	LGBTQ+ community, single parents (app designed for expectant parents)	No	3.81	3.58
Omvana	++	Text size, High contrast text, Color inversion	Internet needed	3	None	No	3.39	3.95
Preksha Meditation	+++	Text size, High contrast text, Color inversion	Downloadable content	1	None	No	1.99	2.67
Relax Melodies	+	Text size, High contrast text, Color inversion, Animation reduction	Downloadable content	2	None	No	4.65	3.73
Simple Habit	+	Text size, High contrast text, Color inversion, Animation reduction	Downloadable content, paid version only	1	None	No	3.45	4.02

Simply Being	++	A+		1	None	No	2.32	3.22
Smiling Mind	++	A+		4	None	No	4.88	4.79
Take a Break	++	A+		1	None	No	1.84	3.17
The Mindfulness App	++	A+		13	None	No	3.94	3.96
Waking Up	+			1	None	Yes	4.04	3.98

Selected Feature and User Experience Reviews of Peer Support Apps

Screen Reader Capabilities
- +++ All buttons spoken
- ++ Most buttons or features spoken, some exceptions
- + Some buttons or features spoken, some exceptions

Customizable Display Features
- A- Text size
- T High contrast text
- ◐ Color inversion

Is app content available offline?
- (wifi) Internet needed, no content available online
- (wifi + person) Internet needed for chats, other content available offline

App Name	Screen Reader Capabilities	Customizable Display Features			Offline Access	Number of Languages Available in App	Content for Selected Target Groups	In–App Peer Support							User Experience Scores (MARS)	
		Text size	High contrast text	Color inversion				Moderated chatroom	Unmoderated chatroom	Moderated forum	Unmoderated forum	1–on–1 peer messaging	Connect in–app with therapist	Referral available	Expert	User
365 Gratitude Journal	+	A-		◐	Internet needed	1	None			●					4.36	3.95
7 Cups	++			◐		34	LGBTQ+	●		●		●	●		3.44	2.75
DBT Coach	++	A-	T	◐	Internet needed for chats	1	None		●	●					3.85	4.09
Habitica	++	A-			Internet needed for chats	19	None	●		●		●			3.88	3.65
iPrevail	++	A-	T	◐	Internet needed for chats	1	None			●		●			4.16	3.56
iRel8	++		T	◐	Internet needed	1	None				●	●		●	2.88	3.47
LGBT+ Amino	+	A-	T	◐	Internet needed	1*	LGBTQ+	●		●		●			3.51	3.7
OOTify	++	A-	T	◐	Internet needed	1	None			●			●	●	3.79	4.09
Pocket Rehab	++	A-	T	◐	Internet needed	1	None			●		●		●	4.07	3.28
rTribe	++	A-	T	◐	Internet needed for chats	1	None	●				●	●		4.05	4.24
Sanvello	+++		T	◐	Internet needed for chats	1	None			●			●		4.8	4.79
Sober Grid	++			◐	Internet needed	1	None			●		●			3.51	3.4
SoberTool	++	A-	T	◐	Internet needed for chats	1	None			●					2.71	3.41
Solace	++	A-	T	◐	Internet needed for chats	1	None	●		●					1.28	2.53
TalkLife	+	A-	T	◐	Internet needed	1	None			●		●			n/a	n/a
Therapeer	++		T	◐	Internet needed	1	None	●							4.23	3.9
Trill Project	+	A-	T	◐	Internet needed	1	LGBTQ+			●		●		●	3.44	3.64
Unmasked Mental Health	++	A-	T	◐	Internet needed	1	None					●			2.74	3.15
Wakie	++	A-	T	◐	Internet needed	1*	None	●		●		●			3.08	3.45
We Are More	++	A-		◐	Internet needed for chats	1	People living with chronic disease			●		●		●	3.15	3.79
What's Up				◐	Internet needed for chats	1	None			●					2.67	3.83
Wisdo	+++	A-	T	◐	Internet needed	1	None			●		●			3.38	4.25

*More languages available in iOS (see Appendix C)

All numbers shown are medians since averages were not available for these metrics on the third-party analytics platform used. Top performing apps are apps with the highest number of downloads. Some apps were included in more than one OAC RFSQ component, which is why some top performing apps are repeated (e.g. Headspace & Ouchie).

OAC RFSQ Component	# apps in this RFSQ category	Data type	# apps with this data available	Metric	Top performing app	Jan 10 - Feb 10	Feb 11 - Mar 10	Mar 11 - Apr 10	Apr 11 - May 10	May 11 - Jun 10	Jun 11 - Jul 10	Jul 11 - Aug 10	Aug 11 - Sep 10	Sep 11 - Oct 10	Oct 11 - Nov 10	Nov 11 - Dec 10
Peer Chat/Digital Therapeutic	75	iOS & Android	23	DAU	Spruce	6022	6353	5100	2619	1286	6513	5505	5608	8792	7010	6746
				MAU		16165	16828	15838	3981	6193	19525	19646	25830	25519	27647	37102
				Downloads		237	263	228	186	198	349	357	415	419	423	428
		iOS only	4	DAU	UpLift	--	256	1281	1340	1053	2219	2195	2043	1453	1506	1220
				MAU		20715	23753	31562	33978	35959	38640	40659	42031	41948	42005	45984
				Downloads		--	98	81	32	99	100	92	73	60	55	38
		Android only	3	DAU	Ouchie	--	--	--	278	662	--	--	--	--	--	--
				MAU		--	110	109	813	8315	15080	18438	21066	28449	31247	29882
				Downloads		--	--	--	92	126	--	--	--	--	--	--
Therapy AVATAR	32	iOS & Android	5	DAU	Headspace	6308	6081	5013	4440	6693	5321	4410	3738	3559	3211	2941
				MAU		39803	38245	34987	33137	35732	33582	30092	26994	25115	22267	17844
				Downloads		263	260	204	198	285	158	172	151	159	110	103
		iOS only	4	DAU	UpLift	--	225	1240	1340	1037	2215	2195	2043	1453	1506	1220
				MAU		--	352	2418	3894	4150	7075	8653	9202	8624	8306	7937
				Downloads		--	98	80	32	92	100	92	73	60	55	38
		Android only	3	DAU	Ouchie	--	--	--	278	662	--	--	--	--	--	--
				MAU		--	--	--	745	3809	--	--	--	--	--	--
				Downloads		--	--	--	92	126	--	--	--	--	--	--
Passive Data	41	iOS & Android	8	DAU	Azova	883	799	169	386	780	131	373	486	359	429	5873
				MAU		11557	10850	979	1728	4494	2182	1225	3610	3890	4035	30883
				Downloads		83	83	84	87	151	11	60	85	83	99	371
		iOS only	2	DAU	CaptureProof	--	--	--	--	--	--	--	--	--	--	--
				MAU		--	--	--	--	--	--	--	--	--	--	--
				Downloads		--	--	9	--	--	7	--	--	--	--	--
		Android only	2	DAU	Melon	--	--	--	--	14	--	--	--	--	--	--
				MAU		--	--	--	--	115	--	--	--	--	--	--
				Downloads		--	--	--	4	4	--	--	--	--	--	--

FREE APPS TO HELP PEOPLE COPE WITH COVID-19 June 2020

This review highlights well-established and popular free apps to help people cope with COVID-19. These apps have either made existing content available for free during the pandemic, or added new content to address issues arising from COVID-19.

App Name / Developer	Platform			Cost		Intervention Components						Available Languages	Population-Specific Tailored Content	Available COVID-19 Specific Content	Year Launched	# of Downloads (in past 90 days)		Published Research Evidence	Vetted in Help@Hand RFSQ?
	iOS	Android	Web	Completely Free	Free, with additional features available in paid version	CBT	Positive Psychology	Mindfulness	Chatbot/AI	Symptom Tracking	Psychoeducation					iOS	Android		
Calm / **Calm, Inc.**	•	•	•		•		•	•				English, German, Spanish, French, Korean, Portuguese	Children	Free resource hub online: https://www.calm.com/blog/take-a-deep-breath	2013	2,279,000	2,272,000	Yes	No
COVID Coach / **National Center for PTSD**	•	•		•		•	•	•		•	•	English	Some resources for military personnel & parents/caregivers	App created for COVID-19 & draws from another app by same developers	2020	16,920	9,412	No	No
Happify / **Happify, Inc.**	•	•	•		•	•	•	•		•	•	English, Chinese, French, German, Japanese, Portuguese, Spanish, Traditional Chinese	None	Has content such as "Managing Stress in Uncertain Times"	2013	30,290	9,125	Yes	Yes
Headspace* / **Headspace Inc.**	•	•	•		•		•	•				English, French, German, Portuguese, Spanish	Children	COVID-19 "Weathering the storm" content pack free for everyone. Premium access is free to the unemployed, health professionals, & educators during pandemic	2012	860,200	851,200	Yes	Yes
NOD / **Grit Digital Health**	•	•		•		•	•	•				English	College students & young people	App redesigned for COVID-19 & has activities for social distancing	2019	1,108	738	No**	Yes
Sanvello* / **Sanvello Health Inc.**	•	•	•		•	•		•		•	•	English, text translations in Spanish & French	None	to the pandemic. Premium access is free during pandemic	2012	63,020	254,800	Yes	No
SuperBetter / **SuperBetter, LLC**	•	•	•	•		•	•				•	English	None	T ("Stay Strong in a Pandemic" & "Stay-at-Home Scavenger Hunt")	2012	10,030	3514	Yes	No
This Way Up / **St Vincent's Hospital Sydney**			•	•		•				•	•	English	Teenagers, young adults, & adults	Guided downloadable workbooks & resources ("Staying on Track During the Pandemic")	2012	N/A – Web app	N/A – Web app	Yes	No
Woebot / **Woebot Labs, Inc.**	•	•		•		•			•	•	•	English	Young adults	Additional COVID-19 lesson ("Perspective")	2018	23,760	115,800	Yes	No
Wysa * / **Wysa Ltd.**	•	•			•	•		•	•	•	•	English	None	Has health anxiety & isolation content free to anyone during pandemic	2016	30,450	45,770	Yes	Yes

* Apps included in Catalyst toolkit located at: https://georgehills.SharePoint.com/sites/helpathand/_layouts/15/Doc.aspx?sourced Resources.docx&action=default&mobileredirect=true

** Randomized control trial completed, but not yet published

Learning Brief: Marketplace Performance of Mental Health Apps during COVID-19

September 2020

Multiple sources have reported increases in mental health needs since the outbreak of COVID-19, as shown by increasing rates of anxiety, depression, stress, sleep disturbance, and substance use.[1,2,3,4] Increased rates of mental health symptoms are especially prevalent among those most directly impacted, such as frontline medical workers[5] and children.[6] Given unique barriers to care that currently exist (e.g. physical distancing measures that may limit contact with providers), people are looking to digital tools to help them manage these stressors. This may potentially lead to an important opportunity for digital mental health. [7,8] Indeed, many digital mental health companies have reported that they have received record numbers of users during the pandemic. [9,10,11]

As such, Tri-City expressed interest in learning about the traffic and use of the following apps since the onset of COVID-19 in March 2020:

- Calm
- Headspace
- iChill
- myStrength
- Sanvello
- Wysa

This learning update presents marketplace performance data on the number of downloads and daily active users (DAU) to examine traffic and use. The data reflects users in the United States during the time period of March – September 2020. The data is combined across iOS and Android apps stores. Data separated for iOS and Android is available on request.

METRIC	DEFINITION
Number of Downloads	Number of new users downloading the app for the first time over a defined time period.[a]
Daily Active Users (DAU)	Number of unique devices that created at least one session (e.g., opened the app) in a 24-hour period.[b]
Average Daily Active Users (DAU)	The average DAU over a period of time.[c]

Overall Number of Downloads and Daily Active Users by Month

Below are the number of downloads and daily active users over two-month periods for each app.

Number of Downloads

	Jan-Feb	Mar-Apr	% change	May-Jun	% change	Jul-Aug	% change
Calm	2,469,074	2,767,405	+12%	3,128,669	+13%	2,796,824	-11%
Headspace	1,282,453	1,279,537	-0.2%	1,100,017	-14%	741,374	-33%
iChill	80	72	-10%	961	+1,235% [d]	327	-66%
myStrength	7,859	15,157	+93%	34,662	+129%	26,941	-22%
Sanvello	48,824	175,191	+259%	234,537	+34%	264,983	+13%
Wysa	68,533	47,883	-30%	58,350	+22%	66,051	+13%

*NOTE: Percent change represents change from previous two-month period

[a] This metric only captures overall new users. Re-downloads do not count toward this metric (i.e., if you break your phone, get a new phone, re-download the same app again – the re-download will not count). App updates also do not count toward this metric.
[b] This means that a user who opened the app once and a user who opened the app 10 times in the last 24-hours are both only counted as one DAU.
[c] Any time that you are looking at DAU over an aggregated period of time (e.g., a week, month, quarter, year, etc.) you are looking at the Average DAU. For example, if you look at the DAU for April 2018, then you are looking at the average of the 30 daily DAU values in that month.
[d] Please note this app had small number of total downloads and DAUs.

Average DAU

	Jan-Feb	Mar-Apr	% change	May-Jun	% change	Jul-Aug	% change
Calm	1,954,907	1,975,848	+1%	2,234,581	+13%	2,246,286	+1%
Headspace	939,467	1,055,420	+12%	960,340	-9%	847,818	-12%
iChill	17	15	-15%	78	+423%	40	-49%
myStrength	984	2,184	+122%	5,800	+166%	5,271	-9%
Sanvello	24,684	60,908	+147%	117,792	+93%	156,249	+33%
Wysa	37,471	26,538	-29%	29,023	+9%	29,442	+1%

*NOTE: Percent change represents change from previous two-month period

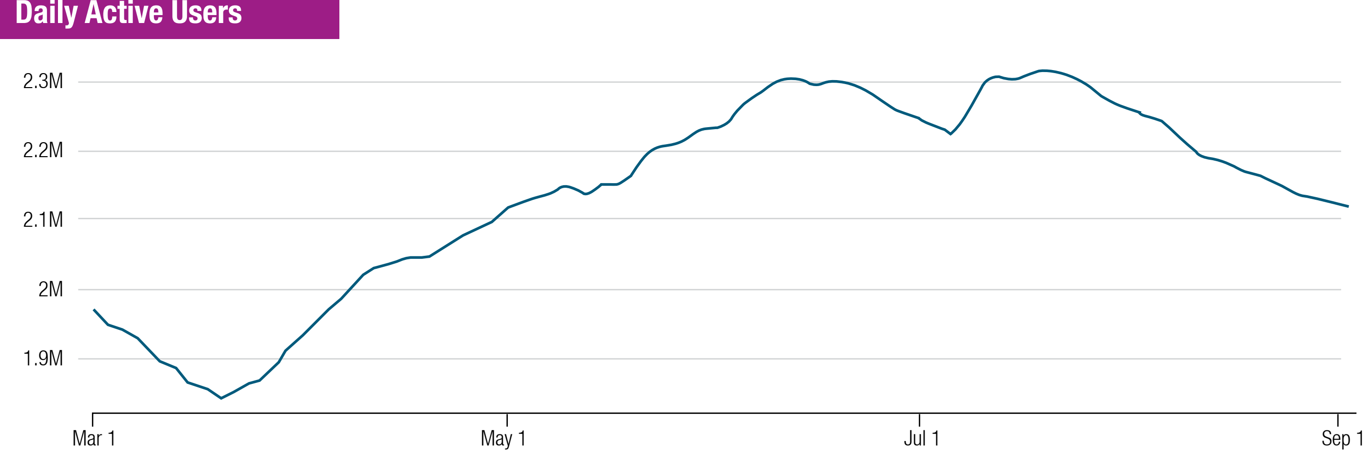
Detailed Number of Downloads and Daily Active Users by App

Below are the number of downloads and daily active users for each app between March 1-September 3, 2020.

