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Mental Health Services
Oversight & Accountability Commission

Meeting Materials Packet

Commission Teleconference Meeting
September 22, 2022
9:00 AM – 12:45 PM

MHSOAC
Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING NOTICE & AGENDA

SEPTEMBER 22, 2022

NOTICE IS HEREBY GIVEN that the Commission will conduct a teleconference meeting on **September 22, 2022, at 9:00 a.m.** This meeting will be conducted pursuant to the Bagley-Keene Open Meeting Act according to Government Code Section 11123. The remote locations from which Commissioners will participate are listed below and are open to the public. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

Date September 22, 2022

Time 9:00 AM – 12:45 PM

Location 1812 9th Street, Sacramento, CA 95811

ZOOM ACCESS:

FOR COMPUTER/APP USE
Link: https://mhsoac-ca-gov.zoom.us/j/81318235793
Meeting ID: 813 1823 5793

FOR PHONE DIAL IN
Dial-in Number: 1 408 638 0968
Meeting ID: 813 1823 5793

Public participation is critical to the success of our work and deeply valued by the Commission. Please see the information contained after the Commission Meeting Agenda for a detailed explanation of how to participate in public comment and for additional meeting locations.

Our Commitment to Excellence

The Commission's 2020-2023 Strategic Plan articulates three strategic goals:

- Advance a shared vision for reducing the consequences of mental health needs and improving wellbeing.
- Advance data and analysis that will better describe desired outcomes; how resources and programs are attempting to improve those outcomes.
- Catalyze improvement in state policy and community practice for continuous improvement and transformational change.

Commission Meeting Agenda

It is anticipated that all items listed as "Action" on this agenda will be acted upon, although the Commission may decline or postpone action at its discretion. In addition, the Commission reserves the right to take action on any agenda item as it deems necessary based on discussion at the meeting. Items may be considered in any order at the discretion of the Chair. Unlisted items may not be considered.

9:00 AM

1. **Call to Order & Roll Call**
   Chair Mara Madrigal-Weiss will convene the Commission meeting and a roll call of Commissioners will be taken.

9:05 AM

2. **Announcements & Committee Updates**
   Chair Mara Madrigal-Weiss will make announcements and the Commission will receive committee updates.

9:20 AM

3. **General Public Comment** *Information*
   General Public Comment is reserved for items not listed on the agenda. No discussion or action by the Commission will take place.

9:50 AM

4. **August 25, 2022 Meeting Minutes** *Action*
   The Commission will consider approval of the minutes from the August 25, 2022 Commission Meeting.
   - Public Comment
   - Vote

10:00 AM

5. **Early Psychosis Programs** *Action*
   The Commission will hear an update on the multi-county Early Psychosis Learning Health Care Network Innovation Project, the Early Psychosis Intervention Grant Program and will receive information about a site-visit to a Coordinated Specialty Care Clinic; *presented by Sharmil Shah, Chief of Program Operations, Tom Orrock, Chief of Community Engagement and Grants, and Tara Niendam, Ph.D., Associate Professor in Psychiatry, Executive Director, UC Davis Early Psychosis Programs*.
   - Public Comment
   - Vote

11:00 AM

6. Mental Health Wellness Legislative Update *Action*

The Commission will hear an update on recent adjustments made to the Mental Health Wellness Act (Senate Bill 82), consider approving funding for the EmPATH emergency psychiatry program, and provide guidance on the priorities for future funding opportunities; *presented by Toby Ewing, Executive Director.*

- Public Comment
- Vote

11:30 AM

7. Break

The Commission may take a short break at the discretion of the Chair.

11:45 AM

8. Behavioral Health Fellowship Funding Proposal *Action*

The Commission received a $5 million budget allocation in 2022-2023. Staff will provide an overview of the Fellowship Project and be presented with options on how best to allocate the $5 million for the Behavioral Health Fellowship project; *presented by Toby Ewing, Executive Director.*

- Public Comment
- Vote

12:30 PM

9. Transition Age Youth (TAY) Advocacy Outline *Action*

The Commission will consider approval of the Request for Proposal outline for advocacy, education, and outreach on behalf of Transition Age Youth; *presented by Tom Orrock, Chief of Community Engagement and Grants*.

- Public Comment
- Vote

12:45 PM

10. Adjournment

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Our Commitment to Transparency	Our Commitment to Those with Disabilities
In accordance with the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at www.mhsoac.ca.gov at least 10 days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov	Pursuant to the American with Disabilities Act, individuals who, because of a disability, need special assistance to participate in any Commission meeting or activities, may request assistance by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov. Requests should be made one (1) week in advance whenever possible.

Public Participation: The telephone lines of members of the public who dial into the meeting will initially be muted to prevent background noise from inadvertently disrupting the meeting. Phone lines will be unmuted during all portions of the meeting that are appropriate for public comment to allow members of the public to comment. Please see additional instructions below regarding Public Participation Procedures.

The Commission is not responsible for unforeseen technical difficulties that may occur. The Commission will endeavor to provide reliable means for members of the public to participate remotely; however, in the unlikely event that the remote means fails, the meeting may continue in person. For this reason, members of the public are advised to consider attending the meeting in person to ensure their participation during the meeting.

Public participation procedures: All members of the public shall have the right to offer comment at this public meeting. The Commission Chair will indicate when a portion of the meeting is to be open for public comment. **Any member of the public wishing to comment during public comment periods must do the following:**

- **If joining by call-in, press *9 on the phone.** Pressing *9 will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line and announce the last three digits of your telephone number. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.
- **If joining by computer, press the raise hand icon on the control bar.** Pressing the *raise hand* will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line and announce your name and ask if you'd like your video on. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

- **Under newly signed AB 1261,** by amendment to the Bagley-Keene Open Meeting Act, members of the public who use translating technology will be given additional time to speak during a Public Comment period. Upon request to the Chair, they will be given at least twice the amount of time normally allotted.

AGENDA ITEM 4

Action

September 22, 2022 Commission Meeting

Approve August 25, 2022 MHSOAC Teleconference Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the August 25, 2022 Commission teleconference meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None

Enclosures (2): (1) August 25, 2022 Meeting Minutes; (2) August 25, 2022 Motions Summary

Handouts: None.

Proposed Motion: The Commission approves the August 25, 2022 meeting minutes.

Mental Health Services
Oversight & Accountability Commission

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date August 25, 2022

Time 9:00 a.m.

Location 1812 9th Street
Sacramento, California 95811

Additional public locations included 1923 Gridiron Way, CMS 122, MC# 1768, Berkeley, CA 94720-1768; 4665 Business Center Drive, Fairfield, CA 94534; 8700 Beverly Boulevard, Los Angeles, CA 90048; 700 S Flower Street, Suite 1000, Los Angeles, CA 90017; 10474 Mather Boulevard, Mather, CA 95655; 44 N Blue Oak Lane, Napa, CA 94558; 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606; 6401 Linda Vista Road, Room 409, San Diego, CA 92111

Members Participating:

Mara Madrigal-Weiss, Chair*
Mayra Alvarez, Vice Chair*
Mark Bontrager
Keyondria Bunch, Ph.D.*
Steve Carnevale*
Rayshell Chambers*
Shuonan Chen*
Itai Danovitch, M.D.*
David Gordon*
Gladys Mitchell
Khatera Tamplen*

*Participated remotely.

Members Absent:

John Boyd, Psy.D.
Sheriff Bill Brown
Assembly Member Wendy Carrillo
Senator Dave Cortese
Alfred Rowlett

MHSOAC Meeting Staff Present:

Geoff Margolis, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Administration
Tom Orrock, Chief, Community Engagement and Grants Division
Sharmil Shah, Psy.D., Chief of Program Operations
Melissa Martin-Mollard, Director, Research and Evaluation
Maureen Reilly, Assistant Chief Counsel
Amariani Martinez, Administrative Support
Cody Scott, Meeting Logistics Technician

1: Call to Order and Roll Call

Chair Mara Madrigal-Weiss called the Meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:06 a.m. and welcomed everyone.

Chair Madrigal-Weiss reviewed a slide about how today's agenda supports the Commission's Strategic Plan Goals and Objectives, and noted that the meeting agenda items are connected to those goals to help explain the work of the Commission and to provide transparency for the projects underway.

Amariani Martinez, Commission staff, called the roll and confirmed the presence of a quorum.

2: Announcements and Committee Updates

Chair Madrigal-Weiss gave the announcements as follows:

Announcements

- Matt Lieberman, the longest serving staff member at the Commission, will be retiring from state service effective at the end of the month. Chair Madrigal-Weiss thanked Mr. Lieberman on behalf of the Commission for his years of service and wished him well on his retirement.
- The July 2022 Commission meeting recording is now available on the website. Most previous recordings are available upon request by emailing the general inbox at mhsoac@mhsoac.ca.gov.
- The next Commission meeting will take place on September 22nd in Sacramento.
- Following the September 22nd Commission meeting, the Commission, in conjunction with PBS-KVIE and community mental health partners, will be hosting a special screening and panel discussion of Ken Burns' recent documentary, *Hiding in Plain Site: Youth Mental Illness*, at 5:30 p.m. on September 22, 2022, at The Sofia theater in Sacramento.

Committee Updates

Chair Madrigal-Weiss invited the Committee Chairs to provide updates on their activities.

Cultural and Linguistic Competency Committee Update

Vice Chair Alvarez, Chair of the Cultural and Linguistic Competency Committee (CLCC), provided a brief update of the work of the Committee since the last Commission meeting:

- The CLCC members met last week and heard a presentation, as part of the Equity in Action component of the agenda, from the Commission's LGBTQ advocacy contractor at the California LGBTQ Health and Human Services Network.
    - The conversation raised issues around their strategies to address the mental health and wellness needs of the LGBTQ community, addressed their collaboration with several other

organizations, especially those representing other marginalized communities across the state to advocate for policies that advance the health and mental health of LGBTQ communities, and addressed the importance of expanding access to gender-affirming health care and the need to identify funding to help sustain local LGBTQ organizations that focus on health and mental health.

  - The conversation also addressed the expansive definition that mental health must encompass in order to advance equity, such as the fact that access to gender-affirming care is mental health care. It is a recognition of and respect for one's identity and is critical to supporting the overall wellbeing of members of the community.

- The CLCC looks forward to hearing from other organizations that are doing excellent work to address inequities in the mental health system.
- The CLCC also heard a presentation from Commission staff on the outreach efforts underway to hear from transition age youth (TAY), particularly ahead of the next Request for Proposal (RFP) for organizations seeking funding to advocate on behalf of TAY.
  - Two listening sessions have taken place in addition to the CLCC presentation. Staff will be in Stockton this week to conduct a focus group to hear more about the advocacy needs of TAY.
  - The CLCC was able to provide input around the desired characteristics of an advocacy organization that serves TAY, but also discussed the need for a statewide organization to work with a coalition of local-level TAY organizations to ensure the focus on the local perspective for statewide advocacy.
- The next CLCC meeting will take place on September 8th.

Client and Family Leadership Committee Update

Commissioner Tamplen, Chair of the Client and Family Leadership Committee (CFLC), provided a brief update of the work of the committee since the last Commission meeting:

- Chair Tamplen and Vice Chair Rayshell Chambers will be meeting with Commission staff tomorrow to discuss upcoming Committee meeting dates.
- The CFLC will continue to work on the creation of a Peer Support Specialist Certification Resource Guide in addition to other areas that Committee members feel are a priority for client and family members.

Research and Evaluation Committee Update

Commissioner Danovitch, Chair of the Research and Evaluation Committee, provided a brief update of the work of the Committee since the last Commission meeting:

- The Committee met on August 17th and heard presentations on the status of the Research and Evaluation Portfolio and the Commission's evaluation of the Triage Grant Programs.

- The Committee will work on how to develop, promote, and enable evaluative strategies that are more relevant to communities and the Commission.

Prevention and Early Intervention Subcommittee Update

Chair Madrigal-Weiss, Chair of the Prevention and Early Intervention (PEI) Subcommittee, provided a brief update of the work of the Subcommittee since the last Commission meeting:

- The Subcommittee released the first draft of its project report on August 24th. The draft report can be found on the Commission's website under the PEI Initiative and has also been distributed through the Commission's ListServ.
- There are several ways for the public to provide comment on the draft report. Written comments can be mailed or emailed to the Commission. Verbal comments will be shared by the Subcommittee during meetings on September 7th and October 6th.

3: General Public Comment

Mandy Taylor, Behavioral Health Equity Manger, California LGBTQ Health and Human Services Network, stated that a California LGBTQ Health and Human Services Network virtual convening is scheduled for next Tuesday for LGBTQ leaders across California. A pre-conference event is scheduled for #Out4MentalHealth partners, who helped create the agenda. 40 representatives from 15 tasks forces statewide will attend the pre-conference. This network will allow partners to have a collaborative conversation with decision-makers to learn more about the grievance process that advocates can use for their departments or commissions if their county behavioral health department is not executing programs in a way that was promised to the public and/or not following current California code or policies.

Theresa Comstock, Executive Director, California Association of Local Behavioral Health Boards and Commissions (CALBHB/C), congratulated Matt Lieberman on his retirement and thanked him for his work in helping to improve and sustain CALBHB/C's service to California's 59 local mental and behavioral health boards and commissions and the communities that they serve.

Steve Dilley, Executive Director, The Veterans Art Project (VETART), announced their statewide event at the State Capitol on October 12th.

Darren DeVillas (phonetic) shared their story of being a homeless veteran holding a sign, living with undiagnosed post-traumatic stress disorder (PTSD) for 30 years, and trying a new, innovative healing modality called the arts, in all its many forms. Through the process of working with crayons, paints, ceramics, woodworking, and storytelling, the speaker began to open up and tell their story. The speaker shared that they now have 15 years of sobriety, they went back to school, are currently an Adjunct Communications Professor at four colleges, and are the Master of Ceremonies for the Pop-Up Art Cafés. The speaker asked the Commission to continue to fund VETART and their innovative programs.

Bill DeVillas (phonetic), sibling of the previous speaker, spoke in support of VETART.

Ivan Sam, Native American Cultural Ambassador, VETART, spoke about using land acknowledgements, sharing knowledge about indigenous people who have served in the military, suicide prevention workshops, and using art as a healing modality. The speaker asked for continued support as VETART does their statewide event in October.

Stacie Hiramoto, Executive Director, Racial and Ethnic Mental Health Disparities Coalition, (REMHDCO)

- Thanked Matt Lieberman for his many years of service and wished him well in his retirement.
- Asked Commissioners to save the date of Friday, October 14th, for a mega-event for the California Reducing Disparities Project (CRDP) in Southern California, that will center on the evaluation that will prove that these community-defined evidence practices work.
- Stated that the Commission was asked at the last meeting to take positions on bills that impacted the Mental Health Services Act (MHSA). Senate Bill (SB) 1338, the Care Court bill, and Assembly Bill (AB) 2242 allow the use of MHSA funds for persons on involuntary holds, something that the MHSA funds were never supposed to do.
- Stated that SB 1302 has been amended to direct the State Controller to distribute funds to the Superintendent of Public Instruction to provide grants to certain local educational agencies to improve or establish health centers that provide comprehensive medical, behavioral, and mental health services. While this is a noble and acceptable purpose for the funds, it violates the established process of having counties, in collaboration with local communities, make these spending decisions. The speaker said this bill is not supported by interested parties statewide who are involved with and knowledgeable about the MHSA.
- Urged the Commission to establish a legislative committee to thoroughly review in a comprehensive manner all bills that involve or affect the MHSA. Principles could be developed to guide the Commission in taking positions on bills in an organized, transparent way and in a way that upholds the long-held values and provisions of the MHSA.

Tonya Savice, Director of Advocacy, VETART, spoke in support of its the Pop-Up Art Cafés that are sponsored by the Commission. The speaker explained that this and other VETART projects are offered as healing modalities to the veteran community as an alternative to using medications to help with chronic medical and mental issues. The speaker stated that the Pop-Up Cafes project helped individuals continue to get supplies to be involved with the arts throughout the COVID-19 pandemic.

Angela Brand, Project Manager, Center for Applied Research Solutions (CARS), and Field Manager, California Mental Health Equity Training and Technical Assistance Center, thanked Matt Lieberman for his many years of service and wished him well in his retirement.

Anna echoed Stacie Hiramoto's comments. The speaker stated they worked on the creation and implementation of the MHSA and reminded everyone that the MHSA was created to promote and increase voluntary peer-run services and the services that are created and designed by individuals

with direct lived experience. The speaker urged the Commission to ensure that MHSA funds will never be spent on forced treatment. This does not work. She also urged the Commission to support and fund local peer-run programs and services. Unfortunately, very often additional funding or new funding does not go directly to those programs but it gets spread out through the whole system in different ways. These services are effective, especially when they are added to already existing services. It is important to focus on that during the implementation of SB 803.

4: July 28, 2022, Meeting Minutes (Action)

Chair Madrigal-Weiss stated that the Commission will consider approval of the minutes from its teleconference meeting of July 28, 2022. She said they are posted on the Commission's website in writing and as a recording.

Public Comment. There was no public comment.

Chair Madrigal-Weiss asked for a motion to approve the minutes. Commissioner Carnevale made a motion, seconded by Commissioner Bunch, that:

The Commission approves the July 28, 2022, teleconference Meeting Minutes as presented.

The Motion passed 8 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Bunch, Carnevale, Chambers, Chen, Danovitch, and Mitchell, and Chair Madrigal-Weiss.

The following Commissioners abstained: Commissioner Tamplen and Vice Chair Alvarez.

5: Creation of Subcommittee on Firearm Violence Prevention (Action)

Chair Madrigal-Weiss stated that the Commission will consider creating a subcommittee to explore opportunities to prevent firearm violence and its impact on individual, family and community mental health and wellbeing, including strategies to improve understanding of the relationship between mental health and firearm violence.

The Chair said this proposal was responsive to Commissioner statements on May 26, and their interest in exploring how the Commission could act on the issue. She recalled that news of the 19 children and two adults killed in Uvalde, Texas had been on the air just before the Commission began this meeting; a week or so prior to that, there had been a mass shooting at Tops Market in Buffalo, New York, and since then there have been 34 more mass shootings nationwide. The Chair emphasized that firearm violence and suicide take a toll on mental health and wellbeing.

Chair Madrigal-Weiss recalled that other members had expressed similar concerns at that meeting, mentioning Commissioners Bunch and Bontrager who spoke to the assumptions people make about firearm violence, and how the media reflects this type of event as a mental health issue. She remembered that Commissioner Bontrager had asked how the Commission could act on this issue.

Returning to the nature of the proposed motion, the Chair hoped that a subcommittee could conduct policy research and provide information for the Commission's consideration. She said conversations are taking place in schools, hospitals and other settings and invited the Commissioners to also discuss this issue.

Discussion

Commissioner Bunch said, speaking from personal experience in the aftermath of the recent spate of firearm violence, there were many conversations in the workplace and family and community settings where people expressed an overwhelming sense of hopelessness. Addressing the Chair, the Commissioner expressed gratitude for the opportunity to discuss formation of a subcommittee. He thought the Commission should recognize that gun violence and other forms of violence impact mental health and families. He said, if we can do anything around that issue to focus on prevention and solutions, then we should do so; it's just too significant of an issue to ignore at this point.

Commissioner Danovitch expanded on the preceding comments about the enormity of the impact of gun violence on mental health, adding that this is an issue he personally feels passionate about. But he wanted to make an argument against becoming involved in respect to the Commission's work, based on capacity. The Commissioner mentioned other mandates and charges that are broad and challenging, such as the effect of homelessness. He said homelessness is different from mental health even though the two get conflated. He felt that the Commission's statutory charter has a direct connection to homelessness, such as the structural problems of housing; and that a worsening condition of homelessness is linked to other programs the Commission is working on. Commissioner Danovitch expressed concern that adding another issue to the Commission's portfolio that is conflated with mental health, such as gun violence, could diffuse focus. He suggested that the Commission should double-down in actionable areas where its interventions have a chance of moving the needle. Commissioner Danovitch suggested that the Commission's purpose would be better served by co-sponsoring or partnering with other organizations that could be more impactful and effective in this arena.

Commissioner Carnevale agreed with both points of view but tended to side with Commissioner Danovitch on capacity. However, Commissioner Carnevale favored studying gun violence in the capacity of early assessment and intervention strategies, consistent with other aspects of the Commission's portfolio where the issue is conflated with mental health. He would support adding gun violence to the list of things the Commission studies if there is a focus on innovation solutions. The Commissioner said it all gets back to the basic neurology of the brain, and policies are not fixing that problem. He stated again, the emphasis should be on early intervention.

Chair Madrigal Weiss responded by saying this was not so much a new area, as an effort to dovetail the issue of gun violence with existing projects; and being intentional on what can be learned from it, to inform those projects. The Chair thought the issue has connections to the Commission's work in Prevention and Early Intervention, school mental health and youth, and triage.

Commissioner Tamplen thanked the Chair for the opportunity to have this discussion and focus on the impact of these events on our lives. She saw a connection between gun violence and a lot of the work that the Commission has been doing, consistent with the earlier remarks. She thought it was important to recognize the stigma against people struggling with mental health challenges. She recognized that many members of the Commission have had lived experience, and could see how the media tends to vilify persons who struggle with mental health challenges even though they are more likely to be the victims and not the perpetrators of violence. The Commissioner expressed concern over the tendency to put people with challenges into the court system and forced treatment. She hoped the Commission could create a conversation about a different approach.

Commissioner Bunch wanted to acknowledge Commissioner Danovitch's comments about capacity, adding previously expressed concern about taking on too much. We can't do everything, she said, even if we want to. However, she thought the issue of gun violence was too big to ignore and volunteered to take a leadership role and offer her support in any

Commissioner Chambers agreed with Commissioner Bunch and stated that more work is needed around the trauma of gun violence, particularly for communities of color. As a black peer, and someone who had to witness a 14-year-old being shot and killed, she thought that gun violence by youth is often related to the lack of structured activity and a history of trauma. She agreed with the Chair that the issue of gun violence does intersect with the Commission's mission and could be dovetailed with the Commissioner's work including early intervention.

Vice Chair Alvarez stated that this is an opportunity to follow through on commitments the Commission may have alluded to or wanted to explore in related areas, to be more action-oriented. In saying so, she agreed with earlier comments that the Commission should question the scope of its authority, and its place in this arena. With reference to Commissioner Carnevale's comments, the Vice Chair referred to the recent report on Prevention and Early Intervention insofar in regard to macro-level issues impacting families and communities, that manifest themselves in mental health challenges. There is no denying that these challenges disproportionately impact marginalized communities; in turn, those communities are often the most impacted by gun violence. Vice Chair Alvarez did not necessarily want to see more reports but hoped that the subcommittee could explore action steps the Commission could take in response to work that has already been written. She asked, where can we work effectively with the counties and other partners, and perhaps hold each other accountable? Vice Chair Alvarez thought that such a dialogue would be welcome in the field of mental health and saw this as an opportunity for the Commission to contribute to a conversation that is already happening on a national level. In closing, she cautioned against linking gun violence to mental health challenges in any work done by the subcommittee, given that this is a myth the media tends to perpetuate. The Vice Chair emphasized that the connection between gun violence and mental health is not backed up by research.

Chair Madrigal-Weiss agreed, and stated that the Commission's other initiatives and reports dovetail; in effect, they are braided in with the effects of trauma on mental health. She noted that individual, family and community wellness are all impacted by gun violence.

Commissioner Mitchell spoke to Commissioner Danovitch's concerns about a full plate, saying she agreed but also believes there is an intersection here that needs further exploration. That is, what is the effect of gun violence on community mental health? Commissioner Mitchell supported doing some research in this area, not only as to the impact in California but also across the nation. The speaker spoke to the enormity of this issue, such that it can no longer be ignored. She thought the Commission was obligated to at least address this issue, with supporting data. Commissioner Mitchell appreciated Commissioner Carnevale's approach, insofar as the speaker has long advocated for preventative measures. How can we take steps toward a change in direction on the issue of gun violence and its impact on mental health? It cannot be ignored, she said.

Commissioner Danovitch sought to clarify earlier remarks, recognizing that the new subcommittee was likely to be approved. He agreed that gun violence is a cross-cutting issue that touches on many of the Commission's ongoing activities. He said there are many other broad-based societal issues that have mental health impacts. As such, the Commission should think tactically and strategically about its existing initiatives; and how they are affected by, and could be effective within, this space. Commissioner Danovitch expressed the importance of separating the top-down issues being addressed around core mental health outcomes, from the bottom-up impacts, in order to maintain the Commission's action orientation and continue to make progress.

Commissioner Gordon shared Commissioner Danovitch's concerns on pushing forward before we have done the research on what we are proposing to do. He also noted that the Commissioner has the benefit of law enforcement expertise, although that member is not in attendance today.

Chair Alvarez responded, saying there have been discussions with Commissioner Bill Brown, who sits as county sheriff. He noted the broad-based concern on "not one more silent moment" which cuts across related mental health fields, where the conversations are trying to follow what research is known in this area. He paraphrased their query: Are we acting on feelings, or science and research? The Commissioner suggested that a new subcommittee could bring together subject matter experts to address the research needs.

Commissioner Bontrager spoke, in part to clarify his earlier comments on this issue at the meeting in May. He cautioned against ascribing a mental health issue after a mass shooting, or anything we can't fathom or find illogical. He expressed a concern that the Commission may be doing so unwittingly, in forming this subcommittee. Commissioner Bontrager hoped that its purpose would be more about the mental health impact of mass shootings, not the cause, insofar as a link to mental health could be perceived as causation and distort the issue.

Commissioner Bunch stated that a big part of forming the subcommittee should be to address stigma and take on that myth, specifically to say mental health challenges are not the cause of mass shootings. He hoped to change that narrative.

Public Comment

Steve Leoni stated

- That it is important when putting out messages, whether this is done in a subcommittee or by other means, to be careful about issues of culture, which also includes traditional American rural individuals. In that traditional culture, people have often used guns for many generations. It has been normalized within that culture and integrated into the social structure for hunting and self-defense.
- That gun culture has become unglued from the traditional way of thinking and in many cases people and communities are amenable to psychological interventions of one kind or another. Context should not be forgotten. Many traditional values still exist, especially rural locations, including in rural areas of California.
- That individuals in rural areas often feel unheard. It is important to ensure that individuals in areas where gun culture is normalized are not inadvertently alienated or made to feel even more unheard by what the Commission produces. They are needed as allies.

Theresa Comstock, Chair, State Rehabilitation Council (SRC), stated that the SRC was asked to consider this issue and to give recommendations to the Department of Rehabilitation. The speaker suggested working together, if all Commissions and Councils are being asked to consider this, and maybe designate a liaison from each group to get together to discuss it. The speaker suggested the UC Davis BulletPoints Project as a resource for firearm injury prevention.

Tonya Savice agreed with the previous speaker. The speaker stated children are concerned about how they will be protected at school. It is important to provide resources to help educate students and parents.

Sharon R. Yates, family member and member of the CFLC, suggested that the Commission partner with companies such as the Rand Corporation, FBI, and the UC system to create a study with solutions for each segment of society.

Mark Karmatz, consumer and advocate, suggested partnering with organizations such as Cal Voices and REMHDCO.

Commissioner Discussion

Chair Madrigal-Weiss asked for a motion to approve the creation of a subcommittee to explore opportunities to prevent firearm violence and its impact on individual, family, and community mental health and wellbeing, including strategies to improve understanding of the relationship between mental health and firearm violence.

Commissioner Bunch made a motion to create a subcommittee on firearm violence prevention ensuring that existing initiatives are taken into account, and that the subcommittee is sensitive to issues of stigma.

Commissioner Tamplen seconded.

Commissioner Mitchell observed that there had been several good public comments. In response, she stated that the Commission's work should be exploratory in nature, and collaborative.

Commissioner Mitchel expressed an opinion that it should focus on the impact of gun violence and avoid the linking it to mental health.

Chair Madrigal-Weiss asked if it would be possible to amend the motion. General Counsel Geoff Margolis responded in the affirmative, adding that staff could create a revised version and share it on the videoconference screen. The Chair asked to see it on the screen. General Counsel Margolis conferred briefly with staff, and a new motion was presented. There was further discussion, resulting in a proposal for two friendly amendments:

- Change "opportunities to prevent firearm violence and its impact" to "opportunities to address the impact of firearm violence" in keeping with remarks by Commissioner Mitchell and others.
- Change "the relationship between mental health and firearm violence" to "the relationship of firearm violence and how it impacts mental health with sensitivity to the issue of stigma" in keeping with remarks by Commissioner Bunch.

As a result of this discussion and the proposed amendments, Commissioner Bunch revised the original motion, which was again seconded by Commissioner Tamplen.

Action: Commissioner Bunch made a motion, seconded by Commissioner Tamplen, that:

> *That the Commission approves the creation of a subcommittee to explore opportunities to address the impact of firearm violence on individual, family, and community mental health and wellbeing, including strategies to improve understanding of the relationship of firearm violence and how it impacts mental health with sensitivity to the issue of stigma.*

Motion passed 9 yes, 2 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bunch, Carnevale, Chambers, Chen, Gordon, Mitchell, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioners voted "No": Commissioners Bontrager and Danovitch.

Chair Madrigal-Weiss appointed Commission Bunch as Chair of the Firearm Violence Prevention Subcommittee. She asked Commissioners to reach out to staff if they are interested in participating in the subcommittee.

6: Commission 2022-23 Spending Plan (Action)

Presenter: Norma Pate, Deputy Director

Chair Madrigal-Weiss stated, that the Commission will consider approval of the 2022-23 Fiscal Year Spending Plan and associated contracts. She asked staff to present this agenda item.

Norma Pate, Deputy Director, provided an overview, with a slide presentation, of the MHSOAC budget overview and expenditure plan, Well Beings Initiative contract, and the IT infrastructure contract with Savant Solutions.

Commissioner Comments & Questions

Commissioner Bontrager asked about the one county that was not awarded an MHSSA grant.

Deputy Director Pate stated Alpine County did not have the capacity to support this program.

Commissioner Gordon noted that most students in Alpine County go to school in Nevada.

Public Comment

Anna stated they were glad the Commission is focusing on children and youth. The speaker stated the Ken Burns documentary on suicide prevention uses medical model terminology with words such as "mental illness" and others. A consumer perspective needs to be represented better. The speaker stated that the importance of using recovery language in the film and for viewers to see and hear the message of hope from individuals who look like them.

Elizabeth R. Stone, former CFLC Member, echoed the comments of the previous speaker. The speaker stated concern that the film focuses on illness and symptoms. The instruments that are used to assess mental wellbeing look for symptoms and do not look for wellbeing and resilience. The immediate reaction is to prescribe medications that can be difficult to get off of and have their own cascade of side effects that require additional medications.

Elizabeth R. Stone stated that the follow-up of this film is not recovery, wellbeing, or next steps but to continue to label this as adult mental illness. This is a disservice to individuals living with mental health challenges who have a lot of information and experiences to share with others on how to be contributing members of society. The speaker stated the importance of focusing on resiliency and skills and how to move forward through adversity.

Mandy Taylor

- Agreed with paying attention to language. She referred to the budget line item for the community advocacy contracts and stated these contracts are vital to the community engaging in local and statewide work and building coalition across the state for advocacy within county systems. Community advocacy contracts are also vital for systemwide statewide change and working together.
- Noted that a 70% reduction of funding going to community advocacy and asked if that reduction is caused by the overall budget reduction or to backloading the contracts similar to what was done this cycle. She noted that backloading contracts is problematic because it does not allow contractors to equitably disburse funds to local partners and support local partners. Partners did not have resources to engage in the work until the second or third year. Even more concerning about backloading contacts is that 15 partners will be required to wait years before they can continue getting funding for the work that they are already doing.

Deputy Director Pate stated, no reduction has been made to the community advocacy contracts. Funds were shifted for COVID impacts in prior years that did not affect the community advocacy contracts.

Mark Karmatz asked for additional information about the showing of Ken Burns' documentary.

Andrea Anderson, Chief of Communications, stated that the Ken Burns documentary, *Hiding in Plain Sight: Youth Mental Illness* will be screened on September 22nd at The Sofia, Home of B Street Theater and is available for viewing on pbs.org.

Commissioner Discussion

Chair Madrigal-Weiss asked for a motion to approve the Fiscal Year 2022-23 Spending Plan and associated contracts. Commissioner Bontrager made a motion, seconded by Commissioner Bunch, that:

The Commission approves the Fiscal Year 2022-23 Spending Plan and associated contracts.

The Motion passed 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Bunch, Carnevale, Chambers, Chen, Danovitch, Gordon, Mitchell, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

7: Immigrant and Refugee Advocacy Augmentation (Action)

Presenter: Tom Orrock, Chief, Community Engagement and Grants

Chair Madrigal-Weiss stated, at the January 2022 Commission Meeting, the Commission directed staff to seek additional funding for immigrant and refugee advocacy, including opportunities to increase available funding in the current competitive procurement for the immigrant and refugee community partnership grant program. As a result of those efforts, the 2022-23 California Budget provided an additional $670,000 annually to the Commission for this program. The Commission will be presented with options on how to allocate these additional funds.

Commissioner Chambers recused herself from the discussion and decision-making with regard to this agenda item pursuant to Commission policy.

Chair Madrigal-Weiss asked staff to present this agenda item.

Tom Orrock, Chief, Community Engagement and Grants, provided an overview, with a slide presentation, of the background, immigrant and refugee advocacy, 2022 Request for Proposal, and additional funding from the Legislature.

Commissioner Questions

Commissioner Bontrager asked about federal funding possibilities for immigrants and refugees.

Tom Orrock stated, the Commission could ask these immigrant and refugee organizations led by CPEHN to explore opportunities for federal funding.

Vice Chair Alvarez stated that the commitment of the Administration to expand coverage to undocumented immigrants and the extension of Medi-Cal provides a tremendous opportunity to ensure access to mental health services. She suggested, while exploring how to respond to the needs of particularly marginalized community and implementing strategies, noting the impacts on the work of the grantees and what they are hearing from communities about navigating the system. This will ensure that the Commission is aware of how systems interact so that the dollars being invested at the local level are leveraging the additional public dollars through the Medi-Cal program, which should be the first place to go for resources.

Vice Chair Alvarez expressed the importance of reporting impacts on access and barriers, due to the expansion of Medi-Cal to cover undocumented communities. She suggested regular updates through the Commission or the CLCC to learn what is happening on the ground as these larger policy initiatives are rolled out.

Tom Orrock stated that the state-level advocacy organization can help the local-level organizations with that effort. There is an opportunity to grow a coalition of local organizations that can be supported by the state-level organization to address those types of issues.

Public Comment

Steve Leoni stated, immigrant and refugee needs are immediate. The speaker advocated for getting the funding out as soon as possible.

Anna agreed with the previous speaker. The speaker suggested including a stipulation that grantees reach out to communities for peers with lived experience as refugees and immigrants and with mental health needs to be part of this effort.

Mandy Taylor spoke in support of the current community advocacy contractors and the amazing inclusive work that they are doing.

Stacie Hiramoto thanked the Commission for their commitment to immigrant and refugee communities and for this extra funding.

Gulshan Yusufzai, Executive Director, Muslim American Society (MAS) Social Services Foundation (SSF), echoed the comments of the previous speaker and spoke in support of the comment about the need to support peer-run organizations. She stated that cultural and linguistic abilities and history within an organization are crucial for serving refugees in a way that does not make additional challenges, given the trauma they have already endured.

Commissioner Discussion

Chair Madrigal-Weiss asked for a motion to award contracts of $402,500, over a three-year contract term, to the next four highest scoring Local Program Applicants from the February 2022 Immigrant and Refugee RFP_002, and that the Commission award a $400,000 augmentation to the contract for the State-Level Advocacy organization, from the February 2022 Immigrant and Refugee RFP_003, to

the California Pan-Ethnic Health Network (CPEHN). Vice Chair Alvarez made a motion, seconded by Commissioner Tamplen, that:

> *The Commission award contracts of $402,500, over a three-year contract term, to the next four highest scoring Local Program Applicants from the February 2022 Immigrant and Refugee RFP_002; and that the Commission award a $400,000 augmentation to the contract for the State-Level Advocacy organization, from the February 2022 Immigrant and Refugee RFP_003, to the California Pan-Ethnic Health Network (CPEHN).*

The Motion passed 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Bunch, Carnevale, Chen, Danovitch, Mitchell, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

Chair Madrigal-Weiss asked Tom Orrock to inform the Commissioners and the public of the names of the next four highest scoring local program applicants from the February 2022 Immigrant and Refugee RFP.

Tom Orrock identified the next four highest scoring local-level advocacy organizations are as follows:

- Orange County Asian and Pacific Islander Community Alliance, Inc.
- Vision y Compromiso
- Healthy House within a Match Coalition
- Hmong Cultural Center of Butte County

Mr. Orrock also identified the state-level advocacy organization as follows:

- California Pan-Ethnic Health Network (CPEHN)

Chair Madrigal-Weiss asked for a motion to confirm its awards of $402,500 contracts to these four local-level advocacy organizations, as identified by Tom Orrock. Commissioner Tamplen made a motion, seconded by Commissioner Carnevale, that:

The Commission confirms its awards of $402,500 contracts to these four local-level advocacy organizations:

- *Orange County Asian and Pacific Islander Community Alliance, Inc.*
- *Vision y Compromiso*
- *Healthy House within a Match Coalition*
- *Hmong Cultural Center of Butte County*

The Motion passed 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Bunch, Carnevale, Chen, Danovitch, Mitchell, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

ADJOURN

Chair Madrigal-Weiss stated that the next Commission meeting will take place on September 22nd. There being no further business, the meeting was adjourned at 11:48 a.m.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
August 25, 2022

Motion #: 1

Date: August 25, 2022

Motion:

The Commission approves the July 28, 2022 meeting minutes.

Commissioner making motion: Commissioner Carnevale

Commissioner seconding motion: Commissioner Bunch

Motion carried 8 yes, 0 no, and 2 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Boyd	☐	☐	☐	☒	☐
3. Commissioner Brown	☐	☐	☐	☒	☐
4. Commissioner Bunch	☒	☐	☐	☐	☐
5. Commissioner Carnevale	☒	☐	☐	☐	☐
6. Commissioner Carrillo	☐	☐	☐	☒	☐
7. Commissioner Chambers	☒	☐	☐	☐	☐
8. Commissioner Chen	☒	☐	☐	☐	☐
9. Commissioner Cortese	☐	☐	☐	☒	☐
10. Commissioner Danovitch	☒	☐	☐	☐	☐
11. Commissioner Gordon	☐	☐	☐	☐	☒
12. Commissioner Mitchell	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☐	☐	☐	☒	☐
14. Commissioner Tamplen	☐	☐	☒	☐	☐
15. Vice-Chair Alvarez	☐	☐	☒	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
August 25, 2022

Motion #: 2

Date: August 25, 2022

Motion:

That the Commission approve the creation of a subcommittee to explore opportunities to address the impact of firearm violence on individual, family, and community mental health and wellbeing, including strategies to improve understanding of the relationship of firearm violence and how it impacts mental health with sensitivity to the issue of stigma.

Commissioner making motion: Commissioner Bunch

Commissioner seconding motion: Commissioner Tamplen

Motion carried 9 yes, 2 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
1. Commissioner Bontrager	☐	☒	☐	☐	☐
2. Commissioner Boyd	☐	☐	☐	☒	☐
3. Commissioner Brown	☐	☐	☐	☒	☐
4. Commissioner Bunch	☒	☐	☐	☐	☐
5. Commissioner Carnevale	☒	☐	☐	☐	☐
6. Commissioner Carrillo	☐	☐	☐	☒	☐
7. Commissioner Chambers	☒	☐	☐	☐	☐
8. Commissioner Chen	☒	☐	☐	☐	☐
9. Commissioner Cortese	☐	☐	☐	☒	☐
10. Commissioner Danovitch	☐	☒	☐	☐	☐
11. Commissioner Gordon	☒	☐	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☐	☐	☐	☒	☐
14. Commissioner Tamplen	☒	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary

Commission Meeting
August 25, 2022

Motion #: 3

Date: August 25, 2022

Motion:

The Commission approves the Fiscal Year 2022-23 Spending Plan and associated contracts.

Commissioner making motion: Commissioner Bontrager

Commissioner seconding motion: Commissioner Bunch

Motion carried 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Boyd	☐	☐	☐	☒	☐
3. Commissioner Brown	☐	☐	☐	☒	☐
4. Commissioner Bunch	☒	☐	☐	☐	☐
5. Commissioner Carnevale	☒	☐	☐	☐	☐
6. Commissioner Carrillo	☐	☐	☐	☒	☐
7. Commissioner Chambers	☒	☐	☐	☐	☐
8. Commissioner Chen	☒	☐	☐	☐	☐
9. Commissioner Cortese	☐	☐	☐	☒	☐
10. Commissioner Danovitch	☒	☐	☐	☐	☐
11. Commissioner Gordon	☒	☐	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☐	☐	☐	☒	☐
14. Commissioner Tamplen	☒	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
August 25, 2022

Motion #: 4

Date: August 25, 2022

Proposed Motion:

That the Commission award contracts of $402,500, over a three-year contract term, to the next four highest scoring Local Program Applicants from the February 2022 Immigrant and Refugee RFP_002, and that the Commission award a $400,000 augmentation to the contract for the State-Level Advocacy organization, from the February 2022 Immigrant and Refugee RFP_003, to the California Pan-Ethnic Health Network (CPEHN).

Commissioner making motion: Vice Chair Alvarez

Commissioner seconding motion: Commissioner Tamplen

Motion carried 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
1. **Commissioner Bontrager**	☒	☐	☐	☐	☐
2. **Commissioner Boyd**	☐	☐	☐	☒	☐
3. **Commissioner Brown**	☐	☐	☐	☒	☐
4. **Commissioner Bunch**	☒	☐	☐	☐	☐
5. **Commissioner Carnevale**	☒	☐	☐	☐	☐
6. **Commissioner Carrillo**	☐	☐	☐	☒	☐
7. **Commissioner Chambers**	☐	☐	☐	☐	☒
8. **Commissioner Chen**	☒	☐	☐	☐	☐
9. **Commissioner Cortese**	☐	☐	☐	☒	☐
10. **Commissioner Danovitch**	☒	☐	☐	☐	☐
11. **Commissioner Gordon**	☐	☐	☐	☐	☒
12. **Commissioner Mitchell**	☒	☐	☐	☐	☐
13. **Commissioner Rowlett**	☐	☐	☐	☒	☐
14. **Commissioner Tamplen**	☒	☐	☐	☐	☐
15. **Vice-Chair Alvarez**	☒	☐	☐	☐	☐
16. **Chair Madrigal-Weiss**	☒	☐	☐	☐	☐

Motions Summary

Commission Meeting
August 25, 2022

Motion #: 5

Date: August 25, 2022

Proposed Motion:

That the Commission confirm its awards of $402,500 dollar contracts to the following Local-Level Advocacy Organizations:

- The Orange County Asian and Pacific Islander Community Alliance, Inc,
- Vision y Compromiso,
- The Healthy House within a Match Coalition, and
- The Hmong Cultural Center of Butte County

Commissioner making motion: Commissioner Tamplen

Commissioner seconding motion: Commissioner Carnevale

Motion carried 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
1. **Commissioner Bontrager**	☒	☐	☐	☐	☐
2. **Commissioner Boyd**	☐	☐	☐	☒	☐
3. **Commissioner Brown**	☐	☐	☐	☒	☐
4. **Commissioner Bunch**	☒	☐	☐	☐	☐
5. **Commissioner Carnevale**	☒	☐	☐	☐	☐
6. **Commissioner Carrillo**	☐	☐	☐	☒	☐
7. **Commissioner Chambers**	☐	☐	☐	☐	☒
8. **Commissioner Chen**	☒	☐	☐	☐	☐
9. **Commissioner Cortese**	☐	☐	☐	☒	☐
10. **Commissioner Danovitch**	☒	☐	☐	☐	☐
11. **Commissioner Gordon**	☐	☐	☐	☐	☒
12. **Commissioner Mitchell**	☒	☐	☐	☐	☐
13. **Commissioner Rowlett**	☐	☐	☐	☒	☐
14. **Commissioner Tamplen**	☒	☐	☐	☐	☐
15. **Vice-Chair Alvarez**	☒	☐	☐	☐	☐
16. **Chair Madrigal-Weiss**	☒	☐	☐	☐	☐

AGENDA ITEM 5

Action

September 22, 2022 Commission Meeting

Early Psychosis Programs

Summary: The Mental Health Services Oversight and Accountability Commission will hear an update on the multi-county Early Psychosis Learning Health Care Network Innovation Project and the Early Psychosis Intervention Grant Program.

Psychosis is a term used to describe conditions that affect the mind where a person's thoughts and perceptions are disturbed and there is a loss of contact with reality (National Institute of Mental Health, 2016). Key features that define the psychotic disorders are: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior, and negative symptoms (American Psychiatric Association, 2013).The National Institute of Mental Health presents the following facts about psychosis: about 8,000 adolescents and young adults in California experience a first episode of psychosis each year (100,000 nationwide); psychosis often begins when a person is in their late teens to mid-twenties; and psychosis affects people from all walks of life (2016). Unfortunately, those who do experience symptoms of psychosis often go face delays in accessing care than last for a year or more (Addington, et al 2015).

Early Psychosis Learning Health Care Network Innovation Project

The Commission, in partnership with the UC Davis Behavioral Health Center of Excellence and others, has established a collaborative Learning Health Care Network (LHCN) to improve access to evidence-based and best-available care for Californians experiencing psychosis early in the development of their needs.

Less than half of California counties have an early psychosis program and existing programs are not consistently offering evidence-based care despite the availability of model programs. To move toward the goal of ensuring that all Californians have access to the most effective care, the Commission has supported the development of this learning collaborative, technical assistance and training, a unified data reporting strategy to ensure fidelity to models of care, and strategies to support sustainable financing of best practices.

All county programs participating in this collaborative operate variations of the Coordinated Specialty Care (CSC) model, an internationally recognized evidence–based practice (Azrin, Goldstein, Heinssen, 2016). The LHCN seeks to create the necessary infrastructure in California to gather real-time data from clients and their family members in existing EP clinic settings that use the CSC model. Data will be collected through a tablet application using a questionnaire.

The collection of data and subsequent aggregation will allow programs to learn from each other and provide the support necessary to participate in the development of a national network that will inform and improve care for individuals with early psychosis across the US.

Eight counties are currently participating in the Early Psychosis Collaborative: Los Angeles, Orange, San Diego, Solano, Napa, Sonoma, Stanislaus and Kern Counties. In addition to the UC Davis Behavioral Health Center of Excellence, other partners include One Mind, Stanford University, UC San Francisco, UC San Diego, and the University of Calgary.

The LHCN developed and now utilizes a digital platform called Beehive to gather real-time data from clients and their family members in existing EP clinic settings and includes training and technical assistance to program providers.

The value of the project will be examined through a statewide evaluation that will assess the impact of the LHCN on consumer and program level metrics, as well as utilization and cost rates of EP programs.

Counties Participating:

COUNTY	Total INN Funding Requested	Local Costs for Admin and Personnel	Contractor/ Evaluation	% for Evaluation	Duration of INN Project
Los Angeles	$4,545,027	$1,575,310	$2,969,717	65.34%	5 Years
Orange	$2,499,120	$1,573,525	$925,595	37.04%	5 Years
San Diego	$1,127,389	$201,794	$925,595	82.10%	5 Years
Solano	$414,211	$291,399	$122,812	29.65%	5 Years
Napa	$258,480	$218,820	$39,660	15.34%	4.5 Years
Sonoma	$475,311	$230,347	$244,964	51.54%	4 Years
Stanislaus	$1,564,633	$1,140,585	$424,048	27.10%	5 Years
Kern	$1,632,257	$1,180,432	$451,825	27.68%	4 Years
Total	**$12,516,428**	**$6,412,212**	**$6,104,216**	**48.77%**	

Kern County, which was recently approved to join the EP-LHCN, is also addressing local fragmentation and better serving individuals with some of the highest levels of need through an EPI-Plus grant which is funding the creation of their first Coordinated Specialty Care (CSC) program. Kern will use the grant award to implement a multidisciplinary team to deliver a range of specific services including qualified professional to provide both case management and specific service elements including nursing services, evidence-based psychotherapy, addictions services, supported employment, family education and support, social and community living skills and case management.

Early Psychosis Intervention Grant Program:

In 2017 AB 1315 (Mullin) established the Early Psychosis Intervention Plus Program (EPI Plus). The Commission's 2019-20 budget included $19,452,000 to expand and improve the fidelity of existing early psychosis and mood disorder detection and intervention services.

In August 2020, the Commission awarded grants to Kern, Lake, San Francisco, Santa Barbara, and Sonoma Counties. After awarding these funds, the Commission retained a balance of $5,565,000 for additional expansion and services that would support early psychosis intervention activities.

In November 2020, the Commission approved recommendations from an Early Psychosis Advisory Committee to allocate those funds as follows:

1. Expand access to care by allocating $4 million to support two additional programs. Those funds were awarded to Santa Clara County and Nevada County, with Nevada supporting a Hub and Spoke model that supports services offered through Colusa and Mono counties.

2. Invest $1 million in workforce development, workforce retention, and public awareness of the early symptoms of psychosis. These funds have not been allocated.

3. Devote $565,966 to research initiatives which would explore the barriers to care and improved access for diverse populations and improve reimbursement models for public and private coordinated care models. These funds have not been allocated.

In addition to these funds, the Commission also has approximately $1.8 million available for new grants. Santa Barbara County has elected to not pursue its initial early psychosis program because of critical staffing shortages. A letter from the county on this matter is attached.

Training and Technical Assistance

Dr. Tara Niendam, Ph.D., Associate Professor in Psychiatry, Executive Director, UC Davis Early Psychosis Programs, who is also the Commission's Training and Technical Assistance contractor for the LHCN and EPI Plus Grant Program, will provide information about the challenges and opportunities that exist in California for expansion of evidence-based programs to address the needs of individuals experiencing a first episode of psychosis.

Her testimony will cover the following themes:

- Lessons learned and initial challenges
- Building the LHCN and EPI Plus program to address the challenges
- Outline of the Coordinated Specialty Care clinic model and expanded interest
- The burden of data collection and service delivery to rural counties
- Learning goals and objectives
- Opportunities for multi-county collaborations
- Potential to link the work to other Commission initiatives

Additional Funding Options:

Option A (Recommended)
Augment returned funds with retained funding and award $2 million to the next highest scoring applicant from the initial EPI Plus procurement.

Pros	Cons
• Ensures that all EPI Plus grant funds will be utilized to launch Coordinated Specialty Care (CSC) programs. • Keeps consistent the current number of grantees. • Expedites the funding for CSC program funding.	• No additional applications will be accepted, and only one organization that applied in the original procurement would be eligible to receive funds.

Option B
Release a new Request for Application and award funds to the most qualified applicant.

Pros	Cons
• Additional organizations would be able to submit applications and participate in the grant program.	• A new competitive bid process will delay efforts to launch programs that address first episode psychosis by approximately 6-9 months.

Enclosures (6): (1) Biography for UC Davis Presenter; (2) Annual Innovation Report, EP LHCN Multi-County Innovation Project, Fiscal Year 2019/20; (3) Annual Innovation Report, EP LHCN Multi-County Innovation Project, Fiscal Year 2020/21; (4) Santa Barbara letter; (5) EPI Plus Grant Program Summaries; (6) Training and Technical Assistance Quarterly Report (Y2Q2)

Handout (1): PowerPoint will be presented at the meeting.

Early Psychosis Programs
Biography UC Davis Presenter

Tara Niendam, Ph.D. Professor in Psychiatry, UC Davis. Executive Director, UC Davis Early Psychosis Programs (EDAPT & SacEDAPT Clinics).

Dr. Niendam's research uses mobile health technology to enhance early identification and treatment of youth and young adults with serious mental illness, with a focus on improving clinical and functional outcomes. The new EPI-CAL project, led by Dr. Niendam in partnership with UC San Francisco, UC San Diego, University of Calgary, The One Mind ASPIRe program, and multiple California counties, will bring client-level data to the clinician's fingertips, and enable large scale data-driven approaches to improve outcomes for EP care. She also directs the EPI-CAL affiliated Training and Technical Assistance Center, which seeks to bring evidence based early psychosis care to all Californians.

Mental Health Services Act

FY 2019/20 Annual Innovation Report: Early Psychosis Learning Health Care Network

Final version submitted December 9th, 2020

Prepared by:

University of California, Davis, San Francisco and San Diego

This report was supported by:

ONE MIND

National Institute of Mental Health

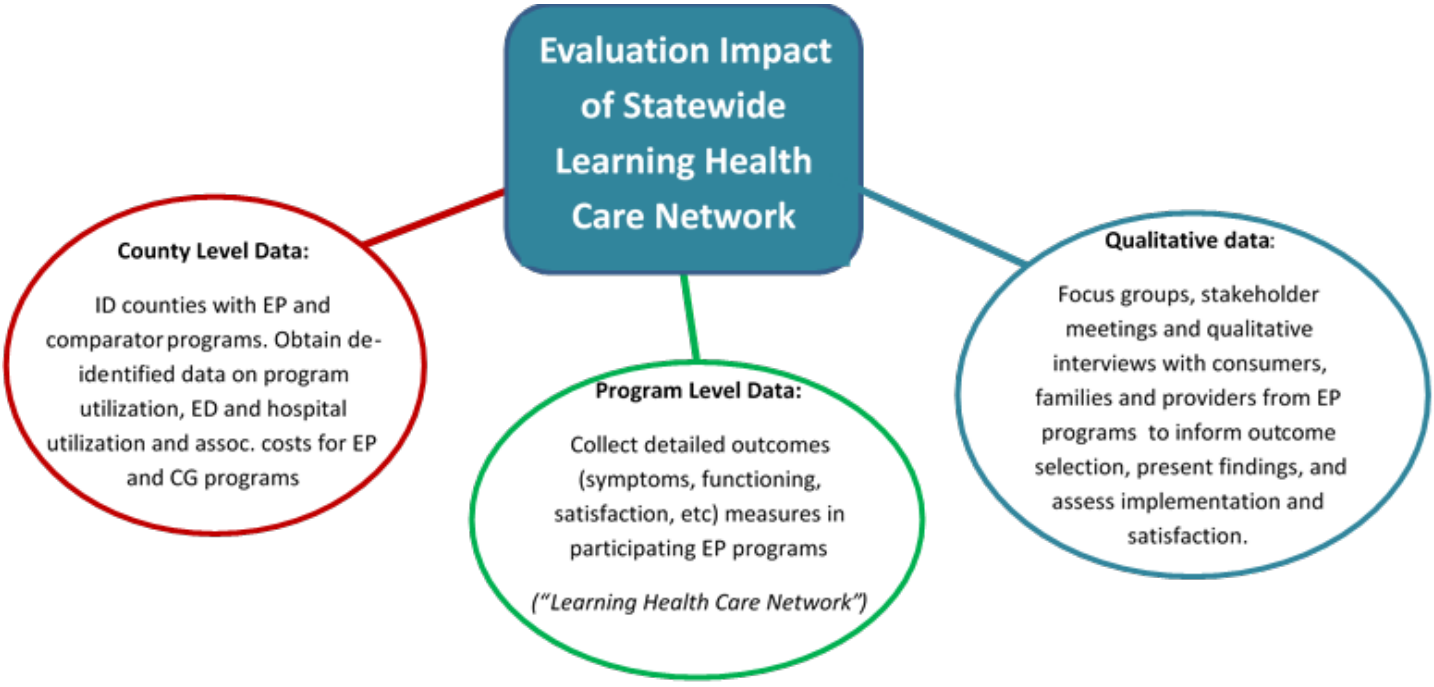
Table of Contents

Background

Multiple California counties (Solano, San Diego, Los Angeles, Orange), in collaboration with the UC Davis Behavioral Health Center of Excellence, received approval to use Innovation or other Prop 63 funds to develop infrastructure for a sustainable learning health care network (LHCN) for early psychosis (EP) programs. One Mind has also contributed $1.5 million in funding to support the project. Napa and Sonoma counties have also been approved to use Innovation funds to join the LHCN and are slated to join the project in the coming months. This Innovation project seeks to demonstrate the utility of the network via a collaborative statewide evaluation to assess the impact of the network and these programs on the consumers and communities that they serve. This project, led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary and multiple California counties, will bring consumer-level data to the providers' fingertips for real-time sharing with consumers, and allow programs to learn from each other through a training and technical assistance collaborative. This Statewide EP Evaluation and LHCN proposed to 1) increase the quality of mental health services, including measurable outcomes, and 2) introduce a mental health practice or approach that is new to the overall mental health system. The project must comply with the regulatory and funding guidelines for evaluation as stipulated by the applicable Mental Health Services Act (MHSA) funding regulations, contract deliverables, and best practices.

There are three components to the data collected for the LHCN: County Level, Program Level, and Qualitative data (Figure 1). Each component of the proposal must be reviewed by an Institutional Review Board (IRB) and approved before commencement of data collection. Further, aspects of the data design will be shaped by the input of stakeholders, including mental health consumers, family members, and providers.

Figure 1. Three Components of the Evaluation Associated with the Statewide LHCN.



This project was approved for funding using Innovation Funds by the MHSOAC in December of 2018. The California Early Psychosis Learning Health Care Network (LHCN) represents a unique partnership between the University of California, multiple California counties, and One Mind to build a network of California early psychosis (EP) programs. Our team has made significant progress towards our goals outlined in the innovation

proposal during the 19/20 fiscal year.

Executive Summary

The purpose of this document is to provide the EP LHCN Mental Health Services Act (MHSA) Annual Innovation Report to review EP LHCN goals accomplished during FY2019/20. This report will include summaries and status updates on the infrastructure of the LHCN, steps taken towards implementation, and barriers that have been identified over the course of the last fiscal year. While the counties involved in the EP LHCN may be at different stages in the process, the overarching LHCN is moving forward as planned. It is important to note that we will not be reporting on MHSOAC participant demographics in the current report as we are still in the pre-implementation phase. While we have collected feedback on various components of the project from a wide range of stakeholders, this feedback is qualitative in nature and is used to better inform the design of the project and program-level intervention. Thus, we will not be reporting participant-level demographic data until data collection begins on the tablet in the LHCN programs.

- Prior to beginning activities for the LHCN, UC Davis had to have an executed contract with each of the participating counties so each party could mutually agree to a scope and terms of work. As of June 2020, UC Davis had executed contracts with Solano, San Diego, and Orange counties. In addition to existing LHCN counties, Sonoma County has received approval to join the LHCN. We are working together to execute their contract before officially beginning activities in their county program.
- All planned research activities have been reviewed and approved by the University of California (Davis, San Francisco, and San Diego) Institutional Review Boards. We have also worked closely with each county to ensure proper human subjects research review has occurred where applicable.
- A major goal of this project period was to finalize outcome domains and measures to be collected from LHCN EP clinics. During the last year, we have conducted 19 focus groups to understand what outcomes stakeholders consider to be most critical to collect in their EP clinic. Participants across sites heavily favored functioning, quality of life/well-being, recovery, and psychiatric symptoms. Functioning was the most frequently endorsed domain across all stakeholder roles. This process has significantly improved our understanding of what stakeholders consider important data to collect during EP care and how to collect it. Throughout the focus groups, stakeholders were highly engaged in the process, and readily shared their perspectives.
- Quorum and the UC Davis research team have worked collaboratively to develop the wireframe for the tablet and web-based applications. We held focus groups to obtain feedback on the application and dashboard's design, flow, and functionality. Our research team synthesized the feedback for the developers for application development; we have endeavored to balance consumer and family needs with provider and staff needs. Overall, stakeholders approved of the look and feel of the application.
- We have held an LHCN Advisory Committee meeting, which was comprised of a county representative from each participating county, a clinical provider from each participating EP program, and consumers and family members who have been or are being served by the participating programs. We will hold Advisory committee meetings on a bi-annual basis.
- In the coming year, we plan to begin testing in application in EPI-CAL/LHCN clinics, starting with alpha testing, beta testing, then full deployment across the network. We have selected two programs in the LHCN network for beta testing.
- In order to prepare for our county-level data evaluation component of the LHCN, we identified and finalized available county-level data, data transfer methods, and statistical analysis methods.
- In the LHCN proposal, we proposed to ask consumers and providers to complete self-report questionnaires. Over the last year, 100 EP program providers and staff completed our first set surveys on E-Health readiness, comfort with technology, and basic demographics.
- A key objective of establishing the LHCN was to enhance California's ability to participate and learn from EPINET, a National Institute of Mental Health funded collaborative linking regional scientific hubs of EP programs across the country. Our application outlined how the initial investment into California's LHCN by five counties and One Mind laid the groundwork for the infrastructure and resources to join EPINET as a regional scientific hub. We were awarded the EPINET R01 in late 2019 and added two

counties and five university sites to our all-encompassing California EP Learning Health Care network project (EPI-CAL).

LHCN Project Goals

The current document summarizes project activities for the LHCN from the first full year of the project. This includes the following project activities as outlined in the original LHCN proposal:

1. Developing and executing a contract with each participating LHCN County

2. Completion and approval of the Institutional Review Board (IRB) protocol covering all aspects of Learning Health Care Network and statewide evaluation data collection

3. Selection of an external company to develop Learning Health Care Network (LHCN) platform application

4. Recruiting for external Advisory Committee and initiation of Advisory Committee Meetings

5. Identification and prioritization of outcomes of interest based on stakeholder feedback

6. Development of wireframe for application submission for review by contractor and stakeholders

7. Selection of and coordination with two counties for beta testing of LHCN app

8. Identification of county-level available data and data transfer methods, and statistical analysis methods selected for integrated county-level data evaluation

9. Finalize methods for multi-county-integrated evaluation of costs and utilization data

10. Initiate LHCN pre-implementation questionnaires

Selection of California's LHCN Project for Inclusion in National EPINET Project

One of the goals of establishing the LHCN was to enhance California's ability to participate and learn from a newly established national network of EP programs and data systems, the Early Psychosis Intervention Network (EPINET). EPINET is a collaboration linking regional scientific hubs across the country that are each connected to multiple EP programs, funded by the National Institute of Mental Health (NIMH). EPINET seeks to identify and collect a standard set of measures from EP programs across the country to improve EP care, standardize outcome measures, examine contributors to variation in outcomes, and elucidate new questions for early psychosis research. Our application to the NIMH outlined how the initial investment into California's Learning Health Care Network by five counties and One Mind laid the groundwork for the infrastructure and resources to join EPINET as a regional scientific hub and network. We were awarded the EPINET R01 in late 2019 and were able to add two counties (Sacramento and San Mateo) and five university sites (UC Davis, Stanford, UCSF, UCLA, UCSD) to our all-encompassing California Early Psychosis Learning Health Care network project (EPICAL). There will be some procedural differences between programs that participate in both LHCN and EPINET (Los Angeles, San Diego, Orange, Solano and Napa) or just EPINET (Sacramento, San Mateo, UC Davis, Stanford, UCSF, UCLA, UCSD); for example, only counties in the initial LHCN project will be participating in the county-level data component of this project. All EPI-CAL sites will participate in the qualitative component (e.g., stakeholder input to identify core outcome domains and measures), EP program fidelity evaluations, and program-level data collection across sites.

This opportunity to join the national network of EP programs will allow our regional California network to gain insight into best practices from 58 coordinated specialty care (CSC) programs across nine states, and to influence national EP standards of care. Additional research goals of the national network are to use this information to reduce duration of untreated psychosis, mitigate suicide risk factors, improve treatment engagement using technology, improve cognition and motivation, and determine the optimal duration of CSC for those experiencing first episode psychosis.

As part of our continued participation as a hub in the EPINET project, Dr. Niendam has participated in multiple in-person and teleconference meetings to harmonize outcomes and discuss potential measures with the EPINET National Data Coordinating Center (ENDCC) and the other EPINET hubs. Dr. Niendam has presented data from our outcomes focus groups (described below) to support outcomes prioritization at the national level. Our participants in our California LHCN are not only helping us prioritize measures for California, but for the nation's EP programs as well.

