"The Technology Suite"
Cohort #2 Proposal Brief to the
Mental Health Oversight and Accountability Commission

INTRODUCTION

With its resources, diversity and collaborative orientation, the California Public Mental Health system has the opportunity to lead the way in using mobile-phone based applications to fundamentally transform how we serve a large, diverse population with an otherwise large unserved and under-served need. To this point, the progress of Kern, Los Angeles, Modoc, Mono and Orange counties (Cohort #1) over the last 10 months, has set the Technology Suite Collaborative well on its way to demonstrating that the public mental health delivery system can drive advancement of technologies that are low cost and high value and generate benefit to communities beyond their traditional service-delivery scope.

As proposed by the initially approved counties, Los Angeles and Kern, the primary purpose of this collaborative MHSA Innovation Project is to increase access to mental health care and support and to promote early detection of mental health symptoms or predict the onset of mental illness. At this stage, ten additional counties/cities (Cohort #2) seek to join the collaborative to pursue the following shared goals:

1. Detect and acknowledge mental health symptoms sooner
2. Reduce stigma associated with mental illness as reported by users
3. Increase access to the appropriate level of care
4. Increase purpose, belonging and social connectedness of individuals served
5. Analyze and collect data from a variety of sources to improve mental health needs assessment and service delivery

Since the MHSOAC's approval in October 2017 for Kern and Los Angeles counties to initiate and form the foundation for this statewide innovation collaborative, the "Tech Suite" has made steady progress towards engaging targeted populations with mobile technologies. During July 2018, Cohort #1 counties conducted targeted small scale 'launches' of an initial application (7 Cups) and similarly are currently conducting targeted deployment for a second application (Mindstrong). Based on learning from this 'soft launch' of 7 Cups, these counties are currently undertaking an expanded outreach and marketing to individuals currently served by their delivery systems. As experience and learning is gained, each county will continue to incrementally expand their outreach and marketing of 7 Cups and clinical integration of Mindstrong.

This progress is the result of many critical activities and accomplishments since initial approval:

- Selection of an initial set of applications (7 Cups and Mindstrong) and preparation of those apps for county-specific deployment;
- Engagement of local peers and end users in the app selection process and launch readiness activities;
- In depth investigation of privacy and security requirements to develop appropriate safe guards for user information (e.g. contractual requirements, privacy policy, guiding principles);

- Development of the central role of peers in the engagement of end-users as well as advancement of application (app) design;
- Selection of a highly qualified evaluator (University of California, Irvine) who is designing and preparing the formative evaluation of the collaborative innovation (See Attachment IV for the Evaluation Learning Objectives and over-arching Logic Model that will drive UCI's evaluation);
- Creation of implementation pathways for selected apps that will streamline and facilitate these efforts in future counties;
- Initiation of a statewide brand development process that will generate both broad brand recognition and population-specific relevance (e.g. sub-branding); and,
- Initiation of culturally and linguistically accurate translations of the 7 Cups apps into Spanish and Vietnamese with statewide partners, while creating the methodology for comparable translation for all participating counties' threshold languages.

See Attachment I for a detailed chronology of milestones and collaborative progress of counties approved to date.

As described in greater detail below, Cohort #1 has developed the foundation for selecting, marketing and securely deploying mobile applications. While this first group of counties will continue to expand the use of apps in their communities and for identified target populations, their progress has successfully set the stage for a 2nd cohort of counties to join the collaborative. Cohort #2 counites will be able to leverage this foundation to expand the Tech Suite's effectiveness for additional population segments, as well as to advance application features/functions to better link with the public mental health system's needs, strengths and capabilities. Their participation will also assure the Tech Suite is developed in the context of the real-world challenges of a statewide approach; in other words, they will help assure this innovation identifies and builds the necessary infrastructure and technical knowledge to make mobile applications viable across the breadth and depth of the need in California's public mental health system.

The value of an expanded collaborative is underscored by a core learning to date: the experience of one population segment using mobile applications is not predictive of all populations. Therefore, it is anticipated that an expanded collaborative will identify populations for whom mobile applications are effective – as well as for those whom they are _**not**_. Both outcomes are equally valuable in terms of setting the stage for statewide deployment of mobile applications.

Counties (and cities) seeking to join the Tech Suite at this time are: Berkeley (City of), Inyo, Marin, Monterey, Riverside, San Mateo, San Francisco, Santa Barbara, Tehama, Tri-City (Pomona, La Verne and Claremont). The total Innovation funding requested by these counties/cities is approximately $42,800,000. See Attachment II for a table of "Cohort #2" counties/cities, including key demographics, summary of stakeholder activities and total funding requested.
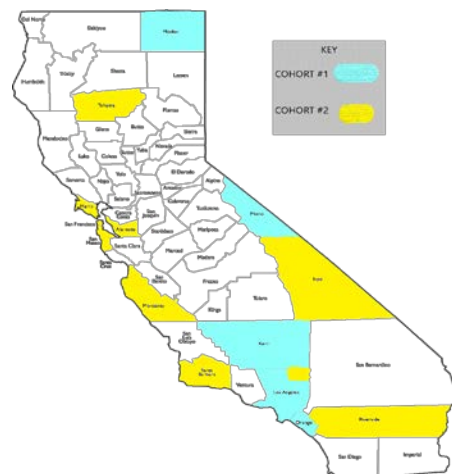
In arriving at this proposed use of innovation funds, each of these counties has undertaken extensive community planning processes that have:

- Identified local mental health needs in the community;
- Examined whether mobile digital technologies can help address those needs;
- Delineated specific populations to target with mobile applications and associated desired outcomes from their use; and
- Designated learning objectives for joining and contributing to the Tech Suite innovation.

Further, each county's involvement represents the opportunity to advance the depth and breadth of the Tech Suite's innovation and associated learning, demonstrate for whom and in what manner digital technologies can successfully address mental health concerns, and to set the course for the statewide deployment of this new modality.

EXPANDING THE COLLABORATIVE: CREATING THE OPPORTUNITY FOR LARGE SCALE CHANGE

The proposed addition of 10 counties/cities to the Tech Suite Collaborative is focused on opportunities in four areas:

> **Cohort #2 Opportunities:**
> - *Diversify conditions for learning*
> - *Create parity in access to mobile applications*
> - *Target outreach and support for specific populations in need*
> - *Expand application functionality to increase effectiveness*

- *Diversify conditions for learning:* The health care field has a history of long delay in innovative practices becoming available to all or most whom could benefit from them. Too often, they reach only small populations served in highly specialized programs. Experience reveals this is often due to those interventions being developed under 'laboratory-like conditions' that do not readily translate to the size, diversity and constraints of real-world environments. The addition of Cohort #2 counties to the Tech Suite represents the opportunity learn how to use mobile technologies at the scale and variety reflective of California – and to set the stage for much faster and pervasive spread of this new modality where it has proven efficacy.

- *Create parity in access to mobile applications:* Cohort #1 counties have demonstrated that the considerable 'barriers to entry" for the deployment of mobile applications become manageable and affordable when undertaken in a collaborative structure. The cost of expertise, hands-on learning, and the applications themselves is substantially reduced when shared; similarly, associated learning curves are shortened. Counties seeking to innovate in the area of digital technologies and who are not allowed to join the collaborative are disadvantaged in their local pursuit. This is especially true for small counties who simply could not undertake this innovation as a solo entity; the cost to acquire and innovate is too high. As such, Cohort #2 counties are seeking parity in access to this innovative approach.

- *Target outreach and support for specific populations in need*: As already indicated, the core pursuit of Cohort #2 counties' proposed innovations is to deploy mobile applications for a diverse set of target populations. As such, their involvement will drive the use and refinement of apps for a variety of communities served by the public mental health system that Cohort #1 counties are not going to reach. The addition of a second cohort will significantly diversify the app use by for high need and/or hard to reach populations. See Attachment III for a table of Cohort #2's target population.

- *Expand application functionality to increase effectiveness:* The direct influence of the public mental health system on the design of mobile technologies represents a next phase in the evolution of digital therapeutics for individuals with mental health concerns. From leadership to front line staff to peers and stakeholders, the deep knowledge of individuals involved in the specialty mental health field is a largely untapped reservoir, in terms of drivers of application design and deployment. Improving mobile applications for use in the public mental health system is a fundamental benefit associated with Cohort #2 counties joining the Tech Suite.

In summary, Cohort #2 will: 1) increase the impact of the selected apps, in terms of size and diversity of populations reached, 2) expand the relevance and effectiveness of the apps to the public mental health system, and finally 3) deepen the necessary learning to support statewide deployment.

INNOVATION OPPORTUNITIES FOR COHORT #2

Innovation is possible when there is an environment for learning and the resources (funding, skill, know-how) to act on that learning. Each instance a county joins the collaborative, both of these elements grow and there exists an opportunity to explore new possibilities and greater effectiveness for those served. Currently, within Cohort #1, counties consistently benefit from shared learning and gain considerably from the collaborative process – and so are experiencing both of these benefits. Cohort #2 counties are positioned to benefit from Cohort #1 counties, from counties within their own cohort – and they will in turn provide benefit to Cohort #1 counties.

The counties in Cohort #1 are currently driving innovation on a variety of fronts, including the collaborative methodology itself, which has resulted in the Tech Suite becoming its own 'innovation platform'. This positions Cohort #2 to generate even more innovation in two categories: 1) customization and tailoring for additional, highly specified target populations, and 2) expanded and refined application functionality. Examples of planned innovation associated with the next 'cohort' of counties to join the Tech Suite include:

Target Populations	App Functionality
o hearing impaired o criminal justice involved o visually impaired o pregnant and new mothers o transgender youth	o 'smart' referrals (highly customized local service recommendations) o linkage with Wellness Recovery Action Plans o linkage with evidence-based practices (e.g. Strengths Model)

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o isolated seniors o *others we cannot predict!*	o *others we cannot predict!*

See Attachment III for a table of the counties' needs, target populations, innovations, aims, etc.