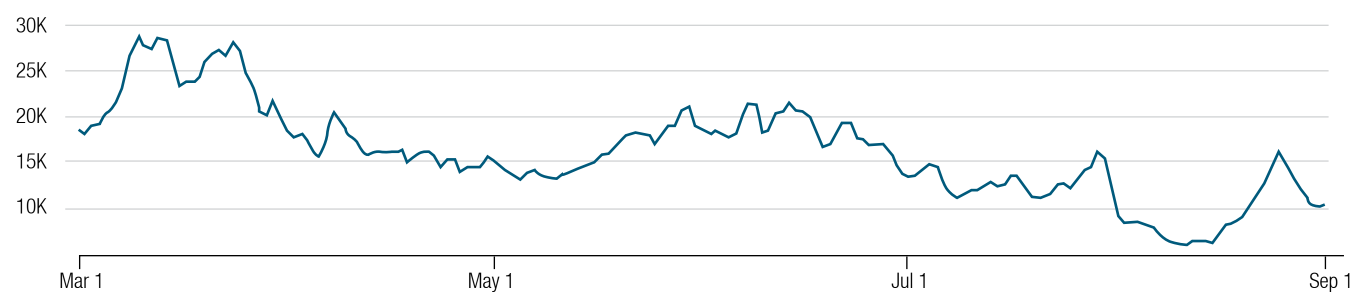
Calm

Downloads

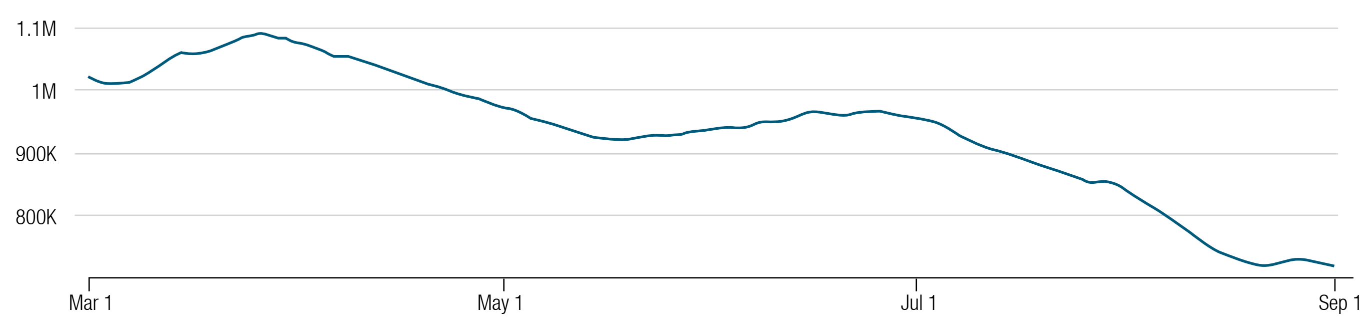
Daily Active Users

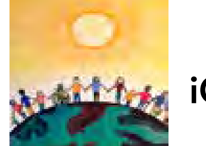


Downloads



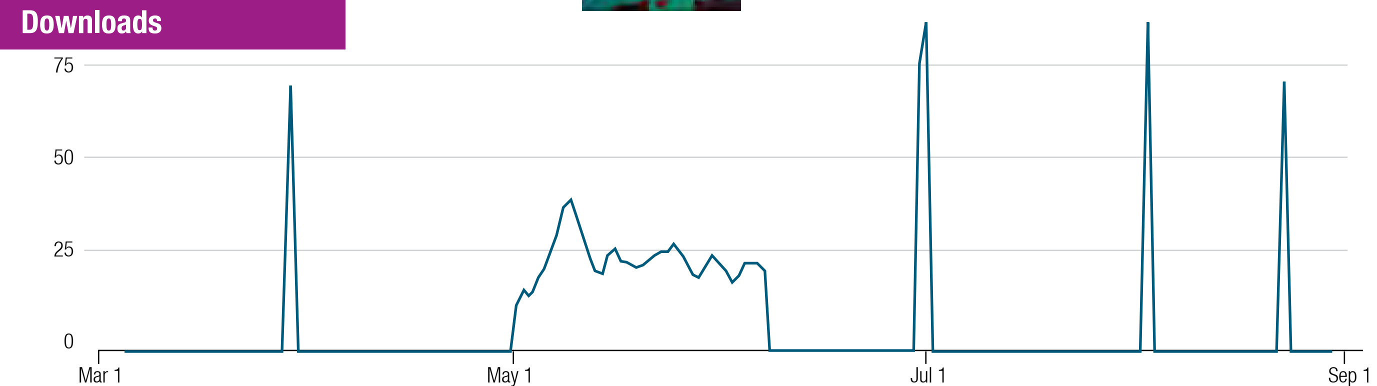
Daily Active Users



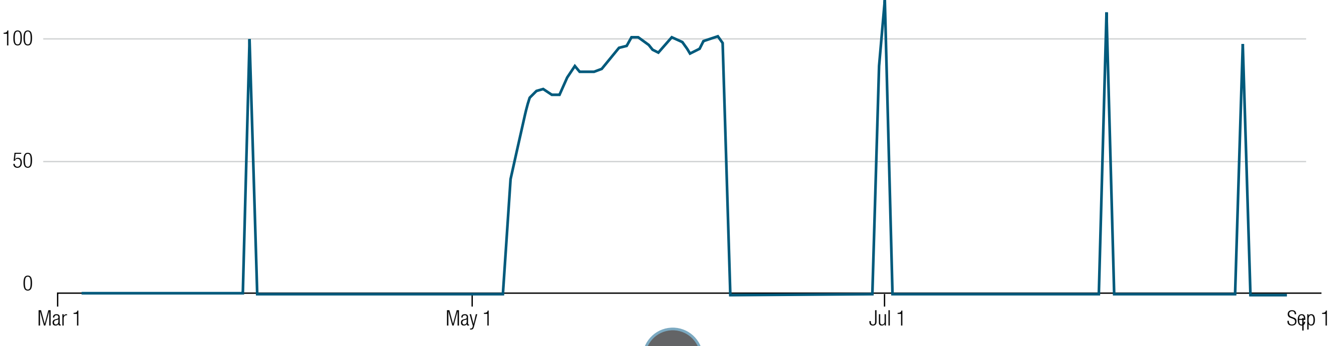


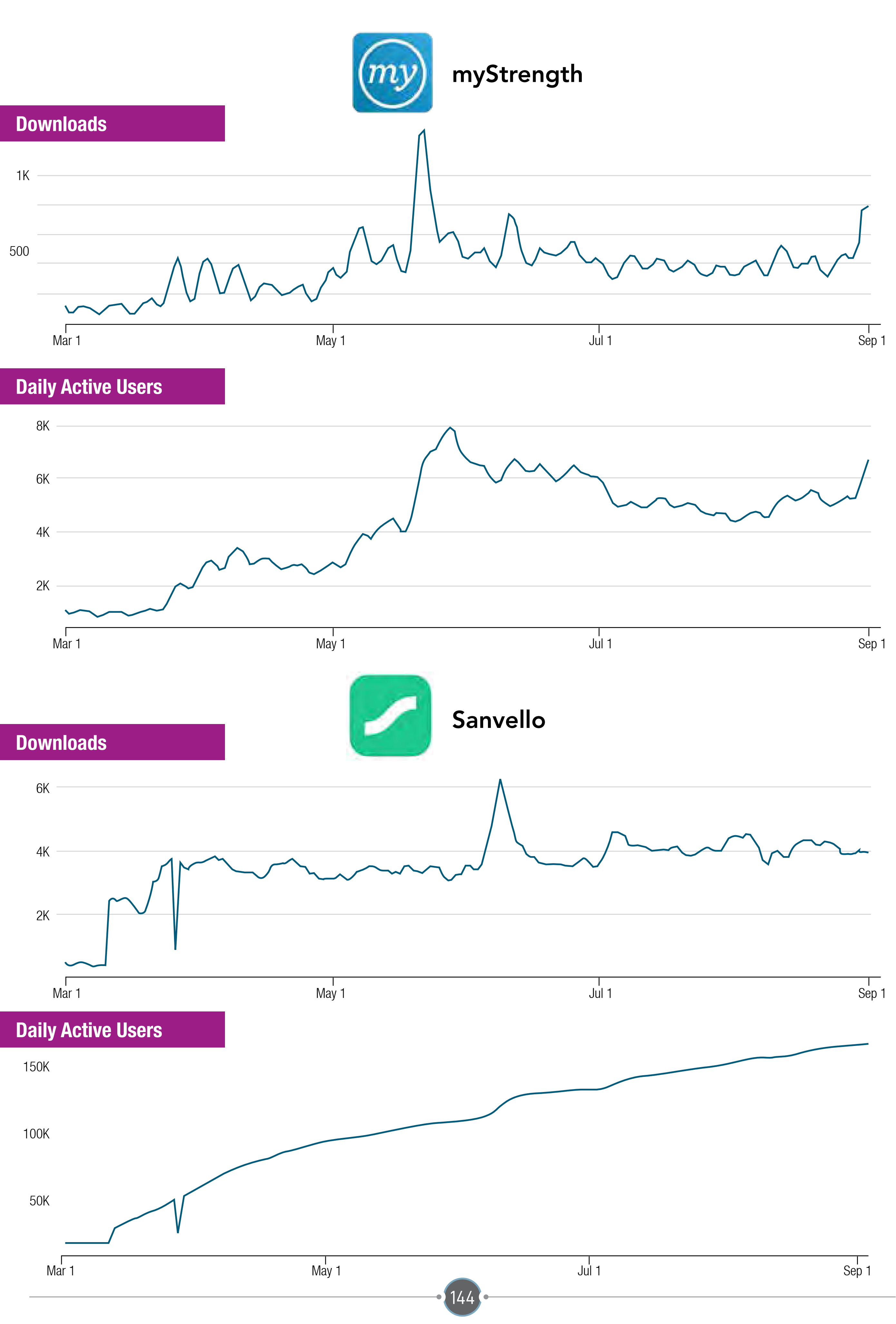
iChill

Downloads



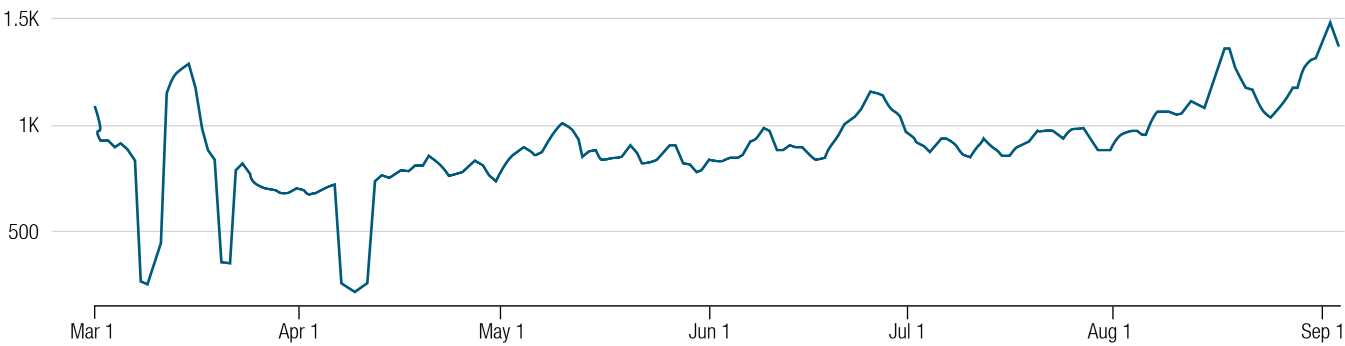
Daily Active Users



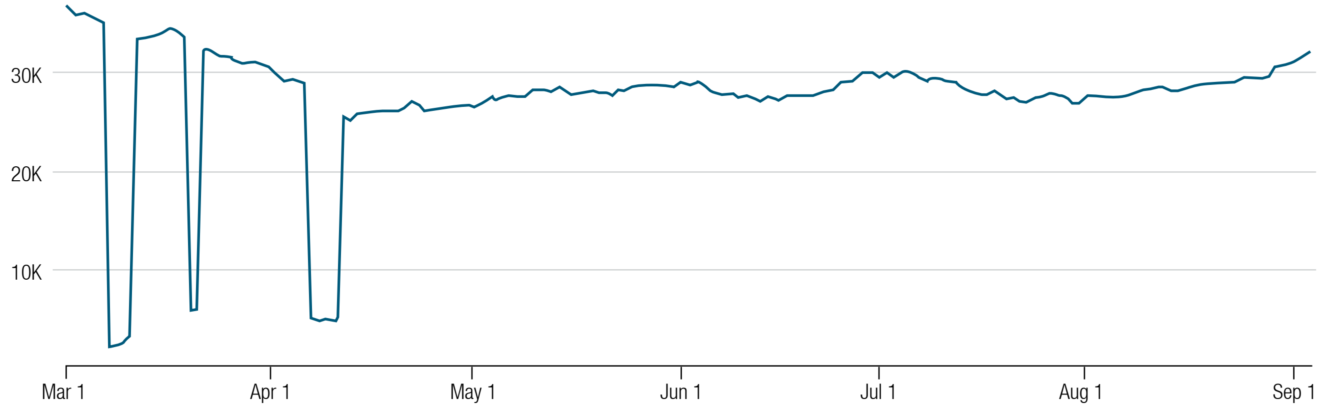


my
myStrength
Downloads
1K
500
Mar 1
May 1
Jul 1
Sep 1
Daily Active Users
8K
6K
4K
2K
Mar 1
May 1
Jul 1
Sep 1
Sanvello
Downloads
6K
4K
2K
Mar 1
May 1
Jul 1
Sep 1
Daily Active Users
150K
100K
50K
Mar 1
May 1
Jul 1
Sep 1

Downloads



Daily Active Users



Notable Partnerships

Below are links to articles describing notable partnerships for each app that may have affected market performance.

Calm membership included on American Express cards [May 18, 2020]

Calm available to Kaiser Permanente members [May 19, 2020

Headspace free for healthcare professionals [March 16, 2020]

Headspace available to NY state residents [Apr 6, 2020]

Headspace available to all LA County Residents [Apr 28, 2020]

Headspace made available for free for people who are unemployed [May 14, 2020]

myStrength available to Kaiser Permanente members[April 2, 2020]

Sanvello announced free premium access for anyone [March 20, 2020]

Sanvello releases free clinician dashboard to mental health professionals [Apr 16, 2020]

Aetna International announces partnership with Wysa [May 18, 2020]

Wysa being offered for free at Cincinnati Children's Hospital [Aug 8, 2020]

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[3] *"Staggering" Increase in COVID-Linked Depression, Anxiety*. (n.d.). Medscape. Retrieved September 10, 2020, from http://www.medscape.com/viewarticle/934882

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[5] Pappa, S., Ntella, V., Giannakas, T., Giannakoulis, V. G., Papoutsi, E., & Katsaounou, P. (2020). Prevalence of depression, anxiety, and insomnia among healthcare workers during the COVID-19 pandemic: A systematic review and meta-analysis. *Brain, behavior, and immunity*.

[6] Courtney, D., Watson, P., Battaglia, M., Mulsant, B. H., & Szatmari, P. (2020). COVID-19 impacts on child and youth anxiety and depression: challenges and opportunities. *The Canadian Journal of Psychiatry*, 0706743720935646.

[7] Torous, J., Myrick, K. J., Rauseo-Ricupero, N., & Firth, J. (2020). Digital mental health and COVID-19: Using technology today to accelerate the curve on access and quality tomorrow. *JMIR mental health*, 7(3), e18848.

[8] Ben-Zeev, D. (2020). The digital mental health genie is out of the bottle. *Psychiatric Services*, appi-ps.

[9] As Headspace booms, the app's popularity outpaces its evidence. (2020, August 7). *STAT*. https://www.statnews.com/2020/08/07/headspace-mindfulness-covid19-employers/

[10] *Healthcare Apps: A Boon, Today And Tomorrow*. (n.d.). Retrieved September 10, 2020, from https://www.forbes.com/sites/eladnatanson/2020/07/21/healthcare-apps-a-boon-today-and-tomorrow/#5700a6101bb9

[11] *Telemedicine, Once a Hard Sell, Can't Keep Up With Demand - WSJ*. (n.d.). Retrieved September 10, 2020, from https://www.wsj.com/articles/telemedicine-once-a-hard-sell-cant-keep-up-with-demand-11585734425

Learning Brief: Mental Health Apps Provided and Recommended By California Insurance Plans

September 2020

The table below summarizes a selection of mental health apps that are provided or recommended by insurance plans across California. The information provided was gathered in Summer 2020.

App	Description	Provided by[1]	Recommended By[2]
Calm	Calm is a mindfulness apps with content for music, meditation, and sleep.	Oscar Kaiser Permanente	Blue of California Anthem Blue Cross
	Headspace is a mindfulness meditation app, which includes content to help users focus, sleep, meditate, and be more physically active.	--	Blue of California
	MyLife Meditation (formerly Stop, Breathe & Think) allows users to check in with how they are feeling, and recommends short guided meditations and mindfulness activities based on current mood.	--	Anthem Blue Cross
my	myStrength allows users to track their mood over time, join supportive online communities, and access other educational and coping resources to help with the management of depression, anxiety, stress, etc.	Kaiser Permanente	--
	Recovery Record is designed to aid recovery from eating disorders using techniques rooted in cognitive behavioral therapy (CBT).	--	Cigna
	Sanvello uses principles of CBT to help users with symptoms of anxiety, depression, or stress.	United Healthcare	--
	Teladoc connects users with medical and behavioral health professional through phone or video.	Tufts Health Plan Molina	--
	Virtual Hope Box contains simple tools to help users with coping, relaxation, distraction, and positive thinking. It also allows users to upload photos and other files to create a "hope box."	--	Anthem Blue Cross
	Wysa is an artificially intelligent (AI) chatbot who can coach users to cope with issues like stress, depression, anxiety, sleep, etc.	Aetna	--

[1] App is included in membership with free or discounted access for insurance plan members.
[2] App is listed on insurance plan's website as a recommended resource, but no free or discounted access benefits for insurance plan members.

MYSTRENGTH AND SIMILAR APPS

September 2020

PRODUCT MATRIX SUMMARY

research evidence. Please note that the Help@Hand product matrix did not have information related to "Specialized Target Populations," "Improving Communication with Isolated Individuals," and "Utilization of Peers" for these apps.

App Name	OAC Component	Additional Product Features	Physical or Behavioral Health	Referral	Monolingual Support	Wearable/ Additional Tech	Published Research Evidence
myStrength	Digital Therapeutics	Addiction Recovery + Goal Setting Mood Tracker + Meditation + Journal + Assessments	Behavioral	Needs Referral	Spanish	None listed on product matrix	No
Happify	Digital Therapeutics	Community / Group Involvement + Goal Setting + Mood Tracker + Meditation + Journal + Assess-ments + Games	Behavioral	No Referral Necessary	Chinese, French, German, Japanese, Portuguese, Spanish, Traditional Chinese	None listed on product matrix	Yes
Meru	Chat (Therapist or Non-Peer) + Digital Therapeutics	Care Coordination + Virtual Appointments / Telehealth + Meditation + Assessments	Physical & Behavioral	Needs Referral	None listed on product matrix	Wearable/ Additional Tech	Yes
SilverCloud	Chat (Therapist or Non-Peer) + Digital Therapeutics	Addiction Recovery + Virtual Appointments / Telehealth + WRAP or Action Planning + Goal Setting + Mood Tracker + Journal + Assessments	None listed on product matrix	No Referral Necessary	None listed on product matrix	None listed on product matrix	Yes

SELECTIONS FROM PUBLISHED RESEARCH EVIDENCE

Below is a selection of the published literature of Happify, Meru, and SilverCloud. Studies related to the feasibility and acceptability of these apps among users and/or studies that had strong research design are shown since they may help inform decisions of Help@Hand Counties/Cities.

Happify

Article Name: "Seeing the 'Big' Picture: Big Data Methods for Exploring Relationships Between Usage, Language, and Outcome in Internet Intervention Data."

Publication year: 2016

What did the study look at? Does greater usage of Happify predict higher well–being?

How did they collect the data? 152,747 users within the app were sampled. The research team used a proprietary measure called the Happify Scale to measure positive emotion and satisfaction with life.

What did they learn? It is challenging to infer data without a control group. The goal of the study was more to understand how to leverage big datasets to understand the effects of using Happify without inferring its effectiveness. Analyzing data within each user led the team to conclude that those who used the app saw greater well–being during periods of time when they used Happify more frequently.

Citation: Carpenter, J., Crutchley, P., Zilca, R. D., Schwartz, H. A., Smith, L. K., Cobb, A. M., & Parks, A. C. (2016). Seeing the "Big" Picture: Big Data Methods for Exploring Relationships Between Usage, Language, and Outcome in Internet Intervention Data. Journal of Medical Internet Research, 18(8), e241. https://doi.org/10.2196/jmir.5725

Article Name: Effect of Brief Biofeedback via a Smartphone App on Stress Recovery: Randomized Experimental Study

Publication year: 2019

What did the study look at? Does using Happify lead to physiological and psychological effects that indicate stress reduction?

How did they collect the data? They sampled 140 participants who were randomized to recover from a stressful situation in one of three ways: with no phone; with a phone (no Happify); and with Happify. The research team measured stress through a self–report measure and by measuring two salivary biomarkers (Salivary cortisol and sAA [salivary alpha amylase]).

What did they learn? The study found significantly lower levels of sAA for those in the Happify group, with no significant differences for the conditions of levels of salivary cortisol and self–reported stress.

Citation: Hunter, J. F., Olah, M. S., Williams, A. L., Parks, A. C., & Pressman, S. D. (2019). Effect of Brief Biofeedback via a Smartphone App on Stress Recovery: Randomized Experimental Study. JMIR Serious Games, 7(4), e15974. https://doi.org/10.2196/15974

Article Name: Testing a scalable web and smartphone based intervention to improve depression, anxiety, and resilience: A randomized controlled trial

Publication year: 2018

What did the study look at? Does use of Happify reduce depression and anxiety symptoms and increase resilience?

How did they collect the data? Final data was taken from 1,051 total users who were randomized into conditions of using Happify or receiving psychoeducation–only. Users were further split into subgroups of recommended usage or low usage of both conditions. The researchers used the PHQ–9, GAD–7, and a proprietary scale to measure depression, anxiety, and resilience, respectively.

What did they learn? Participants who used Happify at recommended levels reported fewer depressive and anxiety symptoms and greater resilience.

Citation: Parks, A. C., Williams, A. L., Tugade, M. M., Hokes, K. E., Honomichl, R. D., & Zilca, R. D. (2018). Testing a scalable web and smartphone based intervention to improve depression, anxiety, and resilience: A randomized controlled trial. International Journal of Wellbeing, 8(2), 22–67. https://doi.org/10.5502/ijw.v8i2.745

Meru

Article Name: Feasibility and Efficacy of the Addition of Heart Rate Variability Biofeedback to a Remote Digital Health Intervention for Depression

Publication year: 2020

What did the study look at? How feasible is it to use Meru with Heartrate Variability Biofeedback and did this treatment show changes in symptoms of depression?

How did they collect the data? An enhanced group (N = 48) where patients received heartrate variability–biofeedback (HRV–B) along with using Meru, was compared to a standard group (N = 48) which only used Meru (no HRV–B). The study took historical outcome data from a group of patients. Researchers used the PHQ–9 to measure changes in symptoms and also used the number of completed exercises and other usage statistics such as hours spent in practice and the number of messages sent between therapist and client to measure engagement.

What did they learn? Patients in the enhanced group were more likely to report a clinically significant improvement in depressive symptom score post–intervention.

Citation: Economides, M., Lehrer, P., Ranta, K., Nazander, A., Hilgert, O., Raevuori, A., … Forman–Hoffman, V. L. (2020). Feasibility and Efficacy of the Addition of Heart Rate Variability Biofeedback to a Remote Digital Health Intervention for Depression. Applied Psychophysiology and Biofeedback, 45(2), 75–86. https://doi.org/10.1007/s10484–020–09458–z

Article Name: Feasibility of a Therapist–Supported, Mobile Phone–Delivered Online Intervention for Depression: Longitudinal Observational Study

Publication year: 2019

What did the study look at? How feasible is it to integrate the Ascend intervention from Meru Health?

How did they collect the data? Researchers conducted 2 pilot studies with a total of 117 Finnish adults with elevated depression symptoms were prescribed a specific intervention within Meru. Researchers examined dropout rates and daily practice with Meru. They also looked at weekly group chat use and changes in depression symptoms using the BDI–II for study 1 and the PHQ–9 for study 2.

What did they learn? Dropout rates were 27% for study 1 and 15% for study 2. Daily practice and group chat use decreased from the beginning of the intervention to 4–weeks after the interven–tion. Depression rates decreased as well during the period. More daily practice and chat group use predicted occurrence of fewer depressive symptoms at 4–weeks after the intervention.

Citation: Goldin, P. R., Lindholm, R., Ranta, K., Hilgert, O., Helteenvuori, T., & Raevuori, A. (2019). Feasibility of a Therapist–Supported, Mobile Phone–Delivered Online Intervention for De–pression: Longitudinal Observational Study. JMIR Formative Research, 3(1), e11509. https://doi.org/10.2196/11509

Article Name: Long–Term Outcomes of a Therapist–Supported, Smartphone–Based Intervention for Elevated Symptoms of Depression and Anxiety: Quasiexperimental, Pre–Postintervention Study

Publication year: 2019

What did the study look at? Does the Ascend intervention in Meru maintain a reduction in symptoms of anxiety and depression up to 12–months post–treatment?

How did they collect the data? The study involved 102 adult participants who were a part of a previous study and who showed a reduction in symptoms of anxiety and depression. Researchers measured change with the GAD–7 and PHQ–9.

What did they learn? The intervention was associated with reductions in symptoms of depression maintained 12–months after the program and symptoms of anxiety maintained 6–months after the program.

Citation: Economides, M., Ranta, K., Nazander, A., Hilgert, O., Goldin, P. R., Raevuori, A., & Forman–Hoffman, V. (2019). Long–Term Outcomes of a Therapist–Supported, Smartphone–Based Intervention for Elevated Symptoms of Depression and Anxiety: Quasiexperimental, Pre–Postintervention Study. JMIR MHealth and UHealth, 7(8), e14284. https://doi.org/10.2196/14284

Article Name: Smartphone–Delivered, Therapist–Supported Digital Health Intervention for Physicians with Burnout

Publication year: 2020

What did the study look at? Is it feasible to use Meru to support physicians experiencing burnout?

How did they collect the data? 36 physicians who were showing elevated signs of work–related stress based on a burnout measure were administered the Meru Health app. Data was available for 33 of the physicians. Researchers used a single–item burnout measure and the PHQ–9. Intervention engagement was measured by user interaction with Meru via the smartphone app (e.g., total number of seconds of completed mindfulness meditation practices).

What did they learn? There was significant decrease in burnout and depressive symptoms. Engagement metrics were not significantly associated with the outcomes.

Citation: Raevuori, A., Forman–Hoffman, V., Goldin, P., Gillung, E., Connolly, S., Dillon, E., ... & Huang, F. Smartphone–Delivered, Therapist–Supported Digital Health Intervention for Physicians with Burnout. https://static1.squarespace.com/static/5cc948f6348cd94004675d2a/t/5f3a2e6362c23339b595ce66/1597648525041/PAMF_PhysicianBurnout_MeruHealth.pdf

SilverCloud Health

Article Name: Supported Internet–Delivered Cognitive Behavioral Therapy Programs for Depression, Anxiety, and Stress in University Students: Open, Non–Randomised Trial of Acceptability, Effectiveness, and Satisfaction

Publication date: 2018

What did the study look at? How feasible is the use of SilverCloud developed platforms?

How did they collect the data? 102 participants were recruited from counseling centers at a U.S. University. The PHQ–9, GAD–7, and DASS–21 were used to assess changes in symptoms. A Satisfaction with Treatment questionnaire was also used to understand acceptability of SilverCloud.

What did they learn? There was a significant decrease in symptoms of depression, anxiety, and stress. Most participants found the programs helpful or very helpful and liked the convenience and flexibility of the intervention.

Citation: Palacios, J. E., Richards, D., Palmer, R., Coudray, C., Hofmann, S. G., Palmieri, P. A., & Frazier, P. (2018). Supported Internet–Delivered Cognitive Behavioral Therapy Programs for Depression, Anxiety, and Stress in University Students: Open, Non–Randomised Trial of Acceptability, Effectiveness, and Satisfaction. JMIR Mental Health, 5(4), e11467. https://doi.org/10.2196/11467

Article Name: An internetdelivered selfmanagement programme for bipolar disorder in mental health services in Ireland: Results and learnings from a feasibility trial

Publication date: 2020

What did the study look at? How feasible is it to use SilverCloud in a treatment facility?

How did they collect the data? 15 patients in a mental health treatment facility in Ireland used SilverCloud for 10–weeks. Feasibility was assessed from the perspective of patients and clinicians, with patient feasibility being measured through engagement with the intervention, and clinician feasibility being measured through metrics like number of patients supported and if the clinicians were active supporters of the product. Researchers also used the Satisfaction with Treatment questionnaire, Bipolar Recovery Questionnaire (BRQ), Quality of Life in Bipolar Scale (QOL.BD), Brief Illness Perception Questionnaire (BIPQ), Internal State Scale (ISS), as well as semi–structured interviews.

What did they learn? There was a high frequency of tool usage. Patients found the intervention acceptable and easy–to–use, but it was noted that there were several barriers to implementation, such as patient access to technology and low numbers of clinicians who became active supporters of the intervention.

Citation: Enrique, A., Duffy, D., Lawler, K., Richards, D., & Jones, S. (2020). An internetdelivered selfmanagement programme for bipolar disorder in mental health services in Ireland: Results and learnings from a feasibility trial. Clinical Psychology & Psychotherapy. https://doi.org/10.1002/cpp.2480

Article Name: A pragmatic randomized waitlist–controlled effectiveness and cost–effectiveness trial of digital interventions for depression and anxiety

Publication date: 2020

What did the study look at? How cost–effective is it to use SilverCloud in stepped–care settings and is it effective in reducing symptoms?

How did they collect the data? The study looked at PHQ–9, GAD–7, and WSAS to measure effectiveness among participants in a stepped–care setting. Calculated quality–adjusted life year (QALY) and a modified–Client Service Receipt Inventory (care resource–use) was also used.

What did they learn? SilverCloud users showed improvements in symptoms of depression and anxiety. The probability of cost–effectiveness was 46.6% over a 6–month period, which increased to 91.2% over a 12–month period.

Citation: Richards, D., Enrique, A., Eilert, N., Franklin, M., Palacios, J., Duffy, D., … Timulak, L. (2020). A pragmatic randomized waitlist–controlled effectiveness and cost–effectiveness trial of digital interventions for depression and anxiety. Npj Digital Medicine, 3(1). https://doi.org/10.1038/s41746–020–0293–8

Article Name: Adapting an internet–delivered intervention for depression for a Colombian college student population: An illustration of an integrative empirical approach

Publication date: 2019

What did the study look at? How can SilverCloud be adapted for different cultures?

How did they collect the data? Researchers used qualitative and quantitative methods to adapt the Space from Depression program from SilverCloud. Researchers adapted the Space from Depression program by including Colombian actors in the videos they used, common phrases used in Colombia, and relevant scenarios. Researchers developed their own measure, the Cultural Relevance Questionnaire (CRQ), which they administered to reviewers of the adapted product to help rate cultural validity.

What did they learn? Researchers found that the changes made to the adapted product was positive, and feedback was used to further improve the product.

Citation: Salamanca–Sanabria, A., Richards, D., & Timulak, L. (2019). Adapting an internet–delivered intervention for depression for a Colombian college student population: An illustration of an integrative empirical approach. Internet Interventions, 15, 76–86. https://doi.org/10.1016/j.invent.2018.11.005

Peer Evaluation Learnings

September 2020

EXECUTIVE SUMMARY

Between April and June 2020, the Help@Hand Evaluation Team conducted one-on-one telephone interviews with Peer Leads (N = 11) and Tech Leads (from Counties/Cities without Peer Leads; N = 2) from the following regions participating in the Help@Hand Collaborative: City of Berkeley; Kern County; Los Angeles County; Marin County; Modoc County; Monterey County; Orange County; Riverside County; San Mateo County; Santa Barbara County; Tehama County; and Tri-City. Interview transcripts were analyzed using Atlas.ti. Results are summarized in **Table 1**. More detailed results will be reported in the Y2Q3 Evaluation Report.

Major Learnings

- **Peer involvement in the Help@Hand Collaborative is overwhelmingly seen as a value-added component**, with Peers offering a unique and critical perspective on product selection, development, and delivery.
- The size and employment models of the Peer workforce are both quite variable across Help@Hand counties/cities, and a number of counties/cities have engaged subcontractors to access Peers and facilitate program management.
- In Year 2 Quarter 1, **Peers were involved in a variety of activities**, including creating materials, outreach, product testing, and being trained in digital literacy.
- In Year 2 Quarter 3, **Counties/Cities plan to involve Peers in virtual outreach, digital literacy training, and reviewing apps**.
- **Integrating Peer input into Help@Hand continues to be an essential element of the project's mission and vision**. A number of counties/cities reported very positive experiences with Peers providing input locally. Perceptions of Peer input at the Collaborative-level was mixed, with some respondents noting room for improvement.
- **Leveraging the power of the Collaborative to enhance the effectiveness of Help@Hand also continues to be critical for project success**. Although a couple of respondents gave very positive and specific examples of assistance they received from other counties/cities in the Collaborative, a majority of respondents expressed an interest in clarifying the decision-making process across the Collaborative.
- Respondents reported a range of challenges to integrating Peers into the Help@Hand Collaborative. **Client-level challenges** included: lack of digital literacy among clients; lack of access to the internet or cell phones among clients; need for bilingual staff and materials; and restrictions on face-to-face contact related to the COVID-19 pandemic. **County/City-level challenges** related to: the COVID-19 pandemic (i.e., re-allocation of county/city resources and work-from-home requirements); limited Peer staffing capacity since many Peers wear multiple hats within their agencies and do not have enough time to spend on Help@Hand; need for better internal communication within and among county/city staff; and difficulty recruiting, hiring and retaining Peers.