1. Developing and executing a contract with each participating LHCN County

Before any work on the LHCN could begin, UC Davis had to have an executed contract with each of the participating counties so each party could mutually agree to a scope and terms of work. As of June 2020, UC Davis had executed contracts with Solano, San Diego, and Orange counties. Each county had slightly different contracting processes and therefore contracts were not all executed at the same time. The Solano County contract was executed on April 6, 2019. The San Diego County contract was executed on October 15, 2019. Orange County proceeded with the plan to contract with UC Davis through CalMHSA. The contract between UC Davis and CalMHSA was executed on January 3, 2020. While the contract with Los Angeles county was undergoing review, it was not fully executed until July 1, 2020. UC Davis is currently working with our partners in Napa and Sonoma counties to develop their contracts.

2. Completion and Approval of the IRB protocol covering all aspects of Learning Health Care Network and statewide evaluation data collection

Starting in January of 2019, staff at UC Davis prepared an IRB protocol to cover all aspects of work that will be performed as part of the LHCN and statewide evaluation. This initial application was submitted for review to University of California, Davis' IRB on April 17, 2019 and UC Davis received full approval from our IRB for the LHCN project on July 17, 2019. Since then, we have made several modifications to our IRB to accommodate minor changes to the consenting process or focus group guides. We added translated materials to hold Spanish-language focus groups for the outcomes selection. We have also had all of the necessary documentation approved for UCSF and UCSD to rely on our UC Davis Single IRB.

In addition to our IRB at UC Davis, our team has worked to make sure that each county has reviewed all proposed human subjects research activities. Each county has their own process and procedures for this review, summarized below:

Solano County
Prior to conducting initial site visits and focus groups in Solano County, we contacted county administrators to inquire if there is a formal review process in their county for human subjects research. Solano County informed us that there is not a formal IRB in Solano County and we sent our IRB protocol, approved by UC Davis, for their records. The county is currently in the process of inquiring if any other actions are needed at this time.

San Diego County
San Diego County has an internal Behavioral Health Research Committee that reviews potential research

proposals. Their procedure includes presenting these research proposals to the committee with an IRB approval established and in place at our institution (UC Davis). However, if the research activities are covered in the scope of our contract with San Diego County, an additional review of research proposals is not required. In our case, all research activities are described in our contract, and thus, we did not have to present a proposal to the Behavioral Health Research Committee.

Los Angeles County
Los Angeles County Department of Mental Health (LACDMH) requires human subjects research projects involving LACDMH programs, staff, and data, to be reviewed by the LACDMH Human Subjects Research Committee (HSRC). In addition to completing an application, LACDMH asks for consent documents, recruitment materials, evidence of PI Qualifications, IRB of Record documents including application and approval letter, and an oath of confidentiality agreements. UC Davis staff had several clarification calls and emails with LACDMH staff during the preparation of this application. We submitted the application to LACDMH HSRC for review on November 25, 2019. The HSRC initiated calls and emails for clarification of various aspects of the application. After HSRC approval, LACDMH Data Security and Privacy Officers completed the final stage of the review process. Our Human Subjects Research Application was approved on April 23, 2020.

Orange County
Orange County staff submitted our approved UC Davis IRB protocol of record and stamped consent forms to their county IRB. The county required the application to be signed by all project PIs. After a review period, our application was approved on January 17, 2020, and we were granted the ability to conduct human subjects research in Orange County.

Napa County
Our approved UC Davis IRB protocol of record and stamped consent forms were submitted to Napa County on January 31, 2020 and are currently under review.

3. Identification of an external company to develop LHCN platform application

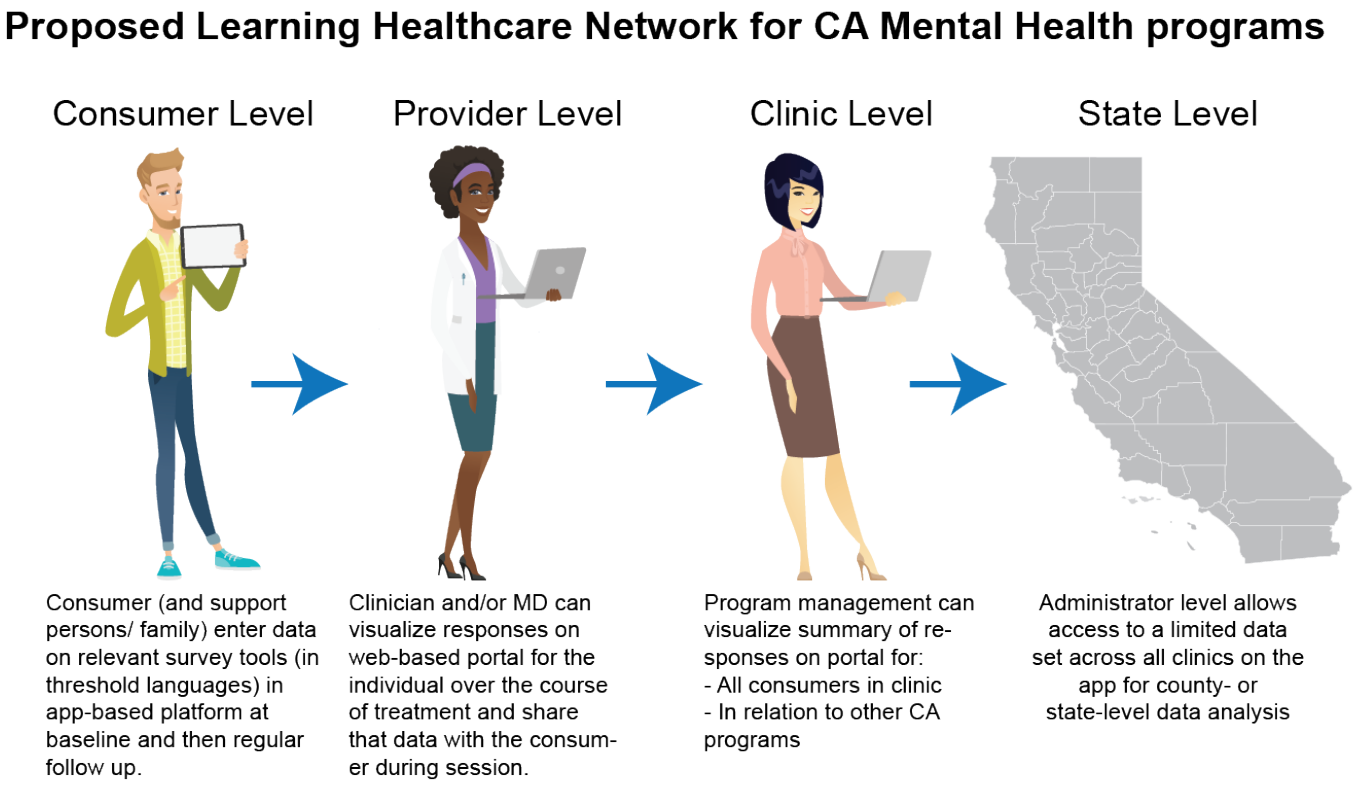
One of the goals of the project period was to identify and select an external company to develop the LHCN platform and application. We have proposed Quorum Technologies as our developer as they have already built two applications for research purposes with UC Davis. Quorum is a Sacramento-based company that specializes in health care application development and creation of integrated specialty applications for large health systems. We have previously contracted with Quorum to build two applications - MOBI and the Duration of Untreated Psychosis (DUP) PQ-B screener application - for research purposes. Currently, UC Davis holds the rights to the MOBI application, which will serve as the foundation for the LHCN application. Due to its prior knowledge of MOBI, Quorum has participated in multiple calls with stakeholders and worked with IT teams across the state to address security needs for MOBI to work for this project. Quorum has an established team located in Sacramento that is ready to modify MOBI for the current project. Their knowledge of the healthcare landscape of California, local staff that can be deployed for project meetings, or stakeholder engagement related to the project, and intimate knowledge of the application makes them uniquely capable of executing this project. UC Davis Health approved our sole source justification for Quorum Technologies, and we signed a Purchase Agreement to establish Quorum as our vendor to build the application. Since then, our team has been working closely with Quorum to provide feedback and direction for the development of the custom LHCN application.

We have also worked with individual counties to ensure that the application Quorum builds will meet their individual county's IT security standards before the application is released in each program. Thus far, UC Davis has facilitated a few conversations between Orange County INN Staff, Orange County Health Care

Agency (HCA) IT, and the Quorum staff in order to discuss Orange County HCA IT security vetting process of the Quorum platform. This has included sharing the UC Davis Health System's IT security vetting process for Quorum with OC HCA IT. In addition to the University's security vetting procedures, OC HCA has shared their own documentation with UCD and Quorum to complete before the application is rolled out. We are in the final stages of signing a data use agreement with Orange County to cover data sharing terms, as well.

The application will serve as the basis of the program-level data component of the LHCN to collect consumer, provider, and clinic level data (Figure 2). The application will visualize consumer-entered data for use in care, and for analysis at the clinic and state level.

Figure 2. Proposed LHCN Application Workflow for CA Mental Health Programs



4. Recruitment for external Advisory Committee and focus groups

The Advisory Committee for the LHCN will be comprised of a county representative from each participating county, a representative of each participating EP program, and up to five consumers and five family members who have been, or are being served, by the participating programs. This committee will be co-led by Bonnie Hotz, family advocate from Sacramento County, and a Peer Advocate, who is yet to be determined.

Recruitment for the Advisory Committee has been ongoing, and we have confirmed membership with multiple stakeholders. These include past consumers, family members, and clinic staff and providers. We are continuing to recruit interested individuals through the participating programs as new programs join the LHCN. We held the first Advisory Committee meeting on May 8, 2020, which was held remotely. We had the call-in option because we have not been meeting in person for non-essential tasks due to the COVID-19 pandemic. During this call, we gave a brief overview of the project for the attendees who were recently recruited. We then went over the progress to date on different components of the project, starting with updates on focus groups,

surveys, and county data analysis. We were not able to get through all of the planned content and held a follow-up meeting in July 2020.

Even though we have already held our first Advisory Committee meeting, we are continuing to distribute flyers (Appendix I) to all participating clinics, as their contracts are coming through, to make sure the Advisory Committee is open to all LHCN member clinics.

5. Identification and prioritization of outcomes of interest based on stakeholder feedback

A major goal of this project period was to finalize outcomes to be collected for the duration of the project. While we identified candidate measures during the proposal phase of the project, we did not want to be prescriptive when it came to the data to be collected in the program evaluation component within the clinics. Instead, we wanted our stakeholders, including providers, staff, consumers and families, to inform the selection of outcomes of interest. Stakeholders joined from participating LHCN clinics, as well as from our greater EPI-CAL network (Table I). While we have continued to hold additional focus groups in recent months since the execution of the Los Angeles County contract, the data presented here is a summary through June 30, 2020 only.

Methods

Study Design
A semi-structured qualitative focus group study was completed to explore stakeholder opinons on how and what data should be collected within the Learning Health Care Network. The data collected was analyzed utilizing a mixed-methods design, incorporating both qualitative and quantitative methods. The findings of this investigation were used to inform the construction of the LHCN core battery.

Participants
Eligible participants included providers, consumers, and family members of consumers who either deliver or receive care at one of the 13 EPI-CAL early psychosis care sites. The list of eligible programs is presented in Table I. For the Spanish-speaking groups, participants were eligible to take part if they identified Spanish as their primary language, and were sufficiently competent in written and conversational Spanish to participate in the focus groups. In order to ensure that the sample recruited best represented the stakeholders who deliver or receive care in the participating programs, no other inclusion/exclusion criteria were adopted.

Table I: Participating EPI-CAL Early Psychosis Program Sites

LHCN/EPINET	County/University	Program
LHCN/EPINET	Solano	Aldea SOAR
	Orange	OCCREW
	Los Angeles	PIER-LA
	San Diego	Kickstart
	Napa	Aldea SOAR
EPINET only	UCLA	Aftercare
	UCLA	CAPPS program
	UCSF	Path Program
	UCSD	CARE clinic
	Stanford	Inspire Clinic
	UC Davis	EDAPT

	Sacramento	SacEDAPT
	San Mateo	(re)MIND|BEAM

In order to explore possible differences in data collection preferences and priorities by provider role, each provider participant was categorized by their role, determined via self-report. The list of possible categories providers could identify as are specified in Table II. In cases where providers could meet criteria for multiple roles (i.e., a team lead who may also work as a clinician for the program), the providers were advised to select the role that best represents their primary function to the program.

Table II: Provider Categories in the Focus Groups

Provider Role	Description
Clinicians	Licensed behavioral health clinicians that are directly involved in the delivery of clinical care.
Coordinators/Administrators	Provider that has non-clinical direct contact with consumers and families
Medical Personnel	Includes prescribers, psychiatrists, and nurses – Individuals whose primary responsibility relates to the review and delivery of medication
Clinical Supervisor/Team Lead	Includes program directors, team leaders, and licensed clinicians whose primary role involves the supervision of other clinicians
Senior Leadership	Include senior clinic leadership, and county administrators – No direct delivery of consumer services
Other CSC providers	Includes Family Advocates, Peer Support Specialists, Case Managers, Recovery Coaches, and Supportive Employment and Education Specialists

Procedures

The process for conducting the groups was completed across three discrete steps: the domain and scale selection process, the development of the focus group guides, and then the recruitment and delivery of the focus groups. The details for each step are specified below.

Domain and Scale Selection Process

The preliminary domains of interest were selected based on findings detailed in the summary report of the prior county engagement process, undertaken to develop the statewide process (Niendam et al., 2018). As part of this process, six California counties who had expressed an interest in participating in the statewide evaluation, along with their corresponding EP programs, were sent a consultation packet and interviewed by a member of the evaluation team. Each meeting was recorded using software embedded in the teleconference software (Zoom). As part of this interview, participants were asked the following question:

> "What are the questions you want answered from this evaluation? What are the key outcomes or impacts that you would like to show from your program to: consumers/families, county/state, program staff, and community stakeholders?"

In the stakeholder meetings, county and program staff consistently emphasized the adoption of outcome measures designed to capture changes in consumer functioning and quality of life. Areas of particular interest

highlighted by participants included homelessness and housing instability; consumers' perception of wellness; the attainment of consumer goals; justice involvement, including convictions and recidivism; suicide, suicide prevention, and self-injurious behaviors; changes in aggressive and/or violent behaviors; changes in consumer distress; and changes in general functioning. These areas of priority were broadly consistent with the domains identified as being potentially associated with, or impacted by, participation in EP programming as part of the review process conducted in the MHSOAC Proposed Statewide Evaluation of EP programs report (Niendam et al., 2017). In this review, a preliminary list of eight outcome variables were identified: (1) healthcare utilization, (2) justice involvement, (3) homelessness, (4) education, (5) income and employment, (6) social and family relationships, (7) clinical disability, and (8) suicide. These lists were combined into the preliminary domain list for inclusion in the core battery, presented in Table III.

Table III: List of the Proposed Domains to Include in the Learning Health Care Network Data Collection Battery

Domains	Definitions Proposed
Clinical Status	Diagnosis, medication, date of onset, and remission status.
Psychiatric Symptoms	The presence of clinical symptoms (e.g. anxiety, depression, mania, hallucinations, paranoia, etc.).
Suicide Risk	The presence of thoughts, wish, plan, or behavior aiming to end one's life.
Service Satisfaction	How satisfied an individual is with the mental health services they receive.
Service Utilization	How often health services are used or received.
Quality of Life / Well-being	How satisfied an individual is with how they live their life (past, present, future).
Recovery	The individual's belief they can live a meaningful life, meet goals they consider important, and develop support to maintain wellness outside treatment.
Risk for Homelessness	History of homelessness or insecure/unstable housing (i.e., couch surfing) and things that increase the risk of homelessness (e.g., foster care, unsteady income).
Incarceration / Recidivism	Experience of arrest, probation, or parole.
Functioning (Social / Role)	An individual's ability, interest, and engagement in employment, volunteering, homemaking, and/or school; and their quantity, quality, and engagement in social relationships with friends.
Cognition	The individual's ability to solve problems, pay attention, process and remember information, or do things quickly.
Family Burden	The impact of a loved one's mental illness on the support person's life.
Family Functioning	How well a family communicates/functions how accepted members feel within the family, and reactions to family problems or successes.
Medication Side Effects	The presence, duration, and severity of medication side effects.
Medication Adherence	Taking medication the way the doctor prescribes (i.e., every day, time of day).

With a preliminary list of domains selected, the next stage was to identify a list of all possible measurement tools to collect data pertaining to each domain. The tools identified were primarily sourced from the PhenX Toolkit (https://www.phenxtoolkit.org/index.php). The PhenX toolkit is a list of non-proprietary data collection measures and protocols identified as being appropriate for biomedical research. The toolkit is divided by disease area, and measures for each area are selected by working groups chaired by domain experts. As part of this project, measures identified as appropriate for use with an early psychosis population by the Early Psychosis Working Group (Dixon et al., 2019), were considered as appropriate for inclusion. The list of scales considered appropriate are detailed in Table IV. The PhenX Workgroup was not able to identify sufficiently low-burden, validated, and reliable measures assessing for outcomes related to risk for homelessness, and so items to measure this construct will be developed by the UC Davis evaluation team. Regarding other proposed domains not represented in the PhenX toolkit, it was proposed that data related to clinical status (i.e., diagnosis, remission status, etc.) could be collected by an adapted form used in the Mental Health Block Grant (MHBG) evaluation.

Table IV: Proposed Measures for each Outcome Domain

Domain	Proposed Measure
Suicide Risk	Suicidal Behaviors Screening Questionnaire-Revised (SBQ-R) Columbia-Suicide Severity Rating Scale (C-SSRS)
Service Satisfaction	MHSIP Youth Services Survey (YSS)
Recovery	Recovery Self-Assessment (RSA) Questionnaire about the Process of Recovery (QPR)
Quality of Life/Well-Being	Lehman Quality of Life Scale Personal Well-being Index (PWI)
Incarceration/ Recidivism	The National Survey on Drug Use and Health (NSDUH)
Functioning	Global Functioning: Social and Role scales (GF-S and GF-R) UCD derived self-report option of social and role domains
Cognition	Penn *Computerized Neurocognitive Battery (CNB)* Matrix Reasoning Test (PMAT), Word Memory Test (PWMT), Digit Symbol Substitution Test (DSST)
Family Burden	Burden Assessment Scale (BAS)
Family Functioning	Systematic Clinical Outcome Routine Evaluation (SCORE-15) Expressed Emotion Scale: Family Communication (EES)
Clinical Status	MHBG Minimum Data Set version 7.3 – diagnosis, past/present psychosocial treatment, medications
Medication Side Effects	Glasgow Antipsychotic Side-effect Scale (GASS) Extrapyramidal Symptom Rating Scale (ESRS)
Medication Adherence	Brief Adherence Scale (BARS)
Psychiatric Symptoms	Modified Colorado Symptom Index (MCSI) Brief Psychiatric Rating Scale (BPRS)
Service Utilization: Psychiatric Hospitalization	County hospitalization records Self-report of hospitalization

Service Utilization: Emergency or Crisis Stabilization	County ED/crisis stabilization unit records Self-report of ED or crisis utilization
Service Utilization: Outpatient	Service unit records by outpatient program
Risk for Homelessness	Items to be developed by the UC Davis evaluation team

Focus Group Guide Development

Following the completion of the preliminary list of domains and their corresponding measures, interview guides were developed by the qualitative evaluation team, and then reviewed by the broader evaluation team. To account for the different degree of background knowledge different stakeholders are likely to have regarding the project and its aims, different guides were developed for the provider, and for consumer and family member groups. An example guide is presented in Appendix II. To ensure consistency in the starting point for the discussions in regard to the terms used, a definition of terms sheet was developed for all focus group participants, based on the definitions outlined in Table III. For the Spanish-speaking groups, these documents were translated by a Spanish-speaking member of the evaluation team (RB).

The interview guide was piloted in October 2019 at our first site visit in Solano County, and was updated incrementally based on the feedback and participant responses during each focus group.

Focus Group Recruitment and Delivery

Following the execution of the relevant county contracts and IRB approval by UC Davis and county review boards (where appropriate), the Project Manager (VT) contacted the EP program lead to arrange the project introductory meeting. Prior to the start of the project introductory meeting, all clinic providers were invited to take part in the focus group and survey portions of the research study. The meeting started with research staff going through the consent process. Following the completion of the consent process, all providers completed a series of surveys, and then participated in a two-hour introductory session into the overall EPI-CAL project. At the end of the introductory session, providers were offered refreshments and a break, and then participated in the focus group. Each focus group took approximately 90 minutes. All focus groups only included participants from that respective EP program/county.

For the consumer and family groups, EPI-CAL EP program providers invited all consumers currently receiving services at their program, and their families, to take part in the site focus group. All interested potential participants attended a brief presentation of the focus group study held by members of the evaluation team, hosted at their EP program clinical site. Following the presentation of the study, consumers and family members were then invited to take part in the focus group, and following their agreement, were consented to take part. In most cases, the consumer and family groups were hosted outside of work hours to maximize attendance. During the groups, an EP provider from that clinic remained on site to provide support in case any possible risk issues emerged. For the consumer and family groups, the introduction, consent procedure, and focus group, all together took approximately 90 minutes.

Following the “shelter-in- place” state mandate for the COVID-19 pandemic, the onsite focus groups were then switched to take place via remote, secure teleconference (Zoom).

After the purpose of the focus group was explained, participants were invited to review the 15 outcome domains under consideration, which were presented on a large poster (Appendix III). Definitions of each domain (Appendix IV) and copies of the PhenX measures under consideration were provided. Participants were asked to identify other domains for consideration (outside of the 15) and ask questions as needed. Additional domains were then added to the poster for focus group consideration. Next, participants were asked

to select four outcome domains they felt were most important for demonstrating the impact of EP care, out of the list of 15, and any additions provided by participants, by placing stickers in their assigned color on a large poster (see Appendix III). This activity sought to: 1) engage participants in the topic; 2) orient the subsequent qualitative discussion to four domains that the group as a whole considered to be most critical; and 3) provide quantitative data that could be examined in the context of the qualitative data. The group facilitator then identified the two to four domains with the highest number of participant votes for discussion. The facilitator and co-facilitator then solicited participants' opinions on these domains, their importance to EP care and consumer outcomes, as well as whether the proposed measures captured information that was relevant to the constructs of interest. Facilitators sought to obtain input from all group members, including contradictory opinions, and input on potential barriers and facilitators, to measure implementation. Once all of the top four domains were discussed, the facilitators shifted to domains with lower ratings to solicit opinions on why some participants had voted for these domains, or why no votes were made for certain domains. At the end, all participants were asked to vote again for their top four domains with their colored stickers. Participants were then asked to report whether their votes changed and, if so, why.

Spanish Focus Group Methods

Our team sought to include Spanish- speaking consumers and families in the outcomes focus groups since Spanish is a threshold language in all participating LHCN counties. First, a team member translated all necessary forms for the focus group (e.g., consent, payment forms, outcome measures, outcome definitions, etc.), which were then reviewed by UCDHS Medical Interpretive Services and approved by our IRB. We initially had three in-person Spanish focus groups scheduled for March in the Solano, San Diego and Sacramento programs. However, these meetings were canceled due to COVID-19. Subsequently, our team recruited Spanish-speaking consumers and family members for remote focus groups. To do this, a team member (RB) was connected to interested participants by respective clinic staff to introduce the study, as this portion of the project is considered research. Interested participants were then consented over the phone; they signed and completed consent and payment forms via DocuSign. Follow-up calls were needed with each participant to assist with signing documents and submitting forms successfully. After receiving all signed forms, a team member mailed necessary documents to participants for reference during the outcomes discussion portion of the study, including a packet of the proposed measures and outcome definitions. A team member coordinated with other bi-lingual team members and participants for availability, scheduled, and carried out interviews with each participant via WebEx, Zoom, or phone calls ranging from one to two hours in duration. Four family members completed the focus group for Sacramento, and two consumers and one family member completed the individual interviews for the San Diego program. Participants from different EP programs were separated to maintain consistency between the structure of other sites' outcomes focus groups and to facilitate an honest conversation about potentially sensitive topics including family burden, family communication, suicide risk, and other outcomes under consideration.

Data Analysis

Analysis of the focus group data involves two components: 1) descriptive data for pre- and post-discussion rankings of relevant domains based on participant sticker voting and 2) a conventional content analysis of the de-identified recorded group discussions.

Quantitative Data

For the pre- and post-discussion ratings, participants' votes for the top four outcome domains were tallied within stakeholder groups and reported as a proportion of votes per domain. Heat maps were developed across all roles at the pre- and post-voting stage. In the primary analysis, English and Spanish-speaking groups were analyzed together. In a sub-group analysis, Spanish- and English-speaking family and consumer focus groups were reported separately, with voter preferences compared and contrasted.

Qualitative Data

Conventional content analysis is typically used to describe a phenomenon, namely stakeholder preferences for data collection in the LHCN battery (Hsieh & Shannon, 2005). The analysis followed an inductive approach. Five coders were involved in the preliminary coding of the transcripts. First, the coders reviewed the transcripts and developed a preliminary coding framework. This coding framework was developed by multiple researchers in a process of multiple coding (Barbour, 2001). All coders coded the same two transcripts separately using the coding framework, and then came together to review coding fidelity. After two transcripts, the team was deemed sufficiently concordant to code transcripts separately. All transcripts were coded either directly into Nvivo 12 (QSR International, 1999), or else was coded in Microsoft Word before being transferred into Nvivo.

After completing each transcript, the coder met with another member of the team to review responses to ensure consistency. For each transcript, the coder and reviewer dyad involved different researchers to minimize the risk of siloing amongst coders. In addition to these meetings, the coding team met on a weekly basis to resolve discrepancies and update the coding framework as necessary. Once all the transcripts were coded, one member of the research team (LM) collated the different coding files across the coding team and combined the analysis into a single Nvivo document. This preliminary coding framework was then analyzed primarily by one member of the coding team (MS), and reviewed first by the rest of the coding team, and then the wider EPI-CAL research team.

Data Triangulation Process

Areas of agreement and convergence between the qualitative and quantitative data were then explored, drawing from the triangulation protocol proposed by (Farmer, Robinson, Elliott, & Eyles, 2006). Of particular interest were areas of agreement, partial agreement, silence, and dissonance that may exist across the different data forms.

Results

Focus Group and Participant Demographics

In total, 19 focus groups and three interviews with stakeholders were completed between September 10th, 2020 and June 30th, 2020. The date each occurred and the type of group conducted is presented in Table V. Data from these groups are detailed in the results below. More recently completed focus groups that are not currently included in the results—including one with the providers at the EPI-CAL UCSF PATH program—was completed on 6/25/2020. Additionally, focus groups were conducted with Los Angeles LHCN clinical sites, now that their contract has been executed. Once the data is transcribed, cleaned, and analyzed, these will be incorporated in the final results at a later date. The demographics of the participants included in the current evaluation are presented in Table VI.

Table V: Focus Group Details by Site

Focus Group Number		Location	Focus Group Details	
			Type	Date
1	LHCN/EPINET Participating Sites	Solano - SOAR	Provider	10/08/2019
2			Family	2/6/2020
3			Consumer	2/6/2020
4		Orange - OCCREW	Providers	1/30/2020
5			Family ł	1/30/2020
6			Consumer	1/30/2020
7		San Diego - Kickstart	Provider	12/16/2019
8			Family	12/16/2019
9			Consumer	12/16/2019
10			Spanish Speaking Family*‡	5/14/2020
11			Spanish Speaking Consumer*‡	5/14/2020
12			Spanish Speaking Consumer*‡	5/15/2020
13	EPINET Only	Sacramento SacEDAPT/EDAPT	Provider	12/13/2019
14			Family	1/22/2020
15			Consumer	1/16/2020
16			Spanish-speaking Family*	4/28/2020
17		San Mateo - Felton	Provider	2/3/2020
18			Family	2/4/2020
19			Consumer	2/5/2020
20		UCLA – CAPPS	Provider	1/29/2020
21		UCLA - Aftercare	Provider	1/29/2020
22		UCSD – Care	Provider	12/16/2019

* Indicates groups that were conducted remotely via Zoom due to the statewide shelter-in-place order.

ł Recording error meant only quantitative data incorporated into the analysis.

‡ Conducted as one-to-one interview, as opposed to focus group.

Table VI: Focus Group Demographics

Variable	n	%
Sites Included in Current Analysis (n = 8, n %)		
University	3	37.5%
Community	4	50.0%
Both	1	12.5%
Funding Source (n = 8, n %)		
EPINET only	5	62.5%
LHCN + EPINET	3	37.5%
Group Type (n = 22, n %)		
Provider	8	36.4%
English Speaking Consumer	5	22.7%
English Speaking Family Member	5	22.7%
Spanish Speaking Consumer*	2	9.1%
Spanish Speaking Family Member**	2	9.1%
Participants (n = 168, n %)		
Provider	94	56.0%
English Speaking Consumer	40	23.8%
English Speaking Family Member	27	16.1%
Spanish Speaking Consumer	2	1.2%
Spanish Speaking Family Member	5	3.0%
Provider Roles (n = 94, n %)		
Clinicians	31	33.0%
Administrators	11	11.7%
Prescribers	10	10.6%
Clinical Supervisors / Team Lead	21	22.3%
Senior Clinic Leadership	4	4.3%
Other (SEES, Peers, Family advocates)	17	18.1%

* Interviews via phone call

** One interview and one focus group

Proposed Additions and Amendments to the Domain List

Within the focus groups, participants proposed an additional 38 different domains to be considered for inclusion into the battery. Following a review of these different domains and their descriptions, many appeared to show considerable conceptual overlap, either with other new domains or existing ones. Therefore, in order to simplify the analysis and ensure that domains were not underrepresented in the data due to parsing, commonalities across all the new and original domains were explored by the five members of the coding team. Drawing from their involvement in the focus groups and their experience of coding the transcripts, the different

domains were re-categorized into 21 distinct areas (see Table VII). These reconfigured domains represent the basis of all the subsequent analyses detailed below.

Table VII: Proposed Additions to the Battery, and how these were Incorporated into the Final List for Review

Amendments/ Additions to the Battery	Original and Proposed Titles	Notes
About You	Demographics	
	Family History*	
	Legal System*	
	Clinical Status	
Cognition	Cognition	
	Social Cognition*	
Family Functioning	Family Functioning	
	Family Satisfaction*	
Functioning	Functioning	
	Premorbid Functioning*	
	Work Engagement*	
Impact of Medication	Medication Side Effects (changes in health).	Previously medication side effects. Includes weight gain/impact on physical health as a consequence of medications
	Beliefs about Medication*	
	Medication Satisfaction*	
Medication Utilization	Medication Adherence	Previously medication adherence
	Access to Medication*	
Psychiatric Symptoms	Impulsivity*	
	Insight*	
	Distress Associated with Symptoms*	
	Questioning Reality*	
	Motivation/Confidence*	
	Optimism*	
	Mood*	
	Psychiatric Symptoms	
Quality of Life/ Wellbeing	Quality of Life-Wellbeing	
	Wellness	
Risk to Self/Others	Suicide Risk	Previously suicide risk
	Non-Suicidal Self-Injury*	
	Homicidal Ideation*	
Service Utilization	Service Utilization	
	Adherence to Treatment Components*	
Service Satisfaction	Service Satisfaction	
	Therapeutic Alliance*	

Newly proposed domains integrated into the analysis		
Access to Support Resources	Access to Social Resources*	
	Access/Receipt of Wider Social Supports/Resources*	
	Accessing Social Service Supports (i.e., SSI, SSDI, Subsidized housing, etc.)*	
	Social Communication*	
	Community Integration/Resources*	
	Access to Social Support*	
	Access to Resources*	
Basic Needs	Activities of Daily Living*	Section includes sleep, nutrition, hygiene, basic functioning
	Sleep*	
Independent Living Skills	Future Planning Skills*	
	Transition to Independence*	
	Independent Living*	
	Transition Plan*	
Psychoeducation	Psychoeducation*	While they are different, in the qualitative data the concepts appear to overlap
	Acceptance*	
Trauma	Trauma*	If the distress discussed relates predominantly to symptoms, as opposed to trauma or experiences, then this will be included within the psychiatric symptoms section
	Distress Associated with Experiences*	
Barriers to Care	Newly proposed domains to be kept as separate*	
Culture		
Mortality		
Stigma		
Substance Use		

Key: *New domains proposed (i.e., still under consideration), either during the voting stage or during the focus group discussion.

Quantitative Findings from the Voting

At the beginning and end of the focus groups, all participants voted for the four domains they considered to be most critical to measure. How participants voted by role is presented in Figures 3 and 4. In both the pre- and

post-focus group discussion voting rounds, functioning was identified as the most critical domain in which to capture data. This was consistent across consumer, family, and provider participants. Other domains with a high proportion of votes include quality of life, recovery, family functioning, and psychiatric symptoms. Similar to functioning, these domains were highly rated across participant roles. In a comparison of the pre- and post-discussion votes, these four domains appeared to receive an increase in the proportion of votes cast. Overall, the emphasis on recovery, quality of life, and functioning appears to suggest that consumers, families, and providers are particularly focused on collecting recovery-oriented outcomes.

In a review of domains that were considered less critical to measure, clinical status, risk for homelessness, law enforcement contacts, service satisfaction, and impact of medication received the fewest votes. Why these particular domains received such few votes was explored qualitatively during the discussions. Across the newly proposed domains, no areas received a high proportion of votes. However, in the post-discussion voting, substance use, trauma, and culture were most frequently identified as important.

There were a number of differences in voting priorities across participant roles. For example, prescribers appeared to be particularly focused on collecting data related to psychiatric symptoms, functioning, and medication utilization. Additionally, while the impact of medication was less important than these domains, prescribers still voted for this domain at a higher rate relative to other provider roles. Senior clinical and county leadership considered risk to self and others, and family burden, more important. Providers in the ‘other’ category, including peers, family advocates, and supportive employment and education specialists (SEES), consistently voted for recovery as one of the most important domains, over and above other participant roles. Broadly speaking, differences in domain priorities across provider roles appears to be attributable to their primary role in delivering care (i.e., peers, family advocates, and SEES staff work primarily on facilitating recovery, while the prescribers’ role focuses primarily on alleviating psychiatric symptoms and issues around medication). This was explored in more depth during the focus group discussions.

Across the different provider roles, consumers, and family members, the areas of priority appear to be broadly consistent, suggesting a consumer-oriented approach from providers. In the post-discussion voting, both consumers and family members identified functioning, quality of life, and psychiatric symptoms as the most important areas in which to collect data. In an exploration of any contrasts between provider, family, and consumer participants, family members and consumers appeared more likely to rate cognition as one of the more important domains relative to most provider groups. In addition, family members appeared to consider the impact of medication more important than most provider groups, with the exception of a few providers.

Figure 3: Pre-Discussion Voting Priorities by Role

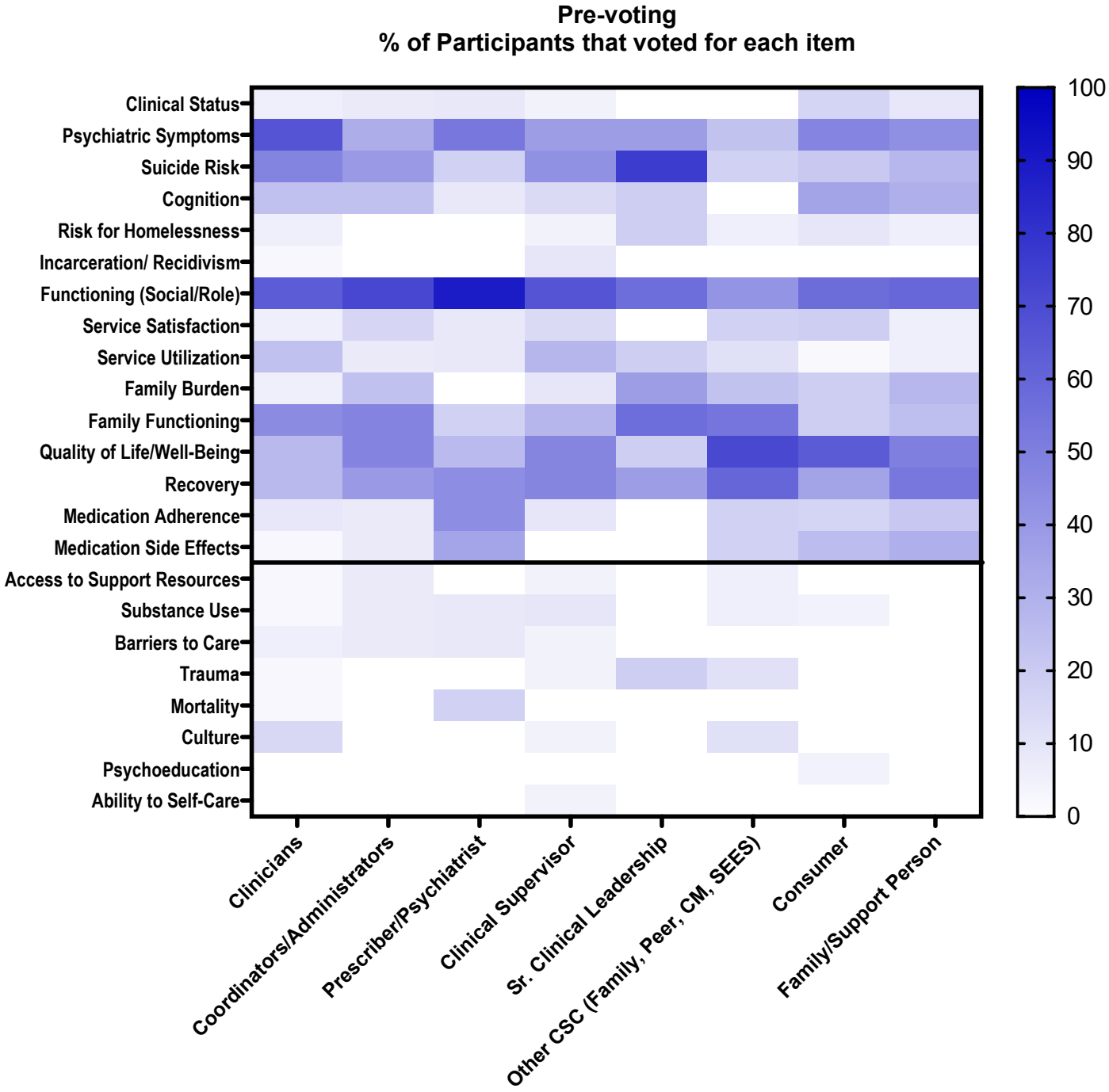
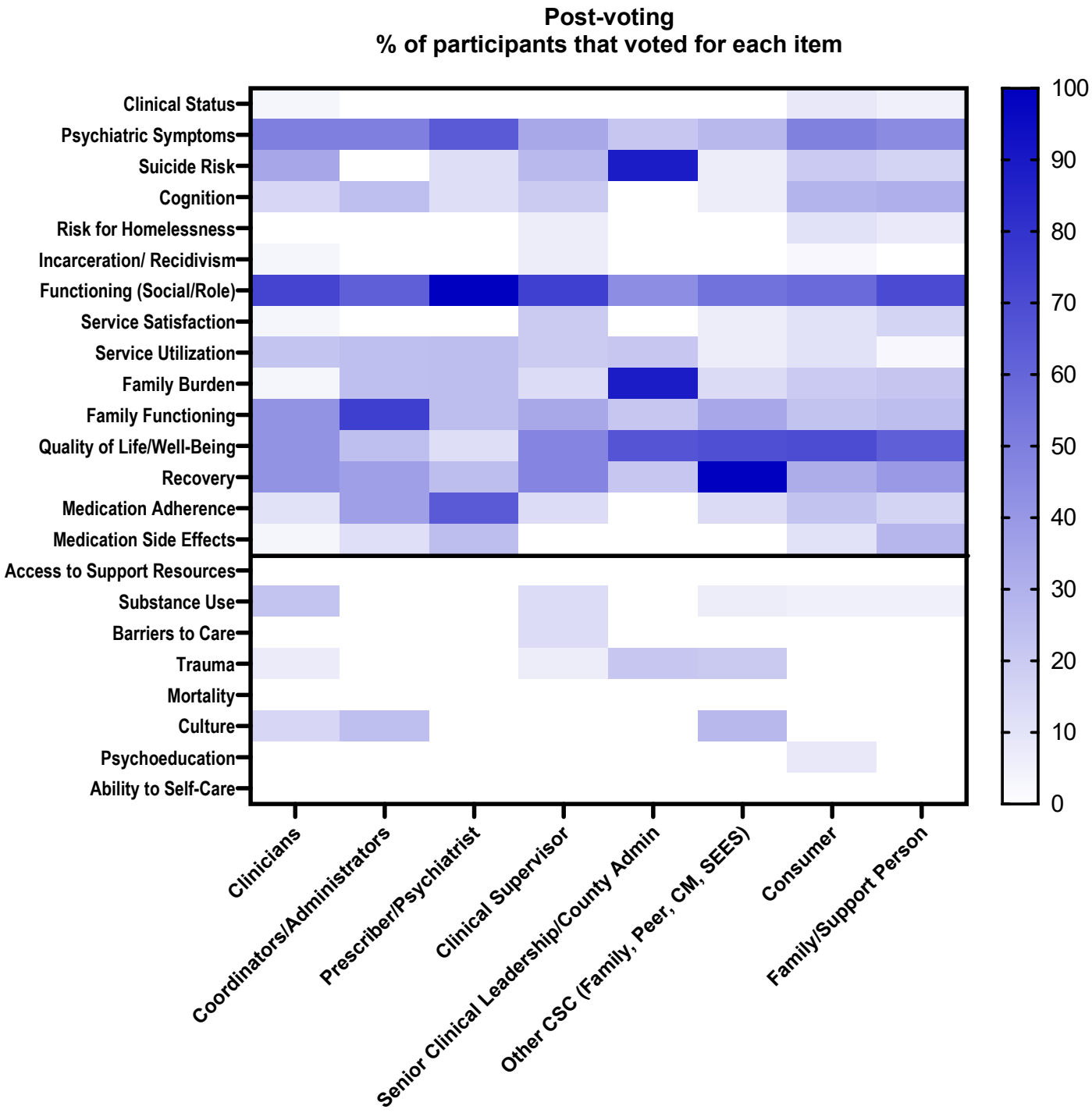


Figure 4: Post-Discussion voting



Comparison of Voting Patterns across English- and Spanish-Speaking Consumer and Family Groups

A subgroup analysis detailing the voting patterns of consumers and family members in English- and Spanish-speaking groups separately are presented in Figures 5 & 6. Due to the small number of participants in the Spanish-speaking cConsumer and family groups (n=2 and n=5 respectively) some caution should be exercised in making comparisons to the English-speaking groups. However, a number of notable differences were evident. For example, in both Spanish-speaking consumer and family groups, clinical status received a high proportion of votes, whereas this was not considered a priority in the English-speaking groups. Instead, in the English-speaking groups psychiatric symptoms appeared to receive a greater proportion of the votes. Concerning more recovery-oriented outcomes, it was also notable that recovery appeared to receive a much higher proportion of the votes in the Spanish-speaking groups, while in the English-speaking groups, quality of life/wellbeing received greater priority.

Interestingly, while the voting priorities across the English-speaking consumer and family groups appeared to be broadly consistent, a number of differences appeared to be evident across the Spanish-speaking consumer and family groups. For example, functioning and family functioning received a very high proportion of votes in the Spanish-speaking consumer groups, while in the English-speaking family groups medication adherence, family burden, and suicide risk received a much higher proportion of votes. Consistent with the findings across the whole sample, the voting patterns across the English- and Spanish-speaking groups appeared to be highly consistent.

Figure 5. Family and Consumers Pre-voting

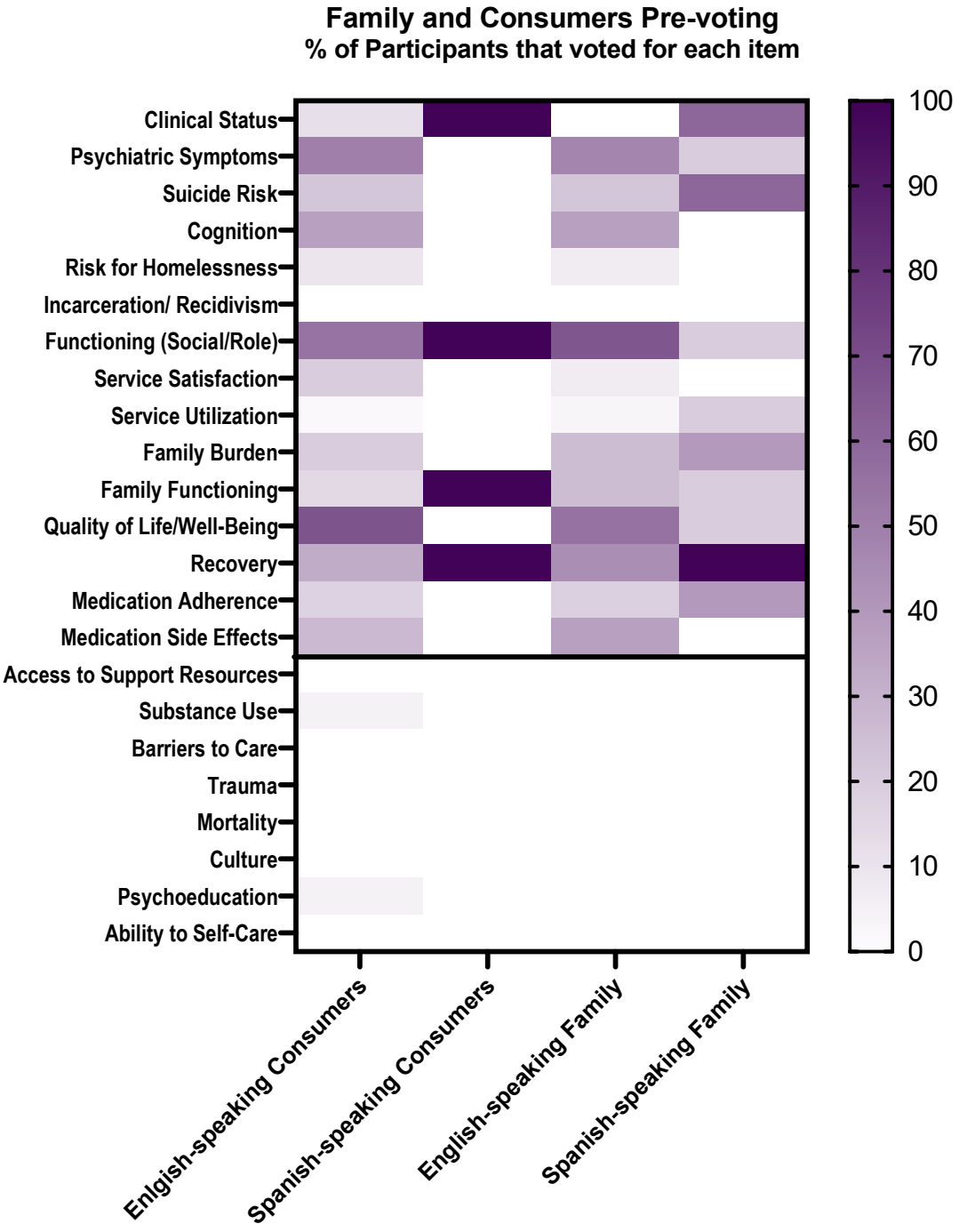
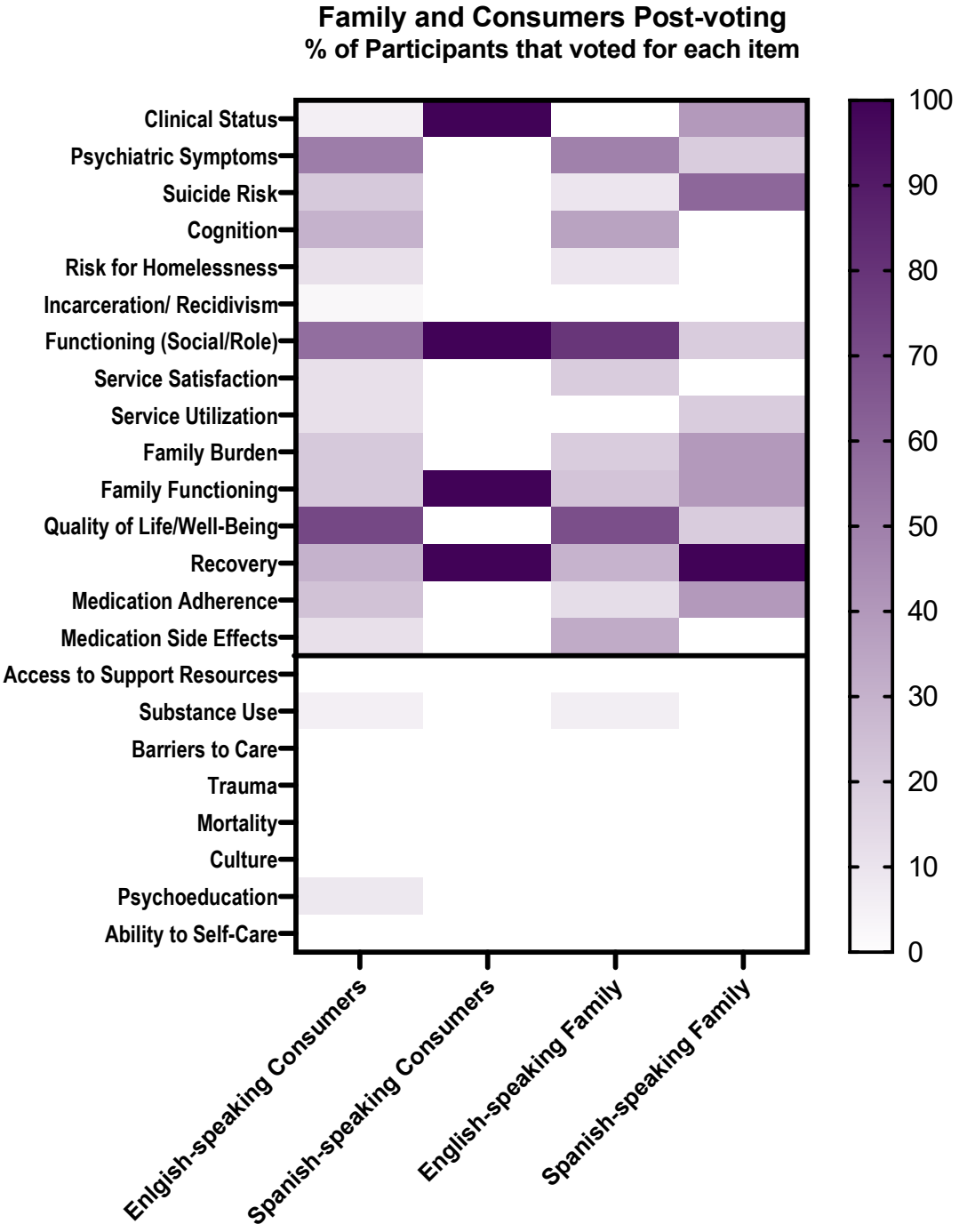


Figure 6. Family and Consumer Post-Voting



Summary of Qualitative Results

Across the 22 focus groups and qualitative interviews completed with providers, family members, and early psychosis program consumers, an extensive array of suggestions and recommendations were given around what data is important to collect, how to define the domains of interest, and how to collect the data itself. These data have been compiled into a summary of recommendations for each of the identified domains detailed below:

Recommendations for Data Collection Based on Participant Feedback

Psychiatric Symptoms: Use MCSI but add provider review field to indicate their perspective from their knowledge of the consumer. Consider adding additional optional template for PANSS/SIPS/BPRS for clinics that use these scales.

Family Functioning: Adopt a broader conception of family functioning than that originally proposed, evaluating the family dynamic, the mental health literacy of the family, and the level of support in care provided by family members. Utilize the SCORE-15 to evaluate family dynamic, add additional questions to tap into other constructs.

Law Enforcement Contacts: Broaden the domain of interest from incarceration/recidivism to include any contact with justice services. However, important to differentiate contacts related to criminal behavior, as opposed to emergency behavioral health contact.

Cognition: Use proposed battery but add the ER-40 in order to capture social functioning. If any scale needs to be removed to accommodate this, then the matrix reasoning task was considered to be the least useful given that it cannot measure pre-morbid cognition.

Family Impact: Replace the term “family burden” with “family impact”. Use the BAS as opposed to the EES as it covers a broader conception of family impact and is less negative than the EES. Of note, it is important to give family members space to complete their responses away from the consumer to ensure that they feel comfortable giving honest answers.

Medication Utilization: Replace the term “medication adherence” with “medication utilization”. Use the BARS, modifying the questions slightly to make it more appropriate for self-report. Additionally, adding an item where providers then review and confirm the response, and an item where consumers can disclose whether they are considering stopping medication would improve the accuracy of data and improve clinical utility.

Impact of Medication: Replace the term “medication side effects” with “impact of medication”. Use the GASS to measure side effects, but to minimize attribution errors introduce the scale as a measure of “changes in health” since taking medication, as opposed to a measure of side effects. In addition to this scale, consider adding two questions to the battery, one that explores any possible positive impact of the medication they are taking, and a second asking consumers in light of the positive and negative aspects of taking their medication, if they are satisfied with their current regimen.

Risk for Homelessness: Few concrete proposals were provided by participants. However, in developing the scale to assess risk for homelessness it was suggested that the consumers’ income stability, their receipt of SSI, and the degree of stress in the home should be considered important factors to include.

Risk to Self/Others: Expand the original domain of “suicide risk” to incorporate NSSI and homicidal thoughts, and change the domain name to “risk to self and others” to incorporate these amendments. Use the SBQ-R to measure suicidal ideation, add questions for NSSI and homicidal ideation, and consider adding the first two questions of the Columbia, which in the event of an endorsement, the clinician can follow up and complete the full assessment.

Substance Use: Suggestion for this to be incorporated into the battery. Data collected should detail the substance(s) used, the frequency, and the method of use.

Independent Living: Consider adding questions relating to the individuals’ capability to live independently which could be answered by the clinician, and two questions asking if the consumer currently lives alone, and if they have ever lived alone.

Mortality: Collect mortality data, either via county records or from the programs themselves.

Culture: Ensure demographics/"about you'' section incorporates detailed information regarding race/ethnicity and country of birth across the family, consumer gender identity, sexual orientation, socioeconomic status, and level of education. Incorporate family understanding of mental health and family support of treatment into the family functioning domain.

Functioning: Considered a critical domain to capture by most but should not be adopted to the exclusion of more subjective measure (i.e., quality of life, recovery). Important to measure role and social functioning separately. Role should include work, school, volunteer, and homemaking tasks. Social functioning should focus on the quality of friendships, as opposed to quantity. Close and casual friendships should be recorded separately, including online friendships. Reporting granular, concrete metrics of functioning was considered most useful, but summary scores also considered to have merit. Given importance, suggestions were made to incorporate both forms of data.

Clinical Status: No comprehensive recommendations came from the focus groups. Suggestion that comorbid diagnoses may impact treatment trajectory or complicate etiology and should be added as data. However, care needs to be taken around reviewing diagnoses made prior to starting treatment at the early psychosis program.

Service Utilization: Important to collect full description of outpatient services (both within and outside the early psychosis services) in addition to hospitalization and emergency room visits. Mixture of consumer self-report and a review of program and county medical records considered an appropriate source of this data.

Service Satisfaction: Little support for the measure presented to the group (YSS). Consider possibility of using the RSA to measure service satisfaction, as opposed to recovery.

Recovery: Use the QPR to capture consumer hope and beliefs around the ability to recovery and live a meaningful life. Consider adding two additional items to capture relapse prevention and progress towards goals.

Quality of Life: Feedback regarding both scales was very mixed, however there appeared to be a general preference for a multiple-itemed scale such as the PWI over the Lehman QoL. Given the importance of the construct to stakeholders, consider a review of alternative scales.

Access to Support and Resources: Ensure detailed information related to social security income and their links to wider social support is included in the "about you" section.

Trauma: Add a trauma measure to the battery. While a scale recording the impact of trauma may have greater utility, the Adverse Childhood Experiences (ACEs) was considered to be more feasible to implement, particularly if the focus is on self-report.

Barriers to Care: Ensure the "about you" section has sufficient information regarding possible barriers to care, including access to transportation, distance from clinic, access to medication, and other cultural factors.

Stigma: Consider adding two sets of questions to the battery: one relating to the self-stigma of experiencing a mental illness, and the other detailing stigma they may experience from others.

Strengths and Limitations

This section of the report details an extensive process to solicit stakeholder feedback around data collection in early psychosis settings, including 168 participants across eight clinics. This engagement process has included family members, consumers, and providers across a diverse range of clinics, including county- and university-based clinics. The programs themselves deliver early psychosis care to a diverse range of consumers in terms of race/ethnicity, socioeconomic status, and current gender identity. To further support inclusion and to ensure that a diverse range of stakeholders could participate, focus groups were held both in Spanish and English.

Consequently, one major strength of this study is that it provides strong representation of the various stakeholders that either utilize or deliver early psychosis care in California.

Regarding limitations, one important consideration is the challenges of implementing this portion of the project against the backdrop of the COVID-19 pandemic, and the subsequent “shelter-in- place” order. This led to one group being cancelled and another postponed (the Stanford Inspire program and UCSF Path program, respectively). In addition, it was necessary to scale back some of the original plans that were intended to further increase engagement. For example, plans were being developed to conduct focus groups in languages besides English and Spanish, such as Mandarin, potentially utilizing a blogging format provided by services such as FocusGroupIt.com. In addition, there was an intention to conduct a focus group with individuals with chronic schizophrenia, and potentially other providers such as education workers, law enforcement partners, and emergency service workers. Linked to this, the first round of Spanish-speaking groups had to be cancelled due to the shelter in place order. This resulted in the groups being shifted to a remote platform (either via telephone or Zoom/WebEx). While successful, it was recognized that internet connectivity was required to participate in the Zoom/WebEx enabled focus groups, which represented a barrier to engagement to some lower SES families. Overall, while this project has exhibited a strong commitment to listening to a diverse range of voices, these issues led to a reduced degree of engagement than what would have otherwise been the case.

Regarding other limitations, contract delays with Los Angeles County meant that the focus group could not be completed prior to June 2020. However, we have conducted focus groups with LA County stakeholders, and the responses from these groups will be integrated into the overall findings. Another limitation was the lack of video recording of the groups, which made it difficult to attribute the quotes in the audio recording to each particular consumer in some instances. Additionally, the provider roles assigned to each participant were self-defined, and so it was possible that some provider participants selected their role incorrectly. This issue may be particularly significant with more senior providers, who typically cover multiple roles within a clinic (i.e., clinician, supervisor, and leader). Finally, in one focus group (OCREW family group), a recording error led to their qualitative data not being integrated into the overall dataset. In order to address this, the facilitators of that particular focus group have reviewed the overall findings presented in this report to ensure that the results are consistent with the experiences of the stakeholder who participated in that group. No major discrepancies were detected.

Conclusion

The extensive outreach process detailed in this report has significantly informed the construction of the Learning Health Care Network battery, ensuring that the data to be collected during the project is feasible to collect and as clinically meaningful as possible. This process has significantly improved our understanding of what stakeholders consider important data to collect during early psychosis care and how to collect it. In addition, it has reinforced the collaborative ethos of the project that has underpinned it since its inception.

The preliminary findings of the results detailed here were presented to the national EPINET Executive Committee meeting on February 6-7, 2020, which included the five EPINET hub Principal Investigators, NIH program officers, and the Westat National Data Coordinating Center. These findings significantly contributed to the standardization of outcomes for the national network. Consequently, this work has not only impacted how data will be collected across the California EPI-CAL programs, but it has also informed the national conversation around what data should be considered to be important and meaningful to stakeholders. This work has therefore ensured that the voices of California early psychosis program stakeholders have been heard on the national level.

Throughout the implementation of the focus groups, providers, family members, and consumers were all highly

engaged in the process and very keen to share their perspectives on how this project should move forward. This collaborative approach appears to have further supported stakeholder buy-in, laying the foundation for an improved product that can better serve the needs of California early psychosis program consumers and families.

6. Development of wireframe for application submission for review by contractor and stakeholders

Quorum and the UC Davis research team worked collaboratively to develop the wireframe for the tablet and web-based applications. The process began with UC Davis providing diagrams of the flow for various aspects of the application including clinic registration, consumer registration, collection of clinical data from consumers and collateral (i.e., family members, support persons), and data visualization of both individual- and aggregate-level data. Based on these diagrams, Quorum developed an initial storyboard to illustrate various aspects of the application. The development process from that point was iterative, with weekly or bi-weekly calls to discuss and troubleshoot the more complicated aspects of the application design and flow. The UC Davis team used these storyboards as materials for focus groups to obtain feedback on the application and dashboard's design, flow, and functionality. Figures 7-10 are examples of what participants were shown to obtain feedback on various elements of the tablet application or dashboard.

Between March 26, 2020 and June 30, 2020, our team conducted 14 focus groups with various stakeholders with 82 total participants. Two groups were held with research staff and data experts (12 participants), six groups were held with providers at EP programs (36 participants), three groups were held with clinic administrators (20 participants), and three groups were held with consumers and families (14 participants). Due to COVID-19, all focus groups were conducted over video conferencing (Zoom). To maximize convenience and availability for staff during this time of transition, multiple groups were scheduled and open to participation from staff at any EPI-CAL clinic. Many of the groups had representation from multiple clinics in the network, which allowed for the study team to better understand the differing needs and environments of programs in the network. The focus groups were 90 minutes long, during which time the EPI-CAL research staff presented various aspects of the application storyboard, which allows for visualization of the look, feel, and functionality of the application prior to development. Each presentation was tailored to demonstrate scenarios pertinent to how specific users (i.e., providers, clinic admin, consumers and families) will interact with the tablet and web applications. We asked for feedback on the look and feel of the application, the functionality of the application as it relates to the current EP program workflow, and ease of use and acceptability for consumers, support persons, and staff.

Our research team discussed and synthesized the feedback for the application developers to support application development. When integrating the feedback into application development, we aimed to balance consumer and family needs with provider and staff needs. Overall, stakeholders approved of the look and feel of the application. Some stakeholders (both consumers and providers) noted that the color scheme and layout seemed overly clinical. They suggested, specifically when presenting surveys, to bring in more color, engaging imagery, and visual information. Occasionally, stakeholders disagreed on whether certain visual aspects of the application were acceptable or not. For example, several providers and family members raised the concern that the current images (drawings of individuals who do not have facial details drawn in) would be disconcerting or upsetting for consumers. However, when we asked consumers about this, they said they felt either neutrally or positively about these images. Often, stakeholders unanimously agreed on an aspect of the user interface that should change, such as changing the color of the survey progress bar in the tablet application to be more prominent.

Stakeholders provided several suggestions to improve integration of the application into their EP clinic workflow and procedures. After demonstrating the process of registering a new consumer in the tablet, clinic staff, consumers, and families alike, emphasized the importance of having an option for clinic staff to pre-register consumers if they gather registration information over the phone prior to the consumer's first visit in the clinic. Stakeholders agreed this would reduce burden on the consumer and demonstrate that the clinic was well organized and listening to the information consumers and family members had already provided.

Some stakeholders provided feedback specific to their role in the clinic. For example, participants in a focus group with clinic administrators from various programs suggested that demographic information that clinic staff regularly report to their county be visualized on the clinic administrator dashboard. We subsequently built in data visualizations for race, ethnicity, sex, gender identity, and other metrics which clinics are commonly asked to report. Consumers and their family members, from their unique perspective as consumers, nearly unanimously agreed that, when viewing data visualizations on the web application with their provider, they would not like to see the results of the symptom survey as the default display. They instead preferred to see a more recovery-oriented measure, such as the Questionnaire about the Process of Recovery (QPR), when first looking at their survey responses. Based on this feedback, we will set the QPR to be the default data visualization presented when a provider is clicking into a consumer's data on the web application.

