August 26, 2022

NOTICE OF RFP SECOND AMENDMENT

Dear Prospective Proposer:

The Peninsula Health Care District is hereby notifying you that there was a calculation error in the allcove™ Youth Drop-In Center Services RFP that has resulted in the following changes:

1) Total maximum RFP Amount
   a. Previous $10,089,732
   b. Current $11,103,732

2) Total yearly Amount
   a. Previous $2,522,433
   b. Current $2,775,933

We thank you for your patience and understanding and hope this change has not inconvenienced your process to submit a proposal.

Sincerely,

Eddie Flores
Director of Youth Behavioral Programs
Peninsula Health Care District

August 22, 2022

NOTICE OF RFP AMENDMENT: DUE DATE EXTENSIONS

Dear Prospective Proposer:

The Peninsula Health Care District is hereby announcing that proposal due dates for the Requests for Proposals allcove™ Youth Drop-In Center Services has been extended as indicated below.

Original proposal due date and time: September 9, 2022 at 5:00 p.m.
Revised proposal due date and time: **September 16, 2022 at 5:00 p.m.**

Sincerely,

Eddie Flores
Director of Youth Behavioral Programs
Peninsula Health Care District

District Office 1819 Trousdale Drive, Burlingame, CA 94010
Phone 650.697.6900 **Fax** 650.652.9374 www.peninsulahealthcaredistrict.org

SAN BRUNO MILLBRAE BURLINGAME SAN MATEO HILLSBOROUGH FOSTER CITY

NOTICE OF REQUEST FOR PROPOSALS OPPORTUNITY

Dear Prospective Proposer:

Peninsula Health Care District is soliciting proposals from qualified and interested providers for the provision of services for a new integrated youth drop-in center, allcove™ San Mateo.

The entire Request for Proposals document for these services can be viewed at and downloaded by going to https://rb.gy/1bgvyz

If unable to download, paper copies of the RFP may be requested via email. Please direct all your questions and inquiries or requests regarding the RFP to this email: allcovesanmateo@peninsulahealthcaredistrict.org

All interested parties are invited to attend the mandatory Proposers Conference to be held on Thursday, August 11, 2022, from 9:30 am – 12:30 pm via Zoom Webinar

Please R.S.V.P. here if you plan to attend remotely via Zoom. A confirmation email will be sent out with the Zoom link once received.

The deadline for submitting a proposal is 5:00 P.M. PST on Friday, September 16th, 2022. Specific instructions on how to apply and submit are available in the RFP document.

We look forward to receiving your application!

Sincerely,

Eddie Flores, MBA
Director, Youth Behavioral Health Programs/Site Director allcove™ San Mateo Peninsula Health Care District

PENINSULA HEALTH CARE DISTRICT REQUEST FOR PROPOSALS

allcove™ Youth Drop-in Center

STATEMENT OF INTENT

Peninsula Health Care District (PHCD) is seeking proposals for the operation of an allcove™ Youth Drop-In Center. The allcove™ Youth Drop-In Center model aims to increase accessibility to free or low cost mental health and wellness services for youth between the ages of 12 to 25 and their families, including mental health, physical health, substance use, peer support, family support, supported education and employment, and linkage to other services.

The allcove™ centers will provide culturally competent and relevant services for vulnerable and marginalized youth populations including, but not limited to, LGBTQ+, unhoused, and indigenous youth.

PHCD is interested in considering any innovative solutions to providing services for these populations. PHCD may select one or more providers to deliver allcove™ Youth Drop-In Center services. An applicant submitting a proposal shall satisfy all requirements outlined in this RFP.

BACKGROUND

Since December 2, 1947, Peninsula Health Care District (PHCD), governed by a publicly elected 5-member board of directors, has addressed the community's health needs. A political subdivision of the State of California, and a California Special District serving the healthcare needs of more than 200,000 mid-Peninsula residents. PHCD serves the communities of San Bruno, Millbrae, Burlingame, Hillsborough, San Mateo, and Foster City by supporting the unique health and wellness priorities of our Peninsula communities, and safeguarding access to health services, today and in the future. PHCD fulfills its commitment to the community through oversight of District assets and infrastructure, planning for future health care needs, and investing taxpayer dollars in local health-focused organizations and programs.

What started as building, owning, and governing Peninsula Hospital, has today developed into bringing health-focused programs and services to the community, to help residents achieve their optimal health. For more than seven decades, PHCD has been the community's partner in good health. For more information please visit: https://peninsulahealthcaredistrict.org.

In August 2018, the California Mental Health Services Oversight & Accountability Commission (MHSOAC) approved Santa Clara County's Mental Health Services Act (MHSA) Innovation Plan totaling $15 million over a four-year period to launch allcove™, an integrated mental health youth drop-in center which seeks to

increase access to vital services for youth ages 12 to 25 at a location that is designed by youth and for youth. Services include mental and behavioral health, physical health, education and employment support, and linkage to other services. The Center for Youth Mental Health and Wellbeing in Stanford's Department of Psychiatry and Behavioral Sciences (Stanford) developed allcove™ with input and leadership from Santa Clara County youth which builds upon Australia's headspace© model.

In addition, the Budget Act of 2019 included $14.6 million in one-time MHSA funding over a four-year period to support the establishment or expansion of integrated mental health youth drop-in centers to build upon the work of Santa Clara County and adapt allcove™ statewide with a focus on vulnerable and marginalized youth and populations of youth with known disparities including, but not limited to, LGBTQ+, homeless, and indigenous youth. The Commission was directed to develop selection criteria and a strategy for program monitoring, providing technical assistance to awardees, and evaluating project outcomes.

In January 2020, the Commission allocated $10 million for grants to expand allcove™ youth drop-in centers and $4.6 million to contract with Stanford as the exclusive implementation support provider for allcove™ to provide technical assistance to grantees and other interested counties or program providers in exploring opportunities for establishing allcove™ youth drop-in centers in their communities.

The Commission released the allcove™ RFA in February 2020 and awarded grants to the following five highest scoring applicants in May 2020:

- Beach Cities Health District (Los Angeles County)
- Peninsula Health Care District (San Mateo County)
- Sacramento County Behavioral Health Services
- Wellnest© (City of South Los Angeles)
- University of California – Irvine & Wellness and Prevention Center

The Commission owns the allcove™ trademark and licenses the allcove™ name to counties, cities, or other local entities at no cost under terms and conditions set forth in a licensing agreement. Use of the allcove™ trademark requires strict adherence to the licensing agreement. Any deviation from the licensing requirements could jeopardize the trademark application on file with the U.S. Patent and Trademark Office.

GENERAL RFP INFORMATION AND KEY ACTION DATES

Solicitation Number	2022-1
Number of contracts expected to be awarded	1 or more
Estimated Value or Range per contract	$11,103,732
Funding Sources	☐Federal ☒State ☐County ☒Other
Expected Contract Start/End Dates*	December 2022 – December 2026
Options to Renew	This is a 4 year contract with no option to renew beyond the term of current funding.
Hard copy proposals required	1 original, electronic copy; 7 hard copies;
PHCD Mailing Address *(for hard-copy communication & proposal submissions)*	Peninsula Health Care District Attn: Eddie Flores, Director of Youth Behavioral Programs 1819 Trousdale Drive Burlingame, CA 94010-4509
E-mail Address for Electronic Submission and Protests	allcovesanmateo@peninsulahealthcaredistrict.org
RFP Released	July 28, 2022
Deadline for Questions, Comments and Exceptions	August 9, 2022, 4:00 p.m. PST
Proposers' Conference date and time	August 11, 2022, 9:30 a.m. PST
Proposers' Conference location	Burlingame Community Center Maple Room 850 Burlingame Avenue Burlingame, CA 94010
Proposers' Conference online option	See Section III.3.1.D. Proposers' Conference
Site Visit Option # 1 – only attend one site visit	August 12, 2022, 1pm
Site Visit Option # 2 – only attend one site visit	August 19, 2022, 9am
Release date for Questions & Answers	August 22, 2022
Proposal Due Date and Time	**September 9, 2022, 5:00 PST**
Evaluation of Proposals*	September 19, 2022
Interviews – if necessary*	Week of September 26 , 2022
Recommendation of selection to Board*	October 27, 2022
Notification of Funded Proposals*	October 31, 2022
Submission of contract to PHCD Board for approval*	December 2022 TBD
Anticipated Contract Award Date*	December 2022 TBD

**Dates are subject to change*

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SECTION I - DEFINITIONS

allcove™ program: A "one-stop-shop" drop-in center which aims to provide access to affordable mental health and wellness services for youth between the ages of 12 to 25 and their families, including behavioral health, physical health, education, employment and peer support, and linkage to other complimentary services, such as housing.

allcove™ model : Key overarching practice principles and components that provide a framework for the integrated youth mental health model that is allcove™. (See Attachment I: allcove™ - A bold, new strategy for youth mental health).

allcove™ center: the allcove™ Youth Drop-in Center.

allcove™ model integrity: a framework and process that supports adherence to the allcove™ model.

Business Day: Monday through Friday, and potentially Saturdays, except for holidays as observed by PHCD.

CAT: Central allcove™ Team at the Stanford Center for Youth Mental Health and Wellbeing.

Clinical Lead Manager: The individual identified by PHCD as PHCD's primary contact for behavioral health and physical health services.

Confidential Information: Information in any form that is not generally known and treated as confidential by a party, including business, financial, statistical, and non-public personal information, trade secrets, know-how, applications, documentation, schematics, procedures, Personally Identifiable Information, information covered by legal privilege, and other proprietary information that may be disclosed or incorporated in materials provided to one party by the other, whether or not designated as confidential, whether or not intentionally or unintentionally disclosed, and whether or not subject to legal protections or restrictions.

Contract Materials: finished or unfinished documents, data, studies, maps, photographs, reports, specifications, lists, manuals, software, and other written or recorded materials produced or acquired by the Contractor pursuant to the Contract for or on behalf of PHCD, whether or not copyrighted.

Contract: The agreement between PHCD and Contractor awarded pursuant to this solicitation.

Contractor: The person or other entity awarded a Contract in conformance with the terms of this solicitation and any subsequently-agreed upon terms.

Coordinating Agency: The agency selected to oversee all services provided at the allcove™ Youth Drop-In Center and ensure integrity to the allcove™ program model.™

Director of Youth Behavioral Programs: The person identified by PHCD as PHCD's primary contact for the receipt and management of the goods and services required under the contract and to provide oversight regarding contract goals with managing deliverables, reporting, documentation, and service delivery.

datacove: allcove ™ program data collection system.

PHCD Data: All information, data, and other content, including Confidential Information and other information whether or not made available by PHCD or PHCD's agents, representatives or users, to a Contractor or potential Contractor or their employees, agents, representatives or Subcontractors, and any information, data and content directly derived from the foregoing, including data reflecting user access or use.

PHCD Systems: The information technology infrastructure of PHCD or any of its designees, including computers, software, databases, networks, and related electronic systems.

Deliverables: Goods or services required to be provided to PHCD under the Contract.

DUNS (Data Universal Numbering System): a proprietary nine-digit number issued by Dun and Bradstreet, Inc. to identify unique business entities. This number assigned to businesses and is used to track information about a company, giving lenders and business partners a way to predict financial stability and establish credit ratings.

Force Majeure: An event or circumstance not caused by or under the control of a party, and beyond the reasonable anticipation of the affected party, which prevents the party from complying with any of its obligations under the Contract, including acts of God, fires, floods, explosions, riots, wars, hurricane, sabotage, terrorism, vandalism, accident, governmental acts, and other events. Pandemics/epidemics do not qualify.

Hosting: Storage, maintenance, and management of hardware, software, and PHCD Data (by a party other than PHCD), on machines and at locations other than those operated by PHCD, where a party other than PHCD has regular responsibility for back-up, disaster recovery, security, upgrades, replacement, and overall responsibility for ensuring that all hardware and software continues to function as intended.

Key Employee: Employees of the Contractor jointly identified by PHCD and the Contractor as possessing unique skill and experience that was a material consideration in PHCD's decision to award a contract.

Maintenance Updates: Any revision, update, improvement, modification, enhancement, correction, bug fix, patch, or new release for a system, platform, software or other product, including any change made as a result of applicable federal, State, or local law.

Major Change: A change to the specified performance, maintainability, operation, power requirements, compatibility, measurement, user interface, reliability, quantity, scale, quality, terms, delivery method, or requirement of any product or service that affects the obligations of the parties or reflects a substantial alteration in circumstances surrounding the agreement, or is of such a nature that knowledge of the change would affect a person's decision-making process.

MHSOAC: California Mental Health Services & Oversight Accountability Commission. Proposition 63, approved by California voters in 2004, created the Mental Health Services Oversight and Accountability Commission to drive transformational change across the state's mental health system. The Commission oversees the implementation of the far-reaching initiative, which imposed a 1 percent income tax on wealthy residents to pay for mental health services and established a framework for continuous improvement of mental healthcare in the state. Partnering with public and private mental health agencies at all levels, the Commission works to ensure that people get the care they need in a timely, comprehensive, effective, and culturally competent manner. In everything, it vigorously promotes community collaboration.

PHCD: Peninsula Health Care District.

PII: (Personally Identifiable Information): information in any format that can be used to identify a specific individual, either used alone or combined with other private or public information that can be linked in some way to a specific individual.

Proposers' Conference: A meeting held to allow prospective proposers an opportunity to gain more background information on the services listed in the RFP and to ask additional questions. Attendance is mandatory in order to submit a proposal.

PST: Pacific Standard Time, including Pacific Daylight Time when in effect

RFI: Request for Information

RFP: Request for Proposals

RFQ: Request for Qualifications

SEE: Supported Education and Employment. SEE is a core service provided to youth who access the allcove™ center with the goal to assist youth aged 12 – 25 in initiating, continuing or completing their educational goals.

Employment related assistance includes supporting youth in developing career goals, job skills, training, employment preparation, and other activities that aid youth in achieving their career goals. The service stream delivers services from a, “youth-centered” perspective, using youth empowerment strategies like shared decision making and motivational interviewing to encourage authentic relationship building and goal-setting.

Service Model: the allcove™ model as developed by the Stanford Center for Youth Mental Health and Wellbeing.

Stanford CYMHW: Stanford Center for Youth Mental Health and Wellbeing

Subcontractor: Agencies engaged by the Contractor to perform work, or specific components of the model or provide goods pursuant to the Contract, including vendors and suppliers

YAG: Youth Advisory Group. The allcove™ Youth Advisory Group serves as the youth voice at the forefront of allcove™ development, direction, engagement and services. The goal of the Youth Advisory Group is to support the development of youth mental health centers that are reflective of the unique youth and young adult culture of each geographic community being served, becoming youth’s own independent place for mental health and wellbeing.

SECTION II - SCOPE OF WORK AND SPECIAL PROVISIONS

2.1 SUMMARY

The allcove™ model, inspired by successful international models in Australia, Canada, and Ireland, creates stand-alone, "one-stop-shop" centers. The allcove™ Youth Drop-In Center model aims to increase accessibility to free or low cost mental health and wellness services for youth between the ages of 12 to 25 and their families, including mental health, physical health, substance use, supported education and employment, peer support, family support, and linkage to other complimentary services, such as housing.

The allcove™ centers will provide culturally competent and relevant services for vulnerable and marginalized youth populations including, but not limited to, LGBTQ+, homeless, and indigenous youth.

allcove™ approaches youth wellness in a comprehensive and youth-friendly way, led by members of an active local Youth Advisory Group (YAG) and Community Consortium to design services and environment they most want to see in their community. Through innovative, evidence-based approaches, allcove™ centers have the flexibility to reflect the unique youth and young adult culture of each geographic community being served and fill a critical gap in the spectrum of youth mental health and wellness services.

With the dramatic rise in suicide rates for children aged 10 to 14 (further data details are included in Attachment I: allcove™ - A bold, new strategy for youth mental health, which is incorporated into this RFP by reference), the status of youth mental health appears to be approaching the breaking point. The alarming increase in distress among youth is not attributed to one exclusive stressor. Rather, climate change, racism, gun violence, income inequality, and charged political discussions (i.e. immigration, LGBTQ+ topics) that have a direct impact on an individual's future are but a few factors that contribute to increased levels of chronic stress among youth, which in turn can lead to anxiety and/or depression.

Because of its whole person approach, the allcove™ model holds the potential to have a significant positive impact on young people's mental health and wellbeing. As an integrated service, allcove™ addresses the overlapping needs of young people, whether through providing vocational support, reducing mental health distress, or initiating conversations with a peer specialist that lead to an appointment with an addiction specialist. The allcove ™ model structure is aligned with many of the key principles outlined in the California Department of Health Care Services' Framework for a Core Continuum of Care, including offering locally tailored, culturally responsive, prevention and early intervention focused, community-based, whole person care. This "no wrong door" approach supports the realities of young people's lives and encircles them with broad support in one setting.

2.2 SCOPE OF WORK

Foundational to the model, and the services provided through this RFP, is service integration and key overarching practice principles that inform the components that together provide a framework for the integrated youth mental health model that is allcove™. The model ensures that young people are provided holistic, evidenced-based integrated services and that young people's experience in any center of the allcove™ network is timely, consistent and of high-quality.

A. Overarching Practice Principles

(1) Youth-centered care

- Services co-designed with youth
- Young people as experts in their own care

- Socially and culturally inclusive
- Holistic service offering
- Strength-based, hope inspired
- Shared decision making
- Peer supported
- Staffed by professionals with expertise and passions for working with youth
- Developmentally appropriate interventions
- Informed consent and confidentiality

(2) Prevention, screening early intervention
- Actively working in the community to build youth resilience, increasing early help seeking, reduce stigma and increase mental health literacy
- Community-based services with active community partnerships
- Use of standardized screening tools to identify the state of health and wellbeing of youth people
- Address and support social determinants of health through psycho-social service offerings

(3) Rapid, easy and affordable access
- Wide service criteria for youth ages 12 to 25
- Drop-in services, when possible
- Located in areas where youth naturally congregate, accessible by public transportation, youth friendly environmental design
- Free or low cost, regardless of personal situation
- Most commonly sought services provided or connected in one location
- Strong linkages to referral sources, such as schools and other educational settings
- Integrated services within the center, with additional linkages to external services that support the continuum of care and higher levels of need

(4) Holistic and integrated care
- Co-location of core service streams, especially mental and physical health
- Multidisciplinary team-based care
- Coordinated care – Internal and external integration with the local youth-serving system
- Family inclusive, as appropriate
- Use of appropriate technology and service delivery modes

B. Model Integrity

The allcove™ model was developed by the Stanford Center for Youth Mental Health and Wellbeing (Stanford CYMHW) with input from its international collaborators, many youth advisors, the state of California, and its communities. The allcove™ model shares common characteristics with similar international integrated youth mental health models which have been tried and tested and refined in time. Further development of locally relevant components has been incorporated and it is foreseen that as the first wave of centers open, the common evaluation will inform further refinement of the model. The licensing program (granting rights to use the allcove™ name and logo) is overseen by the California Mental Health Services Oversight & Accountability Commission (MHSOAC) with technical support and model integrity support provided directly to centers by the Central allcove™ Team (CAT) at the Stanford CYMHW . More information about the history of allcove™ and the principles of model integrity are located in Attachment II: Model Integrity Overview and Attachment III: Model Integrity Guide. Providers

selected to deliver services through the allcove™ Youth Drop-In Center RFP will be required to maintain model integrity.

C. Target Community Area
Peninsula Health Care District encompasses the following city areas: San Bruno, the south-east tip of South San Francisco, Millbrae, Burlingame, San Mateo, Hillsborough, and half of Foster City.

D. Target Population and Eligibility
allcove™ centers welcome youth and young adults ages 12 to 25 who experience mild to moderate mental health needs and are looking for support and services.

E. Coordinating Agency and Service Components
PHCD is seeking an agency provider to provide and manage the delivery of all service components within the allcove™ Youth Drop-In Center. The agency applicant (or Coordinating Agency) must be able to directly provide one of the complete service components. The Coordinating Agency may sub-contract with other providers to fulfill other services that the Coordinating Agency will not directly provide. All service components are to be consistent with the short-term intervention model for mild to moderate services.