Major Recommendations

The learnings indicate that there are potential gains by facilitating greater flow of information across the Collaborative. The impact has been considerable when counties/cities have made personal contact with their counterparts at other counties/cities, particularly given that each county/city has pioneered unique strategies for overcoming challenges that might well be translatable to additional counties/cities. The current structure, in which Peers exchange information with one another in a Peer-only call, limits the potential degree to which counties/cities can learn from one another and rapidly adopt innovations. Recommendations based on this synthesis are:

1. The **Peer Engagement Manager** has a central role in providing strong leadership for the Help@Hand Peer component. Therefore, it is important for Help@Hand to immediately hire a strong Peer candidate for this position. This individual will be able to accelerate the flow of Peer-related information across the Collaborative.
2. The size and complexity of the Help@Hand Collaborative Peer component requires **administrative support for the Peer Engagement Manager** in order to fully support the development and implementation of Peer activities throughout the 14 counties/cities of the Collaborative. Additional personnel may also help facilitate dissemination of information from the Collaborative to the Peers.

Table 1. Themes identified from interviews.

= theme present in 25-50% of interviews. = theme present in greater than 50% of interviews. Selected quotes provided as examples.

Peer Contribution	
	Peers add value to Help@Hand *"You need the culturally-appropriate strategies for each community. You have Peer people who have lived experience who wear that badge and can be an example to people."*
Peer Workforce Models	
	Use of Subcontractors *"We are able to make this happen with the support of a peer-trusted and peer-run [subcontractor who has] an incredible wealth of knowledge when it comes to supporting peer employment and peer tech questions."*
	Variable Peer workforce size *"As of now, there are no Peers assigned to work on this project." "We have 8 total peers – 7 plus myself.""*
Past Peer Activities	
	Creation of Help@Hand materials Outreach Product Testing Peers trained in digital mental health literacy
Planned Peer Activities	
	Outreach Peers to deliver digital mental health literacy training
	App reviewing and testing
Peer Input (County/City-level)	
	Positive assessment of Peer input *"Our leadership team really seems to support and appreciate the skills abilities and work of the peer workforce."*
	Room for improvement *"People are making decisions without having peers involved."*
Peer input (Collaborative-level)	
	Peers well integrated *"What I have seen I feel like we have a really strong voice. I feel like we have a lot of input."*
	Room for improvement *"I get the sense that the Peers feel like they are not heard."*
Horizontal Communication (County/City to County/City)	
	Productive collaborations
Vertical Communication (Collaborative to County/City)	
	Lack of clarity on roles and responsibilities, particularly related to decision making *"It is still unclear where decision making power lies in all of this. Is it the collaborative, or the county? Who from the county is part of the collaborative in terms of decision-making power?"*
Challenges (Client-level)	
	Limited digital literacy Lack of access to technology Language barriers COVID-19-related restrictions on face-to-face outreach
Challenges (County/City- level)	
	COVID-19-related work-from-home and physical distancing requirements COVID-19-related resource redirection Limited time on the project given that Peers and Peer Leads fulfill multiple roles within the county/city Miscommunication between and among county/city staff
	Difficulty finding, recruiting, and retaining qualified Peers *"That has been a challenge: to hire people specifically for Help@Hand and our program."*

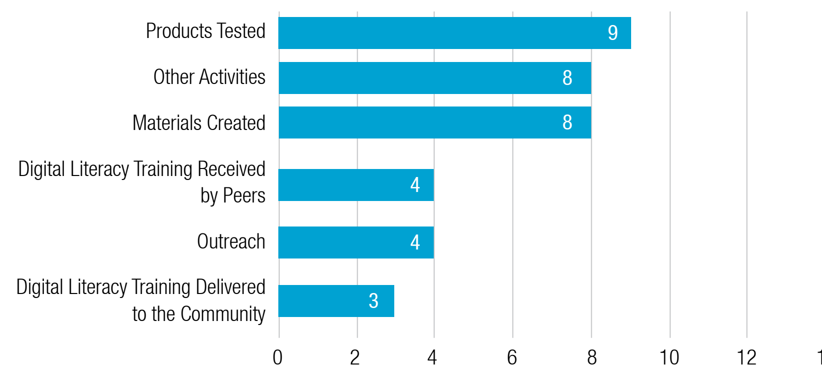
Peer Evaluation Learnings

Year 2, Quarter 3 (July - September 2020)

A brief survey was completed by 14 Peer Leads and 1 Tech Lead at the end of Q3.[1] Participating Counties/Cities included: City of Berkeley, Kern County, Los Angeles County, Marin County, Modoc County, Mono County, Monterey County, Orange County, Riverside County, San Francisco County, San Mateo County[2], Santa Barbara County, Tehama County, and Tri-City. The surveys were followed with an interview to collect additional details, and the interview findings will be summarized in the upcoming Year 2 Evaluation Report. This preliminary learning brief summarizes data from the survey in order to provide rapid feedback on the implementation of the Help@Hand Peer component.

Characteristics of Help@Hand Peer Programs		
Number of Peers Employed Across Counties/Cities		**Use of Subcontracts**
Number of Peers	**Number of Cities/Counties**	
0	1	6 Help@Hand Peer Leads are subcontractors
1	3	
2-4	4	8 Counties/Cities employ Help@Hand Peer outreach workers using a subcontract
5-8	4	
9 or more	2	

Peer Activities Reported during Year 2 Quarter 3



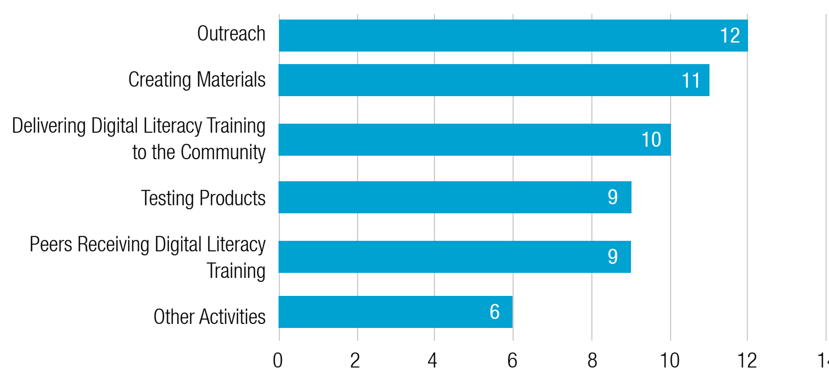
Question wording:

The following questions ask about the activities that Help@Hand Peers engaged in within your city/county during the third quarter of 2020 (July, August, September). Please choose the appropriate answer for each potential activity.

(Response options: Peers did this during 3rd Quarter or Peers did not do this during 3rd Quarter).

** The figure to the left shows the number of interviewees who responded Peers did the activity in the 3rd quarter.*

Peer Activities Planned for Year 2 Quarter 4



Question wording:

The following questions ask about PLANNED Peer activities for the fourth quarter of 2020 (October, November, December). Please indicate which of the following activities are currently planned for Peers to engage in in support of Help@Hand for the fourth quarter of 2020.

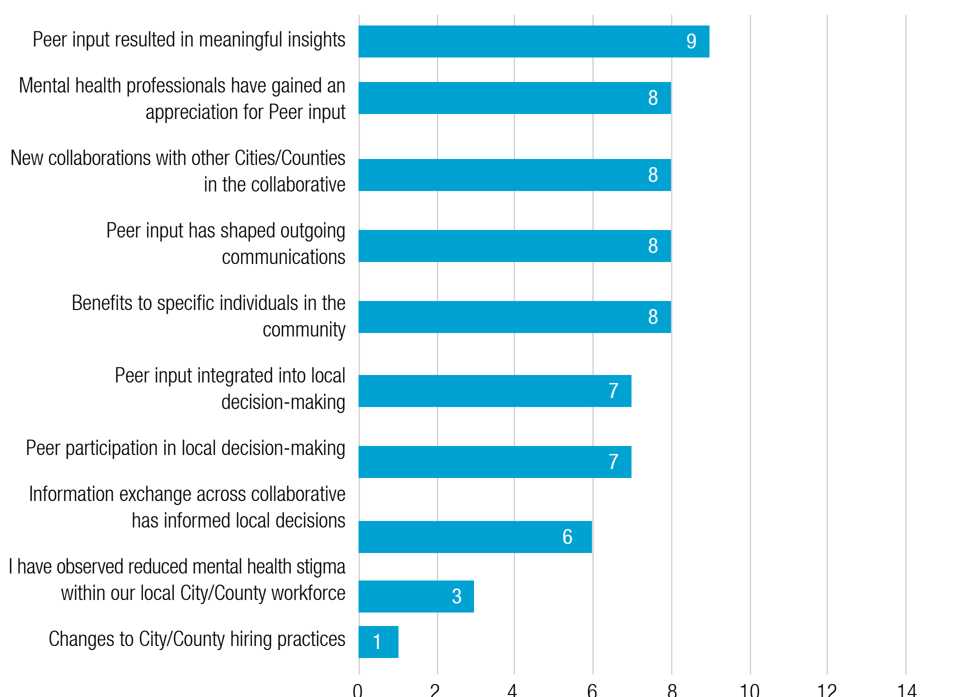
(Response options: We plan for Peers to do this in the 4th Quarter or We do not plan for Peers to do this in the 4th Quarter).

** The figure to the left shows the number of interviewees who responded Peers are planned to do the activity in the 4th quarter.*

[1] The survey was developed based on themes emerging from interviews conducted with county/city Peer and Tech Leads in Year 2, Quarter 2. The survey conducted in Year 2, Quarter 3 had a response rate of 100%. One survey was omitted from the summary of challenges and successes owing to missing data.

[2] Two Peer Leads from San Mateo County were surveyed.

Year 2 Quarter 3 Successes

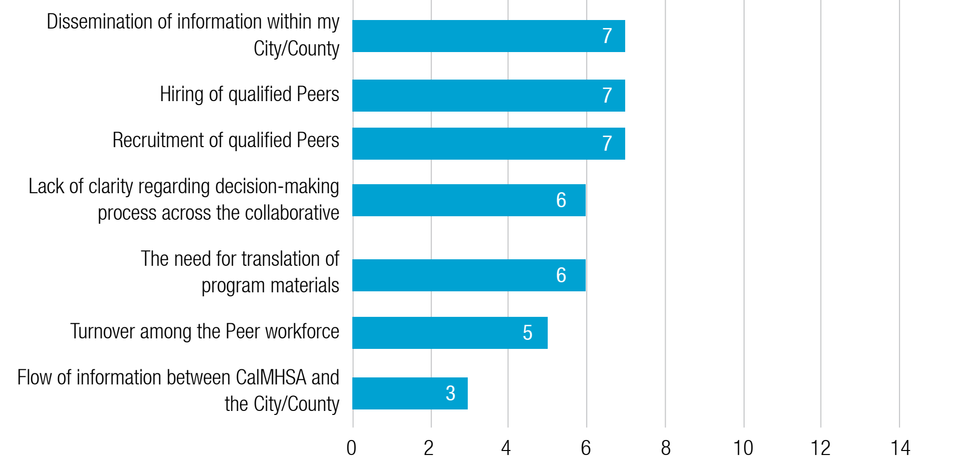


Question wording:

Successes: To help us estimate how wide-spread specific are across the Help@Hand collaborative, please indicate whether your City/ County has experienced any of the following as a consequence of participation in Help@Hand. For this question, you can think about all experiences since the start of the project. Please choose yes or no for each option.

** The figure to the left shows the number of interviewees who identified the specific success.*

Year 2 Quarter 3 Challenges



Question wording:

Challenges: To help us estimate how widespread the following challenges are, please indicate which of the following has hindered your progress as you implemented the Peer component of the Help@Hand project. For this question, you can think of all experiences since the start of the project. Please choose yes or no for each option.

** The figure to the left shows the number of interviewees who identified the specific challenge.*

Summary

Lessons Learned

Lessons learned are organized within each EPIS phase. Within each phase, learnings are further characterized by the key people/process as follows:

- RUHS-BH Leadership
- Peers (Senior Peer Support Specialists and Peer Operators)
- Technology/Take my Hand Features
- Users
- Service Delivery

Recommendations

To facilitate generalizable knowledge across the Help@Hand Collaborative, recommendations are organized in the following categories: Implementation, Organizational Change Management, Technology, and Evaluation.

The Help@Hand evaluation team acknowledges that some of the recommended actions are currently underway. These recommendations are documented, nonetheless, for the benefit of the Collaborative.

Background

Information was synthesized from the rapid deployment of Take my Hand led by Riverside University Health System-Behavioral Health (RUHS-BH) and their Peer team for the purposes of the formative evaluation. This includes identifying lessons learned and providing recommendations from the Help@Hand evaluation team. Sources of data used for this synthesis included: 1) "RUHS-BH Take my Hand Live Peer Chat COVID-19 Rapid Deployment-Test Phase Report" developed by the Help@Hand Team in Riverside County; 2) "Take My Hand Test Phase Report" developed by Riverside County's local evaluators; and 3) Riverside County meeting notes from the Help@Hand evaluation team. This synthesis may provide generalizable insights as to how other counties/cities might successfully implement and sustain Take my Hand and/or apply learnings from Riverside's experience to their own implementations of other technologies.

Thank you to the entire TakemyHand project team for sharing your materials and learnings. Special thanks to Pamela, Shannon, Dakota, Maria Martha, Suzanna, and Christy.

Exploration, Preparation, Implementation, and Sustainment Framework

The Exploration, Preparation, Implementation, and Sustainment (EPIS) framework[27] was used to organize the lessons learned and recommendations for this synthesis. The EPIS framework highlights factors across the four phases that occur when implementing a new intervention or practice.

Exploration Phase

Identifying a Need and Exploring Possible Solutions

Riverside County experienced a high volume of COVID-19 cases early in the pandemic and anticipated an associated rise in mental health needs.

Lessons Learned

RUHS–BH Leadership:

1. Identified a public health need to find a safe alternative to alleviate the growing strain being placed on 911 and 211 crisis call centers at the onset of the COVID-19 pandemic.

Peers:

1. Determined that a Peer chat app would address the public and mental health needs in their community.

[27] See https://episframework.com/ for more information on the EPIS Framework.

2. Recognized that it was important to leverage RUHS-BH's established Peer workforce, incorporating their skills and service delivery into the Take my Hand platform.

Technology:

1. Discovered through exploration that current digital mental health therapeutics (aka apps) were limited due to absence of a trained Peer Support Specialist. Specifically, someone who could address and respond to multiple needs of their community (e.g.; access to behavioral health resources, taking a non-medical approach that is recovery-oriented, multi-language capabilities, an interface that reduces mental health stigma and is multicultural, etc.).
2. Discovered through exploration that current apps did not identify core competencies of Peer support. These core competencies are defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as "the concepts and practices of 'Power Sharing', 'Recovery Coaching', 'Recovery Environment – High Expectation', 'Mutuality' and 'Role Modeling'".
3. Recognized that Take my Hand supplements already existing crisis services, and offers alternatives to these crisis services – by increasing access to Peer support, educating individuals about systems & services within Riverside County, and creating positive repute for the RUHS-BH System.
4. Ventured that Take my Hand might offer cost savings to the County by: lessening the demand on clinical and crisis services through Peer support; reducing translation service costs with its chat function; and promoting efficient use of the behavioral health services that RUHS-BH offers.

Users:

No lessons learned were identified for users during the Exploration Phase.

Service Delivery:

1. Recognized the importance of supporting community members' ability to access support with a Peer Support Specialist at any time without an appointment.
2. Identified that shifting the service location to a live virtual platform might increase accessibility to individuals within and outside of Riverside County's behavioral health system.
3. Identified the importance of Take my Hand expanding the target audience to include new people not currently engaged by RUHS-BH, at any stage of wellness (including prevention and early intervention), with no triaging required.

Recommendations

Implementation

1. Identify current offerings, limitations, and opportunities of the existing service delivery system to support a virtual platform like Take my Hand.

Organizational Change Management

Peer Support Specialists: Training, Oversight, Experience

1. Define the roles and activities of a "Peer".
2. Define the need to be met (e.g., provide non-medical support).
3. Define the target audience.

Technology

1. Identify, develop answers for and integrate into the app Frequently Asked Questions (FAQs).

Evaluation (Local Evaluators and/or Help@Hand Evaluators)

1. Document a timeline of the various assessment time-points.
2. Attempt to systematically capture information obtained during exploration that informed subsequent decision-making.

Preparation Phase

Preparing for Implementation

To prepare for the Implementation of Take my Hand, RUHS-BH began gathering information and identifying factors that would be key to successful implementation, including but not limited to, the following: completing requirements for information technology and security, testing the technology's capacity to handle large volumes of users, mitigating potential risks or harm to users, developing strategic marketing, vetting materials for cultural appropriateness, projecting how the operation of Take my Hand might impact the prioritization of other duties at RUHS-BH, identifying key administrative stakeholders to successful deployment and implementation, identifying fiscal administrative barriers, and further developing the Peer Operator role.

Lessons Learned

RUHS–BH Leadership

1. Recognized that dedicated pre-implementation time is needed to vet and review terms of service by multiple key County employees (i.e., the Director, Information Security office, County Counsel etc.).

Peers

Senior Peer Support Specialist

1. Learned that the depth and nature of training varied across Peer Support Programs. Recognized need to identify core competencies required for Peer Operators.
2. Identified training gaps among Peer Operators (e.g. how Peer Operators could respond to emergent or unanticipated topics).

Peer Operator

3. Recognized that Peer Operators working remotely allowed for chat services to be provided 24/7
4. Identified the need for advanced training around the following topics: crisis transfers, how to use the Take my Hand platform, how to handle "trolls"[28] and controversial topics, and basic Peer support was necessary.

Technology

1. Recognized and corrected limitations of landing page.
2. Identified need to development 'back-end' of product for data collection.
3. Worked with Vendor to facilitate ease of use for consumer, Peer Operator, and Clinical Support[29]

Users

1. Determined it was important to create scripted responses in preparation for frequently asked questions/topics.

Recommendations

Implementation

1. Develop an implementation plan grounded in the exploration and preparation activities completed. This plan can include:
   a. Providing guidance on training Peer Operators (i.e., when the training will take place, who will be involved in the training, what content will be included in the training, defining timepoints of assessing the fidelity of the training, and determining a follow-up plan for assessing the adequacy of that training in terms of continued skill use or needs identified post-training).
      i. Training is a good initial step, and it is important to identify training gaps to assess whether training is sufficient.
   b. Defining the steps needed to obtain leadership approvals for implementation in the clinic.
   c. Identifying when to collect specific website metrics and how those data will be used.
2. Disseminate the implementation plan to relevant clinic leadership, key stakeholders, and local evaluators.
3. Consider areas of potential adaptation to Take my Hand in the event that a nimble response is needed to respond to changes in delivery platforms or implementation processes. These areas of potential adaptation include training materials, training processes, tags and canned responses used, and Take my Hand's accessibility and functionality.

[28] Definition of Troll: "An Internet slang, a troll is a person who starts flame wars or intentionally upsets people on the Internet by posting inflammatory and digressive, extraneous, or off-topic messages in an online community (such as a newsgroup, forum, chat room, or blog) with the intent of provoking readers into displaying emotional responses…." (see https://en.wikipedia.org/wiki/Internet_troll, accessed on 10/22/2020).

[29] There were many changes requested and made to the Vendor during this time to develop the website. Additional details are available upon request to the County or CalMHSA.

4. Develop an implementation plan prior to implementing practice change. Due to the goal of rapidly deploying Take my Hand in response to COVID, development of an implementation plan was not at the forefront of RUHS-BH's deployment efforts. However, an implementation plan may be developed based on the information gathered from the 10- week test phase as RUHS-BH moves forward with piloting Take my Hand in Riverside County.

Organizational Change Management

General

1. Regularly review and update Organizational Change Management plan to reflect changes in leadership, stakeholder engagement, readiness and sustainability.
2. Consider barriers and facilitators to sustainment even in early stages of planning. Create processes that support sustainment (e.g. creating opportunities for continual training, revisiting assigned responsibilities to updated changes).

Peer Support Specialists: Training, Oversight, and Experience

1. Create a structured Peer Operator training curriculum that can be adapted or modified if needed.
2. Review trainings and work collaboratively with Peers to identify any gaps in the curriculum. This might also be useful as an ongoing process as gaps might become more apparent overtime.
3. Review chats to determine how often to offer refresher courses or adapt the training curriculum.
4. Consider County limitations to hiring or contracting Peer Operators and develop a plan to address any challenges to onboarding the Peer Operators (e.g., hold a meeting with the Human Resources department and County leadership to develop a streamlined way to onboard Peers).
5. Define hours of operation for Take my Hand. If Take my Hand is operating 24/7, then a safe and secure place with stable internet connection should be identified (especially those for those individuals working the late night and early morning shifts).
6. Develop a plan to safely handle crisis events with step-by-step instructions on how to do a warm hand-off to a clinician.
7. Develop procedures to address submitted grievances by consumers.
8. Assign tasks and timing in the OCM plan to ensure Peers are allocated to specific tasks and review and training is conducted as regular times.

Technology

1. Identify the best way to integrate the approved terms of service into the Take my Hand platform.
2. Establish and define Take my Hand's cookie policy.
3. Identify the best way to convey the terms of service and cookie policy to consumers.
4. Establish a feature and procedure for consumers to submit grievances.

Evaluation

1. Define an evaluation plan that will guide how to determine whether the questions posed in the implementation effort will be answered. For example, if the question is about the optimal number of Peer Operators to support 10 unique chats per hour, then data about the user volume, length of chats, and perceived Peer Operator efficacy to respond to chats is needed.
2. Identify the most important website metrics (i.e., what RUHS-BH is trying to change or understand) and prioritize them when exporting data.
3. Develop procedures for prioritizing and exporting chat data files (i.e., total chats, Peer Operator performance measures, chat duration, chat rating, chat availability, chat engagement, chat response time, missed chats, tag usage, chat waiting time, chat abandonment etc.)
4. Identify how chat data files will be utilized within a specific County.

Implementation Phase

Pilot Implementation of Take my Hand

RUHS-BH launched Take my Hand on April 17, 2020. The testing phase lasted about 10-weeks and was completed on June 30, 2020. RUHS-BH gathered information from this testing phase and incorporated it into two COVID-19 rapid deployment reports: 1) one cataloging information developed by the RUHS-BH team, and 2) the other synthesizing data from user surveys and Peer Operator interviews. These reports were intended to help inform the Help@Hand Collaborative and document the processes that took place in the planning, development and implementation of Take my Hand. They identified key findings from the testing phase, including areas of growth, challenges experienced, and suggestions for moving forward with Take my Hand in Riverside County.

Lessons Learned

RUHS–BH Leadership

Peers

Senior Peer Support Specialists

Peer Operators

1. Identified that user volume was low and therefore manageable (chats ranged from 0-12 per day with an average number of chats being 1.85). Concerns were voiced that a higher volume of users might lead to consumers not receiving the necessary support or limit the peer support process.
2. Peer Operators recognized the value of being mindful of individual clients' needs. Standardized 'canned' responses were viewed as being less useful due to some clients reporting their responses were unhelpful.
3. Peer Operator's reported that reviewing past chats and observing chats helped to reduce their own anxiety around supporting users through a chat platform.

Technology

1. Learned that call volume fluctuates significantly. Early on in the testing phase, chat volume was its highest. Chats became less frequent as the testing phase went on over time.
2. Identified that accessing resources (on the Take my Hand platform) with Helpline information available and using "canned responses" (term used by RUHS-BH) around connecting the user with crisis-related resources was an effective alternative until a warm hand off with clinical staff could be made.
3. Recognized need to examine use and functionality of tags. Most tags fell under the "other" category due to the chat topic not fitting any of the pre-existing tags.
   a. Other chat topics included: "depression", "COVID-19", "Already linked to RUHS-BH services", "anxiety", "positive feedback", "no response", "unemployment, "crisis intervention", "housing", "TAY"(Transitioned Aged Youth), "LGBT", "homeless", linked to SU Cares", "older adult", "resources", "food bank", "linked to Cares line", "repeat visitor", and "utilities help".

Users

1. Recognized need to continue to describe and address technical challenges. Most technical challenges reported were in regards to WiFi connectivity from both Peer Operators and clients.
2. Recognized need to continue to evaluate the visitor experience. It was noted that visitors to the Take my Hand website left the website when asked to answer questions at the start of a chat.
3. Concerns were expressed around the anonymity of users, especially if they reveal information that required mandated reporting.