Figure 7. Tablet Survey List

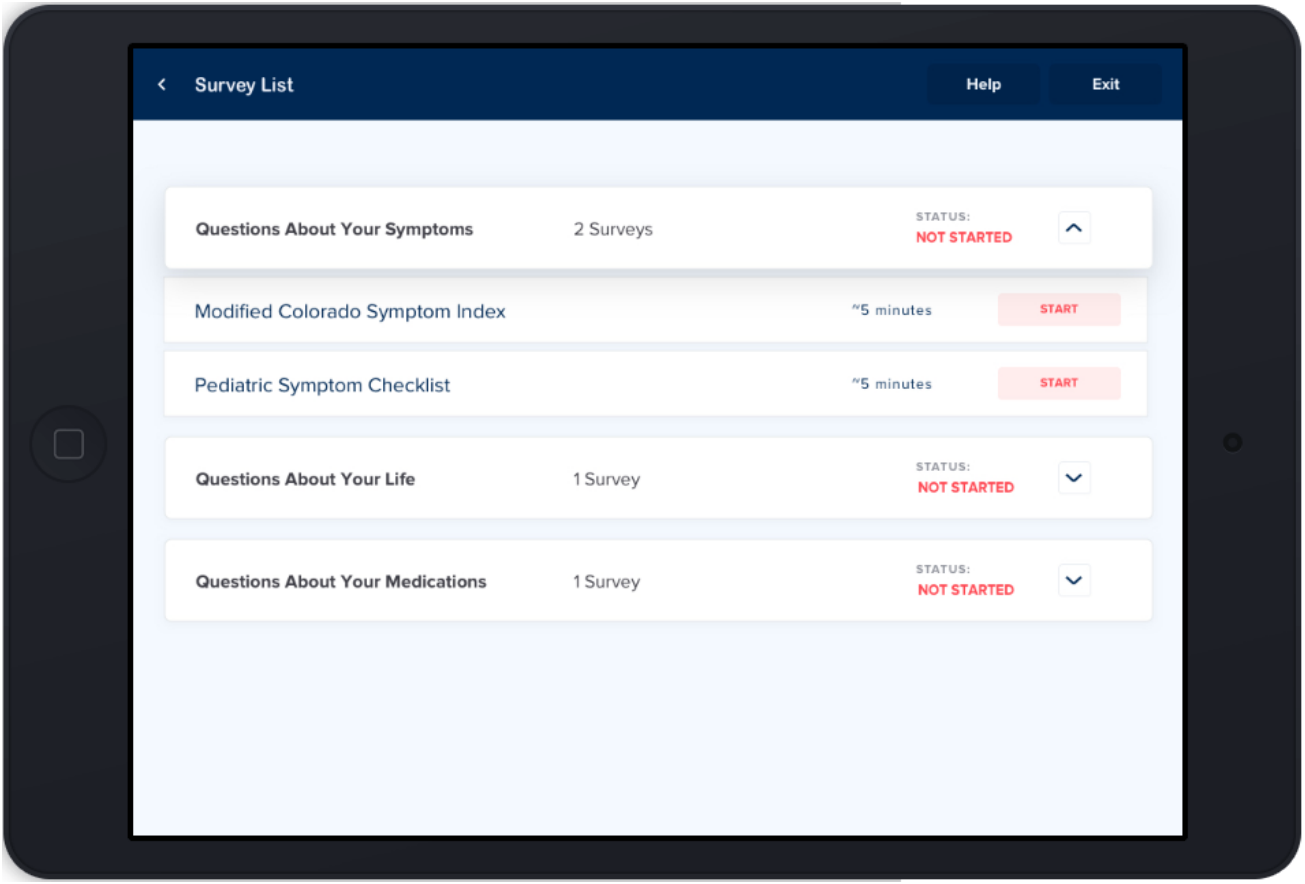


Figure 8. Tablet Survey Item

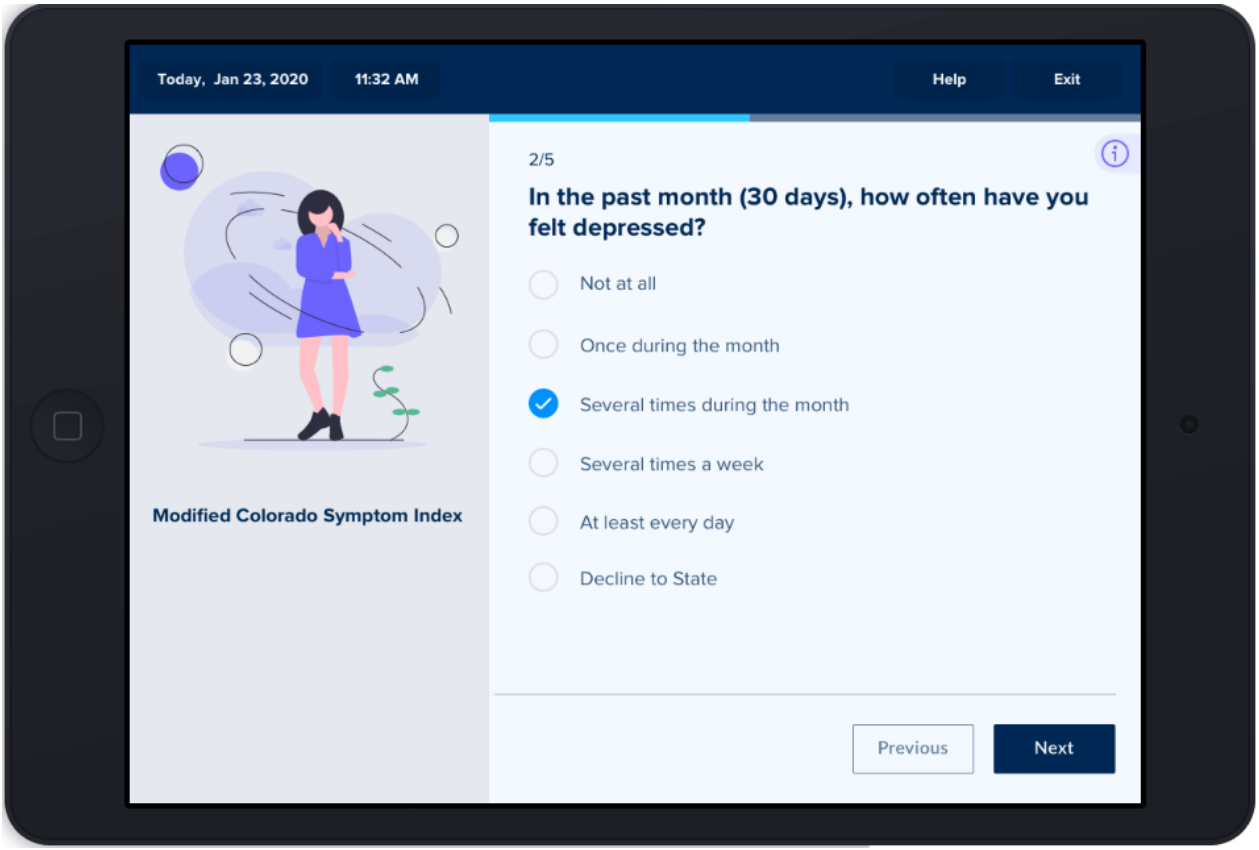


Figure 9. Individual-Level Test Consumer Survey Visualization

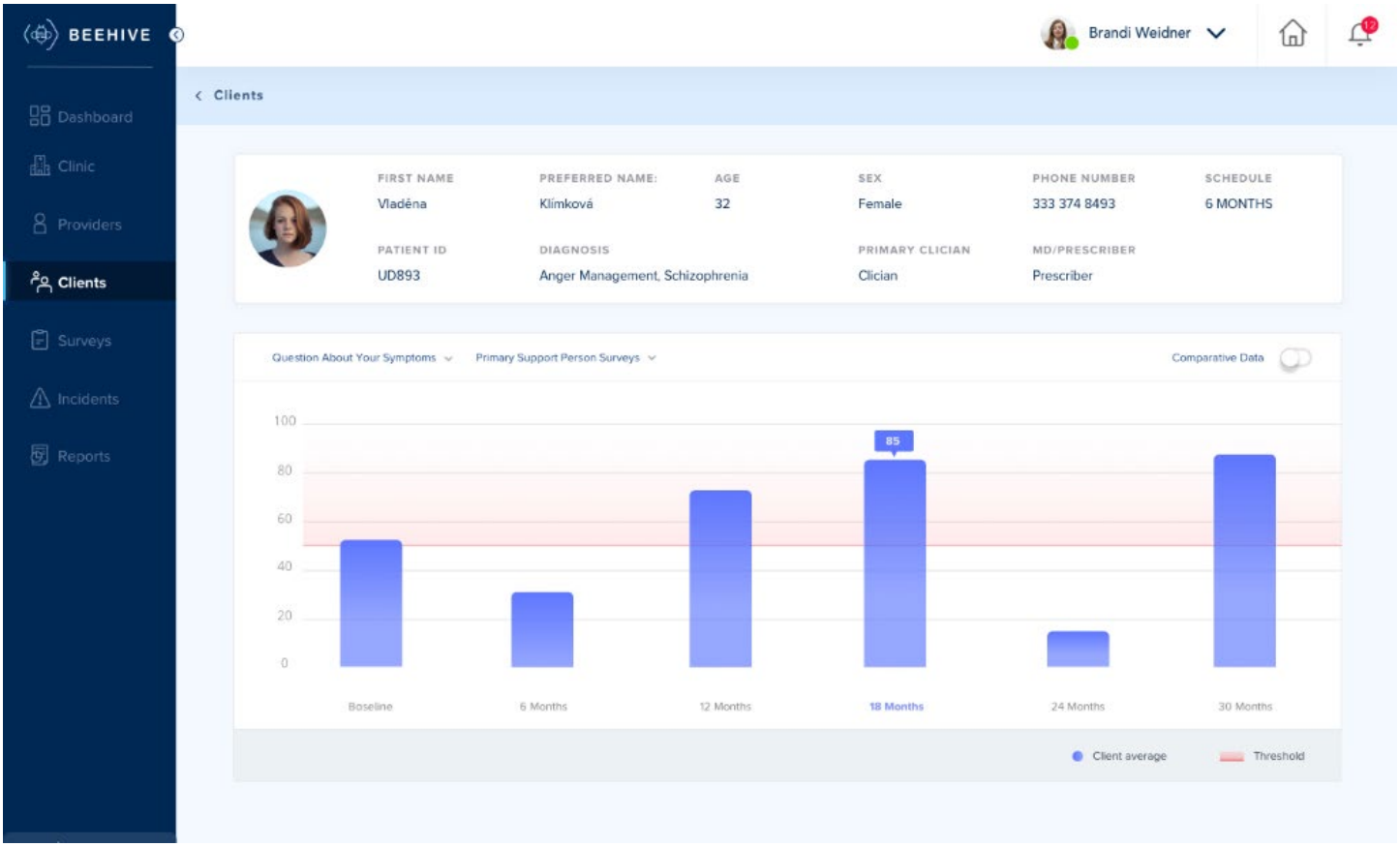
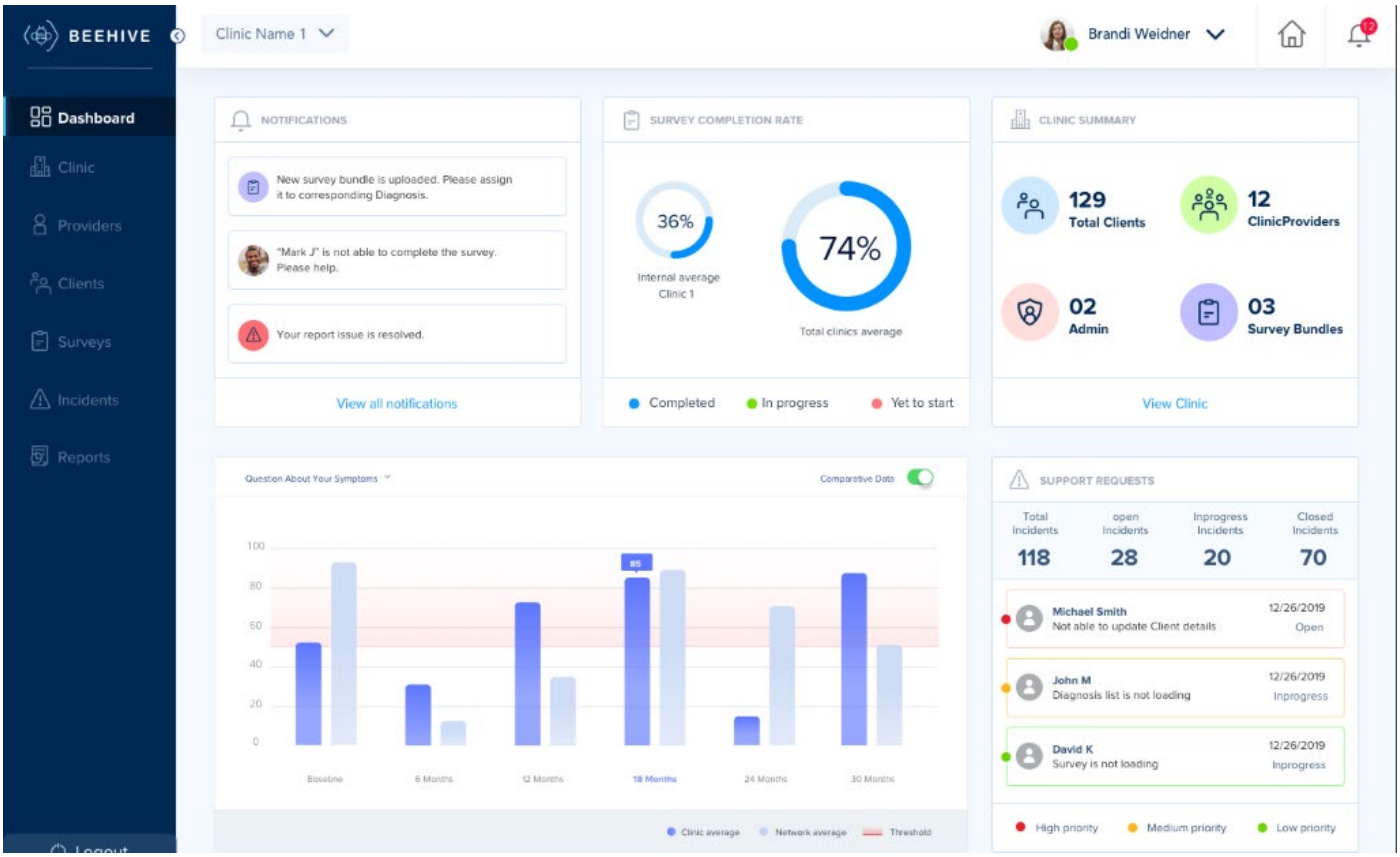


Figure 10. Clinical Administrator Dashboard Homepage



7. Selection of and coordination with two counties for beta testing of LHCN app

At this time, we plan to beta test the application in Kickstart San Diego program and Aldea SOAR Solano. We wanted to have representation from one Southern and one Northern California program for the beta testing of the application. Both of these programs are willing to serve in this capacity. While we originally planned to begin beta testing at these sites in Fall 2020, we have notified them that beta testing will be delayed until January or February 2021.

8. Identification of county-level available data and data transfer methods, and statistical analysis methods selected for integrated county-level data evaluation

One component of the LHCN project is to identify, describe, and analyze the costs incurred by providing early psychosis clinical services, the outcomes associated with such a program, and the costs associated with those outcomes for individuals served by each program in each county. We will also examine services and costs associated with similar individuals served elsewhere in the county. This project component will only include data from those counties who are participating in the LHCN (Los Angeles, Orange, San Diego, Solano, and Napa); it will not include the two counties (San Mateo, Sacramento) or university sites that are included via EPINET support in the overall EPI-CAL project.

For each county, our team held meetings with the EP program managers and the county data analysts. The meeting with the program managers discussed services provided by the EP program, description of consumers served, staffing specifics and billings codes for each service. A follow-up meeting was held with each county to review details of funding sources, staffing levels during certain time-periods, and other types of services provided for specific types of consumers (i.e., foster care). Meetings were held with the county data analysts to discuss details about the data the county will be pulling for the LHCN team during the next period. The

discussion included time-periods for which the LHCN team will request data, description of the consumers from EP programs and how similar consumers served elsewhere in the county will be identified, services provided by each program, and other services provided in the county to the EP consumers (i.e., hospitalization, crisis stabilization and substance use). We have also determined data transfer methods with each county, whereby each county will de-identify consumer level data and upload their data to a secure server housed at UC Davis. Counties will not have access to data from other counties. We are actively discussing data identification with each county and the next steps will be to have each county pull the first set of data, de-identify, and upload it to the UC Davis secure server. We have met with all of the program managers and data analysts from all LHCN counties with active contracts. Our research team has gathered all of the information from each program/county and summarized it in meeting notes and a multicounty data table. For the purposes of this report we have provided a sample of the data collected from each county (see Table VIII).

Table VIII. *Multicounty Program Services and Billing Information*

County	**San Diego**	**Orange**	**Solano**	**Napa**
Program Name	Kickstart	OC CREW	Aldea SOAR	Aldea SOAR
Consumers Served	FEP, CHR	FEP	FEP, CHR	FEP, CHR
Census	140-160	42	26	10-15
Length of Services	(+/-) 2 yrs	2 - 4 yrs	(+/-) 2 yrs	(+/-) 2 yrs
Inclusion - Ages	Ages 10-25	Ages 12-25	Ages 12-30	Ages 8-30
Inclusion - Diagnoses	Any type of psychosis (NOS) but not required, SIPs score of 6	FEP	CHR diagnosis or FEP within 2 yrs	All Psychotic D/Os (within 2 yrs of meeting dx criteria) & CHR diagnosis
Inclusion - Insurance	Medi-Cal, Uninsured	None	Medi-Cal, Uninsured	Medi-Cal, Private, Uninsured
Inclusion - Duration of Psychosis	First psychotic symptoms within 2 years	First psychosis within 2 yrs	First psychosis within 2 yrs	First psychotic episode within 2 years; Attenuated psychosis of any duration
Exclusion - Cognition	IQ under 70 - Case by case discretion	IQ below 70	IQ below 70	IQ below 70

Exclusion - Diagnoses	Case by case discretion: Medical diagnosis that better explains symptoms; substance use	No substance use or medical condition that better explains symptoms	Substance dependence would not allow to participate in treatment – refer to substance abuse treatment, Head injury or medical condition	Substance dependence would not allow to participate in treatment – refer to substance abuse treatment, Head injury or medical condition
Exclusion - Other	Qualitative judgement call: Physically aggressive, sexually inappropriate, safety issues	Not received counseling prior for psychotic disorder in the last 24 months	Qualitative Judgement call: Physically aggressive, sexually inappropriate, safety issues	Qualitative Judgement call: Physically aggressive, sexually inappropriate, safety issues
Assessments - Billing Codes	10	90899-6 (H2015)	90791	10
Assessments - Provider type	Clinicians	Clinician: master's level BHCI, BHCII, psychiatrist	Therapist; clinical supervisor	Therapist
Assessments - Notes	Behavioral Health assessment and HRA (high risk assessment)	If a clinician takes multiple sessions to complete the Initial Assessment, the code 90899-6 should be used for each of the sessions leading up to the completion of the intake process. This code can also be used by a psychiatrist when completing a conservatorship evaluation, a disability assessment, or if an evaluation for medication services is being provided via the telephone		Initial, Annual/Periodic
Targeted case management - Billing Codes	50	90899-1 (T1017)	T1017	50

Targeted Case Management - Provider Type	All direct service staff: clinical team, OT, Peer Support or EES. As well as medical team (NP, Psychiatrist, or LVN)	BHCI, BHCII, psychiatrist, Mental Health Specialist, Psychiatrist, Behavioral Health Nurse, Mental Health Worker	Therapist, family partner; Medical director or PNP	Therapist, Family Partner/SEE
Targeted Case Management - Notes	Monitoring progress toward goals -information gathered from schools and parents	A variety of services can be billed under case management as long as they referred to coordination of care, monitor service delivery and linkage access to community services.	Examples: Therapist discusses consumer with PNP or Family Partner; Therapist or Family Partner discusses consumer need for housing with Caminar; Therapist facilitates consumer's transition to a new service upon completion of program	Linkage to Resources; SEE support
Group Psychotherapy (Multifamily) - Billing Codes	35	90849 (H2015)	H2017	35
Group Psychotherapy (Multifamily) - Provider Type	Clinician, Peer Support Specialist, Education Employment Specialist, OT	BHCI, BHCII, Mental Health Specialist, Behavioral Health Nurse	Therapist, Family Partner	Therapist, Family Partner/SEE
Group Psychotherapy (Multifamily) - Notes	10 different groups offered. Collateral services billed 8-15 to capture other support specialist for any group with multiple facilitators	Group Psych-multifamily	Group rehab	Multi-Family, Peer Group for Adolescents & Adults

9. Finalize methods for multi-county-integrated evaluation of costs and utilization data

The cost and utilization analysis is based on pilot work conducted in Sacramento County, scaled to multiple counties (Niendam et al., 2016). It focuses on consumer-level data related to program service utilization,

crisis/ED utilization, and psychiatric hospitalization, with costs associated with these utilization domains during two time periods: 1) the three years prior to implementation of project tablet in the EP programs (Jan 2017 – Dec 2019) to harmonize data across counties and 2) for the 3 year period contemporaneous with the prospective EP program level data collection via the tablet (Jan 2021 - Dec 2024), to account for potential historical trends during the evaluation period.

Over the first year of this project, we held a series of meetings with EP program staff and county staff to address the project goals. With EP program staff, we reviewed the project goals and planned timeline, and verified the following information for the retrospective data period 1/1/2017 – 12/31/2019: program eligibility criteria, services and staffing, duration of services, collaborative relationships and subcontracting, documentation of pre-enrollment assessment activities and referrals, any changes to these categories over the time period. We also verified current information in these areas and plans for future changes. With county leadership and data analysts we reviewed project goals and timelines, and verified: EHR in use during the retrospective period, billing codes used, availability of different county mental health service types (e.g. outpatient, inpatient, crisis, etc.), other sources required for services, such as private hospital billing databases, and availability of specific variables. With both groups, we discussed the most efficient way for them to extract the relevant data, methods for de-identification, and plans for uploading data files securely. As we gathered information from different counties and their EP programs, we circled back to other counties/programs to discuss similar issues. As of June 30, 2020, we had begun the process of these meetings with three counties. The results of these meetings have been integrated into our plans below.

Early Psychosis (EP) Sample

First, all individuals entering the EP programs January 1, 2017 – December 31, 2019 will be identified using County Electronic Health Record (EHR) data. This list will be cross-referenced with the County EP program(s) to identify those individuals who received treatment versus only eligibility assessment and referral to another service. The programs will also identify which consumers were diagnosed with a first episode of psychosis, and which were diagnosed with a clinical-high-risk (CHR) for psychosis syndrome. Programs differ in whether they serve one or both groups.

Comparator Group (CG) Sample

We will compare the utilization and costs of the EP program participants to utilization and cost among a group of individuals with similar demographic and clinical characteristics who do not receive care in the EP program during the same timeframe in the same County. Individuals meeting similar eligibility criteria for the EP program (e.g., EP diagnoses, within the same age group) who enter standard care outpatient programs in the County during that same time period will be identified as part of the comparator group (CG). First, we will identify all individuals meeting these criteria receiving any outpatient services who are not served in the EP program. An exact definition for the CG sample will depend upon which EP program eligibility criteria can be reliably identified in the County EHR data (e.g., no psychotic disorder diagnosis more than two years prior to index outpatient service). The CG criteria will be finalized later in 2020 and described in the next annual report.

If a sufficient number of these individuals are clustered in specific clinics to match the EP group sample size, we will restrict our analyses to those clinics. Otherwise, we will select all individuals, regardless of primary behavioral health clinic. If there are more CG consumers than EP individuals, we may attempt to statistically match the groups on demographic variables at the group level, although we will summarize demographic characteristics of the entire CG sample.

Service Utilization

Next, data will be requested from the county EHR on all services received by individuals in the EP programs

and all services for members of both groups including 1) any non-EP outpatient services; 2) inpatient services and, 3) crisis/ED services. If possible, we will also work with other systems identified by EP programs as having service use data not otherwise captured in the county EHR (e.g., databases of other EP program services, private inpatient hospitalizations not billed to the county, non-billable peer services, etc.). We have identified these potential additional sources of data in expert interviews with program directors and senior program staff.

Costs

Costs per unit of service will be assigned to each type of service. We will work with county staff to identify the most accurate source of cost data. This may include internal financial accounting systems, contracts, cost reports, or published rates. We will determine whether to apply a single cost across all services (by type of service) or to apply costs that are county- or provider-specific. We will include billable and non-billable services. Additional details on outcomes and cost data sources are described in Table IX below.

Table IX. Outcomes, Sources of Outcome Data, and Methods to Determine Costs Associated with Outcomes

Potential Outcomes of Interest	Sources of Data on Relevant Outcomes	Levels of Analysis	Sources of Cost Data associated with Outcomes
COUNTY LEVEL DATA VARIABLES			
Inpatient hospitalization for mental health concerns	• County hospitalization records	• Number/proportion of individuals hospitalized per group • Number of hospitalizations per group • Number of hospitalizations per individual • Duration of each hospitalization (days) • Total duration of hospitalizations (days) per individual	• Daily rate paid by County • Daily rate Medi-Cal reimbursement
Emergency Department or Crisis stabilization	• County crisis stabilization unit records	• Number/proportion of individuals with crisis visits per group • Number of visits per group • Duration of each visit (hours)	• Hourly rate paid by County
Outpatient service utilization	• Service unit records by outpatient program from County	• Service type • Number of service units (minutes)	• Contract service unit rates

Potential Outcomes of Interest	Sources of Data on Relevant Outcomes	Levels of Analysis	Sources of Cost Data associated with Outcomes
	Examples: • Assessment • Case management • Group Rehab • Group Therapy • Individual Rehab • Individual Therapy • Family Therapy • Plan Development • Medication management • Collateral Services • Crisis Intervention		

Statistical Methods

Analysis of Sample Characteristics
Student T-tests and Pearson Chi-square (or Fisher's exact) tests will be used to compare unadjusted group differences in demographic characteristics (e.g., age, current gender, race, ethnicity, etc.) between the individuals in the EP and comparator groups. Analyses adjusting for county and/or clinic effects will be performed using methods for stratified data, primarily multiple linear or logistic regression analyses. The same methods will be used to examine group differences in clinical characteristics at time of index intake such as primary diagnosis, substance use diagnosis, Global Assessment of Functioning (GAF), as well as the duration of time that clinical services were provided (i.e., duration of follow-up period = elapsed time from initiating clinical services to discharge from services or maximum period EP program allows, whichever is greater).

Analysis of Outpatient Service, Crisis Stabilization, and Psychiatric Hospitalization Data
Data related to outpatient services over the follow up period will be analyzed using generalized linear mixed models to determine if outpatient service use differs between the EP clinic (EP) and comparator group (CG) samples, by total outpatient service time (by minute) and time for each service type (e.g., medication management, individual therapy, group therapy, rehab services), adjusting for a parsimonious set of demographic confounders.

Data related to individuals' experiences of psychiatric hospitalization and crisis/ER usage (see Table IX) over the follow-up period will be examined across multiple levels of analysis: (1) has the individual ever been hospitalized or utilized crisis services; (2) total number of hospitalizations/crisis visits; and (3) total duration of hospitalizations (i.e., length of stay [LOS]) in days. These data will also be analyzed using generalized linear mixed models to determine if hospitalization/crisis outcomes differ between the EP and CG samples.

If sample sizes are large enough, based on power analysis, we will examine the effect of potential moderating variables, including demographic, clinical, treatment participation and program fidelity variables, on service utilization.

Analysis of Costs Associated with Outcomes of Interest

Potential sources of cost data have been identified for specific outcomes of interest: outpatient utilization, ED/crisis utilization, and hospitalization. The distributions of costs will be examined statistically. If costs are highly skewed, a nonparametric bootstrap method may be used in the analyses. Means and confidence intervals of costs will be calculated and compared between groups. Alternatively, we may exclude extreme outliers and use non-parametric methods or mixed-effects models in the analyses. If cost rates differ for children and adults, we will stratify by these groups in the analysis. We will also examine the impact of time (fiscal year) on costs and utilization of these services.

Multi-County Analysis
Data from individual counties participating in this project will be cleaned and standardized in order to integrate samples across counties. Baseline demographic and clinical characteristics will be compared across counties and can be used as covariates in the generalized linear mixed models, which will also include county as a fixed factor to account for unobserved county-level variation correlated with individual outcomes. The larger combined sample size is expected to provide increased statistical power, allowing for a richer set of controls and error structure, for better statistical inference in estimating the effect of the intervention on the EP treatment group. The increased sample size will also permit moderation analyses, such as examining the impact of program fidelity on the relationship between service utilization and clinical outcomes.

Data transfer methods
While data transferred between EP program staff and county data analysts within the same county may be identifiable, all information will be de-identified and provided with a unique numeric ID before being submitted to the UCD evaluation team. Data will be shared through encrypted and password-protected methods. Files will be uploaded to a secure study-specific web portal, housed on secure servers at UC Davis. These files will be accessible to study staff via Secure File Transfer Protocol (SFTP). Counties will be able to upload their own data but will not have access to data on the UCD servers, including any identifiable data from the other counties.

10. Initiate Pre-LHCN Implementation Questionnaires

In the LHCN proposal, we proposed to ask consumers and providers to complete self-report questionnaires in the pre-implementation period of the project. Consumers will be asked to complete self-report questionnaires about insight into illness, perceived utility of the tablet, satisfaction with treatment, treatment alliance, and comfort with technology. We also planned to have providers at each clinic complete questionnaires on treatment alliance, use of data in care planning, perceived effect of use for the LHCN, and Comfort with Technology. In addition to the originally planned pre-implementation surveys, we have also added provider surveys that assess demographics, eHealth Readiness, Organizational Readiness for Changes, Attitudes Towards Evidence Based Practice, Clinician Attitudes of Recovery and Stigma, Modified Practice Pattern Questionnaire, and Professional Quality Scale. This battery of questionnaires has been designed to assess potential factors that could influence outcomes for EP consumers that are measured in the project. Therefore, the study team felt it was important to assess these factors for inclusion in the future analysis of outcomes data.

At this time, we have not had any consumers complete pre-implementation questionnaires. All our planned in-person visits have been put on hold due to COVID-19. We are currently working with programs to devise strategies to be able to contact consumers and families for remote research participation prior to full roll-out of the tablets in each program.

We were able to have providers from some clinics finish a subset of surveys after completing consent during the site visits described above. As of June 2020, we had providers at the following sites complete some of their

questionnaires: San Diego Kickstart, OC CREW, Aldea SOAR Solano, Stanford Inspire, UCLA CAPPS, UCLA Aftercare, UCSD CARE, UC Davis EDAPT, SacEDAPT, UCSF PATH, and San Mateo Felton BEAM (re) MIND. Questionnaires completed thus far include demographics, comfort with technology, and eHealth readiness. To date, 100 EP program providers and staff completed our first set surveys of eHealth readiness, comfort with technology, and basic demographics. We have had 85 EP program providers and staff complete the second set of surveys on organizational readiness for change, burnout and satisfaction, attitudes on evidence-based practices, clinician attitudes on recovery and stigma, and practice style. The results of the findings from the surveys will be summarized in the next report, and summaries with potential action items will be provided to each clinical site as a first step in using data to enhance care delivery in EP programs.

Discussion and Next Steps

Over FY2019/20, the team has worked hard to address each of the initial goals laid out in the LHCN proposal. It should be noted that the LHCN represents one of the first partnerships between the University of California, Davis, San Diego and San Francisco with multiple California counties, building a foundation to implement and expand a collaborative and integrated Innovation project. Through this endeavor, all parties hope to have a larger impact on mental health services than any one county can create on their own. While the project has experienced some delays in contracting and many barriers due to the global COVID-19 pandemic, the team feels confident that we are making excellent progress.

The extensive outreach process detailed in this deliverable has significantly informed the construction of the Learning Health Care Network battery, ensuring that the data to be collected during the project is feasible to collect and as clinically meaningful as possible. This process has significantly improved our understanding of what different groups of stakeholders consider important data to collect during early psychosis care, and how to collect it. In addition, it has reinforced the collaborative ethos of the project that has underpinned it since its inception.

The preliminary findings of the results detailed in this report were presented to the national EPINET Executive Committee meeting on February 6-7, 2020, which included the five EPINET hub Principal Investigators, NIH program officers, and the Westat National Data Coordinating Center. These findings significantly contributed to the standardization of outcomes for the national network. Consequently, this work has not only impacted how data will be collected across the California EPI-CAL programs, but it has also informed the national conversation around what data should be considered to be important and meaningful to stakeholders. This work has therefore ensured that the voices of California early psychosis program stakeholders have been heard on the national level.

Throughout the implementation of the focus groups, providers, family members, and consumers were all highly engaged in the process, and very keen to share their perspectives on how this project should move forward. This collaborative approach appears to have further supported stakeholder buy-in, laying the foundation for an improved product that can better serve the needs of California early psychosis program consumers and families. This further supports the importance of meaningful community engagement when implementing such programs.

We have also made significant progress in the county-level data component of this project in preparation for the first county data pull for the retrospective period.

Barriers to Implementation and Changes from Initial Study Design

One of the initial barriers to completing planned project activities was the delays that counties have faced in executing their contracts. This was initially problematic because we couldn’t finish some activities without

getting feedback from all participating counties, which was challenging for counties who had executed their contract early, like Solano County, as we couldn't move on the next set of objectives in their contract. In addition, it made it difficult to align all contract objectives to the same timeline with such varied start dates. Even so, all parties have worked together and been flexible to make significant progress on our planned LHCN goals. We are mostly on track with our initial proposed timeline with a few exceptions. For example, delays in contracting with the counties led to delays with establishing an agreement with Quorum technologies. Due to this, and other factors outlined below, the original application development timeline has been delayed.

Impact of COVID-19 on EP LHCN Activities

Many of our planned activities have been affected by COVID-19 and our team and participating programs had to shift some aspects of the initial study design to successfully accommodate constraints put in place by COVID-19. Of note, we have continued to conduct several focus groups with all LHCN county programs that have an executed contract. Even though we had to cancel scheduled in-person visits due to COVID-19, our team rapidly adapted to these new remote research parameters in order to continue to meet project goals. This included updating our IRB to reflect the procedural changes needed to accommodate remote research activities. Our participants have also had to adjust; they sign all documents and payment forms remotely via DocuSign. In addition to transitioning outcome focus groups to a remote format, we rapidly transitioned our plans to be able to conduct wire frame groups in a remote format from the beginning. The wire frame focus groups have been extremely valuable in providing data on the application and dashboard design, flow, and functionality from a diverse group of stakeholders. This feedback ensures that we build an application with the users in mind, which will increase adoption and utility.

While completion of the current activities covered in this document have not been delayed with the exception of questionnaire completion, future objectives have been impacted by the global COVID-19 pandemic. The most notable effect is a delay on the beta testing and full roll-out of tablets in the LHCN. In our original timeline, we planned to have the tablets with our custom-built application to collect outcomes data in all programs by early 2021. However, due to unforeseen circumstances such as the global COVID-19 pandemic and delays in securing a sole-source contract with our application developer, this timeline has been delayed. While we do not have an exact date for expected rollout, we believe we will be able to have the application in all of the programs by early Summer of 2021. We have notified all participating program and county leadership of this change.

While selection of sites for beta testing was not affected, actual beta testing has been delayed by about three to four months. We have notified beta test sites to expect beta testing to begin in January or February of 2021.

EP LHCN Goals and Activities for FY 20/21

We have several major objectives we plan to work towards and accomplish in the 20/21 fiscal year. For the program-level component of the EP LHCN project, we plan to initiate and complete alpha and beta testing of the tablet application in the current fiscal year. Any outcome data collected from the beta sites will be summarized, including information from qualitative interviews that help us understand barriers and facilitators to app implementation. Feedback from alpha and beta testing will be communicated to the development team in order to address issues in application design and workflow. In addition to testing, we will get preliminary feedback from focus groups on the alpha and/or beta versions of the application and dashboard. If the application is ready for full role out in all EP LHCN sites during this fiscal year, we will conduct initial site visits to train EP program staff in application implementation and data collection.

We will also establish and finalize the data collection process for obtaining county-level utilization and cost data for the retrospective data pull. This county-level data will cover a prior three-year timeframe for preliminary evaluation for both EP and comparator group (CG) programs. After this data pull, we will prepare a report on

the feasibility of obtaining cost and utilization data from multiple counties.

A final goal of the 20/2021 fiscal year will be to schedule for EP Program Fidelity assessments, in preparation for fidelity assessments that will occur in the next year.

Appendix I: Advisory Committee Recruitment Flyer

EPI-CAL California Early Psychosis Collaborative: Learning Healthcare Network and Statewide Evaluation

Interested in participating in a focus group?

What is the Learning Healthcare Network?

The project will bring together early psychosis programs across California to share information and coordinate collection of outcomes data. A tablet application will collect data from clients and families in the clinic. The clinical team will use the data to help make care choices and support clients to reach their goals.

Why is this research being done?

The goal of the focus group is to better understand which measures to include in the tablet application. We are interested in hearing what aspects of early psychosis treatment progress are most important to clients and families.

What does being a focus group participant entail?

We will meet as a group for 90 minutes and share with you the measures available. The goal is for you to share with us your opinion on which of the measures available are the most important and useful for psychosis treatment, and which measures are the least important.

You will be paid $30 for your participation.

If you are interested or would like more information, please contact:

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**Please do not share personal health information via email*

UCDAVIS BEHAVIORAL HEALTH CENTER OF EXCELLENCE
UCSF University of California San Francisco
UC San Diego
CHPR
ONE MIND

Appendix II: Example Focus Group Guide

FACILITATOR: PASS OUT COLOR STICKERS (one color for pre vote, one for post vote)

Consent Process AND compensation (15mins)—Together in 1 room for simultaneous FGs
Brief staff introductions
Brief intro to project by lead facilitator
Use consent/assent script
Compensation forms and pass out gift cards
Describe feedback form

BEFORE START AUDIO RECORDER:
INTRODUCE SELF AS A RESEARCHER:
"I am coming to you today as a researcher, so you all are the EXPERTs in your own experiences and perspectives. We are here to learn from you."

PROCESS FOR AUDIO:
We are using an audio recording because we want to capture all of the rich information you will be sharing with us today.
"Again as a reminder, please try your best not to say your name or others' names or other identifying information about yourself or others. Please try to speak loudly and clearly and try to only have one person talk at a time. If possible, please refrain from side conversations. We ask this of you so that we can get a really clear audio recording but also as a sign of respect for your fellow person."

Before we start the recording, does anyone have any questions?

FOR FAMILY FGs: Please go around the room and state your relationship to the EP consumer.

Introduction (3mins)

"In December 2018, your clinic joined the Early Psychosis Learning Healthcare Network. As part of this network, additional data will be collected and then be available to individuals in this clinic to be used to actively support treatment. This will provide consumers and family members, with an additional way to help identify and address treatment priorities, and to follow progress over time.

However, for this to work and be useful, it is essential for us to collect data that is meaningful to **you**.

Therefore, the purpose of today is to understand what data you think will be most useful to track as part of ongoing treatment. In addition, we also want to know what you think will be feasible for us to collect in this setting.

Part 1: Outcome prioritization (10mins)
First off, I think it is important for us to show you what kind of outcomes we are currently thinking might be important to collect (Fig 1).

"Take out the outcomes definition handout in your folder and start reading through them."
[FACILITATOR – MAY NEED TO GO THROUGH ALL OF THESE WITH THIS POPULATION]

1) Does anyone have any questions about what these different domains mean?

2) Can you think of other important outcome domains for us to consider that are not on this list? (FACILITATOR: ADD THESE TO THE "OTHER" SPOTS ON THE POSTER)

3) What do you think of "Family Burden"?
   a. FACILITATOR: Go to POSTER AND CROSS OUT BURDEN (under family burden) CHANGE TO IMPACT/STRESS?

4) "Including all of the new and original domains, I'd like everyone to select the 4 outcome domains you consider to be the <u>most important</u> for us to measure by using the ____ color stickers you have in front of you. Before you get up and put these on the poster, take a moment to really think about which 4 you will choose then commit to those. Once you decide, you can all get up. More than 1 person can go up to the poster at a time ☺"

[REMINDER: "PLACE STICKERS IN THE DESIGNATED AREA AT THE <u>*TOP*</u> OF THE BOX OR use SPECIFIED COLOR]

TALLY UP THE STICKERS FOR EACH DOMAIN TO HELP WITH PRIORITIZING REMAINING DISCUSSION.

<u>Part 2: Participant Prioritized Outcomes</u> (35mins –9 mins per top 4)

1. Review selected domains

FACILITATOR: DISTRIBUTE OUTCOME MEASURES RELATED TO THE DOMAINS THEY CONSIDER MOST IMPORTANT ONE DOMAIN AT A TIME. ORIENT THEM TO THE TABLE OF CONTENTS.

"Please do not write on the measures packets or the tables of contents as we will be reusing these for each group we visit"

<u>GO THROUGH WHOLE OF PART 2 FOR EACH SELECTED DOMAIN</u>

FACILITATOR: EXPLORE/ENCOURAGE CONTRADICTIONS. HOWEVER, AIM TO DRAW SOME DEGREE OF CONSENSUS ABOUT WHICH ONES ARE CONSIDERED MOST IMPORTANT/USEFUL. FINISH WITH CIRCLING WHAT THE GROUP CONSIDERS TO BE THE MOST IMPORTANT 4-6 DOMAINS.

Sample questions: Why did you choose this domain? Why did you not choose this domain?
Why is this domain so important to collect over another?

IF THERE IS ONLY 1 MEASURE RELATED TO THIS DOMAIN:

i) This is currently our only measure that attempts to capture information in this domain. Do you think it adequately captures what you think is most important to measure here?

ii) What makes it good/bad? Is it missing anything? What are the areas that are necessary?

IF MORE THAN 1 MEASURE RELATED TO THIS DOMAIN:

i) You have said that measuring outcomes related to this domain would be useful. Here are some of the validated measures that have been identified as appropriate for use. Of these, which ones do you think might be best? Why?

ii) Which ones would you consider definitely not usable (if any)? Why?

2. How much detail is absolutely necessary for each domain?

[FACILITATOR: If necessary, FLESH THIS OUT BY GIVING EXAMPLES:]

If *quality of life* was selected, would just one global score be useful, or would it be more helpful to go into specific sub-domains (satisfaction with housing, social, work/school, treatment, family, etc.)?

i. What information would be helpful, if not absolutely necessary?

ii. Is there any information related to this domain that would not be useful?

3. Final review of measure

1) Do you think there will be any difficulties with using this measure?
2) What might we be able to do to lessen these challenges?
3) Are there any aspects in particular that you think will work well?

Part 3: Other Outcomes (at least 30 mins; but also may be helpful to focus on topics that they are uniquely able to comment on, such as the family fx/burden measure). SPEND REMAINDER TIME HERE TO DISCUSS DOMAINS PAST GROUPS HAVE NOT BROUGHT UP, AIM FOR 5MINS MAX PER DOMAIN, UNLESS CONVERSATION REALLY FRUITFUL).

"Here are some of the measures we are currently considering for the domains that you did not prioritize as a group"

1) Of these, which ones do you think might be the most appropriate (if any)? Why?
2) Which ones would you consider to be definitely not appropriate (if any)? Why?

IF THERE IS 1 MEASURE FOR THE DOMAIN:

i) What do you think of this measure?

ii) Does this measure cover the areas you would like it to measure?

iii) Are there any key pieces, or are all the components important?

IF THERE ARE MULTIPLE MEASURES FOR THE DOMAIN:

i) Of these, which do this think is better? Why?

ii) Are there any you think that are unusable? Why?

iii) Does this measure cover the areas you would like it to measure?

iv) Are there any key pieces to the selected measure, or are all the components important?

Part 4: Re-scoring the outcomes (2mins)

FACILITATOR: PASS OUT COLOR STICKERS 1 MORE TIME.

"Now that we have had the chance to go through many of the different outcomes, I'd like for you to select the 4

you *now* consider to be most important. Using the second set of stickers, please rate your final 4 prioritized measures. Again take some time to think about which 4 you will place and then commit."

FACILITATOR NOTE: Remind participants to PLACE STICKERS IN THE DESIGNATED AREA AT THE ***BOTTOM*** *OF THE BOX OR using_____ color).*

Thank everyone for their participation and valuable input!!

Appendix III: Outcome Domains Focus Group Poster

1st Vote = *Above* dotted line
2nd Vote = *Below* dotted line

KEY
Client self-report measures
Family/Collateral self-report measures
Provider/Prescriber-completed measures
Client OR Family/Collateral measures
Client OR Provider/Prescriber measures

PROPOSED OUTCOME DOMAINS
San Mateo Felton Providers

		Clinical Status	Psychiatric Symptoms	Suicide Risk
Other: _____	Cognition	Risk for Homelessness	Incarceration/ Recidivism	Functioning (Social/Role)
Other: _____	Service Satisfaction	Service Utilization (Inpatient, Outpatient, Emergency)	Family Burden	Medication Adherence
Other: _____	Quality of Life/ Well-Being	Recovery	Family Functioning (Communication/ Quality)	Medication Side Effects

Appendix IV: Proposed Outcome Domains and Definitions

Outcome Areas Under Consideration

Here are some simple definitions of the outcomes we will be discussing today in the focus group. It is important that these should just be seen as a starting point. For some there is no "right" definition. If you understand one of these outcomes to mean something different, then it would be very helpful to bring it up in the discussion. We are here to understand what areas are important to you, so if you think we should be using it in a different way we really want to know about it.

Clinical Status: Diagnosis, medication, date of onset, and remission status.

Psychiatric Symptoms: The presence of clinical symptoms (anxiety, depression, mania, hallucinations, paranoia, etc.).

Suicide Risk: The presence of thoughts, wish, plan, or behavior aiming to end one's life.

Service Satisfaction: How satisfied an individual is with the mental health services they receive.

Service Utilization: How often health services are used or received.

Quality of Life / Well-being: How satisfied an individual is with how they live their life (past, present, future).

Recovery: The individual's belief they can live a meaningful life, meet goals they consider important, and develop support to maintain wellness outside treatment.

Risk for Homelessness: History of homelessness or insecure/unstable housing (i.e., couch surfing) and things that increase the risk of homelessness (e.g., foster care, unsteady income).

Incarceration / Recidivism: Experience of arrest, probation, or parole.

Functioning (Social / Role): An individual's ability, interest, and engagement in employment, volunteering, homemaking, and/or school; and their quantity, quality, and engagement in social relationships with friends.

Cognition: The individual's ability to solve problems, pay attention, process and remember information, or do things quickly.

Family Burden (Stress/Impact): The impact of a loved one's mental illness on the support person's life.

Family Functioning (Communication / Quality): How well a family communicates/functions how accepted members feel within the family, and reactions to family problems or successes.

Medication Side Effects: The presence, duration, and severity of medication side effects.

Medication Adherence: Taking medication the way the doctor prescribes (i.e., every day, time of day).

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Mental Health Services Act: Innovations

Collaborative Statewide Early Psychosis Program Evaluation

FY 2020/21 Annual Innovation Report: Early Psychosis Learning Health Care Network

Final version submitted December 2, 2021

Prepared by:

University of California, Davis, San Francisco and San Diego

This report was supported by:

ONE MIND

National Institute of Mental Health

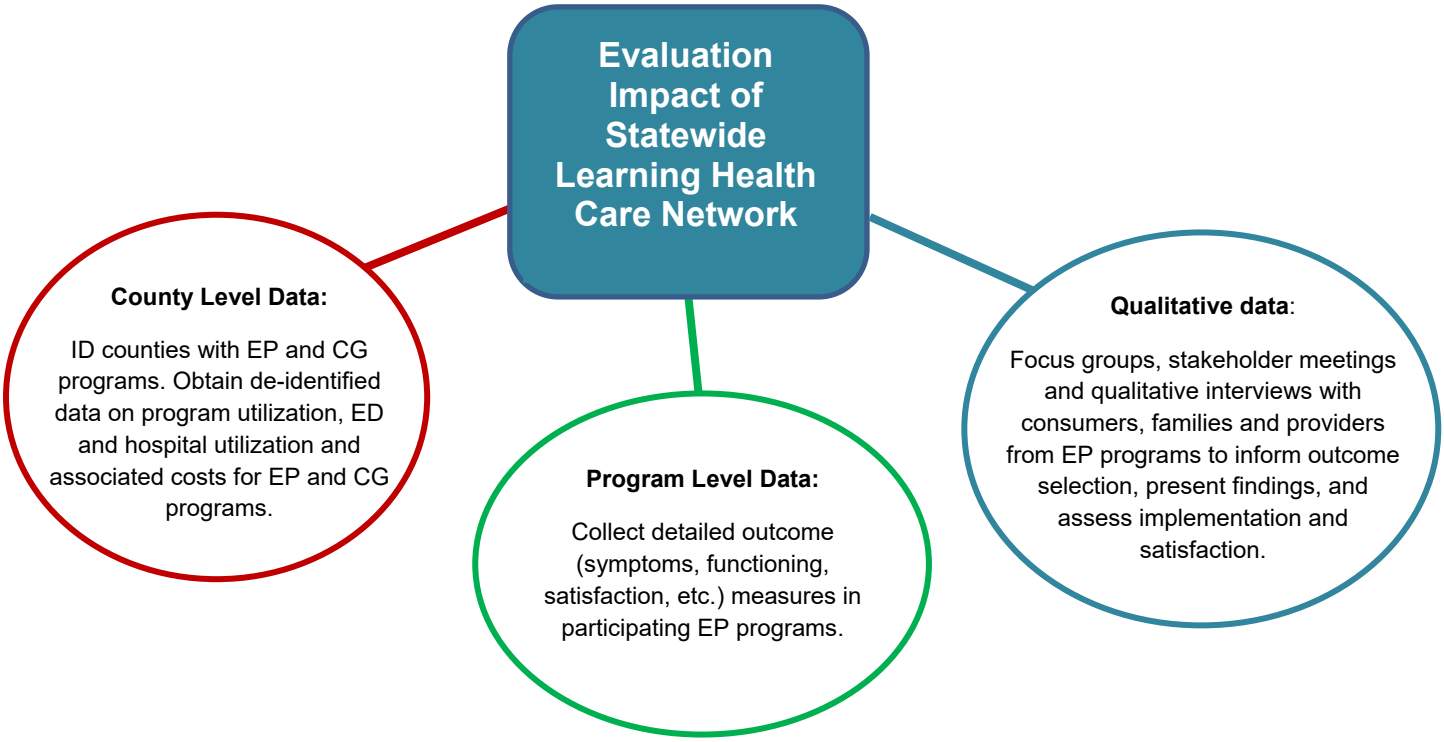
Table of Contents

Background

Multiple California counties in collaboration with the UC Davis Behavioral Health Center of Excellence, received approval to use Innovation or other Prop 63 funds to develop infrastructure for a sustainable learning health care network (LHCN) for early psychosis (EP) programs. Of those counties with approved funding, the following counties have processed and executed contracts between their behavioral health services departments and UC Davis as of June 30, 2021: San Diego, Solano, Sonoma, Los Angeles and Orange. One Mind has also contributed $1.5 million in funding to support the project. Napa and Stanislaus Counties have received approval to use Innovation funds to join the LHCN; their onboarding into the LHCN will be completed over FY 21-22. This Innovation project seeks to demonstrate the utility of the network via a collaborative statewide evaluation to assess the impact of the network and these programs on the consumers and communities that they serve. This project, led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary and multiple California counties, brings consumer-level data to the providers' fingertips for real-time sharing with consumers, and allows programs to learn from each other through a training and technical assistance collaborative. This Statewide EP Evaluation and LHCN propose to 1) increase the quality of mental health services, including measurable outcomes, and 2) introduce a mental health practice or approach that is new to the overall mental health system. The project must comply with the regulatory and funding guidelines for evaluation as stipulated by the applicable Mental Health Services Act (MHSA) funding regulations, contract deliverables, and best practices.

There are three components to the data collected for the LHCN: County Level, Program Level, and Qualitative data (Figure 1). The protocol for collecting each component has been reviewed by an Institutional Review Board (IRB) and approved before commencement of data collection. Further, aspects of the data design will be shaped by the input of stakeholders, including mental health consumers, family members, and providers.

Figure 1. Three Components of the Evaluation Associated with the Statewide LHCN.



This project was approved for funding using Innovation Funds by the MHSOAC in December of 2018. The California Early Psychosis Learning Health Care Network (LHCN) represents a unique partnership between the University of California, multiple California counties, and One Mind to build a network of California early

psychosis (EP) programs. Additionally, we were able to leverage this initial investment to obtain additional funding from the National Institutes of Health (NIH) in 2019, which enabled six university and two county early psychosis programs to join and also linked the California network to a national network of EP programs, including UCSF PATH, UCSD CARE, UCLA Aftercare & CAPPS, Stanford Inspire, San Mateo Felton BEAM UP/(re) MIND, UC Davis EDAPT and SacEDAPT programs. The overarching name of the project, which encompasses the LHCN and the NIH-funded components, is now "EPI-CAL." In this and future reports, we will refer to the LHCN only when describing components of the project that are specific to the LHCN evaluation (e.g., county data analysis).

Our EPI-CAL team has made significant progress towards our goals outlined in the innovation proposal during the 20/21 fiscal year, which are summarized in the current report.

Executive Summary

The purpose of this document is to provide the EP LHCN Mental Health Services Act (MHSA) Annual Innovation Report to review EP LHCN goals accomplished during FY2020/2021. This report will include summaries and status updates on the infrastructure of the LHCN, steps taken towards implementation, and barriers that have been identified over the course of the last fiscal year. While the counties involved in the EP LHCN may be at different stages in the process, the overarching LHCN is moving forward as planned.

- Prior to beginning activities for the LHCN, UC Davis had to have an executed contract with each of the participating counties so each party could mutually agree to a scope and terms of work. As of June 2021, UC Davis had executed contracts with Solano, San Diego, Los Angeles, Orange, and Sonoma counties. The Napa County LHCN and Aldea contracts were under review. In addition to existing LHCN counties, Stanislaus County has received approval to join the LHCN. We are working together to execute their contract before officially beginning activities in their county program.
- We have held two LHCN Advisory Committee meetings in the last fiscal year, which was comprised of a county representative from each participating county, a clinical provider from each participating EP program, and consumers and family members who have been or are being served by the participating programs. We will continue to hold Advisory committee meetings on a bi-annual basis.
- In the coming year, we plan to begin fidelity assessments in EPI-CAL/LHCN clinics. We have scheduled fidelity assessments for all participating programs in the LHCN network with an executed contract.
- We have administered self-report questionnaires to providers and consumers and in the pre-implementation period of the project, as outlined in the LHCN proposal. The battery of questionnaires, including baseline and pre-implementation surveys, have been designed to assess potential factors that could influence outcomes for EP consumers that are measured in the project. By the end of the fiscal year, we have had 11 consumers and eight clinicians complete pre-implementation questionnaires across three participating clinics. While we have eight clinicians who responded, 46 clinician surveys have been completed as clinicians can complete surveys about multiple eligible consumers. We've had 152 providers complete the baseline surveys.
- We have continued to hold focus groups with consumers and providers to elicit feedback on the custom application (Beehive), including six focus groups to develop the End User License Agreement (EULA) and presentation of data-sharing options for Beehive users. Our team used feedback from these groups to update the EULA video and EULA screens in Beehive. We have summarized the qualitative feedback we've received on Beehive in a qualitative report. This includes feedback from wireframe focus groups, alpha version focus groups, and EULA/data-sharing focus groups.
- In the past year, we completed the testing and initial deployment of the Beehive application in EPI-CAL/LHCN clinics, starting with alpha testing, followed by beta testing, then full deployment across the network.
- In order to prepare for our county-level data evaluation component of the LHCN, established the data collection process for obtaining county-level utilization and cost data for a retrospective 3-year timeframe for preliminary evaluation for both EP and comparator group (CG) programs. We have also written a report on the feasibility of obtaining cost and utilization data for this retrospective period.

Current Project Goals

The current document summarizes project activities conducted for the LHCN during the 20/21 fiscal year. This includes the following project activities:

1. Establish a Stakeholder Advisory Committee that will meet at least every 6 months.

2. Schedule for EP Program Fidelity assessments.

3. Complete Pre-LHCN implementation questionnaires

4. Produce qualitative report on ongoing issues and suggestions on the app/dashboard from EP program staff and other stakeholders; including results of focus groups

5. Conduct initial site visits, detailing training of EP program staff in data collection

6. Provide feedback from beta testing of LHCN application for data collection

7. Subcontractor to make modifications to software application and dashboard to reflect findings from pilot testing and qualitative report

8. Get preliminary results on program-level data from 2 pilot EP programs, including interviews with EP programs to understand barriers and facilitators to app implementation

9. Outline plan for training EP program staff from non-pilot programs on app implementation and outcomes measurement

10. Establish data collection process for obtaining county-level utilization and cost data for prior 3-year timeframe for preliminary evaluation for both EP and comparator group (CG) programs.

11. Report on feasibility of obtaining cost and utilization data from preliminary multi-county integrated evaluation.

1. Establish a Stakeholder Advisory Committee that will meet at least every 6 months

The Advisory Committee for the LHCN is comprised of a county representative from each participating county, a representative of each participating EP program, and up to five consumers and five family members who have been, or are being served, by EP programs. This committee is co-led by Bonnie Hotz, family advocate from Sacramento County. Recruitment for the Advisory Committee is ongoing, and we have confirmed membership with multiple stakeholders. These include past consumers, family members, clinic staff and providers. Even though we have already held several Advisory Committee meetings, we continue to distribute flyers to all participating clinics, as their contracts are coming through, to make sure the Advisory Committee is open to all LHCN member clinics. In the 20/21 fiscal year, we held Advisory Committee meetings on December 8th, 2020 and June 7th, 2021.

December 8th, 2020 Meeting

During the first bi-annual meeting of the fiscal year, we gave a progress report on development of the battery, county data analysis, program-level survey data reports, and the alpha phase of the application. When reviewing the battery, family stakeholders expressed that they liked the question regarding how a consumer's role may have changed in response to mental health challenges. County and provider stakeholders appreciated the thoroughness of the battery and pointed out support for asking about involuntary hospitalizations. County stakeholders also expressed support for the level of detail collected regarding risk for

homelessness, and it was pointed out that we might want to ask whether commercial insurance is provided by one's employer due to the heavy cost burden of paying for private insurance.

During initial site visits, providers and staff at each EP program were asked to complete a battery of surveys related to factors that may impact Beehive implementation (e.g., organizational readiness for change, comfort with technology) or consumer-level outcomes (e.g., provider burnout, stigma around mental health, views on recovery). When reviewing the program-level survey data, there was general support for the way data was visualized. Various stakeholders gave helpful insight into how to interpret some of the data, especially how COVID affects the burnout and organizational challenges data. We were also provided with guidance around additional questions that should be asked to help clarify the COVID data, including whether staff may have assignments to homeless shelters or emergency services, anxiety around working with consumers with COVID, and whether staff are fully working from home or have to continue to work in the program in person. Family stakeholders also agreed that this was valuable data as those at a management level can use this data to see if providers are feeling overworked or burned out, which can affect the quality of care.

Finally, we reviewed progress on the development of the application to-date and received generally positive feedback on the alpha version of the application.

June 7th, 2021 Meeting

We held the most recent Advisory Committee meeting on June 7th, 2021. The meeting was also held remotely due to the COVID-19 pandemic. During the meeting, we gave a progress report on the county data analysis, provided a summary of findings from the EULA focus groups, shared the EULA video, discussed progress on Beehive training, and solicited feedback on the Barriers and Facilitators interview guides. When reviewing the EULA video, a consumer stakeholder expressed that the video was very clear and informative; they liked how the video explained how data would be de-identified and liked the images used to represent that. A family stakeholder commented that they appreciated that this video might help new families and consumers to feel more comfortable using the application, especially regarding the transparency and clarity of the video.

When giving an update on Beehive training progress, we had program leadership from pilot programs give their feedback on how Beehive has been integrated into their program so far. Program leadership communicated to the committee that clinicians have made some changes to their schedule and structure of sessions to introduce Beehive and that it can take some additional time when first orienting to Beehive, and that they found planning ahead has been effective. They also shared that consumers have generally had a positive reaction to this platform. Finally, they found it is important to share feedback to leadership from a clinician perspective around how this change impacts additional clinical responsibilities.

Prior to the Advisory Committee meeting, we shared our Barriers and Facilitators interview guides so attendees could review the guides ahead of time in preparation to give feedback at the meeting. The purpose of the Barriers and Facilitators interview is to explore consumer and provider experiences of integrating and utilizing the Beehive system in clinical practice. This includes understanding how intake procedures were modified to incorporate registering new consumers into the system, provider and consumer experiences of adding their data into Beehive, and their experiences of integrating measurement-based based care during the consultation. We wanted feedback at the meeting in order to know if we are asking all the right questions and asking them in the right way. Providers gave feedback that it is very important to understand how Beehive can be integrated into billable time and how long the surveys take to complete. Family stakeholders gave feedback that included clarifying the wording on some questions, including a question that asks the consumer whether the application helped them meet their treatment goals, as well as asking the consumer if the application captured the most important parts of their experience.

2. Complete Pre-LHCN implementation questionnaires

In the LHCN proposal, we proposed to ask consumers and providers to complete self-report questionnaires in the pre-implementation period of the project. Consumers are asked to complete self-report questionnaires about insight into illness, perceived utility of the application, satisfaction with treatment, treatment alliance, and comfort with technology. We also have providers at each clinic complete questionnaires on Treatment Alliance, Use of Data in Care Planning, Perceived Effect of Use for the LHCN, and Comfort with Technology. In addition to the originally planned pre-implementation surveys, we have provider surveys that assess demographics, eHealth Readiness, Organizational Readiness for Change, Attitudes Toward Evidence Based Practice, Clinician Attitudes of Recovery and Stigma, Modified Practice Pattern Questionnaire, and Professional Quality Scale. This battery of questionnaires is termed the “baseline” surveys and have been designed to assess potential factors that could influence outcomes for EP consumers that are measured in the project. Therefore, the study team felt it was important to assess these factors for inclusion in the future analysis of outcomes data.

To date, 152 EP program providers and staff completed our baseline surveys on E-Health readiness, comfort with technology, and basic demographics. We have had 121 EP program providers and staff complete the second set of surveys on organizational readiness for change, burnout and satisfaction, attitudes on evidence-based practices, clinician attitudes on recovery and stigma, and practice style. The results of the findings from the surveys are compiled into a custom report for each clinic, including suggestions for potential action items as a first step in using data to enhance care delivery in EP programs.

At the time of this report, we have had 11 consumers and eight clinicians complete pre-implementation questionnaires across three participating clinics. While we have eight clinicians who responded, 46 clinician surveys have been completed as clinicians can complete surveys about multiple eligible consumers. These survey responses include representation from the Solano Aldea SOAR and San Diego Kickstart clinics. We are currently in the process of continuing to recruit clinicians and consumers from EPI-CAL clinics who have not had Beehive implemented in their program.

3. Schedule for EP Program Fidelity assessments.

Each early psychosis clinic will undergo a fidelity assessment to determine their adherence to evidence-based practices for first-episode services using a revised version of the First Episode Psychosis Services Fidelity Scale (FEPS-FS). The FEPS-FS represents a standardized measure of fidelity to EP program best practices (Addington et al., 2016; First Episode Psychosis Services Fidelity Scale: (FEPS-FS 1.0), 2015). The FEPS-FS was developed using an international expert consensus method, focused on six domains: (1) population-level interventions and access, (2) comprehensive assessment and care plan, (3) individual-level intervention, (4) group-level interventions, (5) service system and models of intervention, and (6) evaluation and quality improvement. The FEPS-FS has been recently revised to meet the agreed upon standards of EP care in the US and allow large-scale fidelity evaluation. Additionally, most programs within EPI-CAL also provide services to individuals with the clinical high-risk syndrome (CHR), for whom evidence-based best practice differs from FEP care in a number of respects. Consequently, to provide a program assessment that most accurately represents the care delivered, alongside the FEP-FS we will be piloting a new scale under development designed to assess the components of care delivered to individuals with the diagnosis of CHR, known as the CHRP-FS.