(1) Coordinating Agency

The Coordinating Agency will be an agency that has developed community trust, history with the target population and has experience providing culturally responsive services and is familiar with the target and vulnerable communities and populations in San Mateo County. Responsibilities and services of the Coordinating Agency include, but are not limited to, the following:

a. Staffing:
   i. Administrative Support/Reception (2.0 FTE) to support the allcove™ Center as a whole, schedule appointments, respond to inquiries, answer phones, gather preliminary information, etc.
   ii. Billing (0.5 FTE) manage all client billing services.
   iii. Staffing for allcove™ Center service components. The Coordinating Agency is responsible to maintain staffing for all service components. Initially, the Coordinating Agency may determine that a scaled-up approach to full staffing is warranted as the number of youth and young adults requesting services will take time to ramp up. Staffing for each service component is listed in Section 2.2.E.2 Behavioral Health Services; 2.2.E.3 Physical Health Services; 2.2.E.4 Youth and Family Peer Support Services; and 2.2.E.5 Supported Education and Employment of this RFP.
   iv. Subcontracting - The Coordinating Agency may elect to directly provide the services or sub-contract with other providers to deliver complete service components that the Coordinating Agency has elected not to directly provide (the Coordinating Agency is required to provide at least one complete service component). The Coordinating Agency is responsible to ensure that all subcontractors adhere to the provisions of this RFP, the standard agreement, and the lease requirements and policies.

b. Coordinating Agency Responsibilities:

i. Implement the allcove™ model with all core components and be open to model integrity monitoring and improvement. Manage model integrity across all allcove™ providers.
ii. Ensure all providers comply with and perform tenant obligations (other than rent payment) under the facility lease.
iii. In partnership with the PHCD Director of Youth Behavioral Programs and PHCD Clinic lead, convene allcove™ providers via regularly scheduled allcove™ collaboration team meetings that promote integration of services, communication, shared decision making, brainstorming ideas for shared spaces and services, and provide an opportunity for knowledge enhancement.
iv. Facilitate the development and review of allcove™ specific policies and procedures and ensure core documents are aligned to the allcove™ model.
v. Include Youth Advisory Group members voice and feedback in all available opportunities for youth inclusion with regard to allcove™ development, implementation, delivery and maintenance of allcove™ center services, programmatic use and use of shared spaces.
vi. Collaborate with the Central allcove™ Team (CaT) and their subject matter experts to assist with development and delivery of services, service integration, youth development, model integrity and to answer any questions.
vii. Coordinate budget allocation, fiscal planning, and other administrative requirements with PHCD Director of Youth Behavioral Programs.
viii. Adopt the datacove™ system and provide governance of data collection with all service components that includes, but is not limited to: gathering of data, evaluations, survey results; and prepare quarterly delivery and service reports to MHSOAC in collaboration with the PHCD Director of Youth Behavioral Programs. When necessary, comply with and execute the grant agreement with the state and its exhibits.
ix. Coordinate supplementary training opportunities for all partner agencies/individuals in collaboration with PHCD and CaT.
x. Facilitate allcove™ center team building and service integration among all partner agencies/individuals, in partnership with the PHCD Clinical Lead and Director of Youth Behavioral Programs
xi. Maintain brand integrity that aligns with allcove™ requirements for facility space, environmental design, signage, messaging tools (including an existing unified website architecture - allcove.org), brochures, branded merchandise, including social media and any marketing or promotional printed or soft materials, etc. according to the allcove™ Brand Guidelines.
xii. Translate, or obtain translations for, all written documents, signage, etc. in threshold languages as needed or requested.
xiii. Attend the allcove™ Learning Community and the Community Consortium meetings and other designated local, regional or state conferences (virtual or in-person) to allow for ongoing collaboration and knowledge transfer that supports the integrity and success with the model.
xiv. Collaborate with the Community Consortium to develop, implement, and continuously improve program best practices across all components.
xv. Collaborate with PHCD Youth Outreach Specialist to manage any incentives used for youth recruitment, engagement and/or participation and/or recognition.

xvi. Work directly with the PHCD Clinical Lead who will be the main point of contact for other clinical service providers regarding facility or equipment issues

xvii. Work with Director of Youth Behavioral Health Programs for all programmatic, administrative and facility requests. Ensure all components and adhere to the stated requirements of the property lease.

xviii. Develop and implement policy and procedures regarding client grievances and critical incidents, including timely notification to PHCD.

xix. Work with PHCD Clinical Lead to ensure that all providers of services have current credentialing, fingerprinting or other background checks completed on a yearly basis.

xx. Manage successful completion of allcove™ program goals and objectives for all service components.

(2) Behavioral Health Services

Service providers applying to deliver behavioral health services must be must be capable of providing support to clients with co-occurring substance use and mental health conditions and have policies and procedures regarding co-occurring assessments, providing appropriate care under the mild to moderate service model, and processes to provide linkages/referrals as appropriate. Clinicians will work in collaboration with the PHCD Clinical Lead. The provider must be willing to work towards certification under drug MediCal to provide field-based treatment and on-site treatment at the allcove™ Center.

Responsibilities and service provided will include, but are not limited to:

a. Staffing:
   i. Licensed behavioral health clinicians (4 FTE) preferably with a Substance Use Disorder Counselor Certification.
   ii. Licensed Psychiatrist (0.40 FTE) preferably with adolescent/young adult expertise.
   iii. Credentialing and fingerprint background check of all staff is the responsibility of the provider/agency.
b. Short-term mental health counseling services for individuals that don't immediately meet medical necessity for serious mental illness; including, but not limited to:
   i. Assessment
   ii. Individual Therapy including drop-in" mental health counseling services
   iii. Family Therapy
   iv. Group Therapy
   v. Crisis Intervention
c. Medication Support Services (licensed psychiatrist, or licensed Nurse Practitioner only), services include, but are not limited to:
   i. Prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals, necessary to alleviate the symptoms of mental illness;
   ii. Evaluation of the need for medication, prescribing and/or dispensing;
   iii. Evaluation of clinical effectiveness and side effects of medication;
   iv. Obtaining informed consent for medication(s); and
   v. Medication education (including discussing risks, benefits, and alternatives with the significant support persons of client.
d. Linkages/referrals to other resources or strategies that support youth and young adults to reach their goals or meet current needs;
e. Psycho-education and prevention workshops (e.g. parenting skills, recognizing

signs/symptoms of mental health crisis, sexual orientation and gender identity, overcoming stress, anxiety, etc.); and

f. Recovery-focused workshops/sessions (e.g. Wellness Recovery Action Planning (WRAP), mindfulness and other non-traditional practices such as drumming and cultural folk healers, music, arts, dance, etc.);

g. Cultural responsiveness provided through a safe and supportive environment for youth with mental illness and/or co-occurring challenges and their families will be created through various strategies including, but not limited to:

   i. Bilingual and bicultural staff, including youth and adult peers, to provide peer-led activities in the youth's primary language;

   ii. Welcoming, non-judgmental to the youth's cultural and ethnic community and other multiracial, multicultural communities including the Lesbian, Gay, Bisexual and Transgender, and Queer or Questioning (LGBTQ+) community;

   iii. Use of evidence-based curriculum that are tailored to the strengths and needs of youth and young adults.

h. Collaboration, integration and coordination of services with all allcove™ center providers.

i. Collaborate with CaT and their subject matter experts to assist with development of services, service integration, and to answer any questions.

(3) Physical Health Services

The provider of physical health services shall deliver basic health care that includes oversight by a California licensed attending physician and onsite nursing support to allcove™ center youth and young adults.

Responsibilities and services provided will include, but not be limited to:

a. Staffing

   i. Licensed medical physician (0.4 FTE) to provide health services and supervision

   ii. Registered nurse or licensed vocational nurse (0.4 FTE) to provide health services

b. Responsibilities and Services

   i. Collaboration, integration and coordination of services with all allcove™ center providers.

   ii. Collaborate with CaT and their subject matter experts to assist with development of services, service integration, and to answer any questions.

   iii. Provide up to 12-15 hours per week of in-person medical and/or nursing support including joint visits with other center providers;

   iv. Routine preventive care, such as vaccinations, screenings for most common health issues among youth and young adults, such as: diabetes, eating disorders, sexually transmitted infections (STIs), nutritional support, birth control, etc.;

   v. Pregnancy testing and prenatal exams;

   vi. Treatment for common illnesses such as colds, the flu, or urinary tract infections (UTIs);

   vii. Treatment for some injuries, such as minor cuts or burns;

   viii. Referral to specialty care for issues which cannot be addressed at the allcove™ center;

   ix. Minor urgent care as medically safe to provide;

   x. Health education classes.

c. Medication Support Services (licensed Nurse Practitioner or Physician only), services include, but are not limited to:
   i. Prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals, necessary to alleviate the symptoms of mental illness;
   ii. Evaluation of the need for medication, prescribing and/or dispensing;
   iii. Evaluation of clinical effectiveness and side effects of medication;
   iv. Obtaining informed consent for medication(s); and
   v. Medication education (including discussing risks, benefits, and alternatives with the significant support persons of client.

(4) Youth peer and Family Support Services
The youth peer support specialists engage with allcove™ youth to develop relationships, act as an advocate, provide peer-to-peer support services and support outreach efforts to all youth in the community, promoting visibility, access and encouraging participation in the allcove™ program.

Youth peer support specialists draw on their own lived mental health experience to support young people seeking services through building trust and engagement, sharing past experiences and assisting with navigating services in the community as well as the integrated services within the allcove™ center, using shared decision-making strategies to foster youth empowerment. They offer peer-based mentoring and emotional support and work collaboratively with youth, their families, and members of the allcove™ center care team.

While allcove™ is a youth focused service, family support services offer education, skills and tools to caregivers, family members and other people with whom the youth identifies who hold a significant role in supporting a young person. Family involvement ranges from including information and perspectives provided by a family member in an assessment, to guided self-help with books and other forms to literature, to group or individual psychoeducation, to participation in brief family meetings and therapy.

Staffing and responsibilities for youth peer support specialists include, but are not limited to, the following:

a. Staffing
   i. Youth Peer Support Specialists (3 FTE). Youth Peer Support Specialists will engage allcove™ youth, providing peer-to-peer support services; and support outreach efforts to all youth in the community promoting visibility, access and encouraging participation in allcove™.
   ii. Age range for Peer Support Specialists is typically between 18-26 years old.
   iii. Designated responsibility for the supervision of peer support specialists

b. Key responsibilities
   i. Collaborating with the allcove™ center providers to brainstorm activities, use of space, and service integration.
   ii. Collaborating with CaT and their subject matter experts to assist with development of services, use of space, and to answer any questions.
   iii. Performing initial orientation support ensuring a welcoming, inclusive and youth-friendly experience for young people as they engage with the allcove™ center and its services.

iv. Collaborate with allcove™ San Mateo Youth Advisory Group to build relationship and rapport, create outreach opportunities, and brainstorm complimentary workshops, services, and events for allcove™ center.
v. Assisting youth and young adults with completion of forms, intake questionnaires and initial screening or assessments as needed.
vi. Serving as a point of contact and support at the center.
vii. Acting as a guide and advocate, sharing and discussing common experiences to develop trust and rapport, encourage and maintain a positive and optimistic outlook.
viii. Participating in goal-setting activities with youth and young adults that come in to the center.
ix. Identifying opportunities for young people to learn, grow and become more confident/improve self-esteem
x. Providing encouragement and support to access supports.
xi. Leading or co-facilitating workshops.
xii. Conducting outreach to educate community partners and peers about center services and resources available, including center tours, public presentations in local schools, or guest speaking engagements.
xiii. Actively engaging with the PHCD Youth Outreach Specialist and the Youth Advisory Group members by participating in the planning of Youth Advisory Group meetings and supporting their events and outreach efforts.
xiv. Communicating, representing and promoting the peer perspective within the allcove™ center.
xv. Completing onboarding orientation and yearly training for Peer Specialists.
xvi. Developing effective working relationships with agencies and organizations to advocate for peer empowerment including wellness, outreach and collaboration in future events and activities.
xvii. Providing outreach to peers in the community through presentations at schools, outreach/tabling events and activities.
xviii. Collaborating to develop communication and marketing materials for program activities.
xix. Completing and maintaining related records and documentation by participating in data collection.
xx. Ensuring that youth and center resources are accessible to young people receiving allcove™ services.

(5) Supported Education and Employment Services (SEE Services)

Foundational to the allcove™ supported education and employment service model is the core belief that youth who are able to set and achieve their own educational and employment goals are more likely to experience mental and physical wellbeing in their lives. The supported education and employment specialist uses youth-centered approaches to compassionately, unobtrusively and respectfully check in with the young person throughout their engagement with allcove™ SEE services. The SEE specialist in their engagement approach is mindful of how the youth is feeling in the moment, how they feel about their goals and what would be helpful to know about their lives so that the specialist can support the youth in having an individualized, holistic, youth-centered plan that is calibrated to the level, pace, and type of support wanted by the youth accessing allcove™ SEE services.

Staffing and responsibilities for supported education and employment specialists include, but are not limited to, the following:

a) Staffing
   i. Supported Education and Employment Specialist (1 FTE)

b) Responsibilities
   i. Collaborate with CaT and their subject matter experts to assist with development of services, use of space, and to answer any questions.
   ii. Collaborate with the allcove™ center providers to brainstorm activities, use of space, and service integration.
   iii. Collaborate with allcove™ San Mateo YAG to brainstorm workshops (whether group or 1-1) that fit needs of San Mateo youth.
   iv. Build an on-going, trust-based relationship with the youth.
   v. Facilitate tours to educational and employment institutions or other agencies.
   vi. Collaborate with community resources, such as: high schools, GED programs, colleges, libraries, financial aid resources, technical or vocational schools, etc.
   vii. Assist youth in developing an "action plan" and provide regular check-ins.
   viii. Provide relevant workshops that center around the youth's education or employment goals (i.e. re-engaging in high school, how to fill in application forms, developing a résumé, identifying youth strengths, etc.).
   ix. Assist youth with identifying barriers to achieving goals and navigating through/around them.
   x. Provide one-on-one post-high school education access support for those who are preparing to enter community college, 4-year college or other post-high school educational experiences.
   xi. Refer and monitor youth linkages to other community resources and offer support with navigating /accessing services or programs.
   xii. Maintain a resource bank of relevant contacts that can assist and support youth that have questions (i.e. financial aid, colleges, universities, tech schools, etc.).
   xiii. Involve youth in selecting education and employment resources and support tools/strategies that work best for them.

F. allcove™ Program Goals

The Coordinating Agency will be responsible to ensure that all service components meet the following program goals:

(1) Increase rapid, easy and affordable access to mental health and physical health care services to youth and young adults 12 to 25 years old (providing drop-in mental health and other supportive services when possible at free or low cost regardless of personal situation).
(2) Increase youth participation in the selection, development and implementation of which groups and services might best meets their community's needs.
(3) Increase youth outreach and engagement, including outreach to vulnerable and underserved populations (including, but not limited to: LGBTQ+, unhoused youth, and indigenous youth).
(4) Curate an environment that is stigma free, welcoming, safe, and provides youth with a soft entry to care.
(5) Provide seamless coordination/integration of services within the allcove™ center.

(6) Reduce mental health stress through evidence-based practices that promote healthy development, support youth, young adults and their families and increase their resilience.
(7) Provide education to the public about the importance of mental health to increase early help seeking and increase mental health literacy.
(8) Reduce negative stereotypes, bias and stigma around mental illness (i.e. in schools, other community entities).
(9) Increase community connections and partner with community agencies to build a robust network of youth-centered support.
(10) Provide integrated services with strong linkages to referral sources, such as: schools, job training, higher education, vocational opportunities, etc.
(11) Provide linkages and soft-handoff for youth to local behavioral health systems for more intensive interventions when needed.

G. Service Availability

The allcove™ Youth Drop-In Center shall be open on Mondays through Fridays from 10:00 a.m. to 7:00 p.m. and then on Saturdays from 10:00 a.m. to 2:00 p.m. as needed. These operating days and times are a minimum expectation, additional days and times may be added as needed under the guidance of the YAG and input from youth.

The Coordinating Agency is responsible to ensure services continue in the event staff or a subcontractor gives notice or otherwise cannot perform their service duties. Ensuring the continuance of services may include plans for service coverage for staff on vacation, medical leave or staff vacancies. In addition, agreements with subcontractors will include language that allows for the transition of services to a new subcontractor in the event an existing provider has given notice. The solicitation process to replace an existing subcontractor shall include engaging the PHCD Director of Youth Behavioral Programs to review/evaluate responses to the solicitation.

H. Training Requirements

All allcove™ staff work together to ensure that a young person's experience is supportive of their wellbeing and provides a moment of pause. To this end, as part of staff on-boarding and ongoing staff development, all staff members are required to participate in training that ensures the provision of ethical, legal, and youth centered services.

(1) For All Providers

All providers delivering services at the allcove™ center shall receive training on the following topics:

- allcove™ Model Integrity
- Anti-sexual harassment training
- Staff Onboarding to allcove™ model – at date of hire
- Suicide Risk & Assessment
- Law and Ethics
- Youth Cultural and Identity Issues
- Youth Engagement and Participation Strategies
- Shared decision making
- Informed Consent
- Crisis Intervention
- Mandated reporter training
- Blood-borne pathogens training
- allcove™ datacove training
- Confidentiality
- HIPAA

- Compliance
- Fraud, Waste, and Abuse
- Critical Incident Management
- Sexual Orientation and Gender Identity (SOGI)
- Interpreter training (if using interpreter services)
- Training for allcove™ team about peer support role and scope of work

(2) For Clinical Providers
In addition to the training listed above, clinical providers shall receive training in the following topics:

- allcove™Clinical Model
- Stepped Care Model
- Clinical Staging
- Single Session Solution Focused Therapy
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Shared-decision making

Other suggested training topics are:

- Active Listening
- Alcohol and Drugs
- Sexual Abuse
- Domestic Abuse
- Parenting
- Working with Youth in Crisis
- LGBTQ+ Issues
- Child and Elder Abuse
- Management of difficult cases

(3) For Physical Health Providers

In addition to the training listed above, providers shall maintain certifications and licenses for the delivery of physical health services.

For Youth Peer Support Providers
In addition to the training listed above, providers shall receive training in the following topics:

- Mental Health 101
- Mental Health First Aid – youth focused
- Diversity, outreach and inclusion
- Peer Support Roles and Responsibilities
- Shared-decision making
- Motivational interviewing
- Strategic sharing (for specialist and supervisor)
- Boundaries and ethics in the peer support role
- Mental models/ladder of inference
- Introduction to community outreach/resourcing
- Introduction to Trauma Informed Practice
- Crisis response/management
- "Self-care" for young professionals
- Youth advocacy in the peer support role
- Working with families
- History of peer support
- Managing youth peer support specialists (supervisor)
- Peer Support Practice Guidelines (supervisor and specialists)
- Virtual Best Practices for Youth and Young Adult Community Mental Health Providers
- Mandated reporting in the peer support role (supervisor and specialists)
- Documentation best practices in Peer Support

(4) For Education and Supported Employment Providers

In addition to the training listed above, providers shall receive training in the following topics:

- Motivational Interviewing
- Strength based and trauma informed approaches to:
  - Supporting youth and young adults with mental health concerns with their educational/employment goals;
  - Goal setting;
  - Discussing barriers
- Introduction to Supported Education and Employment/IPS models of support
- Shared-decision making
- Mandated reporting in the Supported Education and Employment Role

I. Referral in/Intake Process

The allcove™ center has a "no wrong door" philosophy and youth and young adults can initiate services in many different ways. The expectation is that youth and young adults are seen the same day if possible or given an appointment within 5 business days. The most common service requests may be, but are not limited to, the following:

- Dropping in or scheduling an appointment to ask for support.
- Indicating to any allcove™ staff member a need for a specific service or support.
- Intra-center referral from another core service provider.
- Being referred from a partner organization, school or institution.