EVALUATION: CAPTURING LEARNING AND MEASURING IMPACT

The Tech Suite has selected a single qualified vendor (University of California, Irvine) to conduct a formative evaluation of the statewide implementation of the innovation, as well as for each participating county. A formative evaluation is the chosen approach as it is a "rigorous assessment process designed to identify potential and actual influences on the progress and effectiveness of implementation efforts." The goals of the formative evaluation approach which match the needs of the Tech Suite evaluation include:

- Developmental: plan for successful uptake of an intervention by clearly defining the problem and understanding its context, designing or adapting an intervention to address a problem and utilizing an implementation framework to anticipate negative unintended consequences, and understanding the organizational context (e.g. readiness) and stakeholder perspectives on a planned intervention;
- Implementation: help ensure a project is successfully implemented by monitoring key indicators, work with stakeholders to pivot/change/adapt as need arises to respond to both internal and external factors;
- Interpretation: create generalizable knowledge for how to successfully implement the intervention in other settings.

Since joining the Tech Suite, UCI has worked rapidly to develop a plan for this evaluation. After in-depth planning sessions with each county and each application vendor, the UCI team has developed a detailed logic model and an overarching plan. (See Attachment IV for a table of the learning objectives and working draft of the logic model.) While conducting this planning, the UCI evaluation team has also been and continues to monitor launch activities underway in Cohort #1 counties to initiate data collection, to capture early learning and to gain baseline measures as feasible.

COLLABORATIVE CAPACITY

As described above, the Tech Suite's collaborative approach creates a variety of opportunities and benefits for participating counties. Some of the most immediate benefits are increased choice (for mobile applications), accelerated learning in use of this new modality for mental health supports, and cost sharing. Key cost sharing opportunities are:
- Pooling funds for shared needs (procurement and contract administration, evaluation, outreach and marketing, and other technical expertise);
- Technology fees adjusted by county-specific MHSA fund allocation levels; and,

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- Prevention of duplicated overhead and administration associated with local deployment of apps.

This collaborative and shared cost structure is making the development and operation of technical infrastructure more affordable and easier with each successive county and cohort that joins. Below is an outline of functional areas and infrastructure that have been developed and continue to be refined through Cohort #1 efforts. Given the diversity of counties in Cohort #2, their involvement will strengthen this infrastructure and further reveal individual county and shared capacities necessary to support this modality on a large scale. The following table describes Cohort #1 progress in these functional areas and how Cohort #2 will benefit from them.

Technical Support & Function	Cohort #1 Progress and Resulting Cohort #2 Opportunities
Application Procurement, Management & Advancement	• Cohort #2 counites will "inherit" the procurement of 7 Cups and Mindstrong applications, as applicable to the intentions of each. The CalMHSA contracts with these vendors are designed to apply to any county who joins the collaborative and executes a Participation Agreement with CalMHSA. Cohort #2 counties proposed budgets reflect this existing contracted fee structures, which are based on a sliding scale (based on MHSA funding allocation by the State). • Cohort #2 counties who elect to procure a new application will have the benefit of considerable learning and enhanced capability to solicit, evaluate and contract with new vendors.
Outreach & Marketing	• Cohort #1 has developed initial marketing materials that will serve as templates for each Cohort #2 county, shortening the process to develop them. • Cohort #1's current effort to develop a Tech Suite brand and image will be complete in late 2018 and so will be ready for use by Cohort #2 from the outset of their marketing. • Cohort #1 is developing a graduated or incremental approach to marketing each application, and as such is creating a pathway that Cohort #2 can both benefit from and build upon.
Peer Involvement	• With the support of 7 Cups and the CalMHSA team, Cohort #1 has developed job descriptions and training processes for counties' paid Tech Suite peers. Cohort #2 will be able to use these tools for streamlined recruitment and preparation of their local peers – as well as provide further refinement of this critical role. • During this developmental phase of the Tech Suite, CalMHSA is recruiting a state-level peer lead role. This individual will be hired and ready to support Cohort #2's local peers and their central role in linking and engagement.
Clinical Integration for Wellness & Recovery	• Cohort #1 counties have begun mapping how each application will integrate with their clinical processes, an activity that will continue throughout the collaborative to assure integration is achieved in all desired clinical settings. While progress to date will give Cohort #2 a strong starting point, this is an area in which the second group of counties will advance the learning and innovation to the benefit of all counties involved.

Technical Support & Function	Cohort #1 Progress and Resulting Cohort #2 Opportunities
Evaluation & Performance Management	• As proposed and required for an MHSA innovation, Cohort #1 has selected an evaluator (UCI) and supported development of a plan to evaluate this project, including both the statewide and county-specific impact and learning. Cohort #2 counties will benefit from an evaluation methodology that is designed and ready to address their county-specific outcomes and learning objectives. • The localized, unique goals of each county will generate learning and insight critical to meeting the needs of California's diverse population and supporting statewide dissemination and adoption of mobile technology as a new and invaluable modality for the public mental health system. As such, this will enrich evaluation findings.

Privacy & Security Monitoring, Safeguards	• As one of the most critical areas of learning and infrastructure development, establishing the privacy and security of end user's personal health information has been a big part of Cohort #1's initial efforts. The considerable due diligence completed has resulted in the following references to assist each county and the suite as a whole in assuring the privacy and security of end user information:
	   o Privacy & Security Guiding Principles
	   o Template Business Associate Agreement
	   o Information Security and Privacy Requirements
	   o Privacy Policy
	   o (Draft) Technology Framework and Security Plan
	• This thorough 'due diligence' and investigation into the needed safeguards allows each new county to initiate their internal reviews and considerations from the outset of participation, allowing plenty of time for inquiry and sign-off by local authorities.
	• With the addition of Cohort #2 counties, the Tech Suite has the opportunity to establish statewide standards for privacy and security related to mobile application use in general (not just for this innovation). This is not expected to be a one-time effort, but rather an ongoing process to assure changes in technology are translated into necessary changes in privacy and security.

Accounting & Contract Management	• Throughout all of the above activities, the contract monitoring and administration capabilities have been developed and continue to be refined by the CalMHSA team of staff and contractors. This will allow Cohort #2 counties to benefit from the following newly developed supports:
	   o Budget planning and monitoring;
	   o Participation Agreement administration;
	   o Vendor workorder development and management (to translate Innovation proposals into vendor-specific requirements);
	   o Accounting and budget variance reporting;
	   o Project management support via Smartsheet and other collaborative activities; and,
	   o Access to subject matter experts.

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See Attachment V for a timeline of county and collaborative progress.

In summary, what the expansion of the Tech Suite Collaborative represents is a chance to use the innovation platform that has been built by Cohort #1 counties to gain the necessary learning about how and for whom the public mental health system can deploy digital technologies to cost-effectively address large and persistent levels of under and unserved mental health needs.

Attachment I - Cohort #1 Progress/Milestones

TIMEFRAME	ACTIVITY / OUTCOME
Oct 2017	**Collaborative Development:** • Kern and Los Angeles Counties submit proposals to the MHSOAC for a statewide collaborative Innovation project • MHSOAC Commissioners approved statewide collaborative and two inaugural counties to create the foundation for the collaboration

Nov – Dec 2017	• **Collaborative Development & Approach:**
	• CalMHSA engaged to provide administration of the statewide collaborative
	• CalMHSA assigned staff to begin Tech Suite vendor acquisition activities
	
	Technology, Evaluation, Outreach & Marketing Procurement:
	• RFSQ developed and distributed for 5 tech components of the tech suite
	• Panel convened to review submissions to identify set of qualified vendors in each component category
	• Qualified vendors selected in the following categories:
	   o Digital Applications (5 vendors)
	   o Outreach and Marketing (1 vendor)
	   o Evaluation (2 vendors)

Jan – Feb 2018	**Collaborative Development & Approach:** • Mono County submits proposal to the MHSOAC to join the collaborative • Opportunity to join collaborative shared with CBHDA Governing Board • MHSOAC Commissioners approved Mono County to join collaborative **Implementation:** • Collaborative Project Manager hired through CIBHS • Plan for collaborative infrastructure developed • Detailed infrastructure development launched • Individualized county development launched (per existing plans)
Mar – Apr 2018	**Technology Procurement:** • Prequalified vendors given a project orientation • Each vendor conducted an in-person demo and presentation of their apps for teams from initial 3 counites, including peer representatives • County staff and peers practiced with pre-qualified apps to identify initial set of apps • Initial vendors and apps selected: *7 Cups, Mindstrong* • Selected endors provided initial planning contracts to support readiness work **Collaborative Development & Approach:** • Modoc and Orange counties submitted proposal to the MHSOAC to join the collaborative • Monthly call launched for county MHSA Coordinators across the state to support their community planning efforts and Innovation proposal development • MHSOAC Commissioners approved /Modoc and Orange Counties to join collaborative • CalMHSA executed Participation Agreement with Los Angeles and Kern Counties • Learning from initial counties regularly shared with interested counties to increase their understanding of the opportunity and promote greater readiness once approved **Outreach and Marketing:** • Based on limited respondents to initial RFSQ in Nov. 2017, a focused RFP is issued for an outreach and marketing vendor • RFP resulted in 15 letters of interest and then 5 proposal submissions. **Evaluation:**