Each EP program will participate in an assessment of EP program components using the revised FEPS-FS/CHRPS-FS, which will be completed via web-based teleconference. The fidelity assessment will be used to identify program strengths and possible areas for improvement, which can serve an important driver to improving early psychosis care delivered in EP programs in the LHCN. Additionally, the ability to evaluate the

impact of service-level factors on consumer-level outcomes collected by Beehive will provide us with important new insights into what particular components of the EP program of care are associated with improved outcomes in different domains. These findings can then be disseminated across the network (and beyond), further informing care and shaping service delivery.

Assessments will be completed in groups of 2-6 programs per quarter, starting in September 2021 until December 2022. Assessments will be completed by trained clinical staff with expertise in early psychosis care and supported by evaluation administrative and research staff. Prior to the assessment taking place, the assessors and administrative/research support staff will undergo a two-day training to go through the manual and conduct a mock site visit based on real cases. Prior to the evaluation, EP program sites will participate in an introductory meeting, in which an overview of the FEPS will be provided and the components of the evaluation will be discussed. The assessment will be conducted in consultation with Don Addington, M.D. from the University of Calgary, author of the FEPS-FS and CHRPS-FS scales. Dr. Addington will also provide the overview presentation to the participating sites.

At the time of this report, EP program fidelity assessments have been scheduled for two programs for the fall quarter of 2021: Orange County OC CREW program (November 29 - December 3, 2021) and San Diego Kickstart program (November 1-5, 2021). Aldea SOAR Solano is scheduled for the following quarter (January 17-21, 2022), Sonoma Aldea SOAR will take place in the second quarter of 2022, the five LACDMH programs are scheduled for the third quarter of 2022 (July, August, September), and Napa Aldea SOAR is schedule for the fourth quarter of 2022.

4. Produce qualitative report on ongoing issues and suggestions on the app/dashboard from EP program staff and other stakeholders, including results of focus groups.

Over the course of the past year, the EPI-CAL team has conducted extensive qualitative research in order to engage various stakeholders and utilize their valuable feedback to shape the development of the Beehive application. We received qualitative feedback throughout the development of this custom application in three different types of qualitative focus groups: wireframe focus groups, alpha testing groups, and data-sharing/end user license agreement (EULA) focus groups. We have conducted a total of 23 focus groups spanning these three focus group types in order to get detailed feedback and suggestions for the application and dashboard from EP program staff, EP program consumers, and their family members.

Wireframe focus groups

Quorum and the EPI-CAL research team have worked collaboratively to develop the wireframe for the tablet and web-based applications. The UC Davis team used these storyboards as materials for focus groups to obtain feedback on the application and dashboard’s design, flow, and functionality.

Methods
We conducted a total of 16 wireframe focus groups. Each group was 90 minutes long and categorized by the types of participants, including research staff, clinic providers, clinic administration, consumers, and their family members. Two groups were held with research staff and data experts (12 participants), six groups were held with providers at EP programs (36 participants), three groups were held with clinic administrators (20 participants), one group was held with both EP providers and clinic administrators (nine participants from Los Angeles County programs), and four groups were held with consumers and families (17 participants; see Tables 1 & 2). We did not meet separately with consumers and families for these groups, but instead held combined groups for consumers and families to attend together. Due to COVID-19, all focus groups were conducted over video conferencing (Zoom or WebEx). To maximize convenience and availability for staff

during this time of transition, multiple groups were scheduled and open to participation from staff at any EPI-CAL clinic. Many of the groups had representation from multiple clinics in the network, which allowed for the study team to better understand the differing needs and environments of programs in the network. During each group, EPI-CAL research staff presented various aspects of the application storyboard, which allows for visualization of the look, feel, and functionality of the application prior to development. Each presentation was tailored to demonstrate scenarios pertinent to how specific users (i.e., providers, clinic administration, consumers, and families) will interact with the tablet and web applications. We asked for feedback on the look and feel of the application, the functionality of the application as it relates to the current EP program workflow, and ease of use and acceptability for both consumers, support persons, and staff.

Table 1

Total Wireframe Focus Groups	**16**
Research Focus Groups	2
Provider Focus Groups	6
Clinic Admin Focus Groups	3
Provider & Clinic Admin Focus Groups	1
Consumer & Family Focus Groups	4

Table 2

Total Participants*	**94**
Research	12
Providers	36
Clinic Admin	20
Providers & Clinic Admin	9
Consumer & Family	17

**Participants could attend more than one group*

Results

Our research team discussed and synthesized the feedback for the application developers to support application development (see Appendix I). When integrating the feedback into application development, we endeavored to balance consumer and family needs with provider and staff needs. Overall, stakeholders approved of the look and feel of the application. Some stakeholders (both consumers and providers) noted that the color scheme and layout seemed overly clinical. They suggested, specifically when presenting surveys, to bring in more color, engaging imagery, and visual information. Occasionally, stakeholders disagreed on whether certain visual aspects of the application were acceptable or not. For example, several providers and family members raised the concern that the current images (drawings of individuals who do not have facial details drawn in) would be disconcerting or upsetting for consumers. However, when we asked consumers about this, they said they felt either neutrally or positively about these images. Often, stakeholders unanimously agreed on an aspect of the user interface that should change, such as changing the color of the survey progress bar in the tablet application to be more prominent.

Stakeholders provided several suggestions to improve integration of the application into their EP clinic workflow and procedures. After demonstrating the process of registering a new consumer in the tablet, clinic staff, consumers, and families alike emphasized the importance of having an option for clinic staff to pre-register consumers if they gather registration information over the phone prior to the consumer's first visit in the clinic. Stakeholders agreed this would reduce burden on the consumer and demonstrate that the clinic was

well organized and listening to the information consumers and family members had already provided.

Some stakeholders provided feedback specific to their role in the clinic. For instance, participants in a focus group with clinic administrators from various programs suggested that demographic information that clinic staff regularly report to their county, for example, be visualized on the clinic administrator dashboard. We subsequently built in data visualizations for race, ethnicity, sex, gender identity, and other metrics which clinics are commonly asked to report. On the other hand, consumers and their family members, from their unique perspective as consumers, nearly unanimously agreed that when viewing data visualizations on the web application with their provider, they would not like to see the results of the symptom survey as the default display. They instead preferred to see a more recovery-oriented measure, such as the Questionnaire about the Process of Recovery (QPR), when first looking at their survey responses. Based on this feedback, we will set the QPR to be the default data visualization presented when a provider is clicking into a consumer's data on the web application.

During focus groups with Los Angeles County stakeholders in August 2020, our team also asked for feedback about how to adapt both the data collection and data visualization components of the application for use with telehealth. Multiple EP staff participants agreed that a remote data collection option, which would allow consumers to complete surveys from home, would be ideal. Consumer and family stakeholders agreed with providers for the remote option, but and were split between their preference for a mobile application or a personalized link that could be emailed or texted from their provider. Consumer and family stakeholders said they would prefer to look at their data with their provider and would not necessarily want individual access to look at their results from home.

Alpha Version Focus Group

We held a focus group for stakeholders to review the alpha version of the Beehive application to elicit valuable feedback from our stakeholders on the development of the Beehive application. This feedback was valuable as it was the first opportunity for stakeholders to review the application in a production environment, rather than wireframes or plans.

Methods

On October 22, 2020 the EPI-CAL team conducted a focus group with four staff members from an EPI-CAL clinic (SacEDAPT) including a clinician, two peer case-managers, and a clinical supervisor. The focus group began with a demonstration of survey-completion on the tablet application and a demonstration of navigation around the web application, including registering a new consumer and viewing consumer survey data visualizations. Focus group attendees were asked for their comments and questions on the application. They were asked to think about the feasibility of the integration of the application within their current clinic workflow and ease of use. After the demonstration, the focus group attendees logged into the alpha version of the application and were able to test out functions such as consumer registration and data visualization.

Feedback

Focus group participants made suggestions to improve the application, including changes to language, look and feel, features, and information presented to consumers (Table 3). The UCD team discussed these suggestions and the action taken is described in Table 3.

Table 3: Examples of Alpha Focus Group Feedback

Suggestion /Question Content Area	**Example**	**Outcome**

Language Used in Application	It is unclear that “primary language” during tablet registration refers to the tablet display language.	UCD team discussed and decided to rename this field to “Display language” to make this clearer.
Information Presented to Consumers	During consumer follow-up visits, a reminder should be added about confidentiality and how data will be used. This information is covered in detail at the first visit but consumers may forget after 6 months.	UCD team will plan to draft a message to returning consumers at follow-up visits that will remind them of confidentiality and how data will be used.
Application Feature	Will consumers have the option to visualize any service that they deem important as part of their treatment, for example, case management, or just the four options listed (medication management, individual therapy, group therapy, education/employment support)?	UCD team to discuss this feature with developers. It is not part of alpha and is not yet functional, but there will be variation at the program-level and consumer-level services offered and received, so flexibility in this visualization will be needed.
Look and Feel of Application	The image that appears during survey completion does not represent people of color.	While there is diversity of sex/race/ethnicity in the images throughout the survey modules in the application, it is currently showing the same image repeatedly for each survey question. UCD team to ask developers whether different images can appear during each survey to avoid over-representation of one sex/race.

Data-sharing & EULA focus groups

To develop the End User License Agreement (EULA) and presentation of data-sharing options for Beehive, the EPI-CAL team conducted a series of six focus groups to gather stakeholder feedback (n=24). Two different phases of groups were conducted: (1) Data-Sharing Preferences Focus Groups, and (2) EULA Focus Groups. Each type of group was conducted three times with a different group of stakeholders in EPI-CAL EP clinics: (1) providers and clinic staff (n=14), (2) consumers (n= 6), and (3) family members and support persons of consumers (n=4). Some stakeholders attended both phase 1 and phase 2 groups.

Focus groups were conducted remotely via web conferencing (Zoom for the provider group, WebEx for the consumer and family groups), each lasting approximately 90 minutes. Informed consent was collected before the groups.

Phase 1 focus groups

These three groups were conducted in August 2020 to understand stakeholders’ views on how their personal health information is and should be used. The introduction to the discussion topics began with a brief description of the EPI-CAL study and a review of definitions of key terms (e.g., privacy, confidentiality). The first part of the discussion focused on stakeholders’ understanding of and perspective on data sharing. The second part focused on stakeholder’s understanding of and perspective of changing sharing options (i.e., “living informed consent” and “the right to be deleted”). The third part of the discussion focused on stakeholders’ understanding of and perspective on sharing different types of data (i.e., identifiable vs. de-identified) at different levels (i.e., individual- and group-levels).

Using notes and preliminary analysis of the transcripts from these focus groups as guidance, the EPI-CAL team developed the materials for the EULA focus group, described below. In general, stakeholders expressed that they were willing to share their de-identified data in order to “help others” (i.e., increase funding to their EP program or other EP programs, contribute to EP research that will improve treatment options for others, promote policy changes that increase accessibility to EP programs). They indicated that transparency of what data is collected, who has access to the data, and how it will be used is imperative for them to make informed decisions about data sharing. They also highlighted the importance of describing the data protections that are in place (i.e., laws and regulations) as well as knowing how the entity to which they are entrusting their data actually follows those laws and regulations. They expressed that giving them more control over their data (i.e., ability to access their own data, change their data sharing permissions, delete their data) would make them more comfortable sharing data.

Table 4

Total Data-Sharing Focus Groups	**3**
Provider Focus Group	1
Consumer Focus Group	1
Family Focus Group	1

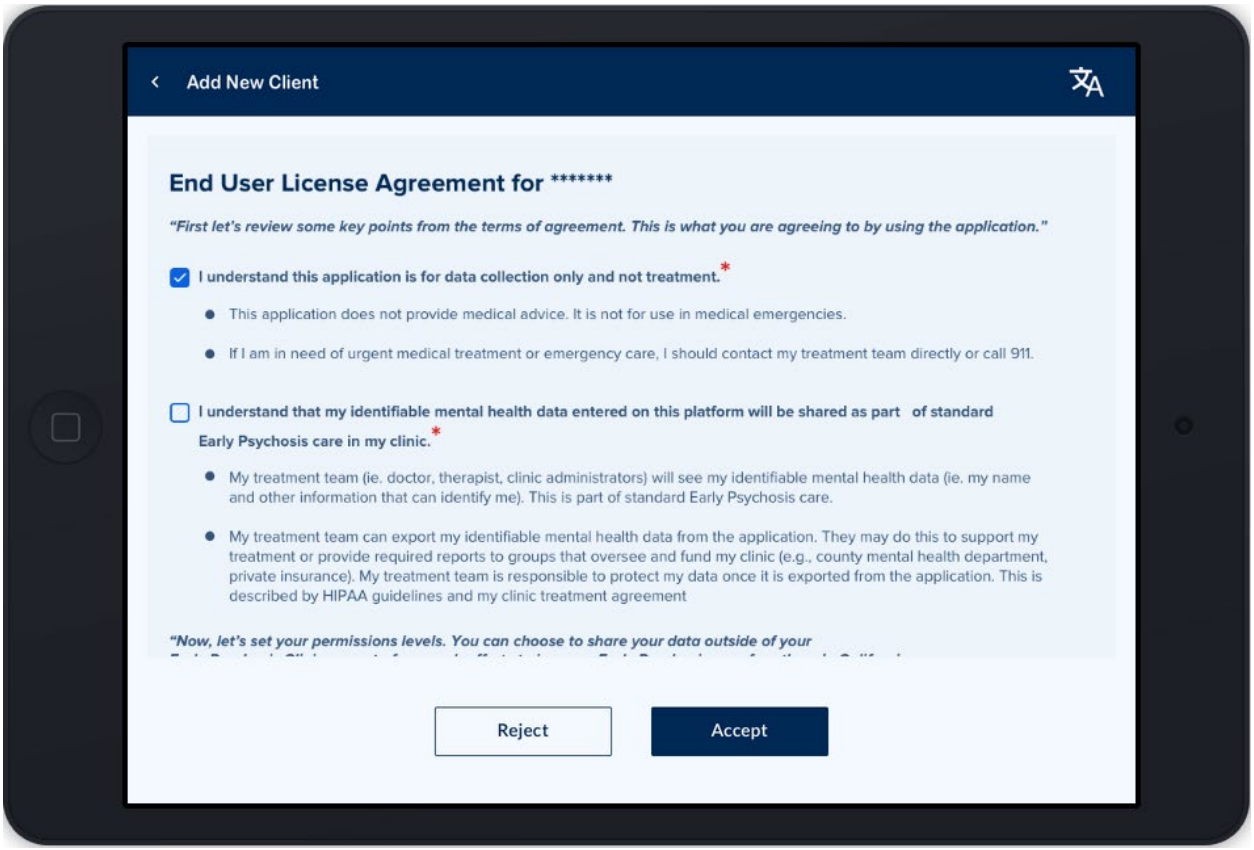
Table 5

Total Participants	**19**
Providers	9
Consumers	6
Family	4

Phase 2 Focus Groups

The three EULA focus groups were conducted in January 2021 to understand stakeholders’ response to how the End User License Agreement (EULA) in Beehive is presented. First, participants were shown an informational video (YouTube link: https://www.youtube.com/watch?v=jzrVmToiGmo&ab_channel=EPI-CAL) created by the research team presenting the key points of the Beehive EULA. After watching the video, participants were asked their opinions about how the information was presented, what questions they still had after watching the video, and how they felt about this method of presenting a EULA. Participants were then shown a demonstration of how the EULA would be presented in the application (Figure 2), with a specific emphasis on the screen on which users may opt-in to data-sharing outside of their clinic for research purposes. Participants were asked for their perspective on how the information was written and presented.

Figure 2: EULA Demonstration



In general, stakeholders thought that using a video to present the EULA was a creative approach that may help users to understand this information better than if they were simply presented this information in a written format alone. All stakeholder groups commented on how to further clarify the information provided.

Provider stakeholders made suggestions about slowing the pace of the video, simplifying visuals, and even culling information from the video to make it simpler. Consumers similarly commented that they would want the ability to pause the video and ask questions of a clinic staff member while watching the video.

In contrast to provider suggestions to remove information from the video to simplify it, consumers approved of the level of detail provided in the video. Consumers said the video helped them to understand the concepts presented. For example, one consumer indicated he had a very clear understanding of how data becomes de-identified by watching the video. Consumers even stated areas where they thought additional detail could be beneficial. For example, consumers thought the video should provide a bit more information about how Beehive would directly benefit them if they chose to use it as part of their care.

Family stakeholders likewise approved of the level of detail provided in the video. For example, they agreed it was important to include the level of detail currently present in the video to describe the relationship between National Institutes of Health (NIH) and EPI-CAL. All participants said the video helped them to have an understanding of the research scope of EPI-CAL and how the data may be used at the national-level as part of the NIH funded study.

When presented with the Beehive EULA screens, stakeholders thought that the written information on data sharing was consistent with the information presented in the video. Stakeholders provided suggestions to change text and formatting. All stakeholder groups agreed that it needed to be made clearer what was optional (e.g., sharing de-identified data with UC Davis researchers) and what was required (e.g., acknowledging that that the application is for data collection, not treatment). A suggestion on how to do this simply would be to add "(optional)" to the text on those statements, rather than relying on a lack of asterisk to indicate that it is

optional. One provider stakeholder suggested requiring a response of yes or no for the options to share data with research, rather than a checked box meaning “yes” and a blank box meaning “no.”

The research team used feedback from these groups to update the EULA video and EULA screens in Beehive. Some changes were implemented for Beta testing (e.g., providing more information about how Beehive may directly benefit users) and others will be considered for future versions of the application (e.g., re-formatting Beehive EULA screen). User feedback from Beta testing will help the team to prioritize what changes to implement moving forward.

Table 6

Total EULA Focus Groups	**3**
Provider Focus Group	1
Consumer Focus Group	1
Family Focus Group	1

Table 7

Total Participants	**14**
Providers	8
Consumers	3
Family	3

Summary

The extensive, iterative, feedback-process detailed in the qualitative section of this report has significantly informed the construction of the Beehive application. We find stakeholder feedback extremely valuable as it ensures that aspects of the application are designed and built with the end-user in mind, increasing the likelihood that other users will find the product useful and valuable. This process has significantly improved our understanding of what different groups of stakeholders consider important in a data-collection application to be used in early psychosis care. In addition, it has reinforced that a collaborative approach is foundational to the success of this project.

5. Conduct initial site visits, detailing training of EP program staff in data collection.

In our original LHCN proposal, we proposed in-person site visits to conduct the initial training for the Beehive application. However, due to the COVID-19 pandemic, we had to adjust our training plan and conduct the first training “site visits” remotely. This began with a pre-training meeting with leadership at each site to discuss which program staff members would be designated as providers, group analysts, or group and clinic admin in Beehive, as well as to cover topics around integrating Beehive into their current data collection system. Next, we conducted a three-part training series to introduce Beehive to each program (Part 1, Part 2, and Part 3). Our remote trainings began with our pilot sites on March 22, 2021 with Part 1 training for UC Davis SacEDAPT and EDAPT. These were followed with trainings for the Aldea SOAR Solano program on March 22, 2021, and the Part 1 training for San Diego Pathways Kickstart on March 31, 2021. In June, 2021, we began to onboard non-pilot sites, starting with the Los Angeles County PIER programs. All LA County PIER programs completed Part 1 trainings in June 2021, starting with The Help Group on June 14, 2021.

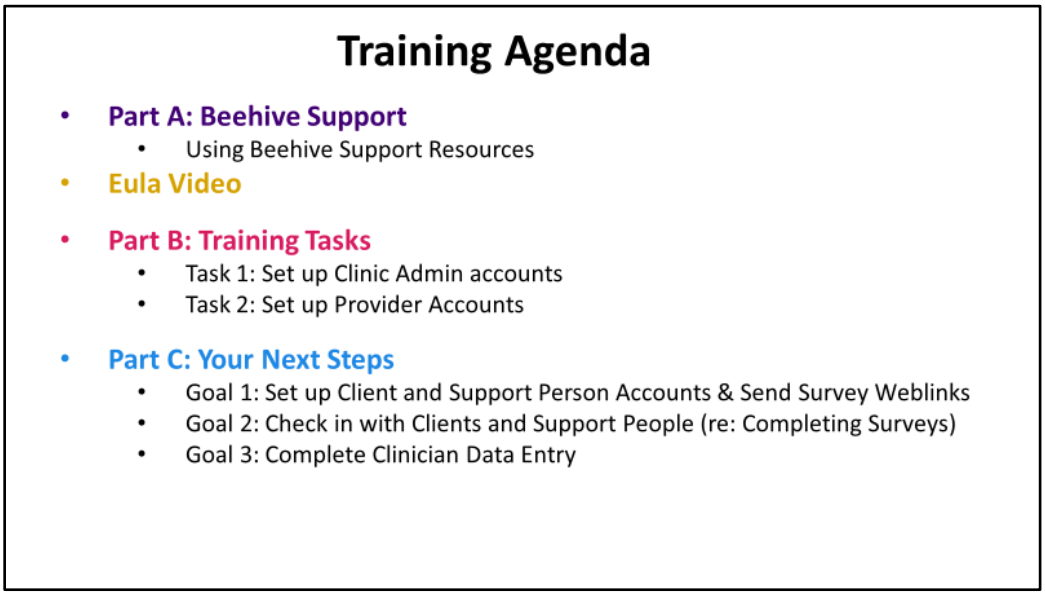
Part 1 Training

The general outline for the first training is as follows:

1. Re-introduction to the EPI-CAL project, including the overarching purpose and goals of data collection via Beehive
2. Presentation on the value of Beehive and data collection
3. Beehive Application training session (see Figure 3)

Presentation- "The Value of Beehive and Data Collection"
An EPI-CAL team member, Leigh Smith, Ph.D., gives a brief presentation that first focuses on how Beehive was developed using input from stakeholders and providers. Next, she provides a historical example of data collection that led to significant innovation in health care by giving a brief vignette of John Snow's work with the Cholera outbreak in London in 1854. She then draws parallels between Snow's work and how Beehive was designed, focusing on a meaningful connection between providers and stakeholders, a holistic approach to data collection, and prioritization of record keeping through automation and data consolidation. After, she speaks about Beehive's power to facilitate dialogue between providers and consumers, and within/between clinics, through reports provided by the Beehive team or generated within Beehive. Dr. Smith covers the purpose of participating in a Learning Health Care Network (LHCN), and how valuable information collection can be in informing treatment. Finally, she emphasizes the ability of Beehive's data collection in shaping care by illustrating how over a million points of data can be generated if each of the 18 EPI-CAL clinics enrolled 80% of their consumers and completed the baseline and two follow-up surveys in the first year.

Figure 3: Training Agenda



Part A: Using Beehive Support Resources
We provide all EP program staff with the link to our detailed resource guide, accessed here: https://sites.google.com/view/beehiveguide/home

The resource guide was created so that EP program staff may reference, in detail, how to use the Beehive application and complete the tasks reviewed during the training. This includes: Creating Clinic or Group Admin Account & Inviting them to Beehive, Accepting Beehive Invite & Completing Registration, and Adding a Provider and Inviting them to Beehive. The resource guide also provides information on how to complete the "homework" that was assigned during the first training, including Adding a Consumer & Support Person and Completing Clinician Data Entry.

End User License Agreement (EULA) Video

We show the EULA video to all EP program staff for two reasons: 1) to streamline the registration process for staff during the training (as all users watch this video as part of the registration process), and 2) to orient them to what consumers and families also see when they first access the Beehive system. The EULA video can be accessed here: https://youtu.be/3E8hiEkIvSQ. The EULA video was developed through focus groups with EPI-CAL stakeholders (consumers, family members and providers) to ensure that core aspects of Beehive (e.g., security, consent and data sharing) were clear to users. The EULA video describes what Beehive is and how it is part of the EPI-CAL project, the purpose of Beehive, how data is shared and stored, and users' options for data sharing. Every new user of Beehive will be presented with the EULA video before making their data sharing choices.

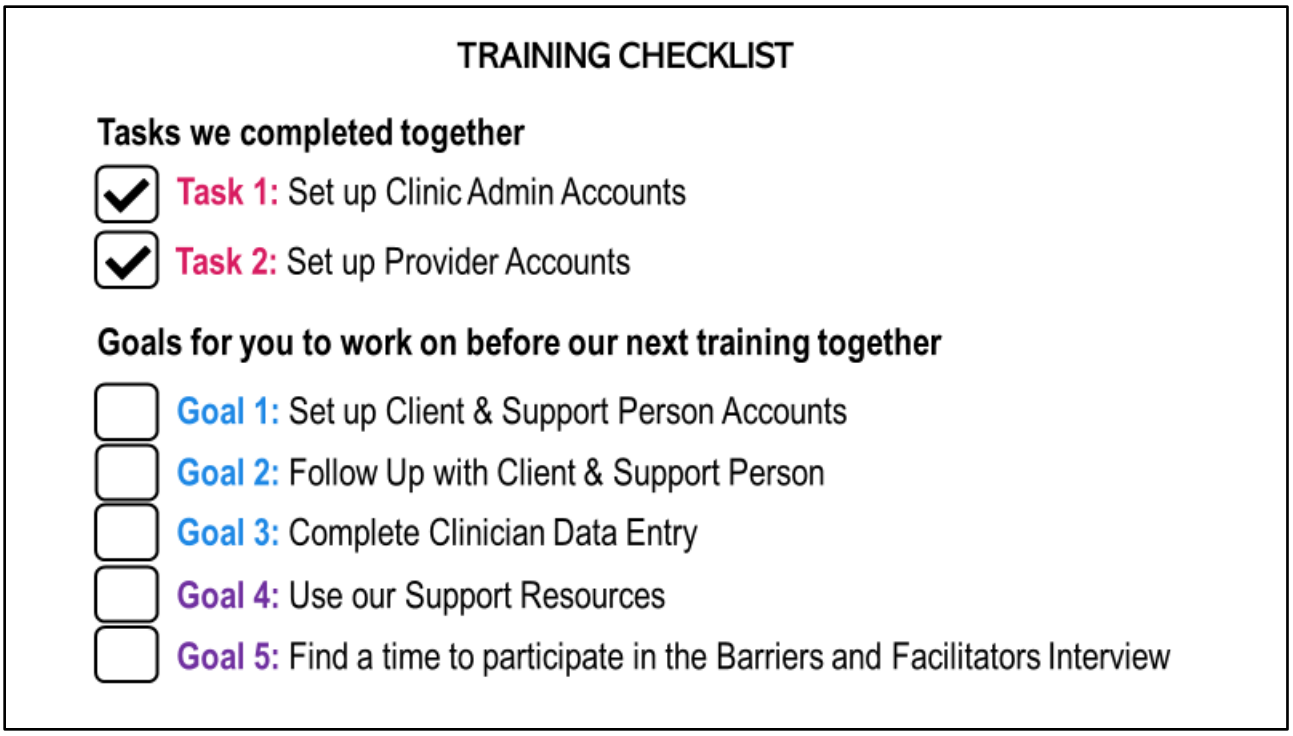
Part B: Training Tasks: Setting up Clinic Admin/Provider Accounts and Registering Consumers
There are three main types of accounts in Beehive; each account is associated with the ability to complete certain actions in the Beehive system in line with that person's job duties. The Group Admin account is for program-level staff members who provide supervision and administrative support across clinics within a particular group – for example, a Group Admin is a person whose position includes oversight of activities at more than one clinic. The Clinic Admin account is for staff members who provide supervision and administrative support within a specific clinic in a group. Finally, Provider accounts are for staff members providing direct services to consumers in a particular clinic, for example therapists, prescribers, and peer support specialists. There is a general hierarchical structure to the relationship between these account types, such as who can invite new users and who can download data from Beehive.

The first training task is to set up Clinic Admin and Provider accounts in Beehive. For the initial Part 1 trainings, EPI-CAL staff created Group and Clinic Admin accounts prior to the first training meeting and sent those specific users their invitations during the live training (for trainings of non-pilot sites, EPI-CAL staff assist all admin users to register at the pre-training meeting). Once participants with Admin-level accounts accept their invitations and completed the registration process, EPI-CAL staff guide them through creating provider-level accounts for their staff and inviting those staff to complete registration in Beehive. For sites utilizing a Single Sign-On (SSO) authentication scheme, the EPI-CAL staff also walk them through the process to log in through their institution.

Part C: Next Steps
Once all providers conclude the registration process, EPI-CAL staff demonstrate the process of registering a consumer and support persons in their support network. Next, the survey collection timeline is introduced. Baseline surveys are available for 75 days after the consumer's intake date (due date of 60 days after intake + 15-day grace period to complete surveys). After baseline, follow up surveys are opened every six months, with a ±15-day window for completion. Next, the process for consumers and primary support persons to complete/request help to complete surveys is shown, along with the steps to manually resend surveys. Participants are then given the goal to register two consumers and their support persons (if applicable) in Beehive, and have the consumers complete their surveys before the next training session (see Figure 4). A Beehive consumer introductory script is provided to support the program staff in talking about Beehive to potential participants.

The original plan for Part 1 training was to cover the process to input clinician entered data during the training session, but due to time constraints, we could not cover this section in the initial training. Instead, clinicians and administrative staff were provided with the section of the resource guide that covers the steps to complete this process, and plans were made to elaborate further on clinician-entered data during a later training once consumers have been added to Beehive.

Figure 4: Training Checklist



Part 2 Training

The second Beehive training focuses on how providers can utilize individual level data in care. The Beehive team introduces the EPI-CAL Core Assessment Battery (CAB), including its domains and how these domains were selected from stakeholder input. Next, the trainer presents two surveys from the EPI-CAL CAB: the Modified Colorado Symptom Index (MCSI) and the Questionnaire about the Process of Recovery (QPR). Then, the trainer shows participants where to find consumer data in Beehive. The trainer then demonstrates how to present the data visualizations available in Beehive and asks the group what questions or concerns the sample visualizations elicit from them. Participants then participate in small group exercises focused on example data visualizations of the MCSI with the goals of 1) exercising their data comprehension skills and 2) practicing using data to explore a consumer's story.

During small group exercises, an example consumer's MCSI scores are displayed, and participants are prompted to discuss the "story" that could be illustrated by this data set. For example, providers are presented with a graph in which MCSI scores are going up over time (indicating more frequent and/or distressing symptoms; Figure 5A) and then asked to interpret possible situations that could be leading to these data trends for this sample consumer. After providers correctly identify that the example consumer is experiencing an increase in frequency and/or number of symptoms, they are asked how they might use this information in treatment (e.g., modify the consumer's treatment plan to help reduce the frequency of these symptoms). When time allows, we cover what the visualizations would look like if there are missing data and the negative impact of gaps in data on its use in care. To this end, providers are presented with MCSI graphs to illustrate that gaps in knowledge can drastically affect data interpretation (Figure 5B). To try to help combat these issues involved with missing data, the team also explains how to increase consumer buy-in to Beehive.

Figure 5: MCSI Example Graphs from Beehive

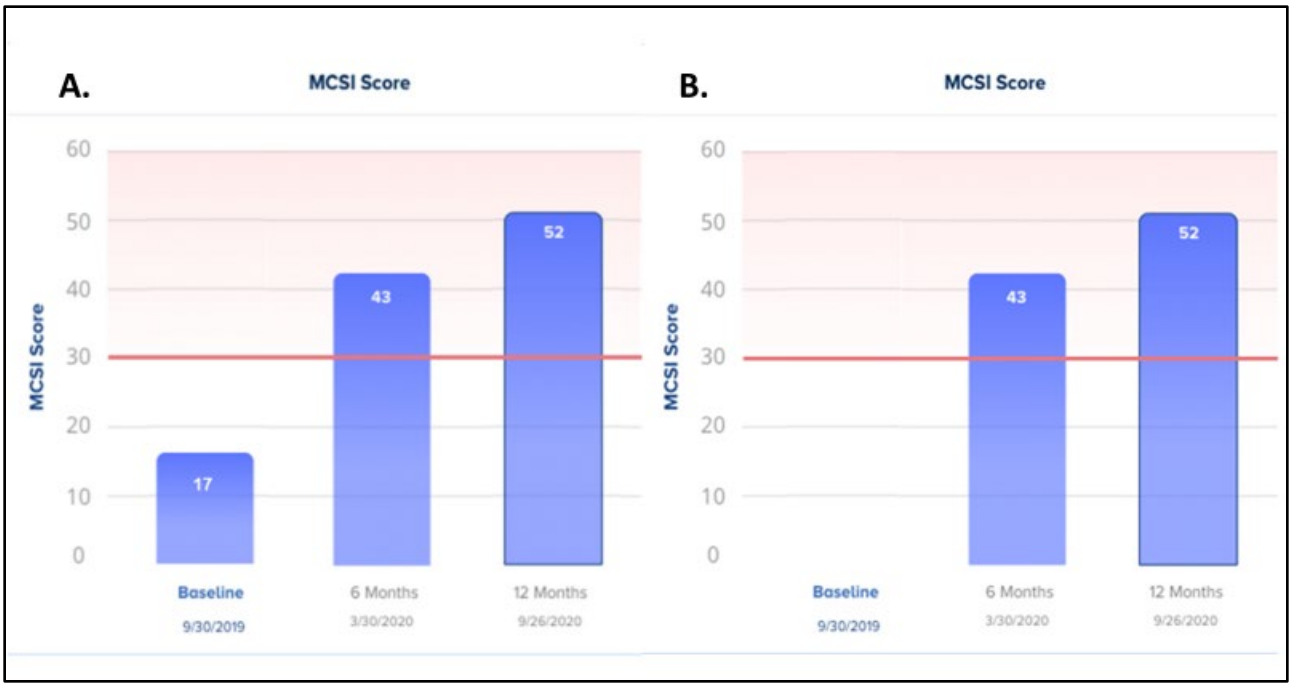


Figure legend: A. Representation of data showing increasing trend in MCSI symptom severity; B. Representation of how missing data (shown here at baseline) impacts the visualization

After these exercises conclude, small groups reconvene back into the larger group, with a member from each group presenting their group's discussion/findings to the rest of the site as a whole. As each small group has different themes and discussions that come up during the exercises, the larger group discussion is meant to help to broaden participants' understanding of data interpretation.

Next, the training details the types of urgent clinical issues that are currently tracked by Beehive, including "Risk to self", "Risk to others", "Risk of homelessness," and "Plan to stop taking medication". These issues were identified during focus groups with EP program stakeholders as critical moments for intervention during treatment. The training team also explains where each one of these alerts can be triggered within the assessment battery. Importantly, we stress that Urgent Clinical Issues in Beehive are not a replacement for each clinic's standard risk management procedures; instead, Beehive can be used as an additional tool to inform their standard risk management approaches. We also cover how to resolve urgent clinical issues using the responses programmed into Beehive (i.e., "Modified treatment plan", "Conducted risk assessment" or "Sent for emergency care") as appropriate for these alerts.

To conclude the training, the trainer introduces the "Data Use in Care" question pop up and its different response options. This pop-up appears intermittently when a user leaves a page on Beehive which displays consumer's data. It asks the user whether they reviewed the data with the consumer or family and then asks them how the data impacted treatment. These response options are the same as the response options programmed into the urgent clinical issues – the training team intentionally takes the approach of presenting these two Beehive features together to help maximize participant comprehension. These data will contribute to a data-driven understanding of Beehive's impact (e.g., whether and how staff use data as part of treatment) on the participating programs of the LHCN.

Thus far, Part 2 trainings took about two hours each and were conducted over the month of April for the pilot programs. SacEDAPT & EDAPT had their Part 2 training on Monday, April 5th, from 8am-11am. Solano's Part 2 training occurred on Monday, April 12th from 11am-1pm. The Pathways-Kickstart Part 2 training was on Wednesday, April 14th from 9am-11am.

Part 3 Training

Part 3 training revolves around applying and expanding the data interpreting skills gained in Part 2 training, with actual data from consumers that was collected after the last (Part 2) training. During Part 3 training, participants are split into small groups, and given a GUID of a consumer that receives services at their clinic. These GUIDs are identified by the site's point person before the start of each Part 3 training and consist solely of consumers that have completed their surveys and have agreed in the EULA to share their de-identified data with UC Davis. This is to ensure that each small group has real-world data to interpret, and that the data for this exercise is ethically sourced.

Before beginning to interpret real consumer data in these small groups, participants are oriented on how to input and view Clinic-entered data and how to assign additional surveys to consumers.

Part 3 training also familiarizes participants to two more measures included in the Core Assessment Battery: the SCORE-15 and the Questionnaire about the Process of Recovery (QPR). These measures were selected because they both capture quantifiable scores on domains (family impact and recovery, respectively) that were identified as high priorities by EP stakeholders during EPI-CAL outcomes focus groups. These measures were chosen for this training as, like the Modified Colorado Symptom Index covered in Part 2 Training, they are scored measures which are visualized in Beehive.

For the small group activity, each participant is assigned to a small group with at least one EPI-CAL team member to orient them to the small group worksheet which includes training activities and discussion questions about finding, interpreting, and using consumer data as part of care. As these trainings require participants to examine their consumer's data (i.e., PHI), EPI-CAL training team members are only present for the beginning of the small group exercise to introduce the activity, but they leave prior to any discussion or sharing of PHI. EPI-CAL staff encourage each participant to take an active role within the small group: note taker, screen sharer, delegate to report during large group debrief, etc. Each small group uses the small group worksheet (Appendix II) to guide their time in the small group.

After the small group exercise, participants rejoin the larger group to share their findings. After each small group has presented their findings with the rest of the groups as a whole, the EPI-CAL team facilitates a large group discussion which encourages participants to look for trends and assess what they could mean. After encouraging pattern recognition, the training team will encourage participants to view their consumer's data through this analytical lens and demonstrate how their treatment plans could benefit from this approach.

In the reporting period, we conducted our initial Part 3 trainings with two sites. Solano's Part 2 training occurred on Monday, June 7, from 11am-1pm. SacEDAPT & EDAPT had their Part 3 training on Monday, June14 , from 8am-11am.

Implementation Support After Initial Beehive Trainings

We introduce each program to their EPI-CAL staff point person who will be reaching out for regular check-ins to resolve any questions they may have as they are familiarizing themselves with the Beehive application. The point persons are introduced during pre-training and the Beehive training series. The initial check-ins are conducted weekly (or as needed by the site) where we will resolve issues as they arise and support staff with accessing resources and learning to use Beehive.

While most point person support consists of email or other electronic communications to answer questions and provide guidance, some sites require additional support. Additional "booster" trainings may be conducted over Zoom, with the potential to expand to in-person trainings as appropriate relative to the COVID-19 pandemic. Also, point person support over video calls is used to provide other forms of support or technical assistance. At one site, a point person began to provide survey completion reminders to clinicians at their weekly Zoom

clinical check-in meetings, while a different site's point person began to provide Urgent Clinical Issue resolution support via their weekly check-in emails.

6. Feedback from beta testing of LHCN application for data collection.

The first part of beta testing was internal user acceptance testing (UAT) by the EPI-CAL team. UAT began when the developers released the beta version of Beehive to the EPI-CAL team, who created test clinics and users at all levels in order to test various use-scenarios to ensure Beehive was working as expected and report any issues in cases where there were typos, bugs, etc. To do this, our team created test accounts as consumers, primary support persons, providers, group analysts, clinic admins, and group admins. These accounts also allowed us to test the sign-up process from different user perspectives. We then reviewed all the surveys in each bundle to check if they were appearing as expected against our survey codebook. We tested survey access and completion on the desktop application (including different browsers), the tablet, as well as Android and iOS mobile devices to confirm proper application formatting on the different types of devices users would access Beehive on. We also interacted with Beehive to emulate other use cases to ensure features outside of the surveys were working as expected (e.g., downloading data reports, viewing and agreeing to data sharing permissions, adding and editing users as a clinic admin). Any typo or bug that was found was reported in a shared review document and corrected internally, if possible, or sent to the developers if it was not an issue that could be resolved by our team. For example, we found that the EULA page was not displaying the video or displaying the data-sharing options correctly. Reports of issues were accompanied by screenshots or screen recordings, where possible, to aid in resolution of items.

After the initial training on Beehive in three pilot programs (see previous section on training), beta testing began in the pilot programs. We solicited feedback from providers and staff in each of the pilot programs after their initial introduction to the Beehive application via a feedback survey (see Appendix III). Thus far, feedback showed that the training was a little too fast paced, that there were plenty of opportunities to give feedback or ask questions, and that users only felt a little confident in using Beehive after the first training. We plan to re-assess users' confidence in using Beehive after the additional trainings take place, as we would expect their confidence to improve after more training and exposure to Beehive. There were mixed responses on practice time, with some individuals expressing the need to have more time to practice using Beehive during the training while others did not need to use training time to practice. There was also variability in the responses regarding the potential value of Beehive, ranging from thinking Beehive will add a little to a great deal of value to their job.

In addition to feedback surveys, we have assigned each pilot program an EPI-CAL staff point person. This point person manages any issues that arise as users implement Beehive in their assigned program. Clinic staff have been provided with their point person's contact information, as well as instructions on how to create a support request ticket in the Beehive application. The ticket system allows Beehive users to create a support request, resolve a request, and escalate a request outside of their clinic or group.

7. Subcontractor to make modifications to software application and dashboard to reflect findings from pilot testing and qualitative report

After receiving feedback from Beehive beta testing (Section "*Feedback from beta testing of LHCN application for data collection*" described above) the EPI-CAL team pushed issues to the application developers to implement in future versions of the application. The types of issues reported were bugs, cosmetic issues, fixes to already implemented features, usability problems, and requested new features.

“Bugs” are errors in the application producing unexpected results. One bug that was identified as part of internal beta testing among the research team was that the response to slider-type questions was not being saved in the database. This was resolved in the next build provided by the developers.

“Usability problems” were aspects of the beta application that did not function as desired, but that were not errors in coding (i.e., bugs). One such issue that was identified as part of internal beta testing among the research team was that character limits and permitted characters needed to be expanded in many of the text boxes throughout the application.

When features were not implemented as originally asked for, the EPI-CAL team categorized these issues as “fixes.” For example, upon receipt of the application, the dropdown menu for “race” within the registration for staff-users, consumers, and primary support persons only allowed for a single selection. The fix for this issue was to allow users to select all that apply in the “race” dropdown. This was implemented in the next release of the application.

“Cosmetic issues” include fixing typos, updating text and imagery in the application, and improving formatting. One cosmetic issue that was identified as part of internal beta testing among the research team was that the image that appeared on the survey instruction and survey question screens did not represent the diversity of the stakeholders for whom the application was developed. The EPI-CAL team had selected images to use throughout the application to represent this diversity. However, the same image appeared repeatedly on the survey screens, which is where consumers and support persons will spend the majority of their time in the application. The resolution to this issue was to change the image to a landscape image to avoid overrepresentation of any one personal identity (i.e., race, ethnicity, gender) on the application.

New features were requested when testing revealed a need for them in the application. For example, EPI-CAL staff determined that additional demographics fields needed to be added to the primary support person registration. Please see Appendix IV for a complete list of items that were identified during pilot testing.

8. Get preliminary results on program-level data from 2 pilot EP programs, including interviews with EP programs to understand barriers and facilitators to app implementation.

Preliminary results on program-level data from 2 pilot EP programs

After our initial trainings with EDAPT/SacEDAPT and Solano SOAR Aldea programs in March, programs were able to begin enrolling consumers into Beehive. Basic demographic information is collected via phone screen and entered into Beehive by clinic staff when initially registering a consumer and their support persons. All consumers had to complete the EULA before being presented with surveys. When consumers complete the EULA, they indicate whether they want to share their data with UC Davis and/or the NIH for research purposes beyond using Beehive for the purpose of their clinical care. Their choices are explained in detail in the EULA video. Our goal is to have 70% of consumers agree to share their data with UC Davis and NIH.

For the current report, we are reporting on data collected up through May 31, 2021 for those who agreed to share their data with UC Davis. Forty-one consumers were registered in Beehive across two pilot clinics, and of those, 22 completed their EULA indicating their data sharing permissions. Of those who completed their EULA, 17 consumers agreed to share their data with UC Davis (77%). Therefore, in the current report we are reporting demographic data for those 17 individuals across two clinics who have registered in Beehive, completed their EULA, and agreed to share data with UC Davis. It is important to note that clinic staff register consumers and invite them to Beehive; consumers then complete their registration and then have the ability to complete surveys. So, if someone has been registered in Beehive, it does not necessarily mean that they have completed any of the outcomes surveys available in Beehive.

Here we report demographic information that is completed at registration, which is a subset of the demographic questions that are asked in Beehive (Table 8). Complete demographic information, including all required PEI fields, are administered via a required consumer-entered Beehive survey. For any cell that has an N less than 5 individuals, this data was masked and both the N and proportion cells were updated with "<5" and "<29%", respectively. If there were 0 individuals who endorsed a response option in the demographic surveys, the category is not represented on Table 1 (e.g., intersex under Sex at Birth); we will continue to add categories to each demographic variable if there are ≥1 individuals in each respective category.

Table 8: Preliminary Demographic Data from Beehive Pilot Testing

SacEDAPT and Solano SOAR Combined Demographics (through 5/31/21)		
Display Language	**N**	**%**
English	17	100%
Age	**N**	**%**
15-20	9	53%
21-25	<10	<58%
>25	<5	<29%
Sex at Birth	**N**	**%**
Female	8	47%
Male	9	53%
Gender	**N**	**%**
Female	7	41%
Male	<10	<58%
Unsure	<5	<29%
Pronouns	**N**	**%**
He/Him	9	53%
She/Her	<10	<58%
They/Them	<5	<29%
Race	**N**	**%**
African/African American/Black	7	41%
American Indian/Alaskan Native	<5	<29%
Hispanic/Latinx Only	5	29%
White/Caucasian	<5	<29%
Ethnicity	**N**	**%**
No - I do not identify as Hispanic/Latinx	9	53%
Yes - I identify as Hispanic/Latinx	5	29%
Prefer not to say	<5	<29%
Unsure/Don't know	<5	<29%

Additionally, providers are able to enter a consumer's diagnosis when they register individuals in Beehive, which is reported in Table 9. In the same manner as the table above, cells with less than 5 individuals were masked and both the N and proportion cells were updated with "<5" and "<29%", respectively. For most diagnostic categories except Schizoaffective disorder, there were less than 5 individuals per cell. Diagnoses are grouped according to two classes of early psychosis: 1) individuals who are deemed to be at clinical high risk for psychosis (CHR), and 2) individuals who have experienced psychotic level symptoms (First Episode

Psychosis, FEP). This reflects the wide range of psychosis diagnoses that are served by the EP clinics represented in this sample.

Table 9: Consumer Diagnoses from Beehive Pilot Testing

Diagnosis	N	%
Clinical High Risk (CHR)		
Attenuated Psychosis Symptoms	<5	<29%
First Episode Psychosis		
Substance Induced Psychotic Disorder with onset during intoxication	<5	<29%
Mood disorders with psychotic features	<5	<29%
Schizoaffective Disorder (Bipolar or Depressive Type Combined)	8	47%
Schizophrenia	<5	<29%
Missing	<5	<29%

When consumers finish registration in Beehive, they then have access to Beehive surveys. After registration is complete, Beehive makes three surveys available for completion: Adverse Childhood Experiences (ACES), primary caregiver background, and questions about other lifetime experiences and static demographics information (see EPI-CAL Enrollment Life Questions, see Table 10). If a consumer is in a survey window (e.g., at intake or six months), Beehive makes available 15 additional surveys that assess various outcomes including family functioning, education, social relationships, demographics and background, medications, and symptoms (see Table 10 and Figure 6). These surveys are presented in different bundles that are grouped based on subject matter and/or timing of the surveys (i.e., whether they receive the survey just at enrollment, or at enrollment and every six months thereafter). EPI-CAL enrollment and required bundles are automatically assigned to every consumer who registers in Beehive. However, each individual clinic also has the option of assigning addition surveys if they choose to do so. The current data only include EPI-CAL enrollment and required bundles.

Table 10: EPI-CAL Enrollment and Required Survey Bundles

Bundle Name	Survey Name	Bundle Timing
EPI-CAL Enrollment Life Questions	EPI-CAL Enrollment Life Questions	Enrollment only
	Adverse Childhood Experiences (ACES)	
	Primary Caregiver Background	
EPI-CAL Experiences Bundle	Life Outlook	Every 6 months, including intake
	Questionnaire About the Process of Recovery (QPR)	
	Modified Colorado Symptom Index (MCSI)	
	Substance Use	
	Legal Involvement and Related	
EPI-CAL Treatment bundle	Intent to Attend and Complete Treatment Scale	Every 6 months, including intake
	End of Survey Questions	

	Hospitalizations	
	Shared Decision Making (SDM)	
	Medications	
EPI-CAL Life Bundle	SCORE-15	Every 6 months, including intake
	Demographics and Background	
	Social Relationships	
	Employment and Related Activities	
	Education	

When enrolled at intake, consumer and identified support persons can be registered in Beehive by clinic staff. Beehive will then prompt them to complete registration, review the EULA, and choose data sharing permissions. Beehive then shows them the surveys that are available for them to complete within each bundle (see Figure 7 below). Respondents can choose which surveys they wish to complete in the order they wish to complete them.

Figure 6: Survey Window Timing

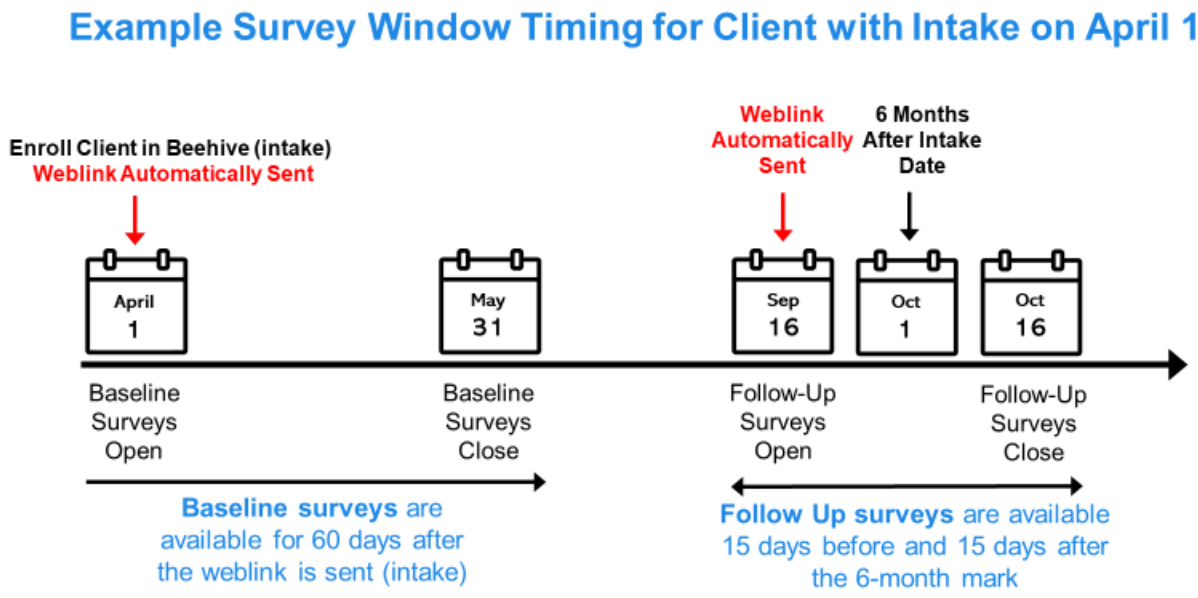
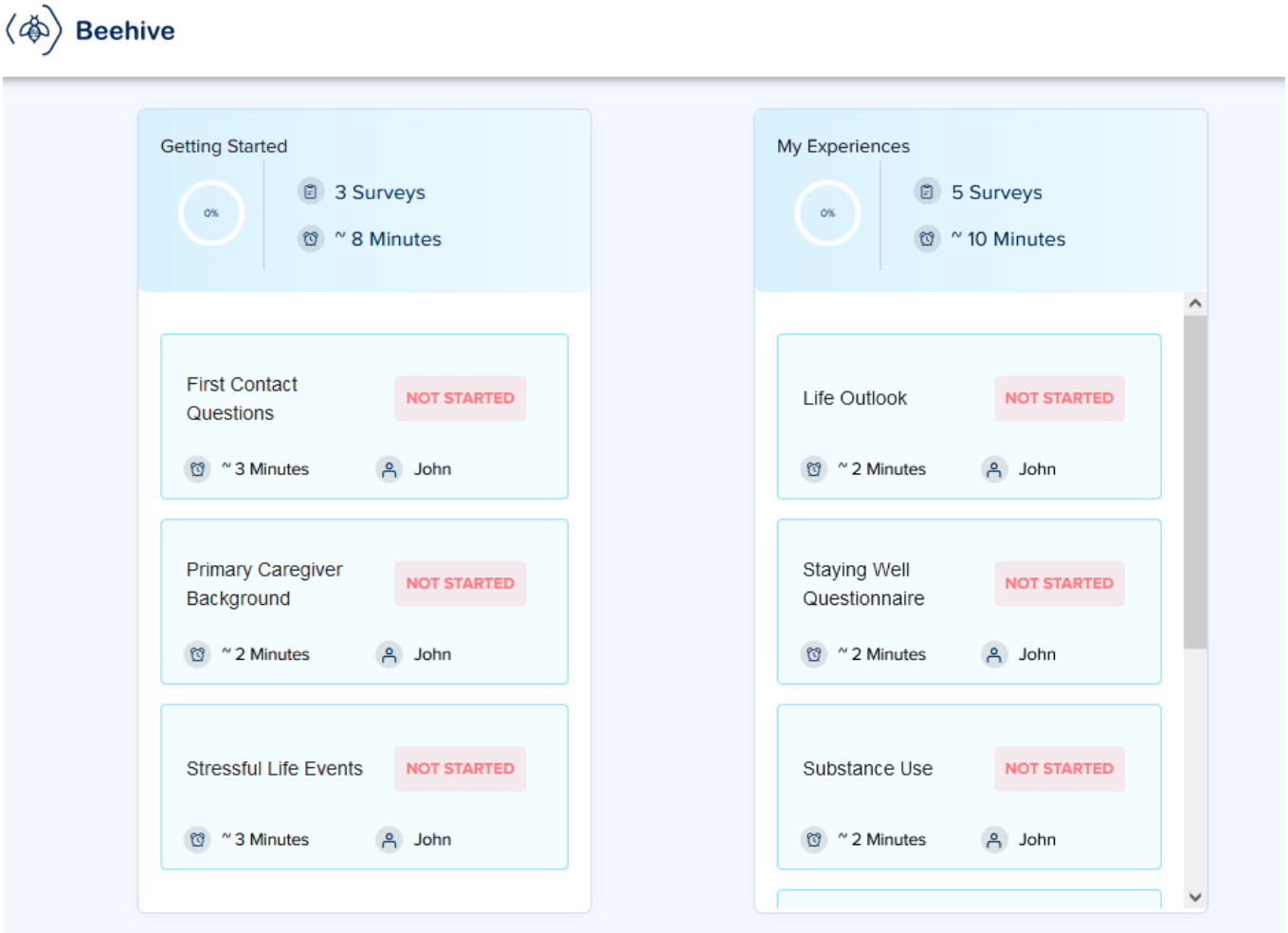


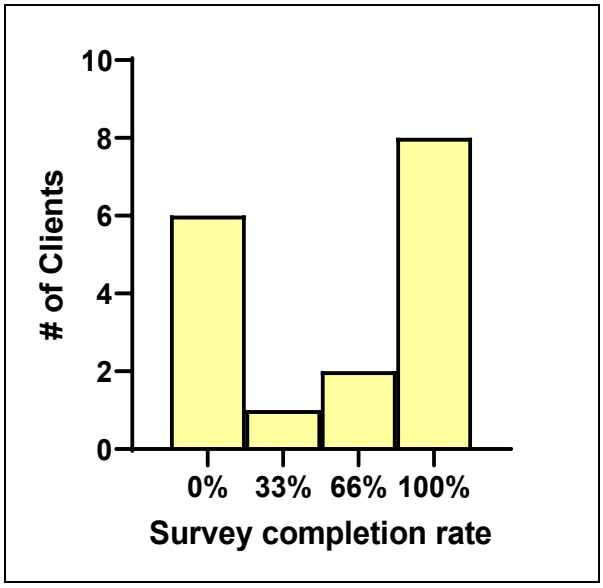
Figure 7: Surveys Available for Consumer to Complete at Baseline



During the initial phase of Beehive roll out, we asked clinics to enroll consumers and support persons who are already engaged in EP care. When these active consumers are enrolled, Beehive prompts them to complete registration, review the EULA, choose data sharing permissions, and complete enrollment surveys. If they are within the active 6-monthly survey window, they are also able to complete the EPI-CAL required bundles.

At this time, we are reporting the survey completion rate from 17 consumers on the three available enrollment surveys (EPI-CAL Enrollment Life Questions, Figure 7) because some consumers were enrolled outside of survey windows and thus were not presented with the remaining 15 surveys. The distribution of survey completion is reported in Figure 8. Survey completion rate ranges from 0-100%, with 47% of individuals completing all three enrollment surveys. The point person at each clinic site will track survey completion and inform clinic staff if there are consumers who are not completing their surveys so that the clinic staff may check in with consumers.

Figure 8: Preliminary Survey Completion Rate for Enrollment Surveys



Exploration of barriers and facilitators to implementation of the Beehive system

To support the successful integration of the data platform into clinical practice, a series of interviews will be completed with providers, consumers, and family members from participating EPI-CAL clinics. The aims for these interviews will be to determine the acceptability of the platform in this setting, identify potential barriers and solutions to implementation, and explore factors that may facilitate implementation. The interviews will focus on provider training, the data collection platform, the logistics of data collection, the data presentation platform, the feasibility and impact of integrating the data into care, and the utility of program-level metrics. To explore these topics, various stakeholders will be interviewed to share their experiences of delivering or receiving care using the application. The interviews will be audio recorded and transcribed, with the transcripts analyzed utilizing a conventional content analysis approach (Hsieh and Shannon, 2005).

Given the heterogeneity of the programs across the network, the complexity of the intake process and subsequent care composition that is the norm in early psychosis programming, and the differing needs of the different community partners involved in the process (consumers, family members, administrative staff, providers, team managers), the interview questions will be framed on a series of multiple levels. First, the interview will focus on specific barriers and facilitators that may exist within the implementation of Beehive at that specific program. Next, more generalizable factors that could potentially exist across programs will be considered. Finally, barriers and facilitators that may relate specifically to different stakeholder groups will be explored. The findings from this investigation will be used to develop a series of guidelines for successful implementation, some of which are pertinent to specific clinics, while others will be generalizable findings that will be disseminated across the whole network. The overall goal of this exercise is for the guidelines to be used by the programs to refine the implementation and integration of the Beehive platform for the benefit of all stakeholders who interact with it.

For the current report, four interviews of providers working at the EDAPT clinic were conducted. Two participants were interviewed once, while the third was interviewed twice. EDAPT is one of two pilot sites which have been charged with implementing the Beehive application into existing practice, which started on March 22, 2021. The interviews were completed by Mark Savill either alone, or with a second researcher (CH). Dr. Savill is the qualitative lead of the EPI-CAL project with expertise in early psychosis and evaluating the implementation of novel interventions in community behavioral health settings. Christopher Hakusui is a Junior Specialist who has played a significant role in the development of the Beehive application, the training, and the integration of the application into clinical services. All interviews were audio recorded, and the analysis of the transcripts will be incorporated into a broader qualitative evaluation of Beehive implementation across all EPI-

CAL clinics, to be detailed in a later report. For the current report, a brief narrative summary of the completed interviews completed is presented below.

Findings

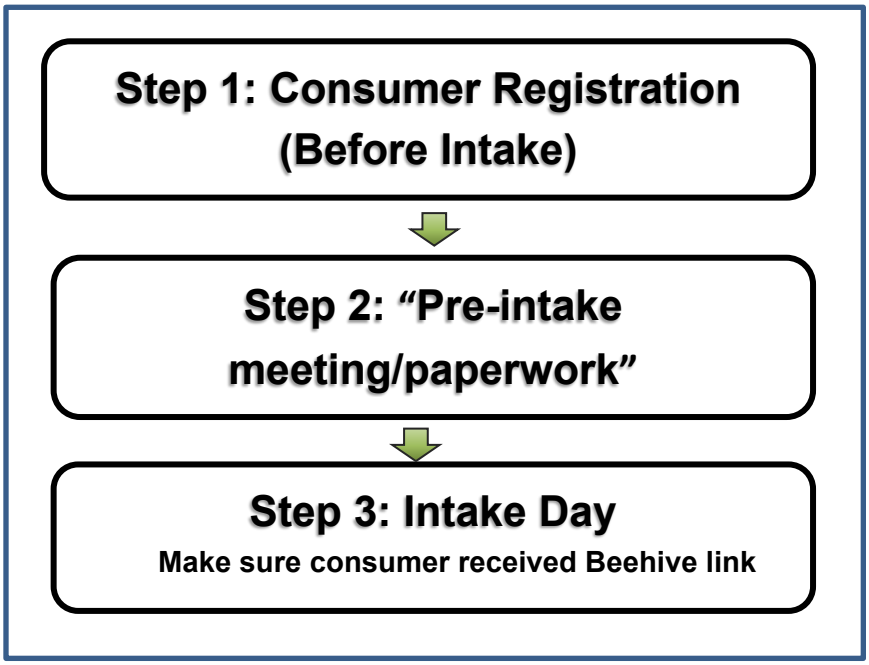
Between 4/7/2021 – 6/17/2021, four interviews were completed with three participants from the SacEDAPT program. One participant was interviewed twice, since they had not yet enrolled a consumer onto the Beehive platform at the time of the first interview and so they had additional insights to share. Two participants were clinic coordinators, and one was a peer case manager. In all cases, the participants' primary role with regards to Beehive to date was enrolling, consenting, and supporting the data collection component of the project. Therefore, the focus on the interviews centered on Beehive training, and the initial implementation of Beehive during the intake process, incorporating scheduling, consenting, enrolling, and baseline data collection both of new intakes and existing consumers. In future reports, as more consumers are enrolled into the Beehive platform and the system is fully integrated into practice, the feasibility and impact of integrating beehive data into clinical care will be explored with consumers, family members, providers, and program leadership.

Initial implementation

Prior to implementation of the Beehive application to their practice, the case managers met to develop a new intake plan that could accommodate the additional components required. During this meeting, the planning process was supported by a member of the research team (VP), which participants recognized as an important component of the process. Once the provisional plan was developed, this was then submitted to senior program management for review/approval.

The final revised intake process is presented in Figure 9. Overall, participants indicated that a significant revision to their original intake protocols was necessary. Subsequently, having the administrative team meet in collaboration with the research team to go through all intake requirements prior to implementation was considered critical. Given the additional time required to enroll consumers into the Beehive application, complete the EULA, and then complete the surveys, the team took the decision that additional steps in their intake procedure were necessary ("Step 1" and "Step 2").

Figure 9: The Revised Intake Process to Accommodate Beehive Requirements



Early Implementation of the Intake Procedure

Participants' interviews indicated that the intake process to date has been consistent with the model developed during the pre-implementation meeting. However, some additional steps have been recently proposed to help with time management when using Beehive during the intake process. This includes having the PCMs schedule an additional appointment to complete consumer and primary support person surveys that were not completed during the initial intake appointment.

Prior to implementation, participants had indicated that the ability for consumers and family members to complete data collection independently prior to the appointment would be critical to effective implementation. However, since the start of data collection, it has been evident that most consumers and family members have required additional support to complete the surveys. The support required typically focused on question comprehension and technical support. Based on current experiences, participants could not identify particular areas where support was consistently requested.