Recommendations

Implementation

1. Keep a log of the various technical difficulties and how they were addressed.
2. Develop a short list of open-ended questions that Peer Operators can use at the start of chats to engage Users and retain them on the chatline (e.g., who is important in your life?).

3. Add new tags to capture life-stressors, such as relationship issues, stress, and parenting.
4. Identify strategies for supporting callers during crisis transfers.

Organizational Change Management

1. Designate payroll codes for Peer Operators to properly account for time spent working the chat.
2. Ensure clinical staff are trained on the purpose, development, and operations of Take my Hand.
3. Define what would constitute a crisis transfer from a Peer Operator to a clinician.
4. Develop a protocol for clinical staff and Peer Operators on how to engage in crisis related services over a chat or phone.
5. Train clinical staff and Peer Operators in engaging in crisis related services over a chat or phone.
6. Develop a streamlined way for Peer Operators, clinicians, and Senior Peer Support Specialists to communicate with one another.

Peer Support Specialists: Training, Oversight, and Experience

1. Train Peer Operators in exploring a user's expression of harm ideation to determine passive thoughts vs. active harm.
2. Develop and regularly review a safety protocol for assessing and managing crisis situations.
3. Develop a peer consultation and training protocol that includes reviewing and observing chats.

Technology

1. Create a feature that can be included in the website metrics data pull that captures technical difficulties on both the Peer Operator and User sides.
2. Define activities that constitute "trolling" (e.g., inappropriate use or behavior on platform(and create a protocol for how to address, de-escalate, and disengage with a "troll."
3. Post the Cookie Policy and Privacy Practices in both English and Spanish on the Take My Hand website.
4. Develop a Frequently Asked Questions page for the Take my Hand website.

Evaluation

1. Establish a technical difficulty monitoring protocol that determines the frequency of assessing and addressing technical difficulties.
2. Establish a fidelity monitoring protocol to assess the quality of support being provided through Take my Hand.
3. Monitor fidelity to the training protocol and determine the frequency of refresher training on the crisis transfer process, the ASIST model, and basics of Peer support.
4. Create a weekly or monthly Take my Hand Peer Operator consultation group to check in on issues that have come up during shifts, exploring solutions to challenges faced by users, and establish a support network for the Peer Operators.
5. Develop a safety protocol that is able to incorporate anonymous users if they disclose information that requires mandated reporting.
6. Identify relevant factors likely to influence call volume (e.g. marketing, PR, local and national events).

Sustainment Phase

Continued Delivery of Take my Hand at Scale

During the Sustainment Phase, it is recognized that the Outer Context (e.g., the OAC, CalMHSA, Statewide policies etc.) and Inner Context structures (e.g., RUHS-BH leadership, Peers, and Clients) and supports are ongoing so that Take my Hand continues to be delivered, with adaptation as necessary, to realize its public mental health impact. Take my Hand is currently preparing to expand within Riverside (to the Transition Aged Youth (TAY) population) and/or to other Counties. Because of this, there are yet no key findings, Lessons Learned, or Recommendations pertaining to the Sustainment Phase. However, the lessons learned and recommendations from the Exploration, Preparation and Implementation phases suggest the importance of returning to past phases to refine processes and apply recommendations in order to facilitate incremental growth and movement towards a sustained implementation system for Take my Hand.

Web Version:

"Mental Health and Technology" [Mental Health and Technology] -

"AG44" [AG44] -
The next questions are about your use of technology.

People may use the internet for streaming video/music, playing games, checking social media, using apps, browsing the web, etc, on a computer or on a phone or mobile device.

On a typical day, how often do you use the internet?

❍ 01 Almost constantly
❍ 02 Many times a day
❍ 03 A few times a day
❍ 04 Less than a few times a day

"AG45" [AG45] - On a typical day, how often do you use a computer or mobile device for social media?

Social media may include Facebook, Instagram, Twitter, Snapchat, YouTube, etc

❍ 01 Almost constantly
❍ 02 Many times a day
❍ 03 A few times a day
❍ 04 Less than a few times a day

"AG46" [AG46] - In the past 12 months, have you tried to get help from an on-line tool, including mobile apps or texting services for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?
❍ 01 Yes
❍ 02 No
If = 2, -3 go to AG48

"AG47" [AG47] - How useful was this?
❍ 01 Very
❍ 02 Somewhat
❍ 03 Not at all

"PN_AG48" [PN_AG48] -

PROGRAMMING NOTE AG48: IF AG46 =2 AND AF81 = 1 THEN CONTINUE WITH AG48 ELSE SKIP TOAG49

"AG48" [AG48] - What is the MAIN REASON you did not try to get help from an on-line tool, including mobile apps, or texting services?

- 1 Got better/ no longer needed
- 2 Wanted to handle problem myself
- 3 Don't own a smartphone or computer or don't have enough space to download new apps
- 4 Didn't know about these apps
- 5 Don't trust mobile apps
- 6 Concerns about privacy and security of data
- 7 Don't think it would be helpful or work
- 8 Cost
- 9 Don't have time
- 10 Received traditional/ face-to-face services
- 11 Don't think I needed it
- 12 Don't have enough space to download new apps
- 91 Other (Specify: _____________)

"AG49" [AG49] - In the past 12 months, have you connected online with people that have mental health or alcohol/drug concerns similar to yours through methods such as social media, blogs, and online forums?

Include online forums or closed social media groups on specific issues, doing hashtag searches on social media, or following people with similar health conditions

- 01 Yes
- 02 No

"AG50" [AG50] - In the past 12-months, have you used online tools to find, be referred to, contact, or connect with a mental health professional?

For example, by texting, on-line messaging, video chat, or a mental health or health-related mobile app

- 01 Yes
- 02 No

CATI Version:

"Mental Health and Technology" [Mental Health and Technology] -

"AG44" [AG44] - The next questions are about your use of technology.

People may use the internet for streaming video/music, playing games, checking social media, using apps, browsing the web, etc, on a computer or on a phone or mobile device.

On a typical day, how often do you use the internet?

Would you say...

01 Almost constantly,
02 Many times a day,
03 A few times a day, or
04 Less than daily?
-7 REFUSED
-8 DON'T KNOW

"AG45" [AG45] - On a typical day, how often do you use a computer or mobile device for social media? Would you say…

[IF NEEDED: "Social media may include Facebook, Instagram, Twitter, Snapchat, YouTube, etc.]

01 Almost constantly,
02 Many times a day,
03 A few times a day, or
04 Less than a few times a day?
-7 REFUSED
-8 DON'T KNOW

"AG46" [AG46] - In the past 12 months, have you tried to get help from an on-line tool, including mobile apps or texting services for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?

01 YES
02 NO
-7 REFUSED
-8 DON'T KNOW

If = 2,-7,-8 goto AG48

"AG47" [AG47] - How useful was this?

01 VERY
02 SOMEHWAT
03 NOT AT ALL
-7 REFUSED
-8 DON'T KNOW

"PN_AG48" [PN_AG48] -

PROGRAMMING NOTE AG48: IF AG46 =2 AND AF81 = 1, THEN CONTINUE WITH AG48 ELSE SKIP TOAG49

"AG48" [AG48] - What is the main reason you did not try to get help from an on-line tool, including mobile apps, or texting services?

1 GOT BETTER/NO LONGER NEEDED
2 WANTED TO HANDLE PROBLEM ON OWN
3 DON'T OWN A SMARTPHONE OR COMPUTER OR DON'T HAVE ENOUGH SPACE TO DOWNLOAD NEW APPS
4 DIDN'T KNOW ABOUT THESE APPS
5 DON'T TRUST MOBILE APPS
6 CONCERNS ABOUT PRIVACY AND SECURITY OF THE DATA

- 7 DON'T THINK IT WOULD BE HELPFUL OR WORK
- 8 COST
- 9 DON'T HAVE TIME
- 10 RECEIVED TRADITIONAL/FACE-TO-FACE SERVICES
- 91 DON'T THINK I NEEDED IT
- 12 DON'T HAVE ENOUGH SPACE TO DOWNLOAD NEW APPS
- 13 Other (Specify: _____________)
- -7 REFUSED
- -8 DON'T KNOW

"AG49" [AG49] - In the past 12 months, have you connected online with people online that have mental health or alcohol/drug concerns similar to yours through methods such as social media, blogs, and online forums?

[IF NEEDED: "Examples include online forums or closed social media groups on specific issues, doing hashtag searches on social media, or following people with similar health conditions."]

- 01 YES
- 02 NO
- -7 REFUSED
- -8 DON'T KNOW

"AG50" [AG50] - In the past 12-months, have you used online tools to find, be referred to, contact, or connect with a mental health professional?

[IF NEEDED: "Examples of online tools include texting, on-line messaging, video chat, or a mental health or health-related mobile app."]

- 01 YES
- 02 NO
- -7 REFUSED
- -8 DON'T KNOW

MENTAL HEALTH TECHNOLOGY QUESTIONS	AGE	COUNTIES												
		LOS ANGELES	SAN DIEGO	ORANGE	RIVERSIDE	ALAMEDA	SAN FRANCISCO	SAN MATEO	KERN	SANTA BARBARA	MARIN	MONTEREY	TEHAMA, ETC.	DEL NORTE, ETC.
On a typical day, how often do you use the internet? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	12-17 y. o.	79.9 [72.0 ; 87.8]	75.2 [60.1 ; 90.3]	87.5 [77.8 ; 97.3]	81.3 [68.4 ; 94.3]	90.5 [78.1 ; 100]	88.5 [68.2 ; 100]	82.9 [56.4 ; 100]	68.0 [35.8 ; 100]	*	*	*	92.9 [79.2 ; 100]	75.8 [32.6 ; 100]
	18-25 y. o.	90.7 [86.8 ; 94.6]	92.0 [86.5 ; 97.6]	93.1 [86.3 ; 99.9]	95.1 [87.5 ; 100]	*	93.6 [84.4 ; 100]	*	84.0 [67.3 ; 100]	95.8 [87.5 ; 100]	*	96.1 [87.9 ; 100]	81.2 [52.5 ; 100]	*
	26-59 y. o.	68.7 [66.0 ; 71.5]	75.4 [71.0 ; 79.8]	70.4 [64.9 ; 75.9]	72.7 [67.6 ; 77.8]	76.2 [68.4 ; 84.0]	87.7 [81.9 ; 93.5]	85.3 [76.8 ; 93.8]	55.7 [44.4 ; 67.1]	71.3 [54.5 ; 88.0]	82.4 [74.9 ; 90.0]	76.1 [62.7 ; 89.4]	61.6 [46.7 ; 76.6]	67.8 [56.2 ; 79.3]
	60+ y. o.	36.1 [32.8 ; 39.4]	41.7 [37.0 ; 46.4]	39.6 [33.5 ; 45.6]	39.7 [33.5 ; 45.8]	40.9 [31.6 ; 50.1]	34.9 [23.3 ; 46.5]	60.4 [47.1 ; 73.7]	30.9 [19.7 ; 42.0]	38.9 [27.9 ; 49.9]	52.7 [42.7 ; 62.8]	50.1 [37.3 ; 62.9]	28.0 [20.6 ; 35.3]	34.8 [25.2 ; 44.4]
On a typical day, how often do you use a computer or mobile device for social media? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	12-17 y. o.	51.0 [42.0 ; 59.9]	66.9 [50.9 ; 82.9]	60.3 [45.8 ; 74.8]	77.8 [64.3 ; 91.3]	*	63.0 [32.6 ; 93.4]	82.0 [55.1 ; 100]	90.1 [73.8 ; 100]	*	*	77.5 [39.8 ; 100]	89.7 [74.0 ; 100]	*
	18-25 y. o.	70.9 [65.2 ; 76.7]	69.7 [60.4 ; 79.1]	64.0 [50.7 ; 77.4]	73.1 [60.5 ; 85.8]	94.1 [85.9 ; 100]	49.2 [26.8 ; 71.7]	*	75.7 [59.4 ; 92.0]	91.5 [80.5 ; 100]	94.8 [82.5 ; 100]	*	73.2 [38.3 ; 100]	*
	26-59 y. o.	43.9 [41.3 ; 46.5]	44.6 [40.4 ; 48.8]	41.2 [35.6 ; 46.8]	46.9 [39.6 ; 54.2]	42.8 [35.3 ; 50.3]	50.5 [43.5 ; 57.5]	29.9 [20.6 ; 39.2]	31.7 [21.5 ; 41.8]	51.9 [35.3 ; 68.5]	28.5 [15.0 ; 42.0]	53.7 [36.4 ; 71.0]	34.6 [22.4 ; 46.7]	35.4 [24.4 ; 46.5]
	60+ y. o.	17.4 [14.6 ; 20.2]	15.6 [12.6 ; 18.5]	13.9 [10.5 ; 17.2]	20.4 [15.4 ; 25.4]	17.9 [10.0 ; 25.9]	16.2 [7.6 ; 24.8]	19.7 [10.9 ; 28.4]	14.8 [6.6 ; 23.0]	20.3 [8.4 ; 32.2]	18.0 [7.6 ; 28.3]	14.4 [7.4 ; 21.4]	15.3 [10.1 ; 20.4]	13.9 [7.5 ; 20.3]

MENTAL HEALTH TECHNOLOGY QUESTIONS (ADULTS ONLY)	DISTRESS LEVEL	COUNTIES												
		LOS ANGELES	SAN DIEGO	ORANGE	RIVERSIDE	ALAMEDA	SAN FRANCISCO	SAN MATEO	KERN	SANTA BARBARA	MARIN	MONTEREY	TEHAMA, ETC.	DEL NORTE, ETC.
On a typical day, how often do you use the internet? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	None to low	57.8 [55.2 ; 60.4]	65.9 [62.7 ; 69.2]	60.8 [56.7 ; 64.8]	58.5 [52.6 ; 64.4]	65.1 [58.6 ; 71.6]	77.3 [70.5 ; 84.1]	77.1 [67.8 ; 86.3]	54.9 [45.5 ; 64.4]	58.1 [46.1 ; 70.0]	73.9 [64.8 ; 82.9]	68.6 [57.0 ; 80.2]	55.0 [43.6 ; 66.4]	49.3 [38.7 ; 59.9]
	Medium	77.3 [72.3 ; 82.4]	73.5 [64.9 ; 82.1]	81.1 [73.2 ; 88.9]	83.2 [73.2 ; 93.1]	82.2 [73.0 ; 91.4]	95.7 [90.7 ; 100]	88.8 [76.0 ; 100]	58.7 [33.6 ; 83.9]	84.4 [68.6 ; 100]	57.3 [25.3 ; 89.3]	85.4 [61.8 ; 100]	58.2 [32.0 ; 84.4]	57.5 [34.4 ; 80.5]
	High	82.5 [77.5 ; 87.5]	88.3 [81.6 ; 95.1]	85.1 [75.0 ; 95.2]	87.6 [81.1 ; 94.2]	77.9 [61.3 ; 94.5]	68.6 [48.0 ; 89.1]	93.2 [84.8 ; 100]	47.6 [24.1 ; 71.0]	95.3 [89.7 ; 100]	93.7 [85.6 ; 100]	95.3 [87.3 ; 100]	47.6 [19.7 ; 75.4]	69.6 [45.7 ; 93.6]
On a typical day, how often do you use a computer or mobile device for social media? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	None to low	35.0 [32.7 ; 37.4]	38.0 [34.7 ; 41.3]	32.2 [27.5 ; 36.9]	34.2 [28.3 ; 40.0]	36.9 [30.6 ; 43.1]	42.6 [35.8 ; 49.4]	24.3 [15.6 ; 33.0]	31.2 [23.5 ; 38.9]	47.2 [35.1 ; 59.3]	36.0 [19.5 ; 52.5]	45.7 [32.2 ; 59.1]	34.7 [22.2 ; 47.2]	22.9 [15.5 ; 30.3]
	Medium	57.1 [51.3 ; 62.8]	43.4 [33.0 ; 53.8]	58.5 [45.4 ; 71.5]	66.7 [53.6 ; 79.8]	59.2 [48.7 ; 69.8]	46.3 [24.2 ; 68.4]	55.8 [31.8 ; 79.8]	45.6 [23.6 ; 67.6]	*	*	*	*	*
	High	59.6 [53.8 ; 65.4]	59.8 [49.8 ; 69.7]	52.9 [38.3 ; 67.6]	60.4 [48.2 ; 72.6]	54.2 [35.0 ; 73.5]	45.2 [24.5 ; 65.8]	*	46.4 [23.9 ; 68.9]	81.0 [62.0 ; 100]	*	68.4 [32.5 ; 100]	*	*

MENTAL HEALTH TECHNOLOGY QUESTIONS (TEENS ONLY)	DISTRESS LEVEL	COUNTIES												
		LOS ANGELES	SAN DIEGO	ORANGE	RIVERSIDE	ALAMEDA	SAN FRANCISCO	SAN MATEO	KERN	SANTA BARBARA	MARIN	MONTEREY	TEHAMA, ETC.	DEL NORTE, ETC.
On a typical day, how often do you use the internet? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	None to low	76.8 [65.2 ; 88.3]	62.9 [36.5 ; 89.2]	87.2 [74.6 ; 99.9]	80.6 [60.4 ; 100]	78.3 [36.1 ; 100]	*	94.4 [81.8 ; 100]	*	*	*	*	82.8 [48.2 ; 100]	91.5 [73.3 ; 100]
	Medium	77.6 [44.7 ; 100]	70.4 [37.3 ; 100]	80.7 [42.3 ; 100]	72.8 [38.0 ; 100]	95.1 [86.2 ; 100]	*	*	*	*	*	*	*	*
	High	84.9 [72.3 ; 97.6]	*	94.1 [85.3 ; 100]	90.5 [78.0 ; 100]	*	81.5 [49.8 ; 100]	*	*	*	*	*	*	*
On a typical day, how often do you use a computer or mobile device for social media? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	None to low	42.5 [30.2 ; 54.9]	57.8 [31.7 ; 83.8]	60.9 [41.5 ; 80.4]	72.3 [48.2 ; 96.5]	*	*	91.1 [74.9 ; 100]	86.2 [62.7 ; 100]	*	*	81.8 [36.4 ; 100]	74.9 [34.1 ; 100]	*
	Medium	78.0 [56.9 ; 99.2]	79.0 [50.5 ; 100]	72.1 [33.9 ; 100]	81.6 [49.4 ; 100]	*	*	*	*	*	*	*	*	*
	High	53.2 [37.0 ; 69.5]	71.6 [44.6 ; 98.7]	*	83.0 [64.2 ; 100]	*	81.5 [49.8 ; 100]	*	*	*	*	*	*	*

The numbers indicated within brackets represent the 95% confidence interval of these estimates.

The "*" are used for the cross-tabs for which the sample was too small, no respondents were in that category, or the estimates were unstable.

This report was prepared as an account of work sponsored by the California Mental Health Services Authority (CalMHSA), but does not represent the views of CalMHSA or its staff except to the extent, if any, that it has been accepted by CalMHSA as work product of the Help@Hand evaluation team. For information regarding any such action, communicate directly with CalMHSA's Executive Director. Neither CalMHSA, nor any officer or staff thereof, or any of its contractors or subcontractors makes any warranty, express or implied, or assumes any legal liability whatsoever for the contents of this document. Nor does any party represent that use of the data contained herein, would not infringe upon privately owned rights without obtaining permission or authorization from any party who has any rights in connection with the data.

For questions or feedback, please contact:
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Innovation Project: Restorative Practices for Improving Mental Health (RPIMH)

DRAFT

Restorative Practices for Improving Mental Health (RPIMH)

Breathe ~ Heal ~ Restore

INNOVATIVE PROJECT PLAN
RECOMMENDED TEMPLATE

COMPLETE APPLICATION CHECKLIST	
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:	
☐ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors. *(Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)*	
☐ Local Mental Health Board approval	Est Approval Date: 5/19/2021
☐ Completed 30 day public comment period	Comment Period: 4/9/21-5/8/21
☐ BOS approval date	Approval Date: ___________
If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: 5/19/2021 *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*	
Desired Presentation Date for Commission: 5/20/2021 via Delegated Authority ***Note: Date requested above is not guaranteed until MHSOAC staff verifies all requirements have been met.***	

DRAFT

County Name: Tri-City Mental Health Authority

Date submitted: April 2021

Project Title: Restorative Practices for Improving Mental Health (RPIMH)

Total amount requested: $949,957

Duration of project: Three Years July 2021-June 2024

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

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

DRAFT

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT:

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

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

CHOOSE A PRIMARY PURPOSE:

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

- ☐ Increases access to mental health services to underserved groups
- ☒ Increases the quality of mental health services, including measured outcomes
- ☒ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

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

Tri-City Mental Health Authority (Tri-City) provides services to a community comprised of three very distinct cities – Claremont, La Verne, and Pomona. Not only do these cities vary by size and population, they also vary financially, by their views on mental health, and by their overall community cultures. However, since March 2020, the residents of these three cities have shared one common concern that has led to an increase in anxiety, depression, fear and overall stress: COVID-19.

According to Ginger.com, the leader in on-demand mental healthcare, prior to the onset on COVID-19 in 2020, 60% of workers reported that stress impacted them at work to the point of tears, which is a 23% increase from 2019 (Ginger, 2020). Those surveyed following the outbreak of COVID-19 indicated even significantly higher levels of stress including claims that this was the "most stressful time of their entire professional career." Additional survey data indicates that although workers agree that their employers have increased its focus on employee mental health as a result of COVID-19, more can be done. Tri-City agrees with this statement and hopes to address this commitment to staff through this plan.

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In addition to the stress and burnout experienced by mental health professionals, Transition Age Youth (TAY) ages 16-25, continues to be both a priority population and yet acknowledged, “difficult to engage” group for Tri-City Mental Health. Although the pandemic has impacted all age groups within the Tri-City area, studies have shown that it seems especially damaging to these vulnerable individuals including youth in foster care.

According to the American Psychological Association, “the potential long-term consequences of the persistent stress and trauma created by the pandemic are particularly serious for our country’s youngest individuals, known as Generation Z (Gen Z). Our 2020 survey shows that Gen Z teens (ages 13-17) and Gen Z adults (ages 18-23) are facing unprecedented uncertainty, are experiencing elevated stress and are already reporting symptoms of depression.” (Harris Poll, 2020)

Transition Age Youth, including those residing in foster care, or who identify as LGBTQ, experience an even greater impact on their lives including living conditions and basic standards of health, education, employment and well-being since the start of this pandemic.

This year-long exposure to elevated stress in mental health service providers compounded with the persistent anxiety and trauma found in the youth of our cities, has launched this mental and emotional health focused project to provide staff and youth in our communities with a menu of independent and self-selected trainings which are easily accessible online and available in a group venue or independent study.

PROPOSED PROJECT

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

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

Community engagement and collaboration have long been the driving forces behind the success of the projects and programs implemented by Tri-City Mental Health under the Mental Health Services Act. By engaging individuals who live and work within the three cities of Claremont, La Verne, and Pomona, Tri-City staff are able to create projects that reflect both the desire and needs of the communities we serve.

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This long-standing alliance is the undertone of the **Restorative Practices for Improving Mental Health (RPIMH)** project which is comprised of a combination of three evidence-based practices, SKY Breathing, Trauma Informed Yoga, and Restorative Practice Circles, which are typically delivered independently and address distinct elements related to physical health and emotional health of participants. Each of these practices are normally offered separately for a fee and as such, may not meet the individual needs of the participants. In addition, the cost is often times prohibitive for the disadvantaged youth we serve.

This project is proposing to combine these three practices into a single course of treatment or healing aimed at addressing the deficits in mental and emotional support currently available in this area. Two target populations are identified and will be engaged for this project: 1) Tri-City clinical and non-clinical staff who are experiencing the effects of COVID 19 leading to elevated stress and potential burnout; and 2) Transition Age Youth (TAY) ages 16-25, who reside within the Tri-City catchment area, including TAY who are at risk due to COVID-19, those who are residing in foster care, or identify as LGBTQ, as well as the staff that support them.

The three practices selected by the workgroup participants include:

SKY Breathing: an evidence-based practice that can help individuals reduce stress and clear their minds through a breath meditation. Improvements noted by researchers and participants include the areas of depression, stress, mental health, mindfulness, positive affect, and social connectedness in addition to better quality of sleep. Researchers have shown that each emotion is linked to a breathing pattern and when you change the way you breathe you can change how you feel.

Trauma Informed Yoga: which emphasizes the impact of trauma on the entire mind-body system and provides an approach to creating a safe and supportive space where participants can learn emotional regulation skills through connection with the breath and increased body awareness. Trauma-informed yoga will increase access to mental health services to underserved groups and help participants develop positive copying mechanisms and increase the quality of mental health services while decreasing the symptoms of depression, anxiety, and stress.