J. Referral out/ Discharge Process

Youth and young adults may be discharged and/or referred to other services for the following reasons:

- Youth and young adults have received up to 6-8 sessions of mental health or physical health services, it is determined no other services are needed and the individuals are discharged from these service components;
- Youth and young adults have received up to 6-8 sessions of mental health or physical health services, it is determined that they are in need of additional services and are referred out to other agencies to provide the appropriate level of services, individuals are discharged from mental health and/or physical health allcove™ service components;
- Youth and young adults have successfully completed their supported education or employment goals; it is determined that no further assistance is needed and they are discharged from this allcove™ service component;
- Youth and young adults have indicated that they no longer need peer support services or are no longer engaging with peer support services, they are discharged from this allcove™ service component;
- Youth and young adults are not showing up for appointments, or are no longer engaging in any services, after 90 days these individuals are discharged from all allcove™ service components.
- After the 90 day period, youth are eligible to return to any of the services should the need arise for another episode of care.

K. Data and Reporting Requirements

All allcove™ center providers are required to collect data using the allcove™ data collection system (datacove™) , and submit reports that include, but are not limited to: pre/post assessments, services

provided, socio-demographic information, key life events tracking, and other information as directed. For more information on the evaluation tools that will be used, see Attachment IV: Evaluation At-A-Glance, which is incorporated into this RFP by reference.

2.3 LENGTH OF AGREEMENT

The initial anticipated duration of the agreement(s) will approximately be for 4 years with the term tentatively to begin December 2022 and end December 2026 (exact dates will be determined at time of contract).

2.4 AUDITS

PHCD will conduct audits twice a year (one self-assessment, one CaT assessment) of services, to ensure the integrity of the allcove™ model is intact, and provides feedback and guidance. Contracts are contingent upon program evaluation, availability of funding, and PHCD Board approval.

2.5 FUNDING

Funding used for the allcove™ Youth Drop-In Center is comprised of a combination of sources and includes, but is not limited to: Mental Health Services Act grant, local funding options, private funding, fundraising activities and/or other grants. During the term of the agreement, PHCD is covering operational costs for the allcove™ Youth Drop-In Center (i.e. rent, office furniture, office supplies, cleaning service, maintenance, etc.). Proposals need to reflect a budget for salaries, benefits, training of service staff and insurance. The anticipated amount of total staff budget funding for the program's agreement term (December 2022 through December 2026) is ELEVEN MILLION ONE HUNDRED THREE THOUSAND SEVEN HUNDRED THIRTY-TWO DOLLARS ($11,103,732). Total yearly funding, and yearly funding per service component, is as follows:

Service Category with FTE	**Funding Amount Per Year**
Coordinating Agency	*Includes salaries, benefits, insurance, training*
Administrative Support/ Receptionist 2.0 FTE	$ 208,000
Billing Support 0.5 FTE	$ 52,000
Subtotal	$ 260,000
Behavioral Health/Substance Use Services	*Includes salaries, benefits, insurance, training*
Licensed Clinicians 4.0 FTE	$ 884,000
Licensed Psychiatrist 0.4 FTE	$ 498,333
Subtotal	$1,382,333
Physical Health Services	*Includes salaries, benefits, insurance, training*
Licensed Physician 0.4 FTE	$ 358,800
Licensed Nurse Practitioner 0.4 FTE	$ 358,800
Subtotal	$ 717,600
Youth and Family Peer Support Services	*Includes salaries, benefits, insurance, training*
Youth Peer Support Specialist 3.0 FTE	$ 253,500
Subtotal	$ 253,500
Supported Education and Employment Services	*Includes salaries, benefits, insurance, training*
SEE Specialist 1 FTE	$ 162,500
Subtotal	$ 162,500
TOTAL	$2,775,933

Funding for subsequent years is contingent upon funding availability, program evaluation, and PHCD Board of Directors' approval.

2.6 FINANCIAL SUSTAINABILITY

It is expected that the Coordinating Agency will partner with PHCD for financial sustainability of the allcove™ Youth Drop-In Center after the initial grant phase is completed as referenced in Section 3.2.J Cost Analysis/Budget of this RFP. The Coordinating Agency will be responsible to obtain funding (such as MediCal reimbursement, local funding options, private funding, fundraising activities and/or other grants) that will be used to financially sustain the allcove™ Youth Drop-In Center.

SECTION III - INSTRUCTIONS FOR PROPOSERS

3.1 PRE-SUBMITTAL ACTIVITIES

A. Questions, Comments, Exceptions

Submit questions, comments, and exceptions, including notifications of apparent errors, by the Deadline for Questions, Comments and Exceptions to the designated questions field associated with this RFP via email: allcovesanmateo@peninsulahealthcaredistrict.org. Questions and comments received after the deadline may not be acknowledged.

(1) Request for changes

If requesting changes to a part of this solicitation, identify the specific words or phrases and the sections and paragraphs in which they occur. State the reason for each request and provide alternative suggested language. Failure to submit requests by the deadline will be deemed a waiver of any exception. The PHCD's consideration of a suggestion does not imply acceptance. If sufficient proposals are received with no requested changes, PHCD may reject those requesting changes.

(2) Request for Substitution of Specified Equipment, Material, or Process

(a) Unless otherwise stated in the solicitation, references to items or processes by trade names, models or catalog numbers are to be regarded as establishing a standard of quality and not construed as limiting competition.

(b) If requesting a substitution for a required item, submit requests by the Deadline for Questions, Comments, and Exceptions. Furnish all necessary information required for PHCD, in its sole judgement, to make a determination as to the comparative quality and suitability of any suggested alternatives. PHCD's decision will be final. If alternatives are accepted, PHCD will issue an addendum to the solicitation.

B. Revisions to the Solicitation

PHCD may cancel, revise, or reissue this solicitation, in whole or in part, for any reason. Revisions will be posted as addenda on the PHCD website: https://peninsulahealthcaredistrict.org/. No other revision of this solicitation will be valid. Proposers are responsible for ensuring that they have received all addenda from the PHCD website.

C. Contact with PHCD Employees

Violation of the following prohibitions may result in a proposer being found non-responsible, barred from participating in this or future procurements, and becoming subject to other legal penalties.

(1) As of the issuance date of this RFP and continuing until it is canceled or an award is made, no proposer or person acting on behalf of a prospective proposer may discuss any matter relating to the RFP with any officer, agent, or employee of the PHCD, other than through the pre-submittal process or as outlined in the evaluation process or protest procedures.

(2) Proposers may not agree to pay any consideration to any company or person to influence the award of a contract by the PHCD, nor engage in behavior that may be reasonably construed by the public as having the effect or intent of influencing the award of a contract.

D. Proposers' Conference and Site Visits

(1) Mandatory Proposers' Conference

All interested parties are invited to participate in a mandatory informational session that will be held as follows:

August 11, 2022; 9:30 – 12:30
Burlingame Community Center
Maple Room
850 Burlingame Avenue
Burlingame, CA 94010

During the Proposers' Conference, PHCD will distribute responses to questions received prior to the Conference and may respond to additional questions received during the Conference. PHCD may choose to provide additional information following the Conference. All questions received during the Conference will be added to a Q&A document that will be later posted on the PHCD website.

For those that are not able to join in person, PHCD is inviting you the following scheduled Zoom meeting:

Join Zoom Meeting
https://us02web.zoom.us/j/85303910448?pwd=Tm81TDdBbTdoaGNYbk4yVVRhekpuZz09

Meeting ID: 853 0391 0448
Passcode: 852901
One tap mobile
+12532158782,,85303910448#,,,,*852901# US (Tacoma)
+12678310333,,85303910448#,,,,*852901# US (Philadelphia)

Dial by your location
+1 253 215 8782 US (Tacoma)
+1 267 831 0333 US (Philadelphia)
Meeting ID: 853 0391 0448
Passcode: 852901
Find your local number: https://us02web.zoom.us/u/kiaFGO4T1

(2) Site Visit

Site visits for the allcove™ Youth Drop-In Center space will be held as follows;

August 12, 2022, 1:00pm; and

August 19, 2022, 9:00am

Location:
26000 South El Camino Real
San Mateo, CA 94403

PHCD will include any questions received at the site visits into the Q&A document that will later be posted on the PHCD website

3.2 RESPONDING TO THE RFP

All proposals must respond to the following categories:

A. Proposal Cover Letter

(1) Provide a one-page cover letter on your letterhead that includes the address, voice and facsimile numbers, and e-mail address of contact person or persons. List the name and title of each person authorized to represent the proposer in negotiations.

(2) Unless the proposer is an individual, all proposals must be signed with a firm/company/partnership/entity name and by a responsible officer or employee indicating that officer or employee's authorization to commit the proposer to the terms of the proposal. Obligations assumed by such signature must be fulfilled.

B. Board Authorization Letter or Resolution

For agency providers: provide a letter or resolution from your board should include specific language that states who has the authority to submit a response to a request for proposals, when that authority begins and when that authority ends.

C. Organizational Capacity and Experience

(1) Provide a statement of qualifications for your organization, including an organizational chart, a statement of the size of firm, and a description of services provided by your organization. Include the organizations ability to meet contract objectives with other public entities.
(2) Provide a statement of the extent of experience/history providing the services requested by this RFP. Include experience/challenges/successes delivering services to youth and young adults.
(3) Provide a statement of existing services that could be leveraged to provide additional support to the allcove™ Youth Drop-In Center.
(4) How many full-time employees (FTEs) do you plan to assign to this project if you are selected?
(5) How many people in total are employed by your company? Delineate between employees and consultants.
(6) If you plan to re-allocate existing staff, include résumés for each individual that would be assigned to provide services requested by this RFP. Résumés must include at a minimum: date and name of educational institutions for any applicable degrees, additional applicable training, any professional certifications and/or licensing, and relatable work experience.

D. Philosophy and Service Model

This section describes your philosophy and service model for meeting the scope of work required by this RFP. Relevant considerations include your understanding of the needs of the target population, the quality and feasibility of your approach to meeting those needs, the manner in which you plan to provide adequate staffing (including planning for absences and back-up coverage, training, background checks, and staff monitoring, etc.), and equipment or other resources provided by you (if applicable). Keep these considerations in mind as you respond to the following:

(1) Articulate your understanding and alignment to the allcove™ principles and model.
(2) Describe how you will fulfill the scope of work described in this RFP. Attach a project plan that includes start-up and fully staffed profiles, implementation activities, and timelines for full capacity within 90 days.
(3) If you will be subcontracting part of the services to another entity or entities, list all of the intended subcontractors and indicate the services they will be providing. Submit with your proposal Letters of Agreement with each of the stated subcontractors.

(4) Describe your experience and commitment to youth participation principles and how you will involve the diverse ethnic/racial and cultural groups of the community served, youth/young adults and those from the LGBTQ+ community in service planning and delivery. List any collaborations with other community-based organizations or other resources.

(5) Describe how you will engage the target population and any stipends/incentives you will use to encourage participation in the services you will provide. If providing a stipend, include the amount and from of payment (gift card, etc.) per participant.

E. Staffing Patterns and Training

(1) Describe your plan for staff training and supervision, specific for each service stream, that includes supervision responsibilities, expected training hours per staff per year, how staffing shortages will be addressed so that there is no interruption in service delivery, and a training program that includes at a minimum the following topics:

- allcove™ Model Integrity
- Anti-sexual harassment training
- Staff Onboarding to allcove™ model – at date of hire
- Suicide Risk & Assessment
- Law and Ethics
- Youth Cultural and Identity Issues
- Youth Engagement and Participation Strategies
- Shared decision making
- Informed Consent
- Crisis Intervention
- Mandated reporter training
- Blood-borne pathogens training
- allcove™ datacove™ training
- Confidentiality
- HIPAA
- Compliance
- Fraud, Waste, and Abuse
- Critical Incident Management
- Sexual Orientation and Gender Identity (SOGI)
- Interpreter training (if using interpreter services)
- Training for allcove™ team about peer support role and scope of work

(2) Include resumés for each individual that would be assigned to provide services requested by this RFP. Resumés must include at a minimum: date and name of educational institutions for any applicable degrees, additional applicable training, any professional certifications and/or licensing, and relatable work experience.

F. Cultural Responsiveness and Customer Service

(1) Describe youth engagement practices and your experience on implementing a strength-based youth environment.

(2) Provide a statement of the anticipated length of time it will take to begin service delivery after a referral (including walk-ins) has been received.

(3) Explain your resolution process for problems that may arise in daily operations, how you handle client grievances, and the process by which you report and resolve critical incidents (i.e. sudden illness, accidents, bullying or aggression involving allcove™ clients; and on-site

substance use). Indicate who is informed or involved in any of the aforementioned situations.

(4) Describe the language capacity within your organization and the availability of interpreter services if any.

(5) Include your organization's plan for providing culturally appropriate services. Attach your cultural competency plan if available. If there is no formal cultural competency plan, then include a description of the following: a) policies and practices that promote diversity, cultural humility and inclusion; b) formal forums or venues for discussing relevant issues; c) how demographic data will be collected and utilized; d) staffing objectives that reflect the diversity of the community served; and e) a relevant training plan for staff.

G. Quality Evaluation and Improvement

Although all providers of the allcove™ center service components will be required learn how to use the datacove™ tool to collect data as directed by the allcove™ data management partner, please include the following information:

(1) Describe the Quality Improvement plan. The plan should include a description of how you conduct ongoing assessment of community need and data review to inform culturally responsive program activities, continuous quality improvement activities, utilization review, peer review, and other issues pertaining to quality improvement mandates and policies.
(2) Describe your process for staff background checks, and the credentialing/licensing process for professional staff if applicable.
(3) Describe the measurements/metrics/deliverables/assessments or other tools that you currently use to evaluate quality of service provision and program impact.
(4) A commitment to participate in the common allcove™ evaluation

H. Claims, Licensure, Non-Discrimination, and Health Insurance Portability and Accountability Act (HIPAA) Violations Against Your Organization

Include claims or violations in which the health and well-being of our clients was compromised, if there was a misappropriation of funds, if there was fraud of any kind, or if there was a claim/violation in regards to an illegal activity. In addition, include any claims or violations that involve the services indicated in the RFP. Please go back 5 years in your report of claims or violations and explain how you respond or address claims or violations when they are made.

List any violations that resulted in claims or legal judgments against you or your agency, especially any of the following:

(1) Current licensure restriction, censure or revocation;
(2) Health Insurance Portability and Accountability Act (HIPAA) violation;
(3) Non-discrimination claims against you/your organization;
(4) Claims/violations which compromised the health and well-being of our clients;
(5) Claims/violations regarding an illegal act;
(6) Misappropriations of funds;
(7) Fraud of any kind.

I. Proof of Insurance

(1) Provide a copy of the insurance certificate as proof of insurance.

(2) Such insurance shall be combined single limit bodily injury and property damage for each occurrence and shall not be less than the amounts specified below:

a. Comprehensive General Liability………. $2,000,000
b. Professional Liability……………………….. $2,000,000 if appropriate
c. Auto Liability……………………………………. $2,000,000 if appropriate
d. Employers' Liability…………………………. $2,000,000 if appropriate
e. Workers' Compensation………………… full statutory overage – if provider has employees

J. Cost Analysis/Budget

The allcove™ Youth Drop-In Center is funded by MHSA Innovation dollars allowing for an initial 4 years of funding for implementation, evaluation and on-going program improvement and best practices. Sustainability planning is a critical component of the allcove™ model and the Coordinating Agency will develop a plan for on-going financial sustainability of the allcove™ Youth Drop-In Center for when grant funding has expired. Specifically, the Coordinating Agency is expected to:

- Engage PHCD Director of Youth Behavioral Programs to develop sustainability framework.
- Engage the Advisory Group regularly to inform sustainability planning.
- Engage fundraising/grant writing consultants to develop a sustainability plan.
- Submit a final sustainability plan by Year 3 of the project.
- Be fully self-sustaining by the close of Year 4.

The following items must accompany your proposal:

(1) Submit a budget for the proposed services using Appendix 1: Budget Template or your own format. This should be a simple budget that only includes staffing and associated costs.
(2) Provide a detailed explanation/narrative for long-term financial sustainability beyond grant funding. Describe what sources of funding you plan to pursue, such as: MediCal reimbursement, local funding options, private funding, fundraising activities or other grants, etc. This is not intended to be a final sustainability plan, but rather will demonstrate your thought process for the long-term continuance of services.
(3) Provide the latest financial audit your agency has completed. If you have not been audited in the last three years, provide three years of financial statements.

K. References and Letters of Recommendation

(1) List at least three business references for which you have recently provided similar services. Include contact names, titles, phone numbers and e-mail addresses for all references provided. Ensure that contact information is current. If the PHCD cannot contact the reference because of incorrect or out-of-date information, the reference will be deemed not to have been provided.

(1) If you choose to use references from clients or family members (which is not required), you must obtain written consent to use their information and the clients and/or family members must be informed that their information will be made public. Provide a statement indicating that you have complied with this requirement for the client/family references you include.

(2) Attach any relevant letters of recommendation that you consider useful in determining your success with building community collaborations and service delivery. Limit the letters to no more than 5 including at least 2 letters from your youth community.

L. Statement of Compliance with Contractual Requirements
A sample of the PHCD's standard contract and administrative requirements (Exhibits A and B) is attached to this RFP. Each proposal must include a statement of the proposer's commitment and ability to comply with each of the terms of the PHCD's standard contract.

In addition, the proposer should include a statement that it will agree to have any disputes regarding the contract venued in San Mateo County or Northern District of California. The proposal must state any objections to any terms in the PHCD's contract template and provide an explanation for the inability to comply with the required term(s). If no objections are stated, the PHCD will assume the proposer is prepared to sign the PHCD standard contract template as-is.

NOTE: The sample Standard Contract Template enclosed with this RFP is a template and does not constitute the final agreement to be prepared for the selected service provider. Do not insert any information or attempt to complete the enclosed sample contract template. Once a provider is selected, the PHCD will work with the selected provider to draft a provider-specific contract using the template. However, each proposal should address the general terms of the standard contract as requested within this RFP.

3.3 PROPOSAL FORMAT REQUIREMENTS

A. Proposal Format

Proposals in response to this RFP should be typewritten or prepared on a computer and have consecutively numbered pages and include the information and format requested in Section 3.2 Responding to the RFP. Proposals will be in Arial 12-point font, 1" margins, and 1.15 line spacing. The entire proposal should not exceed 20 pages, not including attachments, exhibits or charts.

Number all pages of the proposal. Label and order each section as follows:

(1) Cover letter - no longer than one page, signed by an individual authorized to execute legal documents for the proposer, identifying the materials submitted. Identify the name, title and contact information for the person authorized to represent the organization during the RFP process and contract negotiations.

(2) Board, or governing body, authorization letter or resolution granting permission to the authorized person to submit the proposal.

(3) Table of Contents: list all major topics and their respective page numbers.

(4) Proposal Sections, divided by tabs, the content shall be in the following order:

a. Qualifications and Experience

b. Philosophy and Service Model

c. Staffing Patterns and Training

d. Cultural Responsiveness and Customer Service

e. Quality Evaluation and Improvement

f. Cost Analysis/Budget

g. Claims and/or Violations

h. Proof of Insurance

i. References/Letters of Recommendation

j. Letters of Recommendation

k. Attestation Statement of Compliance with PHCD RFP and contractual requirements

l. Exceptions to the solicitation, or to the final revised solicitation, if any

m. Supplementary Documents, as requested

B. Proposal Content

(1) Explain responses so as to be understood by people unfamiliar with industry jargon. Use drawings, diagrams, schematics and illustrations as needed, but do not simply refer readers to an exhibit or other section of the proposal in lieu of a complete response.

(2) Addressing each requirement outlined in this solicitation in the order presented, describe how the requested goods and services will be provided.

(3) If applicable or requested, include a project schedule with milestones, deliverables, dates, and a project management plan.

(4) Specify any needs for physical space or equipment that the PHCD must provide during the engagement.

(5) Explain how work, equipment, and knowledge will be transitioned to the PHCD or a new vendor at the end of the contract period.

C. Supplementary Documents

If additional documents and materials are appropriate, or have been requested by the PHCD, provide in the following order as applicable:

(1) Minimum Qualifications, using PHCD forms if provided.