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TIMEFRAME	ACTIVITY / OUTCOME
	• RAND engaged to assist with approach to evaluation, including development of over-arching approach and critical qualifications and capabilities of collaborative evaluator. • Collaborative determined to proceed with a follow-up Request for Qualification (RFQ) to select an evaluator to support development of evaluation plan as well as conduct the actual evaluation.
	Peer Roles: • Participating counties began preparation of their plan to engage peers to support individual use of apps, as well as inform needed improvements and advancements to those apps • County leads reached out to and engaged initial peer reps into planning activities.
	Implementation: • Budgeting and pricing methodology created to support flexible, formula driven contracts with vendors driven by size of participating county, desired level of customization and allocation of funds for shared needs as well as local supports. • Vendors oriented to formula driven approach to pricing that enables periodic addition of counties to their contract without re-contracting for each county • Supported new counties in their budget planning per slide fee schedule based on county size
May – June 2018	**Privacy and Security:** • The Tech Suite conducted search for agency with technical, legal and operational experience with data sharing and associated privacy and security concerns • Intrepid Ascent worked with The Tech Suite and vendors to determine needs and approach to privacy and security across the elements of the project • *Intrepid Ascent* engaged to support development of privacy and security guidelines, associated vendor contract requirements, contract language for data owner ship and intellectual property, as well as informed consent • Intrepid Ascent develops initial "Privacy and Security Guidelines" and "Clinical Integration and Data Sharing Continuum" to inform data sharing
	Technology Procurement: • The Tech Suite worked with Intrepid Ascent to develop contract for app vendors that support complexity of the project, including: privacy and security issues, customization for specific county size and needs, informed consent and other unique terms and conditions • App vendor contract developed to reflect the aims, legal complexity, and privacy/security of the collaborative developed, including a Work Order to link each county's Innovation Proposal and Participation Agreement with the Vendor Contract
	Peer Roles • The Tech Suite supported a shared learning process to identify the roles of peers in each county's deployment of apps • Counties to evaluated opportunities for existing peers and peer network to support outreach and engagement of target populations (See Section 4 of the Resource Guide) • Individual counties appointed their lead peers for the project • Individual counties, worked with 7 Cups and their local peers, develop the Tech Suite (paid) Peer role and plan recruitment • Individual counties identified existing peer network and plan to engage these individuals in marketing and support of app use

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TIMEFRAME	ACTIVITY / OUTCOME
	Outreach and Marketing: • A Tech Suite independent panel reviewed proposals received in response to RFP and identified a recommended vendor (RSE) • RSE worked with app vendors and counties to develop initial marketing outreach materials (shared and customized per county) • RSE oriented project to brand development process • Leadership from initial 5 collaborating counties accepted CalMHSA panel recommendation and *RSE* awarded outreach and marketing role • RSE created prototype handout cards and flyers to be customized for each county • RSE developed an expedited branding process to generate collaborative brand and awareness campaign
	Evaluation: • The Tech Suite issued a focused RFQ to pre-qualified evaluator candidates to gain deeper understanding of each agency's capabilities • The Tech Suite convened an independent panel to review RFQ responses and develop recommendation for selection • Demographic reporting requirements (per MHSA Innovation regs) provided to app vendors • Leadership from initial 5 collaborating counties accepts CalMHSA panel recommendation and *UCI* awarded evaluator role • App vendors developed method to gain demographic information from end-users in an engaging, person-centered way (to be tested by peers to finalize)
	Implementation: • Cohort #1 carried out detailed readiness work to support initial "soft launch" of the apps in July and then steady expansion after initial debugging • The Tech Suite advanced infrastructure development to support county and vendor contracting, budgeting and associated transactions • Counties developed initial plans and readiness associated for their Soft Launch in July
	Collaborative Development & Approach: • Tech Suite convened a day-long kick-off session for initial counites (cohort #1) • Tech Suite supported Innovation proposal development, including budgets aligned with vendor contracting strategy • Over 100 staff, peers and stakeholders convened in Los Angeles in a shared learning session focused on target population needs, relevant app-based solutions, and IT concerns • Over 20 counties indicated interest in joining the collaborative with at least 12 planning to submit Innovation proposals to the MHSOAC in order to join as part of "Cohort #2" • CalMHSA executed Participation Agreements with Orange, Mono and Modoc Counties
July – Aug 2018	**Implementation:** • 7 Cups launched customized app in Cohort #1 counties
	Outreach and Marketing: • Counties initiated outreach and marketing efforts for 'soft launch' and plan expanded outreach and marketing to support next phase of implementation
	Peer Roles: • Initial local paid peers hired • State-level Peer Lead job description developed, and job notice posted
	Evaluation: • UCI began development of evaluation plan, including conducting in depth orientation with each county and app vendor
	Collaborative Development & Approach: • Counties in Cohort #2 received support to maximize readiness for implementation activities once approved to join the collaborative

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TIMEFRAME	ACTIVITY / OUTCOME
	Technology Procurement: • App vendor contract finalized; formal contract monitoring initiated
Sep - Oct 2018	**Implementation:** • Each county is implementing Mindstrong on a small scale to generate learning about how to link client use of the Health app with clinician use of the Care app **Outreach and Marketing:** • Each county is preparing 'internal' marketing of 7 Cups as the next milestone in deployment of this app **Peer Roles:** • Newly hired Tech Suite peers are being trained to support marketing/outreach and app use • Local peers in existing networks to be trained to support use of apps by individuals they assist **Evaluation:** • UCI is developing comprehensive evaluation plan • UCI is convening a Tech Suite Evaluation Advisory to review/approve the evaluation plan and then monitor evaluation • UCI is collecting initial data associated with current small scale launch of the apps • App vendors are developing project-wide and county-level dashboards and other analytics **Collaborative Development & Approach:** • CalMHSA is preparing for an all-county, all-vendor in-person learning session in Fall 2018 to support transfer of Cohort #1 counties knowledge to Cohort #2 counties and to support all counties planning their next steps to expand (Cohort #1) or initially launch (Cohort #2) **Adapting to Local & Population Needs:** • 7 Cups working with RSE and their partners to develop translation of their app content; initial translations will be Vietnamese and Spanish

Attachment II – Cohort #2 Counties

County	Size*		Key State Characteristics	Summary of Stakeholder Involvement & Local Approvals	Proposed
	#	% of CA			INN $$
Berkeley	121,874	.31%	• Berkeley and Albany are diverse communities with changing demographics. In each city the African American population has decreased in recent years while the Latino and Asian populations have both increased. • Both cities have large student populations, including Albany Village, providing housing for many of University of California's foreign students and their families. • Threshold languages include English, Spanish, Farsi, Cantonese, and Vietnamese, and approximately 28% of Berkeley and 40% of Albany residents speak a language other than English at home. • Each city is comprised of the following racial and ethnic demographics: BERKELEY: 61% White; 8% African American; 20% Asian; 11% Hispanic/Latino; <1% American Indian/Alaska Native; and <1% Native Hawaiian/Pacific Islander (P.I.). ALBANY: 54% White; 4% African American; 27% Asian; 13% Hispanic/Latino; 1% American Indian/Alaska Native; and 1% Native Hawaiian/Pacific Islander (P.I.).	• In FY16/17 a CPP process was conducted which included community input meetings, key informant interviews, focus groups and MHSA Advisory Committee meetings. • Program ideas that could potentially address the needs that emerged from this CPP Process were then vetted through MHSOAC staff, and the MHSA Advisory Committee before proposing to join the multi-county collaborative Technology Suite Project. • In FY17/18 a second CPP was conducted to obtain input on the proposed use of INN funds to join the multi-county collaborative Technology Suite Project. This included MHSA Advisory Committee meetings, Community Input Meetings, and presentations at meetings of the Berkeley Pool of Consumer Champions, and the Mental Health Commission. Broad outreach was also conducted to share information/obtain input on demonstrations of the proposed technologies. Total outreach on this proposed project reached an excess of 100 individuals which included a diverse group of consumers, family members, MHSA Advisory Committee members, representatives from community-based organizations, individuals from un-served, underserved and inappropriately served populations; City Commissioners, Berkeley Mental Health staff, and other MHSA Stakeholders.	$462,916
Inyo	18,577	.05%	• With 10,000 square miles, Inyo is the second largest county in California, but with a population of only 18,800 has the smallest number of persons per square mile and is one of the smallest of the small counties population-wise. • Inyo has the highest elevation in the United States, Mount Whitney, and the lowest elevation, Bad Water in Death Valley. • Only about 2% of the land is privately owned with a majority of the land being National Forest and Park, Bureau of Land Management, and Department of Water and Power. These contrasts mean that for funds that are disbursed by population and other such formulas, Inyo relies on "minimum-based allocations" in order to run programs. • Ethnicity: 66% identify as white alone; 19% identify with Hispanic or Latino origin; 13% identify as American Indian; 2% identify as Asian; and less than 1% identify as African American. 4% of people identify with 2 or more races. Spanish is the threshold language.	• ICHHS/BH held stakeholder meetings with staff from several health agencies as well as with participating perinatal or expectant mothers to see if the proposed project was relevant to their needs and experience. Stakeholders filled out a preliminary survey and the results were used in program planning. • Our stakeholder surveys will address the MHSA standards to see if there is a community partner that hasn't yet been included in our planning and dissemination process, review the cultural competency component for our participants to see what additions need to be made, regularly survey of consumers and consumer-identified friends and family who also download the app to capture their voice, and see if the addition of Wellness Recovery Action Plan education and processes to onboarding in the app helps clients feel the service is centered around recovery and resilience principles.	$448,757
Marin	236,886	.66%	• Marin County has a median age (46.1) almost 10 years older than the state as a whole (36.4) • 30% of Marin adults 65 or older live alone. • Marin is composed of 71% white, 16% Latino, 5% Asian, 2% Black residents • The top income families earn over 21 times more than low income families in Marin County. • Communities of color experience poverty at disproportionate rates.	• To find an innovation solution to meet the mental health needs of older adults, two large community meetings were held (November 27, 2017, and December 13th, 2017). 63 people attended the community meetings, and 48 demographic sheets were collected; 46% identified as clients/consumers and family members. Participants represented veterans, law enforcement, mental health consumers and family members, mental health providers, health and social service providers, and individuals with disabilities.	$1,580,000

County	Size*		Key State Characteristics	Summary of Stakeholder Involvement & Local Approvals	Proposed
	#	% of CA			INN $$
			• Marin City is predominantly African American and has a poverty rate of 33% compared to 8% poverty rate county-wide	• Feedback from the initial community meetings included finding a solution that could serve as many older adults as possible rather than a more targeted approach for a limited number of older adults. However, people also highlighted that homebound or isolated seniors and caregivers should be prioritized. • In January, the Mental Health Advisory Committee was presented with the ideas and feedback from the stakeholder meetings and helped narrow the ideas down. • After the community meetings and Advisory Committee review, a series of key informant meetings with providers and advocates for older adults were held in March and April to discuss potential solutions including the Technology Suite. • Mental Health Advisory Committee and other stakeholders were then invited to participate in a Tech Suite Demo with 7 Cups on Friday, April 27th, or Friday, May 4th.	