Restorative Practice Circles: used to bring together both offenders and victims in an attempt to repair damaged relationships through a process of accountability and forgiveness. The reasoning behind this concept is that when someone offends or hurts someone else, the offender can reflect on their harm to the victim and work towards reconciliation while taking a restorative approach to heal the transgression. Restorative circles have proven to be effective in a variety of educational and community settings. Circles are facilitated by

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individuals who hold credentials including LCSW, MFT, retired educators, college students, community members and individuals with lived experience.

Through the combined application of these three evidence-based practices, this project hopes to address the issues of retention and burnout for Tri-City staff in addition to improving the overall wellbeing of transition age youth and their support staff residing in the cities of Claremont, Pomona and La Verne.

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

This project applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system.

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

Each of the three trainings, SKY Breathing, Trauma Informed Yoga, and Restorative Practice Circles, have been implemented in a variety of settings but not as a “training package” used to address burnout in mental health professionals or to address trauma, depression, and anxiety in youth, including those who identify as LGBTQ, or reside in foster care.

SKY Breathing is typically taught either during an in-person training (pre COVID) or virtually. The length of time varies for each training but is typically delivered in a three-day timeframe. It can be longer for specific populations who may require additional time and support. This training is usually offered as a single method with instructors who are specifically trained in this practice.

Trauma Informed Yoga is also a specialty training that is offered in-person (pre COVID) or virtually. Instructors are also specifically trained in this practice which addresses and supports individuals who have experienced some form of trauma. Although there is a breathing component to this practice, the breath training is not as extensive or specific as SKY Breathing.

Restorative Practice Circle, also known as Restorative Justice, has historically been implement in the justice system and primarily focused on bringing together criminal offenders and their victims in an effort to encourage accountability and restitution or attempt to repair the damage done by the crime. This practice seeks to make a cultural shift from a punitive model to a restorative model. Restorative circles have also proven to be successful in

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educational settings as well where these skills are useful in helping student to build positive relationships and learn to support one another.

This project is proposing to combine these three practices into a single course of treatment or healing aimed at addressing the deficits in mental and emotional support currently available in this area.

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

This project intends to serve approximately 360 individuals over a three-year period. The following represents a projection of the number served and trained over the life of the project. However, these numbers are subject to change based on current and future COVID-19 restrictions and participation.

Tri-City Clinical and Non-Clinical Staff: We estimate serving 120 Tri-City staff over a three-year period. This will include both clinical and non-clinical staff. These trainings will be offered both virtually, where staff will have access to them on-demand or in organized groups, and in person (year two-three), based on updated COVID -19 restrictions.

TAY/LGBTQ/Foster Youth/Support Staff: This project anticipates serving a total of 240 transition age youth who are at risk due to COVID-19, LGBTQ, and/or foster youth and the staff that support them. Trainings will be offered virtually for those who have access to mobile devices, and in-person when COVID-19 restrictions allow. Each of the components will be offered but we anticipate one of more will be more popular or practical for specific populations. TAY and support staff participants will receive stipends as an incentive to participate in the trainings.

These numbers were arrived at based on current Tri-City employment numbers as well as local demographics. Tri-City currently employs 212 individuals, agency-wide and this project is intended to be offered to both clinical and non-clinical staff. Current demographic information for the combined cities of Pomona, Claremont and La Verne estimated the number of youths to average about 20% of the total population[1]. However, this project will serve a sample size of 240 TAY and support staff and then expanded if proven to be successful.

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

[1] US Census Bureau

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Two target populations are identified and will be engaged for this project 1) Tri-City clinical and non-clinical staff who are experiencing the effects of COVID-19 leading to elevated stress and potential burnout; and 2) Transition Age Youth (TAY) ages 16-25, who reside within the Tri-City catchment area, including individuals who are at risk due to COVID-19, residing in foster care, identify as LGBTQ, as well as the staff that support them.

All trainings and support services will be delivered in both English and Spanish, Tri-City's primary threshold languages.

RESEARCH ON INN COMPONENT

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

Research conducted for this project indicates that traditionally, each of these practices are offered as a separate component and outcomes are measured based on the individual impact for each. Although yoga may incorporate breathing as a component, it does not include the specific approach of SKY Breathing which is one of the featured practices in the project.

SKY Breathing teaches breathing techniques and meditation which have been demonstrated to help de-stress both the mind and the body, thus bringing emotional well-being and balance to life. This practice is provided in a variety of community and professional settings but typically as a stand-alone program, although with variations depending on the audience.

Trauma Informed Yoga is a practice that focuses on creating a safe and supportive space where participants, through a connection of breath and increase body awareness, can learn emotional regulation skills. This practice is also provided in a variety of settings including yoga studios or other locations.

Restorative Practice Circles is typically utilized in the judicial and school-based systems. There are some community-based trainings also available. However, these trainings focus only on accountability and relationship repair and do not include the breathing or yoga components.

By incorporating all three of these evidence-based practices, Tri-City will attempt to offer an array of support practices that will increase the quality of mental health wellbeing as well as promoting interagency and community collaboration related to mental health services and supports and/or outcomes.

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B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

In order to determine the innovative approach of this project, research was conducted on the topics of SKY Breathing, Trauma Informed Yoga, and Restorative Practice Circles, as well as similar projects in general. The research indicated that there is no evidence or example of a public mental health agency implementing a program that involves utilizing a combination of these practices for the benefit of both agency staff and transition age youth, using evidence-based trainings to both support and attempt to mitigate the impact of COVID-19.

In addition, by utilizing the MHSA Program Search Tool located on the Mental Health Services Oversight and Accountability website, Tri-City staff reviewed all Innovation projects listed beginning in FY 2012-13 to date and found no projects that appeared to have the components, SKY Breathing, Trauma Informed Yoga, or Restorative Practice Circles listed. In addition, none of the current or previous projects implemented by other counties appear to address staff retention and burnout.

Citations and links to specific articles are located in the Appendix on page 28.

LEARNING GOALS/PROJECT AIMS

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

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

The **Restorative Practices for Improving Mental Health (RPIMH)** project hopes to determine if offering a set of self-help practices, used in combination, can help mental health staff to improve their own mental and physical health while serving clients in both an existing and post COVID-19 world. This project seeks to understand if providing a series of evidence-based training that can be accessed on-demand, will help to reduce stress and improve retention in community mental health.

In addition, will these same set of practices help transition age youth (ages 16-25) to improve their resiliency and emotional regulation while decreasing symptoms of trauma, depression,

anxiety, and stress. These goals were determined by both Tri-City staff and community members as a result of engagement in surveys, workgroups, and outside research.

Goals for this project include:

1. Reduce the rate of burnout in Tri-City staff and increase retention rate
2. Reduce the rate of burnout in community support staff that work with TAY
3. Develop an online menu of wellbeing practices that staff can access on-demand
4. Increase client outcomes when incorporating one or more of these practices
5. Increase access to mental health services for Transition Age Youth (TAY)
6. Decreased symptoms of trauma, depression, anxiety, and stress in the TAY population
7. Increase the number of TAY who are reunited with family members through restorative dialogue

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

Each of these learning goals reflect Tri-City's desire to evaluate, through pre and post evaluations, and ultimately improve the overall mental wellbeing for these critical populations. Through the combination of these evidence-based practices, this project hopes to address the issues of retention and burnout for Tri-City staff in addition to improving the overall wellbeing of transition age youth at risk due to COVID-19, including those who identify as LGBTQ, and foster care youth, in addition to the staff that support them.

EVALUATION OR LEARNING PLAN

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

Each of these learning goals/questions will be evaluated by the method indicated below. Pre and post tests will be administered before and after each training. Results will be compiled and presented to participants and stakeholders on a quarterly basis. Any necessary changes or course corrections will be made at that time.

In addition, performance measure will be developed based on a data collection method platform called Results Based Accountability (RBA). RBA uses a data-driven, decision-making process to help communities to improve the effectiveness of their programs. This method starts with the end in mind and works forward with an emphasis on the target population vs performance of the program.

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- *Reduce the rate of burnout in Tri-City staff and increase retention rate*

Learning Goal	Evaluation Method
Is RPIMH effective in reducing burnout among clinical and non-clinical mental health professionals?	1. *Staff data that includes: Number of people trained in RPIMH and by job position.* 2. *Pre and post survey of participants that includes questions related to burnout and stress.* 3. *Post survey of their use of these practices, how often, and their experiences.* 4. *Follow up survey in six months to learn how they have used these practices (post survey only).* 5. *Pre and Post measures of retention rate by position/clinical and non-clinical.*
Is RPIMH effective in engaging TC staff in a sustained well-being practice?	
Does the knowledge gained through the combination of RPIMH frameworks help staff to integrate these practices in their scope of work?	

- *Reduce the rate of burnout in community support staff that work with TAY*

Learning Goal	Evaluation Method
Is RPIMH effective in improving well-being among youth workers?	1. *Pre and post survey of participants that includes questions related to burnout and stress.* 2. *Survey on how they have used these practices (post survey only).*
Does RPIMH reduce stress among youth workers?	

- *Develop an online menu of wellbeing practices that staff can access on-demand*

Learning Goal	Evaluation Method
Does providing an access on-demand menu of wellbeing practices contribute to retention?	1. *Number of practices offered* 2. *Number of practices accessed* 3. *Number of people who accessed the practices* 4. *Post survey of those who accessed these practices and how they used them to help themselves and others.*

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- *Increase client outcomes when incorporating one or more of these practices*

Learning Goal	*Evaluation Method*
Does the practice of RPIMH by clinicians improve client outcomes?	1. *Post survey of staff to see how often they connect clients with these practices and the number of clients they have connected with.* 2. *Add questions to the client survey (MHSIPs) that address the use and experience of clients when using these practices (post survey only).*

- *Increase access to mental health services for Transition Age Youth (TAY)*

Learning Goal	*Evaluation Method*
Does RPIMH promote interagency and community collaboration related to mental health services by providing an entry point to seeking additional support services?	1. *Number of service requests for Access to Care from community agencies that are involved in this project.* 2. *Number of referrals into Tri-City programs (MHSA, IOET, etc.) from community agencies that are involved in this project.*

- Decreased symptoms of PTSD, depression, anxiety, and stress *in the TAY population*

Learning Goal	*Evaluation Method*
Is RPIMH effective in reducing symptoms of trauma, PTSD, depression, anxiety, and stress *in youth?*	1. *Pre and post surveys of Tri-City Mental Health TAY clients (18 years and older) that includes:* a. *Measures of depression, anxiety, and stress.* b. *The use and experience of clients when using these practices.*
Is RPIMH effective in increasing resiliency among youth?	

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Is RPIMH effective in increasing emotional regulation among youth?	c. *Measures of resiliency emotional regulation, and ability to manage stress.*

- *Increase the number of TAY who are reunited with family members through restorative dialogue*

Learning Goal	*Evaluation Method*
Is RPIMH effective in reuniting families who are estranged or experiencing relationship challenges?	1. *Number of TAY families who participate in RPIMH who are not unified or are experiencing challenges.* 2. *Pre and post surveys measuring communication and interaction. Post survey will also include how often they use these practices and their experiences when using them.*

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

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

Tri-City expects to contract with outside trainers for SKY Breathing, Trauma Informed Yoga, and Restorative Practice Circle trainings. In addition, if possible, this project will utilize trainers that practice within the Tri-City area and are current stakeholders and community members. Funding for these trainers/trainings will be provided through the RPIMH project budget.

The trainings will be coordinated and supervised by the Innovation Coordinator in collaboration with the training representatives. Each of these evidence-based trainings will be evaluated by Tri-City's Best Practices Department and outcomes will be shared with stakeholders via quarterly and annual Innovation project reports as well as through presentations in community stakeholder meetings.

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COMMUNITY PROGRAM PLANNING

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

Since the onset of COVID-19, in-person stakeholder meetings are prohibited which makes frequent communication with stakeholders via email and virtual meetings even more critical to ensure they are aware of resources and support services that are available to them and the community at large. Stakeholder meetings and workgroups were transitioned to a virtual platform in March of 2020 in addition to emails sent with links to online trainings and virtual webinars as well as service updates.

To begin this Innovation planning process, stakeholders were informed and invited during the September 2020 stakeholder meeting to participate in the development of a new Innovation project. Participants who expressed an interest in this process were informed of the workgroup information. In addition, an online survey was distributed to stakeholders to request new ideas to be submitted. From this survey three ideas were submitted which were presented to the Innovation workgroup.

In an ongoing effort to collect additional stakeholder input, stakeholders and community members were emailed and encouraged to complete Tri-City's MHSA Planning Process Survey to share their thoughts and concerns regarding the availability of support services, priority populations and unmet needs within the Tri-City care. This annual community planning survey is available in both English and Spanish and is used to identify the needs and priorities of the three cities. These results are then presented to the Innovation workgroups who were able to incorporate these needs and concerns in the creation of new Innovation projects.

In the most recent planning survey, when asked to identify priority populations, respondents indicated their concern for Transition Age Youth (16-25), including those who reside in foster care or identify as LGBTQ. These results were the impetus that sparked further conversations in the Innovation workgroups where participants addressed the numerous issues encountered by this critical population while developing this project proposal.

The demographics for those completing the Community Planning Survey included:
Gender: 82% Female and 18% Male
Age: Ages 26-59 64% and 60+ 36%
Primary Language English 91% and Spanish 9%
Race/Ethnicity: Hispanic/Latino 27%, White/Caucasian 55%, Other 18%

Other: LGBTQ 9%

In January of 2021, community members and Tri-City staff came together to begin the process of identifying a new Innovation project. Innovation workgroup participants consisted of fifteen members who reflect a diverse group of individuals. These individuals represented Tri-City staff, faith-based leaders, community members involved in juvenile justice, LGBTQ, and transition age youth. Two project ideas were presented by community members; one did not meet the criteria for an Innovation project and the other project was voted to move forward and is presented here. A third option was considered a duplicate of a previous idea.

The following is a list of the public meetings, postings and approvals:
Stakeholder Meetings: 9/30/20, 3/4/21
Innovation Workgroups: 1/21/21, 2/4/21, 2/9/21, 2/10/21, 2/11/21
Estimated Plan Posting Date for 30-Day Comment Period: April 9, 2021
Estimated Mental Health Commission Approval: May 19, 2021
Estimated Governing Board Approval: May 19, 2021

MHSA GENERAL STANDARDS

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

A) Community Collaboration

The overall focus of this project is to create community collaboration around mental health and wellbeing. Tri-City will work with various local organizations representing the target populations as well as the trainers who have been identified to participate in this project. These organizations include faith-based groups, youth organizations, foster care group homes, local LGBTQ Pride Center, and Tri-City Wellness Center.

B) Cultural Competency

Cultural competence and inclusion are vital to creating projects that are accessible to community members residing within the Tri-City area. Each of the practices included in this project proposal are available in both English and Spanish. Tri-City will collaborate with each organization to identify the best cultural approach for working with each of these populations. This information will be incorporated in the training approaches utilized in this project.

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C) Client-Driven

This project was selected after an extensive stakeholder process which included clients, community members and individuals with lived experience. The methods of feedback incorporated were collected through stakeholder meetings, Innovation workgroups and a community planning survey.

D) Family-Driven

Family members have provided valuable insight and feedback as to ways Tri-City can continue to support their needs and approach obstacles they may be facing when seeking services for themselves and their children. This feedback has been incorporated in the planning of this project.

E) Wellness, Recovery, and Resilience-Focused

All three components of this project are wellness, recovery, and resilience-focused. When used in combination, these practices will build on the strengths of each practice and participant to support people-in-recovery and those who may have experienced trauma, to live meaningful lives guided by their own choices.

F) Integrated Service Experience for Clients and Families

Through this project, Tri-City staff will have access to all three practices and able to share these skills with their clients. Clients will then be able to share their experiences with family members and extend these practices/skills to others. In addition, these practices, Restorative Circles in particular, will provide an opportunity for clients and their family members to use this new skill of communication and accountability to heal their broken relationships.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

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

Tri-City Mental Health is committed to the advancement of quality mental health services that are culturally compatible and respectful of the diverse healthcare beliefs of the people served. It is the mission of this Agency to guide and support the staff of Tri-City to ensure cultural and linguistically appropriate programs and services are available for community members residing in the cities of Claremont, Pomona and La Verne by building strong and collaborative relationships through partnerships and community engagement. Tri-City has a robust stakeholder engagement process which includes open communication, pre and post surveys,

workgroups, community stakeholder meetings, and continuous feedback. Materials are offered in both English and Spanish as well as interpreters for non-English speaking participants. Tri-City understands that Innovation projects are ever-evolving and it is necessary to have continuous check-ins with stakeholders to know if there is a pivot that needs to occur.

In addition, Tri-City hosts four community groups where participants are able to provide feedback regarding new and ongoing projects. These groups include ¡Adelante! Latino and Hispanic Wellness Advisory Council, whose primary goal is to instill hope and wellness by empowering community members within the Latino and Hispanic community to advocate and share their experience, knowledge and feedback. The LGBTQ+ Wellness Advisory Council was established to give a voice to LGBTQ+ communities by empowering members to advocate and share their experience, knowledge and feedback. The African American Family Wellness Advisory Council (AAFWAC) whose primary goal is to nurture hope and wellness within the African American community through mental health advocacy and treatment referral. The final group, dedicated to the Asian American Pacific Islander population, is currently in the formation phase and will be serving our AAPI community members in the same capacity as the groups mentioned about.

During the course of this learning project, there will be quarterly evaluations and discussions impacting the project activities based on outcomes. Participants of the project advisory committee will work closely with Tri-City staff in identifying performance and outcome measures that will provide the most credible and timely data for this project.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

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

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

This project is not intended to provide direct services for individuals with severe emotional disturbance (SED)/serious mental illness (SMI). However, this project will provide support for providers in an effort to reduce burnout which directly impacts availability, consistency and continuity of care for person with severe emotional disturbance/serious mental illness.

This project will be evaluated based on participant/stakeholder feedback and various outcomes and performance measures. If determined to be successful, this project may be assumed under the Prevention and Early Intervention plan, as funding allows.

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In addition, both the Tri-City staff, TAY, and TAY support staff who are trained in each of these practices will have the opportunity to continue to train other individuals in the community including clients, peers, family members and other service partners.

COMMUNICATION AND DISSEMINATION PLAN

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

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

This project will be promoted on Tri-City's website as well as all Tri-City social media platforms. Announcements have been made during stakeholder meetings and through direct emails. Tri-City staff will also be included in the launch process once the appropriate approvals have been received. In addition, local community partners who are offering these trainings will be promoting this project internally to their members.

Tri-City will provide stakeholders with periodic status reports during MHSA presentations and through Annual Updates and Three-Year Integrated plans. Tri-City will also seek opportunities to provide information on shared learnings during conferences, community meetings and collaborations with county partners. Program participants will be invited to share their personal experiences during these gatherings and other stakeholders will be able to share this project directly with their community organization, agency or department. The project and all subsequent reports will be posted on Tri-City's website as well as promoted through social media.

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

Breathing Trauma Restorative Stress Burnout

TIMELINE

A) Specify the expected start date and end date of your INN Project
July 1, 2021 to June 30, 2024

B) Specify the total timeframe (duration) of the INN Project
Three Years

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

The following represents a projection of anticipated activities along with the corresponding dates. However, these projections are only estimates and may be adjusted throughout the life of the project based on actual project performance and any unforeseen impact due to COVID-19 restrictions.

Year 1, Quarter 1 July – Sept 2021

- Create outreach and engagement strategy with training consultants
- Prepare outreach and engagement marketing materials
- Determine required documents such as Release of Information and/or HIPAA
- Confirm project participants and related organizations
- Advise and promote trainings to Tri-City staff
- Develop outcome and performance measures to support data collection
- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Begin onboarding process for both Tri-City staff and TAY/TAY support staff
- Begin training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Begin training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Begin training on Restorative Practice Circles for TC staff and community members
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff

Year 1, Quarter 2 Oct – Dec 2021

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Begin onboarding process for both Tri-City staff and TAY/TAY support staff
- Begin training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Begin training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Begin training on Restorative Practices/Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking
- Prepare quarterly report-post on Tri-City website and share with stakeholders

Year 1, Quarter 3 Jan – Mar 2022

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff

- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking
- Prepare quarterly report-post on Tri-City website and share with stakeholders

Year 1, Quarter 4 Apr – June 2022

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practices/Circles for Tri-City staff and TAY/TAY support staff
- Begin train-the-trainer on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Begin train-the-trainer on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Begin train-the-trainer on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking
- Prepare quarterly report-post on Tri-City website and share with stakeholders

Year 2, Quarter 1 July – Sept 2022

- Create annual Innovation Project Report for FY 2021-22
- Review learning questions and performance measures to ensure accurate tracking
- Identify participants to become trainers for FY 2022-23
- Begin onboarding process for community trainers and staff trainers
- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff

Year 2, Quarter 2 Oct – Dec 2022

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff

- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking
- Prepare quarterly report-post on Tri-City website and share with stakeholders

Year 2, Quarter 3 Jan – Mar 2023

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking
- Prepare quarterly report-post on Tri-City website and share with stakeholders

Year 2, Quarter4 Apr – June 2023

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Begin train-the-trainer on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Begin train-the-trainer on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Begin train-the-trainer on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking

Year 3, Quarter 1 July – Sept 2023

- Create annual Innovation Project Report for FY 2022-23

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- Review learning questions and performance measures to ensure accurate tracking
- Begin onboarding process for community trainers and staff trainers
- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff

Year 3, Quarter 2 Oct – Dec 2023

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking
- Prepare quarterly report-post on Tri-City website and share with stakeholders

Year 3, Quarter 3 Jan – Mar 2024

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking
- Prepare quarterly report-post on Tri-City website and share with stakeholders

Year 3, Quarter4 Apr – June 2024

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff

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- Continue training on Restorative Practices/Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking

Year 3, July – Dec 2024

- Process final outcome survey results
- Create final Innovation Project Report
- Assess project for incorporation under Prevention and Early Intervention (PEI)

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

BUDGET NARRATIVE

Tri-City Mental Health Authority (TCMHA) has allocated $950,000 in Innovation funds for the following project: Restorative Practices for Improving Mental Health (RPIMH). This three-year project is expected to commence in July 2021, pending approval from the MHSOAC, and conclude in June 2024.

All cost elements included in this budget are estimated and subject to revision based on final determination of contracts, costs of training, evaluations, and additional services as required.

The amounts included in this budget cover personnel costs, operating costs, costs for consultants, other expenditures.

Personnel Costs:
The salaries and benefits included within this budget are estimated based on the total number of hours of training/participation that is being proposed for Tri-City staff engagement. Approximately 2,300 hours of training/participation for approximately 145 staff over the three-year project period. In addition, a portion of salaries and benefits for Tri-City's INN Program Coordinator and Tri-City's MHSA Projects Manager have also been included.

INN Program Coordinator: The Coordinator will oversee the implementation of the RPIMH project including the planning, organizing, training and directing of activities as they relate to this project.

MHSA Projects Manager: The Manager will monitor the implementation of the RPIMH project and will directly supervise the Coordinator to ensure appropriate progress is being made throughout the project period.

Evaluation/Quality Improvement Staff: Tri-City data analysts will support this program through processing of evaluations, and analysis of data that is gathered throughout the project period.

Operating Costs:
Indirect operating costs are calculated at approximately 15% and would be used to cover the general and indirect operating costs to support this program.

Consultant/Training Costs:
The Consultants Costs will be used to pay for the facilitators which will provide the instruction and training for the three evidence-based practices proposed which include Sky Breathing, Trauma Informed Yoga, and Restorative Practice Circles.

Other Expenditures:
Other expenditures anticipated include the payment of stipends to participants. Also, in addition to the estimated purchase of evaluation tools, Tri-City anticipates the need to purchase licenses for virtual meeting platforms such as Zoom.