(2) Organizational Capacity and Experience, describing work of a similar nature undertaken for a similar entity.

(3) Financial Documents.

(4) Samples, drawings, illustrations and related items.

(5) Attachments, certifications, and forms, executed as applicable.

D. Budget Proposal

(1) A form and/or template may be provided for the Budget Proposal, include all cost and pricing data. Respondents may use their own form or template, as long as the required budget information is included.

(2) Include explanation/narratives as directed.

(3) Include latest financial audit.

3.4 PROPOSAL SUBMISSION

A. Submitting Proposals

Submit proposals as directed below. All components must be received by the designated due date and time to be considered.

(1) Electronic Submissions

Include the proposer name and the RFP title and number in each filename. Submit electronic proposals via the PHCD DropBox upload link: rb.gy/l0ebm4. Proposers can also choose put their electronic version of the proposal onto a USB Flash drive and include the drive with the hard copies sent to PHCD.

(2) Hard copy submissions

(a) Submit seven (7) hard copies of the proposal. Submit proposal copies with all required documents in a sealed package to the designated PHCD Mailing Address. Within the package, proposal documents must be in the order requested in this RFP. Clearly mark the following information on the outside of the package:

- Proposer Name
- Return address
- Solicitation title
- Solicitation number

(b) Submit proposals and all required documentation so as to physically reach the designated address by the Due Date and Time.

(3) Hand-written responses, whether or not submitted electronically, will be rejected, with the exception that signatures may be hand-written.

(4) Submissions are considered to be complete only after all the copies are received (1 electronic and 7 hard copies of the proposal).

B. Errors in Proposals

PHCD will not be liable for any errors in proposals. Proposals may be rejected as unresponsive if they are incomplete, are missing pages or information, or cannot be opened for any reason. PHCD may waive minor irregularities but such waiver will not modify any remaining RFP requirements.

3.5 PROPOSER CERTIFICATIONS

By submitting a proposal, each proposer certifies under penalty of perjury that:

- Its submission is not the result of collusion or any other activity that would tend to directly or indirectly influence the selection process; and
- Proposer is able or will be able to comply with all requirements of this solicitation at the time of contract award; and
- Neither proposer, its employees, nor any affiliated firm providing the requested goods and services has prepared plans, specifications, terms or requirements for this solicitation, or has any other actual or potential conflict of interest; and
- Proposer is aware of the provisions of Section 1090 et seq. and Section 87100 et seq. of the California Government Code relating to conflict of interest of public officers and employees, and is

unaware of any financial or economic interest of any PHCD officer or employee relating to this solicitation.

3.6 WITHDRAWAL OF PROPOSALS

Proposals may be withdrawn, modified, or replaced at any time prior to the Due Date and Time. After that time, whether or not a new solicitation is issued for the same subject matter, withdrawal of a proposal may preclude the proposer from participating in the procurement as a proposer or subcontractor, except that an original equipment manufacturer may participate indirectly through a reseller.

3.7 NO COMMITMENT

Neither submission of a proposal nor the PHCD's receipt of proposal materials confers any right to the proposer nor any obligation on the PHCD. This RFP does not commit PHCD to award a contract, nor will the PHCD defray any costs incurred in preparing proposals or participating in any presentations or negotiations.

3.8 ESTIMATED QUANTITIES

If the solicitation results in an indefinite quantity or a requirements Agreement, the goods and services actually requested by the PHCD may be less than the maximum value of the Agreement and there is no guarantee, either expressed or implied, as to the actual quantity of goods and services that will be authorized under the Agreement.

3.9 PROPOSER SELECTION

At any time in the evaluation process, the PHCD may request clarifications from proposers.

A. Determination of Responsiveness

A responsive proposal conforms to the instructions set forth in this solicitation and any modifications to it. Non-responsive proposals will be rejected. PHCD, in its sole discretion, may waive non-consequential deviations if the deviations cannot have provided an advantage over other proposers.

B. Proposal Evaluation

PHCD will establish an evaluation committee which will evaluate responsive proposals based on the criteria specified in the solicitation. The committee may then recommend one or more top-ranked proposers for final negotiation of contract terms, or may invite one or more proposers for oral presentations and demonstrations, following which those proposers may be allowed to amend their proposals. After evaluating presentations and amended proposals, the committee may recommend one or more top-ranked proposers for final negotiation of contract terms.

C. Determination of Responsibility

The PHCD will make a determination of the responsibility of any proposer under consideration for award, taking into consideration matters such as the proposer's integrity, compliance with public policy and laws, past performance, fiscal responsibility, trustworthiness, financial and technical resources, capacity, and experience to satisfactorily carry out its responsibilities. The PHCD will notify any proposer found non-responsible and allow the finding to be contested.

3.10 CONTRACT AWARD

A. Notice of Intent to Award

Once a decision has been made to award a contract to one or more proposers, PHCD will post a Notice of Intent to Award, on their website: https://peninsulahealthcaredistrict.org/, and send notification to proposers via email as well as through U.S. mail notifying to the selected proposer as well as the remaining proposers of their non-selection. The posting may be inclusion of the recommendation to award as an agenda item on the Board of Director's schedule.

B. Award Procedure

Contract negotiations are neither an offer nor an implicit guarantee that a contract will be executed. Award, if made, will be to the responsive, responsible proposer offering the overall best value to PHCD for the services and goods described in this solicitation, or as applicable, for a specific portion of the services and goods described. Any agreement reached will be memorialized in a formal agreement using the attached Standard Agreement template. PHCD Board approval of the agreement is required.

C. Commencement of Performance

After all parties have signed the Agreement, PHCD will notify the proposer and performance may proceed. Prior to PHCD execution of the Agreement, no PHCD employee may authorize work. Any work performed prior to that time may be uncompensated.

3.11 PUBLIC RECORDS

A. General

(1) All proposals, protests, and information submitted in response to this solicitation will become the property of PHCD and will be considered public records. As such, they may be subject to public review.

(2) Any contract arising from this RFP will be a public record.

(3) Submission of any materials in response to this RFP constitutes:

- (a) Consent to the PHCD's release of such materials under the Public Records Act without notice to the person or entity submitting the materials; and
- (b) Waiver of all claims against PHCD and/or its officers, agents, or employees that PHCD has violated a proposer's right to privacy, disclosed trade secrets, or caused any damage by allowing the proposal or materials to be inspected; and
- (c) Agreement to indemnify and hold harmless PHCD for release of such information under the Public Records Act; and
- (d) Acknowledgement that PHCD will not assert any privileges that may exist on behalf of the person or entity submitting the materials.

B. Confidential Information

(1) PHCD is not seeking proprietary information and will not assert any privileges that may exist on behalf of the proposer. Proposers are responsible for asserting any applicable privileges or reasons why a document should not be produced in response to a public record request.

(2) If submitting information protected from disclosure as a trade secret or any other basis, identify each page of such material subject to protection as "CONFIDENTIAL". If requested material has

been designated as confidential, PHCD will attempt to inform the proposer of the public records request in a timely manner to permit assertion of any applicable privileges.

(3) Failure to seek a court order protecting information from disclosure within ten days of PHCD's notice of a request to the proposer will be deemed agreement to disclosure of the information and the proposer agrees to indemnify and hold PHCD harmless for release of such information.

(4) Requests to treat an entire proposal as confidential will be rejected and deemed agreement to PHCD disclosure of the entire proposal and the proposer agrees to indemnify and hold PHCD harmless for release of any information requested.

(5) Trade secrets will only be considered confidential if claimed to be a trade secret when submitted to PHCD, marked as confidential, and compliant with Government Code Section 6254.7.

SECTION IV - MINIMUM QUALIFICATIONS, EXPERIENCE, AND EVALUATION CRITERIA

4.1 MINIMUM QUALIFICATIONS

All proposals received will be evaluated by an RFP Evaluation Committee. During the evaluation process, the PHCD may require a proposer's representative to answer specific questions orally and/or in writing. The PHCD may also require an interview, a visit to the proposer's offices, other field visits or observations by PHCD representatives, or demonstrations as part of the overall RFP evaluation. Once a finalist or group of finalists is selected, additional interactions or information may be required. The most qualified individual or firm will be recommended by the RFP Evaluation Committee based on the overall strength of each proposal, and the evaluation is not restricted to considerations of any single factor such as cost.

Responses to this RFP must adhere to the format for proposals detailed in Section IV.4.4.Evaluation Criteria. The criteria used as a guideline in the evaluation will include, but not be limited to, the following:

A. Minimum Requirements

(1) The proposer has been actively and normally engaged for the past five years in the performance of services described in this solicitation.

(2) Proposal was submitted on time

(3) Cover sheet was included and proposal is signed by an authorized person

(4) Board or governing body authorization letter or resolution was included granting permission to submit the proposal

(5) Staffing structure and qualifications are included

(6) Proposal followed the requested format

(7) Stated compliance with PHCD RFP and contractual requirements

(8) Proof of Insurance

(9) References

(10) Budget

4.2 ORGANIZATIONAL CAPACITY AND EXPERIENCE

Provide all of the following regarding the prime proposer or Coordinating Agency and if applicable, all joint proposers.

A. Organizational Capacity:

(1) Titles and names of staff members who will be on the team responsible for the project, as well as the expected availability of the various individuals. Include the résumés of key dedicated service staff, and the full-time project manager.

(2) All applicable licenses and license numbers relevant to the project, the names of the holders of those licenses, and the names of the agencies issuing the licenses.

(3) If portions of work will be performed by subcontractors, names of proposed subcontractors other than suppliers and descriptions of their respective responsibilities.

B. Experience

(1) The number of years providing services similar to those contemplated

(2) The number of years providing services to public entities

4.3 EVALUATION CRITERIA

Proposals will be evaluated in accordance with the following evaluation criteria:

(1) 45% - Method and approach

(a) History and structure of proposer (experience doing similar services and target population).

(b) Established community collaborations.

(c) Organizational resources are defined and include letters of agreement and/or intent with any subcontractors that will be providing direct services

(d) Philosophy and service model (does their philosophy match the allcove ™ model and support model integrity).

(e) Does the service model meet the allcove ™ program goals.

(f) Is there involvement by consumers, ethnic minorities and LGBTQ+ in the development and planning of services.

(g) Experience with other public agencies

(2) 30% - Staffing, Program Evaluation, Customer Service

(a) Do key personnel have experience delivering similar services to youth and young adults. Resumes included.

(b) Is staffing sufficient to provide services, language capacity among staff, staff training program.

(c) Culturally responsive practices are embedded into service delivery, experience serving diverse populations.

(d) Escalation plan to manage service issues or consumer complaints.

(e) Claims or violations against agency or individual.

(f) Quality evaluation plan, including on-going process to credential licensed or certified staff.

(g) References included were relevant and diverse.

(3) 25% - Budget

(a) Budget indicates funding needs per year and includes a total amount for the projected term of services.

(b) Budget narrative is complete and fully explains/describes a plan for long-term financial sustainability. This is not intended to be a final sustainability plan, but rather will demonstrate the proposer's thought process for the long-term continuance of services

(c) Explanation for costs that are significantly over budget or if start-up costs are requested.

(d) Agency's most recent financial audit.

SECTION V - INSURANCE

At time of contract, insurance certificates shall name as additionally insured PHCD and its officers, directors, employees, and designated volunteers. Insurance coverages provided by the Provider are to be primary and any insurance maintained by PHCD will be secondary and provide that the Provider will indemnify, defend (with counsel reasonably satisfactory to PHCD), and hold PHCD and its officers, directors, employees, and designated volunteers harmless from any claims arising from the services provided including any claims under HIPSS, and claims arising from alleged professional negligence.

Provide evidence of insurance for each of the checked categories

☒	**General Liability** (Including operations, products and completed operations, as applicable.)	**$2,000,000** - per occurrence for bodily injury, personal injury and property damage. If Commercial General Liability Insurance or other form with a general aggregate limit is used, the general aggregate limit either must apply separately to this project or must be twice the required occurrence limit.
☒	**Automobile Liability**	**$2,000,000** - per accident for bodily injury and property damage.
☒	**Workers' Compensation**	**As required by the State of California** and if the provider has one or more employees
☒	**Employers' Liability**	**$2,000,000** - each accident, **$2,000,000** policy limit bodily injury by disease, **$2,000,000** each employee bodily injury by disease.
☒	**Professional Liability** (Errors and Omissions)	**$2,000,000** - per occurrence.

5.1 SPECIAL INSURANCE REQUIREMENTS

If the work involves services or goods related to computers, networks, systems, storage, or access to PHCD Data or to any data that may, alone or in combination with other data, become Confidential Information or Personally Identifiable Information, the following insurance is required.

(1) Privacy and Network Security

During the term of the Contract and for three years thereafter, maintain coverage for liability and remediation arising out of unauthorized use of or access to PHCD Data or software within Contractor's network or control. Provide coverage for liability claims, computer theft, extortion, network breach, service denial, introduction of malicious code, loss of Confidential Information, or any unintentional act, error, or omission made by users of Contractor's electronic data or systems while providing services to the PHCD. The insurance policy must include coverage for regulatory and PCI fines and penalties, crisis management expenses, and business interruption. No exclusion/restriction for unencrypted portable devices/media may be on the policy.

(2) Technology Errors and Omissions

During the term of the Contract and for three years thereafter, maintain coverage for liabilities arising from errors, omissions, or negligent acts in rendering or failing to render computer or information technology services and technology products, including at a minimum, coverage for systems analysis, design, development, integration, modification, maintenance, repair, management, or outsourcing any of the foregoing.

SECTION VI - ATTACHMENTS

6.1 STANDARD TERMS AND CONDITIONS

Enclosure 1: PHCD Standard Contract Boilerplate Template and Enclosure 2: PHCD Standard Agreement Administrative Requirements are attached for review. Do not complete these forms. The final agreement between PHCD and any successful proposer will be based on these templates.

6.2 ATTACHMENTS AND ENCLOSURES

Attachment I: allcove™ - A bold, new strategy for youth mental health

Attachment II: Model Integrity Overview

Attachment III: Model Integrity Guide

Attachment IV: Evaluation At-A-Glance.

Appendix 1: Budget Template

Enclosure 1: PHCD Standard Contract Boilerplate Template

Enclosure 2: PHCD Standard Agreement Administrative Requirements

Enclosure 3: HIPAA Requirements

Enclosure 4: Fingerprinting Certification

Enclosure 5: Attachment I – 504 Compliance Form

allcove:

A bold, new strategy for youth mental health

allcove

The allcove model, inspired by successful international models in Australia, Canada, and Ireland, creates stand-alone, "one-stop-shop" health centers for young people ages 12 to 25 to access support for mild to moderate mental health needs, physical health, substance use, peer support, supported education and employment, and family support. allcove approaches youth wellness in a comprehensive and youth-friendly way, led by members of an active local Youth Advisory Group and Community Consortium to design the services and environment they most want to see in their community. Through innovative, evidence-based approaches, allcove centers have the flexibility to reflect the unique youth and young adult culture of each geographic community being served and fill a critical gap in the spectrum of youth mental health and wellness services.

Increasing need: A mental health crisis facing American youth

Data show American youth are suffering and have been struggling even prior to the onset of the COVID-19 pandemic. According to the National Center for Health Statistics (NCHS), the rate of suicide among those aged 10 to 24 increased nearly 60% between 2007 and 2017. Between 2007 and 2013, the suicide rate for young people grew at an average rate of 3% per year but between 2013 and 2017, that number shot up to 7% per year. For children aged 10 to 14, the suicide rate tripled between 2007 and 2017, after years of decline (Curtin & Heron, 2019). According to the Centers for Disease Control and Prevention, more students experienced persistent feelings of sadness or hopelessness from 2009 through 2019, regardless of race/ethnicity; and more than 1 in 3 students and almost half of female students reported persistent feelings of sadness or hopelessness in 2019. Looking at the period after COVID-19, there was a greater than 50% increase in suspected suicide attempt emergency department visits among girls ages 12 to 17 in the beginning of 2021 as compared to the same period in 2019 (Yard et al., 2021). Suicide is now the second-leading cause of death for people ages 10 to 24 (The American Association of Suicidology, 2021).

The status of youth mental health appears to be approaching a breaking point. In October 2021, three leading children's health organizations declared a National State of Emergency in Children's Mental Health and in December 2021, U.S. Surgeon General Vivek Murthy issued a National Advisory on the youth mental health crisis. This alarming increase in distress is not attributed to one exclusive stressor. Rather, climate change, racism, gun violence, income inequality, and charged political discussions (i.e., immigration, LGBTQ+ topics) that have a direct impact on an individual's future are but a few factors that contribute to increased levels of chronic stress among youth, which in turn can lead to anxiety and/or depression. Evidence shows that income inequality alone is linked to higher rates of mental health difficulties (Wilkinson & Pickett, 2009). In addition, LGBTQ+, maltreated, runaway, and unhoused youth are at a disproportionately high risk for depression, suicidal ideation, suicide, and self-harming behaviors (Cohen & Bosk, 2020). Successfully identifying and treating mental health issues that youth and young adults are facing is key to ensuring their lifelong emotional and mental wellbeing.

The COVID-19 pandemic has exacerbated the mental health crisis among young people. Feelings of isolation and hopelessness, reduced access to friends, disruptions to school, economic instability, lack of access to resources, stigma, and hopelessness are all factors that fuel the current youth mental health crisis. Many young people have also grieved the loss of connection, key life milestones, and friends/family during the pandemic. For some youth, home can be isolating, and for others, dangerous. Adverse

childhood experiences, including physical abuse, sexual abuse, and neglect are commonplace, with an estimated 656,000 children and adolescents experiencing maltreatment in 2019 (U.S. Department of Health & Human Services, 2021). Stay-at-home requirements unfortunately limit youth's access to mandated reporters, and consequently, the maltreatment that youth experience can go unnoticed (Cohen & Bosk, 2020). The pandemic has been especially challenging for marginalized communities, such as LGBTQ+ youth. In a survey collected by the Trevor Project, 70% of LGBTQ+ youth stated that during COVID-19, their mental health was "poor" most of the time or always, and 42% of LGBTQ+ youth, including more than half of transgender and nonbinary youth, reported that they seriously considered attempting suicide in the past year.

Throughout the pandemic, anxiety, depression, sleep disruptions, and thoughts of suicide have increased for many young adults. In a 2021 study conducted by the Kaiser Family Foundation, results suggested that approximately 56% of young adults ages 18 to 24 reported symptoms of anxiety and/or depressive disorder. These factors, combined with the already challenging transition from adolescence to adulthood, can prove even more difficult for youth with pre-existing mental health risks.

The dominant presence of social media in the lives of young people is another factor that appears to be influencing their mental health. Social media offers an important source of connection, entertainment, and emotional support for youth. On the flip side, exposure to online risks such as bullying, hate speech, graphic content, and unrealistic body images can degrade mental health, with risks seemingly higher for more vulnerable populations, including those in the LGBTQ+ community, youth of color, and those susceptible to self-harm and/or disordered eating. The amount of time spent in front of screens doubled during the pandemic, as did the volume of hate speech youth reported being exposed to (Rideout et al., 2021). Efforts to reduce these harms have been slow and ineffective to date, leaving many young people to navigate these difficult challenges on their own.

A statement released by the White House on the date of President Biden's first State of the Union address highlighted the dire state of mental health in the Nation and proposed priority areas, such as connecting Americans to care through the integration of mental health and substance use services in community-based settings and developing the peer workforce. While we have long known that half of all lifetime cases of mental illness have their onset by the age of 14 (Kessler, 2005), our country has never made the commitment to create the public mental health system our children and families have sorely needed. Even now, when it is clear that successfully identifying and treating mental health issues that youth and young adults are facing is key to fostering their lifelong emotional and mental wellbeing, the current U.S. health system poses many barriers for youth to access the help they need. Spaces that encourage youth voice, establish a safe environment which respects an individual's gender identity and sexual orientation, and ultimately increase youth's accessibility to clinical services and counseling are essential to supporting this vulnerable population.