Overall, the participants suggested that the additional components added to intake process across the three stages took approximately 90 minutes, making the new intake process three hours. The main factors for the increase in time required was attributed to the additional scheduling time necessary to book an additional appointment, registering consumers into Beehive, completion of the EULA video and data permission selections, and length of the surveys consisting of Beehive required surveys and additional SacEDAPT required surveys that were integrated into Beehive. The additional procedures were noted to require additional input to the workload of the clinic coordinators, who voiced difficulty in accommodating this into their existing commitments. Additionally, some participants voiced concerns regarding the additional requirements placed on consumers and their families, particularly those who are referred directly from hospital where the intake process is required to be completed within ten days of discharge. To date, consumers and families have not been interviewed, and so their experiences will be explored and presented in later reports.

In an exploration of potential solutions to these barriers, two participants suggested that reducing the length of the intake survey at Step 3 to the just the components critical to the intake assessments, after which other elements could be completed at later appointments. One participant also suggested that they believe the process would be much more streamlined once on-site assessment resumes, given this would minimize both the technological challenges some consumers face, and would also mean that consumers and families could complete surveys in the waiting room and so would need less online support. Linked to this, another proposal was to explore options where the case managers or clinic coordinators would not be on the Zoom call during the completion of the surveys; however, there were concerns about how consumers and families would address issues without available assistance.

Participants indicated that based on previous experiences, a significant proportion of consumers typically enter data via their mobile telephones. Consequently, ongoing compatibility with mobile internet browsers was considered critical. Regarding the current incompatibility of the system with Internet Explorer, the participants were unsure if this was likely to represent a significant barrier. This issue will be explored in future interviews with consumers and family members.

Enrollment for existing consumers

Of those interviewed to date, one participant reported being involved in enrolling existing SacEDAPT consumers into the Beehive system. Overall, the procedures and challenges implementing the new protocols were considered largely consistent with new intakes, with consumers requiring the same level of support to complete the surveys. Because the surveys were being completed within their existing sessions, the participant voiced concern that this would be taking away from direct service time. To address this, the participant suggested that it would either be necessary for an additional appointment to be scheduled with the clinic

coordinator to complete the survey, or else the survey be completed outside of their treatment session without the clinic coordinator being present.

Training

Overall, participants described the training as helpful and a positive experience. While trainings have focused on the data collection component, all interview participants reported appreciating being involved in all aspects of the training. One participant suggested that being involved in all the elements meant that they would be better placed to address consumer/family member questions or queries about other aspects of the application, while others suggested that being able to see how the data can be utilized was a motivating factor in being involved in the process. Being able to see how this data could be utilized in care meant that data collection efforts were considered more important/meaningful, relative to some prior data collection efforts where neither they nor the consumer were able to access the data afterwards.

In addition to the positive experiences reported, one participant did suggest that the training was very focused on utilizing the Beehive application in care and would have appreciated more information on the enrollment and data collection process. Another participant suggested that a reference manual that details each step of the enrollment and data collection process would be very useful. In particular, a summary of what each survey question was aiming to address was considered to be helpful, given the participants reported struggling to explain how to best respond to particular questions in the survey when asked by consumers.

Importance of support

In order to support the implementation of the Beehive application, all participants suggested that having a designated point person to help address technical and logistical issues was critical. One participant suggested that having a designated person meant issues would be quicker and easier to rectify. In circumstances where that individual may not be available, the participant highlighted the importance of collaboration across provider teams to resolve issues. In addition, the current feedback system where software bugs are reported to the research team was considered effective and prompt.

Acceptability of the application

Despite challenges of data collection, most participants were positive about the possibility of utilizing the data in care. In particular, one participant identified the information collected as part of the recovery-based surveys as very useful to the services they deliver. Participants interviewed also reported being highly positive about the Beehive application, with the immediate data visualization that is available to all members of the clinic considered a significant strength. Finally, one participant indicated that the EULA was well received by consumers, containing important information that addressed multiple questions that stakeholders previously had around the data.

Discussion

Overall, the participants interviewed identified several strengths and challenges in the initial implementation of Beehive. Participants elicited some concern that the current intake process takes significantly longer relative to previous protocols. For one participant, the expectation was that some of these challenges could be alleviated by the return of in-person assessments. Other proposals included: delaying the completion of the survey to after the initial clinical intake, advocating for functionality changes to allow the Beehive system to send surveys prior to the intake date for earlier completion, and reducing the level of online support afforded to consumers during the completion of the surveys. These challenges highlight the importance of the research team providing significant support during the initial implementation process, and the necessity of the research process being as flexible as possible to help minimize stakeholder burden. In later reports, the success of implementing modifications to the intake process will be explored, with facilitators to efficient intake procedures being distributed across the network to support other programs.

More positively, participants recognized the utility of the system, and were looking forward to implementing Beehive into care. Additionally, all participants indicated that the training received was appropriate, helpful, and resulted in them feeling confident they would be able to fulfil their role. The participants indicated that the system was relatively clear and easy to use, particularly when compared to current practices that the application will replace.

Limitations

In reviewing the preliminary findings presented in this report, it is important to consider several significant limitations and caveats. Critically, these data were collected from only four interviews, all including case managers or clinic coordinators and all working at the same clinic. Consequently, a full summary of the potential benefits, challenges, and solutions have not been fully explored. In future reports, providers in other roles such as licensed clinicians, program managers, prescribers, and supported employment and education specialists will be interviewed to understand the utility and challenges of the system across different provider roles. In addition, providers from other clinics will be interviewed as the Beehive system is integrated across the network to explore the similarities and differences in implementation experiences across clinics. Importantly, consumers and family members will also be interviewed to understand the acceptability of the platform, and any barriers and facilitators to implementation from the perspective of those that receive care, in addition to those delivering care. Finally, these interviews will be conducted throughout the implementation process, from initial adoption to the end of the process where procedures and protocols are established. Once collected, these data will then be analyzed in a comprehensive and systematic manner, allowing for a deeper exploration of the implementation process relative to the findings presented in the current report.

Summary

While it is necessary to conduct a much more comprehensive assessment of the implementation of the Beehive application, multiple challenges and potential solutions and opportunities were identified. Going forward, further work to understand the experiences of providers, consumers and family members going through the data collection process and utilizing the data in care will be critical to better understand the challenges and opportunities to delivering more data-driven care in an early psychosis setting through the Beehive application. This work will take place through an extensive interview process that will be detailed in later reports.

9. Outline plan for training EP program staff from non-pilot programs on application implementation and outcomes measurement.

Our team has learned a great deal from the initial Beehive trainings regarding the most efficient way to approach training for non-pilot EP programs. One of the consistent messages was that the initial trainings were too fast paced for many users. Another major learning opportunity was that we did not have enough time to sufficiently cover all the content we had planned in each session. Therefore, instead of breaking out the initial trainings into two 2-hour sessions, we have revised our training plan to include at least three 2-hour sessions for the introduction to Beehive for non-pilot programs as well as provide a fourth training to cover additional content for the pilot programs. We will continue to incorporate any changes and feedback from additional trainings into all future trainings, as we view improvement of our training approach as an iterative process. One change we implemented to save time during Part 1 training was to register all admin users (Clinic and Group Admin) during the pre-training meetings so that we only had to register the remaining providers during the first training. This has saved a substantial amount of time in subsequent Part 1 trainings thus far. We have also broken out into small groups to register providers during Part 1 training so several people can be registered in parallel, which has also contributing to saving time.

Another important piece of information we learned from these first trainings was the need to meet with each program's IT department ahead of time to make sure that emails/server requests from Beehive are not blocked by their organization's network security protocols. For example, Solano Aldea SOAR had delays in the first training because the emails from Beehive were being quarantined. While we were able to work with IT to unblock these emails, we decided to meet with IT ahead of time and test the sign-up email process in the pre-training meeting with leadership to avoid the delays during the training moving forward. Additionally, meetings with site IT to ensure Beehive's ability to properly communicate with its servers through site networks will be conducted. Thus far, we have modified our pre-training approach with five additional programs in preparation from their training and were able to verify ahead of time that Beehive emails would not be blocked during Beehive training.

We have also identified the need to understand more about each program's intake process so that we may customize our training and support approach to each program's existing clinical workflow. We have begun collecting information and meeting with intake coordinators from each program to understand data collected during phone screen and intake, and how and where Beehive consumer registration and surveys will fit into their existing process.

Los Angeles County PIER programs were our first non-pilot sites to receive Beehive training. This process was first initiated with pre-training meetings with each program in May 2021 to set up group and clinic admin accounts, review current clinical data entry practices, and meet with each program's IT contact to ensure the Beehive email can be received by each organization's email. Then, we held Part 1 Beehive training with each program, starting with The Help Group on 6/14, followed by The Whole Child on 6/17, San Fernando Valley Community Mental Health Clinic on 6/18, and finally both Institute for Multicultural Counseling & Education Services (IMCES) programs on 6/21. We also provided tablets to each program that is was providing in-person services. In the reporting period, all clinic admin, group admin, and provider accounts were set up for those who attended the Beehive trainings. Each program was connected with their EPI-CAL point persons who assist them with any questions throughout Beehive implementation. Though each program had the ability to begin enrolling consumer and support people into Beehive by the end of this reporting period, we directed them to wait until penetration testing of the Beehive application was completed and LACDMH had reviewed the report.

During this reporting period, the OC CREW, Napa Aldea SOAR, and Sonoma Elizabeth Morgan Brown One Mind ASPIRe programs were the remaining LHCN programs that needed to receive their initial Beehive training. EPI-CAL staff had been in contact with program leadership from each of the programs to schedule the pre-training meeting, followed by the Part 1 Beehive training.

10. Establish data collection process for obtaining county-level utilization and cost data for prior 3-year timeframe for preliminary evaluation for both EP and comparator group (CG) programs.

Over the last annual period, we held a series of meetings with the EP program staff and county staff to address collection of the county-level utilization and cost data for the prior 3-year timeframe. For each county, we identified EP program information, including description of consumers served, billings codes for each service, funding sources and staffing personnel during the retrospective period. Meetings were also held with the county data analysts to discuss details about the data the county will be pulling for the LHCN team during the next annual period. The discussion included the time-period, January 1, 2017 – December 31, 2019, for which the LHCN team requested data, description of the consumers from EP programs, how similar consumers served elsewhere in the county will be identified, services provided by each program, other services provided in the county to the EP consumers (i.e., hospitalization, crisis stabilization and substance use) and data transfer methods. Follow-up meetings have been scheduled with each county to discuss issues and concerns

with the EP program data pull. Once the LHCN team has reviewed and assessed the EP program data, this data will be used to inform characteristics and availability of data elements for the CG data pull. Meetings will then be scheduled with each county to review the details of the CG retrospective data pull.

Data Collection Process

The county data analysts have identified all consumers served by the EP program between January 1, 2017 – December 31, 2019. This will include individuals who started services with the EP program between January 1, 2017 – December 31, 2019 and exclude any individuals who received services by the EP program prior to January 1, 2017. Once the county data analyst gathered all the data elements for each consumer, they sent the list of consumers to the EP program manager. The EP program manager then confirmed the list of consumers as new consumers as of January 1, 2017 – December 31, 2019, and identified whether they were: 1) clinical high risk (CHR) and enrolled in treatment; 2) first episode psychosis (FEP) and enrolled in treatment; 3) assessed and referred out during January 1, 2017 – December 31, 2019; or 4) other, with reason (e.g., incorrectly assigned to EP program in EHR). They also added any individuals missed and repeated above 1-3 categorization, if necessary. They also sent certain data elements that were not available in the county EHR to the county data analyst, who integrated them into the dataset. These data elements include information included on intake forms such as regional center involvement and referral information. The county data analysts integrated these data elements into the dataset and assigned a random ID to replace medical record numbers (MRN)s, names, and other identifying information and saved the key, in order to create a limited dataset (dates and zip code included). The county data analyst was sent a link to a secure UC Davis web portal, whereby each county can upload their county data securely and will not be able to see any other county's data.

Each county received the following data request via email:

"We are requesting a limited dataset for all individuals served in the specified *EP Program* between these dates: January 1, 2017 – December 31, 2019. Data elements requested include: 1) all diagnosis(es) (psychiatric, substance use, physical health) and dates of diagnoses; 2) year and month of birth (not date); 3) demographics, including: ethnicity (primary, secondary, Hispanic [y/n]); sex; gender; sexual orientation; Medi-Cal aid code; living arrangement (housing status); US military information; veteran status; preferred language (primary, secondary, preferred, family, English verbal proficiency); foster care/adoption; zip code; and insurance status (i.e., insurance type- find out what is available; education level; marital status; employment status); and 4) all county services utilized for the list of consumers that started services between January 1, 2017 – December 31, 2019, including: i) all outpatient mental health services for each individual including but not limited to (and as available); ii) all other mental health services including but not limited to (and as available); inpatient; crisis residential; crisis stabilization; urgent care; long-term care; forensic services and jail services; referral(s) from EP program to other services; law enforcement contacts; justice system involvement; and regional center involvement. For each service, each county will check for these data elements and include as available: service/procedure code; location code, facility code; date; EBP/supported service code; charge description; minutes; number of people in service; episode of care (EOC); encounter type; HP1 and HP2; division; building; face to face; and place of service."

Based on information received during our meetings with each county, there will be some variation in the data elements available for each county (see details in Table 11 below).

Table 11: Data elements summary for all counties retrospective data pull.

Data Type	Data Element	Source	Comments
Non-identifying ID	Identifying consumer ID removed and new ID assigned	County	Available for the following Counties: Orange, LA, San Diego, Solano

Program Name	Program Name	County	Available for the following Counties: Orange, LA, San Diego, Solano
Psychosis – category	1) Clinical High Risk (CHR) and enrolled in treatment 2) First Episode Psychosis (FEP) and enrolled in treatment 3) Assessed and referred out during Jan. 1, 2017 – Dec. 31, 2019 (add reason, if possible) 4) Other and reason (e.g., incorrectly assigned to Kickstart)	Program	Data elements # 1 and # 2 are available for the following Counties: Orange, LA, San Diego, Solano Data elements # 3 is available for the following Counties: Solano; N/A for the following Counties: Orange, LA, San Diego Data elements # 4 is available for the following Counties: Solano; N/A for the following Counties: LA; May not be available for the following Counties: Orange, San Diego
Assessed and referred out - open ended	Assessed and referred out – reason	Program	Available for the following Counties: Solano; N/A for the following Counties Orange, LA, San Diego
Other and reason - open ended	Other – reason	Program	Available for the following Counties: Solano; N/A for the following Counties Orange, LA, San Diego
Diagnoses associated with the episode of care	Diagnosis – Psychiatric	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Diagnosis – Substance use	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Diagnosis – Physical health	County	Available for the following Counties: Orange, LA, San Diego, Solano
Date of birth	Year & month of birth (not date)	County/Program	Available for the following Counties: Orange, LA, San Diego, Solano
Location (consumer zip code)	Zip code (as of first EP service)	County/Program	Available for the following Counties: Orange, LA, San Diego, Solano
Demographics (as of first EP service)	Race	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Ethnicity	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Gender	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Education level	County	Available for the following Counties: LA, San Diego, Solano; N/A for the following Counties: Orange
	Marital status	County	Available for the following Counties: LA, San Diego, Solano; N/A for the following Counties: Orange
	Preferred language	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Insurance status (i.e., insurance type)	County	Available for the following Counties: Orange, LA, San Diego, Solano

	Employment status	County	Available for the following Counties: LA, San Diego, Solano; N/A for the following Counties: Orange
	Living arrangement (housing status)	County	Available for the following Counties: Orange, San Diego, Solano; May not be available for the following Counties: LA
	Sex assigned at birth	Program	Available for the following Counties: Orange, San Diego, Solano; N/A for the following Counties: LA
	Gender identity	Program	Available for the following Counties: Orange, San Diego, Solano; N/A for the following Counties: LA
	Sexual orientation	County	Available for the following Counties: Orange, San Diego, Solano; N/A for the following Counties: LA
	Military service / Veteran status	County	Available for the following Counties: Orange, San Diego, Solano; N/A for the following Counties: LA
	Foster care / Adoption	County	Available for the following Counties: Orange; May not be available for the following Counties: LA, San Diego, Solano
Outpatient mental health services in EP program between Jan. 1, 2017 – Dec. 31, 2019	Date	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Duration	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service / procedure code	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Funded plan (original pay sources, subunit)	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service location code	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Facility code	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Evidence Based Practices (EBP) / supported service code	County	Available for the following Counties: Solano, LA; N/A for the following Counties: Solano, Orange, San Diego
	Medi-Cal beneficiary	County	Available for the following Counties: Orange, San Diego, Solano
All other mental health services utilized by consumers that started services between Jan. 1, 2017 – Dec. 31, 2019	Service / procedure code	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Location code	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Facility code	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service Date	County	Available for the following Counties: Orange, LA, San Diego, Solano

	Evidence Based Practices (EBP) / supported service code	County	Available for the following Counties: LA; N/A for the following Counties: Solano, Orange, San Diego
	Service – Inpatient	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service – Crisis residential	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service – Crisis stabilization	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service – Urgent care	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service – Long-term care	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service – Forensic services and jail services	County/Program	Available for the following Counties: San Diego; May not be available for the following Counties: Orange, Solano
	Service – Referrals	Program	N/A for the following Counties: Solano, Orange, LA, San Diego
	Service – Law enforcement contacts	Program	May not be available for the following Counties: Orange, Solano, San Diego; N/A for the following Counties: LA
	Service – Justice system involvement	Program	May not be available for the following Counties: Orange, LA, Solano, San Diego
	Service – Regional center involvement (any developmental issues)	Program	Available for the following Counties: San Diego; May not be available for the following Counties: Orange, LA, Solano
	Service – Substance use services	County	May not be available for the following Counties: Orange, Solano, San Diego: N/A for the following Counties: LA
	Services – others	County	May not be available for the following Counties: Orange, LA, Solano, San Diego

Our team provided support to the county data analysts and EP program managers regarding the data extraction and integration process through a series of email and phone conversations. Los Angeles, Orange, Solano, and San Diego counties submitted their EP retrospective datasets through the secure web portal to our team. Napa County will deposit their datasets during the next project period.

11. Report on feasibility of obtaining cost and utilization data from preliminary multi-county integrated evaluation.

As part of the LHCN evaluation, service utilization and costs are compared between EP and comparator outpatient programs in that county who serve similar consumers with EP diagnoses (Niendam et al., 2016). These comparator programs are identified by input from county representatives, and an evaluation of county

level data to identify where first-episode psychosis consumers are typically treated in their county outside of the EP program. Individuals with EP diagnoses, within the same age group, who enter standard care outpatient programs during that same time period will be identified as part of the comparator group (CG). This analysis focuses on data from Los Angeles, San Diego, Orange, Napa, and Solano counties only, until other counties join the LHCN and opt in to this part of the project. For this component of the project, the evaluation has two phases: 1) the three years prior to the start of this project (e.g., January 1, 2017 – December 31, 2019) to harmonize data across counties, and 2) for the 3.5-year period contemporaneous with the prospective EP program level data collection to account for potential historical trends during the evaluation period.

Over the last annual period, through June 2021, we held a series of follow-up meetings with each EP program's staff and County staff to address data requested for the retrospective three-year period January 1, 2017 – December 31, 2019. Each county received a limited dataset request for all individuals served in the specified EP program between those dates (see details on data elements in Table 12). Our team provided support to the County data analysts and EP program managers regarding the review and extraction of data through a series of emails, phone conversations, and meetings. The counties submitted their EP retrospective datasets through a secure UC Davis web portal on the following dates: Orange County: December 7, 2020; San Diego County: December 22, 2020; Solano County: February 2, 2021; Los Angeles County: February 18, 2021. Additionally, we requested a data dictionary from each county in order to accurately identify each variable and received the data dictionaries from all counties who submitted datasets. Napa County will deposit their datasets once the county contract has been executed.

The LHCN team reviewed each EP dataset and scheduled any necessary follow-up discussions with the program and/or County staff. All counties submitted multiple data spreadsheets and we are currently working with those counties to integrate them into a multicounty dataset, as well as integrate the data dictionaries across counties to harmonize data elements. Data are currently being cleaned and standardized in order to integrate data across counties into a multi-county analysis.

Description of submitted data

The number of individual consumers in each county's EP dataset is indicated in Table 12 below. All counties serve first episode psychosis (FEP) consumers and some counties also serve consumers at clinical high risk (CHR) for psychosis. These totals represent the number of individuals enrolled and served by the EP programs for the retrospective three-year period January 1, 2017 – December 31, 2019. We also received data on consumers who were assessed for program eligibility but referred elsewhere.

Table 12: Summary of consumers for all counties retrospective data pull.

County	FEP	CHR	Number of Consumers
Orange	Y	N	87
San Diego	Y	Y	353
Solano	Y	Y	78
Los Angeles	Y	Y	91*

*Note: The number of consumers for LA County is still being finalized and may change.

Each county submitted a dataset(s) containing the data elements that were available. As anticipated, there is some variation in the data elements available for each county, which are summarized here and listed in Appendix V below.

Diagnoses. All counties submitted data on diagnosis(es) (e.g., psychiatric, substance use) and dates of diagnoses. Physical health diagnoses were not available in San Diego and Los Angeles counties.

Demographics. All counties submitted data on year and month of birth (not date). Solano County submitted data on the following demographic data elements: ethnicity (primary, secondary, Hispanic [y/n]); sex; gender; sexual orientation; Medi-Cal aid code; living arrangement; US military information; veteran status; preferred language (primary, secondary, preferred, family, English verbal proficiency); foster care/adoption; zip code; insurance status; education level; marital status; and employment status. San Diego County submitted data on all the demographics above with a few exceptions: primary language was submitted instead of preferred language, ethnicity was submitted as a single data element, sex and gender identity were submitted instead of gender. Orange County submitted data on all the demographics above except race, education level, marital status, insurance type, employment status, sex, and foster care/adoption status. Los Angeles County submitted data on all the demographics above except gender/identity, living arrangement, sexual orientation, military/veteran status, and foster care/adoption status.

Mental health services. Each county submitted data for outpatient and other mental health services utilized for the list of consumers who started services between January 1, 2017 – December 31, 2019. All counties submitted services data for date, service/procedure code, and service location. San Diego County submitted additional data for duration. Orange County submitted additional data for duration, funded plan, and Medi-Cal beneficiary. Solano County submitted additional data for Evidence Based Practices (EBP) and Medi-Cal beneficiary. Los Angeles County submitted additional data for EBP.

Other mental health services. In addition to outpatient mental health services, San Diego County submitted data for regional center and justice system involvement. Orange County submitted data for inpatient and justice system involvement. Solano County submitted data for crisis stabilization, crisis residential, and long-term care. Los Angeles County submitted data for inpatient services, Psych ER services, and some law enforcement contacts, justice system involvement, and regional center involvement.

Next steps

The LHCN team will continue to review the submitted datasets and problem-solve with counties regarding any missing data elements, particularly other mental health services received by EP program consumers, which may need to be retrieved from different sources.

The LHCN team has finalized a comparator group (CG) definition in order to identify consumers similar to those served by the EP programs who received services in other county programs. This definition will propose basic elements based on individual consumer characteristics indicating that, during the retrospective period, they experienced early psychosis, but were not served by the EP programs. We will meet with County staff to determine the feasibility of using this definition and then formally request the data. Counties will include the same elements as the data for EP program participants and they will submit the data through the same secure UC Davis web portal as the prior data sets. We will then select subsets in each county of CG individuals matched to the EP program cohort using propensity score matching or other strategies.

In addition to the services data, we will be requesting all related cost data for the services received by consumers in the EP programs and CGs. The LHCN team has met with cost data experts to determine the best course of action for obtaining cost data from the counties. Meetings will be scheduled over the next several months with each county to review the details of the CG retrospective data pull, the cost data, and to problem-solve any issues that arise, as described above. In the second half of 2021, we will conduct the statistical analyses for individual counties and across the integrated dataset.

Discussion and Next Steps

Over this last year, the team has worked to meet each of the goals that were set for this project period. It should be noted that the LHCN represents one of the first collaborative university-county partnerships between the University of California, Davis, San Diego, and San Francisco with multiple California counties to implement and expand an integrated Innovation project. Through this endeavor, all parties hope to have a larger impact on mental health services than any one county can create on their own.

We have completed beta testing of the Beehive data collection system across three pilot EP programs, which has included detailed remote site training. Beta testing officially initiated data collection on the core outcomes battery for the EPI-CAL project, and we have already collected some preliminary demographic and outcomes data from these pilot programs. Beta testing has also provided us the opportunity to obtain detailed feedback from various stakeholders on the training and data collection process via feedback surveys as well as barriers and facilitator interviews so that we may refine our approach when we transition to data collection in non-pilot EP programs. To this end, we have already made several modifications to our training approach based on constructive feedback from pilot programs and have recently implemented these changes in our first non-pilot trainings we held with the LA County PIER programs.

The extensive qualitative focus groups detailed in this report have significantly informed the construction of the Beehive application, ensuring that the product we create is built with the stakeholder in mind to increase utility for users. Throughout the implementation of the focus groups, providers, family members, and consumers were motivated to share their perspectives on the design and flow of Beehive and how data sharing should be presented and talked about. We feel confident that we have built a data collection system that EP program staff, consumers, and family members will actually use and that it will provide data visualizations that can be used to inform and improve early psychosis care.

We have also made significant progress in the county-level data component of this project by conducting the first county data pull for the retrospective period for the EP programs. We look forward to reviewing the data for the comparator groups in the coming months.

Barriers to Implementation and Changes from Initial Study Design

While the project had experienced some delays in contracting and many barriers due to the global COVID-19 pandemic, the team feels confident that we are making excellent progress at meeting our goals and catching up with the original planned timeline. For example, we had originally planned to first conduct beta testing in Fall of 2020 but did not begin until early Spring of 2021. Additionally, in our original LHCN proposal, we proposed in-person site visits to conduct the initial training for the Beehive application. However, due to the COVID-19 pandemic, we had to adjust our training plan and conduct the first “site visits” remotely. To do this, we broke down the initial trainings into a pre-implementation meeting with leadership and three separate Beehive trainings with the whole clinic team. These were all done remotely over web conference, and training materials were provided in digital format. While we hope to conduct future trainings or booster sessions in person at some point, we will continue to hold remaining trainings remotely until further notice.

Another one of the changes from the initial study design was to add the EULA focus groups described in the current report. We added these groups because the success of the learning health care network relies on EP consumers choosing to share their data with EPI-CAL researchers for the purpose of integrating outcomes data across participating clinics. We wanted each user of Beehive to understand how their data might be used, and have agency in data sharing for purposes beyond clinical care. Therefore, we sought to develop an accessible, transparent, and flexible EULA that is presented to each user prior to use of Beehive. To do this, we added multiple data-sharing and EULA focus groups to our study design so that the EULA and related materials could be shaped by the input of stakeholders as part of the Beehive design and implementation

phase of EPI-CAL.

EP LHCN Goals and Activities for FY 21/22

In the next project period, we will continue to train non-pilot EP programs from both the LHCN and larger EPI-CAL network. As implementation of Beehive continues, we will elicit feedback from EP programs how to improve both the training process and Beehive itself via feedback surveys, regular check-ins from point people, and qualitative interviews. Our goal is to continue to improve Beehive in an iterative process and to incorporate stakeholder feedback so that Beehive be a useful data collection and visualization tool for the programs using it. As more programs are integrating Beehive into their clinics, we will continue to do interim analyses of outcomes data collected via the application and plan to have another summary for the next annual report. This will include total enrollment numbers to-date, and a report on those who have completed both baseline and follow up measures.

We will continue to move forward on the county-level data analysis, with plans to provide our initial findings on cost and utilization data from the retrospective period of the multi-county integrated evaluation. Next year's annual report will also include a summary of problems that were identified during the analysis of the retrospective county-level data, so that solutions are identified for the second round of analyses. This will inform the formulation of a plan and finalized timeline for working with counties to access final round of county-level cost and utilization data for EP and CG programs.

We will also conduct our first fidelity assessments and hope to have the assessments completed for San Diego Kickstart, OC CREW, Solano Aldea SOAR, Sonoma Aldea SOAR in the next fiscal year. The fidelity assessments for Napa Aldea SOAR and the five Los Angeles County programs will be conducted in quarters three and four of 2022, so they fall into the next fiscal year. To that end, we will complete fidelity assessment training of our EPI-CAL staff, led by expert consultant Dr. Donald Addington. As part of these fidelity assessments, we will provide detailed feedback in the form of a report to all of the participating sites.

Appendix I: Wire Frame Focus Group Feedback Provided to Quorum (Software Developers)

Scenario	Participant Number/ Comment
New Consumer Registration	• Change “homeless” to “check here if do not have a permanent address” • Absolutely need to have the option to pre-enter basic consumer data prior to their first contact with the tablet. Then need to prompt consumer to review and update info as necessary • In addition to having option to take picture on iPad, we would like to have some stock icon options for consumer to select if they do not want to use their own picture. • We would like for consumer’s preferred name to autofill whenever “consumer” is used in the application. We want to also have Primary Support Person’s preferred name autofill wherever possible. • Change “primary care provider” to “primary health care provider”
Check-In	• During clinic registration, we need to have a pool of services for programs to choose from and then the option for them to use their own language for those appointments. Their language is what would display on tablet application.
Primary Support Person Module	• Add a column or icon to indicate if any PSP are the designated emergency contact
Survey List	• Comments that survey list is too word-heavy/clinical. Suggestions to add colors, to make “cards” (instead of expandable list) • Instead of “completed” on survey list, can there be something visually dynamic to show completion of survey? (want to avoid anything juvenile/frivolous, but want something reinforcing) • Some sort of overall progress indicator • Add who is completing the survey to survey list (autofill preferred name of consumer or support person) • Rename “help” to “ask for help”
Survey Flow/Completion	• Need to make progress bar more visible: move to bottom of screen – between last response option and above next/previous buttons) instead of nested at top, and possible change color to something other than blue • Also move the question progress (i.e., 1/5) down with the progress bar • Move the “prefer not to answer” option further down on the page (i.e., Separate from the other questions… more visual separation between the two so that it is clear it is not part of the scale)
Individual Consumer Profile Page	• Add Tabs to consumer page: data entry tab for each timepoint—includes area for clinician entered data and also shows consumer’s responses to surveys (Baseline, 6 Months, 12 Months, 18 Months, 24 Months) • Instead of drop-down to select survey visualization, can we have some sort of visualization (similar to consumer list) that shows all EPI-NET battery sub bundles? Would also want some sort of color coding/icon system to indicate data that should be reviewed. • Want a visualization of service utilization (include option to filter by date range). Click into cards to see history of attendance • Want a visualization of individual survey items (not just global score). Get into this data by clicking on the bar for a given timepoint? • Is it possible to set a default visualization per consumer (i.e., One consumer wants symptom data to be the default graph, and one consumer wants the recovery data to be the default graph)?
Individual level data visualization	• Change threshold line to toggle-on/off • Add info about threshold if hover over (or click on it?) • Make threshold a solid line (instead of dotted), remove the solid line for max score at the top • Remove toggle option for comparative data. We would like to have the option to add this as a drop down (to make it less visible to consumers) • Visualize incomplete/partial data as a hollow bar

Clinic Aggregate Data	• All aggregate visualizations will need to show “missing” data • Clinic Tab: Also want to see visualizations for gender identity, disability, veteran status, preferred language • Clinic Tab: Rename “diagnosis” widget to “Primary Diagnosis” • Clinic Tab: The monochromatic blue was not well received—need colors that are easier to distinguish from one another on the pie charts (also keep in mind color blind) • Clinic Tab: Visualize duration in program by consumer (based on consumer start date. Break up into 6 month buckets). Want to see this for the whole clinic but also want to see this by provider on each provider’s page. • Survey Completion: Can we click into survey completion widget on dashboard and see a visualization of survey completion by different demographic factors: language, age (under 18 vs 18-25 vs. 22+), FEP vs. CHR, PSP registered vs. no PSP registered
Survey Bundles	• Need some kind of key for providers to link actual measure and any euphemistic names we create (e.g., We have renamed Modified Colorado Symptom Index to “Personal Experiences Inventory”). Click the actual title on the data visualization to see what title the consumer sees?
Clinic Admin Dashboard	• Swap out support request widget for “action items” widget—shows outstanding data to be entered (both monthly clinic data reports as well as outstanding individual level clinician entered data); shows consumers coming into survey window; shows number of open support requests. When monthly report is due, it is at the top of the action items list (in an eye catching color) and cannot be moved or dismissed until it is complete. (Pair with a pop-up when try to exit the page?) When it is submitted, reinforce (dancing unicorn, chrome dinosaur game, “thank you for contributing to science!!”). Put this widget in the current location of “survey completion” widget • On “clinic” widget, switch the icon for providers and consumers (consumers should have more figures than providers)
Consumer List/Info (web app	• Remove Sex from Consumer List • Remove picture from consumer list • Put DOB on consumer list instead of age (display age instead when click into consumer profile) Request to see insurance information on this list—or as part of consumer info page • Show Start Date in Consumer Profile Page Remove sex from consumer list • Want to show an icon for any open alerts per consumer on the consumer list • Show indication of missing data (add icon to data column, allow to sort by missing/incomplete data) on consumer list • All columns should be sortable
Provider Tab	• During provider registration, need a field to indicate whether provider has a supervisor (residents, trainees will be directly supervised by a licensed provider). When such a provider is visualized in the dashboard (i.e., As primary clinician in consumer list), their name should appear with “[supervisor name]” • Wondering about possibility to add a temporary provider to supplant a primary provider (i.e., Vacation, leave of absence). Would want the temporary/covering provider to receive any notifications about consumer and have consumer show in their consumer list. Is it possible to set an end-date for such a temporary provider or would it have to be manually removed?
Alerts	• Want to make “urgent clinical issues” widget more visually different—suggestion to outline it, bold the text. • History of resolved alerts should be displayed (in data tabs on consumer home page) • Want to be sure, when an alert is resolved, the alert history will show “resolved by [provider name]”

Appendix II: Beehive Part 3 Training Small Group Worksheet

Beehive Part 3 Training Small Group

Identify a group note-taker and a person who will report back to the larger group

Survey 1 *(Identify a member of your group to screen share survey 1)*

1. Find one of the 3 measures we have introduced to you in trainings: **Modified Colorado Symptom Index** (MCSI), **Questionnaire on the Process of Recovery** (QPR), or **SCORE Index of Family Functioning and Change** (SCORE-15). Next answer the following questions about that survey:
    a. What is the global score?
    b. Is there a clinical threshold?
    c. Is the global score above or below the threshold? What does that mean?
    d. Which is the highest rated individual item(s)? What does that mean?
    e. Which is the lowest rated individual item(s)? What does that mean?

2. Discussion Questions
    a. How might you use this information in care?
    b. Are the survey responses consistent with your knowledge of the consumer's experiences?
    c. What questions do you have after viewing these surveys?

Survey 2-3 *(Identify a new member of your group to screen share survey(s) 2-3)*

3. Reference the Table of Contents for the EPI-CAL battery (next page). Find one to two additional surveys that you are interested in or that might answer the questions you have from the first survey.
    a. Is there a global score? (i.e., is this survey visualized?). If yes,
        i. Is there a clinical threshold?
        ii. Is the global score above or below the threshold? What does that mean?
        iii. Which is the highest rated individual item(s)? What does that mean?
        iv. Which is the lowest rated individual item(s)? What does that mean?
    b. If there is no visualization, remember you can view the survey responses by clicking the "survey results" button at the top left of the page

4. Discussion Questions
    a. How might you use this information in care?
    b. Are the survey responses consistent with your knowledge of the consumer's experiences?

Additional Discussion Questions

5. Does either survey help you understand the other survey better?
6. Think about the different roles in the clinic and how they might use this data differently
    a. How might a family advocate or peer partner use this information compared to a clinician?
    b. How might a prescriber use this information compared to a case manager?

Appendix III: Beehive Application Training Feedback Survey

Please provide us with your feedback.

1. How would you describe the pace of the training?

- ○ It moved way too slow
- ○ It moved a little too slow
- ○ It moved at the right pace
- ○ It moved a little too fast
- ○ It moved way too fast

2. Did you have enough opportunities to give feedback or ask questions?

- ○ Yes, I felt like I had enough chances to give feedback or ask questions
- ○ No, I did not feel like I had enough chances to give feedback or ask questions
- ○ Kind of...I wish there had been more opportunities to give feedback or ask questions.

3. Did you have enough time to practice using Beehive during the training?

- ○ I would have liked a lot more time to practice
- ○ I would have liked a little more time to practice
- ○ I had the right amount of time to practice
- ○ I didn't need as much time as you gave to practice
- ○ I didn't need to practice during the training at all

4. How confident do you feel about using Beehive to complete your assigned tasks (registering consumers and support people in Beehive, and entering clinic data)?

- ○ Not at all confident
- ○ A little confident
- ○ Moderately confident
- ○ Very confident
- ○ Extremely confident

5. Honestly, how much value do you think Beehive will add to your job?

- ○ None at all
- ○ A little
- ○ A moderate amount
- ○ A lot
- ○ A great deal

If you have any suggestions for how we can improve this training, please write them below:

_____

Appendix IV: Summary of issues reported to developer during Alpha and Beta testing

Type	Issue Id	Summary	Fixed in build	Description
Bug	BEEHIVE-114	Redundant Texting messages	Next Build	1. Got a text message for the patient [removed]. The screen says 'No Records'. We should not send any erroneous and redundant text message. 2. Also, the weblink is showing 'unsecured'. Is it because it is the test environment? Can we use the same certificate to make sure this is secured message?
Bug	BEEHIVE-110	EULA video + data sharing screen does not display for PSP on iPad app	Next Build	See the linked screen recording for the issue: **Issue:** EULA video and data sharing language does not display for PSP, instead an error pop-up which says "please accept EULA permissions" appears **Additional Details:** This PSP was created on 4/30 on iPad app (V1.0.13). This error does not occur on the weblink solution. For this same test PSP, the EULA video displayed when accessing surveys via the weblink.
Bug	BEEHIVE-104	Consumer demographics form not including all active consumers	Next Build	**Issue:** Active consumer is excluded from consumer demographics report based on date range selection. **Details:** Two consumer demographics reports were pulled from the same clinic. Both reports had the same end date selected (4/8/21) but had different start dates (4/1/21 & 1/1/21). The report with the earlier start date included one additional consumer ([removed]). This demographics report is supposed to include all active consumers within the date range selected. [removed] is still active and should also show in the report from 4/1/21-4/8/21.
Bug	BEEHIVE-99	"Question Not Found. Contact Administrator" Appearing intermittently	Next Build	Please see the linked screen recording: **Issue Description:** Intermittently during survey completion, an error will briefly appear while launching a survey: "Question Not Found. Contact Administrator." However, the survey progress despite the brief appearance of this pop-up and without the need to press "ok". **Requested fix:** This pop-up should never appear for survey respondents if it is not an applicable error.
Bug	BEEHIVE-106	Level 4/5 users can resolve urgent clinical issues and PHI is displayed to them	Next Build	**Issue:** If a level 4 or 5 user clicks "unresolved" on urgent clinical issues page, a pop-up to resolve the urgent clinical issue appears AND it includes PHI (consumer name). See the linked screen recording: **Fix:** 1. Level 3A, 4, & 5 users should not be able to resolve urgent clinical issues (see table of permissions attached). This would prevent the pop-up from appearing in the first place and hence PHI would not be displayed to level 3A, 4, or 5 users. 2. If the above fix is not able to be implemented quickly, we need to remove the consumer's name (replace with GUID) from the pop-up for level 3A, 4, or 5 users.
Bug	BEEHIVE-83	Recurring Bundle not appearing as scheduled	April 15, 2021	**Issue:** The recurring bundles are not available for survey completion when scheduled. **Notes:** User created a consumer with an intake date 6 months ago (9/17/2020). When consumer went to complete weblink surveys, only the enrollment bundle was available. Consumer should also have 3 Beehive Required bundles which recur every six months available to complete.

Bug	BEEHIVE-75	Issues with Survey Version and Bundle Version in Report	Next Build	In reports we have been downloading from Beehive, we have noticed some missing or illogical data in the "Bundle Version" and "Survey Version" columns. **Sample Report 1 demonstrates issue: Survey version date is later than survey completion date.** The rule should be that the survey version must always be an earlier date than survey completion date. The survey version should record what version of the survey was completed. **Sample Report 1 demonstrates issue: Survey version is newer than bundle version.** The rule should be that the bundle version is updated every time a survey is updated. So, the bundle version should never be older than the survey version. **Sample Report 2 & 3 demonstrate issue: "N/A" in Survey version or Bundle version fields.** The rule should be that this field includes either the date of creation or the date of last update. It should never be missing.
Bug	BEEHIVE-109	Network error when logging into UAT environment	Next Build	I am getting a “network error” when trying to log into the web app (happening on both Chrome and Firefox) with both the [beehiveprodacc@gmail.com] (mailto:beehiveprodacc@gmail.com) account as well as other testing accounts I set up (e.g., level 3 user). I can, however, log into the new version of the iPad app (V1.0.13) with my level 3 username and credentials. I can log in successfully to the production environment web app, as well.
Bug	BEEHIVE-108	Disable regular login for SSO Users	Next Build	UCDavis emails are still able to log in the normal way (i.e., log in without SSO). We need to close the loop and require that UCD emails log in with SSO only.
Bug	BEEHIVE-102	Clinic admin not able to see group admin	Next Build	**Issue:** When logged in as a clinic admin account, group admin are not visible on the admin tab (even when "all clinics" is selected) **Requested fix:** Clinic admin and providers should be able to see group admin and group analysts which belong to their group on the admin tab.
Bug	BEEHIVE-101	Race variable on demographics report not showing full details as entered during registration	Next Build	**Issue:** The specific race options selected by the consumer/staff member during consumer registration on tablet or web app are not displaying in the data report. In the attached report, the consumer's race is registered in Beehive as "Cambodian" under the subheading of "Asian." However, only "Asian" shows in the data report. **Fix:** The data report should show the subheading selection(s) entered during registration.
Bug	BEEHIVE-97	Provider name showing for application admin and application owner on consumer data page	Next Build	**Issue:** While logged in as application owner or application admin, the prescriber’s name and treatment team lead name are visible on consumer data page: **Fix:** For these fields, name should be replaced by GUID. Note that this is also how this page should appear for the group analyst role as well.
Bug	BEEHIVE-107	Login _ Password Length	Next Build	For Dashboard/Clinic users, When Logging, there is a Password rule to limit the password between 6 to 12 characters. Please remove the upper restriction of 12 characters. It is very hard to limit the user from entering longer and complex passwords.
Bug	BEEHIVE-85	Survey Due Date	April 15, 2021	**Issue:** All of the consumers in the below screen shot have the same intake date, but their survey due dates are not all the same. All

		Displaying Incorrectly		of the survey due dates below **should** be May 15, 2021 (i.e., 60 days after intake). **Testing Notes:** Testing indicates that the survey due date is dependent on additional surveys being assigned to the consumer. The consumers with a due date of March 17, 2021 do not have any additional surveys assigned to them.
Bug	BEEHIVE-73	Weblink not being automatically resent	April 15, 2021	Per the weblink rules shared in chat: "The weblink should be sent to the consumer/primary support person until they complete their surveys (The email and/or SMS will be sent once in a day if consumer/PSP has not answered the surveys)." **Issue:** None of our team or testers have experienced this feature of the weblink. We have only received weblink emails/texts automatically when the consumer is first registered. After that, any other weblink emails/texts received are because a user has manually re-sent them via the button on the consumer page. If this is in fact, a rule, **we would like to change the frequency of the weblink being automatically re-sent to every 72 hours** (not every 24 hours) until the surveys are completed.
Bug	BEEHIVE-94	Repeating Bundles not available as scheduled	April 15, 2021	We have set up our Beehive Required bundles to repeat every 6 months. These bundles have been available for consumers who register within their intake window. However, for consumers who are registered in Beehive outside of their baseline window, (e.g., at 12 months after intake, 24 months after intake), the repeating bundles (for consumers, PSP, and clinicians) are not available as scheduled. (Ex. GUID: [removed]) The appropriate recurrence of bundles was tested in the staging environment in March and the bundles were available as appropriate. This seems to be a new issue.
Bug	BEEHIVE-98	Data Reports showing consumer DOB for application owner & application admin	April 15, 2021	When downloading the consumer demographics report from the application owner and application admin level, Consumer's DOB is displaying instead of just the month and year. I've attached the Report guidelines for easy reference. At Level 4/5 and this field should only display month and year of birth.
Bug	BEEHIVE-103	Group Analyst Permissions unable to be changed	Next Build	**Issue:** Once a group analyst is created, their permissions level is frozen and unable to be modified by Level 3, 4, or 5 users. **Fix:** Level 3, 4, and 5 users should be able to change the permissions of a group analyst to another admin role. This is to address issues when staff roles may change or to fix errors that may be made by users during user registration.
Bug	BEEHIVE-95	Reports are missing data	Next Build	Reports are missing data within specified time range. The first attached report ("Sample Report 4") was one that was pulled on 3/17 for the "Life Outlook" Survey. This report was previously included in sample tickets. It demonstrates the number of records that were in the report between 2/22-3/17 The second attached report was pulled today from the date range 2/22-4/1. It was pulled for the "Life Outlook" Survey. It includes no data and no variable names.
Bug	BEEHIVE-96	Bug with de-identification for Application Owner & Application Admin	Next Build	When logged in as an application admin or application owner, our team discovered that if you type a provider's name into the search bar, their de-identified (i.e., GUID only, no name) record will appear. This should not be possible since application admin and application owners should NOT see provider name anywhere in the application.

Bug	BEEHIVE-24	Repeating primary support person bug	Next Build	Primary support person was added once on web application (browser= Firefox). Now, the same PSP record shows up multiple times on iPad and web apps.
Bug	BEEHIVE-93	Urgent Clinical Issues are No Longer Populating	March 15, 2021	Urgent clinical issues are no longer populating as intended. For example, test consumer [removed] answered MCSI_13 question as follows (completed surveys on weblink) This is a response that produces an alert according to survey design: Also encountered this error for consumer [removed] (completed surveys on tablet) Alert designated in survey design: Note that this feature was previously functioning as intended. This bug is new (likely as of the last update?) No urgent clinical issues showing on group admin dashboard:
Bug	BEEHIVE-36	Checkbox to indicate PSP is same as Emergency Contact not appearing at group admin level	March 15, 2021	**Here is the view of the PSP page when logged in at group admin (there is no check box to indicate that PSP is the same as emergency contact):** **This is the view when logged in as a provider or clinic admin (iPad & web): There are check boxes to indicate that the PSP is the same as the emergency contact**
Bug	BEEHIVE-72	Weblink not being auto-sent to PSP upon registration	March 15, 2021	Per rules shared in slack: weblink should be auto-sent to PSP via both email and text upon their registration in Beehive. **Issue:** Our team is noticing a consistent bug across multiple accounts that the weblink is not automatically sent to PSP via email, but it is automatically sent via text message. **Other notes:** When the weblink is manually sent (via "re-send surveys" button on consumer page), weblink is sent via both email and text. So, this bug appears to only be related to the application automatically sending emails. The weblink is automatically sent to consumer correctly via whatever method is selected in "preferred contact."
Bug	BEEHIVE-82	Data report: Value for slider question displaying as "N/A" in data report instead of the value	March 15, 2021	**Issue with data collection on slider questions:** * Any response given in the tablet is showing as "N/A" in the data report. * Responses given on the weblink are showing up properly in data report, UNLESS zero is the response, in which case it is showing up as "N/A". * Whenever the response in the data report is "N/A", it is displaying as zero on the consumer data page. In the attached data report, you will see values of N/A. These questions were answered and should be a variety of different answers. This is the visualization of survey responses in the application. These values were answered as "3" & "7" on the iPad, but both show as zero here:
Bug	BEEHIVE-91	Survey Not Progressing as Intended on iPad App	March 15, 2021	Issue: When completing survey on the iPad, the error: "Couldn't find the next question, Please contact staff" appears. This is a new error on a survey which has otherwise been functional since the last time it was edited on Feb 25. I have recreated this issue on several different test consumers during survey completion on the iPad. Please see the screen recordings for an illustration of this: **On iPad, Survey will not progress past question 1:** On weblink, Survey progresses as intended:** **Logic was never modified for this survey in survey design. Each question simply leads to the next:**

Bug	BEEHIVE-4	Issue with User Registration	March 15, 2021	GUID: [removed] User cannot complete registration. After entering a password that matches the rules shown in the modal, user gets this screen and an OTP is never sent to him. I have re-sent the invite to Beehive to have the user try to complete registration from a new link, and the same error is seen. User has tried to register with different passwords matching the requirements and continues to get the same error.
Bug	BEEHIVE-79	Reports: Need comma separation on multiple select variables	Next Build	For data fields which may include multiple responses (i.e., multi-select questions in Beehive), we need to have comma (or some other character that is not a space) separation between response options. This is especially important once "option:" is removed from the data report. Please see the attached example, consumer demographics tab, column H for how we would prefer for this to be in the data report. Issue is demonstrated in Sample Report 2 Column T which was pulled from Beehive.
Bug	BEEHIVE-68	Age not updating	Next Build	Test consumer's birthday is today and age has not updated in the system. The age should be 18 but it is still displaying as 17.
Bug	BEEHIVE-74	Provider-entry data required icon not appearing	Next Build	Data icon which indicates provider data entry is not appearing for consumers, even when there is still data to be entered for the consumer. See screen recording linked: For reference, here is an example from a different web version which shows the icon:
Bug	BEEHIVE-78	Make "other (please specify)" response it's own column	Next Build	As demonstrated in the example reports previously provided, we would prefer for the free text data entered when "other (please specify)" is selected to be it's own column. Please see the attached document "Beehive Report Examples_2021_0201", Alerts tab, Column Q for an example of how this would be pulled into it's own column. Currently the free text is included in the same column as the multiple choice selection (see sample report 2, row 8, column T)
Bug	BEEHIVE-62	Unable to Submit Registration of New Consumer on Tablet	Next Build	User is encountering error "Looks like entered email ID already exists" with an email that has not already been used in the application. User attempted to use 3 different emails (all of which were not already used in the application) and continued to receive this error message.
Bug	BEEHIVE-48	Data-Use Pop-up Not appearing	Next Build	Our team has not been able to create the data-use pop-up that is shown in this storyboard (after leaving consumer data page): We have tried at level 1, 2, & 3 users by visiting the consumer's data page more than 20 times at each level and the pop-up has not generated.
Bug	BEEHIVE-87	Free Text for "Other (please specify)" not available in data reports	Next Build	**Issue:** If "other (please specify)" is selected during survey completion on the iPad, the text entered is not showing up in the data report or on the survey results tab. **Other testing notes:** This seems specific to data entered in the tablet. Our team has completed consumer surveys via weblink and selected "other (please specify)" then entered free text into those fields. The data entered appears in the data report and is also available when viewing survey results from consumer data page. I entered data for one consumer via weblink and it showed up on both survey results and data report.
Bug	BEEHIVE-33	Logic Resetting	March 8, 21	The logic is resetting during survey creation. Please see linked videos which capture this bug.
Bug	BEEHIVE-27	PSP weblink always directs to EULA	Next Build	PSP web link invite always goes to EULA after typing in OTP. The weblink should only direct to the EULA if it has not been completed. Otherwise, if the EULA has been completed, weblink should direct to survey bundle screen.

Bug	BEEHIVE-81	Total # of Questions shown in Survey Completion Incorrect	Next Build	This survey (PSP Demographics and Background) has 6 questions but the total questions of the survey displays as "5" Note that this survey has other reported issues with it which may be contributing towards this bug.
Bug	BEEHIVE-80	Survey Failing to load after first question in Weblink Environment; Functions Properly on iPad	Next Build	After submitting a response to the first question of this survey, instead of displaying the next question, this screen is seen on the weblink: Note that on the tablet, the next question **does** display Other notes: 1.This has been recreated on our end— multiple testers have experienced this issue. 2. The survey this is from ("PSP: Demographics and Background"), has de-activated questions in it. Unsure if that is contributing to the problems we are seeing.
Bug	BEEHIVE-84	EULA video is no longer appearing for PSP on weblink	Next Build	Please see the screen recording for a PSP who was just created and accessed surveys for the first time via weblink. EULA video does not appear as it should. This issue has been recreated by several of our team members on different browsers (chrome, firefox, edge, safari). **Other testing notes:** EULA video appears appropriately for new consumers on weblink. EULA video appears appropriately for new consumers and new PSP on tablet.
Bug	BEEHIVE-57	Beehive ipad App is crashing prior to displaying EULA video	March 15, 2021	User experienced app crashing repeatedly prior to EULA video being displayed. **Consumer registration:** The app crashed at the point of transfer of ipad from clinic staff to consumer. This happened 3 times in a row then did not happen the subsequent 3 times in a row (tested a total of six times). See the linked screen recording. Where this recording ends is the point at which the application crashed. (could not capture the actual crash as it would end the screen recording and prevent it from saving): **Adding a new PSP to an already registered consumer to complete PSP surveys:** Also experienced the app crash when adding a new primary support person to an existing consumer. User attempted again to add the PSP and the app crashed in the same place. User attempted a third time and the application displayed the EULA video without crashing. (Tested total of six times): Note that crash reports were sent in testflight for both of these events. In both scenarios of the app crashing, the data that was previously entered for the new consumer or PSP was not saved, and user would need to start over with the registration process. Since we have not noticed this happening on the web app or with the weblink, we have a few weeks to solve this issue. The first beta site we are training will exclusively use web app and weblink. However we will start introducing the tablets at our site training on **3/22/21**, so we will need a solution by that point.
Bug	BEEHIVE-51	PSP Data report is empty	March 15, 2021	There is no data available in the PSP survey report. It was pulled within a time frame when data should have been entered for multiple PSP.
Bug	BEEHIVE-41	Survey Report Not showing Survey Responses	March 8, 21	The Survey Report is not showing survey responses to each variable name. (We understand reformatting of reports is happening in the next build, but just wanted to point out this crucial information is missing from the report even before it is formatted appropriately)
Bug	BEEHIVE-52	Spanish text displaying	March 15, 2021	The Spanish survey of a title displayed for a consumer for whom Spanish was not selected as the primary language. Please also note that the survey questions and responses were still in English.

		when Spanish language not selected		Screen recording: Consumer profile which shows English as the display language:
Bug	BEEHIVE-65	Camera not functioning in Beehive	Next Build	During consumer registration or editing an existing consumer\>choose consumer profile picture\>click a picture Camera screen is black, shutter button doesn't work. This issue occurred on multiple devices where the camera is verified as working outside of Beehive application. Link to screen recording:
Bug	BEEHIVE-63	Consumer Profile cannot be updated or submitted dependent on answer to ethnicity	March 15, 2021	This issue occurs on both web app and ipad app. On the web app, we receive this error depending when attempting to update race and ethnicity for existing consumers. This appears when filling in missing data for consumers that existed prior to today's code push, but only when "no, I do not identify as hispanic/latinx" or "prefer not to say" are selected. It also occurs for consumers that were created after the code push when you attempt to change their answer to ethnicity. On the ipad app, no error message appears, but the user cannot submit the update to registration. (screen recording linked below)
Bug	BEEHIVE-54	Data-Use Pop-Up Display Logic does not reset when user selects "no"	March 15, 2021	When user selects "no" as the response to the initial pop-up, the pop-up will show at every visit to the consumer's data page until the user selects "yes." The appearance of this question should not be dependent on the user's answer to the first question. It should appear between every 5-10 visits regardless of whether they answered yes or no at the previous appearance of this pop-up. Hence, if the user selects no, they should not see this pop-up at the next visit to the data page. Please see the video linked below to for a demonstration of this problem:
Bug	BEEHIVE-64	Ward of Court Piped Text not Functional on Web App	March 15, 2021	When other text is entered during consumer registration for ward of court on ipad, the piped text is functional (note the word "test") Functional: However, it is not functional in the web app when registering a consumer. Not functional:
Bug	BEEHIVE-18	Survey names and bundle names not appearing on PSP weblink	March 8, 21	Browser: Firefox PSP for consumer GUID: [removed]
Bug	BEEHIVE-31	Users are seeing support requests they should not be able to see	March 15, 2021	A Group admin is able to see a support request submitted by a Level 4 user. As a reminder here are the rules relating to permissions levels and the ability to see support requests: * Group Analyst-- see own requests * Providers- See own requests * Clinic admin- see requests made by users within clinic * Group admin- see requests made by users within group * Application Admin— see all requests across system * Application Owner— see all requests across system
Bug	BEEHIVE-8	Issue with editing bundle prior to	March 8, 21	When editing a bundle (before it has been published), there is an error that occurs in the "participant type" drop down. Instead of showing the three categories of participants, it is repeating "60 days schedule"

		publishing it		
Bug	BEEHIVE-42	Report response options inconsistent with dropdown options	March 8, 21	Responses in the application are correct, but they are not always reflected in the data reports. See the attached xlsx file with highlighted fields. 1. Typo: "HISPANIC_LATINUX" should be "HISPANIC_LATINX" 2. "Refused" is not an option on the race drop down. It is "Prefer not to say" 3. Treat spaces consistently. Sometimes an underscore is used, sometimes the space is removed completely.
Bug	BEEHIVE-2	Other Text Box Appearing Inappropriately During Admin Registration	March 8, 21	The "Other:" Textbox is appearing when "Research staff" is selected in the primary role drop down. It does not appear when "other" is selected in the primary role drop down.
Bug	BEEHIVE-7	Date of Last Update not Updating	March 8, 21	The column "date of last update" is not updating appropriately. The following surveys were updated today (2/19/21) and the date displaying in this column is still the date of creation (2/18/21)
Bug	BEEHIVE-29	Slider Question Type Bug	March 8, 21	We have a slider question in the "Life Outlook" Survey. The response range for this question is set from 0-10. When a survey respondent selects 0, the application treats the question as unanswered.
Bug	BEEHIVE-38	Group Analyst Permission Level Seeing Identifiable Data	March 8, 21	In the current build, group analyst is seeing identifiable data (i.e. consumer names). **Permissions for Group analyst allow de-identified data only**. Consumer list and urgent clinical issues should show IDs only.
Bug	BEEHIVE-26	PSP EULA completed on weblink does not display on tablet & vice versa	March 8, 21	After PSP completes EULA on weblink, this information does not update on the tablet application. Tablet application still says EULA not completed:
Bug	BEEHIVE-45	CSV upload failing	Next Build	CSV upload fails with template provided via slack.
Cosmetics	BEEHIVE-20	EULA Text Formatting	March 8, 21	1. Our team would like to add the following key to every instance of the EULA/data sharing language: *-required The asterisk should be in red as it appears in the application. 2\. We would also like to make **bold** the phrases that refer to exporting identifiable data. Please see the attached documents for reference. ****
Cosmetics	BEEHIVE-111	Update PSP Data-Sharing Language to reflect initial request	Next Build	Now that the consumer name auto-populates in the PSP EULA, please reference the document initially shared for the text on this screen (attached again for your convenience). These changes should be made to reflect what was initially requested: * Remove the quotation marks that appear in the italicized text (stricken through in red in the attached image) * Remove the sentence "Note that the consumer refers to…" (stricken through in red in the attached image)

				These changes should also be made to the Spanish language version.
Cosmetics	BEEHIVE-53	Add text to support requests to remind users not to submit PHI	Next Build	We would like to add the following text before text fields in support requests as a reminder that users should not enter sensitive patient information: "Reminder: Do NOT submit PHI"
Cosmetics	BEEHIVE-67	Fix Typo in Emergency Contact Dropdown	Next Build	Option should be "Spouse/Partner" NOT "spouse/parent"
Cosmetics	BEEHIVE-56	Update Instructional Text in Sex Dropdown on Staff Registration Screen	March 15, 2021	The instructional text in the dropdown for sex-assigned-at-birth should say "Select Sex" not "Select Gender"
Cosmetics	BEEHIVE-3	Survey Creation: Typo in Other Option	March 15, 2021	There is a typo in the survey creation module for the "Other (please specify)" option. Please correct from "specifiy" to "specify"
Cosmetics	BEEHIVE-50	Fix typo on race visualization	March 15, 2021	This may be automatically solved when fixing the typos that show in the data reports (linked issue), but if not, wanted point out the typo of "Hispanic Latinux" (it should be "Hispanic/Latinx") here as well.
Cosmetics	BEEHIVE-58	Remove "!" from EULA error message	March 15, 2021	Please remove the exclamation point from this statement: "Please select the mandatory options to accept EULA!" The message should instead read: "Please select the mandatory options to accept EULA"
Cosmetics	BEEHIVE-25	Update Language on "Upload Picture" Button	March 8, 21	For both the **web application** and **ios application**, we would like this button to say "Choose Picture" instead of "Upload Picture"
Cosmetics	BEEHIVE-6	Update text header	March 8, 21	Per feedback in alpha, please update the identified header in consumer registration to "Display Language" and not "Preferred language"
Cosmetics	BEEHIVE-30	Make consistent the presentation of phone numbers	March 8, 21	On edit consumer info page on web application: PSP phone number should be presented with dashes, as the emergency contact phone number is presented.
Cosmetics	BEEHIVE-17	Add a space to OTP consumer email template	March 8, 21	Would like to add a space between ":" & "OTP" to make it consistent with other OTP emails and make copy & paste easier. Currently: Would like it updated to : "Your one-time password is: 960894"

Cosmetics	BEEHIVE-49	Update text on data review pop-up per September 2020 feedback	March 8, 21	Per feedback given on 9/23/20, please update the text on this pop-up to: **Did you review this data with the consumer or family?**
Cosmetics	BEEHIVE-34	Survey Instructions & Survey Completion Images	March 8, 21	The images in the survey instructions and survey completion pages do not represent the diversity of the consumers we serve, so to improve UX, we would like to change these images. **We would like this image for survey instructions:** **We would like this ribbon/badge icon for survey completion:** Ideally, we would like to add color overlays (at least to fill in the star and the question mark) in the same color scheme as previous images.
Cosmetics	BEEHIVE-28	Update icon in Action Items Widget	March 15, 2021	In the Action items widget, update the icon when there is nothing overdue. Instead of red text with a red icon when nothing is overdue (image 1), can the text be green with the green icon currently used in the alerts widget (image 2)?
Cosmetics	BEEHIVE-14	Update Languages Header in User Registration	March 8, 21	The "languages other than English in which you are fluent enough to conduct therapy/provide services" needs to be a "select multiple." (currently can only select one). Since English is a response option in this drop-down, we would also like to update this header to "**Languages in which you are fluent enough to conduct therapy/provide services"**
Cosmetics	BEEHIVE-23	Updates to Alerts	March 15, 2021	**Alerts Text updates:** * We would like to remove "resolved by N/A" from the alerts widget. * Instead of "Survey Alert" we would like for the keyword from the survey to be piped in. * The formatting of the alerts should be: **\[Consumer Name\]** endorsed **\[keyword\]** on **\[Date, MM/DD/YYYY\]** * Example: **Kathleen Nye** endorsed **Risk to Self** on **2/23/2021** **Alerts Display updates:** * When alerts are resolved, they should not display in the widget **Other Alerts Functionality** * We would like to introduce a feature whereby users can click on some portion of the alerts card to be directed to the survey question/registration item that triggered the alert. Can you let us know if this is something that can be accomplished in Beta or if our team needs to prioritize it somewhere in Phase II?
Feature	BEEHIVE-40	PSP Registration Page	Next Build	In our testing of PSP surveys, we have realized we need to add a registration page as we have for clinic users and consumers to ask demographics questions such as race, ethnicity, sex, gender, DOB. This is a new request and we do not expect it to be in the March build. However, we would like to understand how much time this will take to implement.
Feature	BEEHIVE-55	Click Alert Card to Bring User to Alert Trigger	Next Build	We would like to introduce a feature in Phase II whereby users can click on some portion of the alerts card to be directed to the survey question/registration item that triggered the alert.
Feature	BEEHIVE-88	Implement Rule that Survey version captures the version of	Next Build	From BEEHIVE-75: **Sample Report 1 demonstrates issue: Survey version date is later than survey completion date.** The rule should be that the survey version must always be an earlier date than survey completion date. The survey version should record what version of the survey was completed.

		the survey that consumer completed		
Feature	BEEHIVE-113	Adding 2 additional fields to user registration	Next Build	Due to new reporting requirements from one of our funders (NIH), we need to add 2 additional fields to user registration. 1. Start date at agency 2. Start date with CSC team Both fields should have date validation. We would like for "Start date at agency" to be required for all users. We would like for "Start date with CSC team" to be **required fields for users at level 1, 2, 3, and 3A**, but **OPTIONAL for levels 4 and 5** (level 4 and 5 users may not be part of a CSC team). We understand that these changes may not be feasible to make until the end of the sprint timeline which runs through 8/9/21. Let us know when we can expect these changes.
Feature	BEEHIVE-112	Adding Variables to Consumer Demographics Form	Next Build	Given our understanding of how the consumer demographics report has been coded, we would like to add 3 additional fields to it to facilitate it's use: * intake date * registration date * status We have also realized there is no place for the free text for "ethnicity" in the demographics report so have updated the template here as well. Please see the attached for details (changes from previous version of this document are highlighted). Is it possible to wrap these in with the remaining reports in 6/14/21 UAT?
Fix	BEEHIVE-89	Implement rule that Bundle version updates whenever a survey within it is updated	Next Build	From BEEHIVE-75: **Sample Report 1 demonstrates issue: Survey version is newer than bundle version.** The rule should be that the bundle version is updated every time a survey is updated. So the bundle version should never be older than the survey version.
Fix	BEEHIVE-77	Data Reports: Remove "Option:" from data reports	Next Build	As demonstrated in the example reports, we would prefer that the survey reports include only the text of the response and the additional text ("Option:) which is demonstrated in columns U-Z in the attached report.
Fix	BEEHIVE-39	Instructional Text Formatting	March 8, 21	For the instructional text, we want this to just be a single text box (as boxed in red below) without a header.
Fix	BEEHIVE-13	Race item needs to be "select multiple"	March 15, 2021	The race drop down in user registration and consumer registration currently only allows for selection of one race. This is a "select all that apply" question and needs to allow for user to select all. Can this race question be formatted in the same way as the "clinic" selection (After user says "yes, I work in another early psychosis program that uses Beehive"?) during user registration? We like this formatting for the following reasons: 1. You can see every answer you have selected 2. It is very clear and easy to remove options once you have selected them.
Fix	BEEHIVE-19	Web App/Weblink EULA Formatting	March 15, 2021	When the EULA is presented on the web application or weblink, our team would like the following formatting change: Instead of having the required components pre-checked, we would like for all check-boxes to be blank and require the user to actively

				select each check box. This would match how the EULA is presented on the ipad application for consumers and PSP.
Fix	BEEHIVE-5	No template CSV file for consumer import	Next Build	There is no template CSV file provided for the consumer import function. Users do not know how to format data for it to be accepted by the system. Need a downloadable template file to be available in the application. In the mean time, can your team provide us with a template so we can test this feature?
Fix	BEEHIVE-59	Inaccurate Variable Name in .CSV upload template	March 15, 2021	Column F in the template .csv provided for upload needs to match the variable name for this variable provided in reports (attached, see consumer demographics report). The variable name (or header) for column F is "Sex" not "Gender".
Fix	BEEHIVE-21	Weblink Session Expired while completing surveys	March 8, 21	One our testers experienced their weblink session ending while they were in the midst of actively completing surveys. They said they had been in the session for about 1 hour, but that the session had not gone idle. Want to problem solve around this as we do not want users to be kicked out while they are actively completing surveys, even if the session has been open for some time. Related to this: when the session end, the entire chrome browser shut down (After user selected "ok"). Is it possible for the page to reset rather than shut down the whole browser (anticipate this may be annoying to users)?
Usability Problem	BEEHIVE-32	Need a way to remove questions from surveys	March 8, 21	Once a question is created in a survey, there is no way to remove it (Even prior to publishing in a bundle). There is no delete function. Questions can be de-activated. But even questions that are de-activated are still appearing for survey respondents. Questions were deactivated prior to adding to bundles and prior to publishing bundles.
Usability Problem	BEEHIVE-115	Weblink logic	Next Build	Sandesh had previously suggested setting a maximum number of times that a weblink is pushed automatically. We have discussed and wanted to start by asking for weblinks to only be automatically sent during the survey window (i.e. 75 days after intake, 15 days +/ due date for Follow-up bundles, and 15 days after assignment of additional unscheduled survey)
Usability Problem	BEEHIVE-10	Generate random unique password for new users	March 15, 2021	Our team noticed that the same password "12345678" is always assigned as the first password for account set-up. Can we instead use a randomly generated and unique password for each person to enhance security?
Usability Problem	BEEHIVE-9	Update URL in Registration Email	March 8, 21	The url for our website has changed slightly and we need to update the hyperlink in the registration email ("What is Beehive?"):
Usability Problem	BEEHIVE-22	Remove names from urls/links	March 8, 21	Survey weblinks and user registration links currently include first and last name. These absolutely need to be removed from the weblinks. Time permitting, should also be removed from the user registration links.
Usability Problem	BEEHIVE-60	Simplify and Clarify .CSV Template	Next Build	**Current Problem/Issue:** Currently, the .csv template for adding consumers is both incomplete (it does not include all registration fields, so users will still need to go in to each consumer's profile one at a time to complete registration) AND overwhelming (despite not including all registration fields, it includes many fields). **Our solution:** Since we cannot immediately solve the first issue of completeness (per your comments in BEEHIVE-45), we would like to make this template more simple and more approachable.