Monterey	443,281	1.11%	• As the "safety net" mental health care provider, being aware of the geographic distribution of Monterey County's highest-needs populations is critical for effective planning and service delivery. Monterey County is the 3rd largest county by land mass in the state, and has four geographic regions:
			  o The Salinas Valley, the Coastal Region, North County and South County. The Salinas Valley region is comprised of the City of Salinas and immediately adjacent towns.
			  o The Coastal Region encompasses all cities on the coast from Marina to Big Sur, and includes Carmel Valley. The combined cities of the Coastal Region that total a population size close to that of Salinas has a proportionally low number of Medi-Cal beneficiaries.
			  o North County is made up of the small, rural and/or agricultural towns and districts north of Salinas.
			  o South County is the expansive area of Monterey County south of Salinas. The South County region consists of several larger cities with populations above 15 and 30 thousand people, as well as several remote, sparsely populated rural districts. As the City of Salinas is by far the most populous area of the county, its region has a corresponding majority of beneficiaries. The relatively small North County region has an equal proportion of beneficiaries, while about 1 in 5 Medi-Cal beneficiaries in Monterey County are found in the expansive South County region.
			
			• Demographically, Monterey is reflective of California with a majority Hispanic/Latino population and an aging population. The general population characteristics of the county are:
			  o Median Age: 33
			  o Children & Youth: 23%
			  o TAY: 15%
			  o Adult: 46%
				• Community planning process activities supporting this innovation began in spring of 2017, and were carried out as part of the MHSA 3-Year Program Plan and Annual Update planning processes. In total, this innovation project was informed and refined by community stakeholders through a series of 13 focus groups with 232 participants, and community survey with 214 respondents, and 4 community workshops with 114 individuals. Spanish translation and interpretation services were provided in all community engagements. Mora than half of community engagement occurred in communities or organizations with majority Hispanic/Latino populations.	$2,526,000

County	Size*		Key State Characteristics	Summary of Stakeholder Involvement & Local Approvals	Proposed
	#	% of CA			INN $$
			o Older Adult: 17% o Hispanic/Latino: 57% o White: 32% o Asian: 6% o African American: 3% o Other: 2% The economy of Monterey County is primarily supported by agricultural activities, tourism and the public sector (i.e. local government and military agenices).		
Riverside	2,415,955	6.07%	• 4th largest county in California by population and by land area • Riverside County is roughly the size of the State of New Jersey, containing frontier, rural, and metropolitan population densities, resulting in plan implementation barriers of small, medium and large counties combined • Riverside County ranked 3rd in population growth in counties nationwide; the only California county to make the list of "Top 10 Gainers" in the last US Census Bureau report • Estimated by 2025, Riverside's population will grow to 2,692,006 (California Dept. of Finance) • Diversity: 48% Latino/Hispanic; 36% Caucasian; 6.4% African-American; 6% Asian/PI. • Riverside County Dept. of Public Health (2014) estimated the LGBT population between 71,000 to 236,000, potentially making this community the 3rd largest minority group in Riverside County • Riverside County is home to one of the two schools for the deaf in California. Estimated population of deaf individuals nationally is 10%; Riverside County estimate is 17%. • 38% of Riverside County residents were living at or below 199% of poverty in 2016 • Older Adults (age 60+) represents 20% of the population • TAY (age 16-25) represent 15% of the population	Over 1,200 individual stakeholders • 2 Adult System of Care Committee mtgs • 2 Behavioral Health Commission mtgs • 1 Center on Deafness Inland Empire staff mtg • 2 Children's Committee mtgs • 1 Criminal Justice Committee mtg • 2 Cultural Competency Reducing Disparities Committee mtgs • 1 Deaf Awareness Week event • 1 Desert Regional Board mtgs • 1 Eating Disorder Collaborative mtgs • 1 Inland Empire Kindness Campaign mtg • 1 Legislative Committee mtg • 2 May is Mental Health Month Fairs – Western and Mid County Regions • 1 Mid County Regional Board mtg • 1 Model Deaf Community Committee • 1 NAMI San Jacinto mtg • 1 Older Adults System of Care Committee mtg • 2 Riverside Resilience community mtgs • 11 TAY Collaborative meetings – Desert, Mid, and Western County Regions	$25,000,000
San Francisco	883,963	2.22%	For cities with over 200,000 people, it is the second most populated city in the country, second only to New York. San Francisco is diverse, and has a minority-majority population, with around 33% of its population being of Asian descent, 15% Latinx, and only 41% of its population is non-Hispanic White	• Visitacion Valley Service Providers • Sunset Mental Health Center Service Providers and Community Advisory Board members • Excelsior Family Connections Chinese families and staff • San Francisco LGBT Center • Curry Senior Center: Mental Health Services Act Advisory Board meeting • Transitional Age Youth Full Service Partnership Meeting • Richmond District Neighborhood Center Service Provider Meeting • Department of Rehabilitation Co-op Administration Meeting • San Francisco Veterans Town Hall Meeting • Excelsior Family Connections Spanish Speaking Families and Staff Meeting • San Francisco Behavioral Health Services Adult/Older Adult Service Providers Meeting • Asian Pacific Islander Wellness Center: Transgender Program Community Members and Service Providers	$2,273,000

County	Size*		Key State Characteristics	Summary of Stakeholder Involvement & Local Approvals	Proposed
	#	% of CA			INN $$
				• Rafiki Coalition: Black/African American Community • Huckleberry Youth Programs: Transitional Age Youth Service Providers Meeting • Crisis Intervention Training Meeting Workgroup: Law Enforcement, Peers and Service Providers • San Francisco Behavioral Health Services Mental Health Services Act Advisory Committee Meeting • San Francisco Public Library: Combined Mental Health Services Act Provider and Advisory Committee Meeting • City College of San Francisco Health Education Department Workforce Development Networking Session • San Francisco Behavioral Health Services Client Council	

San Mateo	774,155	1.94%	• Diversity:
			  o 39.5% White
			  o 27.8% Asian or Pacific Islander
			  o 24.8% Hispanic or Latino residents
			• Over 46% of the County population five years of age and older spoke a language other than English at home; of this population, 45% spoke English less than "very well".
			• Threshold languages are Spanish, Tagalog, Chinese (Mandarin and Cantonese) and Russian. Concentration languages include Tongan and Samoan
			• One of the larger suburbs on the San Francisco Peninsula.
				5 Regional Community Service Areas (Coastside, Central, North, South, East Palo Alto regions)
				1 Peer Recovery Collaborative
				1 Family Partners & Peer Workers
				1 Monolingual Spanish Parent Group
				1 Monolingual Chinese Community Group
				1 Youth Commission
				1 Older Adult Group
				1 Mental Health and Substance Abuse Commission meeting Comment
				1 Diversity and Equity Council
				1 BHRS Management meeting
					$3,872,167

Santa Barbara	453,457	1.14%	• Santa Barbara County is part of California's central coast, between Ventura County to the south and San Luis Obispo County to the north. According to the US Census Bureau, as of July 1, 2017, the population of Santa Barbara County was 448,150. A mid-sized county, Santa Barbara County ranks 19th in population size among all California counties. The US Census for 2011 identified the three largest cities as Santa Maria (North County), 99,553; Santa Barbara (South County), 88,410; and Lompoc (Central County), 42,434. • The overall county Latino population was 41.9% in 2010, and this number has increased to 45%. The percentage of Santa Barbara County residents who are Latino increases as one heads north. For example, Santa Maria's population is 70.6% Latino. • In recent years, Santa Barbara County has become increasingly diverse. Significant micro-communities are growing, encompassing various groups, including indigenous Oaxacan/Mixteco-speaking migrants and immigrants from central and South Asian countries, including China, the Philippines and Thailand. • The county's only non-English threshold language is Spanish.	• During community Innovation brainstorming sessions held from September to November 2017, stakeholders were asked for innovative project ideas based on addressing service gaps and affirmed that online technology could help improve access for key populations and enhance peer opportunities. • Stakeholder suggestions included implementing new computer applications and using digital communication that appeal to youth and hard to reach populations outside of the largest cities in the county. • Between November 1, 2017 and April 24, 2018, the proposed Technology Suite was discussed at 12 stakeholder forums held throughout the County. Approximately 620 individual stakeholders were invited to each of these forums, and a total of 120 attended.	$4,912,852
Tehama	64,039	.16%	• Poverty: At 22%, the percent of people living in poverty Tehama County is twice the state (16%) and national averages (15%). • Geographic isolation: 60% of Tehama County residents live in unincorporated areas compared to 14% of California. At 2,950 square miles, geographic distances within the county itself are significant. The county is placed within an isolated	• Initiated with restructuring of the subcommittee included increasing and deepening the committee's membership, and membership includes adult consumers; families of consumers; seniors; law enforcement; local NAMI; director-level staff of public medical, substance abuse and child protective services; Latino; LGBTQ+; K-12 educators and administrators; health care;	$118,088