Fragmentation and barriers to access

Because of its whole person approach, the allcove model holds the potential to have a significant positive impact on young people's mental health and wellbeing. As an integrated service, allcove addresses the overlapping needs of young people, whether through providing vocational support, reducing mental health distress, or initiating conversations with a peer specialist that may lead to an appointment with an addiction specialist. allcove's model structure is aligned with many of the key principles outlined in the California Department of Health Care Services' Framework for a Core Continuum of Care, including offering locally tailored, culturally responsive, prevention and early intervention focused, community-based, whole person care. This 'no wrong door' approach supports the realities of young people's lives and encircles them with broad support in one setting.

Unfortunately, the structure of California's existing mental health care system does not operate holistically, and for the most part, centers linking primary care and mental health care for youth via an integrated approach are rare. For both publicly and commercially insured youth, California lacks a systematic early intervention approach for youth mental health at a public health level. Instead, the youth-serving mental health system is highly fragmented and disparate, organized around numerous eligibility requirements, including age, diagnosis, severity, county of residence, insurance coverage, and income. Financial pre-authorization and reimbursement through Medi-Cal and private insurance are also based on these fragmented criteria, which present additional challenges to the sustainability of an integrated program such as allcove. The potential for realigning payment structures, which is currently under consideration with CalAIM and other structures being developed across California, would better support more holistic, integrated care models such as allcove, creating much needed advancement within our systems of care and the ability to meet the ever-pressing healthcare needs of young people. If financial sustainability can be achieved and allcove is able to fill this critical gap, linkages to more intensive services when needs are identified will also be more rapidly and easily available.

A new model to meet the moment: allcove

The first of its kind in the U.S., the allcove model is a network of integrated youth mental health centers designed with, by, and for youth that reduce stigma, embrace mental wellness, increase community connection, and provide access to culturally-responsive services. Modeled after successful international models such as headspace in Australia, Foundry in British Columbia, and Jigsaw in Ireland, allcove centers are embedded within the communities they serve and reflect the unique needs of local youth. allcove services include mental and physical health, substance use, peer support, supported education and employment, and family support.

The allcove approach creates a network of community-based centers where young people ages 12 to 25 can access a range of emotional, physical, and social services - all on their own terms. The centers engage youth through direct-to-youth marketing strategies, help detect, prevent, and treat mild to moderate mental health needs, and connect young people to their local community behavioral health system for more intensive interventions. Developed by Stanford's Center for Youth Mental Health and Wellbeing within the Department of Psychiatry and Behavioral Sciences at the Stanford University School of Medicine, allcove envisions revolutionizing mental health care for young people across the United States by making early intervention services easily accessible, welcoming, and culturally responsive through a network of allcove centers. A summary and diagram of the core allcove model components can be found in Appendix A.

On June 25, 2021, with the central involvement of the centers' Youth Advisory Groups and partners, the allcove centers in Palo Alto and San José opened. Led by the County of Santa Cara Behavioral Health Services Department and partner agencies Alum Rock Counseling Center, Santa Clara County Valley Medical Center, and the Stanford Center for Youth Mental Health and Wellbeing, these centers have led the way for the nascent creation of an allcove center network across California communities.

Supported in part by the California Mental Health Services Oversight and Accountability Commission, five additional communities are currently establishing allcove centers in Sacramento, the Beach Cities and Peninsula Health Care Districts, Los Angeles, and Orange County. The Central allcove Team also supports the grassroots planning and organizing of coalitions who are committed to the development of an allcove center in their communities, such as the Santa Barbara coalition led by the Santa Barbara Neighborhood Clinic and many others still in the scoping phase.

Each center has a Youth Advisory Group (YAG), infusing the critical component of youth voice across the allcove model, as well as within each community center. Each center's YAG, which represents the diversity and lived experiences of the community, is involved in the hiring process for new staff, training and evaluation, determining which groups and services might best meet their community's needs, and assisting with outreach and design of services and spaces. Guided by a vision where "every youth belongs, chooses the support they need and thrives," the allcove model is designed to create meaningful, positive experiences for every person who comes to a center.

In addition, each center establishes a Community Consortium, which provides a formal mechanism to build a collaborative platform of local individuals and organizations who have a vested interest in supporting the health and wellbeing of young people in the community. The Community Consortium provides strategic advice to the center and ensures that it is embedded in the local youth-servicing system to better support the many needs of young people and their families.

The Central allcove Team (CaT) at Stanford's Center provides implementation support, training, resources, evaluation, and model infrastructure for all communities who are implementing allcove. This oversight is described by McGorry et al. as a critical success factor in ensuring model fidelity through service establishment reviews, continuous monitoring and quality improvement, and a licensing of a common brand to prevent erosion of the evidence-based aspects of care (McGorry et al., 2022). The Central allcove Team collaborates with international partners who represent networks of integrated youth mental health services worldwide. Joint projects include developing a common minimum data set and data collection system with Foundry in British Columbia, and other Canadian partners; planning opportunities to share knowledge with providers in low to medium resource countries through the World Economic Forum and Orygen Global's Global Framework for Youth Mental Health pilot initiative; and interfacing with other established networks of providers, such as headspace in Australia and Jigsaw in Ireland, to share expertise and leverage existing models and approaches.

A blend of best practice approaches

The U.S. Surgeon General's December 2021 Advisory suggests that communities take the following steps to support youth mental health, all of which can be achieved through allcove:

- Educate the public about the importance of mental health, and reduce negative stereotypes, bias, and stigma around mental illness.
- Implement evidence-based programs that promote healthy development, support children, youth, and their families, and increase their resilience.
- Ensure that programs rigorously evaluate mental health-related outcomes.
- Address the unique mental health needs of at-risk youth, such as racial and ethnic minorities, LGBTQ+ youth, and youth with disabilities.
- Elevate the voices of children, young people, and their families.

allcove is anchored in a model of care that considers the holistic needs of young people. It blends several best practices to create a strong, youth-directed set of services that are well-positioned to meet the needs of youth. Early intervention works; yet too often, mental health care is only available to those who are in crisis. Through its robust integrated care model, allcove is creating a culture that encourages young people to come to a place where they can feel comfortable accessing an array of early supports, get help before reaching a point of crisis, and gain both the skills and a community in which to thrive, both as young people and into their adult lives. Fundamental best practices woven into the allcove model include:

Integrated care

Integrated youth services provide a holistic approach to care that promotes better coordination and access to services. They typically focus on early intervention and integrate a youth-friendly physical space, care coordination, brief therapy, services including physical health, mental health, and social services, and connections with community-based partners and technological supports (Settipani et al., 2019). Overall, the purpose of integrated youth services is to establish highly accessible and youth-friendly centers designed to meet the unique needs of youth in a multidisciplinary system with close connections to local specialist services and community organizations (Rickwood et al., 2017). A description of the level of service integration allcove strives for is in Appendix B.

One element that separates integrated youth mental health centers, like allcove, from other community resources, is the accessibility and availability of a range of resources in one, youth-friendly location. These centers provide various clinical services, support for school and employment, peer counseling and more, all while in a space that is designed with and for youth, with service providers who are trained and motivated to respond to the unique challenges of this age group. Due to the complex patterns of symptomatology that are sometimes characteristic of the youth and young adult population, providing youth-specific services are essential to meeting their needs. By curating an environment that is stigma-free and provides youth with a soft entry to care, young people are more likely to access services and remain engaged throughout the process.

To effectively respond to the diversity and complexity of needs among young people, a multilayered approach to care is required, where different service levels have the capacity to manage the high volume of presentations and full spectrum of need. allcove provides a range of holistic, integrated care services and linkages to services for higher severity when necessary. These centers are not designed to be a substitute for existing primary care services, but rather, to complement the rest of the healthcare system. In their review of early intervention models for youth, Colizzi et al. (2020) assert that the evidence suggests that health professionals, service providers, and policymakers must "join forces to deliver integrated and multidisciplinary actions in mental health, especially in the early steps of the prevention chain" (Paragraph 35).

By providing a space that offers both mental and physical health services, youth are likely to feel less stigma and better equipped to understand and utilize the intersection of physical and mental health. According to an independent evaluation of headspace, physical health services were popular among young people that accessed the service, with 62% of the young people surveyed reporting improved physical health since using the service (Muir et al., 2009). Additionally, both clinicians and young people reported that it was extremely useful to have medical and counseling services co-located, as this not only encouraged young people to seek help, but also increased the likelihood that they would follow the medical advice they were given.

The benefits of integrated service models are additionally supported by a systematic meta-analysis that examined 31 randomized clinical trials looking at the health outcomes of youth who accessed care in primary care settings. The study found a 66% probability that a randomly selected youth would have a better outcome after receiving integrated medical-behavioral treatment compared to a randomly selected youth receiving usual care. The strongest effects were observed for treatment interventions that targeted mental health (BC-IYSI Working Group, 2015). These studies provide further evidence of the favorable outcomes for the implementation of integrated youth mental health services.

Upstream, early intervention services

As stated previously, 50% of mental disorders first emerge by the age of fourteen and 75% by age twenty-four (Kessler et al., 2005). Yet most are not treated within the first several years after onset, leading to costly personal and societal outcomes. While some cases of mental illness are transitory, those

that emerge early in life can commonly follow a course that is characterized by chronicity and multiple episodes of relapse (Gibb et al., 2010). This painful reality can be associated with a range of adverse outcomes that include premature death, social isolation, poor functioning, and poor educational and vocational productivity (Gibb et al., 2010; Walker et al., 2015). According to Radez et al. (2021), "untreated mental health disorders in children and adolescents are related to adverse health, academic and social outcomes, higher levels of drug abuse, self-harm and suicidal behavior and often persist into adulthood…creating a substantial global socioeconomic burden" (Paragraph 2). This burden could be alleviated through provision of early intervention services targeting this vulnerable age group. Colizzi et al. (2020) illustrate the evidence-based rationale for this developmental phase being a critical intervention period:

- Mental health is a core component influencing one's ability to function in life and will have effects on academic, social, behavioral, and professional achievements in adulthood.
- The adolescent brain is vulnerable due to its neurodevelopmental changes.
- Mental health disorders are the main cause of disability-adjusted-life-years (DALYs) for youth, accounting for 45% of the global burden of disease.
- People under age 25 years report the greatest delay to initial treatment from onset of symptoms.
- Many traditional mental health services have proven ineffective in reaching the youth population with necessary and appropriate care.

When youth ultimately decide to contact professional services, their first contact is most likely to occur through their general primary care provider (Lawrence et al., 2015). Yet many young people are reluctant to discuss emotional concerns with their general practitioner (Purcell et al., 2011). And while general primary care providers are an essential resource that connect youth with specialized services, including mental health care, simply providing youth with a referral is insufficient. Youth are less likely to follow through on referrals without an adult that is engaged in the process, which increases the risk of youth not accessing necessary services (The National Child Traumatic Stress Network, 2000). Creating a highly accessible and engaging entry point to care, like allcove, can enable positive outcomes by addressing mental health needs early, altering their course before they intensify.

In their 2021 position statement encouraging early identification of mental health issues in young people, Mental Health America states that "early identification, accurate diagnosis, and effective treatment of mental health and substance use conditions can alleviate enormous suffering for young people and their families dealing with behavioral health challenges. Providing early care can help young people to more quickly recover and benefit from their education, to develop positive relationships, to gain access to employment, and ultimately to lead more meaningful and productive lives" (Paragraph 1). Studies have shown that there is compelling evidence that the course and functional impacts of even the most serious forms of mental illness can be positively altered through early intervention (Correll et al., 2018; Killackey et al., 2019). Young people face various obstacles to accessing mental health care, consisting of individual (i.e., cultural stigma, extreme self-reliance) and service-level barriers (i.e., insurance, lack of resources available within the community, etc.). One commonly reported barrier was not perceiving a problem as serious enough and waiting for the problem to improve on its own – an ineffective approach which the availability of youth-focused early intervention services could help alter (Radez et al., 2021).

Youth engagement, participation and development

The voices of young people continue to be crucial in the advocacy and design of youth-friendly spaces. When organizations and centers delegate resources to involve youth in the development process, all parties benefit in this exchange. Youth can more confidently access these spaces during moments of distress, and providers are given an inside understanding of the unique challenges and experiences of

youth as they navigate the world. Improving the youth friendliness of mental health and substance use services includes incorporating youth voice in organization, policy, environment, service providers, and treatment services, and has implications for treatment uptake, engagement and satisfaction (Hawke et al., 2019).

Youth engagement

Satisfaction with mental health services can influence young people's engagement with mental health services and outcomes (Aguirre et al., 2020). Promoting youth engagement in mental health and substance use prevention and treatment interventions can result in greater health outcomes for youth (Dunne et al., 2017). In a study that evaluated 40 reports focused on youth engagement in mental health and substance use interventions, factors that improved rates of engagement in program development included:

- Focusing on resilience rather than vulnerabilities.
- Creating a welcoming and non-judgmental space.
- Using staff with life experiences like targeted youth.
- Having participating youth work directly with targeted youth.
- Having flexibility in eligible age groups, hours of operation, and the mandatory requirements of youth (Dunne et al., 2017).

McGorry et. al (2022) make the case for why a "broad-spectrum" youth-focused approach is more appropriate for reaching this population than traditional systems; describing how they need to be "co-designed, accessible, with 'soft entry' (i.e., no or very low barriers to entry), community-based, non-judgmental and non-stigmatizing, where young people feel comfortable and have a sense of trust" (Paragraph 31).

Overall, youth engagement in health interventions is related to improved, targeted outcomes of treatment programs. The integration of services for comorbid mental health and substance use conditions in the form of increased collaboration among providers has also been shown to improve engagement in prevention and treatment programs through increased retention.

Youth participation

Youth participation in mental health settings is fundamental to service design and delivery and provides mutual benefit to both young people as well as the organization. The purpose of youth participation, regardless of setting, is to empower and engage young people around issues that are relevant to them. Effective youth participation ensures that young people are incorporated as active valued members of a team and not just engaged in a passive capacity or given token roles (Checkoway, 2011). Encouraging the participation of youth strengthens the personal and social development of young people, and further prepares providers to adequately meet the needs of the youth they serve. In addition, youth are provided with the opportunity to gain skills and a sense of empowerment, as well as make healthy connections with positive role models. To be successful, it is essential for integrated youth mental health centers to promote and encourage youth participation in both service design and delivery.

Youth development

Mental health challenges can significantly affect the development of youth, as this experience can have an enduring impact on their health and social functioning in adulthood (Kowadenko & Culjak, 2018).

Adolescents experiencing mental health conditions may face several challenges such as isolation, stigma, discrimination and difficulty in accessing health services (WHO, 2012). Youth development programs have the potential to improve youth outcomes by supporting them with education, job training, skill development and mentorship. Integrated youth centers create opportunities for youth to gain these crucial skills and providing valuable life skills (i.e., resume writing, interviewing, tax preparation, cooking, computer programming, graphic design, event planning) has the potential to engage or re-engage disconnected youth.

Embedded in and responsive to community

allcove center programming is guided by the model's core principles but retains the ability to be flexible, evolving, and responsive to needs that are identified by youth and/or community members. One of the most important roles of the YAG is to provide voice to the emergent needs of their peers. Their feedback can then be incorporated into outreach activities, partnerships, group programming, and other interventions. Examples could include programming around navigating social media use, specific support around the college or job application process, grief counseling in communities impacted by gun violence or a natural disaster, and culturally-influenced events designed with the intention of reaching a particular cultural or ethnic group in the community.

A critical component of the allcove model is the Community Consortium. The consortium is a strategic partnership that comprises service partners from the local community that work together to offer comprehensive support in a coordinated way for young people aged 12 to 25. The consortium ensures local ownership of services and works to identify strategic priorities related to the quality, safety, and sustainability of the service model and then responds to these priorities through shared action. It is also through the consortium that all five service streams of the allcove model (mental health, physical health, substance use, supported education/employment, and peer support) are delivered. Ideal organizations for consortium membership include primary care practices, public and private mental health organizations, drug and alcohol agencies, vocational and employment service providers, schools, youth, and community and human service agencies. Community Consortium representation from young people, families, and targeted vulnerable populations is also essential.

Harnessing the power of peer support

Youth peer support is a core stream of the allcove model, with peer support specialists playing important functions throughout a young person's care journey. Encouraging peer support roles in youth centers reflects the importance of youth with lived experience supporting other youth who may be experiencing similar challenges. Peer support specialists are often one of the first team members to engage youth accessing an allcove center and play a unique role in helping youth feel welcome through relationship building and providing a "listening space" to explore together what allcove has to offer. Their role extends to community outreach, youth engagement, care coordination, and modeling strategic sharing of personal stories and help-seeking behaviors.

Empowering peers in support of one another is a tremendous opportunity to extend the reach of youth mental health services during this time of great need. And while much of the peer workforce has been focused on recovery from severe mental illness, allcove can define and demonstrate how peer support for mild to moderate mental health needs can be integrated into centers and rolled out on a statewide scale. California's SB 803 was passed in the fall of 2020 to expand the behavioral health workforce by allowing certification of peer support specialists. While the state is now developing a certification process, as nearly all other states have done, the network of allcove centers offers a great opportunity for the development of a unique peer support specialist role for those needing early intervention support in

a less intensive care setting, while also supporting the expansion of the peer support workforce across the state.

allcove: the central community link in the public mental health early intervention continuum of care

Young people continue to face increasing rates of mental health challenges without a service system in place to support their early intervention needs. Given the early onset of mental health conditions in adolescents and young adults, there has been an expanded interest in meeting the needs of young people where they are, such as in school settings. In addition, as recognition of the value of early intervention for higher end psychiatric conditions has been recognized, such as the long-term benefit of treatment for those with early signs of psychosis, programs have expanded across the country to support those with early psychotic symptoms and those at risk for psychosis. At the same time, there are multiple challenges to expanding services throughout our schools and in ensuring that young people are screened and identified early and linked to early psychosis programs. As youth-friendly, integrated community-based spaces developed by and for young people, allcove centers have the potential to serve as the integral community link in this critical public mental health continuum of care. allcove serves as the central service point in the early intervention continuum from school health to allcove centers to early psychosis programs.

Supplementing school mental health: allcove as a school-linked service

allcove centers expand the connections between school and community so that youth can access support wherever they are. Part of the focus of allcove centers is engaging with community partners to build a collaborative platform and seamless continuum of care through strong collaboration and a shared goal to support youth. The support offered at centers complement those offered by school mental health services and school-based health centers in the following ways:

- allcove's broad eligibility criteria of the 12 to 25-year-old age range, regardless of insurance status, means that young people who are transitioning out of, or between, educational settings, can continue to access the early intervention support they need.
- The menu of allcove clinical services complement and expand the capacity of school-based services, especially in moments of high demand as seen in schools post-COVID.
- The menu of allcove services, specifically group programs and peer support, can provide additional support to youth who are in school. allcove centers and schools can collaborate with shared group programs and/or presentations in either setting to increase mental health literacy, develop life skills, and be linked to social services in the community.
- Youth value both informed consent and confidentiality when accessing health services, and this is often challenging in a school setting, where HIPAA-FERPA issues can be complex. Whereas schools fall under the Family Educational Rights and Privacy Act (FERPA), which requires parental notification on health services, allcove centers are covered under the Health Insurance Portability and Accountability Act (HIPAA), which allows for minor consent and confidentiality of services to follow state and federal laws related to health care access. On campus, youth can find it difficult to discreetly access mental health services and some students may be reluctant to disclose their mental health or academic challenges to counseling staff who may be in close communication with teachers, or parents, or others who might be writing potential college recommendations. Students may also be concerned with how disclosure of mental health issues will impact perceptions of school staff and thus the academic opportunities they are offered. allcove provides youth with a potentially confidential alternative that is within the community and independent of their school

life, allowing young people to choose which option best fits with their needs. This might then increase the possibility that a youth feels comfortable addressing a challenge early, allowing for a trusted allcove staff member to help bring family to the table earlier in the intervention process.