				Requested fix: * Can the .csv template only include the the fields in the attached document? * We assume that the variables "Ward" and "IsSelfConsent" are required for basic registration functionality. If they ARE NOT required for this .csv upload, then we would like to remove them from the template. If they ARE required, then we would like to rename them to make it easier for users to understand what they are entering. * You have explained what the "ward" variable means. We propose changing the wording to "Consumer Is a Minor" * We do not know what "IsSelfConsent" means. Please let us know so that we can consider how to best communicate this to clinic users.
Usability Problem	BEEHIVE-35	Sizing Issues on Weblink	Next Build	During testing, our team experienced a variety of "sizing issues" when completing surveys via weblink option on a mobile device. We are linking to the following video which demonstrates some of these issues: * User must zoom out, drag on first screen in order to center * Progress bar is not visible unless user know it is there and makes an effort to drag down to see it * Issue navigation buttons not appearing or requiring scrolling past a lot of blank space in order to appear We would like to discuss this on the call on Thursday, 2/25/21. Some possible solutions we have thought of are 1. Pinning items (e.g. question & progress bar pined to top; next/previous buttons pinned to bottom) 2. No splitting of words (the problem with allowing word splitting is demonstrated in below picture on the minimum anchor. It makes it difficult to read)
Usability Problem	BEEHIVE-90	Allow hyphens and apostrophes in name fields	Next Build	The system does not currently allow for hyphens or apostrophes to be included in first or last names entered into Beehive. Users may have hyphens or apostrophes in their first name (e.g. D'Angelo, Jean-Paul) or last name (e.g. Smith-Wiggins) and users need to be able to enter the proper punctuation.
Usability Problem	BEEHIVE-46	Allow application users to return to EULA to update data permissions	Next Build	All level users in the application who complete a EULA need to be able to return to the EULA to update their data permissions. This should follow the same EULA data permissions edit flow as implemented for consumers and primary support persons.
Usability Problem	BEEHIVE-47	Add registration fields to user profile	Next Build	All registration fields should be displayed as part of user profile. Users also need the ability to edit/update these fields (for example, education or license status may change) This is okay to consider for April 15 release
Usability Problem	BEEHIVE-105	'Key Word Graph' Axis not fixed to min/max values	Next Build	**Issue:** The item visualization ('key word graph') x-axis is not locked and hence does not always show the full range of possible scores. **Fix:** As discussed on 11/05/2020, we want for the min and max scores for both graphs (global and keyword) to be fixed. This allows users to easily tell when a score is low vs. when it is high. This has already been implemented on the global graph. Below is an example of what the individual, keyword graph, should look like using the data above.
Usability Problem	BEEHIVE-92	Change time of day at which	April 15, 2021	On Friday our team started receiving weblink notifications from the staging environment for consumers who need to complete surveys. We noticed that these surveys are either being sent out at 10pm or 12am. Neither of these times is ideal to send out surveys. Can we

		weblink is auto-sent		please update the time of day at which the weblink is auto-sent to 6PM PT? Hopefully there is also an option to have this time automatically adjust to the time changes that result from moving in and out of daylight savings time.
Usability Problem	BEEHIVE -100	Reports Showing "no" for data-permissions on EULA's which are not complete	April 15, 2021	**Issue:** In data reports, the "data permissions" variables display the same for consumers who have not completed the EULA as they do for consumers who have not agreed to share data for research (i.e. "No"). See the attached data report. This consumer has not completed a EULA. **Fix:** If the EULA has not been completed, these fields should read N/A.
Usability Problem	BEEHIVE -76	Extra characters in date field in data report	March 15, 2021	In reviewing the data reports, we are unsure what all of the characters indicated in column T (variable name: Demo_PSP_1) mean. This field has date validation. We see the dates but we also see extra characters ("T….") that seem to be referring to a timestamp? Fields which have date validation do not need a timestamp in them.
Usability Problem	BEEHIVE -71	UI Update for "other" text box	March 15, 2021	When consumer selects "other (please specify)" response option, the text box does not appear in line with that particular option. This may be confusing for users. We understand that modifying the way this appears may be a substantial change, so we would like to discuss this on an upcoming call to understand on what timeline it would be reasonable to ask for this change.
Usability Problem	BEEHIVE -37	Reports variable names	Next Build	To improve end-user understanding of data fields, we would like to update the date variable names to include "(UTC)". Variable names have been updated in the attached excel document, and the changes have been highlighted.
Usability Problem	BEEHIVE -69	Vertical Scroll Bar cut off of display on mobile devices	Next Build	On multiple mobile devices, the vertical scroll bar on the right hand side is cut off of the screen and there appears to be no vertical scroll bar. Can we fix the formatting of this to ensure that the scroll bar displays on mobile devices?
Usability Problem	BEEHIVE -66	Weblink UI update: Reset to top when submitting question	Next Build	During weblink survey completion, if user has scrolled to the bottom of a list of responses, then submits the answer, the next question will not re-orient to display the question. Instead, it shows the responses lower on the list (as if the view has been saved from the previous question) We need for the page to re-set to the top of the screen and show the question when the user navigates through the survey.
Usability Problem	BEEHIVE -70	Rename error message that populates for age in consumer registration	Next Build	We would like to reword the error messages that appear during consumer registration when an age that does not match whether consumer was set up as an adult or as a minor during registration. Current error message is not clear for users. New error message when incorrect age is entered for an adult: Age\<18 check DOB New error message when incorrect age is entered for minor: Age≥18 check DOB
Usability Problem	BEEHIVE -12	Weblink Formatting Issue	March 8, 21	Some of our survey questions have response options that are multiple lines long. When this happens the formatting of the text and the check boxes becomes confusing. It is hard to tell which check box goes with which response option For example, in the image below, there should be more space between the text of different response options (currently the second line of a response option is hanging very closely to the first line of the next response…).

Usability Problem	BEEHIVE-43	Reduce frequency of requiring OTP	March 15, 2021	Currently OTP is required every time user logs in. This may be quite burdensome for clinic users at sites that do not use SSO. Can we instead require OTP once per day per device?
Usability Problem	BEEHIVE-11	Show/Reveal characters when entering OTP	March 8, 21	When entering the OTP into Beehive, we would like for those characters to be shown/revealed (rather than hidden with "******" as it is currently set up).
Usability Problem	BEEHIVE-44	Update CSV button text	March 8, 21	Please change text to "Click here to attach CSV file" In the button boxed in red above, please update the text to "Upload CSV File" since that is the button used to upload, and not attach the file.
Usability Problem	BEEHIVE-16	Allow more characters in the degree textbox during user registration	March 8, 21	During user registration, the text box to specify specialty of degree does not allow enough characters. Currently, not enough space for the most common PhD we will see, "Clinical Psychology." If there needs to be a character limit, would ask for it to allow 50 characters.

Appendix V: Data Elements Summary for all Counties Retrospective Data Pull

Data Type	Data Element	Available by County	Comments
Non-identifying ID	Identifying consumer ID removed and new ID assigned	SD - available	
		OC - available	
		Solano - available	
		LA - available	
Psychosis – category	1) Clinical High Risk (CHR) and enrolled in treatment 2) First Episode Psychosis (FEP) and enrolled in treatment 3) Assessed and referred out during Jan. 1, 2017 – Dec. 31, 2019 (add reason, if possible) 4) Other and reason (e.g., incorrectly assigned to program)	SD - available	Only 1 and 2 available
		OC - available	OC Crew serves only FEP consumers
		Solano - available	
		LA - available	
Diagnoses associated with the episode of care	Diagnosis – Psychiatric, Substance Use, Medical	SD - available	Consumer can have multiple diagnoses
		OC - available	Primary, secondary, tertiary, and quaternary diagnoses
		Solano - available	Primary, secondary, and tertiary diagnoses
		LA - available	Consumer can have multiple diagnoses
Year and Month of Birth	Year and month of birth (not date)	SD - available	
		OC - available	
		Solano - available	
		LA - available	
Location (consumer zip code)	Zip code (as of first EP service)	SD - available	
		OC - available	
		Solano - available	
		LA - available	
Demographics (as of first EP service)	Race	SD - available	
		OC - available	
		Solano - available	
		LA - available	Race and ethnicity combined into one variable

Ethnicity	SD - available	
	OC - available	2 items on ethnicity - Hispanic ethnicity and self-reported primary and secondary ethnicity
	Solano - available	
	LA - available	Race and ethnicity combined into one variable
Gender	SD - unavailable	
	OC - available	
	Solano - available	
	LA - unavailable	Variable for sex only
Education level	SD - available	
	OC - unavailable	
	Solano - available	
	LA - available	
Marital status	SD - available	
	OC - unavailable	
	Solano - available	
	LA - available	
Preferred language	SD - available	Primary language available
	OC - available	
	Solano - available	
	LA - available	
Insurance status (i.e., insurance type)	SD - available	
	OC - unavailable	
	Solano - available	
	LA - available	
Employment status	SD - available	
	OC - unavailable	
	Solano - available	
	LA - available	
Living arrangement (housing status)	SD - available	
	OC - available	
	Solano - available	

		LA - unavailable	
	Sex	SD - available	
		OC - unavailable	
		Solano - available	
		LA - available	
	Gender identity	SD - available	
		OC - available	
		Solano - available	
		LA - unavailable	
	Sexual orientation	SD - available	
		OC - available	
		Solano - available	
		LA - unavailable	
	Military service / Veteran status	SD - available	
		OC - available	
		Solano - available	
		LA - unavailable	
	Foster care / Adoption	SD - available	Indicator only, before 2017 & in 2017-2019
		OC - unavailable	
		Solano - available	
		LA - unavailable	
Outpatient mental health services in EP program between Jan. 1, 2017 – Dec. 31, 2019	Date	SD - available	
		OC - available	
		Solano - available	
		LA - available	
	Duration	SD - available	
		OC - available	
		Solano - available	
		LA - available	
	Service / procedure code	SD - available	
		OC - available	
		Solano - available	

		LA - available	
	Funded plan (original pay sources, subunit)	SD - available	
		OC - available	
		Solano - unavailable	
		LA - available	
	Service location code	SD - available	
		OC - available	
		Solano - available	
		LA - available	
	Facility code	SD - unavailable	
		OC - unavailable	
		Solano - unavailable	
		LA - unavailable	
	Evidence Based Practices (EBP) / supported service code	SD - unavailable	
		OC - unavailable	
		Solano - available	
		LA - available	
	Medi-Cal beneficiary	SD - available	Combined with original pay source
		OC - available	
		Solano - available	
		LA - available	
All other mental health services utilized by consumers that started services between Jan. 1, 2017 – Dec. 31, 2019	Service / procedure code	SD - available	
		OC - available	
		Solano - available	
		LA - available	
	Location code	SD - available	
		OC - available	
		Solano - available	
		LA - available	
	Facility code	SD - unavailable	
		OC - unavailable	
		Solano - unavailable	

		LA - unavailable	
	Service Date	SD - available	Assignment open date and assignment close date
		OC - available	
		Solano - available	
		LA - available	
	Evidence Based Practices (EBP) / supported service code	SD - unavailable	
		OC - unavailable	
		Solano - available	
		LA - available	
	Service – Inpatient	SD - available	
		OC - available	Emergency room
		Solano - unavailable	
		LA - available	
	Service – Crisis residential	SD - available	
		OC - available	
		Solano - available	
		LA - unavailable	
	Service – Crisis stabilization	SD - available	
		OC - available	
		Solano - available	
		LA - unavailable	
	Service – Urgent care	SD - available	Crisis outpatient and urgent outpatient
		OC - unavailable	
		Solano - unavailable	
		LA - unavailable	
	Service – Long-term care	SD - available	
		OC - available	
		Solano - available	Psychiatric health facility service
		LA - unavailable	
	Service – Forensic services and jail services	SD - available	
		OC - unavailable	

		Solano - unavailable	
		LA - unavailable	
	Service – Referrals	SD - unavailable	
		OC - unavailable	
		Solano - unavailable	
		LA - available	
	Service – Law enforcement contacts	SD - unavailable	PERT contacts only
		OC - unavailable	
		Solano - unavailable	
		LA - unavailable	
	Service – Justice system involvement	SD - available	
		OC - available	Juvenile court/Juvenile hall
		Solano - unavailable	
		LA - unavailable	
	Service – Regional center involvement (any developmental issues)	SD - available	
		OC - unavailable	
		Solano - unavailable	
		LA - unavailable	
	Service – Substance use services	SD - unavailable	
		OC - unavailable	
		Solano - unavailable	
		LA - unavailable	
	Services – Others	SD - unavailable	
		OC - unavailable	
		Solano - unavailable	
		LA - unavailable	

*Note: The availability of these data elements is still being finalized.

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August 16, 2022

Via First Class Mail and E-Mail

Chelsea Yuen
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814
accounting@mhsoac.ca.gov

Re: Notice of Termination of Agreement No. 19MHSOAC089 to Establish the Early Psychosis Intervention Plus (EPI Plus) Program

Dear Chelsea Yuen,

In accordance with paragraph F (Termination) of Exhibit A of the above-referenced agreement ("Grant Agreement"), the County of Santa Barbara Department of Behavioral Wellness ("Behavioral Wellness") is issuing this notice to terminate the Grant Agreement due to critical staffing shortages.

The termination will be effective on September 30, 2022. Our fiscal department will work with your team to reimburse all unspent grant funds to date.

Should you have any questions, please contact me at (805) 681-5233.

Sincerely,

DocuSigned by:
Antonette "Toni" Navarro
2095C5A16FE1474...
Antonette Navarro, LMFT
Director of the Department of Behavioral Wellness

cc:
Tom Orrock

Mental Health Services
Oversight & Accountability Commission

AB 1315 (Mullin)
Early Psychosis Intervention Plus (EPI Plus)
Program Summaries

On October 2, 2017, Governor Brown signed Assembly Bill 1315 (AB 1315), establishing the Early Psychosis Intervention Plus (EPI Plus) Program, creating the Early Psychosis and Mood Disorder Detection and Intervention Fund (Fund) within the State Treasury and directing the Mental Health Services Oversight and Accountability Commission to implement the program.

The EPI Plus Program establishes a framework and strategy to support collaborative efforts to shift emphasis in California's mental health system to early detection and intervention. Through programs that harness a coordinated specialty treatment approach, evidence-based therapies, family support, medication management, and recovery-oriented practices to address psychotic symptoms and promote resilience, the EPI Plus Program is intended to improve the lives of Californians with mental health needs before those needs escalate and become severe or disabling.

Funding for the EPI Plus Program derives from donations, federal, state and private grants and other sources of revenue. Monies for the program will be utilized to support community-level early psychosis and mood disorder detection and intervention programs for adolescents and young adults. Additionally, AB 1315 establishes an advisory committee to provide guidance in administering a competitive selection process to provide funding for these programs.

In August of 2020, the Commission awarded five (5) grants of $2 million each to county behavioral health departments as part of a competitive bid process. In that procurement Lake, Kern, San Francisco, Santa Barbara, and Sonoma were awarded funds to expand their existing early psychosis intervention programs and bring them to full fidelity to the Coordinated Specialty Care model. Program summaries are included in this document.

In November of 2020, the Commission approved an RFA outline which supported a new or existing early psychosis program and a Hub and Spoke model program. At the April 2020 Commission meeting the two highest scoring applicants; Santa Clara (new or existing), and Nevada (Hub and Spoke) are recommended for award. The remaining $1.5 million was set aside to support public awareness efforts, workforce development and retention targeting ethnically and linguistically diverse personnel, and research to identify barriers to treatment improve access to care for diverse populations, and to explore new reimbursement strategies. Program summaries for the recommended awardees are also included in this document.

Spotlight on EPI Plus – Nevada (Hub and Spoke)

County Name:

Nevada County

Budget Allocation:

$1,991,515 Million Dollars

County Program Information & Summary:

This Multi-County Collaborative will be implementing the first phase of an innovative project that can ensure access to evidence-based early psychosis care in a format that is effective, and uniquely culturally congruent. UC Davis SacEDAPT will serve as the project's Hub for services. The participating counties (Nevada, Alpine, and Mono) will serve as the project's Spokes. CalMHSA will serve as the Administrative Coordinator. The project will be called REACH, which stands for Rural EPI Access through Cultural Humility. While this project includes three counties, the goal is to expand the Collaborative to include additional small/rural counties over time.

The population size for each county is presented as such, Nevada count has 98,000 persons, Mono has 15,000 persons, and Alpine has just over 1,000. All three counties are designated as underserved areas by the Federal Health Resources Administration. Workforce shortages are often addressed through multicounty collaborations such as the one proposed by Nevada County. The grant would be phase one of a larger project envisioned to address the unmet EPI needs of rural counties with an innovative telemedicine-based approach within to rural/frontier and remote areas of the state.

The Collaborative Members will establish a long-term solution in a first of its kind, innovative multicounty collaborative to deliver Early Psychosis care in rural communities through a contractual relationship with the world-renowned University of California, Davis (UC Davis) Early Diagnosis and Preventative Treatment (EDAPT) Clinic based in Sacramento. UC Davis EDAPT will serve as the project's Hub of services. The participating Counties (Nevada, Alpine, and Mono) will serve as the project's Spokes. CalMHSA will serve as the Administrative Coordinator.

Nevada County identified 15 diverse local community groups they plan to work with to implement the program in which they plan to prioritize the following populations: TAY, Native American Communities, Latinx, LGBTQI, homeless, or at-risk of homeless, rural and frontier communities.

Spotlight on EPI Plus – Santa Clara (New)

County Name:

Santa Clara County

Grant Amount:

$1,736,270 Million Dollars

County Program Information & Summary:

Santa Clara County (County) Behavioral Health Services Department's (BHSD) outreach, screening, assessment, and early intervention program targets youth and young adults ages 10-25 throughout the entire County of Santa Clara. Through the Raising Early Awareness and Creating Hope (REACH) program, community-based organizations and BHSD work together to raise awareness of early warning signs of psychosis, and quickly triage at-risk youth and young adults to a continuum of coordinated, stepped-care services. The program recognizes the importance of engaging individuals as early as possible in the appropriate level of care to help prevent, delay, or lessen the severity of psychotic illness and improve lifelong health and recovery outcomes. Youth and young adults, ages 10-25, who are Medi- Cal beneficiaries or uninsured, in the County, are eligible for screening and assessment for risk of psychosis. AB 1315 funds will allow Santa Clara County to expand services to commercially insured youth and young adults. The program will serve 104 unduplicated youth and young adults over the four year grant period. Individuals assessed as clinical high risk for psychosis (CHR-P) are eligible for the County's Coordinated Specialty Care (CSC) program, while those with private insurance are referred to stepped care within their provider network—including first episode of psychosis (FEP) programs and Stanford's INSPIRE Clinic. BHSD has contracted with two community-based organizations, Starlight Community Services (Starlight) and Momentum Mental Health (Momentum), to provide REACH program services.

Under current services, the County is limited to providing Prevention and Early Intervention (PEI) services to youth and young adults ages 10-25 who are state Medi-Cal eligible or uninsured. The Inspire Clinic through Stanford provides treatment for young adults who are CHR or have had a first episode of psychosis. BHSD First Episode Psychosis program has a minimum age limit of 16.

Spotlight on EPI Plus - Kern

County Name:

Kern County

Grant Amount:

$1,999,924 Million Dollars

County Program Information & Summary:

KernBHRS' EP program is fragmented. Through the use of this grant, KernBHRS would like to piece together existing EP programming into a Hub and Spoke model that will streamline EP through a central access point and provide a warm handoff into the appropriate system of care within KernBHRS. The goal is to move towards a more organized system that has a strong emphasis on Coordinate Specialty Care (CSC) for EP. This approach will also create a means to track individuals receiving care more easily for EP.

Furthermore, this grant will allow KernBHRS to expand efforts in multiple areas. One area of focus is incorporating other minority subgroups. Currently, KernBHRS has only penetrated the Spanish Speaking and LatinX community for services. KernBHRS would like to also be able to focus on increased outreach to Asian & Pacific Islanders, African Americans & Blacks, LGBTQ, School aged Youth, etc. Another area for enhancement would be regarding the educational formats and opportunities, as mentioned with MHFA and NAMI for family/ caregiver psychoeducation.

Additionally, a large emphasis in expansion efforts will aim to add an EP bilingual outreach and education worker with lived experience and an EP system navigator to the KernBHRS Outreach and Education team. These two positions will be filled by individuals that have experience with KernBHRS and understand the complexities of programming within the department. Some of the responsibilities would include assist, with the support and oversight from the Medical Director, in knitting together the current EP programming. These tasks will help to create a more collaborative and streamlined EP program with extensive outreach, education, fast tracking into care for psychosis, and a follow-along care-through approach of a collaborative team.

Lastly, KernBHRS would like to expand efforts that include programming comparable to NAVIGATE. Additionally, KernBHRS would like to increase resources for individuals with EP or their first episode of psychosis (FEP) along with their family members to improve psychological and functional well-being.

Spotlight on EPI Plus - Lake

County Name:

Lake County

Budget Allocation:

$4,712,690 Million Dollars

County Program Information & Summary:

Presently, the program does not offer high-fidelity Supported Employment. Through Case Management, the program can provide some supports around vocational functioning. The program seeks to enhance the co-occurring integrated SUD Services; this represents an area of growth. A structured weight-management program is not available to help support participants with managing metabolic issues related to treatment. Also, the program capacity is limited due to low staffing. Lake is a small, rural County but has a high demand for services due to the overall population experiencing significant risk factors, such as poverty, trauma and toxic stress. The program also does not provide a structured curriculum for family education and support.

With this grant, the program would be able to significantly expand services and obtain training to make current services more robust. The program aims to obtain formal training on the use of the SIPS and also CBT and ME for treatment-resistant symptoms of psychosis. The program would also be able to implement a Supported Employment program which would require training and staffing. Additionally, this would allow for an increase in the psychoeducational groups offered to both participants and families. The program hopes to include integrated co-occurring treatment with the addition of a substance use treatment counselor or a mental health professional credentialed to provide substance use disorder counseling.

Lastly, this grant would expansion in providing trainings to the community on the identification of at-risk youth and youth already experiencing potential prodromal symptoms. Just this year, the program established a distinct team. The team expanded from a single clinician specializing in early psychosis to a team leader/waivered mental health clinician, a mental health rehab specialist, and a mental health case manager. The program is also working on integrating more with prevention staff through our MHSA programming to increase outreach and engagement to community partners who serve this population and who are in a position to potentially identify youth at-risk of or currently experiencing early onset of psychosis. The program is beginning to implement the Structured Interview for Prodromal Symptoms (SIPS) and will use this as an assessment tool to determine eligibility for these services.

Spotlight on EPI Plus – Nevada

County Name:

Nevada County

Budget Allocation:

$1,991,515 Million Dollars

County Program Information & Summary:

This Multi-County Collaborative will be implementing the first phase of an innovative project that can ensure access to evidence-based early psychosis care in a format that is effective, and uniquely culturally congruent. UC Davis SacEDAPT will serve as the project's Hub for services. The participating counties (Nevada, Alpine, and Mono) will serve as the project's Spokes. CalMHSA will serve as the Administrative Coordinator. The project will be called REACH, which stands for Rural EPI Access through Cultural Humility. While this project includes three counties, the goal is to expand the Collaborative to include additional small/rural counties over time.

The population size for each county is presented as such, Nevada count has 98,000 persons, Mono has 15,000 persons, and Alpine has just over 1,000. All three counties are designated as underserved areas by the Federal Health Resources Administration. Workforce shortages are often addressed through multicounty collaborations such as the one proposed by Nevada County. The grant would be phase one of a larger project envisioned to address the unmet EPI needs of rural counties with an innovative telemedicine-based approach within to rural/frontier and remote areas of the state.

The Collaborative Members will establish a long-term solution in a first of its kind, innovative multicounty collaborative to deliver Early Psychosis care in rural communities through a contractual relationship with the world-renowned University of California, Davis (UC Davis) Early Diagnosis and Preventative Treatment (EDAPT) Clinic based in Sacramento. UC Davis EDAPT will serve as the project's Hub of services. The participating Counties (Nevada, Alpine, and Mono) will serve as the project's Spokes. CalMHSA will serve as the Administrative Coordinator.

Nevada County identified 15 diverse local community groups they plan to work with to implement the program in which they plan to prioritize the following populations: TAY, Native American Communities, Latinx, LGBTQI, homeless, or at-risk of homeless, rural and frontier communities.

Spotlight on EPI Plus – San Francisco

County Name:

San Francisco County

Budget Allocation:

$6,341,655 Million Dollars

County Program Information & Summary:

The San Francisco Early Psychosis Plus program will utilize the funding to enhance, expand, and fill gaps in the quality and capacity of its existing early psychosis system. The program has several significant gaps and unmet needs. Among the most significant of our region's current gaps are the following:

- There are many more young people experiencing or at risk for early psychosis who could benefit from our program's services.
- Because of the high level of ethnic and linguistic diversity in our region, the addition of new bilingual / bicultural staff would provide effective services to more youth and families whose primary language at home is not English.
- Our program could benefit from the expanded incorporation of substance use assessment and treatment at all levels of project services.
- While youth and family peers are already extensively involved in the development and implementation of early psychosis services at Felton, this involvement could be significantly increased, in turn supporting even greater engagement, participation, and retention in project services by both young people and their families.
- Expanded and enhanced community education and outreach would help more families and youth-serving agencies and adults identify young people exhibiting symptoms of early psychosis, while informing them of the resources available through Felton Institute and the SF TAY System of Care.
- The use of emerging telehealth and telepsychology approaches - including systems available through smart phone-based apps - has the potential to greatly expand both the participation and the long-term retention of young people and families in early psychosis intervention programs.

The overarching goal of the proposed Early Psychosis Intervention Plus program is to reduce the Duration of Untreated Psychosis (DUP) in youth, TAY, and young adults living in San Francisco, California**.** Among other outcomes, the proposed reduction will lead to a significant decrease in the severity of early psychosis symptoms, an overall reduction in client suffering, and an increase in the chance for clients to achieve full recovery and remission of symptoms, and to experience a meaningful and happy life.

Spotlight on EPI Plus – Santa Barbara

County Name:

Santa Barbara County

Budget Allocation:

$3,839,909 Million Dollars

County Program Information & Summary:

Currently the program serves clients aged 18 to 21 who are often moved from Children's System of Care to Adult levels, which may not meet all of the clients' needs. The goal of the program is to serve FEP clients ages 16 to 25 within a TAY-specific program that can offer support beyond two years.

While many staff members are trained on CBT, a goal is to have all staff who may encounter FEP clients be trained on CBT and other evidence-based tools, including screening tools to appropriately identify clients for the program to ensure appropriate coverage as the program grows. Areas that need specific attention include access to clozapine and other anti-psychotic medications with proper medication management supports, implementation of a peer provider program, explicit admission requirements, standardized screening procedures and creating opportunities for client support systems to receive education about psychosis and actively engage in the treatment process with their person. In addition, it is important for staff to gain specific training on providing family education and facilitating support groups for FEP clients and their families/support system members.

Additionally, grant funding will allow the program to expand services by hiring additional staff and securing training resources needed to support the activities outlined in the component descriptions below. The program will identify and train most of the CSC staff, establish the Multi-Disciplinary Team, improve the timeliness of contact with referred clients and outreach when they have missed an appointment. The program will also review pharmacotherapy process, increase education and initial outreach efforts, ensure there is sustainable and appropriate client to staff ratios, begin to enhance provisions for clients to access a full range of services including increasing family engagement/groups and building social and community living skills.

The current FEP program lacks formalized structure (due to a lack of appropriate staffing levels and coordination) and services are generally provided in an ad hoc manner. Current and new clients will benefit greatly from the implementation of a formalized CSC program, creating a foundation for providing services in a coordinated, integrated method.

Spotlight on EPI Plus - Sonoma

County Name:

Sonoma County

Budget Allocation:

$4,203,263 Million Dollars

County Program Information & Summary:

Prior to establishing the ASPIRe program, Sonoma County MHSA Capacity Assessment, 2016-2019 reported a gap in community knowledge in how to access the mental health system of care, potentially creating delays for those in need. Some family members reported feeling "lost" at the initial stage of their loved one's mental illness. They were often leading the process and were unsure if they should seek services and did not know who to ask for support with such a major decision. Sometimes this resulted in waiting to seek help until their loved one experienced a crisis, which they felt could be prevented by having more education about mental illness and information on the resources available. For those that knew they wanted to access services, many reported not knowing where to go to learn about Sonoma County's behavioral health system generally, or specific services and providers. Some stakeholders reported taking a long time to figure out what steps to take to help their loved one and noted the adverse emotional impact of not being able to provide immediate support.

The service delays described above may have led to an increased use of crisis services in the county. There exists a high level of need among consumers in Sonoma compared to other California counties. Many residents used crisis services through the Crisis Stabilization Unit (CSU), inpatient hospitals, and emergency departments.

The ASPIRe program's operations plan is modeled after the highly successful Supportive Outreach and Access to Resources (SOAR) program in Solano County. This EPI Plus funding will primarily be used to expand FTE's, secure necessary and additional technical assistance through training and fidelity consulting, modify the staffing structure to ensure adequate and ongoing coverage for staff absences or turnover, modify the service model to include substance use/abuse disorder treatment (previously an elimination criteria for admittance to the program), and create systems so that the clinic can provide IM medications.

Mental Health Services Act

AB1315 EPI Plus Training and Technical Assistance Program

Deliverable 3e:

Training and Technical Assistance Quarterly Report (Y2Q2)

Final version submitted May 31st, 2022

Prepared by:

University of California, Davis

This report was supported by:

Mental Health Services
Oversight & Accountability Commission

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Background

Research shows that intervention within 18 months of psychosis onset is associated with better long-term outcomes (Kane et al., 2016), including reduced rates of suicide, hospitalization, incarceration, homelessness; improved quality of life, social/family relationships, work and school functioning; and reduced costs of care. These findings, in combination with an influx of state (Prop 63 PEI, AB1315, SB1004) and federal (Mental Health Block Grant) dollars, led to rapid development of early psychosis (EP) programs across California. Data collected through a needs survey in 2018 revealed that EP programs in California consistently need initial training and ongoing technical assistance (TA) across core areas of EP care as well as program development and management. The survey also revealed the ways in which that TA could be provided and interest in contracting directly for clinical services, if they were available via telehealth or another approach.

Through these surveys and ongoing stakeholder engagement opportunities, a number of key needs were identified to support 1) increasing access to EP care for all Californians, 2) ensuring a high quality of EP services when they are provided, and 3) using consistently collected data to inform direct care, support program quality improvement, and provide outcomes to the county and state levels. To address these needs, the MHSOAC supported the development of the California Early Psychosis Training and Technical Assistance Program through AB1315.

Project Goals

Based on the data collected by prior projects and stakeholder input, the MHSOAC supported the development and funding for a California Early Psychosis Training and Technical Assistance Program, which is led by UC Davis in collaboration with UC San Francisco and Stanford. The primary purpose of this project is to provide training and technical assistance (TTA) to the Early Psychosis Intervention (AB1315 EPI) Plus Grantees of the Mental Health Services Oversight and Accountability Commission. The TTA will assist Grantees with their implementation, operation, and data collection for EPI programs using the Coordinated Specialty Care (CSC) model. The TTA will assist EPI Plus Grantees to reach higher levels of fidelity to the CSC model, which targets individuals who are in the early stages of psychosis or mood disorder. The TTA contract will allow for Grantees to receive specialized training to provide high quality, evidence-based services.

Deliverable 3: Overview

The current document summarizes the individual TTA plans for EPI Plus Grantees and related activities undertaken during this project period. Specifically, we describe:

3.1 The progress made by each EPI Plus Grantee toward the goals identified in the TTA plans from Deliverable 2

3.2 Hiring progress for all positions outlined in the University's budget

3.3 Training dates, progress updates, and ongoing consultation to Grantees in evidence-based assessment, treatment, medication management, and all other CSC model components

3.4 Consultation dates, recipients, and subject matter of meetings around program initiation, scaling, and modifications to meet needs

3.5 Learning Collaborative activities

3.6 Progress on development of statewide supports

3.7 Significant barriers to EPI Plus program implementation by Grantees

Deliverable 3.1: Progress made by each EPI Plus Grantee toward the goals identified in the TTA plan

3.1.a. Staff hiring and training progress

Each Grantee is expected to hire the positions outlined in their budget. However, counties have reported to the team a significant deficit in qualified applicants to open positions and a high turnover rate among employees - trends which are reflected in physical and mental health service providers across the country. To address these challenges, we have created an online learning platform through Canvas where staff can participate in

trainings online/on-demand. Sites have continued using our current learning management system Canvas to complete on-demand trainings, accompanied by a comprehensive training manual, consultations, and a tracking sheet that has been introduced to county programs in order to expedite their training progress for these online trainings. For trainings that cannot be completed asynchronously, we have provided several live training courses online via Zoom and distributed an attendance record compiled by our team that is updated after each training (see Appendix I). Please see Table 1 below for information on training attendance for this quarter.

We initially proposed that each staff member be expected to attend the majority of trainings relevant to their role within 3 months of their start date/contract start date, and all trainings within 6 months. Due to hiring challenges, staff shortages, and contract delays, we are reevaluating this initial timeline to be more in line with the current realities these sites are facing. We are also discussing this issue with each site during our monthly consultations and advising accordingly.

Table 1: *Number of county staff who participated in live TTA trainings this quarter*

Title	Date	Training type	Kern	Lake	MCC	San Francisco	Santa Barbara	Santa Clara	Sonoma
Trauma in EP: Treatment	3/18/22	Monthly drop-in	3	4	2	7	4	1	1
Providing Psychoeducation in EP Care	3/24/22	module	3	1	2	1	3	3	2
CBT Overview	4/1/22	module	2	7	2	7	2	5	2
CBT Informed Skills (part 1)	4/22/22	module	2	5	1	17	2	6	2
Role of Families in EP Care	4/22/22	Monthly drop-in	2	0	3	10	0	3	3
CBT Informed Skills (part 2)	5/6/22	module	3	7	1	14	2	7	4
CBT Informed Skills (part 3)	5/13/22	module	2	5	1	6	1	7	2
Clozapine: A Guide for Clinicians	5/20/22	module	4	0	2	6	3	0	1
Formulation-Driven CBT: Part 1	5/26/22	module	1	1	0	0	0	2	1
Connecting with Communities	5/27/22	Monthly drop-in	2	0	2	4	0	1	0

We detail below narrative summaries on counties' progress on hiring, training, and other goals identified in the TTA plan.

Kern

Consultation with Kern County this quarter focused on preparations for the soft opening of their EP clinic in early April. They have only recently been approved for Innovation funding for their team, who are currently in a holding pattern until that funding is received.

1) *Staff:* Kern County has successfully filled all but one of their positions after facing multiple challenges with turnover. Their staff are currently employed in other existing services and will formally start working in the EP program now that the Innovation funding is secured to join the LHCN and cover additional EP program costs. Statuses of the positions outlined in their initial TTA plan are outlined below:

Table 2: *Kern County hiring status*

Position	Status	Notes
Team Leader	filled	
Bilingual Outreach Worker (with lived experience)	filled	Peer Advocate is currently filling this role, due to challenges with turnover. Kern will revisit filling this position later
Recovery Specialists	filled	1 hired, 1 identified. Both bilingual. The identified staff member has not fully transitioned over to the clinic
Behavioral Health Unit Supervisor	filled	
Behavioral Health System of Care Administrator	filled	
SEE Specialist	filled	
Peer Advocate	filled	
Clinician	filled	
Family Advocate	vacant	Interviews in progress
Psychiatrist	filled	

2) *Training:* Although hiring challenges and turnover have delayed initial training completion estimates, newer staff have been given Canvas accounts and have started their training on-demand using this online platform. We have provided clinic leadership with records to track the training progress of their new staff, where possible (see Appendix I). More seasoned staff have continued to access both our live and on-demand trainings this quarter, as well as our monthly drop-in trainings (see Table 1).

3) *Implementation of CSC Components:* Kern County has identified the following goals as targets for Year 1:

   a) *Client/prescriber ratio:* In consultation with Drs. Niendam and Hardy, the optimal client: prescriber ratio of 100:1 has been discussed. As a result, the FTE for the prescriber was reduced to .10 from 1.0.

4) *Eligibility criteria/Screening:* Eligibility and screening criteria for clients has been discussed in TTA consultation meetings and has been covered in subsequent TTA trainings. Parameters for admission were honed, identifying target clients as: 1) Living within the Bakersfield Metropolitan Area, 2) Aged 15-25 years (to map onto TAY system of care), and 3) within 3 years of first episode of psychosis onset. Discussion also included considerations of substance use, noting that outreach should not directly target clients in active substance use treatment, but that young people experiencing psychosis beyond the half-life of the substance should not be excluded. Clinic leadership is looking through their EMR and working with supervisors for additional referrals to the program, while also limiting their outreach to accommodate their current capacity. We have advised clinic staff to phone screen more thoroughly upon initial contact with clients and have encouraged them to utilize our "Early Psychosis Clinic Phone Screen" training available on Canvas. We have also provided them with samples of referral/screening forms for their reference while they create these forms for their clinic.

5) *Additional areas of focus:*
   a) *Development of targeted materials for clinic use:* In preparation for the soft opening of their clinic, Kern requested assistance with developing materials such as referral forms, welcome packets, flyers, and pamphlets. We have provided them with examples from clinics such as Felton, SOAR, and SacEDAPT, while also orienting them to the materials provided on Canvas.

6) *Program Evaluation:*

a) *Outcomes Evaluation:* Kern County has decided to join the Learning Health Care Network. Despite significant challenges finalizing the budget due to confusion around funding streams and staff turnover, the LHCN team has received a finalized budget narrative from Kern County for revision and the Innovation Plan was approved by the MHSOAC on 5/26/22.

b) *Fidelity Evaluation:* A formal assessment of their fidelity to the CSC model is scheduled for 2023.

Lake

Consultation with Lake County has focused on balancing CSC fidelity with what is realistic in a rural community setting with limited staff and resources. They are one of many sites impacted by high-turnover and staff burnout, resulting in long wait-list times for clients. They have begun implementing their TTA plan to ensure fidelity to the CSC model. See details below.

1) *Staff*: Most recently, Lake has adapted to industry-wide hiring challenges by filling many positions identified in their TTA plan with contracted workers, including their Medical Director, Psychiatrist, Nurse Practitioner, and Physician, all of whom are working remotely. Lake is still in search of both a Case Manager and also a Peer Support Specialist. The county continues to work to fill these roles and we will continue to provide support around this, focusing on the considerations of workforce development relevant to a rural county. Lake has also recently contracted with an external entity that will provide Supported Education and Employment services, but reached out to our team and MHSOAC about how to implement SEE service delivery in EP programs. We have provided them with some possible scenarios, depending on the billing procedures within their county, and have offered additional consultation around this topic, if needed. Lastly, we have encouraged Lake to incorporate their contracted workers (see below) into monthly meetings to integrate them into the team, with the eventual goal of including them 1-2 times per month. We have provided an update on Lake's hiring activities for the past quarter in Table 3 below.

Table 3: *Lake County hiring status*

Position	Status	Notes
Supported Education and Employment Supervisor	Contract worker	Part time. See above
Supported Education and Employment Specialist	Contract worker	Full time. See above
Peer Support Specialist	Vacant	Team is discussing whether to hire or identify someone to fill this position
Case Manager	Vacant	Currently interviewing for this position
Parent Partner/Specialist		
Medical Director	Contract worker	Not seeing patients or prescribing, but attending trainings. Only has 1 hour per month dedicated to the EP program. Remote
Psychiatrist	Contract worker	Prescriber, remote. Hoping to have additional in-person prescriber (contracted) by July
Nurse Practitioner	Contract worker	Supporting prescribers, remote
Physician	Contract worker	Assisting with prescribing, remote

2) *Training:* Current Lake County staff are attending the asynchronous trainings available on Canvas, and the TTA assessment training team is currently working on addressing Lake's request from last quarter, which was for more accessible, user-friendly assessment tools for use at their clinic. We have also worked with the team at Lake to problem-solve ways their contracted workers can attend applicable TTA trainings while not overextending the county's budget, since hourly billing would apply to training attendance. Our team recommended having the county's Medical Director attend some of these trainings in lieu of their contracted psychiatrist and debriefing them afterwards. Lake has also sent several of their staff to the CBTp trainings offered this quarter (see Table 1). A smaller number of staff are also tentatively planning to attend future Formulation-Driven CBTp trainings next quarter (see Table 9). The team is also poised to attend our assessment training consultations next quarter, as having more staff trained on assessments will help reduce their waitlist and allow more people in their community to receive EP care. Lastly, Lake has communicated a desire to utilize the CSSRS more frequently to make screening more efficient. We have encouraged them to revisit our trainings on this assessment tool for utilization at their clinic.

3) *Implementation of CSC Components:* Lake County has identified the following goals as targets for Year 1:

a) *Create program-specific outreach/psychoeducational materials and increase community outreach:* Lake county's focus has shifted away from this priority, as they are currently at capacity at their clinic. Rather than directing their efforts toward outreach due to a low number of referrals, Lake has had to develop a waitlist and a triage list to handle the high volume of referrals they are currently receiving. We will continue to advise them on how to problem-solve around this issue.

b) *Offer additional outreach and community trainings to help identify at-risk youth:* Last quarter, in order to support some of their high-risk clients, Lake County developed a virtual LGBTQIA+ support group using elements of the peer support model to meet the needs of many of their existing clients. As mentioned above, their focus has shifted away from outreach this quarter in favor of streamlining their intake and assessment processes to better serve clients.

4) *Additional Areas of Focus:*

a) *Screening and Assessments:* Lake County has communicated significant challenges with staff turnover and hiring (as mentioned above), making timely screening of new clients difficult. The current screening process was discussed and the program was advised to replace an outdated questionnaire with the Prodromal Questionnaire-Brief (PQ-B). PQ-B materials were provided during our monthly-drop in training on the PQ-B Screening in January, which was attended by most site staff. These materials are also available in Canvas, and digital versions of both the PQ-B Screenings and the COMPASS-10 screenings are included on the tablets provided by the LHCN. We are hoping to provide training on the Mini SIPS next quarter, which we hope will be more user-friendly in the community setting and aid sites such as Lake County in streamlining their assessment process. Leadership at Lake have also worked with our assessment training lead, Dr. Rachel Loewy, to develop an assessment pathway and troubleshoot the challenges of conducting a comprehensive assessment with a long waitlist. We have identified the staff who will receive individual consultation to competency in assessment, as well as attend the group assessment consultation meetings. At present, Lake County is looking to hiring and training new hires to help address current issues with the backlog of assessments.

5) *Program Evaluation*

a) *Outcomes Evaluation:* Lake County has elected to participate in the California Early Psychosis Learning Health Care Network and has sent us a finalized contract for our review. We are awaiting final internal review.

b) *Fidelity Evaluation:* A formal assessment of fidelity will occur in 2023.

San Francisco

The EP program in San Francisco County is managed by the Felton Institute. Felton is a non-profit organization that has an existing CSC program (reMIND), and also manages CSC programs in 4 other counties, with integrated management, training, and evaluation across counties. Felton and San Francisco County are working in close collaboration on this project to expand services and ensure program fidelity. San Francisco County and Felton Institute have continued implementing their TTA plan. See details below.

1) *Staff:* Felton has recently experienced some staff turnover and are looking to replace their Clinical Team Leader and Clinical Care Manager. Their Bilingual Nurse Practitioner also left their position, but SF has already identified someone to fill this position. The county has highlighted hiring challenges unique to CSC, in addition to industry-wide hiring challenges impacting staffing at their clinic. Specifically, the team noted that, after completing training in CBTp, staff members are recruited for new jobs and choose to leave CSC positions in favor of opportunities that do not require additional professional development in a specialized area. We have provided an update below on recent hiring activities.

Table 4: *San Francisco County hiring status*

Position	Status	Notes
Bilingual Therapist	vacant	Evaluating budget capacity for additional therapists
Bilingual SEES	filled	Peer IPS worker
Peer Support Specialist/Co-Facilitator	filled	Interns are currently running groups and working with clients, unsure of whether these can transition to fully "in-house"
Family Peer/Support Specialist	filled	Starting in June
Training and Evaluation Manager	vacant	
Behavioral Health Director	filled	
Clinical Team Leader	vacant	
Clinical Care Manager	vacant	
Bilingual Psychiatric Nurse Practitioner	filled	New hire: person formerly in this position resigned in April 2022

2) *Training:* Current team members have attended recent monthly drop-in trainings, as well as the other live trainings provided in recent months (see Table 1). Many Felton staff have attended the CBTp trainings offered this quarter, with applicable clinic staff planning on joining additional Formulation-Driven CBTp trainings scheduled for next quarter (see Table 9). One challenge our team has identified is our lack of capacity to accommodate participants from other reMIND programs at our post-training consultation groups, as those programs are not EPI Plus Grantees. Due to the integrated nature of the multiple reMIND programs, this has proven challenging for both our team and San Francisco County's EP program as a whole.

3) *Implementation of CSC Components:* San Francisco County has identified the following goals as targets for Year 1:

   a) *Create program-specific outreach/psychoeducational materials*: San Francisco/Felton have obtained separate funding to hire an Outreach Specialist to implement outreach plans for their clinic. The TTA team worked with San Francisco last quarter to identify possible areas for outreach via outreach mapping, and provided them with customizable psychoeducational and outreach materials. Because much of our conversations during consultation meetings once again centered around the county's program evaluation and hesitancy to participate in the LHCN, conversations around this year 1 goal were deprioritized this quarter.

4) *Additional Areas of Focus:*

a) *Assessment Training/Consultation Needs:* After announcing the launch of our weekly assessment training consultation groups, we discussed San Francisco's needs around assessment training consultation. San Francisco currently provides weekly consensus meetings around diagnosis and treatment for the entire team, including tape reviews to evaluate competency among newer staff from external consultant Dr. Ryan Melton. Upon further discussion with the TTA assessment team lead, Dr. Rachel Loewy, San Francisco determined that their attendance at TTA-provided group assessment consultations would be redundant. However, the individual consultation to competency in assessment is not fully covered by Dr. Melton, and the TTA materials were identified as potentially useful. Therefore, we agreed to revisit assessment training needs when the individual consultation component is launched. We have also encouraged the team at San Francisco to inform us if they would like to join the weekly consultation groups in the future or if any additional needs arise that we can assist with in this area.

5) *Program Evaluation:*

a) *Outcomes Evaluation:* TTA consultation calls have focused largely on discussions regarding San Francisco's participation in the LHCN as a means of program evaluation and data collection. At this time, the county and Felton have chosen to proceed with their own internal data collection system. Conversations with the LHCN team regarding a data crosswalk have shown that program evaluation without joining the LHCN will be a heavy lift for both the county and the EPI-CAL team. Interim Project Manager for the LHCN, Kathleen Nye, has sent guidelines to the county for their review, and a data dictionary and sample reports are tentatively scheduled to be sent to the county by June.

b) *Fidelity Evaluation:* We have concluded the interview portion of the formal fidelity assessment and are in the process of rating the clinic. We expect ratings to be completed by the end of next quarter.

Santa Barbara

Santa Barbara's CSC model currently consists of three teams embedded in existing services, with coordinated supervision. The team is currently working on reviewing current caseloads to identify eligible FEP clients for their EP program. Their team, county management, and county leadership has been one of many heavily impacted by industry-wide challenges in staffing, capacity, and turnover. Despite their determination and ingenuity, Santa Barbara has informed us that these barriers may prohibit them from effectively utilizing this grant and fulfilling their training requirements. Their leadership is currently determining the future of their participation in the program, and in the meantime, we have reassured them that we are here to support their development however we can. The information provided below is tentative based on previous conversations with the county and is subject to change, pending their decision on their future participation in the TTA program.

1) *Staff:* Santa Barbara has recently experienced turnover within their team but have filled a few open positions and identified a staff member to serve as an interim Team Supervisor after the retirement of the previous Supervisor. Due to industry-wide hiring challenges, Santa Barbara will focus on filling vacant positions rather than finding additional funding for new positions at their clinic. For the time being, they will begin incorporating discussion of clients into their existing team meetings rather than having separate clinical team meetings. We have detailed their hiring activities for this quarter below.

Table 5: *Santa Barbara County hiring status*

Position	Status	Notes
Recovery Assistant (3)	Filled	Onboarded (2) and moved to FTE, 1 onboarding
Peer Advocate (3)	Filled	

Family Advocate	Filled	Lead Peer Advocate is covering this role. Needs supervision
Psychiatrist (3)	Filled	
SEES	On leave for 1 year	Recovery Assistant with SEES experience may be providing interim coverage
Team Supervisor – TAY Clinic	Filled/TBD	Interim
Clinicians	N/A	These positions were not allocated in the EPI Plus grant, but were identified as existing staff funded through other sources who would be partially allocated to this program.
Case Worker	filled	
Lead Recovery Specialist	filled	
Research and Evaluation Support Staff	vacant	

2) *Training:* To address concerns about limited time to attend and implement training at the clinic level, our team has been giving Santa Barbara customized guidance on which trainings to prioritize to best suit their needs while still ensuring fidelity. We plan to incorporate customized learning paths and the incorporation of outside equivalent trainings into our new Learning Management System, to be implemented in the future. For now, we have directed the team to skip trainings on subjects their staff is already competent on, and have strongly suggested they prioritize intake assessment training. Per our recommendation, the team is considering bi-weekly meetings for staff performing intakes and treatment to discuss cases. The team also communicated a need for additional training on Clozapine and some staff attended our Clozapine training on May 20th (see Table 1).

3) *Implementation of CSC Components:* Santa Barbara County has identified the following components as targets for Year 1:

   a) *Create program-specific outreach/psychoeducational materials:* Santa Barbara County has customized the outreach templates provided by TTA staff and are using the customizable PowerPoint templates provided to train staff on CSC.

   b) *Provision of psychoeducation through both individual and group formats:* Training staff in psychoeducation has been identified by the TTA team as a higher initial priority than more specialized treatments like CBTp. 10 staff have completed the Psychoeducation in Psychosis training. The TTA team is currently planning an additional training on psychoeducation, as well as ongoing group consultation for staff.

   c) *Increase targeted community outreach, particularly in school-based settings:* Santa Barbara County has shifted their focus to assembling their full team before tackling targeted community outreach, prioritizing in-reach and identifying existing clients for their EP program. They have prepared a community outreach PowerPoint, but want to get an idea of their current capacity for new and existing clients before engaging in outreach outside the system.

   d) *Implement explicit admission criteria and standard screening procedure:* After identifying their eligibility and screening criteria with Dr. Rachel Loewy earlier this year, Santa Barbara is working on streamlining their phone screen process. We have advised the team to use phone screens as a combination case/chart review and general information gathering tool and to create a checklist to help guide clinicians during assessments.

4) *Program Evaluation:*

a) *Outcomes Evaluation:* Santa Barbara County has been working towards finalizing their contract to join the LHCN, but their contracts department has recently put this contract on hold while internal leadership decides on the future of their participation within EPI-CAL in general. We hope to have more updates soon.

b) *Fidelity Evaluation:* Santa Barbara's fidelity assessment is tentatively scheduled for 2023.

Santa Clara

A substantial portion of our consultation with Santa Clara County this quarter focused on transitioning efforts from CHRp to FEP clients to adhere to the conditions of the EPI Plus grant. We have detailed additional activities among the county for this quarter below.

1) *Staff:* After having experienced substantial staffing changes last quarter, Santa Clara has filled some positions, with many still vacant. Please see an update on Santa Clara's staffing below:

Table 6: *Santa Clara County hiring status*

Position	Status	Notes
Mental Health Program Specialist/Project Manager	filled	Offer extended
Program Manager (2)	filled	Interim until hired
Momentum Program Manager	vacant	
Therapist	filled	
Peer Advocate (Momentum)	vacant	
Family Partner (Momentum)	vacant	
Peer Advocate (Starlight)	filled	These two positions filled by the same person
Family Partner (Starlight)	filled	
Clinician (2)	1 filled, 1 vacant	Starting in July
Case Manager	filled	
Medical Provider (Starlight)	filled	Will start working on this team, per CSC model (see below)
Medical Provider (Momentum)	filled	Has time set aside for EP program

2) *Training:* New hires are in the process of completing the asynchronous training materials on Canvas in an effort to expand their knowledge of how to provide services to FEP clients. The county is also pursuing training outside of the TTA with PIER on the SIPS while our team develops a training on the Mini SIPS that we believe will be more user-friendly in a community setting. We have encouraged Santa Clara to complete asynchronous trainings on Canvas on the CSC Model, Eligibility and Screening, and the PQ-B, in an effort to redirect their efforts more towards serving FEP.

3) *Implementation of CSC Components:* Santa Clara County has identified the following components as targets for Year 1:

a) *Create program-specific outreach/psychoeducational materials:* Santa Clara County has hired a staff member to focus closely on outreach and psychoeducation. Conversations around this Year 1 goal this quarter focused on adapting language in the county's outreach materials to be more culturally inclusive and accessible. Upon close review of eligibility criteria and how this information is presented in outreach presentations, it was determined that SC should remove references to past or current trauma, current substance use, or housing status in their criteria determining ineligibility. Instead, the focus should be on eligibility that will support clients to access initial screening and assessment.

4) *Increase capacity to serve larger proportion of incident cases:* At present, Santa Clara's focus is on serving insured CHRp clients using EPI funds, however, only one insured CHRp client has been enrolled in the program since the project commenced. As such, we have focused much of our efforts on discussing serving FEP rather than CHRp clients (see *Additional Areas of Focus* below).

5) *Additional Areas of Focus:*

   a) *Transition from serving primarily CHRp to FEP:* While Santa Clara County's proposed EPI Plus grant program, REACH, has focused on enrolling uninsured or MediCal CHRp clients, their aim in joining the TTA was to be able to expand services to privately insured CHRp. Our team, in partnership with the team at MHSOAC, have strongly encouraged SC to expand services to FEP, as the EPI Plus grant is oriented towards CSC/FEP rather than CHRp. The team has experienced challenges in obtaining referrals to their program, which we have identified as a product of excessively narrow eligibility criteria. They have proposed converting some of their client slots in the REACH program previously identified as CHRp to FEP for clients who transition to FEP while in the program, as opposed to accepting new FEP clients into the program via outreach. Under their current model, FEP clients who are currently in the REACH program would be converted to FEP within REACH, but new FEP clients would be referred to the EP clinic at Las Plumas, which our team has identified does not adhere to the CSC model. The team at Santa Clara has received our feedback and concerns in partnership with the MHSOAC and will communicate these concerns with their executive board for discussion regarding possible next steps. We will follow up with their team in July. We had also identified the lack of medical providers on their team, a deviation from the CSC model. In consultation with Dr. Kate Hardy, the team at SC identified Medical Providers at their clinic who could provide these services on an as-needed basis.

6) *Program Evaluation:*

   a) *Outcomes Evaluation:* Santa Clara County is interested in joining the California Early Psychosis Learning Health Care Network (LHCN) and attended an introductory meeting with orientation materials in late March. We are awaiting a response from the county and plan to continue following up with them.

   b) *Fidelity Evaluation:* A formal assessment of fidelity will occur August 29th – September 2nd, 2022. Because there is no formal fidelity tool for CHRp, our team plans to pilot the CHRPs for this county's fidelity assessment.

Nevada/Colusa/Mono Multi-County Collaborative

In partnership with the EDAPT Clinic at UC Davis, the MCC (spearheaded by Nevada County) has drafted a hub and spoke model with UC Davis functioning as the hub and collaborating counties operating as the spokes. As the hub, UC Davis will provide direct clinical care while the county spokes will focus on outreach, case management, and screening of CHR and FEP individuals for referral to the hub.

Consultations and team meetings this quarter focused largely on preparing Nevada county for a soft launch of their program, while introducing both Colusa and Mono to the MCC and addressing confusion around their roles in the hub and spoke model. Our team provided Colusa County with an introductory presentation on the TTA and the nature of our program (see Appendix VII), along with other materials orienting them to the program. We also completed a SWOT assessment for Colusa County to ensure we are helping the county progress towards fidelity.

The Clinical Services contract between UC Davis and CalMHSA as part of the hub and spoke model is under review by the contracts team at UC Davis. The goal is to complete this by the end of this quarter. Colusa County's Participation Agreement was received by the board of supervisors for approval and should be fully executed soon.

1) *Staff:* Since last quarter, UC Davis has hired or identified nearly all positions, many of which have lived experience (except the Clinic Coordinator position). Some of these staff are currently in the process of being onboarded and will be fully onboarded next quarter. Colusa county has started attending weekly

MCC team meetings with UC Davis and Nevada County, with Mono County tentatively set to join monthly or on an as-needed basis.

Table 7: *MCC hiring status*

Position	Status	Notes
Director	filled	
Outreach Trainer	filled	Will start August 1st, 2022. Director will cover duties in the interim
Psychiatrist	filled	
Program Manager/Supervisor	filled	
Clinician (unlicensed)	filled	Clinician is covering in interim. Another has been hired for this role and will start August 1st, 2022
Family Advocate	hired	Covered by 2 individuals, one starting June 1st, and another starting mid-June of 2022
Peer Engagement Specialist	hired	Starting May 31st, 2022
Clinic Coordinator	vacant	Posting has been submitted to hire
Supported Education and Employment Specialist	vacant	Person identified, but need to post to hire. Posting has been submitted

2) *Training:* During our meeting with Mono County, the MHSOAC, and CalMHSA, we clarified with Mono county that spoke counties are not required to attend trainings on Canvas, but will instead receive onsite trainings on eligibility, screening, and other components of CSC relevant to their roles within the hub and spoke model. We will continue to clarify this with the other spoke counties as well, and hope to begin these in-person trainings next quarter. We have encouraged spokes to attend both live and on-demand trainings not as a requirement as EPI Plus Grantees, but rather as optional trainings to supplement their knowledge and improve client outcomes.

3) *Implementation of CSC Components:* At present, the primary focus for MCC counties is on establishing contracts and methods for cross-county documentation. CalMHSA is taking the lead on contracts, while UC Davis has taken lead on developing a procedures document for all steps of the model by county to ensure that documentation and billing requirements are met. Both Nevada and Colusa counties have identified clients who are appropriate for referral for initial screening, pending execution of the contract with UC Davis. We are continuing to work on clarifying requirements for spoke counties participating in the EPI Plus MCC while working towards accommodating smaller, more rural counties, such as Colusa and Mono.