County	Size*		Key State Characteristics	Summary of Stakeholder Involvement & Local Approvals	Proposed
	#	% of CA			INN $$
			region, with travel to the closest major urban area, Sacramento three hours by car. Public transportation options are limited. • Limited transportation options: Because of the County's size and lack of public transportation, travel is private-vehicle dependent. As noted, the Tehama County has a significant poverty rate. Poverty, geographic barriers, lack of public transportation and large distances result in transportation becoming an economic challenge and a barrier to care. • Workforce shortage: Tehama has significant behavioral health workforce shortage. As a behavioral health employer, the county struggles to find and retain behavioral health staff. • Stigma discourages individuals from seeking services: Stigma and a lack of understanding about of mental illness symptoms are challenges for Tehama County. Individuals can be wary of using services in a small, deeply interconnected county where maintaining anonymity and/ or privacy may seem difficult.	social services; faith-based organizations; local non-profit service providers; advocates. • The subcommittee met and recommended a draft Community Participation Plan for Mental Health Board approval. • A series of four widely-publicized public community stakeholder meetings in diverse county locations, two with bi-lingual Spanish support. Each meeting lasted 1.5 hours. • A series of targeted meetings including LGBTQ+, transition age youth consumers and adult consumers. Each meeting lasted 1.5 hours.	
Tri-Cities	225,393	.57%	• The combined demographics for three cities includes 57% Latino, 26% White, 9% Asian Pacific Islander, 6% African American, 2% multiracial and less than one percent American Indian. • Roughly, 48% of the Tri City population speaks monolingual English, while 42% speaks Spanish as the primary language at home. Another 6.7% speak an Asian Pacific Islander language as the primary language, and 3.5% of the population speaks a language other than the ones already named. • Forty-three percent of the population has an income that is less than 200% of the federal poverty threshold. • With a population of almost 220,000, Tri-City is considered a mid-size county with two unique statistics: 1) our three cities are home to four universities with a combined student population of over 45,000; and 2) our combined older adult population is 19%, which exceeds the same population in Los Angeles County of 15%.	• Innovation workgroups were convened beginning in November 2017 • In March 2018, this project was presented to stakeholders over the course of two MHSA meetings where the approval response was, again, overwhelming. • In preparation for this project, Tri-City conducted several focus groups targeting populations including foster care youth, older adults, LGBTQ, monolingual Spanish speakers and peers participating in the Courageous Minds Speakers Bureau. Additional focus groups are scheduled and outcomes will be available upon request. • The MHSA Public Hearing was held on May 16 and hosted by Tri-City's Mental Health Commission at the La Verne Community Center. Over 130 individuals attended this annual event consisting of community stakeholders, professionals, faith-based organizations, and local schools and colleges located in the cities of Pomona, Claremont and La Verne. The Innovation project was approved by the Commission and then presented to the Governing Board and adopted on June 20, 2018.	$1,674,700

*Source: California Department of Finance Demographic Research Unit
Report E-4, Population Estimates for Cities, Counties, and the State, 2011-2018, with 2010 Benchmark, Released: May 1, 2018
County and State Population Estimates, 2011-2018, with 2010 Benchamark
Cities, Counties, and State Population Estimates, 2011-2018, with 2010 Benchmark
For more information: http://www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1/
Data Prepared by: Demographic Research Unit California Department of Finance

Attachment III – Cohort #2 Innovations

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
Berkeley	• Support wide array of individuals with mental health supports who do not qualify for intensive mental health services. • Meet the needs of both a large TAY population (including students of University of Berkeley and Berkeley Community College) and a growing senior population. • Provide low cost high impact mental health supports, as the need for supports far outweighs the available resources.	• Increase Access to/Availability of Services for Various Populations: Ex. Access to services for individuals in middle income group who make too much money to qualify for Medi-Cal, but not enough to pay for a private Mental Health provider; Bilingual individuals; undocumented individuals; Clients who reside in Albany; Individuals with less severe Mental Healthissues, isolated individuals, etc. • Increase Coordination of Services and Transitions • Address Stigma: Including cultural stigma related to seeking out Mental Health services. • Provide additional supports for TAY/Youth Mental Health Needs	• Isolated individuals (including senior citizens) who may have one or more disabilities; • Transition Age Youth • Individuals who are in need of mental health services and supports but don't meet the eligibility criteria to receive services at Berkeley Mental Health.	Work with the vendor to have all local mental health and ancillary services available in one place on an accessible App.	• Test whether having an accessible mobile/computer App of resources increases access to mental health services to various populations that are not currently served at Berkeley Mental Health • Assess whether providing an App that would assist individuals in recognizing signs and symptoms of mental health concerns, would promote better outcomes. • Assess whether technology-based services would Increase the coordination of accessible information of area mental health resources; • Test whether technology-based services will provide better coordination of care for clients who are accessing multiple social services, promoting community collaboration and better mental health outcomes • Assess whether the utilization of technology-based services will reduce stigma around accessing mental health services; • Assess whether the provision of technology-based services will increase access and promote better mental health outcomes for transition age youth.
Inyo	• While national statistics show that between 50-80% women feel a short-term depression related to hormonal shifts after giving birth, 1 in 5 new mothers experience more severe and longer lasting depressive symptoms ranging in a spectrum of perinatal mood and anxiety disorders (PMADs) that can occur up to a year after giving birth. Other than a single Postpartum Support International volunteer who	• Users report Mindstrong increased their awareness of their own wellbeing, and active steps they can take to support it. • Users report that Mindstrong removed mental health access barriers such as concerns about stigma and confidentiality. • Families and friends synced to a patient's alerts report they have observed benefits in improved	• New mothers • Youth prior to transitioning out of high school	• Clients are able to view their brain biomarkers on their phone whenever they would like, and they can permit a select friend or family group to monitor this information via smart phone as well if they would like to flex their personal resource network prior to clinical contact. • Incorporate WRAP principles and educational support tools into the care offered through this tech to increase	• Test how digital phenotyping technology can be harnessed to provide a new tool for prevention or early intervention with some underserved populations in our county. • A successful pilot program with positive outcomes for perinatal mothers and transition age youth in Inyo with this technological approach that lays the foundation for spreading

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
	covers both Inyo and Mono counties, Inyo does not have a dedicated infrastructure to support this group of women who are already statistically less likely than men to have an unmet need for mental health treatment according to CalMHSA's "Monitoring California's Mental Health" study of CHIS data published by Rand in 2018, which found that women needing treatment for a mental health issue were less likely to receive it than their male counterparts. • For Inyo's transition-age youth (TAY) population, pressures associated with transitioning from high school to secondary education or the work force can be amplified by Inyo's 4-5 hour geographic isolation from populous urban centers in any direction. This causes many contemplating a move toward independence to struggle with anxieties about navigating freeways, crowds, and urban systems without any previous experience. For youth deciding to stay in Inyo for their early adulthood, trying to find a living wage job and rent in an inflated housing market can seem just as daunting. These normal stresses can prove overwhelming when combined with an individual's physical and mental health struggles.	recovery times, mood stabilization, or willingness to reach out for support. • The integrated WRAP approach increases users' sense of control and agency in their own recovery. • Users report that Mindstrong normalized their experience of depression or anxiety and decreased their sense of isolation. • Perinatal clients perceive the personal benefits of Mindstrong so clearly, they would recommend Mindstrong to their family and friends, or utilize Mindstrong again themselves during another pregnancy and perinatal event. • Higher percentages of high schoolers using Mindstrong maintain their grades, sports eligibility, and graduate at higher rates than high schoolers opting out of Mindstrong participation. • A percentage of high school graduates continue to use the application as part of an ongoing support strategy.		our understanding of how client-developed and client-driven tools enhance consumer satisfaction and engagement.	this tech to an even more diverse field clients with a variety of behavioral health needs. • Because this technology holds the potential to signal patients (and their self-determined sphere of care) that early, accurate signs of out both the local and global implications related to this project. • Relapse, remission, or even efficacy of treatment are occurring, it also could reduce the high cost of care associated with higher levels of intervention that occur in cases where prevention and early intervention opportunities go unnoticed.

Marin	• Seniors in the county face barriers to accessing mental health services including:
	  o seniors in Marin City and other areas in the county report encountering stigma around accessing mental health services
	  o seniors in geographically isolated areas such as West Marin report difficulty getting to and from services
		Amongst older adults:
		• Decrease in utilization of emergency services
		• Increased social connectedness, belonging and purpose
		• Reduction in symptoms of depression, anxiety and other mental health concerns
		• Increased ability to age-in-place, reduction in residential placements
			Older adults that are underserved because of geographic, physical, economic, language or cultural barriers to accessing services	• Technology-based multi-county collaborative project that focuses specifically on older adults
				• Utilizing a locally developed training curriculum on mental health in older adults as an outreach and engagement strategy for the tech suite
					• Will older adults either at risk of or who are experiencing symptoms of mental illness use virtual peer chatting accessed through a website or through a phone application?
					• Will the use of virtual peer chatting and peer-based interventions result in users [older adults], reporting greater social connectedness, reduced symptoms and increases in well-being?

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
	o homebound older adults or those with limited mobility across the county find their options to be limited • Older adults and their caregivers are at increased risk for depression because of social isolation and loneliness	• Increased public awareness of mental illness in older adult population and reduction in stigma Amongst families and caregivers: • increased capacity to support their older adult family member			• What virtual strategies contribute most significantly to increasing an individual's capability and willingness to seek support, specifically in the older adult community? • For each of the above learning questions, what are the most effective engagement and treatment strategies for sub-categories of older adults (i.e. ages 65-75, Vietnamese, caregivers, etc.)
Monterey	Monterey County has a critical need to increase services the underserved Latino communities. As stated in the FY18-20 MHSA 3-Year strategic plan, MCBH has a goal to increase the service utilization rate of Latino's by 7% by the end of FY20. As the safety net provider for mental health services, Monterey County Behavioral Health (MCBH) looks to the Medi-Cal eligible population as a proxy for determining where needs are greatest in our community and how MCBH services may be best directed. Service utilization data has consistently indicated the Latino population to be drastically underserved, as they represent 75% of the Medi-Cal eligible population and comprise 54% of beneficiaries served by MCBH.	Develop a new web-based screening tool that to help individuals understand their potential needs and quickly connect them to appropriate treatment. Desired outcomes: • Increased access to mental health services in Monterey County (new clients) • Increased number of referrals into MCBH systems of care • Demonstrated accuracy in prescribing appropriate mental health service needs • Reduction in MCBH clinical staff time billed for evaluation/assessment services • Increase in clinical staff time billed for therapeutic treatment services	All County Populations	Develop a comprehensive web-based mental health assessment application that can screen for a broad spectrum of mental health disorders and refer individuals to the appropriate level of care within the MCBH system. The tool will be developed to: • Screen for a broad range of disorders, from low-risk with mild need to severe with urgent need. • Easy use by community-based providers to help individuals understand the need for treatment. • Maintain confidentially standards. • Interface with MCBH's Avatar electronic health record system to provide more seamless transitions into care. • Work fluidly in Spanish. • Incorporate perspectives from the Latino community and will include cultural nuances that reflect how Latinos understand and relate to mental health. • 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.	• Determine if this screening tool accurately gauges type and severity of mental illness. • Determine if this application provides meaningful and accurate referral connections to the appropriate service / resource as efficiently as possible. • Assess whether this web-based screening tool reduces the hours and cost associated with in-person assessments. • Assess the impact the implementation of this application has on the total volume of clients entering ACCESS services, including its effect on the demographics of clients served. • Assess whether individuals (staff, community provider, peer, etc.) using this application to assist a person in need find this application useful for connecting that person to resources. Many local agencies expressed interest in testing this, including local law enforcement who hope to use this to link community members to care.
Riverside	• Service to Hearing and Visually Impaired Communities: National studies indicate that approximately 10% of the total population is deaf. In Riverside, that number is estimated to	• Early Detection • Suicide Prevention • Improve Outcomes for High Risk Populations	• Early Detection o TAY • Suicide Prevention o Men over the age of 45 o Adults over the age of 65	• TAY Drop-in Center "Technology Ambassadors" o TAY members, as PSS interns (with stipends) report to a full-time PSS employee, become Tech	• Determine if the peer chat feature will increase accessibly to the hearing and visually impaired communities. • Determine whether digital phenotyping create better outcomes