- An additional benefit of linking allcove centers with school mental health or school-based services is the reality that schools often close over summer breaks, vacations, and holidays for extended periods of time. Furthermore, school-based services are usually not available to those who drop out or are suspended or expelled from school, which is often when services and support are most needed. The ability to link school services with community allcove centers allow for a continuum of early intervention care during breaks or school transitions for students. allcove centers can also serve as critical partners to school programs when there is a school-related crisis such as a post-vention event following a death or loss at a school. Having strong connections with allcove centers allows for the ability to bring in a strong community partner who knows how to support young people and their families in times of need for additional school mental health support.

Supplementing early psychosis programs

With their early intervention focus and comfortable, youth-supportive environments, allcove centers present an excellent setting to identify those who might be at clinical high risk for psychosis or needing early psychosis care. In the U.S. approximately 100,000 young people experience a first episode of psychosis each year, with peak onset occurring between the ages of 15 to 25 years old (Heinssen et al., 2014). According to Heinssen et al., “psychotic disorders such as schizophrenia can derail a young person’s social, academic, and vocational development and initiate a trajectory of accumulating disability” (Paragraph 5). Yet, intervening as early as possible can dramatically improve one’s recovery. A study by Howes et al. (2021) indicated a relationship between longer duration of untreated psychosis and more severe negative symptoms, a high chance of previous self-harm, and lower chance of remission, suggesting that the timing of intervention is critical. The results of the National Institute of Mental Health’s Recovery After an Initial Schizophrenia Episode (RAISE) research initiative were compelling enough to inspire national expansion of early psychosis program funding through each state's mental health block grant, leading to the presence of over 350 early psychosis programs across the U.S.

Through their effective youth engagement and soft entry points, international programs like allcove have been shown to serve as effective sites for partnership with early psychosis programs to identify youth at risk for or in the early stages of a psychotic process. Programs such as allcove provide valuable sites for screening and identifying those at risk for psychosis early, linking them to the appropriate level of early psychosis care, ensuring recognition of their symptoms and enabling treatment to begin as quickly as possible, thus supporting the potential to shorten duration of untreated psychosis and improving long-term outcomes for young people. As allcove centers develop across California and nationally, the strong linkage to the growing numbers of early psychosis programs provides a critical pathway in a public mental health early intervention continuum of care.

Poised for statewide expansion

Development of the allcove model by the Stanford Center, with input from its international collaborators, many youth advisors, the State of California, and its pilot communities has been nearly a decade in the making, ultimately leading to the opening of the first allcove centers in June of 2021. Following these first two prototype centers in Palo Alto and San José, plans are underway to turn this ground - breaking model into a statewide movement to expand allcove centers across California. Overwhelming interest from dozens of communities throughout the state and the U.S. has prompted the Stanford Center to develop the Central allcove Team (CaT), which has created a clear framework and infrastructure for successful expansion and implementation of allcove centers. The Central allcove Team aims to provide

implementation assistance to interested communities, support allcove center establishment and services according to model integrity, ensure appropriate and consistent allcove data collection, and facilitate knowledge - sharing across the network of centers and interested collaborators. A key aspect to the long-term sustainability and scalability of the allcove model is that each interested community will engage a lead agency that will ultimately be responsible for the operational and funding of their location(s).

In 2020, the California Mental Health Services Oversight and Accountability Commission awarded seed funding for allcove centers in five communities (Sacramento, Beach Cities, Los Angeles, Irvine, and San Mateo) and has championed the vision of dozens of allcove centers opening across the state. The CaT has been fielding increasing requests for information, collaboration, technical assistance, and consultation from communities of all sizes interested in opening an allcove center in their area. To date, CaT has provided varying levels of consultation to groups in the California counties of Alameda, Southern San Mateo, Santa Cruz, Monterey, Santa Barbara, San Diego, Sonoma, and San Francisco, Native communities in Humboldt County, and to communities in other states, including Alaska, Arizona, Maryland, New Mexico, New York, Pennsylvania, and Texas.

Achieving long-term sustainability

The creation of allcove centers in California is the first international effort to implement the integrated youth mental health model in a country without a national health insurance program. As allcove centers emerge across the state, it will be important for the centers to collaborate on the development of reimbursement strategies for services for uninsured, Medi-Cal-eligible, and commercially-covered young people and families, allowing for allcove center sustainability and expansion statewide and nationally. While financial sustainability models are being developed and tested through the first pilot centers, new centers will have to allocate and/or raise funds to cover their expenses for the first few years of operations. Ensuring that services at allcove centers are free or low cost for all youth comprises one of the most important principles of the allcove model in providing rapid, easy, and affordable access to mental health care.

Concurrent to work being implemented at a community level by local centers, the California Mental Health Services Oversight and Accountability Commission, the Stanford Center, and the California Health Care Foundation are working at a state-wide strategic level with state agency partners, foundations, commercial partners, and financial consultants to develop innovative funding models, such as private-public partnerships and other arrangements, that will benefit all centers going forward.

Communities in California can also partner with their county behavioral health systems to leverage the funding governed by the Commission through the Mental Health Services Act. In developing a funding model, centers will have to consider the following:

- Medi-Cal and commercial insurance coverage and reimbursement possibilities for mental health, physical health, substance use, supported education and employment, and youth peer support services.
- Considering services not covered by insurance reimbursements.
- Funding services for uninsured youth.
- Funding non-treatment services (some supported education and employment services, youth peer support specialist services, etc.).
- Ensuring informed consent and confidentiality for youth in payment mechanisms related to Medi-Cal and commercial services according to state and federal laws.
- Coordinating interagency administrative and financial components between center service providers.

- Blending or braiding private, philanthropic, and other funding streams such as state or federal suicide prevention funds, school mental health, prevention and early intervention funds, innovation funds, and other emerging public funding opportunities.

Addressing the rising youth mental health crisis within a fragmented health system will require systems-level thinking, as well as changes that cut across existing financial barriers that currently prevent innovative models such as allcove to take hold and be sustainable long-term. At the same time, the rollout of the CalAIM program and California's commitment to expand healthcare services for all provides a valuable opportunity to potentially pilot allcove as a critical integrated care model that can meet young people with the services they need now and support their healthy passage into adulthood.

A path forward

The time spanning early adolescence through early adulthood is a vital juncture in which to detect and address mental health issues when they are mild or first presenting, providing support to help young people grow into thriving adulthood. And yet, the U.S. mental health system is not resourced to detect and prevent emerging mental health issues in youth and young adults, despite their astonishing prevalence. Youth are rarely accessing these systems or frequently not until they are in crisis. This lack of accessible, early mental health services is creating tragic and expensive consequences in communities across the country.

The allcove model offers a unique opportunity to create an early access point, blending youth culture and each community's local context to offer a comprehensive range of supportive services that young people are seeking. Seizing on the promise of the allcove model by charting new pathways via public policies, reimbursement mechanisms, investments, and community collaborations could be an opportunity to stem the tide of increasing need and offer young people the support they both need and deserve.

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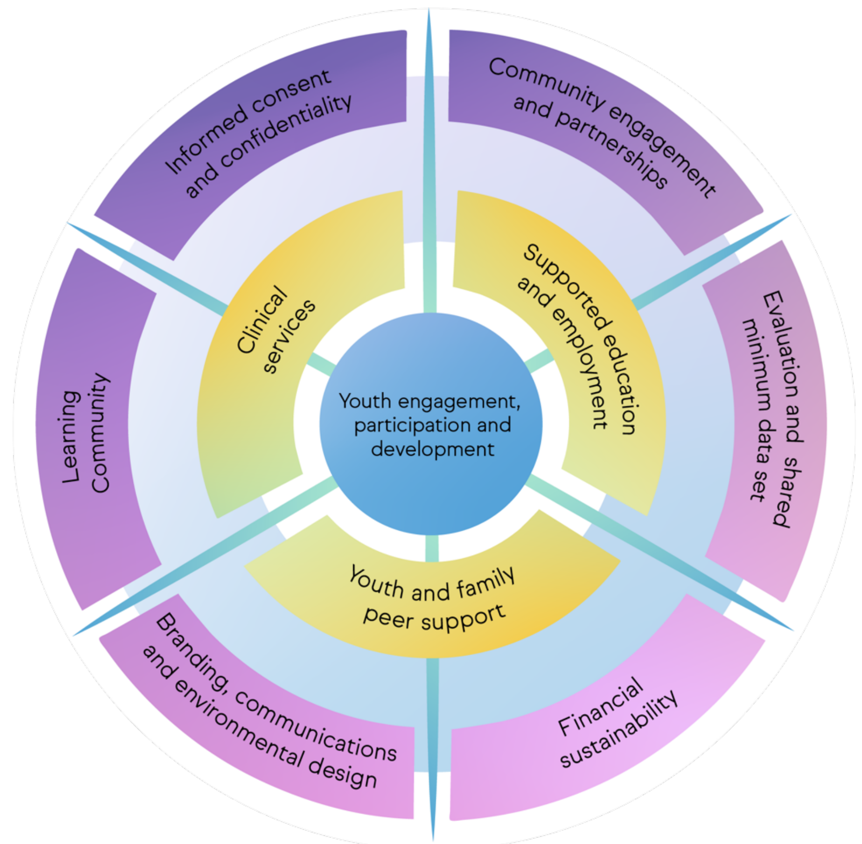
Appendix A

Core allcove model components

Key overarching practice principles and components provide a framework for the integrated youth mental health model that is allcove. Closely aligned with the Global Framework for Youth Mental Health, these principles and the model components ensure that young people are provided holistic, evidence-based, integrated services and that each young person's experience in any center of the allcove network is timely, consistent, and high-quality.

Practice principles:

- Youth-centered care
- Prevention, screening, and early intervention
- Rapid, easy, and affordable access
- Holistic and integrated care



Core model components:

1. Youth engagement, participation, and development
2. Clinical services
3. Supported education and employment
4. Youth and family peer support
5. Branding, communications, and environmental design
6. Evaluation and shared minimum data set
7. Community engagement and partnerships
8. Financial sustainability
9. Informed consent and confidentiality
10. Learning Community

Youth engagement, participation and development

Every allcove center is guided by an active Youth Advisory Group (YAG), composed of young people from the local community who represent diversity in race, ethnicity, gender identity and expression, sexual orientation, lived experience, ability, and socioeconomic status. The goal is to ensure that youth voice and experience is included in the development and services of each center. Youth advisors also serve as community ambassadors for the program, conducting outreach and education through schools, community events, conferences, social media and within their own peer groups.

Clinical services

At the core of the model are early intervention mental health, physical health and substance use services offered to meet the mental and physical care needs of young people ages 12 to 25. The services are provided in an integrated fashion and service providers, who may be from a range of organizations, work as a team to support the young person and their family. Service providers work collaboratively within shared pathways for care, matching the intensity of care to the individual needs of young people. Services may range from individual to group to family support. Linkages to other complementary services at the center and in the community ensure a holistic support for youth wellbeing.

Supported education and employment

A supported education and employment specialist is part of the service team at every center, offering young people assistance in navigating their school and work lives. Young people are offered opportunities to participate in a range of individual services, groups and workshops focused on developing skills to support transitions and progress through school or career. These opportunities include educational rights, studying or test preparation, resume development, career planning, job searching, interview preparation, job placement referrals, school applications, financial support, and course-load management.

Youth and family peer support

Peer and family support are core allcove services that assist young people and families to navigate systems and connect with a range of services. With a peer or family support specialist on the team, young people and families can connect with another person who has personal experiences navigating mental health or substance use needs and who can be a sounding board and assist in accessing allcove and/or other resources. Both peer and family support staff offer non-judgmental support and understanding and can help others navigate systems to locate the appropriate services and resources.

Branding, communications, and environmental design

The essence of allcove is expressed through its brand, co-designed through an extensive, iterative engagement with youth from across California and the United States. Maintaining brand integrity is fundamental to consistently reaching youth with the common messaging, vocabulary, styling, and touchpoints that resonate with and matter to them. allcove centers reflect a brand that has been informed by an intentional youth-designed process based on the optimal service flow that centers the youth experience. At the same time, the allcove brand maintains some flexibility to be adapted to reflect the local community's context and culture.

Evaluation with shared minimum data set

The integrated youth mental health model that allcove is based upon is being continuously evaluated and refined internationally for both clinical value and cost effectiveness. The allcove program is linked to these international evaluation efforts and has developed a minimum data set and common data collection system, known as the datacove. The capture of the same data by all centers in the allcove network will provide critical information to better serve young people across California; to evaluate their experience with allcove; to assess the cost effectiveness of the program, and to link to international data sets to better understand and meet the needs of young people globally.

Community engagement and partnerships

The voice of community partners, including families and caregivers, schools, community-based agencies, social service providers, advocacy organizations, and the business community are critical to ensuring that centers are supporting the needs of their community's youth and families in a collaborative manner. The formal mechanism for this connection is the Community Consortium, which meets regularly to provide strategic advice and a collaborative platform to support the center as a strong community partner. Community partnerships also allow for the creation of referral loops and pathways to both additional onsite services and warm handoffs to develop a seamless range of services to meet the presenting needs of youth who come to an allcove center.

Financial sustainability

Key to creating accessibility and early intervention is the ability to offer services that are low to no cost. Thus, financial sustainability of the allcove model is one of the innovation's most fundamental challenges. As centers emerge across the state and nation, collaborative sustainability efforts and strategies for uninsured, Medi-Cal, and commercially-covered young people and families will be required to expand opportunities for center funding through public-private partnerships.

Informed consent and confidentiality

The autonomy and flexibility to reach out for support on one's own terms is a fundamental value that allcove youth and centers share. Center intake procedures, data policies, billing structures and physical and online experiences are designed to protect privacy, while at the same time complying with state and federal laws governing informed consent and confidentiality for minors and adults. Through statewide coordination, the Central allcove Team supports local centers in navigating this complexity and ensuring laws are followed and policies are implemented consistently and appropriately.

Learning Community

The Central allcove Team fosters and manages a national learning community, a network of lead agencies implementing centers in their communities, infused by the expertise of international partners doing similar work. The Learning Community communications infrastructure includes a Slack workspace, email list, webinars, conferences and site consultation, allowing for collaboration and ongoing knowledge transfer to support integrity and success with the model.

Appendix B

Service Integration

To understand the model of integration that allcove proposes it is necessary to clarify what is meant by service collaboration versus service integration. The SAMHSA-HRSA Center of Excellence for Integrated Health Solutions describes six levels of collaborative/integration (SAMHSA HRSA Center of Excellence for Integrated Health Solutions, 2020).

These levels are listed below, and their characteristics are described in a simplified version of the SAMHSA HRSA table on the following page:

- **Level 1 – Minimal collaboration**
- **Level 2 – Basic collaboration at a distance**
- **Level 3 – Basic collaboration on site**
- **Level 4 – Close collaboration onsite with some system integration**
- **Level 5 – Close collaboration approaching an integrated practice**
- **Level 6 – Full collaboration in a transformed/merged integrated practice**

Acknowledging that full integration takes time, the allcove model proposes that the core services start at an integrated level five working towards full integration of level six.

Coordinated		Co-located		Integrated	
Level 1 **Minimal collaboration**	**Level 2** **Basic collaboration at a distance**	**Level 3** **Basic collaboration onsite**	**Level 4** **Close collaboration onsite with some system integration**	**Level 5** **Close collaboration approaching an integrated practice**	**Level 6** **Full collaboration in a transformed/merged integrated practice**
In separate facilities, where they: • Have separate systems. • Communicate about cases only rarely and under compelling circumstances. • Communicate, driven by provider need. • May never meet in person. • Have limited understanding of each other's roles.	In separate facilities, where they: • Have separate systems. • Communicate periodically about shared patients. • Communicate, driven by specific patient issues. • May meet as part of larger community. • Appreciate each other's roles as resources.	In same facility not necessarily same offices, where they: • Have separate systems. • Communicate regularly about shared patients, by phone or email. • Collaborate, drive by need for each other's services and more reliable referral. • Meet occasionally to discuss cases due to close proximity. • Feel part of a larger yet non-formal team.	In same space within the same facility, where they: • Share some systems, like scheduling or medical records. • Communicate in person as needed. • Collaborate, driven by need for consultation and coordinated plans for difficult patients. • Have regularly face-to-face interactions about some patients. • Have a basic understanding of roles and culture.	In same space within the same facility (some shared space), where they: • Actively seek system solutions together or develop work-a-rounds. • Communicate frequently in person. • Collaborate, driven by desire to be a member of the care team. • Have regular team meetings to discuss overall patient care and specific patient issues. • Have an in-depth understanding of roles and culture.	In the same space within the same facility, sharing all practice space, where they: • Have resolved most or all system issues, functioning as one integrated system. • Communicate consistently at the system, team and individual levels. • Collaborate, driven by shared concept of team care. • Have formal and informal meetings to support integrated model of care. • Have roles and cultures that blur or blend.

SAMHSA HRSA Center of Excellence for Integrated Health Solutions. (2020). *Table 1. Six Levels of Collaboration/Integration (Core Descriptions)*. https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56

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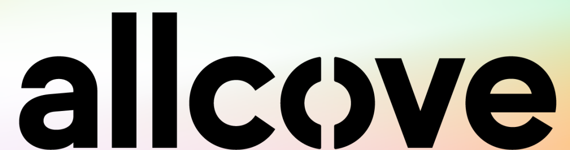
Model integrity overview

allcove model integrity



allcove model integrity

allcove™ is a program initiated by the Center for Youth Mental Health and Wellbeing in Stanford's Department of Psychiatry and Behavioral Sciences. The allcove model has been developed by the Stanford Center with input from its international collaborators, many youth advisors, the state of California, and its communities.

The licensing program (granting rights to use the allcove name and logo) is overseen by California's Mental Health Services Oversight and Accountability Commission with technical support and model integrity support provided directly to centers by the Central allcove Team at the Stanford Center.

It is recommended that this document be read in conjunction with:[1]

- *Model integrity guide.*
- *Model integrity review manual.*
- *Model integrity tool – Baseline.*

Model components

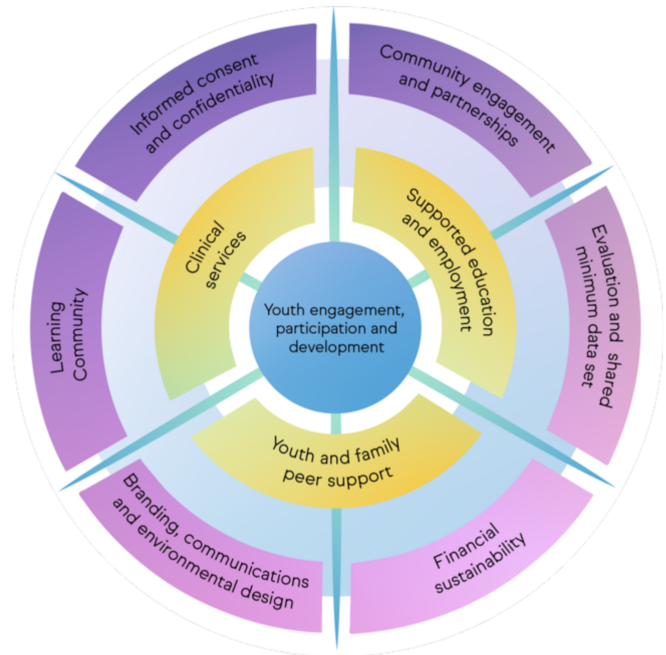
The model refers to the essential components that together provide a framework for the integrated youth metal health model that is allcove. Protecting model integrity ensures that young people are provided holistic, evidence-based, integrated services and that young people's experiences in any center of the allcove network are timely, consistent, and high-quality.

The model has been informed by international best practices[2] and shares the characteristics of integrated youth mental health centers world-wide[3]. Some of the components are overarching dimensions of the model while others are service delivery components.