We are working primarily with Nevada county as the leader in this collaborative to focus on the following in year 1:

a) *Increase capacity to serve larger proportion of incident cases:* In consultation with Drs. Niendam and Hardy during EPI Plus meetings, MCC has noted a smaller capacity than expected and adjusted their referral goals accordingly. They currently plan to accept approximately 15 referrals during the first year, with Nevada taking on a bigger caseload than the other spoke counties to ensure equitable distribution according to the size of each spoke.

b) *Create program-specific outreach/psychoeducational materials:* Discussions around this year 1 goal this quarter focused on a three-step process as the programs develop, including 1) accepting already identified clients into the hub for assessment/treatment 2) in-reach to existing county programs, medical record review, etc., and 3) outreach to community providers, high schools, and other community

settings/agencies (see Appendix III). Colusa and Mono counties are planning to follow this same approach.

c) *Engage with organizations representative of all target populations:* We will continue to work with the counties to identify and engage organizations representative of all target populations. Because this will include close consideration of resources and organizations specific to agencies within a rural location, we are consulting with national experts in CSC program development within rural and frontier locations to support this.

4) *Additional Areas of Focus:*

a) *Hub and spoke model:* As mentioned previously, we received feedback from Mono county regarding confusion about the hub and spoke model, requirements to participate in this model and receive TTA and clinical services from the spoke (UC Davis), training requirements, and what accommodations are available for small rural counties. We will work to further clarify the specifics of the hub and spoke model and will coordinate with CalMHSA to develop a list of requirements and expectations for spokes participating in this collaborative. During our conversation at our May monthly consultation meeting, we worked with Colusa and Nevada counties to clarify the roles of both the hub and the spokes, specifying that the hub provides all core CSC components and supports outreach for local spokes, while the spokes 1) support referrals to UC Davis as the spoke, 2) attend weekly MCC team meetings (this requirement is flexible depending on team capacity), 3) support coordination of care via local case management and crisis support, and 4) support outcomes evaluation locally, if needed. We also developed an organizational chart (see Appendix IV) to provide an at-a-glance understanding of the model and a flowchart to illustrate our phased rollout of the hub and spoke approach (see Appendix III).

5) *Program Evaluation:*

a) *Outcomes Evaluation*: MCC will participate in the California Early Psychosis Learning Health Care Network, as well as utilize CalMHSA to support data reporting efforts. MCC, UC Davis, and CalMHSA are developing the contract for this and do not currently have a timeline due to delays with the Clinical Services contract.

b) *Fidelity Evaluation:* A fidelity assessment for these sites is scheduled for 2023.

Sonoma

1) Sonoma County has continued implementing their TTA plan to support their EP program, which is primarily managed by Aldea Children & Family Services ("Aldea") and called SOAR. Buckelew Programs is contracted to provide the peer support. *Staffing:* Aldea has been restructuring their staffing in an attempt to adapt to current industry-wide staffing shortages. Part of this restructuring has included removing their Senior IT Technician position from the list of positions funded by EPI Plus, and adding a Peer Case Manager position to compensate for recent turnover. Aldea manages CSC programs in two other counties, and staff from these programs are occasionally able to cover roles in Sonoma, their newest program, as it becomes established. Please see a full status of positions within their EP program below.

Table 8: *Sonoma County hiring status*

Position	Status	Notes
Senior Director	filled	Filled by 2 people
Program Director	filled	
Psychiatrist	filled	
Psychiatric Nurse Practitioner	filled	
Clinical Supervisor	filled	Lead therapist is shifting into this role over time, taking over duties from current supervisor

Program Coordinator	filled	
Therapist (2)	vacant	Second therapist is temporary coverage from Napa clinic, as a short-term solution
Compliance Supervisor	filled	
PQI Manager	filled	
Applications System Admin	filled	
Peer Case Manager	vacant	Will be filled by Buckelew. Searching for someone to fill this position full time at Sonoma's EP program
Family Advocate	vacant	Temporarily supported by Napa, Buckelew as a short-term solution

2) *Training:* Most of Aldea's Sonoma SOAR staff have already been trained by UC Davis through a pre-existing contract, and since last quarter, all clinicians except one new hire are up-to-date on trainings that are required by the TTA. We have also provided Aldea with resources to help track their staff's attendance in recent live trainings. Our team is working to ensure uniformity between the TTA and UCD-contracted trainings in our approach to consultations as we develop our assessment consultation model before its launch. Aldea has also agreed to pilot our assessment competency checklist, which we plan to implement with other sites as part of this training model.

3) *Implementation of CSC Components:* Sonoma County has identified the following components as targets for Year 1.

   a) *Supported Education and Employment Services (SEES):* Conversations this quarter focused on this CSC component and its inclusion in Sonoma's EP program. Our team maintains that, while the inclusion of SEES within community clinics is not typical, it is a crucial part of the CSC model and should be developed accordingly at the clinic setting. We have connected the county with external training resources while our program works on developing our approach to training on this CSC component, including any didactic training and/or consultation needed. Sonoma's goal is to train their Peer Case Manager (a position filled by Buckelew) to provide SEE services while they search for someone to fill this position full time for Sonoma's EP program only, as this position is most effective when focused on local career opportunities and connections.

   b) *Integration of Family Advocate:* The Sonoma County Aldea SOAR program is still seeking a Family Advocate who can work exclusively with them, but Napa County Aldea SOAR's Family Partner has been able to serve Sonoma families while the position is seeking applicants. Aldea has identified a few areas in which the CSC model conflicts with existing county models, billing codes, agency policies, and program capacities. For example, although family members provide input into the initial client assessment, MediCal billing codes make it difficult for families to be seen for treatment until after the treatment plan is created. However, according to the CSC model, the family should be included in treatment from program enrollment forward. We have strongly encouraged Aldea to introduce the Family Advocate during the client/family welcome session to reinforce the importance of family involvement and participation in EP care, but to perform a full assessment of family needs later to bypass this billing issue. We have also encouraged them to 1) present the Family Advocate meeting as standard procedure rather than wait for the primary clinician to refer families as needed, and 2) not to refer to Peer and Family Advocate roles as "support staff," but rather to highlight them as integral team members. SOAR managers report these changes have been very helpful. We anticipate that Sonoma's fidelity assessment in October will assist them in developing this CSC component to fidelity.

4) *Additional areas of focus:*
   a) *Medication Management (Clozapine/Long-Acting Injectables):* Although this was prioritized as a target

for part of this year, it was moved to year 2 due to staff turnover, logistical storage issues, and medical staff being out on medical leave. We have also provided a training on Clozapine this quarter, which is available on-demand, and are developing an LAI training to be provided next quarter.

5) *Program Evaluation:*

   a) *Outcomes Evaluation:* Sonoma County's program is already participating in the Learning Health Care Network.

   b) *Fidelity Evaluation:* Their site fidelity assessment is scheduled for October 10th-14th, 2022.

Deliverable 3.2: Hiring progress for all positions outlined in the University's budget

UC Davis

UC Davis has filled or hired nearly all positions outlined in our budget. We are currently onboarding a Project Policy Analyst I for the UC Davis team who will provide research and administrative support to project staff, including our collaborators at UCSF and Stanford. We are also completing interviews for a Project Policy Analyst who will provide administrative and other support.

UCSF

UCSF has hired all positions outlined in their budget, including Drs. Loewy and Stuart, the Project Coordinator (Misha Carlson) and Assistant Coordinator (Christopher Blay). We are in the process of reclassifying Dr. Kristin LaCross to a Psychologist title, although she has already been fulfilling that role in her current title as a Staff Research Associate.

Stanford

Stanford has completed filling all positions outlined in their budget, including Dr. Hardy, a CBTp Trainer and Consultant, an Assessment Trainer and Consultant, a Research Assistant, and two Project Coordination staff members. There have been no updates to their staffing this quarter.

In an effort to streamline our internal decision-making processes and increase efficiency and productivity within our team, we have developed an organizational chart (see Appendix IV) that shows our internal team structure. Through this process, the TTA recognized areas where specific training and technical assistance will be needed (e.g. Peer support, Supported Education and Employment). Therefore, we are working to identify individuals within our 3 sites to fill these roles within the TTA to ensure that we are able to provide the breadth of support needed to develop and maintain CSC programs across the state. We will continue to adjust this internal structure as we evaluate our team's capacity and the needs of Grantees receiving training and technical assistance from our program.

External Consultation

The EPI Plus team identified a need for expert consultation in three areas, which include: program development in rural regions; expert consultation for developing CSC programs in a statewide context; and bolstering participation from service users and families on advisory councils.

The focus on the development of CSC programs in rural and low-population regions was driven by the recognition that several of the programs participating in EPI Plus are situated in rural counties or cover rural areas across the county. In addition, partnerships with tribal health exist in several counties. To date, there is no established model for implementation of CSC within low population density areas in the United States. Dr. Katherine Hayden-Lewis and Tamara Grace Sale, MA, both affiliated with Oregon Health Sciences University-Portland State University, will act as consultants in this process with a focus on rural communities. They have extensive experience of program development in these communities as developers of the Early Assessment

and Support Alliance (EASA) in Oregon. As one of the first community CSC programs in the United States, EASA is a well-established model that has been expanded across Oregon and adopted in other states across the country. Further, Katherine Hayden-Lewis and Tamara Grace Sale are experts in first episode psychosis in diverse populations, particularly with rural populations currently served by EASA. They will consult with us on how to best support participation in the EPI-CAL network by our geographically and culturally diverse communities, beginning with needs assessment strategies in rural regions.

Additionally, we have identified a need for expert consultation for developing CSC programs in a statewide context. While the TTA team has expertise in developing local CSC programs, we realized we needed support and consultation on how to build a larger, statewide TTA infrastructure that is sustainable. OnTrackNY has developed a TTA approach to support the development and maintenance of CSC programs across the state, while also supporting CSC development nationally. Their experience in this space will be invaluable to the development of the California TTA program. Therefore, we are working with OnTrackNY to initiate the consultation process, with a plan to provide direct support to the TTA team over the next year.

Finally, the EPI Plus team is invested in building up sustainable participation of clients and families on advisory and steering committees, whether those are pre-existing committees or newly-formed ones specific for these stakeholders. We have begun an informal consultation process with representatives from OnTrackNY and EASA to discuss how to elevate the interests of clients and families in ways that are meaningful for them and also provide vital input for CSC service provision. Recently, we also consulted with Khatera Aslami-Tamplen, a prominent Peer Advocate and organizer more proximally located in Alameda County. Khatera's expertise has been especially valuable for our work in facilitating a movement of peer integration within CSC, since she was one of the founding members of CAMHPRO and served as Executive Director of Peers Envisioning and Engaging in Recovery Services (P.E.E.R.S). As the Consumer Empowerment Manager at Peers Organizing Community Change (POCC), she is deeply involved in transforming mental health systems via inclusion of and leadership by service users. We have had several conversations about how to build from the strength of existing groups and promote organic growth of councils based on shared interests and enthusiasm. We hope to develop a more formalized consultation relationship with representatives from OnTrackNY and EASA. We will also continue to consult with Khatera Aslami-Tamplen as we roll out engagement strategies in the coming months.

Deliverable 3.3: Summary of Training Progress

Comprehensive Trainings in Coordinated Specialty Care for Psychosis

We successfully launched our monthly drop-in training series last quarter after identifying a need amongst counties for additional didactic content alongside the subjects covered in our Canvas trainings and during our monthly meetings with each site. These monthly-drop in trainings are one-hour didactic lectures on topics requested by Grantees that are welcome to all clinic staff, regardless of role within the clinic. Our last training in this series is scheduled for June and will cover compassion fatigue (see below).

Over the last quarter, we have provided additional live trainings on components of CSC. Many of these trainings have been recorded and made available for on-demand learning on Canvas. We plan to offer trainings that must be attended live on a regular basis for staff who were unable to attend previous live trainings or staff who are new to their position within the county. We believe these live training components are essential to ensure knowledge transfer for some topics, although our primary goal is to provide and record all didactic trainings for on-demand attendance first. Site managers were provided with staff attendance records for each live training (see Appendix I). The training activities provided this quarter include:

<u>Required CSC training modules</u>

- Providing Psychoeducation in Early Psychosis Care
- Cognitive Behavioral Therapy (CBT) Overview
- CBTp Informed Skills (parts 1-3)
- Clozapine: A Guide for Clinicians
- Formulation-Driven CBTp (part 1)

Monthly drop-in trainings

- Trauma in Early Psychosis: Treatment
- Role of Families in EP Care
- Connecting with Communities: Outreach and Education About Psychosis

Training Program Development Activities for Next Quarter: Over the next quarter, we will wrap up the didactic portion of our monthly drop-in trainings series and pivot to including content that leverages the expertise of county staff, in addition to developing future training materials for those trainings which we have not yet convened. At this time, we currently have the following trainings planned for next quarter:

Required CSC training modules

- Formulation-Driven CBTp (parts 2 and 3)
- Structured Interview for Psychosis-Risk Syndromes (SIPS)
- Structured Clinical Interview for DSM Diagnoses (SCID)
- Long Acting Injectables
- Assessment Feedback and Welcome Session

Monthly drop-in trainings

- June: Clinic Team Wellbeing and Avoiding and Managing Burnout

Information on scheduled trainings has been distributed to the counties via our bi-weekly newsletter, Outlook, and Eventbrite.

Post-training Consultations: Lastly, our internal assessment and CBT training teams have developed models for ongoing consultations to follow didactic trainings. Our intent for these consultations is to train clinic staff members to competency on assessment tools and CBTp after completing the didactic lectures and assignments provided this year. Each site will attend a weekly group consultation led by TTA staff for ongoing consultation. We have gathered data on interest and availability among sites to schedule these monthly ongoing meetings (see Tables 9 and 10 below) and are working to finalize our policies and procedures regarding these consultation before scheduling.

1) *CBTp Consultations:* Staff who attended CBTp Informed Skills Training (Clinicians/Therapists, Case Managers, Family Advocates/Partners, Peer Advocates/partners, SEES/Occupational Therapists) will participate in 4 months of weekly consultation and fidelity review. Clinicians who participate in the Formulation-Driven CBTp training (Clinicians/Therapists only) will join 6 months of CBTp consultation and competency review to support clinicians to become competent in CBTp (see our training flowchart for CBT in Appendix V). Table 9 below includes a tally of staff who will be attending these trainings per site:

Table 9: *Number of county staff who will participate in CBT consultations*

County	CBT Informed Skills consultations	Formulation Driven CBT consultations
Kern	3	2
Lake	6	5

San Francisco	6	3
Santa Barbara	We will receive an update once leadership has decided the future of county's involvement in the grant	We will receive an update once leadership has decided the future of county's involvement in the grant
Santa Clara	0 – will need to wait to train new staff	0 – will need to wait to train new staff
Sonoma	3	0
MCC	N/A - UC Davis hub staff will receive internal support	N/A - UC Davis hub staff will receive internal support

2) *Assessment Consultations:* Our assessment training team has developed a variety of documents to support individual and group assessment consultation including meeting and case presentation guidelines, a competency checklist for evaluation and structured feedback, and an integrated assessment packet designed specifically for ease of use in community-based CSC programs. These materials were all created based on feedback from programs regarding their specific needs. We have set up a digital scheduling system, *Appointy,* which will allow providers to schedule one of our assessment trainers to attend their session remotely for consultation, which we will begin using next quarter. Weekly assessment consultation groups will consist of a one-hour weekly group meeting per site to be attended by all assessors at the site level who are performing assessments at their clinic, with one assessment trainer from the TTA in attendance to lead the group consultation and discussion. To evaluate county needs, we have compiled information on how many assessors at the site level will need to attend these trainings in Table 10 below.

Table 10: *Number of county staff who will participate in Assessment consultations*

County	Assessment consultations
Kern	2
Lake	2
San Francisco	3 (3-4 positions who will need this training are vacant). Most likely opting out
Santa Barbara	We will receive an update once leadership has decided the future of county's involvement in the grant
Santa Clara	Still need input despite follow-up
Sonoma	N/A - receives this through separate contract with UC Davis
MCC	N/A - UC Davis hub staff will receive internal support

Deliverable 3.4: Summary of Consultation Activities

Individual program development consultation

The EP TTA will continue to provide ongoing regular meetings with each EPI Plus Grantee to allow for discussion of key program decisions, including hiring plans, program implementation, budgets, supervision, management, and financing, among others. Progress toward TTA goals will be discussed and Grantees will be encouraged to provide feedback to the TTA team on training received and any challenges that need to be addressed. Meeting details for the last quarter (3/01/22 - 05/31/22) are reported in Table 11 below.

Table 11: Consultation meetings with Grantees and EP TTA leadership

County	Meeting Date	Meeting Attendees	Discussion Topics

Santa Clara	Thursday, March 3rd, 3pm	County: Grant coordinator, Mental Health Program Specialist, Outreach Coordinator TTA team: Dr. Hardy, Stanford Clinical Research coordinator, UC Davis TTA Project Manager	Staffing, training, contracts, funding, screening procedure, inclusion criteria, referral pathway, fidelity assessments.
	Thursday, April 7th, 3pm	County: Grant coordinator, Mental Health Program Specialist, Outreach Coordinator, two program managers, MMH program manager TTA team: Dr. Hardy, Stanford Clinical Research coordinator, UC Davis TTA Project Manager	Staffing, training, contracts, funding, screening procedure, inclusion criteria, referral pathway, fidelity assessments, prescriptive language.
	Tuesday, May 17th, 4pm	County: Grant coordinator, Mental Health Program Specialist, Outreach Coordinator, two program managers, MHSOAC Health programs specialist, MHSOAC Chief of Commission, Operations and Grants, TTA team: Dr. Hardy, Stanford Clinical Research coordinator, Stanford Postdoctoral Fellow, UC Davis TTA Project Manager	Training, screening process, eligibility criteria, FEP vs CHR, assessment training/consultation, CBTp training, staffing
San Francisco	March Meeting cancelled		
	Tuesday, April 5th, 12pm	County: Clinical Manager DPH, Program Director, Early Psychosis Associate Director, MHSOAC Health programs specialist, MHSOAC Chief of Commission, Operations and Grants TTA team: Dr. Hardy, Stanford Clinical Research Coordinator, UC Davis TTA Project Manager, UC Davis Staff Research Associate	Data crosswalk, data collection process/protocol, contracts/funding, year 1 TTA plan, staffing, training, LHCN, fidelity assessments

	Tuesday, May 3rd, 12pm	County: Clinical Manager DPH, Program Director, Early Psychosis Associate Director, MHSOAC Health programs specialist, MHSOAC Chief of Commission, Operations and Grants, TAY System of Care Director TTA team: Dr. Hardy, Dr. Loewy, Stanford Clinical Research Coordinator, Stanford Postdoctoral Fellow, UC Davis TTA Project Manager, UC Davis Staff Research Associate	Data crosswalk overview, diagnostic assessments, data collection, welcome packet, staffing, training/consultation needs
Kern	Thursday, March 24th, 3pm	County: Heather Hornibrook Adult System of Care, team leader, administrative assistant, Jessica Armstrong, Behavioral Health System of Care Administrator, administrative assistant TTA Team: Dr. Hardy, Stanford Clinical Research Coordinator, UC Davis TTA Project Manager	Soft opening recap, staffing, outreach and identification of potential clients, eligibility criteria contracts/funding, budget amendment, LHCN, training updates, suicide prevention training
	Thursday, April 21st, 3pm	County: Team leader, administrative assistant, Behavioral Health System of Care Administrator, Outreach and Program Specialist TTA Team: Dr. Hardy, Stanford Clinical Research Coordinator, UC Davis TTA Project Manager	Numbers enrolled, staffing, budget amendment, LHCN, training updates, assessments, developing targeted material, referral form
	May meeting cancelled – staff has conflicting event on date of scheduled meeting. Could not find a date to reschedule.		
Lake	Wednesday, March 23rd, 11am	County: Deputy Administrator Clinical Services, Clinician TTA Team: Dr. Hardy, Stanford Clinical Research	Outreach mapping, training updates, CBTp trainings, formulation training, staffing, assessment check-in, outreach process

		Coordinator, UC Davis TTA Project Manager	
	Could not find a time to meet in April		
	Wednesday, May 25th, 11 AM	County: Deputy Administrator Clinical Services, Clinician TTA Team: Dr. Hardy, Stanford Clinical Research Coordinator	Training, Prescriber/Clinician roles clarification, CBTp informed skills training, Assessment training, staffing, SEE service delivery/billing, contracts/funding
Sonoma	Monday, March 7th, 10am	County: Chief Executive Officer, Program Director, Senior Clinical Mental Health Director, MHSA Analyst TTA team: Dr. Loewy, UCSF Clinical Research Coordinator, UC Davis TTA Project Manager	Staffing, training, contract/budget progress, assessment supervision and consultation, program restructuring, messaging and branding, medication management, family advocate integration, SEES services.
	Monday, April 4th, 10am	County: Chief Executive Officer, MHSA Analyst, Chief Program Officer TTA team: Dr. Loewy, UCSF Clinical Research Coordinator, UC Davis TTA Project Manager	Staffing, training, contract/budget progress, assessment supervision and consultation, peer and family partner integration.
	Monday, May 2nd, 10am	County: Chief Executive Officer, MHSA Analyst TTA team: Dr. Loewy, UCSF Clinical Research Coordinator, UC Davis TTA Project Manager	Staffing, training, contract/budget progress, assessment supervision and consultation, family advocate integration, family psychoeducation, fidelity assessment preparation, SEES services.
Santa Barbara	Friday, March 11th, 9am	County: Team Lead/Supervisor, Research and Evaluations Manager, Manager of Internships and Training TTA team: Dr. Loewy, UCSF Clinical Research Coordinator, UC Davis TTA	Training, staffing, assessment supervision, budget/contracting, setting up a weekly team meeting, staff outreach, program structural changes, SEES services.

		Project Manager	
	Friday, April 8, 9am	County: Research and Evaluations Manager, Manager of Internships and Training TTA team: Dr. Loewy, UCSF Clinical Research Coordinator, UC Davis TTA Project Manager	Training, staffing, assessment supervision, budget/contracting, building a welcome packet, medication management, standard screening procedures.
	Friday, May 20th, 9 AM	County: Research and Evaluations Manager, Manager of Internships and Training TTA team: Dr. Loewy, UCSF Clinical Research Coordinator, UC Davis TTA Project Manager	Staffing, budget/contracting, larger issues with program and grant structure.epi pl
MCC (Nevada/Colusa/ Mono)	Thursday, March 10th, 3pm	County: Alaina Jones, Clinic coordinator, CalMHSA Senior Business Analyst, administrative assistant, MHSA Lead Grant Coordinator, supervisor/program director, MHSA staff TTA: Drs. Hardy and Niendam, Stanford clinical research coordinator, UC Davis TTA project manager	Billing and documentation, Colusa participation agreement, contracts (MHSA, OAC), staffing
	Could not find a time to meet in April		
	Thursday, May 12th, 3pm	County: Clinic coordinator, CalMHSA Senior Business Analyst, MHSA staff, administrative assistant, MHSA Lead Grant Coordinator, supervisor/program director, TTA: Drs. Hardy and Niendam, Stanford clinical research coordinator, UC Davis TTA project manager	Colusa participation agreement, contracts (MHSA, OAC), staffing, hub & spoke model, referrals

Deliverable 3.5: Learning Collaborative Activities

Early Psychosis Learning Collaborative

At this time, our next annual Learning Collaborative is tentatively scheduled for September of 2022, with other collaborative activities planned to take place during monthly drop-in trainings and on our listserv. We have sent counties a survey for input on availability, preferred discussion topics, and possible contributions to the collaborative. Responses for this survey are due by June 1st, 2022.

Deliverable 3.6: Progress on development of statewide supports

We have developed a Canvas course site, titled "California Early Psychosis Intervention Training" for use as a virtual learning space for the CSC trainings and developed a training manual to supplement and provide an overview of our course site that will provide Grantees with an overview of our trainings and time commitments required for each training. Grantees were also provided with tracking sheets to aid them in tracking their own training progress and the training of their staff. Unfortunately, Canvas is limited in its tracking capabilities, making it difficult for our team to track the overall training progress of EPI Plus Grantees.

To address this problem, we have recently signed an agreement with Cornerstone to access a more sophisticated Learning Management System. Cornerstone will enable us to track and distribute all training progress among sites, automate email communication between instructors and students, design customized automated learning paths that will address the individual needs of each role within each site, translate course materials into different languages, capture and record prerequisites, issue certificates of completion and continuing education certifications, create email reminders for students and instructors, integrate with Zoom or Microsoft Teams for live trainings, and incorporate and provide personalized, user-friendly dashboards for students and managers to access, among other features. We are currently working with the team at Cornerstone to develop this platform to our specifications, and we are hoping to begin orienting our internal team to this new platform and announce its launch to counties during the next quarter.

In an effort to develop a listserv as a support for our sites, we have developed a two-pronged approach consisting of 1) an email newsletter and 2) a community platform software. These approaches will serve as a more modern and user-friendly approach to the traditional listserv, enabling counties to interact with one another in real time and receive streamlined branded communication from our team. We have launched a monthly newsletter through MailChimp that contains announcements, helpful tips, information about upcoming trainings, and other resources for distribution to sites. After an initial internal pilot period, we plan to launch an official EP TTA team platform on Microsoft Teams as a resource for county programs to communicate with our team and with one another and collaborate between annual Learning Collaboratives, which has been a frequent request among sites. We plan on launching this platform early next quarter.

Lastly, we have developed and distributed a welcome packet (see Appendix VI) that includes information on the EP TTA program, the services and assistance the TTA provides to Grantees, the history of the program, TTA team contacts, a flow chart of projects and agencies, a description of the MHSOAC and its role in our project, an introduction to our collaborators at UCSF and Stanford, a list of all EPI Plus Grantees, an overview of fidelity and fidelity measures, an overview of what training and assistance we provide, and information about expectations for EPI Plus Grantees. So far, we have received feedback that this Welcome Packet has been a helpful resource for both counties and our own internal staff. We also had the opportunity to use this welcome packet and a corresponding welcome PowerPoint presentation (see Appendix VII) when introducing Colusa County to our program.

Deliverable 3.7: Significant barriers to EPI Plus program implementation by Grantees

Overall Barriers & Challenges

As described in section 3.1a above, the EPI Plus Grantee programs' primary challenges include staff turnover and difficulty filling positions. It has been especially difficult to find qualified applicants for some positions, e.g., bilingual providers. The struggle to hire and retain skilled staff reflects a national trend that is significantly

impacting mental health care. The behavioral health workforce shortage in CA is so significant that legislation has recently been introduced to address the problem (SB 964-Weiner). The impact of the shortage is even greater on specialty programs that require intensive training for staff in evidence-based practices. This difficulty in filling positions has led to an inability for programs to reach their TTA goals or for our team to complete trainings with all roles within the participating EP programs. As a consequence of being short-staffed, existing staff are being pulled into other programs for coverage and being redeployed as the existing county programs and services are stretched thin during the continuing COVID-19 pandemic. This landscape presents unique challenges to the already difficult process of launching a new program, especially one that requires extensive training, and has also prevented programs from becoming well-established enough to warrant a fidelity assessment within the timeline originally established. We hope to focus on staff turnover and retention challenges, as well as addressing clinic staff burnout, during our next monthly drop-in training on Compassion Fatigue and at our next annual Learning Collaborative so that programs may learn key strategies from each other to identify what has worked well.

Another challenge reported by several counties, particularly those with new programs, is the intensive training hours required to launch an EP program to fidelity. This is especially difficult given the staffing challenges outlined above, and the timing of the summer 2021 trainings, which occurred prior to many program hires. We have developed several solutions to these challenges, including 1) encouraging the start of weekly meetings/trainings to develop team cohesion and complete trainings, offering for TTA staff to attend for Q & A, and 2) identifying critical trainings that should be priorities prior to enrolling clients, and those that are either optional or can be delayed.

Another challenge, also described by new programs, is implementing a new and intensive assessment process into their existing workflow. This challenge is being addressed by one-on-one consultation with the Assessment Lead, Dr. Loewy, to identify the most efficient ways to implement assessment components within the overall county system. For example, some programs will conduct all assessment components within their EP team. Others will implement initial screening through the centralized county Access team, followed by the remaining components within the EP program. This is an example of an anticipated challenge (“tailoring”) that the monthly consultations were designed to address.

Discussion and Next Steps

During the next project period, we plan on improving our overall training approach, including utilizing Cornerstone on Demand to develop separate customized learning paths and other unique approaches to address feedback we have received. We also plan to launch ongoing consultation groups for assessment and CBTp and provide additional didactic trainings. We are hoping these new expansions of our training model will provide a more comprehensive and user-friendly learning experience for Grantees.

We also hope to have fully developed and launched our community platform on Microsoft Teams as part of our effort to develop a listserv as a statewide support and facilitate mentorship and collaboration between sites throughout the year.

Lastly, we are in the process of finalizing a contract with the California Department of Healthcare Services to provide TTA to additional EP programs across California. Our scope of work with DHCS will allow us to provide training and technical assistance to approximately 29 counties with EP programs across the state of California to assist them in improving client outcomes among FEP clients. We are receiving and reviewing FEP narratives submitted by these counties and developing a summary of the EPI programs described by Grantees in their applications to determine whether programs are eligible for funding and assistance. Our next steps are to hold a large group meeting that will orient applicants to our program, provide a schedule of upcoming trainings, and to request SWOT analyses from each county.

We will continue to pursue opportunities to support additional California programs and counties in reaching fidelity for their EPI programs, with the ultimate goal of developing a Statewide network to reach all Californians.

References

Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., . . . Heinssen, R. K. (2016). Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program. *American Journal of Psychiatry, 173*(4), 362-372. doi:doi:10.1176/appi.ajp.2015.15050632

Appendix I: Training Attendance Records

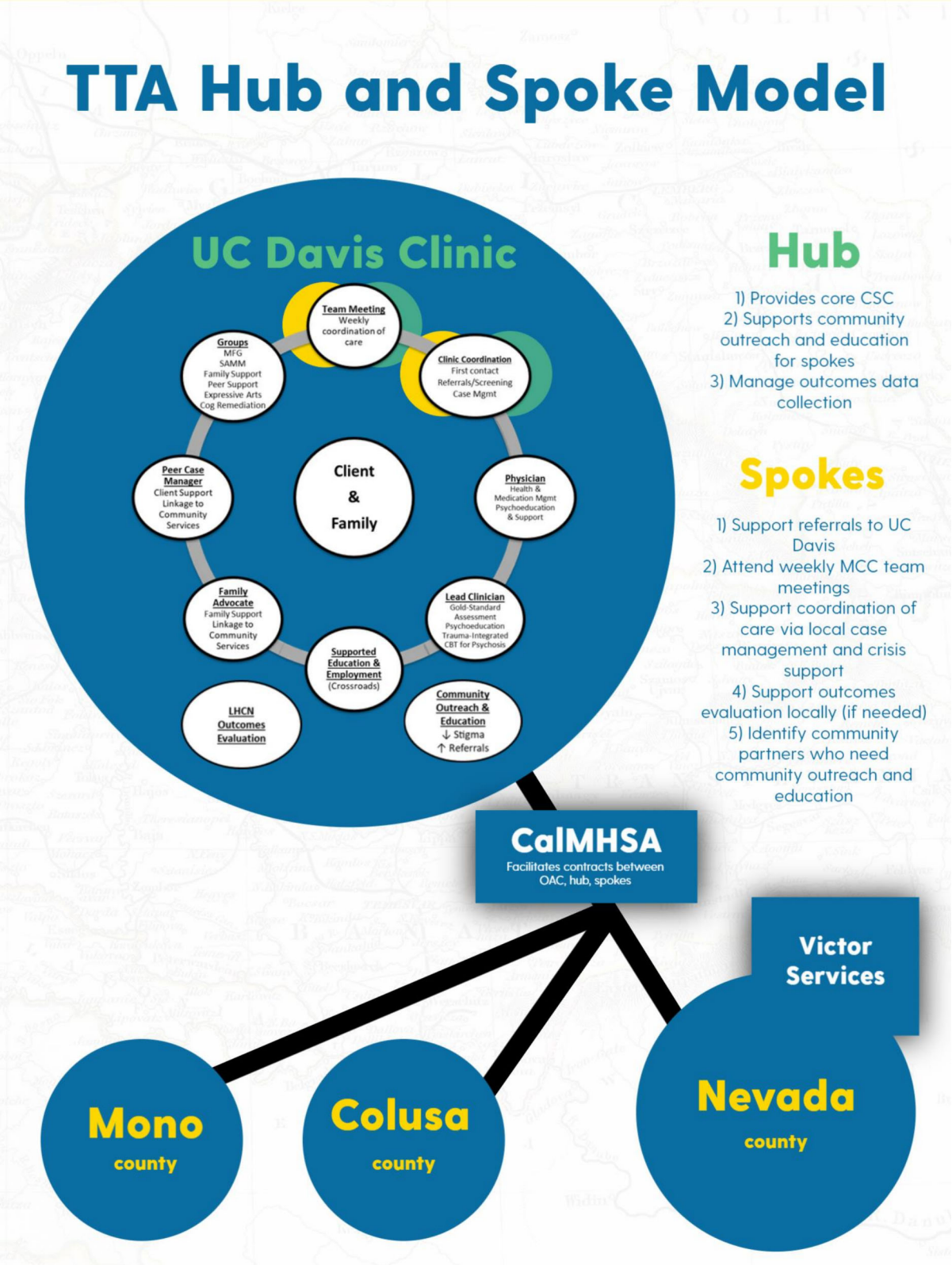
Our training attendance record for all CSC training modules is here.

https://ucdavis.box.com/s/7km78w9s12657han7ptkfwwhxkrrlehk

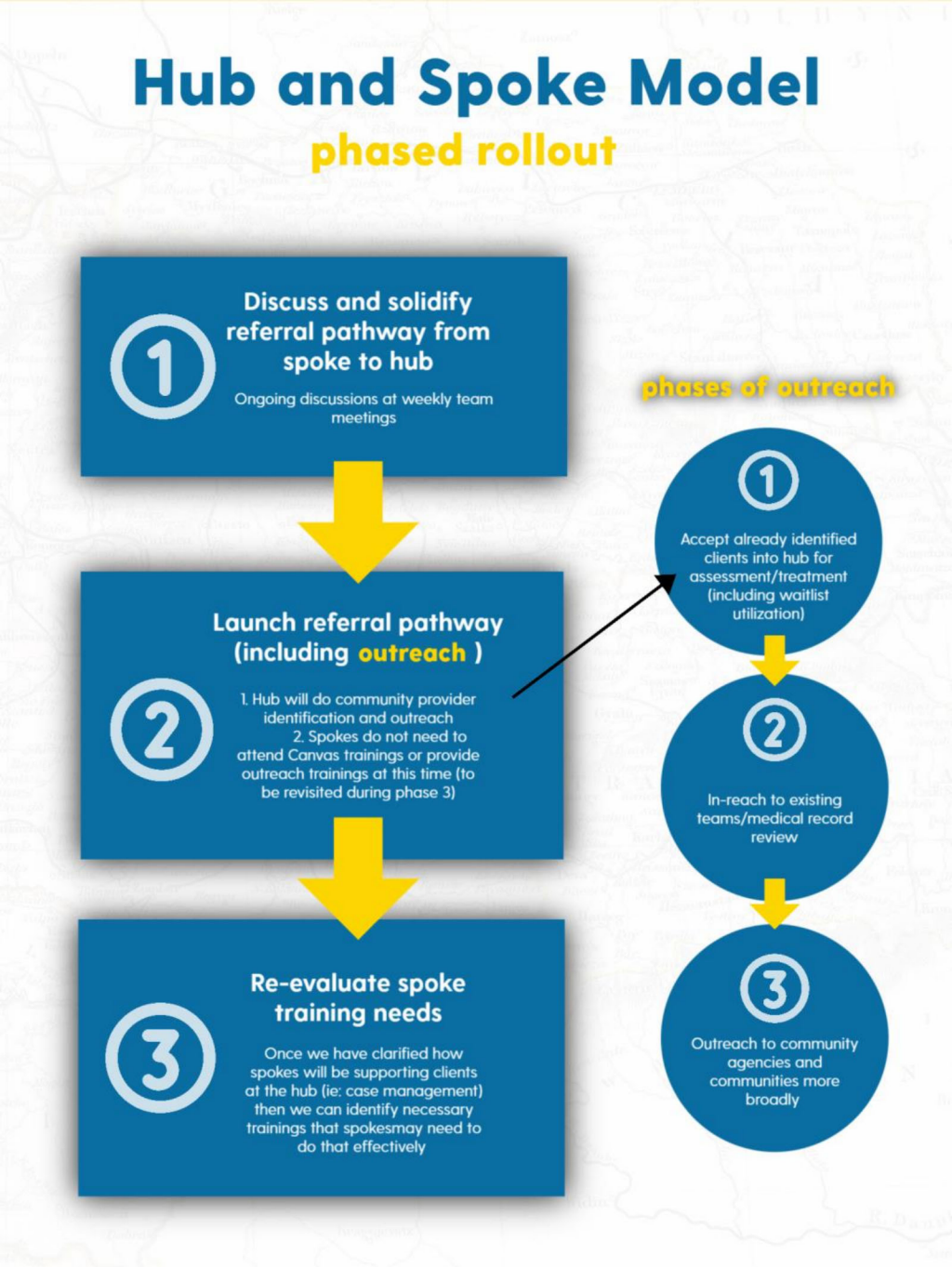
Our training attendance record for all monthly drop-in trainings is here.

https://ucdavis.box.com/s/dfbppa3inp6e04773m6hfpuuq181tq1i

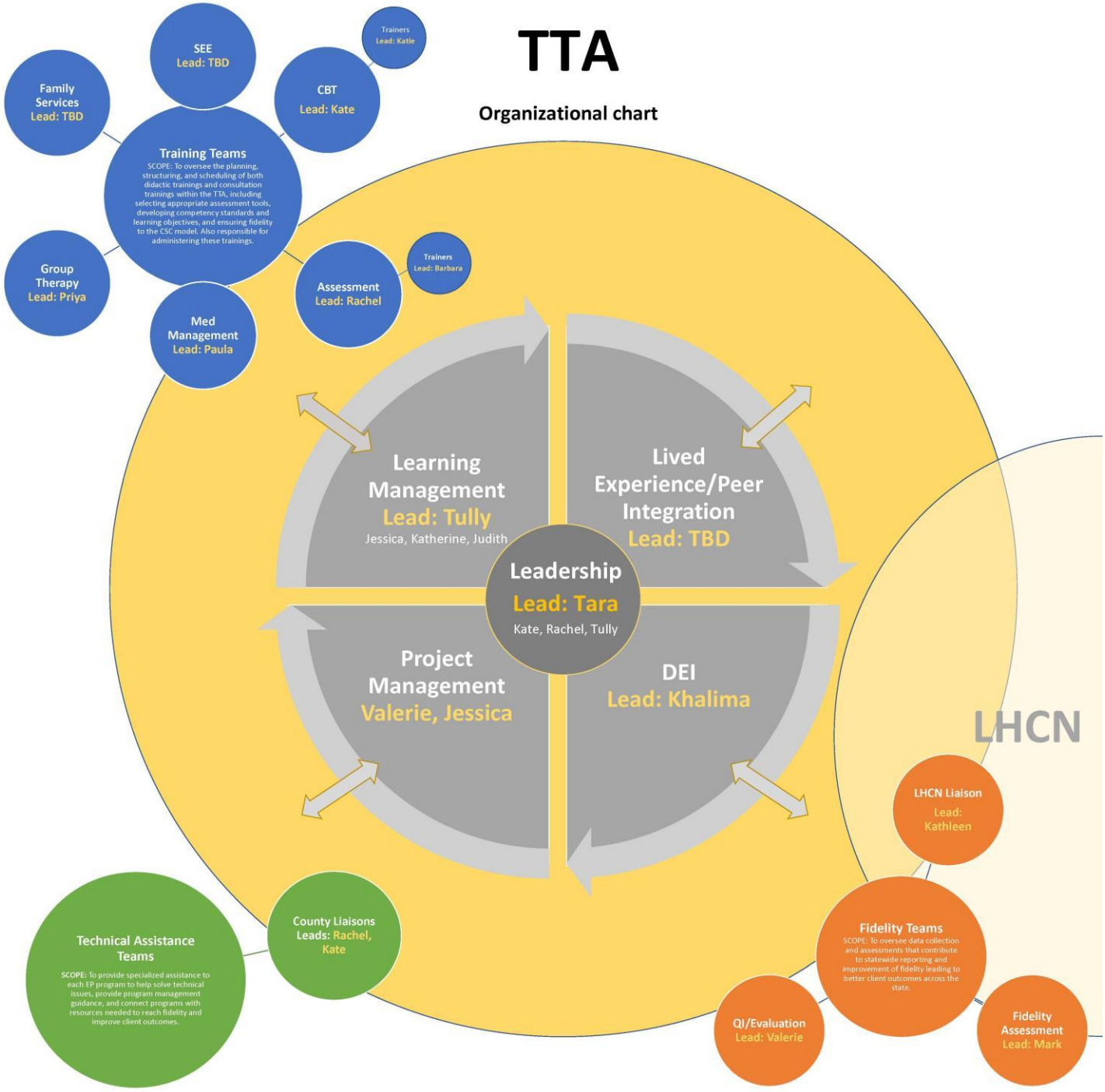
Appendix II: Hub and Spoke Model Organizational Chart



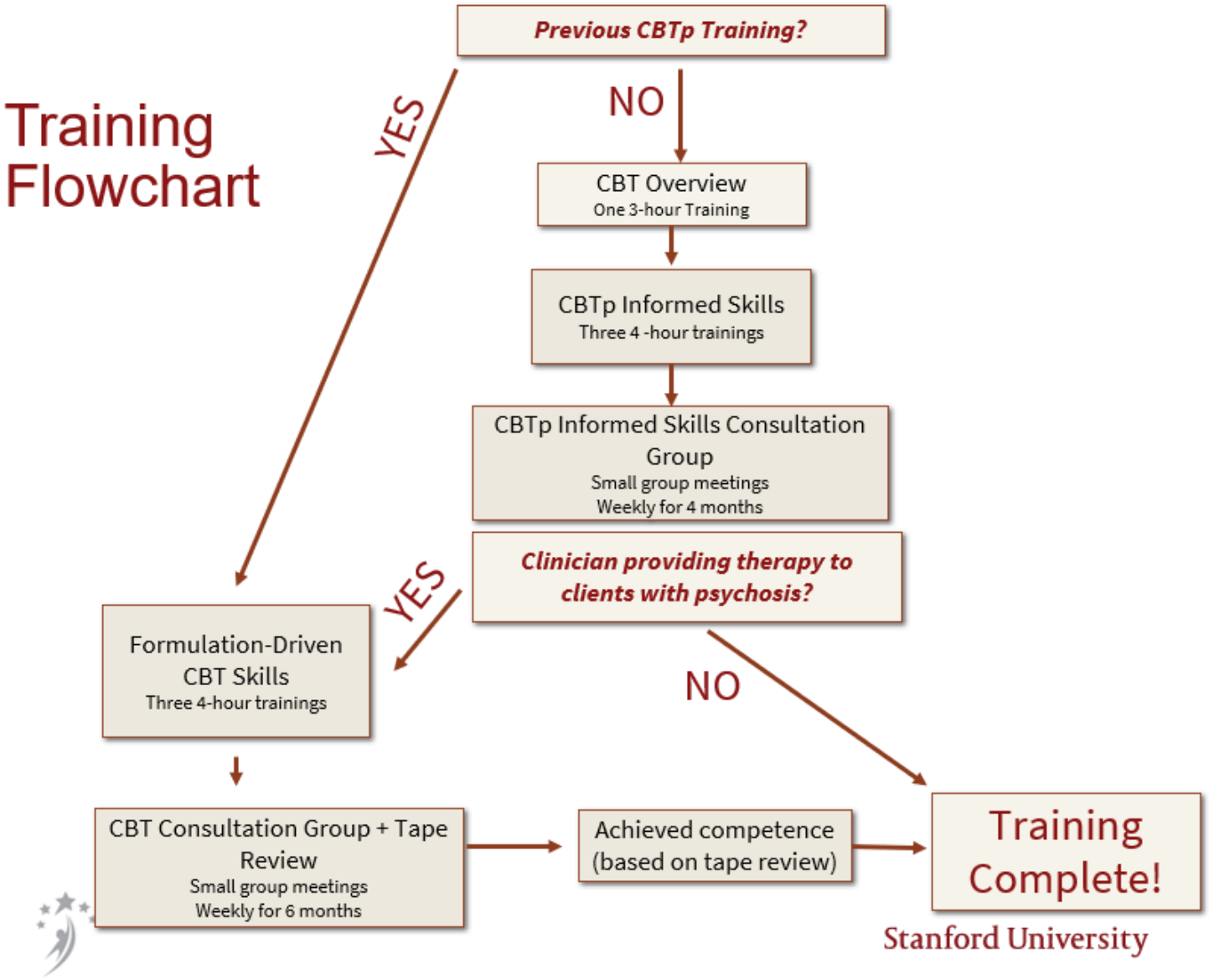
Appendix III: Hub and Spoke Phased Rollout



Appendix IV: TTA Internal Organizational Chart



Appendix V: CBT Training Consultation Flowchart



Appendix VI: TTA Welcome Packet

welcome to the TTA

Early Psychosis Training and Technical Assistance Center

Welcome! We're excited to provide you with training and assistance to aid you in the endeavor of providing in-depth early psychosis intervention services to people in your community.

About the TTA

history

In October of 2017, Governor Jerry Brown approved California Assembly Bill 1315. This law mandated the Mental Health Services Oversight and Accountability Commission (MHSOAC) to create and oversee a committee to expand the provision of high-quality, evidence-based early psychosis and mood disorder detection and intervention services in California. The MHSOAC established the Early Psychosis Intervention Plus (including psychotic conditions plus mood disorders) committee and the EPI Plus grant, which provided grant dollars to counties looking to improve existing EP programs for clients experiencing Recent Onset Psychosis, or create new ones. This initiative allowed for the creation of the EPI-CAL Early Psychosis Training and Technical Assistance Center (TTA), a program that provides training and technical assistance to EPI Plus grantees. Additional sponsorship from the California Department of Healthcare Services (DHCS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2022 has allowed us to expand our program to include Grantees of the Mental Health Block Grant (MHBG).

mission

The Early Psychosis Training and Technical Assistance Center was developed by UC Davis, in collaboration with UC San Francisco and Stanford University. We provide training and technical assistance to support implementation and sustainability of EP (Early Psychosis) programs across California. Our goals are to support the provision of high-quality EP care to all Californians and to promote recovery and better outcomes through a learning healthcare network approach.

To understand more about the TTA, you'll need to understand more about the other programs connected to ours.

EPI-CAL

The TTA is a component of the California Early Psychosis Intervention (EPI-CAL) program. EPI-CAL receives funding from several different counties through the MHSOAC, OneMind, and the National Institute of Mental Health (NIMH). The EPI-CAL program is comprised of two different initiatives: the Learning Health Care Network (LHCN) and the TTA. The primary goals of EPI-CAL are to understand:

1) the current status of existing Early Psychosis programs across California
2) which practices among which programs are promoting client recovery
3) the needs and priorities of clients, families, and communities, AND;
4) how data can influence collaborative care decisions in real time.

This program contributes to a national evaluation of Coordinated Specialty Care through NIMH-funded EPI-NET (Early Psychosis Intervention Network).

EPI PLUS

This was the name of the grant the MHSOAC provided to eligible counties to apply for funding to receive TTA services for their early psychosis programs serving clients with Recent Onset Psychosis.

We are honored to currently provide training and technical assistance to the following counties as part of the EPI Plus grant:

Kern county
Lake county
Multi-County Collaborative (MCC) - Mono, Colusa, and Nevada county
San Francisco county
Santa Barbara county
Santa Clara county
Sonoma county

LHCN

EPI-CAL aims to improve the quality of services and measure the impact of treatment. To do this, we have created a learning health care network (LHCN) of California EP programs. The goal of this network is to standardize practice and support knowledge-sharing. To make evaluation of these different EP programs possible, network members have agreed to gather the same information across the same timeframe. Clients, families, and providers will provide information by answering surveys at regular intervals throughout treatment. Surveys will be offered in 13 different languages to meet the needs the diverse communities represented in the LHCN. Surveys will ask questions such as how clients are doing at work or school, how their social life is, and how they feel about their future.

The technology used by the LHCN (Beehive) will bring the information provided by clients and families back into their care. The providers will have access to their clients' data to use as part of their regular appointments with clients and families. We hope this will empower clients to use their own data in care decisions.

EPI Plus grantees are highly encouraged to use the 15% of their grant dedicated to data collection to join the LHCN. Sites who do not participate in the LHCN for data collection will be required to obtain the same data through their own methods and share it with the LHCN. They will be asked to complete a data crosswalk and present an alternative plan to the OAC to show how this requirement will be met.

For more information on joining the LHCN, please email Kathleen Nye at knye@ucdavis.edu.

EPI-CAL

California Early Psychosis Intervention Program

EP TTA

Training and Technical Assistance Center

Receives AB1315 (state) and county funds

LHCN

Learning Healthcare Network

Receives MHSA funds, INN funds, PEI funds (state)

San Diego, Orange, LA, Solano, Napa, Sonoma, Stanislaus

EPI-CAL R01

Receives NIMH funding (federal)

LA, Orange, San Mateo, Sonoma, Sacramento, Solano, Napa

You are here!

EPI PLUS

Early Psychosis Intervention Plus

Receives OAC funds from AB1315 (state)

Lake, Kern, Santa Barbara, Santa Clara, San Francisco, Sonoma counties, MCC (Nevada, Colusa, Mono)

DHCS

Department of Health Care Services

Pending state contract

about CSC

the Coordinated Specialty Care model

EPI PLUS grantees are expected to provide services consistent with the Coordinated Specialty Care Model (CSC), a team-based program providing an array of evidence-based interventions for psychosis.

Here in the US, the primary investigation of CSC was completed through the RAISE project, which examined the effectiveness of CSC in community care settings (Kane et al., 2016). This project focused on individuals ages 15-25 with non-organic, nonaffective psychosis (e.g. DSM-IV diagnoses of schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder and psychosis NOS) who had been ill for less than 5 years. Treatment was time limited (e.g. less than 3 years). The CSC model in these programs provided team-based care with the following components: assertive case management, individual or group psychotherapy, supported employment and education services, family education and support, and low doses of select antipsychotic agents (Heinnsen, Goldstein & Azrin, 2014). Results of this study showed that individuals who received CSC earlier in their course of illness (before 74 weeks) showed greater improvements in functioning and clinical symptoms.

Original CSC Model tested by RAISE (Heinssen, Goldstein, Azrin, 2014)

Our CSC Model

Based on the result of studies like RAISE, CSC programs were started across the US. In California, many programs were started with MHSA PEI or other dollars as early as 2003 – over a decade before the results of RAISE. Consequently, the implementation of CSC services in California has been more diverse than in other regions of the US. Many CSC programs serve Recent Onset Psychosis, which refers to individuals who have experienced the onset of threshold psychosis within the past 5 years. California programs also tend to include both non-affective and affective psychosis in this group, as well as individuals with post-partum or substance-induced psychosis. Ages served can vary from as young as age 8 up to age 65. Regardless of the populations served, the core tenets of CSC are still required to yield the anticipated positive outcomes, including team-based care with assertive case management, individual or group psychotherapy, supported employment and education services, family education and support, and low doses of select antipsychotic agents. Many California programs have incorporated peer and family partners at all levels of the program (e.g. from decision making to service delivery) as well as evidence-based clinical assessment, outreach, and substance use treatment. These components are all assessed by the FEPS, which is the measure of CSC fidelity that will be used by the TTA. The TTA will assist EPI Plus Grantees in reaching higher levels of fidelity to the CSC model, which targets individuals who are in the early stages of psychosis or mood disorder.

Clinical High Risk (CHR) refers to individuals showing clinical signs that they may be at higher risk for the development of psychosis. While we encourage EP programs to identify and serve CHR clients, it should be noted that the primary function and priority of the TTA is to assist programs that target and treat ROP, according to the terms of the EPI Plus grant.

our team

This program, presented by UC Davis, is a collaboration with our colleagues at UC San Francisco and Stanford University.

Please note that TTA Project Manager Jessica Windhaus will be your primary point of contact. You can contact Jessica at jrwindhaus@ucdavis.edu

UC DAVIS
UNIVERSITY OF CALIFORNIA

Our program is led by Dr. Tara Niendam, (Program Director, Associate Professor in Psychiatry and Behavioral Sciences, UC Davis). Dr. Niendam oversees the TTA program, is the primary contact for the MHSOAC, and supports EP programs as needed. The program Assistant Director is Dr. Laura Tully (Assistant Director, Associate Professor in Psychiatry and Behavioral Sciences, UC Davis). Dr. Tully leads the Learning Management Team and serves on the Leadership Team.

UCSF
University of California
San Francisco

Our team at UC San Francisco is led by Dr. Rachel Loewy (UCSF Site PI, Professor, Psychiatry and Behavioral Sciences, UC San Francisco). Dr. Loewy serves on the Leadership Team, works in collaboration with UC Davis and Stanford colleagues to manage and provide assessment training activities, and provides consultation to EP programs.

Stanford

Our team at Stanford is led by Dr. Kate Hardy (Stanford Site PI, Clinical Psychologist, Clinical Professor, Co-Director, INSPIRE Clinic, Co-Section Chief of INSPIRE Section). Dr. Hardy serves on the Leadership Team, manages and provides CBTp training activities, and provides consultation to EP programs.

we do what

* Develop a TTA plan based on an initial site evaluation to bring your EP program to fidelity and improve client outcomes (modifications will be made, as needed)

* Provide live and on-demand/online trainings on components of the CSC model, including assessment, training, medication management, outreach, new/emerging evidence-based practices, and other CSC model components

* Provide ongoing periodic consultations with your team to address and troubleshoot obstacles and discuss progress toward TTA goals according to your program's TTA plan, and generally assist with sustainability and development of your EP program

* Carry out fidelity assessments in collaboration with your team to monitor progress towards fidelity and evaluate the impact of TTA activities

* Provide a monthly newsletter with helpful tips, upcoming trainings, and more

* Provide limited psychoeducational and outreach materials in threshold languages

* Convene an annual Learning Collaborative for EP programs and encourage collaboration between EP programs

* Share relevant EP resources and opportunities

what you do

As a grantee of this program, you are expected to...

* Provide services to ROP (Recent Onset Psychosis) clients within your county

* Provide the MHSOAC a budget worksheet within 60 days of contract execution

* Attend trainings assigned to you by your role at your clinic and track participation and progress (all staff)

* Attend monthly consultations with our team (program/county leadership)

* Work collaboratively towards increasing EP program quality

* Participate in fidelity assessments

* Participate in data collection to aid in the tracking of progress towards fidelity amongst all EP programs in California. The best way to do this is to join the Learning Healthcare Network (LHCN)

Our sponsors

Mental Health Oversight and Accountability Commission (MHSOAC)

To ensure all people get the help they need, in 2004, state voters approved Proposition 63, also known as the Mental Health Services Act (MHSA). This sweeping law calls for transformation of the mental health system while improving the quality of life for Californians living with mental health challenges.

The MHSA levies a 1 percent tax on personal incomes above $1 million and generates enough dollars each year to fund nearly 25 percent of the state's public mental health system. Its proceeds support a wide range of prevention, early intervention, treatment services, and the development of the infrastructure, technology, and workforce needed to deliver them.

The Mental Health Services Oversight & Accountability Commission (frequently referred to as the MHSOAC or OAC) was established as a result of the passing of the MHSA and embodies a bold vision of a mental health system that emphasizes recovery and puts consumers of mental health services and their families, along with other stakeholders, at the center of decision-making.

The focus on Prevention and Early Intervention (PEI) and Innovation (INN) as two of the 5 components of the MHSA have made this program possible. The MHSOAC serves as the main sponsor of this program and provides oversight and accountability to the program, as its name would suggest.

National Institute of Mental Health (NIMH)

The National Institute of Mental Health (NIMH) is the lead federal agency for research on mental disorders. NIMH is one of the 27 Institutes and Centers that make up the National Institutes of Health (NIH), the largest biomedical research agency in the world. The mission of NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure.

To carry out this mission, NIMH, as established by the Mental Health Act of 1946 and in accordance with Title IV of the Public Health Service Act, conducts and supports biomedical and behavioral research, health services research, research training, and health information dissemination with respect to the causes, diagnosis, treatment, management, and prevention of mental illnesses. As mental health is an important part of overall health, NIMH invests in research on adaptive and maladaptive behaviors to better understand mental function and dysfunction. More information is available at https://www.nimh.nih.gov

One Mind

One Mind's mission is to accelerate collaborative research and advocacy to enable all individuals facing brain health challenges to build healthy, productive lives. One Mind has become the leading brain health nonprofit committed to healing the lives of people impacted by brain illness and injury through global, collaborative action.

OneMind secures and leverages major funding from philanthropy, government, and industry for patient-centered brain research and scalable implementation of improved diagnostics and treatments, brings together innovative and influential scientists, clinicians, patient advocacy groups, industry leaders, health care providers and policy makers to identify and solve important problems in brain health, and uses their voice and resources to build support for more research funding, combat stigma, and shape a policy and legislative agenda that better serves the lived experience community. More information is available at onemind.org

fidelity measures

what is fidelity and what are fidelity assessments?

Fidelity is the degree to which an activity is delivered consistent to evidence-based practice (EBP). In the TTA, the fidelity assessments will measure how closely your program is delivering Coordinated Specialty Care in accordance with EBP, against a set of objective criteria.

There will be three assessments over the course of the program: a baseline assessment, a mid-point assessment, and an end-point assessment. Additionally, each assessment will come in one of two different types; either a formative assessment, or a full assessment. Which version your program completes will depend upon how established your program is at each point. At each assessment point, the fidelity team will discuss with you which one is most appropriate for your program.

For each assessment, we will utilize the FEPS-FS version 1.1.. The FEPS-FS is the First Episode Psychosis Service – Fidelity Scale, developed by Dr. Don Addington, and assesses fidelity to best practices delivered by a team that provides treatment and care for clients with Recent Onset Psychosis (sometimes referred to as "First Episode Psychosis"). The manual for the scale, along with its accompanying documentation, is available, for free at the following location: https://press.ucalgary.ca/books/9781773852089/. In the FEPS-FS, there are 37 items that will be assessed on a scale of 1-5, with a score of 4 or higher indicating good fidelity to EBP. For programs that treat the clinical high-risk syndrome (CHR) in addition to full psychosis, the fidelity assessment will include additional items from the Clinical High Risk for Psychosis – Fidelity Scale (CHRPS-FS). These assessments will be conducted using administrative data, patient numbers and staffing, health record data, components common to all patients, interviews with clinic staff, and clinical services and staff training provided.

At the end of the assessment, we will provide your clinic with a detailed report of the findings. This will include a summary your program strengths, and possible modifications that could be made to deliver early psychosis care consistent with current best practices.

The fidelity assessments are crucial in identifying areas of strength and opportunities for growth within your program, informing TTA goals and the nature of support our program provides, identifying potential for data to support county/funder dialogue, and evaluating the impact of the TTA on the improvements that your programs achieve over time. Grantee improvement on fidelity scores over time is the primary outcome metric for the TTA.

We will provide a more in-depth presentation on fidelity assessments closer to the assessment date for each site.

training

As part of our program, we provide a suite of training modules designed to aid programs in developing or sustaining their EP programs in accordance with the CSC model. As a TTA member, you have access to these learning activities designed to prepare you and your team to work with Early Psychosis populations in clinical settings, with a particular focus on implementing the Coordinated Specialty Care (CSC) Model.

Training is delivered via a mix of self-paced learning activities, assignments, low-stakes quizzes, live webinars/lectures, recorded videos, and group discussions. All training materials are provided and should be completed on our Learning Management System, Canvas. For more information on how to utilize Canvas, please view our introduction video at www.youtube.com/watch?v=tsuPqXHscdg. If you or your staff have not received an invitation to enroll in Canvas or need additional assistance, please reach out to our Project Manager Jessica Windhaus at jrwindhaus@ucdavis.edu

Staff at your clinic will be assigned different trainings depending on their role within your clinic, and are encouraged to complete trainings in the order provided. Our training manual is a comprehensive overview of our current training offerings, including assigned trainings by role, a description of our trainings, training completion tracking tools, and an introduction to Canvas. Please refer to it for additional information about our trainings.

Our training content covers evidence-based assessment and treatment of individuals experiencing early psychosis, with a particular focus on the Coordinated Specialty Care (CSC) model, including: community based outreach with rapid referral to reduce Duration of Untreated Psychosis (Lynch et al., 2016), comprehensive assessment using gold-standard clinical interviews (Structured Clinical Interview for DSM Diagnoses [SCID], Structured Interview for Psychosis Risk Syndromes [SIPS]), and team-based Coordinated Specialty Care (Heinssen et al., 2014). We also provide training in specific treatments, including cognitive behavioral therapy for Early Psychosis (CBTp) (Kingdon and Turkington et al., 2004) and high-risk youth (Morrison et al., 2004), Family Focused Therapy (Miklowitz et al., 2014), supported education and employment (Crowther et al., 2001), integrated substance abuse management (Eckman et al., 1999), peer and family support (Huey et al., 2007), and evidence-based medical management (Buchanan et al., 2010).

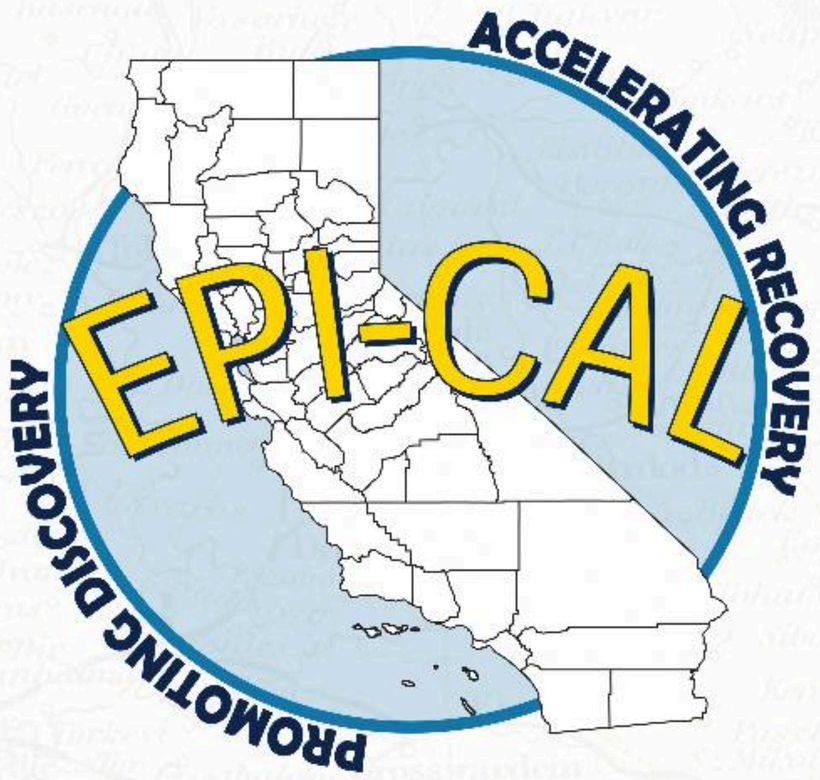
technical assistance

Each grantee completed a self-assessment of fidelity as part of their EPI PLUS application. These assessments will be reviewed and updated by your TTA consultant, then used to draft your TTA plan. The Plan tracks staff training and sets annual goals towards improving fidelity for specific program components. Grantees will provide input on the Plan goals and can change the goals as necessary, in collaboration with the TTA consultant. Plan progress is regularly reported to the MHSOAC.

Additionally, as part of our program, we offer periodic consultations and provide specialized assistance to each EP program to help solve technical issues, provide program management guidance, and connect programs with resources needed to reach fidelity and improve client outcomes. These consultations typically last one hour and take place via Zoom with your program's assigned TTA consultant, those in leadership roles within your clinic and/or county, and any other staff you would like to have present at these meetings.