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives

	be 17%. Though traditional avenues of recruiting ASL speaking employees, having deaf and hard of hearing representation at our advisory committees and the use of ASL interpreters are unutilized to engage this population, the hearing impaired remain underserved. During our most recent Public Hearing, the visually impaired community also advocated for improved services for their unique engagement and service needs.
	• Better Outcomes for Higher Risk Populations:
	  o First Onset: The State is prioritizing the detection and treatment of first onset psychosis as a State-wide standard in Prevention and Early Intervention. Research indicates that prodromal signs of the illness can be detected and early intervention can delay the disorder.
	  o Re-Entry: Riverside County has one of the highest parolee populations in the State. The criminal justice reentry population is at high risk of failing to connect with behavioral health services upon discharge from jail in addition to being at high risk for homelessness. Moreover, the re-entry population has exceptionally high rates of behavioral health need.
	  o FSP Consumers: Full Service Partnership (FSP) programs are designed to serve consumers who have the highest service utilization and the greatest risk for relapse. We have traditionally not done well at engaging this population and the consequences of a lack of service results in
		• Improve Service Access to Underserved Communities and for Rural Regions, Mid-County and Desert Regions	o TAY
			• Improve Outcomes for High Risk Populations
			  o **Re-entry** Consumers (AB109, Whole Person Care)
			  o FSP Consumers
			  o Eating Disorder program consumers
			• Improve Service Access to Underserved Communities and for Rural Regions
			  o **Deaf** and **Hard of Hearing**
			  o Ethnic cultural and LGBT communities
			  o Mid-County and Desert Regions
				Suite experts and serve as presenters and coaches
				  o Partner with our cultural communities advisory groups to present Wellness Education at community identified venues
				  o Serve as coaches or tech use consultations to any program or consumer utilizing the Tech Suite
				• Care Plan Tools for FSP, Re-entry Programs, and Eating Disorder program
				  o Introduced to program participating consumers as an additional service option
				• Allied Health Care Partnership in Rural Communities
				  o Primary Care and Urgent Care Education Program on Serving BH Consumers
				  o Education provided by Peers and Clinical Educator
				  o Participating allied providers will have access to use Tech Suite with their clientele
				• Outreach and Engagement
				  o Wellness Technology community presentations at locations related to target populations
				  o Engagement tools for PEI Promotores and Community Health Promoters programs
				  o Program participation tools for PEI Specialized Ethnic Community Initiatives programs
					for higher risk populations: onset; re-entry; FSP consumers; eating disorders; and, suicide prevention.
					• Determined if using artificial intelligence that is culturally tailored increases to traditionally underserve communities?
					• Determine whether the use of technology eliminates some of the barriers to access that rural and frontier communities encounter.
					• Determine if the inclusion of TAY Ambassadors is useful in the integration of behavioral health technology.

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
	repeated arrests, acute hospitalizations, and chronic homelessness. o Suicide Prevention: In Riverside County, males died at greater rates than females due to self-inflicted injury. • Eating Disorders: Better Outcomes for Consumers with Eating Disorders: Though the therapeutic professions have grown more sophisticated in serving people with eating disorders, the disorders remain challenging to treat due to the co- morbid physical health problems that result from the disorder, as well as the addictive dynamics that often fuel the disorder in secrecy. • Geographic Service Barriers to Rural and Frontier Communities: Riverside is a diverse county consisting of metropolitan, rural, and frontier regions. For some areas, access to services can be extremely difficult due to a lack of resources and transportation issues. In small towns, limited surrounding services decrease the potential for consumer engagement due to stigma and the possibility of the town hearing about the behavioral health needs of individuals. If there is only one access point to services, anonymity and privacy are impacted.				
San Francisco	• Feedback gathered through the Community Planning Process (CPP), which included specific outreach to and inclusion of the transgender community, resulted in expressed needs and support for peer mental health support and information about up-to-date local resources through an online platform. • A main finding from an intensive Transitional Age Youth (TAY) strategic	• Increased purpose • Increased feelings of belonging • Increased social connectedness • Increased quality of life • Reduced stigma of mental illness • Increased wellness	All San Franciscans with an emphasis on transition age youth (TAY) ages 16-24 and socially isolated transgender adults.	• The use of technology as a tool to connect individuals to mental health support and services is a new approach to overall public mental health service delivery as well as a focus on technology solutions for underserved groups.	• Will individuals who have accessed virtual peer chat services be compelled to engage in manualized virtual therapeutic interventions? • Will the use of virtual peer chat and peer-based interventions result in users reporting greater social connectedness, reduced symptoms and increased wellness? • What virtual strategies contribute most significantly to increasing an

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
	planning process was that the TAY population has internal barriers to receiving services including sensitivity regarding stigma for accessing services, mistrust of traditional service providers, not being aware of their need for services, and not being aware how to access services. • Through the CPP process, TAY were selected as the second target populations, as they would be likely to use technology to support their wellness and better connect with services.				individual's capability and willingness to seek support? • What are the most effective strategies or approaches in promoting the use of virtual care and support applications and for which populations (i.e. transition age youth, socially isolated transgender adults, others)? • Will issues pertaining to privacy and/or data security present a barrier to the use of these applications? • What percent of TAY and isolated transgender individuals feel satisfied with the engagement and outreach strategies?
San Mateo	Reach individuals not currently connecting with the public behavioral health system, specifically due to cultural and linguistic needs or finding it challenging to receive or access services in traditional office settings.	• Engage hard-to-reach and isolated residents in services • Connect them to in-person services if appropriate, promote social connectivity with peers • Mitigate the barriers of stigma for culturally specific communities.	• Transition-age youth in crisis • Isolated older adults • Monolingual Chinese and Spanish speaking	• Care coordination capacity to support the Chinese monolingual speaking community. • For youth in crisis, the capacity to identify and show on a local map, safe places for youth to go when in need was identified.	• Does the availability and implementation of technology-based mental health apps connect transition age youth in crisis, older adults experiencing isolation, and the Spanish and Chinese monolingual communities to in-person services; • Does engaging with the apps promote access to mental health services and supports? • Does engaging with the apps effectively promote wellness and recovery?
Santa Barbara	• In FY 2016-17, adults discharged from a psychiatric facility waited, on average, six days to receive an appointment for mental health services. Engagement through online applications could assist individuals with a point of contact and support system immediately following hospitalization, ideally reducing the wait time for some individuals. • The Technology Suite could serve some of the individuals who, for a variety of reasons, do not attend appointments in a timely manner. For example, nearly 30% of the individuals requiring follow-up assistance following crisis care do not attend an	• Improve peer support services and access to care focused on prevention, early intervention, family support and social connection to reduce hospitalizations and use of emergency services among individuals 16 and older.	Focus on at least one component of the Technology Suite –Peer to Peer Chat and Digital Therapeutics (PPCDT) – for three at-risk and/or underserved populations: • adults discharged from psychiatric hospitals and/or recipients of crisis services; • transition-age youth who are students at colleges and universities; and • individuals age 16 and over living in geographically isolated communities, such as Guadalupe, New Cuyama and others.	• Innovation funding offers Santa Barbara County its first opportunity to test the use of web-based peer-to-peer communications to promote greater access to peer support, behavioral health services and linkages to treatment. • The proposed project combines two powerful forces – peer support and digital technology – in the service of clients and the community.	