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BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
1.	Salaries	$169,518	$177,994	$146,537			$494,049
2.	Direct Costs						
3.	Indirect Costs						
4.	**Total Personnel Costs**	**$169,518**	**$177,994**	**$146,537**			**$494,049**
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
5.	Direct Costs						
6.	Indirect Costs	$45,903	$47,099	$30,906			$123,908
7.	**Total Operating Costs**	**$45,903**	**$47,099**	**$30,906**			**$123,908**
NON RECURRING COSTS (equipment, technology)		**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
8.							
9.							
10.	**Total Non-recurring costs**						
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
11.	SKY Breathing	$42,000	$42,000	$16,000			$100,000
12.	Trauma Informed Yoga	$42,000	$42,000	$16,000			$100,000
13.	Restorative Practices	$42,000	$42,000	$16,000			$100,000
14.	**Total Consultant Costs**	**$126,000**	**$126,000**	**$48,000**			**$300,000**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
15.	Stipends for TAY & Community Participants	$8,000	$8,000	$8,000			$24,000
16.	Other-Supplies, Materials	$3,500	$3,000	$1,500			$8,000
17.	**Total Other Expenditures**	**$11,500**	**$11,000**	**$9,500**			**$32,000**
BUDGET TOTALS		**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
Personnel (line 1)		**$169,518**	**$177,994**	**$146,537**			**$494,049**
Direct Costs (add lines 2, 5, 11, 12 and 13 from above)		**$126,000**	**$126,000**	**$48,000**			**$300,000**
Indirect Costs (add lines 3, and 6 from above)		**$45,903**	**$47,099**	**$30,906**			**$123,908**
Non-recurring costs (line 10)		**-**	**-**	**-**			**-**
Other Expenditures (line 17)		**$11,500**	**$11,000**	**$9,500**			**32,000**
TOTAL INNOVATION BUDGET		**$351,921**	**$361,093**	**$236,943**			**$949,957**

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BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)

ADMINISTRATION:

A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
1.	Innovative MHSA Funds	$330,490	$338,591	$221,192			$890,273
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	**$330,490**	**$338,591**	**$221,192**			**$890,273**

EVALUATION:

B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
1.	Innovative MHSA Funds	21,431	$22,502	$15,751			$59,684
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**	**$21,431**	**$22,502**	**$15,751**			**$59,684**

TOTAL:

C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
1.	Innovative MHSA Funds	**351,921**	**$361,093**	**$236,943**			**$949,957**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	**$351,921**	**$361,093**	**$236,943**			**$949,957**

*If "Other funding" is included, please explain.

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Capital Facilities and Technological Needs Project Proposal

Mental Health Services Act
Capital Facilities and Technological Needs Project Proposal

Subject:

Approval for the expenditure of funds in the amount of $300,436 as follows:

1) Cerner Electronic Health Record (EHR) system implementation costs at $270,436
2) Unite Us referral management platform costs at $30,000.

Summary:

Tri-City Mental Health (TCMH) intends to expend existing MHSA funds assigned to Capital Facilities and Technological Needs to implement a new Electronic Health Record system and client referral management platform.

The Office of the National Coordinator for Health Information Technology's (ONC) Cures Act Final Rule passed in 2020 is designed to empower patients with their health record in the modern health IT world. It supports seamless and secure access, exchange, and use of electronic health information. The rule is designed to give patients and their healthcare providers secure access to health information. It also aims to increase innovation and competition by fostering an ecosystem of new applications to provide patients with more choices in their healthcare. It calls on the healthcare industry to adopt standardized application programming interfaces (APIs), which will help allow individuals to securely and easily access structured electronic health information using smartphone applications. The rule includes a provision requiring that patients can electronically access all of their electronic health information (EHI), structured and/or unstructured, at no cost.

To meet the needs of the ONC rule, TCMH intends to migrate its current EHR platform from Welligent to the Cerner Electronic Health record platform. TCMH is seeking stakeholder approval for a portion of the implementation costs of the Cerner EHR platform.

Additionally, TCMH does not currently have a centralized referral management platform. Such a system would allow TCMH to ensure the quality of referrals delivered by TCMH, as well as allow for both increased transparency and follow-up from both the TCMH clinical and Community Navigator staff as well as the participants.

Background:

1) TCMH has being using Welligent as its primary client information system since 2011. The platform also handles client scheduling, call center, client check-in and payment collection, individual and group progress notes, clinical features including medication management, billing and reporting. Due to the extensive requirements of the ONC rule regarding interoperability, Welligent is no longer sufficient to meet the Agency's responsibilities.

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Beginning January of 2020, the TCMH executive team has undergone an extensive request for proposal process to determine the best EHR platform to meet both the needs of the agency, as well as the regulatory requirements. The request for proposal process solicited bids from four platforms, with an extensive review conducted by a committee of clinical, MHSA, and operations staff resulting in Cerner as the best fit to meet all requirements.

In February 2021, Cerner produced a project quote and timeline that will result in a full transition of services to the Cerner platform by July of 2022.

2) Unite Us will be implemented as a pilot over the next 3 years within two departments of Tri-City that are primary access points to care and services: Access to Care and Community Navigators. Both of these teams are responsible to receive referrals for requests for treatment services and/or requests for basic needs necessary for well-being.

Tri-City's philosophy is that all referrals for services and needs outside of its system of care require review and diligence on the part of the staff in order to ensure that the referrals being given out are currently available and easily accessible to the person requesting assistance. At this time, that process is done manually by Tri-City's staff, which limits not only the resources staff is able to access in real time, but also may be inefficient in terms of the growing numbers of referrals as a result of the pandemic. The Unite Us platform will be piloted to see if the use of this electronic organized community network system not only increases the number and of persons served in regards to referrals and resources for care to support over well-being, but whether or not use of the platform serves to create a more comprehensive and connected network of community partners that results in quicker and more responsive services for persons in need throughout the three cities.

Capital Technological Needs Listing:

Technological Platform	Projected Funding
Cerner Electronic Health Record System Implementation	$270,436
Unite Us Platform Implementation	$30,000

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Tri-City Mental Health Authority
AGENDA REPORT

DATE: **June 16, 2021**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Toni Navarro, LMFT, Executive Director**

BY: **Mica Olmos, JPA Administrator/Clerk**

SUBJECT: **TCMHA Governing Board will Consider Forming an Ad-Hoc Committee to Interview and Select Potential Mental Health Commission Membership Applicants**

Summary

Article IV, Section D [Appointment] of the Tri-City Mental Health Authority (TCMHA) Mental Health Commission (MHC) Bylaws, states that Commission members shall be appointed by the Governing Board. Accordingly, staff is recommends that two Governing Board Members form an Ad-Hoc Committee to interview and select potential MHC Membership Applicants.

Background:

The Mental Health Commission is an advisory body to the Governing Board of TCMHA; serve without compensation; and it has no policy or budget authority. Section 5604.2 of the California Welfare and Institutions Code (WIC) defines in detail the duties of a MHC. Following the resignation of Commissioner Daniel Rodriguez in October 2020, which brought the MHC to the minimum membership requirement, the TCMHA JPA Administrator/Clerk began recruitment efforts for potential candidates to serve on the Commission and invitations to apply for membership were distributed to community organizations, service organizations and area providers located in Claremont, La Verne, and Pomona; posted on Tri-City's website posted and on the three Cities websites; and distributed through social media outlets of Tri-City and the three Cities.

Funding

None Required.

Recommendation:

Staff recommends that the Governing Board select two of Board Members to participate in an Ad Hoc Committee to interview and select potential MHC Membership Applicants.

Attachments:
None.

AGENDA ITEM NO. 10

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **June 16, 2021**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Toni Navarro, LMFT, Executive Director**

SUBJECT: **Executive Director's Monthly Report**

STATEWIDE COUNTY BEHAVIORAL HEALTH UPDATES

Governor's Budget

As reported in the May 2021 Executive Director's Monthly Report, Governor Newsom's final budget proposal contains significant investment in mental health/behavioral health including for direct services to youth and behavioral health workforce development. As of the writing of this report, it is not known how much of what was proposed will be accepted and passed by the Legislature before its deadline for ratification of June 15th. It is anticipated that at the Tri-City Governing Board Meeting on June 16th, the Executive Director will have information on final decisions and what the impact/benefit for county behavioral health will be and will report those out to the Board.

California Advancing Innovation in Medi-Cal (CalAIM) Update

As a member of the California Behavioral Health Directors' Association (CBHDA), Tri-City's leadership receive notification of and are eligible to participate in events hosted by California State Association of Counties (CSAC). On Friday, June 11th, the Executive Director received the following communication from CSAC and is sharing the information in this report to the Governing Board should any Board Member be interested in hearing more about two new proposed benefits under CalAIM, Enhanced Care Management and In-Lieu of Services. In coming months, Tri-City's Executive Staff will meet with those Managed Care Plans representing 96% of Tri-City's Medi-Cal beneficiaries, LA Care and Health Net, to discuss their plans for administering these services and what role Tri-City may have in providing these services to its clients who meet criteria to receive them. Below here is the announcement of a webinar that CSAC is hosting on June 23rd to make county leaders (and those who govern the two city behavioral health jurisdictions) more aware of exactly what and for whom ECM and ILOS are intended:

> *The CSAC Finance Corporation is pleased to partner again with Health Net & California Health & Wellness to offer all county supervisors, staff and others an opportunity to hear more about the California Advancing and Innovating Medi-Cal (CalAIM) initiative through our upcoming CalAIM 101 webinar. CalAIM is a new, multi-year initiative by the California Department of Health Care Services implementing broad delivery system, program and*

payment reform across the Medi-Cal program. All counties will play a role in CalAIM's system transformation.

*Please join us on **<u>Wednesday, June 23rd at 11:00am</u>** to hear more about the key features of CalAIM including the Enhanced Care Management (ECM) benefit and in lieu of services (ILOS) offerings, which are key features of Medi-Cal's framework for addressing social determinants of health and improving health equity statewide. Medi-Cal managed care health plans (MCPs) will be responsible for administering both ECM and ILOS in close collaboration with counties.*

Go HERE to register: CalAIM Webinar

Speakers will include: Martha Santa Chin, Government Programs Officer for Health Net of CA & California Health & Wellness; Sydney Turner, Manager of Health Policy for Health Net of CA & California Health & Wellness & Brianna Lierman, Regional Vice President, Centene.

HUMAN RESOURCES UPDATE

<u>Staffing – Month Ending May 2021:</u>

- Total Staff is 193 full-time and 17 part-time plus 19 full time vacancies 3 part time vacancies for a total of 222 positions.
- There were 1 new hires in May.
- There were 2 separations in May.

<u>Workforce Demographics May 2021</u>**:**

- American Indian or Alaska Native = 0.48%
- Asian = 9.09%
- Black or African American = 8.61%
- Hispanic or Latino = 56.46%
- Native Hawaiian or Other Pacific Islander = 0.48%
- Other = 8.61%
- 2 or more races = 1.44%
- White or Caucasian = 14.35%

<u>Posted Positions in May 2021:</u>

- Clinical Supervisor I AOP (1 FTE) *1 hire pending*
- Clinical Supervisor I School Partnership (1 FTE)
- Clinical Supervisor I COP (1 FTE)
- Clinical Therapist I/II Adult FSP (3 FTEs)

- Clinical Therapist I AOP (3 FTEs)
- Clinical Therapist I/II COP (2 FTEs)
- Clinical Therapist I/II COP SPT (2 FTEs)
- Housing Wellness Advocate (.5 FTE)
- Medication Support Services Supervisor (1 FTE)
- Mental Health Specialist COP SPT (.5 FTE) *1 hire pending*
- Program Support Assistant II (1 FTE)
- Psychiatric Technician I/II/III – Adult FSP (2 FTEs) *1 hire pending*
- Wellness Advocate I (1 FTE) *1 hire pending*

HOUSING DIVISION UPDATE

This month the Tri-City Housing Division Manager has provided data on its three multi-family MHSA-funded housing projects:

<table>
<tr><th colspan="4">A Year's Snapshot of Permanent Supportive Housing Unit Compositions (6/2020-6/2021)</th></tr>
<tr><td></td><td>Parkside Fam Apart
(21 units)</td><td>Cedar Springs
(8 units)</td><td>Holt Family Apartments
(25 units)</td></tr>
<tr><td># Unit Move-Ins</td><td>2</td><td>1 applicant in process</td><td>1 (2 applicants in process)</td></tr>
<tr><td># Unit Move-Outs</td><td>2</td><td>1</td><td>3</td></tr>
<tr><td>Household Sizes</td>
<td><table><tr><td>HH sizes</td><td># of units</td></tr><tr><td>1</td><td>12</td></tr><tr><td>2</td><td>5</td></tr><tr><td>3</td><td>2</td></tr><tr><td>4</td><td>2</td></tr><tr><td>5</td><td>1</td></tr></table></td>
<td><table><tr><td># of hh members</td><td># of units</td></tr><tr><td>1</td><td>4</td></tr><tr><td>2</td><td>1</td></tr><tr><td>3</td><td>1</td></tr><tr><td>4</td><td>1</td></tr><tr><td>5</td><td>1</td></tr></table></td>
<td><table><tr><td># of hh members</td><td># of units</td></tr><tr><td>1</td><td>12</td></tr><tr><td>2</td><td>7</td></tr><tr><td>3</td><td>3</td></tr><tr><td>4</td><td>2</td></tr><tr><td>5</td><td>1</td></tr><tr><td>6</td><td>1</td></tr></table></td></tr>
<tr><td>Female or Male Head of Households</td><td>Female – 17
Male – 4</td><td>Female – 7
Male – 1</td><td>Female – 18
Male – 8</td></tr>
<tr><td># of Single-Parent Households</td><td>5</td><td>3</td><td>6</td></tr>
<tr><td># of Working Households</td><td>6</td><td>3</td><td>5</td></tr>
<tr><td># of Households on SSI</td><td>15</td><td>3</td><td>19</td></tr>
<tr><td># of Households on General Relief (GR)</td><td>2</td><td>2</td><td>0</td></tr>
<tr><td># of Households with at Least One Person Enrolled in TCMHA Clinical Services</td><td>12</td><td>3</td><td>18</td></tr>
<tr><td># of Households that Identified Financial Issues Directly Related to COVID</td><td>2</td><td>1</td><td>4</td></tr>
</table>

Note: Some totals might add up to more than the units we have at each site. Move-outs and move-in are to be taken into account.

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **June 16, 2021**

TO: **Governing Board of Tri-City Mental Health Authority**
Toni Navarro, LMFT, Executive Director

FROM: **Diana Acosta, CPA, Chief Financial Officer**

SUBJECT: **Monthly Finance Report**

UNAUDITED FINANCIAL STATEMENTS FOR THE TEN MONTHS ENDED APRIL 30, 2021 (2021 FISCAL YEAR-TO-DATE):

The financials presented herein are the PRELIMINARY and unaudited financial statements for the ten months ended April 30, 2021. These financial statements include the activities from the clinical outpatient operations as well as activities from the implemented MHSA programs under the CSS, PEI, INN, WET and CFTN plans.

The increase in net position (income) is approximately $3.8 million. MHSA operations accounted for approximately $3.2 million of the increase, which is primarily the result of recognizing MHSA revenues on hand at the beginning of the fiscal year. MHSA non-operating revenues are reflected when MHSA funds have been received and are eligible to be spent.

During fiscal 2020, Tri-City received MHSA funding of approximately $10.2 million, of which $6.6 million were for approved programs for fiscal 2020-21 MHSA operations and was reflected as MHSA Revenue Restricted for Future Period on the Statement of Net Position (balance sheet) at June 30, 2020. These restricted MHSA revenues have now been recorded as non-operating revenues in fiscal 2020-21. In addition, during fiscal 2020-21 approximately $12.7 million in MHSA funding has been received of which $6.6 million was identified and approved for use in the current fiscal year 2020-21 and recorded as non-operating revenues, bringing the total MHSA non-operating revenues recognized to date up to approximately $13.2 million. Unlike the requirement to reflect all available and **approved** MHSA funding when received as non-operating revenues, MHSA operating costs are reflected when incurred. Therefore, the matching of revenue to expense is not consistent as the timing of expenditures will lag behind the timing of revenue recognition.

The remaining increase in net position of approximately $535 thousand is from Clinic outpatient operations, which is the result of operations for the ten months ended April 30, 2021.

The total cash balance at April 30, 2021 was approximately $33.8 million, which represents an increase of approximately $2.7 million from the June 30, 2020 balance of approximately $31.1 million.

Outpatient Clinic operations, after excluding any intercompany receipts or costs resulting from MHSA operations, had an increase in cash of approximately $1.3 million. MHSA operations reflected an increase in cash of approximately $1.4 million, after excluding intercompany receipts or costs resulting from clinic operations. The increase reflects the receipt of approximately $12.7 million in MHSA funds offset by the use of cash for MHSA operating activities. MHSA dollars (which are derived through the receipts of 1% of millionaire's income taxes) were delayed as a direct result of extending tax return deadlines and as such all behavioral health agencies experienced a reduction in cash receipts in the last few months of the previous fiscal year. As the tax filing deadline has now passed, Tri-City received $4.5 million in the August distribution (based on July's tax remittances) of MHSA funds, thus resulting in an overall increase in cash in MHSA.

Approximately $10.1 million in Medi-Cal cash receipts have been collected for both Outpatient Clinic Operations and MHSA Operations within the ten months ended April 30, 2021. Additionally, approximately $802 thousand has been received through June 10, 2021. Of the total amounts received in the current fiscal year, approximately $1.6 million is related to interim cost report settlements covering fiscal years 2013-14, 2015-16 and 2016-17.

UPCOMING, CURRENT EVENTS & UPDATES

Overall Financial Update

We are continuing to closely monitor for any new developments and updated revenue projections from CBHDA. As highlighted previously, the current revenue projections by CBHDA estimate that some revenues (such as MHSA revenues) will increase in fiscal year 2020-21 as a result of delays in tax returns, however these same revenues are expected to decrease in the following years (through FY 2022/23). As such, planning appropriately to ensure we meet the needs of our community, and having the ability to make changes as we go will be necessary in the upcoming years, especially if projections wind up being significantly different than currently projected.

The fiscal year 2020-21 independent financial statement audit interim fieldwork is scheduled to begin mid-June 2021 with the final phase scheduled to begin in August 2021. The issuance of the audited financial statements is targeted for October of 2021.

FY 2020-21 Bankruptcy Payments

The total bankruptcy liability balance as of April 30, 2021 was $331,064 and upon approval of Resolution 579, Tri City issued final payments bringing the total bankruptcy liability to zero as of the date of this report.

MHSA Funding Updates

Estimated Current Cash Position – The following table represents a brief summary of the estimated current MHSA cash position as of the ten months ended April 30, 2021 which includes estimates to project the ending cash balance at June 30, 2021.

		MHSA	
Cash at April 30, *2021*	$	25,084,775	
Receivables net of Reserve for Cost Report Settlements		(941,607)	
Prudent Reserves		(2,200,000)	*
Estimated Remaining Expenses for Operations FY 2020-21		(1,813,682)	**
Reserved for future CFTN Projects including TCG		(1,247,389)	
Reserved for Future Housing Projects		-	****
Total Estimated Adjustments to Cash		(6,202,678)	
Estimated Available at June 30, 2021	$	18,882,097	
Remaining funds received in FY 2020-21	$	2,733,942	***

* Per the recently approved SB 192, Prudent Reserves are now required to be maintained at an amount that does not exceed 33% of the average Community Services and Support (CSS) revenue received for the fund, in the preceding 5 years.

** Estimated based on adopted operating budget for Fiscal Year 2020-21, actual and estimated amounts to year end (06/30/2021).

*** Represents MHSA receipts received in May and June 2021

**** In addition to the $1.2 Million previously designed for housing, an additional $1.6 Million was designated for housing, as approved at the May 15, 2019 Governing Board Meeting. Following the Governing Board Approval of the West Mission Housing Project and the approval of all the respective documents, the $2.8 Million designed to this project, was transferred to the project project during the month of April 2021.

MHSA Reversion

Each remittance of MHSA funds received by Tri-City is required to be allocated among three of the five MHSA Plans, CSS, PEI and INN. The first 5% of each remittance is required to be allocated to INN and the remaining amount is split 80% to CSS and 20% to PEI. While the WET and the CapTech plans have longer time frames in which to spend funds (made up of one-time transfers into these two plans), the CSS, PEI and INN plans have three years.

Amounts received within the CSS and PEI programs must be expended within three years of receipt. INN amounts must be programmed in a plan that is approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) within three years of receipt, and spent within the life of the approved program. Upon approval by the MHSOAC, INN amounts have to be expended within the life of said program. For example, a program approved for a five-year period will have the full five years associated with the program to expend the funds.

To demonstrate the three-year monitoring of CSS, PEI and INN dollars, the following table represents the funds as of a date in time, June 30, 2020, and the year in which they were received.

Remaining Funds as of June 30, 2020 (Per Audited Financial Statements)

	CSS	PEI	INN	Total
	13,009,920	1,833,229	1,867,814	16,710,963
2016-17				-
2017-18			819,183	819,183
2018-19	5,535,602		556,900	6,092,502
2019-20	7,474,318	1,833,229	491,731	9,799,278
Total at 6/30/20	13,009,920	1,833,229	1,867,814	16,710,963

Estimated FY 2020-21 Expenditures per MHSA Plan		
CSS	PEI	INN
10,712,194	2,217,534	316,438

- The 2018-19 CSS remaining dollars, in the amount of $5,535,602, are required to be spent by June 30, 2021 to avoid being subject to reversion. As demonstrated in the table above, anticipated expenditures in the CSS plan in fiscal year 2020-21 are designed to mitigate the risk of reversion.

- The 2019-20 CSS remaining dollars, in the amount of $1,833,229, are required to be spent by June 30, 2022 to avoid being subject to reversion. As demonstrated in the table above, anticipated expenditures in the PEI plan in fiscal year 2020-21 are designed to mitigate the risk of reversion.

- The 2017-18 INN remaining dollars as well as approximately 50% of the 2018-19 dollars are all part of the MHSOAC approved Help@Hand Program (formerly Tech Suite) which is expected to be completed December 2023, and as such these amounts are not at risk of reversion. The remaining 2018-19 amounts that are not associated with the Help@Hand program are required to be in an MHSOAC approved program by June 30, 2021 in order to avoid being subject to reversion. Additionally, the 2019-20 amounts are required to be in an MHSOAC approved program by June 30, 2022. Work groups and stakeholder meetings are currently underway to develop a plan to be presented to the MHSOAC for approval by the end of the fiscal year.