Specific topics on which we provide consultation include the following:

* EP program design and development
* Program initiation, scaling, and modifications to meet need
* Management issues and supervision
* Workforce development and retention targeting clinical and support staff, including peers
* Use of outcomes data to show impact of program investment
* TTA training activities and progress (see "training" section)
* Sustaining program fidelity
* All components of the CSC model



for questions, please contact TTA Project Manager

Jessica Windhaus
jrwindhaus@ucdavis.edu

updated April 2022

Appendix VII: TTA Welcome Presentation

welcome to the TTA

Early Psychosis Training and Technical Assistance Center

Welcome! We're excited to provide you with training and assistance to aid you in the endeavor of providing in-depth early psychosis intervention services to people in your community.

ACCELERATING RECOVERY

EPI-CAL

PROMOTING DISCOVERY

About the TTA

history

In October of 2017, Governor Jerry Brown approved California Assembly Bill 1315. This law mandated the Mental Health Services Oversight and Accountability Commission (MHSOAC) to create and oversee a committee to expand the provision of high-quality, evidence-based early psychosis and mood disorder detection and intervention services in California. The MHSOAC established the Early Psychosis Intervention Plus (including psychotic conditions plus mood disorders) committee and the EPI Plus grant, which provided grant dollars to counties looking to improve existing EP programs for clients experiencing Recent Onset Psychosis, or create new ones. This initiative allowed for the creation of the EPI-CAL Early Psychosis Training and Technical Assistance Center (TTA).

mission

The Early Psychosis Training and Technical Assistance Center was developed by UC Davis, in collaboration with UC San Francisco and Stanford University. We provide training and technical assistance to support implementation and sustainability of EP (Early Psychosis) programs across California. Our goals are to support the provision of high-quality EP care to all Californians and to promote recovery and better outcomes through a learning healthcare network approach.

our team

This program, presented by UC Davis, is a collaboration with our colleagues at UC San Francisco and Stanford University.

Your county's contact info:

Main Contact/TTA Program Manager: Jessica Windhaus, jrwindhaus@ucdavis.edu
County Liaison: Dr. Kate Hardy, khardy@stanford.edu
Clinic Contact: Dr. Tara Niendam, tniendam@ucdavis.edu

Dr. Tara Niendam, (Program Director, Associate Professor in Psychiatry and Behavioral Sciences, UC Davis) oversees the TTA program, is the primary contact for the MHSOAC, and supports EP programs as needed.

Dr. Laura Tully (Assistant Director, Associate Professor in Psychiatry and Behavioral Sciences, UC Davis) leads the Learning Management Team and serves on the Leadership Team.

Dr. Rachel Loewy (UCSF Site PI, Professor, Psychiatry and Behavioral Sciences, UC San Francisco) serves on the Leadership Team, works in collaboration with UC Davis and Stanford colleagues to manage and provide assessment training activities, and provides consultation to EP programs.

Dr. Kate Hardy (Stanford Site PI, Clinical Psychologist, Clinical Professor, Co-Director, INSPIRE Clinic, Co-Section Chief of INSPIRE Section) serves on the Leadership Team, manages and provides CBTp training activities, and provides consultation to EP programs.

EPI-CAL

California Early Psychosis Intervention Program

EP TTA

Training and Technical Assistance Center

Receives AB1315 (state) and county funds

LHCN

Learning Healthcare Network

Receives MHSA funds, INN funds, PEI funds (state)

San Diego, Orange, LA, Solano, Napa, Sonoma, Stanislaus

EPI-CAL R01

Receives NIMH funding (federal)

Sonoma, Sacramento, Solano, Napa

You are here!

EPI Plus

Early Psychosis Intervention Plus

Receives OAC funds from AB1315 (state)

Lake, Kern, Santa Barbara, Santa Clara, San Francisco, Sonoma counties, MCC (Nevada, Colusa, Mono)

DHCS

Department of Health Care Services

Pending state contract

EPI-CAL

The TTA is a component of the California Early Psychosis Intervention (EPI-CAL) program. EPI-CAL receives funding from several different counties through the MHSOAC, OneMind, and the National Institute of Mental Health (NIMH). The EPI-CAL program is comprised of two different initiatives: the Learning Health Care Network (LHCN) and the TTA. The primary goals of EPI-CAL are to understand:

1) the current status of existing Early Psychosis programs across California
2) which practices among which programs are promoting client recovery
3) the needs and priorities of clients, families, and communities, AND;
4) how data can influence collaborative care decisions in real time.

This program contributes to a national evaluation of Coordinated Specialty Care through NIMH-funded EPI-NET (Early Psychosis Intervention Network).

EPI Plus

This was the name of the grant the MHSOAC provided to eligible counties to apply for funding to receive TTA services for their early psychosis programs serving clients with Recent Onset Psychosis.

LHCN

EPI-CAL aims to improve the quality of services and measure the impact of treatment. To do this, we have created a learning health care network (LHCN) of California EP programs. The goal of this network is to standardize practice and support knowledge-sharing. To make evaluation of these different EP programs possible, network members have agreed to gather the same information across the same timeframe. Clients, families, and providers will provide information by answering surveys at regular intervals throughout treatment. Surveys will be offered in 13 different languages to meet the needs the diverse communities represented in the LHCN. Surveys will ask questions such as how clients are doing at work or school, how their social life is, and how they feel about their future.

The technology used by the LHCN (Beehive) will bring the information provided by clients and families back into their care. The providers will have access to their clients' data to use as part of their regular appointments with clients and families. We hope this will empower clients to use their own data in care decisions.

about CSC

the Coordinated Specialty Care model

EPI PLUS grantees are expected to provide services consistent with the Coordinated Specialty Care Model (CSC), a team-based program providing an array of evidence-based interventions for psychosis.

Original CSC Model tested by RAISE (Heinssen, Goldstein, Azrin, 2014)

what we do

* Develop a TTA plan based on an initial site evaluation to bring your EP program to fidelity and improve client outcomes (modifications will be made, as needed)

* Provide live and on-demand/online trainings on components of the CSC model, including assessment, training, medication management, outreach, new/emerging evidence-based practices, and other CSC model components

* Provide ongoing periodic consultations with your team to address and troubleshoot obstacles and discuss progress toward TTA goals according to your program's TTA plan, and generally assist with sustainability and development of your EP program

* Carry out fidelity assessments in collaboration with your team to monitor progress towards fidelity and evaluate the impact of TTA activities

* Provide a monthly newsletter with helpful tips, upcoming trainings, and more

* Provide limited psychoeducational and outreach materials in threshold languages

* Convene an annual Learning Collaborative for EP programs and encourage collaboration between EP programs

* Share relevant EP resources and opportunities

what you do

As a grantee of this program, you are expected to...

* Provide services to ROP (Recent Onset Psychosis) clients within your county

* Provide the MHSOAC a budget worksheet within 60 days of contract execution

* Attend trainings assigned to you by your role at your clinic and track participation and progress (all staff)

* Attend monthly consultations with our team (program/county leadership)

* Work collaboratively towards increasing EP program quality

* Participate in fidelity assessments

* Participate in data collection to aid in the tracking of progress towards fidelity amongst all EP programs in California. The best way to do this is to join the Learning Healthcare Network (LHCN)

training

As part of our program, we provide a suite of training modules designed to aid programs in developing or sustaining their EP programs in accordance with the CSC model. As a TTA member, you have access to these learning activities.

*Training is delivered via a mix of self-paced learning activities, assignments, low-stakes quizzes, live webinars/lectures, recorded videos, and group discussions.

*All training materials are provided and should be completed on our Learning Management System, Canvas.

*Staff at your clinic will be assigned different trainings depending on their role within your clinic

*Clinic staff are encouraged to complete trainings in the order provided

*Our training manual is a comprehensive overview of our current training offerings, including assigned trainings by role, a description of our trainings, training completion tracking tools, and an introduction to Canvas. Please refer to it for additional information about our trainings.

technical assistance

As part of our program, we offer periodic Zoom consultations and provide specialized assistance to each EP program to help solve technical issues, provide program management guidance, and connect programs with resources needed to reach fidelity and improve client outcomes.

Specific topics on which we provide consultation include the following:

* EP program design and development
* Program initiation, scaling, and modifications to meet need
* Management issues and supervision
* Workforce development and retention targeting clinical and support staff, including peers
* Use of outcomes data to show impact of program investment
* TTA training activities and progress (see “training” section)
* Sustaining program fidelity
* All components of the CSC model

fidelity and fidelity measures

what is fidelity and what are fidelity assessments?

Fidelity is the degree to which an activity is delivered consistent to evidence-based practice (EBP). In the TTA, the fidelity assessments will measure how closely your program is delivering Coordinated Specialty Care in accordance with EBP, against a set of objective criteria. Grantee improvement on fidelity scores over time is the primary outcome metric for the TTA.

There will be three assessments over the course of the program: a baseline assessment, a mid-point assessment, and an end-point assessment. Additionally, each assessment will come in one of two different types; either a formative assessment, or a full assessment. Which version your program completes will depend upon how established your program is at each point. At each assessment point, the fidelity team will discuss with you which one is most appropriate for your program.

For each assessment, we will utilize the FEPS-FS version 1.1.. The FEPS-FS is the First Episode Psychosis Service – Fidelity Scale, developed by Dr. Don Addington, and assesses fidelity to best practices delivered by a team that provides treatment and care for clients with Recent Onset Psychosis (sometimes referred to as "First Episode Psychosis").

At the end of the assessment, we will provide your clinic with a detailed report of the findings. This will include a summary your program strengths, and possible modifications that could be made to deliver early psychosis care consistent with current best practices.

The fidelity assessments are crucial in identifying areas of strength and opportunities for growth within your program, informing TTA goals and the nature of support our program provides, identifying potential for data to support county/funder dialogue, and evaluating the impact of the TTA on the improvements that your programs achieve over time.

We will provide a more in-depth presentation on fidelity assessments closer to the assessment date for each site.

Our sponsors

Mental Health Oversight and Accountability Commission (MHSOAC)

National Institute of Mental Health (NIMH)

One Mind

Your TTA plan

Each grantee (including MCC counties) completed a self-assessment of fidelity as part of their EPI PLUS application. This assessment was reviewed and updated by your TTA liaison, then used to draft your TTA Plan.

This plan tracks staff training and sets annual goals towards improving fidelity for specific program components. Grantees will provide input on the Plan goals during consultations and can change the goals as necessary, in collaboration with the TTA team. Plan progress is regularly reported to the MHSOAC.

Your TTA plan

Let's review and update the SWOT analysis that was completed for the MCC last year to include Colusa county

Next steps

After this meeting, we will send you...

1) Welcome packet
2) Information on how to join Canvas to begin training
3) Training manual
4) The link to register for our newsletter
5) Additional next steps

Please reach out to jrwindhaus@ucdavis.edu with any questions!

AGENDA ITEM 6

Action

September 22, 2022 Commission Meeting

Mental Health Wellness Legislative Update

Summary: The Commission will hear an update on recent modifications made to the Mental Health Wellness Act (Senate Bill 82) and will consider approving funding for the EmPATH emergency psychiatry program and provide guidance on the priorities for funding opportunities.

Background: The Commission's budget includes $20 million per year to support the Mental Health Wellness Act, also referred to as the Triage Grant Program or SB 82. Over the past ten years, two rounds of Wellness Act funding have been provided to county behavioral health departments through a competitive grant process. As initially drafted, SB 82 limited the use of these funds to supporting the hiring of supplemental personnel by county behavioral health agencies to support crisis services.

In October of 2021, through public hearings and site visits, the Commission began to identify challenges in the use of these funds and priorities for the investment of the next round of funding. The Commission initially identified three priorities: 1) Strategies to reduce unnecessary Emergency Department utilization and hospitalizations, 2) Opportunities to support services for children ages zero to five, and 3) Programs to meet the needs of older adults.

To improve the efficacy of these limited funds, the Commission also directed staff to engage the Governor and Legislature in opportunities to expand how these funds could be used. Specifically, the Commission directed staff to seek statutory changes to allow these funds to be used to support crisis prevention and early intervention, in addition to crisis response services. Given those expanded uses, the Commission sought support to use these funds to work with partners other than county behavioral health departments, to support strategies other than supplemental staffing, to allow matching fund requirements and to allow competitive or non-competitive procurements when doing so is in the public interest.

During the 2022-23 budget process, the Legislature and Governor authorized those changes to the Mental Health Wellness Act.

Prioritizing Uses of Mental Health Wellness Act Funding: In prior rounds of Wellness Act funding, the Commission has allocated these funds across multiple fiscal years. This strategy allows the Commission to release a larger grant allocation, provides local partners with more time to utilize these funds, and allows for more efficient allocation of Commission staff time to support this component of the Commission's work. Staff recommends allocating four years of

Wellness Act funding through one or more procurements, for a total of $80 million in grant investments.

Emergency Psychiatric Assessment, Treatment and Healing, EmPATH. During the Commission's October 2021 meeting, it received a presentation from Dr. Scott Zeller on the value of the EmPATH program, which streamlines emergency department assessment of the health needs of mental health consumers and quickly transitions them out of emergency departments into a calming space that allows for the rapid support of behavioral health needs. Research indicates the EmPATH model can result in 70-80 percent reductions in transfers from emergency departments to locked psychiatric hospital facilities. Following Dr. Zeller's presentation, the Commission organized site visits to EmPATH units in Los Angeles and Sacramento Counties.

The Commission will consider authorizing $20 million in Wellness Act funding to expand the use of the EmPATH model, with at least one grant to support an EmPATH program equipped to meet the needs of children and youth.

Additional Wellness Act Priorities. At the October 2021 Commission meeting, Commissioners also received a presentation from Dr. Jackie Wong, MSW, Executive Director of California's First Five Commission, on the behavioral health needs of children ages zero to five. And the Commission highlighted the need to invest in programs designed to meet the needs of older adults.

Commission staff will facilitate a discussion on how best to respond to the needs of these community members and best uses of the available Wellness Act funding.

Presenter(s): Toby Ewing, Executive Director

Enclosure: Proposed Outline of Request for Application (RFA) for EmPATH Programs

Handout: PowerPoint will be presented at the meeting.

Mental Health Services
Oversight & Accountability Commission

Proposed Outline of Request for Application (RFA)
for EmPATH Programs

Commission Meeting – September 22, 2022

The Commission is authorized through the annual state budget to award $20 million per year in Mental Health Wellness Act funds to support one or more entities to improve California's ability to respond to mental health crises. These funds can be used to support crisis prevention, crisis intervention and crisis response services.

On October 28, 2021, the Commission heard testimony and expressed support for using a portion of these funds to expand the availability of Emergency Psychiatric Assessment, Treatment and Healing (EmPATH) models through hospitals in California. Following that Commission hearing, the Commission hosted site visits to two EmPATH programs in California.

Consistent with prior Commission decisions, staff is proposing to utilize a portion of its Mental Health Wellness Act funds - $20 million over four years – through a competitive procurement process to improve understanding and awareness of the EmPATH model, encourage its adoption, and to provide technical assistance and an evaluation that, if successful, will support the scaling of the EmPATH program throughout California.

Preliminary research indicates that the EmPATH model can reduce the time mental health clients spend in hospital emergency departments and reduce the need for psychiatric hospitalizations by as much as 80 percent. EmPATH programs can reduce costs, enhance recovery, and improve outcomes yet are not widely available in California. Of particular interest is the opportunity to deploy the EmPATH model to improve available services and reduce the need for psychiatric hospitalizations among children and youth.

Interested organizations will be asked to provide a proposal that reflects an understanding of the EmPATH model, how it would be deployed within a hospital or in partnership with a hospital to reduce emergency department utilization, time to care, and improve crisis services with the overall goal of reducing the need for psychiatric hospitalization, justice system involvement and/or homelessness. The procurement process will encourage the grant recipient to partner with one or more county behavioral health agencies, community organizations or others to ensure the EmPATH program is part of the community continuum of care.

Recommended Funding

The total amount available for this procurement is $20 million. Staff recommends dedicating $17 million to support program grants and $3 million to support technical assistance and evaluation. Given the limited and specialized nature of EmPATH programs, staff requests permission to allocate technical assistance funding and evaluation funding through sole source procurements. Doing so will require the Commission to determine that doing so is in the public's interest.

Outline for the RFA

Funding for individual EmPATH programs will be capped at $3 million over a three-year period, with the possibility of a no-cost time extension. At least one grant will be awarded to a grantee that seeks to establish an EmPATH program that services children and youth.

Each grantee will be required to:

- Participate in a technical assistance and evaluation learning collaborative.
- Submit annual or more frequent reports on progress against the goals outlined in their proposal.

- Provide a budget on how the funds will be spent as part of their plan. Matching funds will be encouraged.
- Submit a sustainability strategy to support the program following the end of the grant cycle.

The RFA will include an incentive to work in conjunction with one or more county behavioral health agencies and community-based organizations to encourage the program to be integrated into the county behavioral health continuum of care.

Minimum Qualifications

The following minimum qualifications must be met.

All eligible bidders must:

1. Be an established organization which has been in operation for 2 years or more and has experience providing services consistent with the EmPATH model.
2. Operate a licensed emergency medical department or apply in partnership with an entity that operates a licensed emergency medical department.
3. Be registered to do business in California.

RFP Timeline

- November 4, 2022: RFA released to the public
- January 6, 2023: Deadline to submit proposals
- February 2023: Commission issues Notice of Intent to Award

AGENDA ITEM 8

Action

September 22, 2022 Commission Meeting

Behavioral Health Outcomes Fellowship Funding Proposal

Summary
The Commission will consider approval of an outline for a Request for Qualifications to award $5 million from the Mental Health Services Fund to establish a Behavioral Health Outcomes Fellowship designed to drive transformational change and reduce racial, ethnic, and cultural disparities in mental health outcomes. The funds will be used to launch a partnership between the Commission and an academic institution.

California Behavioral Health Outcomes Fellowship for Transformational Change:
The Commission received $5 million in one-time funding from the Mental Health Services Fund in the 2022-23 Budget to establish a behavioral health outcomes fellowship focused on supporting the ability of public behavioral health leaders to improve outcomes across California.

These one-time funds provide an opportunity for the Commission to launch a partnership with an academic institution that maintains a robust public administration program and a history of supporting public sector employees with education and training. Through a competitive bid process, staff will seek a partner that is committed to developing a program that will be responsive to the needs of public behavioral health leaders and become financially self-sufficient following a five-year funding cycle.

This public-private partnership is intended to bring together academic experts and private sector leaders with state, local and community behavioral health staff to provide education, training, guidance and mentoring on results-based accountability, data-informed decision-making, the development and use of performance metrics and related strategies focused on achieving improved outcomes in California's behavioral health system with an emphasis on addressing disparities.

Background
From 2018 to 2022, the Commission successfully leveraged $5 million in one-time time funding to support multiple county learning collaboratives focused on innovation. Each of those initiatives included an engagement and training component for county staff and/or community members to support the broader value of innovation, strategies to leverage data, opportunities to build performance metrics into contracts, methods to use short-term funding to incentivize new approaches to service delivery and more robust collaboration. Through that work the

Commission saw a demand for training and professional development from county and community partners.

The State and counties have struggled to meet public behavioral health needs within existing resources. Traditional responses to those challenges have primarily called for making new investments to expand access to existing service delivery systems. While more resources are needed, the MHSA calls for investments in innovation to improve the ability of limited public funding to cover a greater share of needs.

The goal of this initiative is to ensure that state and local behavioral health teams have the training, professional development, and guidance they need to support the transformational change goals of the MHSA.

Implementation Plan
Commission staff will work with a contractor to develop a training and professional development Fellowship that will be self-sustaining and focused on meeting the training needs of California's public mental health leaders. MHSA funds would be structured into a tiered financing contract that provides more funding upfront with declining funding over time to support increased reliance on self-generated revenues as the project matures. Self-generated revenues could come from a combination of private-sector financing, tuition, fees or other sources tied to participation in the Fellowship. This structure embeds results-based accountability into the initial use of these funds and leverages the market to ensure quality and relevance as indicated by self-generated revenues.

Staff will work with the selected partner(s), ideally one or more academic institutions and/or community-based organizations with strong records of providing public administration training and supporting behavioral health needs, to identify outcomes and accountability strategies for the term of the five-year contract and beyond.

Presenter: Toby Ewing, Executive Director

Enclosures: Proposed Outline of Request for Proposal (RFP)for Behavioral Health Performance Fellowship

Handouts: A PowerPoint and outline will be made available at the Commission Meeting.

Mental Health Services
Oversight & Accountability Commission

Proposed Outline of Request for Qualifications (RFQ)
for Behavioral Health Performance Fellowship

Commission Meeting – September 22, 2022

The Commission is authorized through the annual state budget to award $5 million in Mental Health Services Act funding to launch a Behavioral Health Performance Fellowship that would focus on supporting public sector behavioral health leaders to focus on outcomes, with an emphasis on addressing racial, ethnic, LGBTQ+, and related disparities.

Earlier this year the Commission directed staff to work with the Governor and Legislature to secure funding to launch a performance fellowship that would be available to state and local public sector behavioral health leaders. The goal of the fellowship is to support the ability of behavioral health leaders to achieve the goals of the Mental Health Services Act, including enhancing awareness and skills tied to prevention, early intervention, and innovation, as well as effective uses of data and analytics, transparency, community engagement, incentives and other strategies tied to performance and outcomes.

The Commission sought and received $5 million in funding to launch a Behavioral Health Performance Fellowship in partnership with one or more partners, including an academic institution with a history of providing education and training in the principles of public administration. The Commission proposed to allocate these funds over multiple years with a commitment to sufficient initial year funding to support planning and the development of the Fellowship with declining annual support over the course of the grant to incentivize the Fellowship partners to develop on-going revenues streams that can sustain the program over time.

Recommended Funding

The total amount available for this procurement is $5 million.

Outline for the RFQ

Staff recommends the use of a competitive Request for Qualifications to solicit proposals from interested parties. The RFQ would be designed to ensure that interested parties have the expertise and capacity to develop a Fellowship consistent with the goals of the Commission's budget proposal, including:

- Background in education and training in the field of public administration, data analytics and data-informed decision-making, and related topics.
- Understanding and expertise in the behavioral health field, including trends in evidence-based practices, recovery, wellbeing, community engagement, and the roles of peers and family members.
- Expertise in disparities, implicit bias, and strategies to address each, and related challenges.

- Familiarity with the role of leadership, health and human services system design in California, the roles of incentives and disincentives in outcomes, fiscal policy and program capacity and staffing, and related opportunities.

The RFQ will include an incentive to engage state and county behavioral health partners to ensure the relevance and sustainability of the proposed Fellowship program, and may include an incentive to include matching funds.

Minimum Qualifications

The following minimum qualifications must be met.

All eligible bidders must, individually or collectively, meet the following minimum requirements:

1. Be an established entity in operation for 10 years or more with a robust history providing education and training in the field of public administration.
2. Have a history of work in the behavioral health field, for five years or more, with demonstrated expertise in the areas mentioned above.
3. Able to demonstrate 10 or more years of fiscal sustainability, from revenue streams other than grant funds, in amounts that exceed the contributions from this grant opportunity.
4. Be licensed or registered to do business in California.

Tentative RFQ Timeline

- October 7, 2022: RFQ released to the public
- November 4, 2022: Deadline to submit qualifications
- November 16, 2022: Commission issues Notice of Intent to Award

AGENDA ITEM 9

Action

September 22, 2022 Commission Teleconference

Transition Age Youth (TAY) Advocacy Outline

Summary: The Commission will consider approving a Request for Proposal outline for advocacy, education, and outreach on behalf of Transition Age Youth (TAY).

Background: The Commission, through a competitive application process, provides funding to organizations to support the mental health needs of nine specific populations through advocacy, training and education, and outreach and engagement activities. These nine populations are: Consumers, Families, Diverse Racial and Ethnic Communities, Immigrants and Refugees, K-12 Students, Parents and Caregivers, LGBTQ, Veterans, and Transition Age Youth.

TAY Advocacy Contracts

In August of 2019, the Commission awarded a three-year statewide advocacy contract to California Youth Empowerment Network (CAYEN) in the amount of $1,840,000 in response to a Request for Proposal for mental health advocacy on behalf of transition age youth. Since contract execution, CAYEN has partnered with local level organizations throughout the state and advocated on the needs of young people through TAY-led action teams at the local and state level.

Current Funding Available

The contract with CAYEN expires on December 31, 2022, and a new RFP is proposed to be issued in the amount of $2,010,000 for a three-year grant term**.**

Community Engagement

In July of 2022 Commission staff began organizing community engagement sessions to gather input from TAY communities that will guide the design of the upcoming TAY advocacy contract. The Commission held two public listening sessions in August 2022 to hear from TAY and adult allies on the specific needs of TAY. Another listening session was held with members of the Commission's Cultural and Linguistic Competency Committee to gain further input on addressing cultural and linguistic barriers and reaching marginalized TAY populations. In partnership with the Child Abuse Prevention Council, Commission staff held a focus group with 11 young people in Stockton to hear about their experiences with different types of services,

understand how they can better be supported, and learn about what kind of advocacy would be most impactful for TAY.

Community Engagement Findings:

- TAY have been severely impacted by the COVID-19 pandemic, leading to an increase in adverse outcomes for young people including feelings of isolation, depression, and suicide. Many young people turn to the Internet and social media to find support from their peers.
- TAY from underserved groups have felt they lack representation in many discussions regarding youth needs. These TAY include ethnically diverse, disabled, homeless, foster, transitioning and gender-nonconforming, and juvenile justice-involved youth.
- TAY have mostly negative experiences with providers of mental health services due to lack of training in working with young people, lack of awareness of the needs of LGBTQ and transitioning youth, and lack of respect and humility for TAY needs.
- TAY would like opportunities to be involved in gaining the skills and experience needed to advocate for themselves at the community, local, and state level.
- A statewide effort is needed for outreach to underserved communities and to partner with local organizations from all regions of California to bring the collective voice of TAY to the State Legislature.

The Commission is requested to approve the proposed outline of the scope of work for an advocacy contract for TAY and to authorize the release of the Request for Proposal (RFP) for the work as summarized in the proposed outline enclosure.

Proposed Motion:

The Commission approves the proposed outline of the Request for Proposal for the TAY Advocacy Contract to support advocacy, training and education, and outreach and engagement efforts on behalf of TAY populations, and the Commission authorizes staff to initiate a competitive bid process and enter into contracts with the highest scoring applicant.

Presenter: Tom Orrock, Chief of Community Engagement and Grants

Enclosures (2): (1) Proposed Outline of Request for Proposal (RFP) for the Transition Age Youth Stakeholder Contract; (2) TAY Community Engagement Findings

Handouts (1): A PowerPoint will be presented at the meeting.

Mental Health Services
Oversight & Accountability Commission

Proposed Outline of Request for Proposal (RFP)
for the Transition Age Youth Advocacy Contract

Commission Meeting – September 22, 2022

The Commission is authorized through the annual state budget to award $670,000 per year to one or more organizations to support mental health outreach, engagement, advocacy, education, and training on behalf of diverse Transition Age Youth (TAY) in California with a focus on reducing disparities.

Consistent with prior Commission decisions, staff is proposing to release a Request for Proposals for one or more organizations – working under a single contract with the Commission - to conduct state-level and statewide outreach, engagement, advocacy, education, and training for diverse Transition Age Youth over a three-year period. Total funds available for this RFP will be $2,010,000.

Interested organizations will be asked to provide state-level and local-level activities, which may involve partnering with and supporting local level organizations, to improve mental health outcomes for diverse Transition Age Youth. The procurement process will encourage the contractor to partner with local organizations serving TAY in each of California's five geographic regions.

Recommended Funding

The total amount available for the statewide advocacy organization is $670,000 per year for a three-year total of $2,010,000.

The contract term will be three-years (36 months). Each year the statewide advocacy organization will provide a State of the Community Report that includes information on the activities completed, what was learned throughout the year, and recommendations on how the mental health system could be transformed to better meet the mental health needs of TAY with a focus on reducing disparities.

Outline for the RFP

One contract will be awarded to an organization to provide outreach, engagement, advocacy, education, and training on behalf of diverse TAY populations throughout California.

Statewide Advocacy Contractor Responsibilities

The organization will propose a plan that meet the following goals:

- Conduct advocacy activities at the local and state levels that address the critical mental health needs of Transition Age Youth, with an emphasis on ethnically diverse, homeless, child welfare involved, transitioning and gender nonconforming, juvenile justice-involved, and disabled TAY.
- Provide training and education for mental health service providers, professionals, peer workers, and others who serve TAY to be more aware of and to meet the needs of Transition Age Youth more effectively, with an emphasis on reducing disparities.
- Implement outreach and engagement strategies that raise awareness of the needs of TAY within communities, inform TAY of available services and supports, and create advocacy and work opportunities to empower and elevate TAY.

The contractor will write and publish an annual report each year. This report will provide a narrative with qualitative and quantitative data detailing:

- Counties and communities reached during contracted activities.
- Information on the current needs of TAY, including unmet needs.
- Recommendations on policies and community interventions for transforming the mental health system to better meet the needs of TAY with emphasis on reducing disparities.

The contracted organization will provide a budget on how the funds will be spent as part of the plan.

Minimum Qualifications

The following minimum qualifications must be met.

All eligible bidders must:

1. Be an established state-level organization which has been in operation for 2 years and has experience with programs and services related to the unique mental health needs of California's TAY populations;
2. Have experience and capacity to provide technical assistance and support to local community-based organizations;
3. Have experience and familiarity with providing access to care for Transition Age Youth, with emphasis on addressing disparities, with an emphasis on ethnically diverse, homeless, child welfare involved, transitioning and gender nonconforming, juvenile justice-involved, and disabled TAY.
4. Be a non-profit organization, registered to do business in California;
5. At least 51% of the paid staff, board members, or advisory board members are TAY.

RFP Timeline

- October 14, 2022: RFP released to the public
- December 2, 2022: Deadline to submit proposals
- December 27, 2022: Commission issues Notice of Intent to Award

Mental Health Services
Oversight & Accountability Commission

Transition Age Youth Community Engagement
Request for Proposal 2022

In August of 2022 Commission staff gathered information from Transition Age Youth (TAY) communities to learn about the critical needs of young people and to guide the design of the next TAY advocacy contract. As part of the community engagement efforts, Commission staff held two public listening sessions, a discussion with the MHSOAC Cultural and Linguistic Competency Committee, and one focus group in Stockton in partnership with the Child Abuse Prevention Council of San Joaquin County. Staff also met with the current TAY advocacy organization California Youth Empowerment Network to gain feedback from their advocacy work.

TAY Listening Sessions
August 2, 2022 & August 4, 2022

Identifying the critical mental health needs of TAY

COVID- 19 Pandemic, isolation, and social media

- The need for support has greatly increased due to the COVID-19 pandemic. There is not a lot of support because there is nothing in place to support the sudden, overwhelming amount of mental health services needed. This has caused young people to turn to each other for support or to internalize and become bogged down by it.
- It is becoming increasingly popular to go to social media and students form almost trauma bonds, where students will connect fully on the basis of having similar experiences. This is becoming increasingly toxic because students do not know how to resolve many mental health issues and need adult help. It does not help students to only talk to peers who are experiencing academic and home pressures on top of mental health pressures, which is becoming cluttered and difficult to distinguish.
- Along with social media and media portrayal, there is a certain niche on YouTube where people can talk about how they have recovered from certain mental illnesses, especially eating disorder recoveries. This is harmful in the sense that it perpetuates the idea that recovery only looks one way or the steps provided are the only steps to take. Even though the intent could be to provide resources, it can create an idea or portrayal, almost a romanticization, of mental illness or a way to do mental illness recovery.
- Young people are finding support among peers, but peers are not always equipped to handle these difficult conversations effectively. It is imperative to pour resources into youth peer-led, peer support, school-based type resources where individuals are empowered and have access to information to share with other youth to more effectively support one another.
- Isolation is a major factor to consider for the mental health of young people today. In the post-pandemic world, young people are struggling to re-assimilate themselves into social settings. They are developing a lot of things like depression, which affects other aspects of their life such as school. Re-assimilating young people into the social scene is important.

- Students are pressured to succeed in school and work in order to find employment in increasingly competitive career fields.
- A positive outcome of the pandemic is the quick innovations that quickly sprung up, such as remote meeting attendance allowing greater accessibility and personal safety.

Disproportionately affected or overlooked TAY groups

- Many TAY populations are being left out of the conversation. TAY who are disproportionately affected include BIPOC, LGBTQ, women, Asian and Pacific Islander, Latinx, low income, foster youth, criminal justice-involved, and refugee and immigrant youth.
- Youth with physical disabilities are often excluded from mental health care discussions. It is important that resources are accessible for everyone.
- It is important to include representatives from all communities in the conversation. Immigrants often get lost in this conversation, especially those who cannot access or are afraid to access mental health services because of a language barrier or citizenship status. Some communities have cultural resistance to talking about mental health.
- It is important to reach often overlooked TAY including college students, immigrant minorities, and TAY from smaller and rural counties.

Addressing the mental health needs of TAY

TAY-oriented, culturally relevant mental health services

- It is important, when thinking about the mental health needs of young people to actively invest in what truly helps young people rather than investing in something that does not have research to back it up, or does not have youth supporting it.
- There is an interest in mental health intersectionality, especially as new ways of labeling people are being developed. There is an interest in race, sexual orientation, etc., and how those things play a part in how a person experiences mental health. Students are interested in academic competition; academic stress and the COVID-19 pandemic are continuing to impact mental health with fears of future pandemics.
- Behavioral health systems must fund community organizations to care for TAY.
- There is a great need for access to culturally congruent mental health services. Youth tend to access culturally congruent organizations that are grounded in community.
- It is assumed that, once an individual gets help, mental health improves. This is not the case – mental health fluctuates. Even when people are doing better, it does not mean they will not struggle again. Individuals need ongoing support.

School-based support

- At schools, with the obvious increase in needs, it is important to recognize that teachers and staff are being put at the front of this crisis. This system is leaning on the onsite staff's ability to reach and connect but, when they are not properly educated or prepared, the youths' ability to find support becomes limited.
- It is important not only to provide education for youth, but also for adults. Teachers need to be informed and educated in mental health so they can respond in a much more positive way. This is important.

- Many individuals struggle to even recognize that they need help. This is why education is so valuable and crucial. Education is the pathway to empathy and change.
- School wellness centers that are free and confidential for students are a great resource.
- Need for immediate response to mental health crises at schools. Employing psychiatrists and assigning them to specific school districts or schools would speed up this process. Hour or longer wait times have been experienced for county psychiatrists to respond to a mental health crisis on school campuses.

Traditional health care settings and other clinical-type mental health services

- The location in terms of resources is important. Resources are tend to only be available in middle to higher income communities.
- A TAY individual rated the traditional health care systems as unfavorable, citing their experience with mental health hospitals, witnessing other youth who would be in-patients for months. The speaker stated they saw people at their worst and other people who were able to go home. Being in that experience and witnessing those individuals going through those experiences, knowing that there is still much work to be done, the foremost way to bump up their view of the system would be ongoing direct funding.
- TAY cannot afford these resources. Some mental health resources are very expensive. The speaker shared the example of their medication alone, which without insurance would be $1,000 per month.
- Most free or low-cost therapy only allow up to 12 sessions. This is not enough for many youth with ongoing mental health concerns who can't afford to pay for therapy out of pocket

Identifying ideal characteristics of TAY advocacy organizations

- Organizations with missions that have relevance to youth issues, authenticity, and honesty.
- Change for youth should come from youth.
- Demonstrate sustainable funding and ability to make more resources available beyond just a phone number or a therapist.
- Organizations that are disseminating digestible information. Filling gaps and creating pathways for accessibility and clarity for youth to better understand and get involved.
- Organizations with active involvement opportunities for youth. Youth love to get involved, especially now, because they feel that the only ones advocating for youth is themselves.
- Youth can recognize performative activism, specifically ones that are involved in the mental health space. Performance activism is not only upsetting and annoying, but actively hurts individuals.
- Youth advocacy and priorities should be led by youth themselves. They should have boards or advisory committees that have more than 50% youth on them.
- Organizations that have a leadership and staff that represent the communities of California (not white).
- Organizations that have opportunities for mentorship.

- Organizations that actively recruit from marginalized youth populations, including criminal justice involved youth and foster care youth.
- Organizations that have individual, regional, local, state, and national level type actions.
- Advocacy organizations often only hear from privileged youth due to the times and locations of their meetings. Everyone's perspective is important. It often is self-selection for youth who have time or who want to get engaged in state and local advocacy. Many individuals are overlooked. Individuals who should be speaking on certain issues are not the ones who are given the opportunity to be involved.
- For an organization to be truly impactful, it needs to be specifically catered for each community because every community is different. One solution will not fit everyone. It is impossible to care for communities from a top-down approach. It needs to be a bottom-up grassroots effort.
- Organizations who are open-minded, caring, inclusive, credible, and trustworthy.

Ensuring mental health providers and professionals are equipped to serve TAY

Negative experiences with providers

- There is a lack of mental health care professionals who can reach young people and who are competent to young people's experiences. Younger health care providers are needed who look like youth and speak their language. More mental health professionals need to encourage new age communication such as a song or TikTok post that helps young people communicate through that avenue to the mental health professional.
- As the need for support has increased, it does not mean that everyone has access to it. This is a major issue. One youth was able to see their therapist once a month for 15 minutes, even though they had insurance. Another experienced having to wait 8 hours in the emergency room to receive help.
- Concern was shared about individuals who do not have health insurance or who cannot afford services.
- Providers should create a space of safety. There are many people who did not have a good experience with their therapist or counselor. A safety net is important when being vulnerable. Part of the safety net is showing their education. How educated are they on these topics? How informed and prepared can they be in terms of responding to people's needs?

Appropriate training for TAY mental health providers

- It is most important that people know that they can reach out and not feel ashamed. There is so much shame and perceived weakness about going to therapy or getting medication. People may look at others differently based on that experience. This needs to change through education. Mental health in schools is very necessary. That is a step forward.
- A peer-to-peer connection is lacking, especially coming from COVID. Many students still feel isolated. Coming back to school was another huge transition but like no other. It was not just moving up a grade or even moving to high school. It was almost about completely coming back into society.
- Peer and community-based mental health care services. In particular, youth of color and youth with mental health disabilities, especially in today's world, are increasingly wary of the process of institutionalizations as it currently exists and law enforcement interaction with mental health

care supports. It is important that youth have mental health supports where they can interact with peers in a less carceral setting.

- Suggest having referrals to free tutoring services as well as walk-in/online counseling services pertaining to dating, drugs, and suicide.
- So many youth are unable to get parental consent for therapy or mental health care. Mental health resources must be structured so that access is not limited by parents as a barrier.
- A big problem is a stigmatized culture involving mental health for Black and brown people. Mental health professionals should be visiting predominantly Black and brown schools, high schools especially, and advertising themselves as resources versus students reaching out to therapists. Expecting youth to reach out is not realistic because in the process of reaching out they will face criticism from their parents, teachers, and even community mentors, many of whom will invalidate their mental health challenges altogether. The help that is given as of right now feels "one-size fits all" when resources specific to Black, LGBTQ, etc. experiences are necessary. Professional adults who have experienced these specific hardships from society are needed to help young adults who are facing those same challenges now.
- Aside from addressing the stigma so youth feel comfortable to reach out for help before they are in crisis, major structural changes to the mental health systems need to happen. Many youth and families have major challenges simply navigating the process, never mind affording it or finding networks/therapists that are representative of their community or experience.

Ensuring effective outreach to TAY and their communities

Availability of relevant information and community resources

- Part of the mental health crisis is associated with misinformation, lack of information, and lack of education in relation to mental health. This need is not being met by school communities, which is where it should be addressed with school-based programs that provide research-informed, data-driven, human-centered support to effectively address needs.
- The location in terms of resources is important. Resources are usually in affluent, predominantly white, neighborhoods.
- Ensure that services are accessible and affordable. Locating student wellness centers on campus makes services more accessible and affordable for students and they do not have to rely on parents.
- Many students go to organizations that their parents support first, such as religious organizations. Many great churches point youth in the right direction, while some are oppressing and discriminatory.
- Although community-based organizations provide good supports, transportation is a barrier for students who have no public transportation available or whose parents are unwilling to provide it. Also, affordability and insurance aspects are barriers to students.

Outreach and engagement at schools

- Schools are a place for students to receive mental health services, but not all students attend school.
- Many schools are making it difficult for youth to come forward. Youth are not going to schools as an organization to be comfortable to talk to about their mental health needs because they are afraid of repercussions. That is a huge issue, when not all of the wellness center members or

all school counselors are properly educated about students who need to be listened to, heard, and validated.

Mental health workers on campus

- So many schools do not even have a school therapist or social worker, so students are trying to connect with a school counselor, but counselors are only there to talk about college, not life experiences.
- It is frustrating when schools have one therapist per several thousand kids, and even more so when that one much-needed therapist is discriminating against students. It is hard enough to check in with therapy in a school setting which has such a stigma, let alone talk to authorities about a negative experience.

Language-based support and services

- Mental health services and resources are often not adequately translated into common languages such as Dari and Pashto; adequate interpretation would benefit both youth and family members.
- It would also be good to have forums with interpreters for recently arrived immigrant and refugee youth.

Parents and TAY mental health

- Some TAY cannot access resources because their parents or guardians have a stigmatized view of mental health, and TAY often cannot access resources without parental consent.
- There is a disconnect between clients and their parents. Parents tend to raise their children how they were raised and they have a difficult time understanding that the way it worked for them then cannot be applied to the youth population today, especially for LGBTQ, particularly transgender, youth. Lack of parental support adds to feelings of isolation. Parents need to be educated about what their children are going through.

Empowering TAY to advocate at the community, local, and state levels

- Action speaks louder than words. Awareness is great, but action can accomplish things. Doing something about issues and providing resources that are beneficial is the change that is needed.
- Think about where youth are pouring their time and efforts, and where they are benefiting, which is through grassroots, on-the-ground organizations, and initiatives.
- Advocacy training to understand the context of the policy discussions including civic engagement, how to advocate, and organizational structure.
- Representation in leadership. There still is very little representation for minorities so that will be a crucial step forward.
- There is a need for a younger and more diverse workforce.
- Accessible meeting times (not during the school day/year), broad reach, multiple modalities of communication (text, email, etc.).
- Anyone that engages in advocacy for students needs to work directly with them simultaneously from the ground-up.
- Youth involvement in decision making is crucial.

Cultural and Linguistic Competency Committee Meeting
August 23, 2022

Members of the Cultural and Linguistic Competency Committee shared their feedback on the procurement process for the upcoming TAY Request for Proposal.

- It is important to engage with counties to learn the capacity for new clients and families
- Communities are integrated, not segregated. Contract awardee should be rooted in the local community and have the capacity to integrate all elements of a community, ensure that all elements of the community are integrative to help build the capacity of TAY, families, work environments, and faith-based spaces.
- It is important for local organizations throughout California to put together a statewide effort. There should be effort to mitigate resources only going to Sacramento-based organizations. It is important that these funds empower local community organizations to formulate and roll out a grass roots effort towards a statewide partnership.
- Open conversations with local communities is critical to best understand how to be comprehensive and holistic in all approaches in advocating on behalf of TAY. It is important to reframe and think outside of the box to innovate systems to strengthen prevention components.
- The TAY advocacy organization should have integrity, experience, knowledge, and an open mind towards collaborating with and learning from local communities.
- It is critical to remove the perception that the TAY LGBTQ community only exists in certain cities, such as West Hollywood. Most of the LGBTQ youth in Los Angeles are Latinos who live throughout the entire county. It is important for all LGBTQ individuals to have access to culturally appropriate services that speak the same languages in their communities. When the process is decentralized in allowing organizations and local communities to compete, it brings a voice closer to the people of their community.
- It is important to look at the procurement process from a practical perspective. The pandemic changed the way things are done—it is impossible for one state level organization to reach all communities. Funds should empower local community-based organizations who have hands-on experience.

TAY Focus Group
Child Abuse Prevention Council, Stockton, CA
August 26, 2022

TAY Advocacy Organizations

TAY shared the following desired characteristics in their ideal youth advocacy organizations.

- It should be obvious that the organization genuinely cares about young people and their needs
- The organization should be familiar with providing easier access to care for gender non-conforming and transitioning youth
- A possible mandatory requirement for the funded organization: 30 to 50 percent TAY making up the paid staff positions and/or the decision-making body

School-Based Mental Health Services

TAY shared the following thoughts regarding mental health services being provided on school campuses.

- Based on prior experiences, the quality of care by counselors on campus can vary widely. One incident shared by a TAY involved a crisis counselor not being helpful or dismissive during a self-harm incident. Some on-campus counselors have used harmful language and did not respect confidentiality.
- For some TAY, the ease of access and availability was a positive aspect of counselors on campus.
- Some TAY have had good experiences with counselors employed by the school who were available remotely. Online campus counselors welcomed walk-in "visits," demonstrated genuine care for experiences, and brought some positive changes to life outlook
- Posters and visual aids on campus are good ways of keeping TAY informed of services
- Additionally, the idea of integrated care centers, such as youth wellness centers, provided excitement and positive responses. An integrated care center would allow young people to address other challenges in their lives outside of mental health. Integrated care centers may take the form of other establishments, such as a church.

Other Mental Health Care Settings

TAY cited the following health care settings as being ineffective for receiving effective mental health support.

- Traditional health care provider systems (such as Kaiser Permanente) are too large to navigate easily and are expensive. The quality of individual clinicians can vary widely due to the large number of available providers.
- Emergency rooms don't prioritize mental health needs. Mental health emergencies are dismissed or placed low on the priority list. Emergency room staff have labeled youth as "superficial" and invalidated a trans individual. Most cases have led to being discharged from the hospital with no help provided.
- The County Behavioral Health Services department provides varying degrees of quality in service and experience. Some negative experiences include clinicians who invalidated the youth, and untrained and unaware clinicians who did not know how to communicate with youth. Some

positive experiences include a case manager who helped a youth client find housing, a therapist, and medication.

Experiences With Providers

TAY shared the following negative experiences with clinicians, counselors, and therapists.

- Clinical providers and their staff demonstrate lack of training and awareness when working with, communicating with, and serving youth clients.
- Clinical staff demonstrated hostility towards LGBTQ, trans, and gender-nonconforming youth through transphobic behavior.
- Clinical providers tend to defer to the youth's parents/accompanying adults for communication, undermining and de-valuing the youth's experiences and problems. Providers sharing what should be confidential information with the parents is problematic: the parent can be hostile towards the youth or ongoing familial issues can become exacerbated at home.
- Some clinical providers have threated to share or report a youth's experiences with their parent as a way to "control" the youth
- Providers can be knowingly or unknowingly invalidate the experiences and problems of youth clients, creating further harm for the youth. Providers do this by questioning the experiences shared by youth, dismissing the experiences as being part of being young, or claiming that the youth has not experienced "real problems" because they are young.

TAY expressed the following as positive experiences with providers, or desired qualities they would like to see in their providers.

- Providers and peer workers with lived experiences
- Providers who show genuine care in the youth and their experiences.
- **"Her office was my office."**
- Clinicians who advocate on behalf of their youth client brings a sense of security and provides encouragement, positivity, and upliftment. Some have reported providers who "saved" them from their overbearing or hostile parents by speaking up on behalf of the youth and validating what youth may be having issues with at home.

Training for Providers Serving TAY

TAY stated the following as being necessary or critical in training that all providers receive for serving young people.

- Listening to understand, being soft and affirming, and showcasing full respect for TAY regardless of background, age, etc.
- Understanding and knowledge of gender and sexuality
- Training modules that are designed and taught by young people
- Training that places providers in specific scenarios where the reaction and handling of the situation will be observed and critiqued by youth
- Ability to avoid or unlearn the instilling of own values and beliefs into care youth clients

- TAY observed many providers with master's level education (MSW, LMFT, etc.) don't have the lived experience to back up training
- TAY shared it was mostly important that their therapist looked and spoke like them, but more important is that their therapist helps them feel comfortable and affirmed.

Outreach to TAY

TAY use the following methods or sources when researching or seeking more information on an unfamiliar topic.

- Internet search
- Social media, specifically TikTok, whose format allows information to arrive to the user in an easy-to-consume video format. Content tends to be more timely and relevant compared to other social media platforms
- Parent, mentor, guardian, and/or family member that is trusted and familiar
- Friend or coworker who is knowledgeable on the topic
- School-based resources found on campus
- Community-based organizations, including outreach programs and faith-based

Involving TAY in Advocacy

TAY expressed the desire to be involved in local and state level advocacy, given that the opportunities for advocacy work were relevant and meaningful.

- TAY want the ability to speak to state legislators directly
- TAY should feel welcome to look, dress, and feel as themselves when advocating in front of legislators
- TAY want legislators to feel and understand what young experience. **"Get legislators to feel what we feel."**
- Youth shared their experiences with the San Joaquin Youth Action Board (YAB) as an example of effective youth involvement. They shared that youth and adult allies should petition to their counties to start their own YABs modeled after San Joaquin.
- Additionally, TAY strongly suggested advocating to Boards of Education, Superintendents, and state legislators to include practical life lessons into school curriculums. This conversation stemmed from the idea that TAY learning to be independent and have their other needs met (housing, budgeting, job) will lead to positive mental health outcomes.
- TAY expressed the desire to have the negative stigma and label of being young and inexperienced to be removed when in these advocacy roles

CAYEN Feedback on TAY Advocacy Contract

Provide flexibility for the contractor to release funds to subcontractors as needed.

- It is beneficial to work with local level organizations
- The current TAY contract mandates the contractor to distribute all subcontractor funds at the beginning of the contract.
- Instead, allow the contractor to distribute initial start-up funds to subcontractor, then distribute funds tied to deliverables to keep organizations accountable.
- Tying funds to deliverables provides scaffold and creates accountability for local subcontractors.

Require lesser number of cohorts or local organizations to work with each year

- Working with TAY requires a lot of time and resources.
- Intentional training, mentorship, and emotional support are critical for effectively collaborating with and supporting TAY Advocates.
- TAY, by definition, are in transition – this is accompanied by challenges not typically faced in adult advocate populations.
- TAY experience being unsheltered and food insecure, and being in unsafe places to participate (many youth hide or avoid their participation in the advocacy project due to home life stigma surrounding mental health, LGBT, etc.).

Remove the mandate requiring partnerships with youth organizations that are based on school campuses

- There are so many unserved youths across California that aren't on campuses and don't have opportunities to be seen and heard to engage in advocacy.
- The Commission already funds projects that are dedicated to school-based programs.
- There is a greater need to serve young people in their communities.

Specifically require that the contractor has TAY on staff or will hire TAY for project

MISCELLANEOUS ENCLOSURES

September 22, 2022 Commission Meeting

Enclosures (4):

(1) Evaluation Dashboard
(2) Innovation Dashboard
(3) Department of Health Care Services Revenue and Expenditure Reports Status Update
(4) Tentative Upcoming MHSOAC Meetings and Events

Mental Health Services
Oversight & Accountability Commission

Summary of Updates

Contracts

New Contract: None

Total Contracts: 3

Funds Spent Since the August Commission Meeting

Contract Number	Amount
17MHSOAC073	$ 0.00
17MHSOAC074	$ 0.00
21MHSOAC023	$ 0.00
Total	**$ 0.00**

Contracts with Deliverable Changes

17MHSOAC073
17MHSOAC074
21MHSOAC023

Mental Health Services
Oversight & Accountability Commission

Regents of the University of California, Davis: Triage Evaluation (17MHSOAC073)

MHSOAC Staff: Kai LeMasson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $2,453,736.50

Total Spent: $**1,858,431.78**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No No
Data Collection and Management Report	Complete	6/15/20	No

Deliverable	Status	Due Date	Change
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21- 3/15/23	No
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21- 6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	In Progress	9/15/21 Fall 2022	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Complete	7/15/21	No
Draft**s** Formative/Process Evaluation Final Report (a and b)	Not Started	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, Los Angeles: Triage Evaluation (17MHSOAC074)

MHSOAC Staff: Kai LeMasson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $2,453,736.50

Total Spent: **1,858,431.78**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

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Midpoint Progress Report for Formative/Process Evaluation Plan	Complete	7/15/21	No
Drafts Formative/Process Evaluation Final Report (a and b)	Not Started	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (21MHSOAC023)

MHSOAC Staff: Rachel Heffley

Active Dates: 07/01/21 - 06/30/24

Total Contract Amount: $5,414,545.00

Total Spent: **$1,061,087.52**

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis activities including a summative evaluation of Triage grant programs.

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Complete	09/30/21	No
Quarterly Progress Reports	Complete	12/31/21	No
Quarterly Progress Reports	Complete	03/31/2022	No
Quarterly Progress Reports	Complete	06/30/2022	No
Quarterly Progress Reports	In Progress	09/30/2022	No
Quarterly Progress Reports	Not Started	12/31/2022	No
Quarterly Progress Reports	Not Started	03/31/2023	No
Quarterly Progress Reports	Not Started	06/30/2023	No

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Not Started	09/30/2023	No
Quarterly Progress Reports	Not Started	12/31/2023	No
Quarterly Progress Reports	Not Started	03/31/2024	No
Quarterly Progress Reports	Not Started	06/30/2024	No

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD

SEPTEMBER 2022

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	1	10	**11**
Participating Counties (unduplicated)	1	9	**10**
Dollars Requested	$844,750	$59,276,021	**$60,120,771**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2017-2018	34	33	$149,548,570	19 (32%)
FY 2018-2019	53	53	$304,098,391	32 (54%)
FY 2019-2020	28	28	$62,258,683	19 (32%)
FY 2020-2021	35	33	$84,935,894	22 (37%)
FY 2021-2022	21	21	$50,997,068	19 (32%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2022-2023				

Mental Health Services
Oversight & Accountability Commission

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TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2022-2023				

INNOVATION PROJECT DETAILS

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Santa Cruz	Healing The Streets	$5,735,209	5 Years	12/9/2021	Pending
Under Review	Orange	Clinical High Risk for Psychosis in Youth	$13,000,000	5 Years	2/26/2022	Pending
Under Review	Yolo	Crisis Now	$3,584,357	3 Years	6/1/2022	Pending
Under Review	Shasta	Hope Park (Extension)	$104,760	N/A	6/17/2022	Pending
Under Review	Sonoma	Semi-Statewide Electronic Health Record	$5,526,045	5 Years	6/30/2022	Pending
Under Review	Colusa	Practical Actions Towards Health (PATH) - EXTENSION (formerly called Social Determinants of Rural Mental Health)	$983,124	5 Years	8/8/2022	Pending
Under Review	Alameda	Peer-led Continuum for Forensics and Reentry Services	$8,615,531	5 Years	7/25/2022	Pending
Under Review	Alameda	Alternatives to Confinement	$13,432,653	5 Years	7/25/2022	Pending
Under Review	Tuolumne	Family Ties: Youth and Family Wellness	$217,953	5 Years	8/22/2022	Pending
Under Review	Santa Barbara	Housing Retention and Benefit Acquisition	$8,076,389	5 Years	9/8/2022	Pending

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Napa	FSP Multi-County Collaborative	$844,750	4.5 Years	8/1/2022	8/29/2022

APPROVED PROJECTS (FY 22-23)			
County	Project Name	Funding Amount	Approval Date

DHCS Status Chart of County RERs Received
September 22, 2022, Commission Meeting

Below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated August 30, 2022. This Status Report covers FY 2019 -2020 through FY 2020-2021, all RERs prior to these fiscal years have been submitted by all counties.

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these for Reporting Years FY 2012-13 through FY 2020-2021 on the data reporting page at: https://mhsoac.ca.gov/county-plans/.

The Department also publishes County RERs on its website. Individual County RERs for reporting years FY 2006-07 through FY 2015-16 can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2020-21 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

DHCS also publishes yearly reports detailing funds subject to reversion to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). These reports can be found at: https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Fiscal-Oversight.aspx.

DCHS MHSA Annual Revenue and Expenditure Report Status Update

County	FY 19-20 Electronic Copy Submission	FY 19-20 Return to County	FY 19-20 Final Review Completion	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion
Alameda	1/29/2021	2/1/2021	2/8/2021	1/26/2022	2/3/2022	2/8/2022
Alpine	7/1/2021		10/15/2021	1/26/2022	2/3/2022	2/15/2022
Amador	1/15/2021	1/15/2021	2/2/2021	1/27/2022	2/3/2022	2/10/2022
Berkeley City	1/13/2021	1/13/2021	1/13/2021	2/1/2022	2/3/2022	3/1/2022
Butte	3/2/2022	3/2/2022	3/11/2022	8/11/2022	8/12/2022	8/15/2022
Calaveras	1/31/2021	2/1/2021	2/9/2021	1/31/2022	2/4/2022	2/8/2022
Colusa	4/15/2021	4/19/2021	5/27/2021	2/1/2022	2/4/2022	2/15/2022
Contra Costa	1/30/2021	2/1/2021	2/22/2021	1/31/2022	2/4/2022	3/11/2022
Del Norte	2/1/2021	2/2/2021	2/17/2021	1/28/2022	2/7/2022	2/23/2022
El Dorado	1/29/2021	1/29/2021	2/4/2021	1/28/2022	2/4/2022	2/9/2022
Fresno	12/29/2020	12/29/2021	1/26/2021	1/26/2022	2/7/2022	2/16/2022
Glenn	2/19/2021	2/24/2021	3/11/2021	3/21/2022	3/22/2022	4/6/2022
Humboldt	4/9/2021	4/13/2021	4/15/2021	8/15/2022	8/16/2022	8/24/2022
Imperial	2/1/2021	2/1/2021	2/12/2021	1/31/2022	2/4/2022	2/15/2022
Inyo	4/1/2021	4/2/2021		4/1/2022	4/12/2022	
Kern	2/2/2021	2/2/2021	2/8/2021	2/3/2022	2/7/2022	2/17/2022
Kings	1/4/2021	1/4/2021	3/11/2021	2/22/2022	2/22/2022	3/11/2022
Lake	2/9/2021	2/9/2021	2/17/2021	2/1/2022	2/8/2022	2/23/2022
Lassen	1/25/2021	1/25/2021	1/28/2021	2/2/2022	2/8/2022	2/17/2022
Los Angeles	3/11/2021	3/16/2021	3/30/2021	2/1/2022	2/7/2022	2/22/2022
Madera	3/29/2021	3/30/2021	4/15/2021	3/25/2022	3/29/2022	5/19/2022
Marin	2/2/2021	2/2/2021	2/17/2021	1/31/2022	2/7/2022	2/9/2022
Mariposa	1/29/2021	1/29/2021	3/11/2021	1/31/2022	2/7/2022	2/25/2022
Mendocino	12/30/2020	1/4/2021	1/20/2021	2/1/2022	2/7/2022	2/24/2022

DHCS Status Chart of County RERs Received
September 22, 2022, Commission Meeting

County	FY 19-20 Electronic Copy Submission	FY 19-20 Return to County	FY 19-20 Final Review Completion	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion
Merced	1/11/2021	1/12/2021	1/15/2021	1/27/2022	2/7/2022	2/8/2022
Modoc	4/29/2021	5/4/2021	5/13/2021	4/27/2022	4/28/2022	4/28/2022
Mono	1/29/2021	1/29/2021	2/16/2021	1/18/2022	2/7/2022	2/17/2022
Monterey	2/24/2021	3/1/2021	3/11/2021	2/2/2022	2/7/2022	2/9/2022
Napa	12/23/2020	12/24/2020	12/28/2020	2/7/2022	2/8/2022	3/3/2022
Nevada	1/29/2021	2/16/2021	2/18/2021	1/31/2022	2/2/2022	2/3/2022
Orange	12/31/2020	1/20/2021	2/9/2021	1/31/2022	2/3/2022	2/17/2022
Placer	2/3/2021	2/22/2021	2/23/2021	1/31/2022	3/17/2022	4/13/2022
Plumas	2/25/2021	3/19/2021	3/25/2021	7/14/2022	7/14/2022	
Riverside	2/1/2021	3/31/2021	4/8/2021	1/31/2022	2/4/2022	3/11/2022
Sacramento	1/29/2021	2/1/2021	5/6/2021	1/31/2022	2/3/2022	3/11/2022
San Benito	7/28/2021	7/30/2021	8/3/2021			
San Bernardino	3/3/2021	3/4/2021	3/17/2021	3/23/2022	3/23/2022	3/29/2022
San Diego	1/30/2021	2/1/2021	2/4/2021	1/31/2022	2/3/2022	2/18/2022
San Francisco	1/29/2021	3/19/2021	3/22/2021	1/31/2022		2/4/2022
San Joaquin	2/1/2021	2/2/2021	2/11/2021	3/22/2022	3/23/2022	3/25/2022
San Luis Obispo	12/31/2020	1/20/2021	1/20/2021	1/26/2022	2/2/2022	2/7/2022
San Mateo	1/29/2021	2/1/2021	2/16/2021	1/31/2022	8/3/2022	8/4/2022
Santa Barbara	12/29/2020	12/30/2020	1/5/2021	1/26/2022	1/26/2022	2/10/2022
Santa Clara	1/28/2021	2/11/2021	3/3/2021	1/31/2022	2/15/20222	2/18/2022
Santa Cruz	3/29/2021	4/5/2021	4/15/2021	3/25/2022	3/25/2022	4/4/2022
Shasta	1/14/2021	1/15/2021	1/19/2021	1/25/2022	1/26/2022	2/10/2022
Sierra	12/31/2020	3/10/2021	4/12/2021	1/31/2022	2/2/2022	2/28/2022
Siskiyou	2/16/2021	6/11/2021	6/15/2021	7/18/2022	7/18/2022	8/10/2022
Solano	2/1/2021	2/1/2021	2/25/2021	1/31/2022	2/2/2022	2/8/2022
Sonoma	1/29/2021	3/5/2021	4/12/2021	1/31/2022	2/3/2022	2/22/2022

DHCS Status Chart of County RERs Received
September 22, 2022, Commission Meeting

County	FY 19-20 Electronic Copy Submission	FY 19-20 Return to County	FY 19-20 Final Review Completion	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion
Stanislaus	12/31/2020	1/5/2021	1/5/2021	1/31/2022	2/2/2022	2/15/2022
Sutter-Yuba	1/30/2021	2/1/2021	3/9/2021	2/9/2022	2/10/2022	2/15/2022
Tehama	4/27/2021	n/a	5/21/2021			
Tri-City	1/27/2021	3/4/2021	3/30/2021	1/31/2022	2/2/2022	5/25/2022
Trinity	2/1/2021	2/2/2021	2/17/2021	7/5/2022	7/5/2022	7/27/2022
Tulare	1/26/2021	1/27/2021	2/10/2021	1/31/2022	2/2/2022	2/10/2022
Tuolumne	6/2/2021	8/11/2021	8/11/2021	1/31/2022		2/4/2022
Ventura	1/29/2021	2/2/2021	2/16/2021	1/28/2022	2/2/2022	2/14/2022
Yolo	1/28/2021	2/2/2021	2/2/2021	1/31/2022	2/2/2022	2/2/2022
Total	**59**	**57**	**58**	**57**	**55**	**55**

Mental Health Services
Oversight & Accountability Commission

Tentative Upcoming MHSOAC Meetings and Events

Updated 9/10/2022

OCTOBER 2022

- 10/18: Cultural and Linguistic Competency Committee Meeting
  - 3:00PM – 5:00PM
  - Public

- 10/25: Client and Family Leadership Committee Meeting
  - 1:00PM – 3:00PM
  - Public

- 10/27: October Commission Meeting
  - 9:00AM – 1:00PM
  - Public

NOVEMBER 2022

- 11/10: Cultural and Linguistic Competency Committee Meeting
  - 3:00PM – 5:00PM
  - Public

- 11/15: Client and Family Leadership Committee Meeting
  - 1:00PM – 3:00PM
  - Public

- 11/17: November Commission Meeting
  - 9:00AM – 1:00PM
  - Public