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
	appointment within 24 hours. The hope is that for many, comfort with using a computer or smartphone in a private setting will lead to prompt assistance and support.				
Tehama	• Geographic and socio-economic isolation. • Poverty. • A significant behavioral health workforce shortage. • Stigma.	• Detect mental illness earlier particularly among youth and transition aged youth (TAY). • Intervene earlier to prevent mental illness and improve client outcomes, particularly among youth and transition aged youth (TAY). • Provide alternate modes of engagement, support, and intervention among individuals living in remote, isolated areas and those who feel stigma in accessing traditionally-presented mental health services.	• Individuals in remote, isolated areas of the county; • Youth and TAY in all areas of the county who may be more comfortable accessing services using a tech-based and youth-culture oriented platform; • Those at risk of suicide who may be more willing to engage in private and confidential services, including adult men; • People who have not accessed services for whom a virtual mode of service may their needed threshold type to accessing support.	• Virtual support, information and/or care is likely to be a significant additional tool in addressing issues related to geographic and socio-economic isolation. • Another level of support for the Latino population. • The Tech Suite may address how best to reach out to and support youth and TAY in a mode that is most comfortable.	• Does a virtual platform reduce time from detection of symptoms to accessing care? • Can online social engagement reduce the severity of mental health symptoms among TAY/youth? Those living in remote, isolated areas? What is most effective in promoting the use of virtual care and support within TAY/youth and those living in remote, isolated areas? • What portions of the virtual platform show the most engagement by consumer group type (TAY/youth, geographically isolated and the rural Latino population, men at risk of suicide, others?) • What tools show the most efficacy, and how does that differ by client type?
Tri-City	• Multiple Innovation workgroups expressed concern for the younger population of the three cities, including college students and transition age youth (TAY) as well as older adults and non-English speaking community members. Focus groups targeting transition age youth from the Tri-City area reveal the stigma associated with receiving services in a traditional clinical setting is considered a challenge for many who then choose to forego treatment rather than risk the label of mental illness. Alternatively, it was noted that these same individuals have a strong connection to technology, including texting and social media. • By 2050, it is expected that the United States population age 65 and over will	• Expanding access to services for TAY and college students by providing an alternative for those who are reluctant to seek services due to self-stigma. Address the early signs of mental illness to reduce hospitalizations and duration of mental illness. • Increase access to services for older adults; specifically those who are homebound and unable to access treatment due to health issues or lack of transportation. • Build strong relationships with monolingual Spanish and Vietnamese speaking populations who are considered unserved/underserved and experiencing barriers to services including language, distrust and fear due to immigration status.	Primary 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. Secondary Beneficiaries • Peers, volunteers and persons connected with Tri-City who are interested in becoming trained virtual support persons and offering their support through chat or other technologies.	• Peer College Liaison(s): College students with lived experience will focus on the outreach and engagement of students in need of support as well as develop relationships with mental health staff on each of the four college campuses. In addition, these liaisons will connect with other transition age youth in the community to create an awareness of these online support services. • Peer Older Adult Liaison(s): Older adults with lived experience who are able to foster relationships with other seniors who may feel isolated or reluctant to seek services, will visit senior community locations to help guide them through the process of identifying available treatment options both online and through direct care.	• Can the use of this technology enable our peers and volunteers to become trained listeners and use their lived experience to help persons struggling with similar life situations? • Does becoming a trained listener and participating in peer chats help our peers and volunteers in their path to wellness and self-development? • Will the capacity to chat in their native language attract unserved/underserved community members to use this technology? • Does participating in virtual chats or social engagement lead the consumer to use additional services from Tri-City such as visiting the Wellness Center, participating in groups or enrolling in services?

County	Needs	Aims	Target Populations	Example Innovation	Example Learning Objectives
	almost double in size. Accommodating the mental health needs of this growing population will require new and innovative solutions. Two of the primary challenges include self-imposed isolation and lack of transportation. In response to this concern, Tri-City conducted focus groups in preparation for this project. Based on feedback received through surveys and older adult participants, 75% indicated they would be likely to seek mental health support if it was available online 24/7. • Finally, through the use of multi-language applications, Tri-City hopes to continue to expand our current language options for non-English speaking individuals who may consider this a viable approach to mental health support.		• Current clients enrolled in services who are seeking additional sources of support. •	• Peer Monolingual Liaison(s): Individuals with lived experience who are fluent in Spanish (or other non-English language) and able to act as cultural brokers building trusting relationships with unserved and underserved community members in need of mental health support but experiencing barriers due to culture or stigma. • Specialized training or access to training for peers, volunteers, and community members who seek to become virtual support persons. In addition to training provided by the technology vendors, which will help peers to learn the basics of using the application and becoming online "listeners", peers will also have access to Tri-City sponsored trainings that include Cultural Competency, Motivational Interviewing, Community Resiliency Model, and Adverse Childhood Experiences. • Peers becoming paid listeners will be encouraged to leverage this employment experience as a stepping stone towards a career in a number of fields including customer service and peer advocacy. By expand the role of our current paid peers, we hope to create additional leadership roles and offer specialized training through our existing Peer Employment Program (PEP). In addition, each peer will have access to employment specialists located at our Wellness Center.	

Attachment IV – Evaluation Learning Objectives and Logic Models

Target Audience: Are the apps reaching the intended target audiences, and has this initiative reduced known health disparities in access and/or outcomes?

EVALUATION OF THE IMPLEMENTATION STRATEGY: ADOPTION, REACH, MAINTENANCE		EVALUATION OF USER EXPERIENCE/USABILITY (1) Clinician (2) Patient/Client; (3) Listener		EVALUATION OF THE OUTCOMES/EFFECTIVENESS
Learning Objectives:				

Mental Health App Environment: (ENVIRONMENTAL SCAN)
 	
 • What products exist with similar features to 7Cups and MindStrong?
 • Questions this can answer: What alternatives might users consider to 7Cups and MindStrong?
 • How do 7Cups and MindStrong compare to other apps in the market?
 • Questions this can answer: What is the market share of 7Cups and MindStrong to similar apps in the market? What features might people expect when using an app like 7Cups or MindStrong? What user experience might people expect when using an app like 7Cups or MindStrong?
 • What changes occur within 7Cups and MindStrong over time?
 • Questions this can answer: How might users experience with 7Cups and MindStrong change over time? How might users expectations of 7Cups and MindStrong change over time?
 	
 County:
 • What are the <u>processes</u> that characterize the implementation of the Tech Suite at the county-level?
 • What are important or necessary <u>conditions</u> to support implementation and maintenance of the Tech Suite at the county-level?
		County-Level Clinician: Clinician
		 • *What are the factors that impact <u>use</u> of the Tech Suite at the **clinician** level?*
		    a) What features / aspects of the apps facilitate or hinder use?
		    b) How do clinicians engage with their patients on the app?
		    c) How do clinicians use app data in assessment and treatment of their patients?
		    d) What characteristics of the clinic environment promote effective use?
		    e) How does their day-to-day job responsibilities affect use and vice versa?
		    f) What things do they like / what frustrates them? Why?
		    g) What changes would they make to better suit themselves / their patients?
		
		 Client/Patient: Client/patient
		 • *What are the factors that impact <u>use</u> of the Tech Suite at the **client/patient** level?*
		    a) What features / aspects of the apps facilitate or hinder use?
		    b) What characterizes users vs. non-users (abandoners)? / Who uses & how long?
				How does use of 7cups and/or Mindstrong lead to the following:
				
				 (LO1) Detect and acknowledge mental health symptoms sooner
				
				 (LO2) Reduce Stigma associated with mental illness
				
				 (LO3) Increase access to support and care
				
				 (LO4) Increase purpose, belonging, and social connectedness
				
				 (LO5) Analyze and collect data from a variety of sources to improve mental health needs assessment and service delivery

- What are the important or necessary resources to support implementation and maintenance of the Tech Suite at the county-level?
- What characteristics of implementation at the county-level impact outcomes of the Tech Suite?
- What is the role of the peer recruiter in each county? What is their level of training? Describe activities? What audiences are they targeting and how? What is the effectiveness of their efforts? (align with RSE)

Clinic/Organization:
- What are the processes that characterize the implementation of the Tech Suite at the clinic/organization level?
- What are important or necessary conditions to support implementation and maintenance of the Tech Suite at the clinic/organization level?
- What are the important or necessary resources to support implementation and maintenance of the Tech Suite at the clinic/organization level?
- What characteristics of implementation impact outcomes of the Tech Suite?

User (County-Level Clinician, Patient/Client, Listener)
- *What are the necessary factors to support adoption of the Tech Suite at the clinician level? Who and at what level do clinicians adopt?*
  a) What are effective strategies in promoting clinician adoption?
  b) What factors support and hinder adoption? (Privacy? Context? Experience?)
- *What are the necessary factors to support adoption of the Tech Suite at the patient / client level?*

c) How do clients interpret, reflect on, and use their data (Mindstrong / Growing Paths in 7 Cups)?
d) How useful do they find the interactions with different clinicians / peers on the apps?
e) How does the use of these apps impact interactions with their clinicians (if applicable)?
f) How do the apps fit into their day-to-day lives?
g) How does use impact stigma?
h) What changes would they make? Why?

- *What characteristics of use/maintenance use impact outcomes of the Tech Suite at the client/patient level?*
  a) How does engagement / use impact the severity of mental health symptoms, social connectedness, stigma?
  b) What strategies contribute most to increasing an individual's capability and willingness to seek support inside and outside of the apps?
  c) How does their interaction with Peer Listeners influence perceived support, connectedness (7 Cups)?

7-cups Peer Listener: Listener
- *What are the factors that impact use of the Tech Suite at the listener level?*
  a) What features / aspects of the apps facilitate or hinder use?
  b) Why did they become a peer listener? What motivates them to be one?

a) What are the most effective strategies or approaches in promoting the adoption of apps and for which target audiences?
b) What hinders adoption? (Privacy? Context? Stigma? Experience?)
c) **Non-adoption**: What are the characteristics of people who do not adopt the app? What are the reasons for not adopting?

c) Are they also clients (i.e., looking for support from others)?
d) How do the apps fit into their day-to-day lives?
e) What changes would they make? Why?