Attachments

Attachment 12-A: April 30, 2021 Unaudited Financial Statements

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF NET POSITION

	AT APRIL 30, 2021			AT JUNE 30, 2020		
	TCMH Unaudited	MHSA Unaudited	Consolidated Unaudited	TCMH Audited	MHSA Audited	Consolidated Audited
Current Assets						
Cash	$ 8,744,573	$ 25,084,775	$ 33,829,348	$ 7,395,355	$ 23,736,461	$ 31,131,816
Accounts receivable, net of reserve for uncollectible accounts $392,573 at April 30, 2021 and $543,736 at June 30, 2020	3,244,312	1,803,910	5,048,222	4,191,840	2,588,279	6,780,119
Total Current Assets	11,988,884	26,888,686	38,877,570	11,587,195	26,324,740	37,911,935
Property and Equipment						
Land, building, furniture and equipment	3,814,696	9,546,502	13,361,198	3,699,755	9,384,214	13,083,969
Accumulated depreciation	(2,497,027)	(3,733,810)	(6,230,838)	(2,403,631)	(3,434,225)	(5,837,856)
Total Property and Equipment	1,317,668	5,812,692	7,130,361	1,296,123	5,949,989	7,246,112
Other Assets						
Deposits and prepaid assets	109,486	601,525	711,011	70,955	491,199	562,154
Note receivable-Housing Development Project	-	2,800,000	2,800,000	-	-	-
Total Noncurrent Assets	1,427,155	9,214,217	10,641,372	1,367,079	6,441,188	7,808,267
Total Assests	$ 13,416,039	$ 36,102,903	$ 49,518,942	$ 12,954,274	$ 32,765,928	$ 45,720,202
Deferred Outflows of Resources						
Deferred outflows related to the net pension liability	2,776,741	-	2,776,741	2,776,741	-	2,776,741
Total Deferred Outflows of Resources	2,776,741	-	2,776,741	2,776,741	-	2,776,741
Total Assets and Deferred Outflows of Resouces	**$ 16,192,780**	**$ 36,102,903**	**$ 52,295,683**	**$ 15,731,015**	**$ 32,765,928**	**$ 48,496,943**
LIABILITIES						
Current Liabilities						
Accounts payable	234,586	219	234,805	235,067	188,826	423,893
Accrued payroll liabilities	241,898	390,677	632,575	561,169	80,419	641,589
Accrued vacation and sick leave	658,201	1,079,778	1,737,979	604,179	865,609	1,469,787
Reserve for Medi-Cal settlements	3,400,076	2,745,517	6,145,593	2,942,066	2,366,312	5,308,378
Current portion of mortgage debt	30,688	-	30,688	30,688	-	30,688
Total Current Liabilities	4,565,448	4,216,190	8,781,639	4,373,168	3,501,166	7,874,334
Intercompany Acct-MHSA & TCMH	456,327	(456,327)	-	370,961	(370,961)	-
Long-Term Liabilities						
Mortgages and home loan	746,195	88,309	834,504	771,683	88,309	859,992
Net pension liability	5,462,528	-	5,462,528	5,462,528	-	5,462,528
Unearned MHSA revenue	-	6,392,919	6,392,919	-	276,421	276,421
Total Long-Term Liabilities	6,208,723	6,481,228	12,689,951	6,234,211	364,730	6,598,940
Liabilities Subject to Compromise						
Class 2 General Unsecured Claims	-		-	-		-
Class 3 Unsecured Claim of CAL DMH	200,512		200,512	397,351		397,351
Class 4 Unsecured Claim of LAC DMH	130,552		130,552	258,713		258,713
Total Liabilities Subject to Compromise	331,064	-	331,064	656,064	-	656,064
Total Liabilities	11,561,562	10,241,092	21,802,654	11,634,403	3,494,935	15,129,339
Deferred Inflow of Resources						
MHSA revenues restricted for future period	-	-	-	-	6,625,123	6,625,123
Deferred inflows related to the net pension liability	217,236	-	217,236	217,236	-	217,236
Total Deferred Inflow of Resources	217,236	-	217,236	217,236	6,625,123	6,842,359
NET POSITION						
Invested in capital assets net of related debt	540,785	5,812,692	6,353,477	493,753	5,949,989	6,443,742
Restricted for MHSA programs	-	20,049,119	20,049,119	-	16,204,682	16,204,682
Unrestricted	3,873,197	-	3,873,197	3,385,622	491,199	3,876,821
Total Net Position	4,413,982	25,861,811	30,275,793	3,879,375	22,645,870	26,525,245
Total Liabilities, Deferred Inflows of Resources and Net Position	**$ 16,192,780**	**$ 36,102,903**	**$ 52,295,683**	**$ 15,731,015**	**$ 32,765,928**	**$ 48,496,943**

Definitions:
TCMH=Tri-City's Outpatient Clinic
MHSA=Mental Health Services Act (Proposition 63)

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET POSITION
TEN MONTHS ENDED APRIL 30, 2021 AND 2020

	PERIOD ENDED 4/30/21			PERIOD ENDED 4/30/20		
	TCMH Unaudited	**MHSA Unaudited**	**Consolidated Unaudited**	**TCMH Audited**	**MHSA Audited**	**Consolidated Audited**
OPERATING REVENUES						
Medi-Cal FFP	$ 3,194,104	$ 2,849,474	$ 6,043,578	$ 3,110,539	$ 2,697,162	$ 5,807,701
Medi-Cal FFP FYE Prior Year	126,765	1,894	128,659	-	-	-
Medi-Cal SGF-EPSDT	801,179	620,913	1,422,092	872,296	644,912	1,517,207
Medi-Cal SGF-EPSDT Prior Year	(29,906)	15,202	(14,704)	-	-	-
Medicare	791	1,270	2,061	2,331	1,364	3,695
Contracts	17,500	24,002	41,502	60,641	24,112	84,753
Patient fees and insurance	1,312	-	1,312	2,360	-	2,360
Rent income - TCMH & MHSA Housing	25,537	77,634	103,171	28,830	73,191	102,021
Other income	1,742	389	2,131	1,696	500	2,196
Net Operating Revenues	**4,139,025**	**3,590,777**	**7,729,802**	**4,078,693**	**3,441,241**	**7,519,934**
OPERATING EXPENSES						
Salaries, wages and benefits	6,459,375	10,029,161	16,488,536	5,631,363	9,208,156	14,839,519
Facility and equipment operating cost	547,668	944,009	1,491,676	511,254	1,112,898	1,624,151
Client lodging, transportation, and supply expense	251,197	1,361,445	1,612,641	135,516	1,193,691	1,329,207
Depreciation	121,751	350,227	471,978	85,883	303,828	389,710
Other operating expenses	491,105	1,062,694	1,553,799	475,313	1,107,387	1,582,699
Total Operating Expenses	**7,871,095**	**13,747,535**	**21,618,629**	**6,839,328**	**12,925,959**	**19,765,286**
OPERATING (LOSS) (Note 1)	**(3,732,070)**	**(10,156,758)**	**(13,888,827)**	**(2,760,634)**	**(9,484,718)**	**(12,245,352)**
Non-Operating Revenues (Expenses)						
Realignment	3,485,843	-	3,485,843	3,166,975	-	3,166,975
Contributions from member cities & donations	70,236	-	70,236	70,236	-	70,236
MHSA funds	-	13,246,166	13,246,166	-	11,753,939	11,753,939
Grants and Contracts	533,806		533,806	-	-	-
Cares Act Stimulus & Telehealth	185,943	-	185,943	-	-	-
Interest Income	24,245	117,783	142,028	81,336	418,327	499,664
Interest expense	(33,396)	-	(33,396)	(34,765)	-	(34,765)
Gain on disposal of assets	-	8,750	8,750	508	8,731	9,238
Total Non-Operating Revenues (Expense)	4,266,677	13,372,699	17,639,375	3,284,290	12,180,997	15,465,287
INCOME (LOSS)	**534,607**	**3,215,941**	**3,750,548**	**523,656**	**2,696,279**	**3,219,935**
INCREASE (DECREASE) IN NET POSITION	**534,607**	**3,215,941**	**3,750,548**	**523,656**	**2,696,279**	**3,219,935**
NET POSITION, BEGINNING OF YEAR	3,879,375	22,645,870	26,525,245	3,229,029	21,242,083	24,471,112
NET POSITION, END OF MONTH	**$ 4,413,982**	**$ 25,861,811**	**$ 30,275,793**	**$ 3,752,684**	**$ 23,938,362**	**$ 27,691,046**

(**Note 1**) "Operating Loss" reflects loss before realignment funding and MHSA funding which is included in non-operating revenues.

Definitions:

Medi-Cal FFP= Federal Financial Participation Reimbursement
Medi-Cal SGF-EPSDT=State General Funds reimbursement for Medi-Cal services provided to children under the "Early and Periodic Screening, Diagnosis and Treatment" regulations.
TCMH=Tri-City's Outpatient Clinic
MHSA=Mental Health Services Act (Proposition 63)

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF CASH FLOWS
TEN MONTHS ENDED APRIL 30, 2021 AND 2020

	PERIOD ENDED 4/30/21			PERIOD ENDED 4/30/20		
	TCMH Unaudited	MHSA Unaudited	Consolidated Unaudited	TCMH Audited	MHSA Audited	Consolidated Audited
Cash Flows from Operating Activities						
Cash received from and on behalf of patients	$ 5,562,809	$ 4,679,126	$ 10,241,935	$ 3,014,148	$ 2,593,269	$ 5,607,417
Cash payments to suppliers and contractors	(1,328,981)	(3,667,080)	(4,996,061)	(1,201,258)	(3,995,506)	(5,196,764)
Payments to employees	(6,724,624)	(9,504,734)	(16,229,358)	(5,890,339)	(8,712,447)	(14,602,786)
	(2,490,796)	(8,492,688)	(10,983,484)	(4,077,449)	(10,114,684)	(14,192,133)
Cash Flows from Noncapital Financing Activities						
MHSA Funding	-	12,701,851	12,701,851	-	9,275,650	9,275,650
CalHFA-State Administered Projects	-	35,690	35,690	-	-	-
Realignment	3,485,843	-	3,485,843	3,771,688	-	3,771,688
Contributions from member cities	70,236	-	70,236	70,236	-	70,236
Grants and Contracts	500,841	-	500,841	-	-	-
Cares Act Stimulus & Sierra Telehealth Funds	185,943	-	185,943	-	-	-
	4,242,863	12,737,541	16,980,405	3,841,924	9,275,650	13,117,574
Cash Flows from Capital and Related Financing Activities						
Purchase of capital assets	(143,296)	(212,930)	(356,226)	(164,152)	(249,902)	(414,054)
Principal paid on capital debt	(25,488)	-	(25,488)	(24,118)	-	(24,118)
Note receivable from Housing Development Project	-	(2,800,000)	(2,800,000)	-	-	-
Interest paid on capital debt	(33,396)	-	(33,396)	(34,765)	-	(34,765)
Intercompany-MHSA & TCMH	85,366	(85,366)	-	(540,536)	540,536	-
	(116,813)	(3,098,296)	(3,215,109)	(763,572)	290,634	(472,938)
Cash Flows from Investing Activities						
Interest received	38,963	193,008	231,971	102,985	519,310	622,295
Sale of investments	-	8,750	8,750	508	8,731	9,238
	38,963	201,758	240,721	103,493	528,040	631,533
Cash Flows from Reorganization Items						
Cash payments to Bankruptcy Class 3 and 4 Unsecured	(325,000)	-	(325,000)	(1,030,000)	-	(1,030,000)
	(325,000)	-	(325,000)	(1,030,000)	-	(1,030,000)
Net Increase (Decrease) in Cash and Cash Equivalents	1,349,217	1,348,315	2,697,532	(1,925,604)	(20,360)	(1,945,964)
Cash Equivalents at Beginning of Year	7,395,355	23,736,461	31,131,816	7,483,365	24,449,208	31,932,573
Cash Equivalents at End of Month	**$ 8,744,573**	**$ 25,084,776**	**$ 33,829,348**	**$ 5,557,761**	**$ 24,428,849**	**$ 29,986,609**

Definitions:

TCMH=Tri-City's Outpatient Clinic
MHSA=Mental Health Services Act (Proposition 63)

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET POSITION
ACTUAL TO BUDGET COMPARISON
TEN MONTHS ENDING APRIL 30, 2021
(UNAUDITED)

	TRI-CITY MENTAL HEALTH OUTPATIENT CLINIC (TCMH)			TRI-CITY MENTAL HEALTH SERVICES ACT (MHSA)			TRI-CITY MENTAL HEALTH AUTHORITY CONSOLIDATED		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
OPERATING REVENUES									
Medi-Cal FFP	$ 3,488,209	$ 3,527,427	$ (39,217)	$ 3,107,387	$ 3,779,047	$ (671,660)	$ 6,595,596	$ 7,306,473	$ (710,877)
Medi-Cal FFP Prior Year	133,240	-	133,240	2,066	-	2,066	135,306	-	135,306
Medi-Cal SGF-EPSDT	868,697	1,332,643	(463,945)	677,113	880,246	(203,133)	1,545,810	2,212,888	(667,078)
Medi-Cal SGF-EPSDT Prior Year	(27,614)	-	(27,614)	16,578	-	16,578	(11,036)	-	(11,036)
Medicare	791	2,500	(1,709)	1,270	1,167	103	2,061	3,667	(1,606)
Patient fees and insurance	1,312	2,083	(772)	-	-	-	1,312	2,083	(772)
Contracts	17,500	16,667	833	24,002	-	24,002	41,502	16,667	24,835
Rent income - TCMH & MHSA Housing	25,537	29,167	(3,630)	77,634	92,042	(14,407)	103,171	121,208	(18,038)
Other income	1,742	1,083	659	389	-	389	2,131	1,083	1,048
Provision for contractual disallowances	(370,390)	(471,215)	100,825	(315,661)	(461,346)	145,685	(686,051)	(932,561)	246,510
Net Operating Revenues	**4,139,025**	**4,440,354**	**(301,329)**	**3,590,777**	**4,291,155**	**(700,378)**	**7,729,802**	**8,731,509**	**(1,001,707)**
OPERATING EXPENSES									
Salaries, wages and benefits	6,459,375	6,952,552	(493,176)	10,029,161	10,886,004	(856,844)	16,488,536	17,838,556	(1,350,020)
Facility and equipment operating cost	547,785	585,615	(37,830)	944,025	1,223,117	(279,092)	1,491,810	1,808,732	(316,922)
Client program costs	244,633	100,073	144,561	1,337,733	1,008,314	329,419	1,582,366	1,108,387	473,979
Grants			-	64,000	66,667	(2,667)	64,000	66,667	(2,667)
MHSA training/learning costs			-	90,603	129,176	(38,573)	90,603	129,176	(38,573)
Depreciation	121,751	76,338	45,413	350,227	299,381	50,846	471,978	375,718	96,259
Other operating expenses	497,550	603,517	(105,966)	931,787	1,129,071	(197,284)	1,429,337	1,732,588	(303,250)
Total Operating Expenses	**7,871,095**	**8,318,093**	**(446,999)**	**13,747,535**	**14,741,729**	**(994,194)**	**21,618,629**	**23,059,823**	**(1,441,193)**
OPERATING (LOSS)	**(3,732,070)**	**(3,877,739)**	**145,669**	**(10,156,758)**	**(10,450,574)**	**293,817**	**(13,888,827)**	**(14,328,313)**	**439,486**
Non-Operating Revenues (Expenses)									
Realignment	3,485,843	3,046,120	439,723	-	-	-	3,485,843	3,046,120	439,723
Contributions from member cities & donations	70,236	70,236	-	-	-	-	70,236	70,236	-
MHSA Funding	-	-	-	13,246,166	13,246,166	-	13,246,166	13,246,166	-
Grants and contracts	533,806	100,000	433,806	-	-	-	533,806	100,000	433,806
Cares Act Stimulus & Telehealth	185,943	-	185,943	-	-	-	185,943	-	185,943
Interest (expense) income, net	(9,151)	22,491	(31,641)	117,783	276,667	(158,884)	108,632	299,158	(190,526)
Other income-gain on disposal of assets	-	-	-	8,750	-	8,750	8,750	-	8,750
Total Non-Operating Revenues (Expense)	**4,266,677**	**3,238,847**	**1,027,830**	**13,372,699**	**13,522,833**	**(150,134)**	**17,639,375**	**16,761,680**	**877,696**
INCREASE(DECREASE) IN NET POSITION	**$ 534,607**	**$ (638,892)**	**$ 1,173,499**	**$ 3,215,941**	**$ 3,072,259**	**$ 143,682**	**$ 3,750,548**	**$ 2,433,366**	**$ 1,317,182**

Definitions:

Medi-Cal FFP= Federal Financial Participation Reimbursement
Medi-Cal SGF-EPSDT=State General Funds reimbursement for Medi-Cal services provided to children under the "Early and Periodic Screening, Diagnosis and Treatment" regulations.
TCMH=Tri-City's Outpatient Clinic
MHSA=Mental Health Services Act (Proposition 63)

TRI-CITY MENTAL HEALTH AUTHORITY
ACTUAL TO BUDGET VARIANCE EXPLANATIONS
TEN MONTHS ENDING APRIL 30, 2021

COMMENT: PLEASE NOTE, THE DISCUSSION BELOW MAY USE THE FOLLOWING ABBREVIATIONS:
TCMH==TRI-CITY MENTAL HEALTH (OUTPATIENT CLINIC OPERATIONS)
MHSA==MENTAL HEALTH SERVICES ACT (ACTIVITIES INCLUDE CSS, PEI, INN, WET AND CAP/TECH PROGRAMS)

Net Operating Revenues

Net operating revenues are lower than budget by $1 million for the following reasons:

1. **Medi-Cal FFP revenues for FY 2020-21** were $711 thousand lower than the budget. Medi-Cal FFP revenues were $39 thousand lower for TCMH and $672 thousand lower for MHSA. At TCMH, the adult program revenues were higher than budget by $312 thousand and the children program revenues were lower by $351 thousand. For MHSA, the adult and older adult FSP programs were lower than budget by $584 thousand and the Children and TAY FSP programs were lower by $88 thousand. Additionally, as the results of the fiscal years 2013-14, 2015-16 and 2016-17 interim cost report settlements, a total of $135 thousand in prior years Medi-Cal FFP revenues were recorded to the current year operations.

2. **Medi-Cal SGF-EPSDT revenues for fiscal year 2020-21** were lower than budget by $667 thousand of which $464 thousand lower were from TCMH and $203 thousand lower were from MHSA. As was mentioned above, however, a net adjustment of $11 thousand in prior years Medi-Cal SGF-EPSDT revenues were recorded due to the fiscal years 2013-14, 2015-16 and 2016-17 interim cost report settlements. SGF-EPSDT relates to State General Funds (SGF) provided to the agency for provision of qualifying Medi-Cal services for Early Prevention Screening and Diagnostic Testing (EPSDT) to children and youth under 21 years. These funds are in addition to the FFP reimbursed by the federal government.

   > *Medi-Cal and Medi-Cal SGF-EPSDT revenues are recognized when the services are provided and can vary depending on the volume of services provided from month to month. Projected (budgeted) services are based on estimated staffing availability and the assumption that vacant positions will be filled.*

3. **Medicare revenues** are lower than the budget by $2 thousand. Tri-City records revenue when the services are provided and the claims are incurred and submitted.

4. **Contract revenues** are higher than budget by $25 thousand of which $1 thousand higher was from TCMH and $24 thousand higher was from MHSA. At TCMH, the higher revenues were due to the Bonita Unified School District contract. At MHSA, the higher contract amount represents the Clifford Beers Housing's share of cost for funding a Residential Services Coordinator position to provide on-site services to all residents at the Holt Avenue Family Apartments.

5. **Rent Income** was lower than the budget by $18 thousand. The rental income represents the payments collected from the tenants staying at the Tri-City apartments on Pasadena and at the MHSA houses on Park Avenue and Baseline Road.

6. **Other income** is $1 thousand higher than budget.

7. **Provision for contractual disallowances** for fiscal year 2020-21 is $247 thousand lower than budget due to lower revenues.

Operating Expenses

Operating expenses were lower than budget by $1.4 million for the following reasons:

1. **Salaries and benefits** are approximately $1.4 million lower than budget and of that amount, salaries and benefits are $493 thousand lower for TCMH operations and are $857 thousand lower for MHSA operations. These variances are due to the following:

   TCMH salaries were lower than budget by $103 thousand and benefits are lower than budget by $390 thousand due to lower various insurances.

   MHSA salaries are lower than budget by $439 thousand. The direct program salary costs are lower by $229 thousand due to vacant positions and the administrative salary costs are lower than budget by $210 thousand. Benefits are lower than budget by $418 thousand. Of that, health insurance is lower by $242 thousand, retirement contributions are lower by $100 thousand, workers compensation is lower by $53 thousand and state unemployment is lower by $46 thousand. These lower costs are offset by higher employer training costs.

2. **Facility and equipment operating costs** were lower than budget by $317 thousand. Facility and equipment operating costs were $38 thousand lower for TCMH and $279 thousand lower for MHSA.

TRI-CITY MENTAL HEALTH AUTHORITY
ACTUAL TO BUDGET VARIANCE EXPLANATIONS
TEN MONTHS ENDING APRIL 30, 2021

COMMENT: PLEASE NOTE, THE DISCUSSION BELOW MAY USE THE FOLLOWING ABBREVIATIONS:
TCMH==TRI-CITY MENTAL HEALTH (OUTPATIENT CLINIC OPERATIONS)
MHSA==MENTAL HEALTH SERVICES ACT (ACTIVITIES INCLUDE CSS, PEI, INN, WET AND CAP/TECH PROGRAMS)

3 **Client program costs** are higher than the budget by $474 thousand. This included a payment of $396 thousand to the City of Pomona-Hope for Home Year-Round Emergency Shelter for which the amount was budgeted and spread out throughout the fiscal year.

4 **Grants for fiscal year 2020-21** awarded under the Community Wellbeing project are lower than the budget $3 thousand due to timing.

5 **MHSA learning and training costs** are lower than the budget by $39 thousand.

6 **Depreciation** is higher than budget by $96 thousand.

7 **Other operating expenses** were lower than budget by $303 thousand of which $106 thousand lower were from TCMH and $197 thousand lower were from MHSA. At TCMH, attorney fee is lower than budget by $60 thousand, personnel recruiting fee is lower by $41 thousand, conference and mileage expenses are lower by $8 thousand. These lower costs are slightly offset by higher IT related professional fee. For MHSA, professional fees are lower than the budget by $123 thousand, attorney fees are lower by $14 thousand, personnel recruiting fees are lower by $36 thousand, conference and mileage reimbursement are lower by $25 thousand and dues and subscriptions are lower by $33 thousand. These lower costs are offset by higher security expense.

Non-Operating Revenues (Expenses)

Non-operating revenues, net, are higher than budget by $878 thousand as follows:

1 **TCMH non-operating revenues** are $1 million higher than the budget. Of that, realignment fund is higher than the budget by $440 thousand. Contributions from member cities are in line with the budget. Grants and contracts are higher than the budget by $434 thousand including the City of Pomona Measure H program, Pomona Vision 2030 Project, Pomona Rental Assistance program, Los Angeles County Covid-19 Community Equity Fund and Adverse Childhood Experiences grant. Additionally, Tri-City received approximately $86 thousand from the Federal 2020 Stimulus Cares Act Relief Funds and $100 thousand Telehealth Infrastructure funds from Community Mental Health Services Block Grant. Lastly, interest income netted with interest expense is lower than the budget by $32 thousand.

2 **MHSA non-operating revenue** is in line with the budget.
In accordance with Government Accounting Standards Board, MHSA funds received and available to be spent must be recorded as non-operating revenue as soon as the funds are received. Funds are available to be spent when an MHSA plan and related programs have been approved and the proposed expenditures for those programs have been approved through an MHSA plan, MHSA update, or State Oversight and Accountability Commission.

The differences in actual to budget are broken out as follows:

	Actual	Budget	Variance
CSS funds received and available to be spent	$ 10,712,194	$ 10,712,194	$ -
PEI funds received and available to be spent	2,217,534	2,217,534	-
WET funds received and available to be spent	-	-	-
CAP/TECH funds received and available to be spent	-	-	-
INN funds received and available to be spent	316,438	316,438	-
Non-operating revenues recorded	$ 13,246,166	$ 13,246,166	$ -

CSS, PEI and INN recorded revenues are all in line with the budgets.

Interest income for MHSA is lower than budget by $159 thousand.

Other Non-Operating Revenues were from the trade-ins of three MHSA vehicles.

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET POSITION
TEN MONTHS ENDED APRIL 30, 2021 AND 2020

	PERIOD ENDED 4/30/21			PERIOD ENDED 4/30/20		
	TCMH Unaudited	**MHSA Unaudited**	**Consolidated Unaudited**	**TCMH Audited**	**MHSA Audited**	**Consolidated Audited**
REVENUES						
Medi-Cal FFP, net of reserves	$ 3,194,104	$ 2,849,474	$ 6,043,578	$ 3,110,539	$ 2,697,162	$ 5,807,701
Medi-Cal FFP FYE Prior Year	126,765	1,894	128,659	-	-	-
Medi-Cal SGF-EPSDT	801,179	620,913	1,422,092	872,296	644,912	1,517,207
Medi-Cal SGF-EPSDT Prior Year	(29,906)	15,202	(14,704)	-	-	-
Medicare	791	1,270	2,061	2,331	1,364	3,695
Realignment	3,485,843	-	3,485,843	3,166,975	-	3,166,975
MHSA funds	-	13,246,166	13,246,166	-	11,753,939	11,753,939
Grants and contracts	551,306	24,002	575,308	60,641	24,112	84,753
Cares Act Stimulus & Telehealth	185,943	-	185,943	-	-	-
Contributions from member cities & donations	70,236	-	70,236	70,236	-	70,236
Patient fees and insurance	1,312	-	1,312	2,360	-	2,360
Rent income - TCMH & MHSA Housing	25,537	77,634	103,171	28,830	73,191	102,021
Other income	1,742	389	2,131	1,696	500	2,196
Interest Income	24,245	117,783	142,028	81,336	418,327	499,664
Gain on disposal of assets	-	8,750	8,750	508	8,731	9,238
Total Revenues	**8,439,098**	**16,963,476**	**25,402,573**	**7,397,749**	**15,622,238**	**23,019,987**
EXPENSES						
Salaries, wages and benefits	6,459,375	10,029,161	16,488,536	5,631,363	9,208,156	14,839,519
Facility and equipment operating cost	547,668	944,009	1,491,676	511,254	1,112,898	1,624,151
Client lodging, transportation, and supply expense	251,197	1,361,445	1,612,641	135,516	1,193,691	1,329,207
Depreciation	121,751	350,227	471,978	85,883	303,828	389,710
Interest expense	33,396	-	33,396	34,765	-	34,765
Other operating expenses	491,105	1,062,694	1,553,799	475,313	1,107,387	1,582,699
Total Expenses	**7,904,491**	**13,747,535**	**21,652,025**	**6,874,093**	**12,925,959**	**19,800,052**
INCREASE (DECREASE) IN NET POSITION	**534,607**	**3,215,941**	**3,750,548**	**523,656**	**2,696,279**	**3,219,935**
NET POSITION, BEGINNING OF YEAR	3,879,375	22,645,870	26,525,245	3,229,029	21,242,083	24,471,112
NET POSITION, END OF MONTH	**$ 4,413,982**	**$ 25,861,811**	**$ 30,275,793**	**$ 3,752,684**	**$ 23,938,362**	**$ 27,691,046**

NOTE: This presentation of the Change in Net Assets is NOT in accordance with GASB, but is presented only for a simple review of Tri-City's revenue sources and expenses.

Definitions:
Medi-Cal FFP= Federal Financial Participation Reimbursement
Medi-Cal SGF-EPSDT=State General Funds reimbursement for Medi-Cal services provided to children under the "Early and Periodic Screening, Diagnosis and Treatment" regulations.
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Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: June 16, 2021

TO: Governing Board of Tri-City Mental Health Authority
Toni Navarro, LMFT, Executive Director

FROM: Elizabeth Renteria, LCSW, Chief Clinical Officer

SUBJECT: Monthly Clinical Services Report

CLIENT CENSUS DATA

Each month, information and data and will be shared about the services provided and the clients that have been supported. This month's data set comes from our electronic health record and highlights the ethnic breakdown of client's receiving services at Tri-City Mental Health Authority.