[1] allcove tool kit
[2] World Economic Forum Global Youth Mental Health Framework at https://www.weforum.org/reports/a-global-framework-for-youth-mental-health-db3a7364df
[3] Integrated (one-stop shop) youth health care: best available evidence and future directions
Sarah E Hetrick1, Alan P Bailey1, Kirsten E Smith2, Ashok Malla3, Steve Mathias4, Swaran P Singh5, Aileen O'Reilly6, Swapna K Verma7, Laelia Benoit8, Theresa M Fleming9, Marie Rose Moro8, Debra J Rickwood10, Joseph Duffy6, Trissel Eriksen11, Robert Illback12, Caroline A Fisher13, Patrick D McGorry1

The components of the allcove model are:

1. Youth engagement, participation and development.
2. Clinical services.
3. Supported education and employment.
4. Youth and family peer support.
5. Branding, communications and environmental design.
6. Evaluation and shared minimum data set.
7. Community engagement and partnerships.
8. Financial sustainability.
9. Informed consent and confidentiality.
10. Learning Community.



Overarching practice principles

Key practice principles are embedded in all components.

Youth-centered care

- Services co-designed with youth
- Young people as experts in their own care
- Socially and culturally inclusive
- Holistic service offering
- Strength-based, hope inspired
- Shared decision making
- Peer supported
- Staffed by professionals with expertise and passion for working with youth
- Developmentally appropriate interventions
- Informed consent and confidentiality

Prevention, screening early intervention

- Actively working in the community to build youth resilience, increasing early help seeking, reduce stigma and increase mental health literacy
- Community-based services with active community partnerships
- Use of standardized screening tools to identify the state of health and wellbeing of young people
- Address and support social determinants of health through psycho-social service offerings

Rapid, easy and affordable access

- Wide service criteria for youth ages 12 to 25
- Drop-in services, when possible
- Located in areas where youth naturally congregate, accessible by public transportation, youth friendly environmental design
- Free or low cost, regardless of personal situation
- Most commonly sought services provided or connected in one location
- Strong linkages to referral sources, such as schools and other educational settings
- Integrated services with linkages to external services that support the continuum of care and higher levels of need

Holistic and integrated care

- Co-location of core service streams, especially mental and physical health
- Multidisciplinary team-based care
- Coordinated care – Internal and external integration within the local youth-serving system
- Family inclusive, as appropriate
- Use of appropriate technology and service delivery modes

allcove model integrity framework

The *model integrity framework* [4] translates the components into the essential operational dimensions that together provide guidance on operationalizing the model.

These are:

1. Infrastructure.
2. Center and cultural environment.
3. Access and initiating services.
4. Service delivery and youth response monitoring.
5. Community networking and integration of services.
6. Workforce.
7. Staff training and development.

While the use of the framework and the review process shares some characteristics with a certification process, its goal is to provide a mechanism to align allcove implementation to international practice, endorse creative ways to locally adapt the model, and to provide establishing centers with guidance on how to operationalize the components at various stages of the center lifecycle. The Central allcove Team hopes to further refine the framework and review processes as it works with the commission and lead agencies on establishing allcove centers in California and with Stanford Center's international collaborators.

[4] *Model integrity guide*

Review approach and process

Along with information gathered during center visits and interviews, review for model integrity using the *framework* and the *model integrity tool*[5] is a process that identifies dimensions and corresponding sample indicators to ensure that centers provide services and support consistent with the model.

The process serves to set implementation benchmarks at a baseline level for when the center first opens and at full implementation level, as the service matures. In this respect it is seen as a continuous improvement process. The model integrity indicators provide some sample evidence items that illustrate how the core components can be implemented within the center's local context.

The review approach facilitates addressing local challenges to operationalize the components and establish new strategies to address barriers. The alternating process of self-assessment and Central allcove Team-guided review will support centers to determine locally suitable ways of implementing allcove. Additional resources will be provided by the Central allcove Team in the tool kit to support the review process during the implementation cycle.

The close collaboration provided by ongoing technical assistance and dialogue will ensure that all parties in the service partnership align to the common goal of providing safe and effective services to young people and their families.

Scope of review

The review process will examine information gathered:

- Through the datacove and/or other sources and records.
- Through center model integrity self-assessments.
- Through Central allcove Team-guided model integrity reviews.
- During site visits, implementation and evaluation meetings.
- During interviews with young people and staff.
- Through the Central allcove Team review of a set of core center documents, drafted by the lead agency in collaboration with service delivery partners, that articulate key indicators across multiple sub-components. More information is provided in the model integrity resources within the allcove tool kit.

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[5] *Model integrity tool – Baseline I*

Model integrity guide

allcove model integrity

allcove

Introduction

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Section 1

Model and practice principles

Foundational to the model are key overarching practice principles that inform the components that together provide a framework for the integrated youth mental health model that is allcove. The model ensures that young people are provided holistic, evidence-based integrated services and that young people's experience in any center of the allcove network is timely, consistent, and of high-quality.

While the model has been informed by international best practices[2] and shares the characteristics of integrated youth mental health centers world-wide[3], the Central allcove Team hopes to further develop and refine the model as it works with the commission, the lead agencies of allcove centers in California and Stanford Center's international collaborators.

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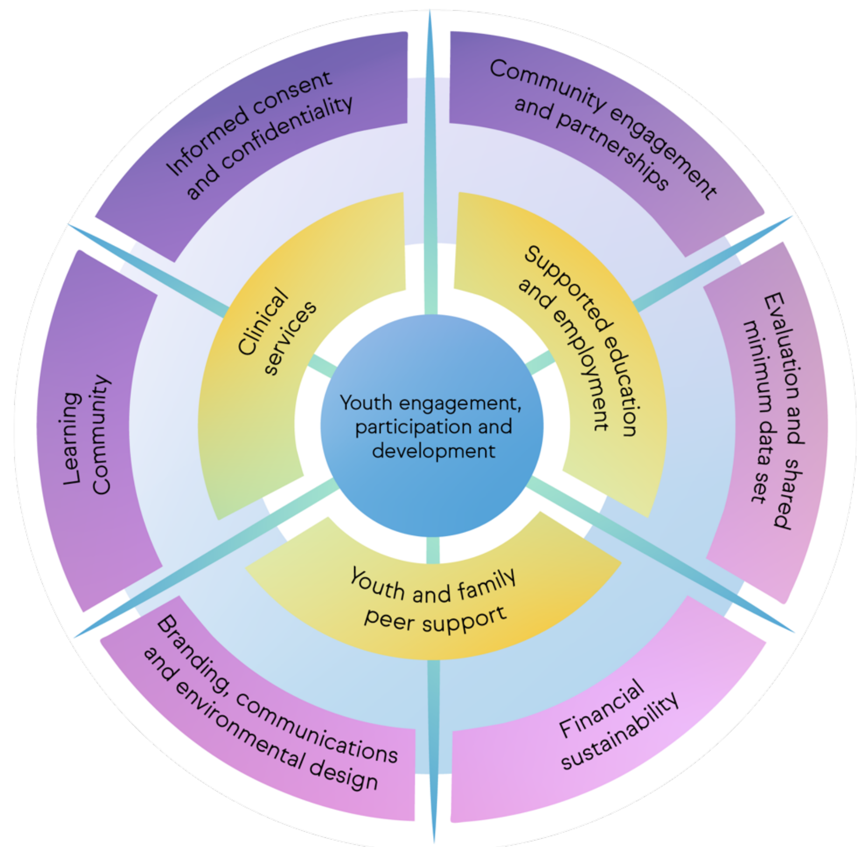
Components of the allcove model

The first component of *youth engagement, participation and development* identifies a pillar of the model and the fundamental importance of keeping the voice of youth central to the program.

Components two to four relate to core direct service streams, and components five to 10 are overarching or facilitating components.



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Furthermore, collaborative sustainability efforts and strategies continue to expand opportunities for center funding through public-private partnerships.

Informed consent and confidentiality

The autonomy and flexibility to reach out for support on one's own terms is a fundamental value that allcove youth and centers share. Center intake procedures, data policies, billing structures and physical and online experiences are designed to protect privacy, while at the same time complying with state and federal laws governing informed consent and confidentiality for minors and adults. Through statewide coordination, the Central allcove Team supports local centers in navigating this complexity and ensuring laws are followed and policies are implemented consistently and appropriately.

Learning Community

The Central allcove Team fosters and manages a national learning community, a network of lead agencies implementing centers in their communities, infused by the expertise of international partners doing similar work. The Learning Community communications infrastructure includes a Slack workspace, email list, webinars, conferences and site consultation, allowing for collaboration and ongoing knowledge transfer to support integrity and success with the model.

Section 2

Model integrity framework

The *model integrity framework* below translates the model's components into the essential operational dimensions and sub-dimensions that together provide a framework for the implementation of the integrated youth metal health model that is allcove. Alignment to the dimensions of the framework and components of the model ensures that young people are provided holistic, evidence-based integrated services and that every young person's experience in any center of the allcove network is timely, consistent, and high-quality.

These are:

- Dimension 1: Infrastructure.
- Dimension 2: Center and cultural environment.
- Dimension 3: Access and initiating services.
- Dimension 4: Service delivery and youth response monitoring.
- Dimension 5: Community networking and integration of services.
- Dimension 6: Workforce.
- Dimension 7: Staff training and development.

Model integrity framework

Dimension 1: Infrastructure	
Sub-dimension benchmark	
1.1	The center mission statement reflects the allcove model and mission statement.
1.2	All services (including mental health, physical health and substance use) are billed for and paid by public or private insurance, state, federal, foundation or other funds, at no direct cost to the client.
1.3	An allcove specific Youth Advisory Group is active in the initial design and ongoing operations of the center.
1.4	An allcove specific Community Consortium includes representative stakeholders (youth, families, community members) who are active in the initial design and ongoing operations of the center.
1.5	Center has the capacity to collect and report all required common data elements by the Central allcove Team for program evaluation and quality improvement purposes.
1.6	Center conforms with the allcove licensing requirements on branding, communications and marketing, data collection, research and evaluation, facility principles and participation in the Learning Community.
1.7	Lead agency effectively manages safe and efficient operations of the center facility, finances and workforce, including organizational-level licenses and certifications that permit mental health, physical health, substance use, peer support, family support and supported education and employment to be delivered at the center.
1.8	Center has mechanisms to audit and evaluate the performance of the service in partnership with young people and their families.
1.9	Center has mechanisms for seeking, gathering and responding to confidential feedback from young people and their families.

Dimension 2: Center and cultural environment	
Sub-dimension benchmark	
2.1	Center's environment, with shared input and decision making with youth in its design, is non-clinical with a youth-friendly focus.
2.2	Center is a welcoming, culturally inclusive, and safe environment for appointments or limited informal socializing.
2.3	Online and printed informational materials are youth-designed, inclusive of diverse perspectives and imagery, and address the allcove integrated approach for the delivery of the following services: • Mental health. • Physical health. • Substance use. • Youth peer support. • Family support. • Supported education and employment. They clearly define the menu of service options, shared decision-making approach and the time-limited nature of services provided at the center.
2.4	Architectural and interior design layout of the center's space reflects the culture and context of the local community.
2.5	Center values and implements a multi-disciplinary, collaborative approach to providing holistic care to young people.
2.6	A diverse group of youth, who reflect the local community, are present and actively engaged in all service development and implementation.

Dimension 3: Access and initiating services	
Sub-dimension benchmark	
3.1	Timely, easy access to initiating care either online, by telephone or through drop-in.
3.2	Broad eligibility criteria: Young people 12 to 25 seeking help with mild to moderate needs in mental health, physical health, substance use, peer support, family support, and supported education and employment.
3.3	Standardized screening measures implemented in agreement with the Central allcove Team are consistently used with all youth to determine support, risks, strengths, needs, problem acuity and severity.
3.4	A protocol exists to identify and triage acute mental health, physical health, substance use and social risk issues, including suicidality, overdose, intoxication, withdrawal, medical crises or safety concerns.
3.5	A protocol for documenting diagnosis exists for mental health, physical health and substance use needs.
3.6	Initial encounter has a clear protocol for explaining consent to services, obtaining and renewing authorization for use and disclosure of information (with or without guardian involvement) and confidentiality (and its limits and expiration) in alignment with California and federal laws for minor consent.
3.7	The initial encounter includes a shared decision-making approach to review findings and options for services.
3.8	The service is physically accessible to all young people across the community, is ADA compliant and located close to public transportation hubs and to locations where young people naturally gather.
3.9	Service is open at times when young people can access it, including evening and/or weekend options.
3.10	High-risk, vulnerable and marginalized youth and populations of youth with known disparities (LGBTQ+, unhoused, and BIPOC youth) are identified and proactively engaged.

Dimension 4: Service delivery and youth response monitoring	
Sub-dimension benchmark	
4.1	Service plans exist and are developed transparently and with youth co-production, and include the following elements: type of service, frequency, duration and outcome monitoring.
4.2	Time-limited, evidence-based mental health treatments are delivered onsite for mental health needs, including daily access to psychosocial interventions and weekly access to prescriptions for psychotropic medication (examples: trauma-focused cognitive behavioral therapy, antidepressant medication).
4.3	Best practice and evidence-based mental health and substance use interventions are available at the center for co-occurring mental health and substance use needs.
4.4	Best practice and evidence-based physical health care is delivered onsite full time to manage physical and sexual health and some treatments are available for primary care (examples: skin issues, cold and flu symptoms).
4.5	Youth-informed wellness options are available onsite.
4.6	Supported education and employment services are available onsite full time.
4.7	Youth peer support and peer-run activities are offered on site full time.
4.8	A continuum of family support services is provided onsite including family education, wellness, and brief family and parenting interventions.
4.9	Care coordination services exist onsite for social risk needs related to housing, legal, financial, immigration, food, transportation, educational and other issues.
4.10	Measurement-based tracking of progress on service plans exists for individual youth and for the center in aggregate.
4.11	Use of technology is integrated appropriately into the continuum of care.

Dimension 5: Community networking and integration of services	
Sub-dimension benchmark	
5.1	With the most suitable health care and social service partners, the center has memoranda of understanding, agreements or documented understandings of methods to coordinate care, accept referrals, refer or link youth with specialists (examples: substance use services, psychiatry, infectious diseases) or social services (examples: department of children and family services, probation and parole).
5.2	With mental health, substance use, physical care providers, and social service agencies, for individual youth, the center has developed clear plans for care coordination including referral, confirmed linkage, and a plan for ongoing communication.
5.3	Center staff adhere to federal and state regulations regarding release and exchange of information, respects limits of youth and parental consent, and use HIPAA and 42CFR and ADA-compliant forms.
5.4	An outreach process exists for young people for whom there is clinical concern and who are not attending the center.
5.5	Clear pathways and/or protocols exist for coordination with schools and/or workplaces in which center youth are involved.
5.6	Community Consortium efforts on network relationship maintenance and development to support and improve youth services are evident and consistent.
5.7	Center leadership engages in regular meetings with other organizations in the geographic region to identify emerging needs, troubleshoot issues, improve communication and strengthen the network of care.
5.8	There is a planned, coordinated and resourced approach to community awareness and engagement to contribute to suicide prevention, increase mental health literacy, address stigma, increase help seeking and advocate for the health and well-being needs of young people.

Dimension 6: Workforce	
Sub-dimension benchmark	
6.1	Medical providers with primary care and/or psychiatry specialty are available, preferably having advanced certification in child, adolescent or young adult practice.
6.2	Behavioral health clinicians (social workers, mental health counselors, psychologists, licensed drug and alcohol counselors) have license or certification in mental health and/or substance use, and clinical expertise or experience working with youth and/or young adults.
6.3	Case managers have expertise in assertive or intensive community participation and interaction with schools, juvenile justice, social services, crisis services, and behavioral health organizations focused on young people.
6.4	Supported education and employment specialists have expertise in the full continuum of youth and/or young adult educational and local employment entities and regulatory issues, including 504, IDEA, IEPs, and supported employment models.
6.5	Youth outreach specialists have experience with young people across diverse identities, communities, and educational populations and experience in facilitating youth advisory groups, outreach and curriculum development.
6.6	Center has diverse group of staff who reflect the local community.
6.7	Center has a clear supervision procedure for clinical staff, including documentation of frequency, format, areas for professional growth and development and ethical guidance.
6.8	Center has a clear supervision procedure for non-clinical staff, including documentation of frequency, format, areas for professional growth and development and ethical guidance.
6.9	Center has a clear supervision procedure for youth peer support specialists, including documentation of frequency, format, areas for professional growth and development and ethical guidance.
6.10	Reception and administrative staff, who are full time and onsite and have interest, expertise and experience working with young people, are available.
6.11	Center manager has at least master's level clinical training and expertise and experience working with young people and is available full time onsite.

Dimension 7: Staff training and development	
Sub-dimension benchmark	
7.1	All staff members, clinical and non-clinical, have completed training conducted by the Central allcove Team through the Learning Community.
7.2	All staff members, clinical and non-clinical, have completed onboarding and ongoing in-service trainings in ethics, laws, youth cultural and identity issues, youth development, engagement and participation, informed consent and confidentiality regarding youth, health and social service.
7.3	All non-clinical staff, such as administrative and support personnel, have completed onboarding and ongoing in-service trainings regarding the principles of youth-centered care, informed consent and confidentiality regarding youth, youth engagement and participation, and integrated care services.
7.4	All clinical staff have completed onboarding and ongoing in-service trainings in evidence-based integrated youth services for mental health, risk review, crisis, management, substance use, trauma, shared decision-making, informed consent and confidentiality regarding youth, family interventions, peer support partnership, supported education and employment and referral services.
7.5	All youth who serve on the Youth Advisory Group or as peers have completed onboarding and ongoing in-service training in ethics, basic interaction and support skills, crisis recognition and intervention, youth advocacy and leadership, facilitation, presentation and workshop development.

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ATTACHMENT IV

Evaluation At-A-Glance

Evaluation Tools: Youth Services

The all-cove cross-site evaluation is designed to measure who is being served; what services they received, how much, and from whom; and how their mental health and wellness changed during their service participation. At intake, youth will complete a series of questionnaires that include sociodemographic information, current and historical experiences, and two validated assessment scales that measure overall distress and wellbeing. There are other scales that are included in datacove that serve administrative, programmatic, and/or clinical utility; those instruments and items are not included in the evaluation design itself.

	Intake	Post-Visit	Monthly	Discharge
Youth	Socio-Demographic Information Key Life Events Tracker Flourishing Scale YP-CORE / CORE-10	Post-Visit Questionnaire	Key Life Events Tracker Flourishing Scale YP-CORE / CORE-10	Key Life Events Tracker Flourishing Scale YP-CORE / CORE-10
Provider		Service Information		

Survey/Instrument	Description
Socio-Demographic Information	Describe youth being served through allcove
Service Information	Describe types of services youth receive (e.g., mental health, physical health, employment)
Key Life Events Tracker	Measure significant changes in youth's life (e.g., housing, education, employment, juvenile justice system involvement)
Post-Visit Questionnaire	Measure shared decision making, ease of access, provider relationship, and sense of utility
Flourishing Scale	A 12-item scale adapted for use with adolescents to assess domains of flourishing (e.g., social relationships, happiness and life satisfaction)
YP-CORE / CORE-10	Validated tools that measure psychological distress in youth ages 11-16 and youth ages 17 and older, respectively

Evaluation Tools: Program and Organizational Information

The allcove cross-site evaluation includes measuring consistent program and organizational information to quantify components of the allcove model, including youth partnership, mental health stigma, integrated care, and community collaboration.

The following tools are validated survey instruments to be completed **semi-annually.** They can all be administered during a standing meeting; some are to be completed by each individual and some are to be completed collectively by the group.