• *What characteristics of use/maintenance impact outcomes of the Tech Suite at the **listener** level?*
a) What qualities make an effective peer listener?
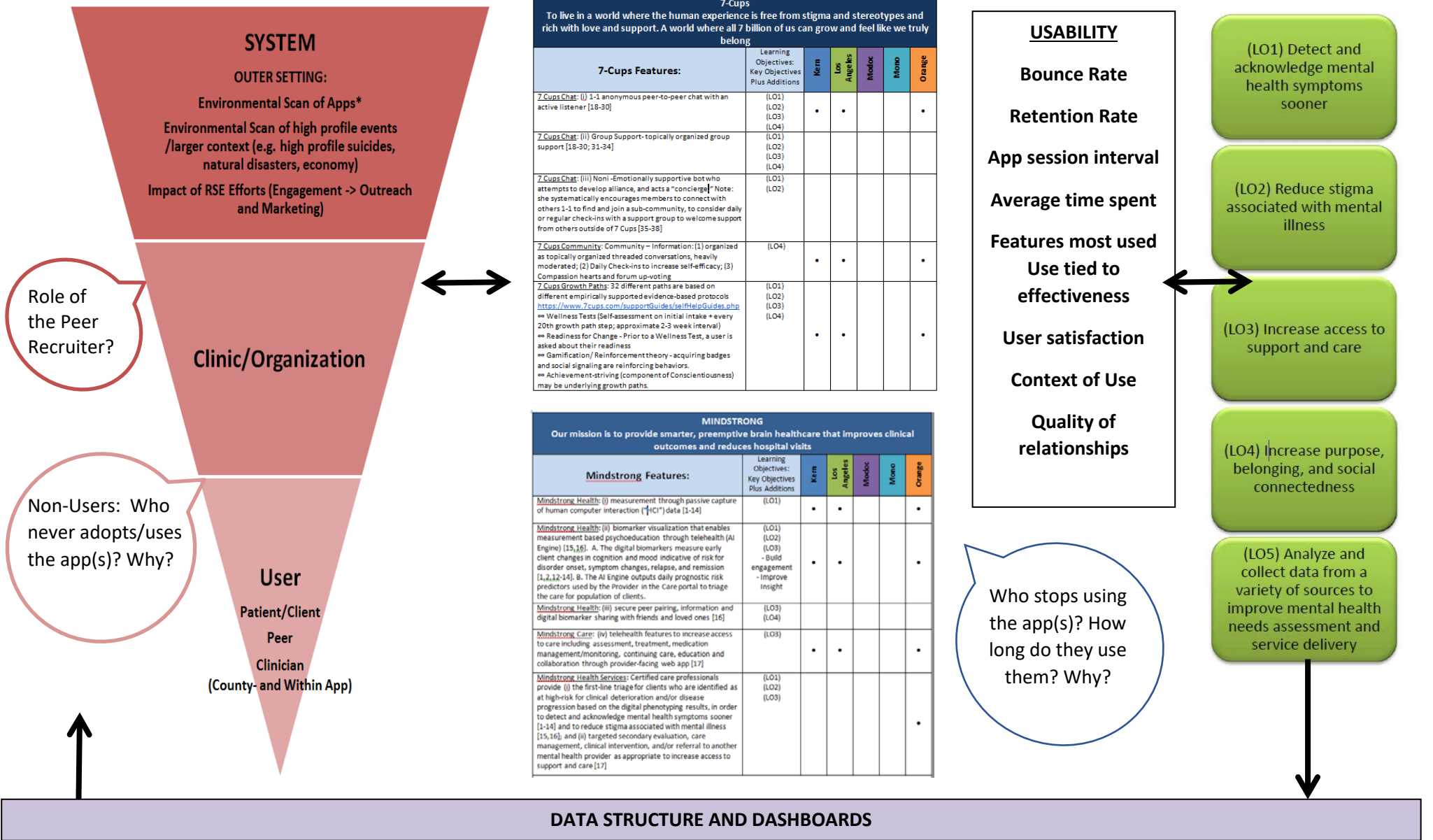b) How does interacting with clients impact peer listener's sense of belonging, purpose, stigma?

EVALUATION OF THE IMPLEMENTATION STRATEGY:
ADOPTION, REACH, MAINTENANCE

EVALUATION OF USER EXPERIENCE/USABILITY
(1)Clinician (2) Patient/Client; (3) Listener

EVALUATION OF THE OUTCOMES/EFFECTIVENESS

SYSTEM

OUTER SETTING:

Environmental Scan of Apps*

Environmental Scan of high profile events /larger context (e.g. high profile suicides, natural disasters, economy)

Impact of RSE Efforts (Engagement -> Outreach and Marketing)

Clinic/Organization

Role of the Peer Recruiter?

Non-Users: Who never adopts/uses the app(s)? Why?

User

Patient/Client

Peer

Clinician

(County- and Within App)

7-Cups

To live in a world where the human experience is free from stigma and stereotypes and rich with love and support. A world where all 7 billion of us can grow and feel like we truly belong

7-Cups Features:	Learning Objectives: Key Objectives Plus Additions	Kern	Los Angeles	Modoc	Mono	Orange
7 Cups Chat: (i) 1-1 anonymous peer-to-peer chat with an active listener [18-30]	(LO1) (LO2) (LO3) (LO4)	•	•			•
7 Cups Chat: (ii) Group Support- topically organized group support [18-30; 31-34]	(LO1) (LO2) (LO3) (LO4)					
7 Cups Chat: (iii) Noni -Emotionally supportive bot who attempts to develop alliance, and acts a "concierge" Note: she systematically encourages members to connect with others 1-1 to find and join a sub-community, to consider daily or regular check-ins with a support group to welcome support from others outside of 7 Cups [35-38]	(LO1) (LO2)					
7 Cups Community: Community – Information: (1) organized as topically organized threaded conversations, heavily moderated; (2) Daily Check-ins to increase self-efficacy; (3) Compassion hearts and forum up-voting	(LO4)	•	•			•
7 Cups Growth Paths: 32 different paths are based on different empirically supported evidence-based protocols https://www.7cups.com/supportGuides/selfHelpGuides.php ∞ Wellness Tests (Self-assessment on initial intake + every 20th growth path step; approximate 2-3 week interval) ∞ Readiness for Change - Prior to a Wellness Test, a user is asked about their readiness ∞ Gamification/ Reinforcement theory - acquiring badges and social signaling are reinforcing behaviors. ∞ Achievement-striving (component of Conscientiousness) may be underlying growth paths.	(LO1) (LO2) (LO3) (LO4)	•	•			•

MINDSTRONG

Our mission is to provide smarter, preemptive brain healthcare that improves clinical outcomes and reduces hospital visits

Mindstrong Features:	Learning Objectives: Key Objectives Plus Additions	Kern	Los Angeles	Modoc	Mono	Orange
Mindstrong Health: (i) measurement through passive capture of human computer interaction ("HCI") data [1-14]	(LO1)	•	•			•
Mindstrong Health: (ii) biomarker visualization that enables measurement based psychoeducation through telehealth (AI Engine) [15,16]. A. The digital biomarkers measure early client changes in cognition and mood indicative of risk for disorder onset, symptom changes, relapse, and remission [1,2,12-14]. B. The AI Engine outputs daily prognostic risk predictors used by the Provider in the Care portal to triage the care for population of clients.	(LO1) (LO2) (LO3) - Build engagement - Improve Insight	•	•			•
Mindstrong Health: (iii) secure peer pairing, information and digital biomarker sharing with friends and loved ones [16]	(LO3) (LO4)					
Mindstrong Care: (iv) telehealth features to increase access to care including assessment, treatment, medication management/monitoring, continuing care, education and collaboration through provider-facing web app [17]	(LO3)	•	•			•
Mindstrong Health Services: Certified care professionals provide (i) the first-line triage for clients who are identified as at high-risk for clinical deterioration and/or disease progression based on the digital phenotyping results, in order to detect and acknowledge mental health symptoms sooner [1-14] and to reduce stigma associated with mental illness [15,16]; and (ii) targeted secondary evaluation, care management, clinical intervention, and/or referral to another mental health provider as appropriate to increase access to support and care [17]	(LO1) (LO2) (LO3)					•

USABILITY

Bounce Rate

Retention Rate

App session interval

Average time spent

Features most used

Use tied to effectiveness

User satisfaction

Context of Use

Quality of relationships

Who stops using the app(s)? How long do they use them? Why?

(LO1) Detect and acknowledge mental health symptoms sooner

(LO2) Reduce stigma associated with mental illness

(LO3) Increase access to support and care

(LO4) Increase purpose, belonging, and social connectedness

(LO5) Analyze and collect data from a variety of sources to improve mental health needs assessment and service delivery

DATA STRUCTURE AND DASHBOARDS

ATTACHMENT V – TIMELINE OF PROGRESS

Tech Suite Implementation Timeline

	Oct-17 Month 1	Nov-17 Month2	Dec-17 Month 3	Jan-18 Month 4	Feb-18 Month 5	Mar-18 Month 6	Apr-18 Month 7	May-18 Month 8	Jun-18 Month 9	Jul-18 Month 10	Aug-18 Month 11	Sep-18 Month 12	Oct-18 Month 13	Nov-18 Month 14	Dec-18 Month 15	Jan-19 Month 16	Feb-19 Month 17

Privacy Review, Compliance, and Informed Consent Progress

Los Angeles / Kern / Modoc / Orange / Mono / Cohort #2

- Initial 7C Approval
- Initial MS Approval
- Initial MS Approval
- Initial 7C Approval
- Initial 7C Approval
- Initial MS Approval
- Ongoing Monitoring

Peer Development

Los Angeles / Kern / Modoc / Orange / Mono County / Cohort #2

- Contracted with Peer Organization
- Initial Peers Hired
- Ongoing Peer Recruitment and Development

7 Cups Readiness and Deployment

Los Angeles / Kern / Modoc / Orange / Mono / Cohort #2

- Customization
- Internal Marketing Expansion

Mindstrong Readiness and Deployment

Los Angeles / Kern / Modoc / Orange / Mono County / Cohort #2

- Customization
- Initial Clinic Integration & Launch

Project-wide

OAC	LA/Kern approved			Mono Approved		Modoc / Orange approved				OAC Update		OAC Update				
Collaborative Management Infrastructure				Project Manager hired			Peer Consultant Hired	IT & Security Firm Hired					Peer Lead to be hired			
Application Vendors	RFI process initiated		Vendor Selection														
Outreach & Engagement	RFI process initiated			RFP	O&E Selection												
Evaluation	RFI process initiated			RFP	Evaluation Selection												
Contracting	7 Cups						Start Up	Executed									
	Mindstrong						Start Up	Executed									
	RSE					Start Up			Negotiating								
	UCI						Start Up	Negotiating									

Key

Symbol	Meaning
⊓ (Participation bracket)	Participation Agreement Signed
◆	7 Cups Internal Soft Launch
●	Mindstrong Launch in Initial Clinics
★	County Peer Lead Hired
▮	Initial Peer Orientation and Training
7C	7 Cups
MS	Mindstrong

September 21, 2018