Race/Ethnicity

	Adult Outpatient	FSP Adult/Older Adult	FCCS	Children's Outpatient	FSP Children/TAY
American Indian or Alaskan Native	1%	2%	0%	0%	0%
Asian	3%	1%	4%	2%	4%
Black/African American	15%	21%	11%	8%	13%
Hispanic or Latino	57%	45%	46%	81%	69%
White/Caucasian	19%	26%	35%	6%	9%
Another Race	3%	4%	4%	3%	4%
Not Reported	2%	1%	0%	1%	1%

ACCESS TO CARE

There was a total of 194 service requests made for adults in the month of May. In terms of request type, 21 were walk-in service requests, 147 were called-in, there were 23 SRTS referrals, there were 2 in- writing referrals and 1 FSP/FCCS referral. There was a total of 26 service requests that were hospital discharges. There were 25 referrals received from IOET for adults. Most service requests were called in over the phone at 75.77% (147) which is now the preferred method of processing service requests due to COVID-19.

There was a total of 129 intakes initiated by staff during the month of May for both adults and children by the following departments: Access To Care, Adult Outpatient Program, Child/Family Outpatient Program, Full-Service Partnership Program, School Partnership Team, and Intensive Outreach and Engagement Team. There were approximately 6 individuals that did not meet medical necessity during initial assessment. Access to Care clinicians initiated a total of 77 intakes which is 59.68% of the total number of intakes initiated for the month of May for the entire agency**.**

<u>Below is a breakdown of dispositions based on the 194 service requests received for May/2021</u>:

- .51% (1) Pending disposition.
- 77.83% (151) Initial Appointment Given.
- .51% (1) Sent out due to Crisis (5150/5585) (different from wellness checks).
- 5.67% (11) Individual/collateral declined Services.
- 2.06% (4) Referred back to private insurance.
- 8.76% (17) Referred to another MH agency.
- 1.03% (2) Referred to other type of agency.
- 3.60 % (7) Unable to contact individual/collateral.

There was a total of 64 service requests received at the Royalty location for children and TAY in the month of May. Of the 64 service requests, 0 were walk-ins, 30 were called-in, 27 were in-writing referrals, 1 was an FSP referral and 6 were SRTS referrals. There was 1 hospital discharges and 8 referrals from IOET.

CO-OCCURRING SUPPORT TEAM

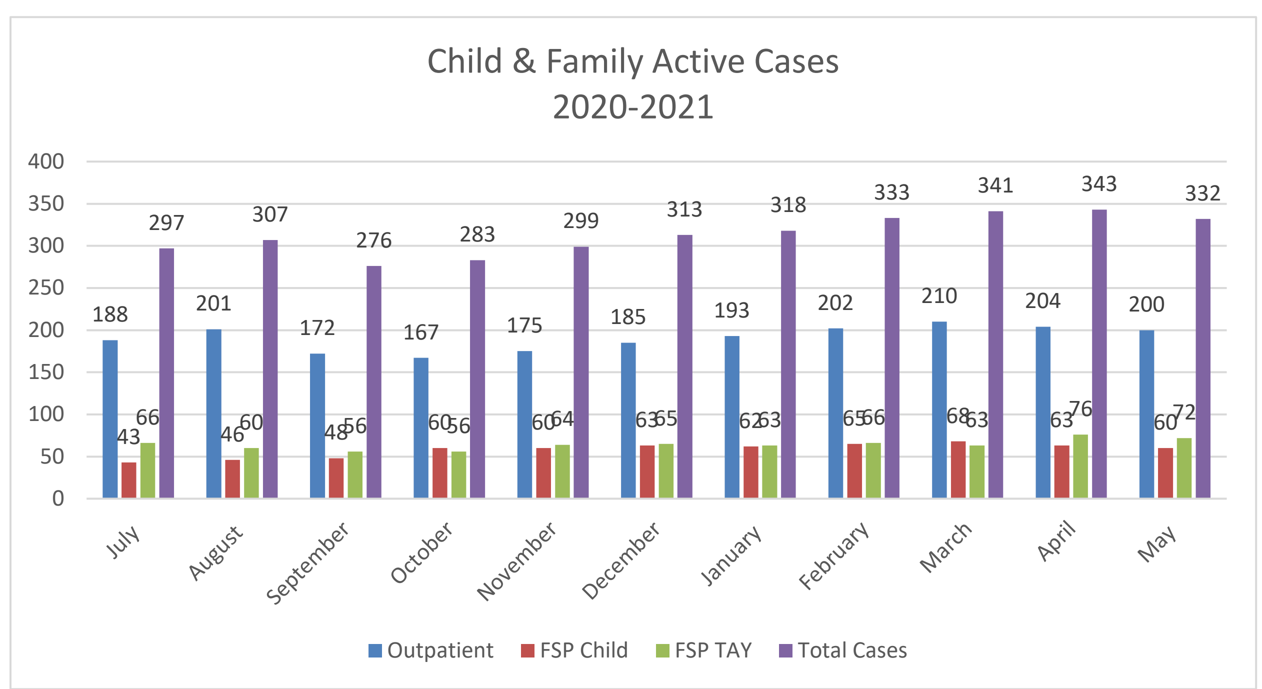
The Co-Occurring Support Team is offering 6 co-occurring (substance abuse and mental health disorders) education and support groups to an average of 50 clients weekly. Group content focuses on topics such as health and wellness, relapse prevention and managing mental health symptoms. The groups are offered to adults, transition age youth and parents.

CLINICAL WELLNESS ADVOCATES TEAM

Referrals to the clinical wellness team remains consistent and robust with an average of 16 referrals each month from the clinical teams. Clinical Wellness advocates have assisted clients in attending appointments more consistently and taught valuable life skill such communicating effectively with both treatment team and other community service providers.

CHILD AND FAMILY SERVICES

Overview: Active, Intakes & Closings



**Data Provided by QA as of 6/1/2021*

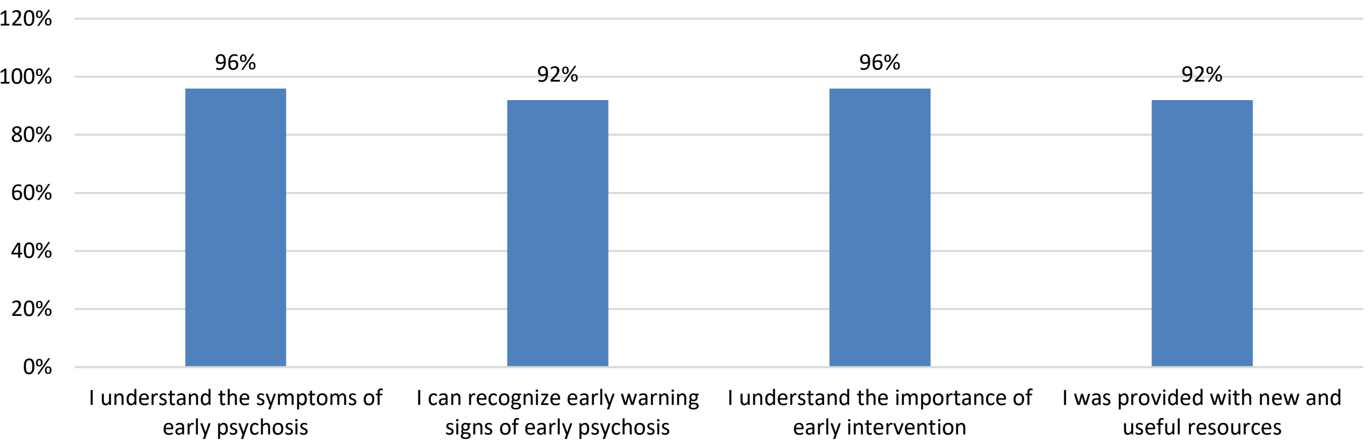
Participation of cases in Children and Family Services remains consistent. In May 2021 332 children, youth and their families were seen for care. Face to face, in the community appointments are being offered regularly and clinicians are providing both individual and family care.

SCHOOL PARTNERSHIP TEAM (SPT)

The number of school referrals received this month was the second highest within this school year at grand total of 30 referrals. In May the Tri-City – SPT team became a partner of the Ganesha Community School Advisory Board. This advisory board focuses on supporting both students and parents with resources, mental health, and health needs at Ganesha High School. The advisory board will also be working with coordinating trainings for parents for the next school year with the MHSA programs.

EARLY PSYCHOSIS

In May of 2021, the early psychosis team conducted workshops for 25 community members on how to identify young people experiencing psychosis and how to refer them tot services with Tri-City. Below is feedback data from the workshop participants.

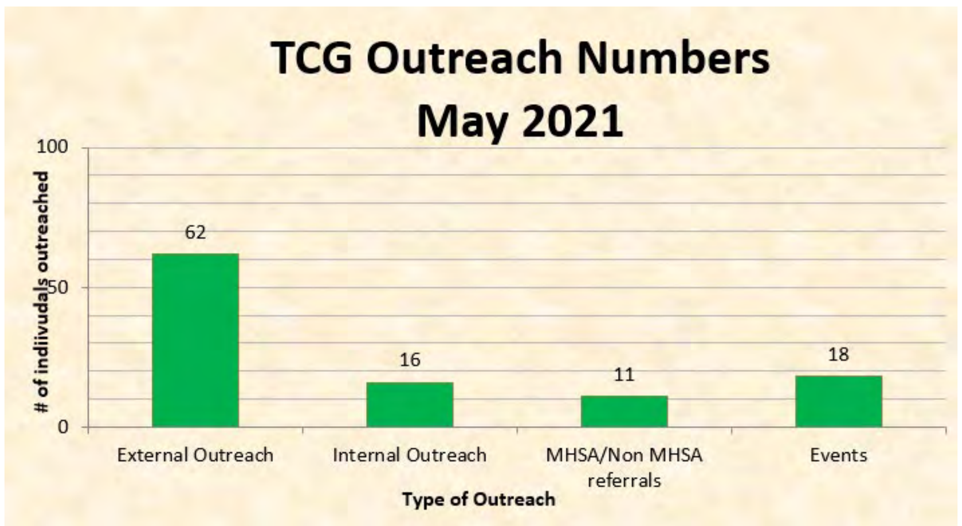


ADULT SERVICES

Adult Services processed three new Full-Service Partnership referrals in the month of May. Currently, there are 28 clients receiving housing support through Hope for Home. Adult program staff are planning a graduation event for the summer for clients who have met treatment goals and to celebrate recovery. Adult program team staff have also offered additional sessions of Foundation for Recovery groups to manage the increase in need for services.

THERAPEUTIC COMMUNITY GARDEN (TCG)

Above: *Various summer seeds sewn in February 2021 (left) and seedling progression after 2-3 months of growth (right).*



Above: *Outreach numbers for May 2021.*

On May 21, 2021, Therapeutic Community Garden staff joined Community Liaisons for the Pomona Unified School District, for a virtual event during Mental Health Awareness Month. The Parent University program aims to provide community resources to parents within the district. During this event, the team was invited to present the Therapeutic Community Garden (TCG) services and lead a brief mindfulness practice to support parent's wellness. Mindfulness through sight was used to bring awareness to the present and allow participants a. Participants were guided through a five-minute exercise both in English and Spanish and were provided with information on how to access services at Tri-City Mental Health and how to participate in the Therapeutic Community Garden.

SUCCESS STORY

Transitional Age Youth
A 25-year-old TAY client had a positive experience with treatment that led to an improved relationship with his family and a reduction in distressing symptoms. This TAY client has received FSP services for several years due to severe and persistent psychosis and substance use leading to hospitalization, incarcerations, and family conflict. Mother has been actively involved with his care and received support from Tri-City staff to better understand her son's mental health needs and the course of his illness. Through education and coaching from the clinical team mother has learned how to support her son more effectively and she has found additional resources for her own needs. Both mother and son report an improved relationship and a reduction in the frequency and severity of symptoms. It should be noted that the client has not had a recent hospitalization nor interaction with law enforcement, and he is stable and in the family home.

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **June 16, 2021**

TO: **Governing Board of Tri-City Mental Health Authority**
Toni Navarro, LMFT, Executive Director

FROM: **Seeyam Teimoori, M.D., Medical Director**

SUBJECT: **Medical Director's Monthly Report**

SERVICES PROVIDED BY TRI-CITY INTENSIVE OUTREACH AND ENGAGEMENT TEAM (IOET), PACT AND SUPPLEMENTAL CRISIS TEAMS IN MAY 2021

IOET Program

- Number of all new outreach= 96
- Number client given intake appointments= 48
- Number of clients opened= 19
- Total number of ALL clients outreached= 210
- Total number of homeless served= 134
- Percentage of clients outreached that are homeless= 63%
- Percentage of clients enrolled this month in formal services that are homeless= 57%

Service area:

- Pomona= 182
- Laverne= 6
- Claremont= 22
- Total= 210

Health Issues:

- Number of initial health assessments completed= 9
- Number of clients linked to primary care physician appointments= 17

Supplemental Crisis Calls

- Number of calls received= 27

Service Area
- Pomona= 12

- Laverne= 2
- Claremont= 3
- Outside service area= 10

Psychiatric Assessment and Care Team (PACT)

- Number of new individuals added for the month= 36
- Number of closed individuals for the month= 40
- Number of holds written for the month= 8 holds
- Number enrolled in formal services for the month= 2
- Number pending intake appointment for the month= 0
- Number referred to IOET this month= 8

Service highlights:

May 22nd, 2021, Tri City in coordination with Los Angeles County Department of Health Services hosted its 2nd Vaccination clinic on grounds. Collaboration between The Intensive Outreach and Engagement Team and clinical teams saw 20 individuals get vaccinated on that day. Combined with our previous vaccination clinic help on 4/20/2021, overall, 42 individuals received at least 1 vaccination.

During the month of May, PACT staff members had the opportunity to have Claremont City Council Member, Mr. Jed Leano for a ride along with PACT to observe PACT daily and operations and real time interactions with individuals PACT serviced in the community.

Dr. Kim Rioux, IOET supervisor and Cristina Canzonieri, LMFT, Co-Occurring Support Team supervisor, provided support to a local community partner agency (staff and clients) as they processed the unexpected death of a staff member. They offered needed guidance and support during a very distressing time.

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **June 16, 2021**

TO: **Governing Board of Tri-City Mental Health Authority**
Toni Navarro, LMFT, Executive Director

FROM: **Rimmi Hundal, Director of MHSA & Ethnic Services**

SUBJECT: **Monthly MHSA and Ethnic Services Report**

ETHNIC SERVICES

Tri-City's various advisory councils continue to meet monthly and have active participation of both Tri-City staff and community representatives. Some of this month's highlights include:

- The AAFWAC co-chairs shared social media graphics that were created in recognition of May Mental Health Awareness Month including positive affirmations, coping skills and the promotion of the advisory council. An internal resource guide was distributed to Tri-City staff, stakeholders and local organizations which included local resources, webinars and educational information to support Black and African American well-being. AAFWAC will host a virtual tour of the African American Museum of Beginnings in July.
- AAFWAC members have distributed information to educate staff about the origin of Juneteenth, the nationally celebrated commemoration of the ending of slavery which takes place every June 19th, and shared the various Juneteenth celebrations happening in the local area.
- The RAINBOW Advisory Council hosted a webinar titled "Starting the Conversation: How to Support Inclusion with the LGBTQ+ Community" in honor of Mental Health Awareness Month.
- RAINBOW members focused on collaboration with representatives from PFLAG Claremont and the Pomona Pride Center regarding an upcoming summit in August 2021 focusing on increasing the awareness of local organizations in support of the LGBTQ+ communities. Advisory Chair and participants shared their thoughts on creating a co-branded LGBTQ+ Inclusion Resource Guide as an ongoing goal for the fiscal year.
- In honor of Pride Month which is June, RAINBOW Co-Chairs will host another webinar that features guest panelist from PFLAG Claremont and the Pomona Pride Center on June 28th at 4pm.

WORKFORCE EDUCATION AND TRAINING (WET)

In celebration of May as Mental Health Awareness Month 2021, an extensive campaign about mental health and self-care was launched across social media platforms. Posts related to stigma reduction and activities meant to boost mental health were posted on a near-daily basis.

During the month of May, Tri-City Mental Health's social media pages saw a dramatic increase in reach:

- Tri-City reached 3,319 people on Facebook, an increase of 414% over the previous month.
- On Instagram, Tri-City reached 359 people and on Twitter, Tri-City made 2,908 impressions.
- The most successful post was a Facebook live event and Webinar entitled "Ending the Silence: How to Support the Asian American and Pacific Islander (AAPI) Community. Introductory remarks were shared by Jed Leano, City of Claremont Mayor Pro-Tem and Vice Chair of the Tri-City Governing Board; Fiona Ma, California State Treasurer and a special recorded message from Congresswoman Judy Chu, U.S. Representative for California's 27th Congressional District and Chair of the Congressional Asian Pacific American Caucus (CAPAC). This webinar delved into the historical, generational and current racial trauma experienced within the AAPI community and the importance of community healing.

Staff trainings offered this past month included:

- "Embracing the Biology of our Nervous System to Foster Wellness and Self-Compassion" on May 27 from 10am to noon. In total 32 people attended the session, and a recording of the event was made available to staff that were unable to attend due to various reasons.
- On June 2nd, 38 members of the staff also received a training on a Stress and Resilience Intervention hosted by the Early Life Stress and Resilience Program. The Early Life Stress and Resilience Program (ELSRP), part of Stanford's Department of Psychiatry and Behavioral Sciences, consists of an integrated, multidisciplinary team that seeks to address the devastating impact of trauma exposure on child development through three core components: research, clinical work, and community outreach. The training focused on how public mental health staff can support the public using a crisis support intervention. It was developed based on evidence-based practices for stress including Psychological First Aid (PFA), Skills for Psychological Recovery (SPR) and Cue-Centered Approaches (CCA).

PREVENTION AND EARLY INTERVENTION (PEI)

Peer Mentor Program

On May 18th mentors celebrated the end of the program year. Mentors shared some positive experiences that occurred throughout the year. Over the next month, Peer Mentor staff will continue to outreach and recruit for perspective mentors and begin scheduling interviews for candidates who are interested in being part of the program.

Stigma Reduction

May was celebrated as **Mental Health Awareness Month** at Tri-City with great enthusiasm**.** Throughout the month, staff shared ideas, tips, and resources on how to practice selfcare and support those who are struggling with their wellbeing. To promote mental health awareness, Claremont High School Baseball team requested green ribbons so all players could wear them during their games in solidarity of mental health support and awareness.

The month ended with a "Directing Change Showcase" webinar on May 28th. The Directing Change Program is an Each Mind Matters initiative. It is a film contest that engages students and young people throughout California to learn about topics of suicide prevention and mental health in an innovative way.

Tri-City area video submissions from Cal Poly Pomona, Claremont High School, Mt. View Elementary, and School of Arts and Enterprise were showcased and viewed.

WELLNESS CENTER

The Wellness center finalized the planning for the 11th annual summer camp. The camp is scheduled from June 21st until July 16th. Seven children are signed up to participate and their supplies will be delivered to them at home by Tri-City staff. The themes for Summer camp this year, include: "Fantastic Me" (introductions), "Shining Stars" (self-esteem), "Aspire to Be a Great Kid Genius" (building creative and imagination skills using STEM learning), and "Summer Sunset" (termination and looking forward to the school year ahead).

In collaboration with various partners, the Employment Team has scheduled 3 virtual hiring events. The first hiring event will take place on June 23rd from 11am to1pm for Visiting Angels. Visiting Angels is looking to hire home healthcare workers. The second hiring event will take place on July 7th from 11am to 1pm for Motherly Comfort. They are also looking to hire home health care workers and the third one is on July 21st from11am to 1pm for Fed Ex Ground. Fed Ex is looking to hire 300 people for their new facility in Chino.

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: June 16, 2021

TO: Governing Board of Tri-City Mental Health Authority
Toni Navarro, LMFT, Executive Director

FROM: Natalie Majors-Stewart, LCSW, Chief Compliance Officer

SUBJECT: Monthly Best Practices Report

COMPLIANCE PROGRAM

As part of the agency's compliance program, The Chief Compliance Officer issued an internal memo to alert the Tri-City workforce of potential areas of compliance risk related to telehealth services and remote work. The goal of the memo was to provide both education and guidance to help mitigate potential risks to breaches of protected heath information, as well as, risk to non-compliance with other agency policies.

The Best Practices team will continue to monitor and develop quality improvement processes best practices for telehealth and remote work activities.

INTENSIVE CARE COORDINATION (ICC) AND INTENSIVE HOME-BASED SERVICES (IHBS)

The Best Practices - Quality Assurance team provided training for Child and Family Services Program staff regarding the updates to the prior-authorization process for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS).

POST-COVID-19 TELEHEALTH SERVICES AND CLAIMING

At the start of the pandemic, several governmental flexibilities were granted to allow for more types of mental health services to be provided and reimbursed through the use of video and telephone calls.

As the Department of Health Care Services (DHCS) continues to prepare for post pandemic service operation in the state of California, there are recommendations to continue to allow for many of the same services to be provided via video call and telephone. However, with that recommendation, there are also preliminary discussions about separating the fee schedule for face to face - video services from audio only - telephone services, which may result in a lower reimbursement rate for telephonic/audio-only modalities.

Tri-City leadership will continue to monitor the development of these plans, and in the meantime, will gather and analyze internal data to assess for any potential fiscal and/or quality care impacts that these changes may bring. Additionally, data will be gathered to help identify if any correlations exist amongst service modality, satisfaction, and treatment outcomes. This data can help drive clinical decision making on choosing the best type of modality (in person, video, telephone) for treatment.

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **June 16, 2021**

TO: **Governing Board of Tri-City Mental Health Authority**
Toni Navarro, LMFT, Executive Director

FROM: **Ken Riomales, Chief Information Officer**

SUBJECT: **Monthly Information Technology Report**

I.T. OPERATIONS

- Discussions are underway for the Agency to review cost/relationships with I.T. vendors. The goal is to review spend and look for opportunities to either improve service/products or reduce costs to align with utilization. Estimated timeline for initial vendor review is end of July.

- I.T. process improvement is on-going. Areas of I.T. process improvement include:
  - I.T. procurement – Checks and balances need to be implemented to address staffing coverage and responsibilities. To ensure appropriate assignment of duties amongst I.T. resources, and internal review is underway. Estimated time for completion is TBD. Additionally, further discussions with Finance are needed to align I.T. processes with overall organizational accounting.
  - Help Desk Triaging Process – In order to accurately represent departmental productivity, a review of support processes and categorization of support requests is being conducted. The goal is ensuring proper resources are assigned to respective duties and that proper expectations are communicated to end-users. The estimated timeline for completion of review and implementation of new support workflows is end of August.

I.T. SECURITY

- As a requirement of our partnerships with LA DMH and the State of California, Tri-City is required to conduct regular security assessments to ensure the Agency is following industry accepted security standards. I.T. is currently in the process of reviewing security vendors for the purpose of conducting an assessment for Tri-City. The goal of the assessment is to ensure Tri-City meets minimum industry security standards and to determine level of vulnerability/penetration. I.T. hopes to select a vendor by end of June/early July. The overall security assessment will take approximately 4-6 weeks to complete. We will then take the results of the assessment and determine next steps as it relates to cybersecurity. This more than likely will result in a future presentation to the Board communicating findings and recommendation moving forward. Estimated timeline for completion of security assessment is end of August.

CUSTOMER SERVICE

- Customer service improvement is on-going. The I.T. team, in general, already provides good customer service. Most Tri-City employees have reported positive interactions with the team. By aligning this metric with on-going process improvement areas, I.T. will be better situation to address the needs of the organization long term.

- Discussions are underway to determine level of technical assistance to be offered by Tri-City I.T. to clients/non-Tri-City employees. I.T. has agreed to provide user guides; and level of acceptable direct interaction is being evaluated.

PROJECT MANAGEMENT

The following are the high priority projects (but not exclusive) under the purview of I.T.:

- RingCentral Unified Communication Rollout. In collaboration with Best Practices team. A project plan and timeline have been developed with work currently under way. Tentative enterprise go-live date is end of August 2021.

- PC Hardware Refresh – Due to delays as a result of Covid, the hardware refresh schedule has fallen out of sync. Course correction is underway with the remaining hardware scheduled for deployment by no later than end of July 2021.

- Internal Security Assessment and Review – Planning is underway to perform in-depth I.T. security assessment for Tri-City. ETA for selection of vendor is end of June. Security assessment will take approximately 4-6 weeks to complete.

- Network Review – Tri-City is currently collecting bids via formal RFP to refresh our current network and Internet Service Provider (ISP) service. The project is twofold: 1) modernize the current infrastructure to reflect current industry standards that consider real-time security threats and operational uptime. 2) potentially reduce costs.