Name	Domain	Length	Administration	Respondent	Frequency
Youth & Adult Partnership Tool (Y-AP)	**Youth-adult partnership**: youth voice in decision making and supportive adult relationships	11 Item Validated measurement tool	Completed individually during a YAG meeting.	Youth Advisory Group Members	Semi-annually
Opening Minds Scale for Health Care Providers (OMS-HC-15)	**Stigma** among healthcare providers	15 items	Completed individually during a staff or care team meeting	Service Providers	
Integrated Practice Assessment Tool (IPAT)	**Integrated practice** and care integration	8 question decision tree model defined by *A Standard Framework for Levels of Integrated Healthcare* issue brief	Completed collaboratively by 2 or more persons during a staff or care team meeting	Service Provider Team	
Wilder Collaboration Survey	**Collaboration** at the organizational level	44 questions	Completed collaboratively during a consortium meeting	Community Consortium Members	

Indigo Project

APPENDIX 1: allcove™ BUDGET WORKSHEET

Peninsual Health Care District - RFP Budget Worksheet

A. Expenditures							
1. Personnel Expenditures **example employees -** add additional rows as necessary							
a. Employee Salary - list all employees	**Title**	**Salary**	**% of time**	**Yr. 1**	**Yr. 2**	**Yr.3**	**Yr.4**
i. Executive Director, salary, % of time							
ii. Employee 1, title, salary, % of time							
iii. Employee 2, title, salary, % of time							
iv. Employee 3, title, salary, % of time							
v. Employee 4, title, salary, % of time							
b. Subtotal of all salaries							
Employee Benefits							
i. Part-time benefits							
ii. Full-time benefits							
iii. Subtotal of benefits							
d. Subtotal of Personnel Expenditures							

B. Revenues - if applicable	**Yr. 1**	**Yr. 2**	**Yr.3**	**Yr.4**
1. Grants				
2. Donations				
3. Other Revenue				
Total Revenue				

C. Start-Up Costs (describe in budget narrative)	**Yr. 1**	**Yr. 2**	**Yr.3**	**Yr.4**
1.				
2.				
3.				
Subtotal One-Time Start-Up Costs		N/A	N/A	N/A

D. Total Proposed Operational Budget				

ENCLOSURE 1

AGREEMENT BETWEEN PENINSULA HEALTH CARE DISTRICT

AND [Contractor name]

This Agreement is entered into this _____ day of _______________, 20_____ by and between Peninsula Health Care District, hereinafter called "PHCD," and [Insert contractor legal name here], hereinafter called "Contractor."

* * *

Whereas, PHCD provides health and other services to teens and young adults who reside within PHCD's jurisdiction through the allcove ™ program; and,

Whereas, it is necessary and desirable that Contractor be retained for the purpose of allcove ™ Youth Drop-In Center services; and,

Whereas, the Director of Youth Behavioral Health Programs for PHCD has been designated as the Program Manager for PHCD.

Now, therefore, it is agreed by the parties as follows:

1. Exhibits and Attachments

The following exhibits and attachments are attached to this Agreement and incorporated into this Agreement by this reference:

Exhibit A—Services
Exhibit B—Payments and Rates
Exhibit C-–Memorandum of Understanding Property Use
Attachment H—HIPAA Business Associate Requirements
Attachment I—§ 504 Compliance *(Delete this if not needed)*
Attachment IP – Intellectual Property

2. Services to be performed by Contractor

In consideration of the payments set forth in this Agreement and in Exhibit B, Contractor shall perform services for PHCD in accordance with the terms, conditions, and specifications set forth in this Agreement and in Exhibit A.

3. Payments

In consideration of the services provided by Contractor in accordance with all terms, conditions, and specifications set forth in this Agreement and in Exhibit A, PHCD shall make payment to Contractor based on the rates and in the manner specified in Exhibit B. PHCD reserves the right to withhold payment if PHCD determines that the quantity or quality of the work performed do not meet the requirements of this Agreement or the

allcove program. In no event shall PHCD's total fiscal obligation under this Agreement exceed DOLLARS ($___). In the event that the PHCD makes any advance payments, Contractor agrees to refund any amounts in excess of the amount owed by the PHCD at the time of contract termination or expiration. Contractor is not entitled to payment for work not performed as required by this agreement.

4. Term

Subject to compliance with all terms and conditions, the term of this Agreement shall be from December 9, 2022 through December 9, 2026.

5. Termination

This Agreement may be terminated by Contractor or by the Chief Executive Officer for PHCD or designee at any time without a requirement of good cause upon thirty (30) days' advance written notice to the other party. Subject to availability of funding, Contractor shall be entitled to receive payment for work/services provided prior to termination of the Agreement. Such payment shall be that prorated portion of the full payment determined by comparing the work/services actually completed to the work/services required by the Agreement, by prorating monthly payments until the termination date if payments are made on a fixed monthly basis, or other equitable basis as determined by the Project Manager.

PHCD may terminate this Agreement or a portion of the services referenced in the Attachments and Exhibits based upon the unavailability or reduction of Federal, State, or County funds by providing written notice to Contractor as soon as is reasonably possible after PHCD learns of said unavailability of outside funding.

PHCD may terminate this Agreement for cause. In order to terminate for cause, PHCD must first give Contractor written notice of the alleged cause. Contractor shall have five business days after receipt of such notice to respond and a total of ten calendar days after receipt of such notice to cure the alleged breach. The Program Manager may extend the cure period in writing. If Contractor fails to cure the breach within this period, PHCD may immediately terminate this Agreement without further notice or other action. The option available in this paragraph is separate from the ability to terminate without cause with appropriate notice described above. In the event of a substantial breach that jeopardizes the allcove program or participants in the reasonable judgment of the Program Manager, PHCD may immediately suspend performance of services and payment under this Agreement pending the resolution of the process described in this paragraph.

Contractor may terminate this Agreement for cause based on the failure of PHCD to make a payment in accordance with Exhibit B. Contractor shall give notice of the alleged failure and provide PHCD with 10 days to cure the alleged default.

6. Contract Materials

At the end of this Agreement, or in the event of termination, all finished or unfinished documents, data, studies, maps, photographs, reports, and other written materials (collectively referred to as "contract materials") prepared by Contractor under this Agreement shall become the property of PHCD and shall be promptly delivered to PHCD. Upon termination, Contractor may make and retain a copy of such contract materials if permitted by law.

7. Relationship of Parties

Contractor agrees and understands that the work/services performed under this Agreement are performed as an independent contractor and not as an employee of PHCD and that neither Contractor nor its employees acquire any of the rights, privileges, powers, or advantages of PHCD employees.

8. Hold Harmless

a. General Hold Harmless

Contractor shall indemnify and save harmless PHCD and its officers, agents, employees, and servants from all claims, suits, or actions of every name, kind, and description resulting from this Agreement, the performance of any work or services required of Contractor under this Agreement, or payments made pursuant to this Agreement brought for, or on account of, any of the following:

(A) injuries to or death of any person, including Contractor or its employees/officers/agents;

(B) damage to any property of any kind whatsoever and to whomsoever belonging;

(C) any sanctions, penalties, or claims of damages resulting from Contractor's failure to comply, if applicable, with the requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all Federal regulations promulgated thereunder, as amended; or

(D) any other loss or cost, including but not limited to that caused by the concurrent active or passive negligence of PHCD and/or its officers, agents, employees, or servants. However, Contractor's duty to indemnify and save

harmless under this Section shall not apply to injuries or damage for which PHCD has been found in a court of competent jurisdiction to be solely liable by reason of its own negligence or willful misconduct.

The defense of PHCD shall be conducted by counsel reasonably acceptable to PHCD.

b. **Intellectual Property Indemnification**

Contractor hereby certifies that it owns, controls, and/or licenses and retains all right, title, and/or interest in and to any intellectual property it uses in relation to this Agreement, including the design, look, feel, features, source code, content, and/or other technology relating to any part of the services it provides under this Agreement and including all related patents, inventions, trademarks, and copyrights, all applications therefor, and all trade names, service marks, know how, and trade secrets (collectively referred to as "IP Rights") except as otherwise noted by this Agreement.

Contractor warrants that the services it provides under this Agreement do not infringe, violate, trespass, or constitute the unauthorized use or misappropriation of any IP Rights of any third party. Contractor shall defend, indemnify, and hold harmless PHCD from and against all liabilities, costs, damages, losses, and expenses (including reasonable attorney fees) arising out of or related to any claim by a third party that the services provided under this Agreement infringe or violate any third-party's IP Rights provided any such right is enforceable in the United States. Contractor's duty to defend, indemnify, and hold harmless under this Section applies only provided that: (a) PHCD notifies Contractor promptly in writing of any notice of any such third-party claim; (b) PHCD cooperates with Contractor, at Contractor's expense, in all reasonable respects in connection with the investigation and defense of any such third-party claim; (c) Contractor retains sole control of the defense of any action on any such claim and all negotiations for its settlement or compromise (provided Contractor shall not have the right to settle any criminal action, suit, or proceeding without PHCD's prior written consent, not to be unreasonably withheld, and provided further that any settlement permitted under this Section shall not impose any financial or other obligation on PHCD, impair any right of PHCD, or contain any stipulation, admission, or acknowledgement of wrongdoing on the part of PHCD without PHCD's prior written consent, not to be unreasonably withheld); and (d) should services under this Agreement become, or in Contractor's opinion be likely to become, the subject of such a claim, or in the event such a third party claim or threatened claim causes PHCD's reasonable use of the services under this Agreement to be seriously endangered or disrupted, Contractor shall, at Contractor's option and expense, either: (i) procure for PHCD the right to continue using the services without infringement or (ii) replace or modify the services so that they become non-infringing but remain functionally equivalent.

Notwithstanding anything in this Section to the contrary, Contractor will have no obligation or liability to PHCD under this Section to the extent any otherwise covered claim is based upon: (a) any aspects of the services under this Agreement which have been modified by or for PHCD (other than modification performed by, or at the direction of, Contractor) in such a way as to cause the alleged infringement at issue; and/or (b) any aspects of the services under this Agreement which have been used by PHCD in a manner prohibited by this Agreement.

The defense of PHCD shall be conducted by counsel reasonably acceptable to PHCD.

9. Assignability and Subcontracting

Contractor shall not assign this Agreement or any portion of it to a third party or subcontract with a third party to provide services required by Contractor under this Agreement without the prior written consent of PHCD. Any such assignment or subcontract without PHCD's prior written consent shall give PHCD the right to automatically and immediately terminate this Agreement without penalty or advance notice. Contractor shall ensure that any subcontrators, independent contractors, or assignees are fully licensed to provide the services required by this Agreement and that they comply with all of the terms and conditions of this Agreement including, but not limited to, records retention, nondiscrimination, and insurance.

10. Insurance

a. General Requirements

Contractor shall not commence work under this Agreement unless and until all insurance required under this Section has been obtained and such insurance has been approved by the Program Manager. Contractor shall furnish PHCD with certificates of insurance evidencing the required coverage, and there shall be a specific contractual liability endorsement extending Contractor's coverage to include the contractual liability assumed by Contractor pursuant to this Agreement. These certificates shall specify or be endorsed to provide that thirty (30) days' notice must be given, in writing, to PHCD of any pending change in the limits of liability or of any cancellation or modification of the policy. The insurance requirements in this section may be modified or reduced in writing by the Program Manager when such requirements are excessive or inapplicable to the services to be provided by Contractor.

b. Workers' Compensation and Employer's Liability Insurance

Contractor shall have in effect during the entire term of this Agreement workers' compensation and employer's liability insurance providing full statutory coverage. In signing this Agreement, Contractor certifies, as required by Section 1861 of the

California Labor Code, that (a) it is aware of the provisions of Section 3700 of the California Labor Code, which require every employer to be insured against liability for workers' compensation or to undertake self-insurance in accordance with the provisions of the Labor Code, and (b) it will comply with such provisions before commencing the performance of work under this Agreement.

c. <u>Liability Insurance</u>

Contractor shall take out and maintain during the term of this Agreement such bodily injury liability and property damage liability insurance as shall protect Contractor and all of its employees/officers/agents while performing work covered by this Agreement from any and all claims for damages for bodily injury, including accidental death, as well as any and all claims for property damage which may arise from Contractor's operations under this Agreement, whether such operations be by Contractor, any subcontractor, anyone directly or indirectly employed by either of them, or an agent of either of them. Such insurance shall be combined single limit bodily injury and property damage for each occurrence and shall not be less than the amounts specified below:

(a) Comprehensive General Liability… $2,000,000

(b) Motor Vehicle Liability Insurance… $2,000,000

(c) Employer's Liability Insurance…… $2,000,000

(d) Professional Liability………………. $2,000,000

Motor Vehicle and/or Professional Liability coverages may be waived by the Program Manager when inapplicable to the scope of services in Exhibit B but any waiver shall not affect Contractor's duty to indemnify and defend PHCD as required by Sections 8(a) and (b) above.

PHCD and its officers, agents, employees, and Board of Directors shall be named as additional insureds on any such policies of insurance, which shall also contain a provision that (a) the insurance afforded thereby to PHCD and its officers, agents, employees, and Board of Directors shall be primary insurance to the full limits of liability of the policy and (b) if the PHCD or its officers, agents, employees, and Board of Directors have other insurance against the loss covered by such a policy, such other insurance shall be excess insurance only.

In the event of the breach of any provision of this Section, or in the event any notice is received which indicates any required insurance coverage will be diminished or canceled, PHCD, at its option, may, notwithstanding any other provision of this

Agreement to the contrary, immediately declare a material breach of this Agreement and suspend all further work and payment pursuant to this Agreement.

11. Compliance With Laws

All services to be performed by Contractor pursuant to this Agreement shall be performed in accordance with all applicable Federal, State, PHCD, and municipal laws, ordinances, and regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Federal Regulations promulgated thereunder, as amended (if applicable), the Americans with Disabilities Act of 1990, as amended, and Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of disability in programs and activities receiving any Federal or PHCD financial assistance. Such services shall also be performed in accordance with all applicable ordinances and regulations, including but not limited to appropriate licensure, certification regulations, provisions pertaining to confidentiality of records, and applicable quality assurance regulations. In the event of a conflict between the terms of this Agreement and any applicable State, Federal, PHCD, or municipal law or regulation, the requirements of the applicable law or regulation will take precedence over the requirements set forth in this Agreement.

Contractor will timely and accurately complete, sign, and submit all necessary documentation of compliance.

12. Non-Discrimination and Other Requirements

a. General Non-discrimination

No person shall be denied any services provided pursuant to this Agreement (except as limited by the scope of services) on the grounds of race, color, national origin, ancestry, age, disability (physical or mental), sex, sexual orientation, gender identity, marital or domestic partner status, religion, political beliefs or affiliation, familial or parental status (including pregnancy), medical condition (cancer-related), military service, or genetic information. Nothing in this subsection shall be construed to require Contractor to provide services to persons who do not qualify for the allcove program, due to age, residence outside the PHCD jurisdictional boundaries, or other program exclusions.

b. Equal Employment Opportunity

Contractor shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this Agreement. Contractor’s equal employment policies shall be made available to PHCD upon request.

c. Section 504 of the Rehabilitation Act of 1973

Contractor shall comply with Section 504 of the Rehabilitation Act of 1973, as amended, which provides that no otherwise qualified individual with a disability shall, solely by reason of a disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of any services this Agreement. This Section applies only to contractors who are providing services to members of the public under this Agreement.

d. Compliance with Equal Benefits Laws or Policies

Contractor shall comply with all laws and published PHCD policies for contractors relating to the provision of benefits to its employees and their spouses or domestic partners, including, but not limited to, such laws prohibiting discrimination in the provision of such benefits on the basis that the spouse or domestic partner of the Contractor's employee is of the same or opposite sex as the employee.

e. Discrimination Against Individuals with Disabilities

The nondiscrimination requirements of 41 C.F.R. 60-741.5(a) are incorporated into this Agreement as if fully set forth here, and Contractor and any subcontractor shall abide by the requirements of 41 C.F.R. 60–741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities.

f. History of Discrimination

Contractor certifies that no finding of discrimination has been issued in the past 365 days against Contractor by the Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or any other investigative entity. If any finding(s) of discrimination have been issued against Contractor within the past 365 days by the Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or other investigative entity, Contractor shall provide PHCD with a written explanation of the outcome(s) or remedy for the discrimination prior to execution of this Agreement. Failure to comply with this Section shall constitute a material breach of this Agreement and subjects the Agreement to immediate termination at the sole option of the PHCD.

g. Reporting; Violation of Non-discrimination Provisions

Contractor shall report to the Program Manager the filing in any court or with any administrative agency of any complaint or allegation of discrimination on any of the bases prohibited by this Section of the Agreement or the Section titled "Compliance with Laws". Such duty shall include reporting of the filing of any and all charges with the

Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or any other entity charged with the investigation or adjudication of allegations covered by this subsection within 30 days of such filing, provided that within such 30 days such entity has not notified Contractor that such charges are dismissed or otherwise unfounded. Such notification shall include a general description of the circumstances involved and a general description of the kind of discrimination alleged (for example, gender-, sexual orientation-, religion-, or race-based discrimination).

Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and cause for suspension and/or termination as provided in Section 5 above.

h. Compliance with Living Wage Ordinance

Contractor shall be responsible for compliance with any applicable Living Wage Ordinance or equivalent in effect in the jurisdiction in which the services under this Agreement are to be provided for any employees or agents of Contractor.

13. Retention of Records; Right to Monitor and Audit

(a) Contractor shall maintain all required records relating to services provided under this Agreement for three (3) years or such longer period as may be required by law after PHCD makes final payment and all other pending matters are closed, and Contractor shall be subject to the examination and/or audit by PHCD, a Federal grantor agency, and the State of California.

(b) Contractor shall comply with all program and fiscal reporting requirements set forth by applicable Federal, State, and local agencies and as required by PHCD.

(c) Contractor agrees upon reasonable notice to provide to PHCD, to any Federal or State department having monitoring or review authority, to PHCD's authorized representative, and/or to any of their respective audit agencies access to and the right to examine all records and documents necessary to determine compliance with relevant Federal, State, and local statutes, rules, and regulations, to determine compliance with this Agreement, and to evaluate the quality, appropriateness, and timeliness of services performed.

14. Merger Clause; Amendments

This Agreement, including the Exhibits and Attachments attached to this Agreement and incorporated by reference, constitutes the sole Agreement of the parties to this Agreement and correctly states the rights, duties, and obligations of each party as of this document's date. In the event that any term, condition, provision, requirement, or

specification set forth in the body of this Agreement conflicts with or is inconsistent with any term, condition, provision, requirement, or specification in any Exhibit and/or Attachment to this Agreement, the provisions of the body of the Agreement shall prevail. Any prior agreement, promises, negotiations, or representations between the parties not expressly stated in this document are not binding. All subsequent modifications or amendments shall be in writing and signed by the parties.

15. Controlling Law; Venue

The validity of this Agreement and of its terms, the rights and duties of the parties under this Agreement, the interpretation of this Agreement, the performance of this Agreement, and any other dispute of any nature arising out of this Agreement shall be governed by the laws of the State of California without regard to its choice of law or conflict of law rules. Any dispute arising out of this Agreement shall be venued either in the San Mateo County Superior Court or in the United States District Court for the Northern District of California.

16. Notices

Any notice, request, demand, or other communication required or permitted under this Agreement shall be deemed to be properly given when both: (1) transmitted via facsimile to the telephone number listed below or transmitted via email to the email address listed below; and (2) sent to the physical address listed below by either being deposited in the United States mail, postage prepaid, or deposited for overnight delivery, charges prepaid, with an established overnight courier that provides a tracking number showing confirmation of receipt.

In the case of PHCD, to:

Name/Title: [insert]
Address: [insert]
Telephone: [insert]
Facsimile: [insert]
Email: [insert]

In the case of Contractor, to:

Name/Title: [insert]
Address: [insert]
Telephone: [insert]
Facsimile: [insert]
Email: [insert]

17. Electronic Signature

This Agreement shall not be effective until it has been approved by the PHCD Board of Directors and signed by the PHCD Chief Executive Officer or the Program Manager. This Agreement may be executed in counterparts and by electronic or facsimile signatures.

18. Payment of Permits/Licenses

Contractor shall be duly licensed to provide the services required by Exhibit B and shall obtain any license, permit, or approval required from any agency for work/services to be performed under this Agreement at Contractor's own expense prior to commencement of said work/services. Failure to do so will result in forfeit of any right to compensation under this Agreement.

19. Miscellaneous Provisions

(a) Time is of the essence in this Agreement.

(b) Nothing in this Agreement shall be construed to give any rights or benefits to anyone other than PHCD and the Contractor.

(c) None of the provisions of this Agreement may be deemed to have been waived unless such waiver is specified in writing. Waiver of one provision or right shall not be construed as a waiver of any other provision or right.

(d) This Agreement shall be binding on and inure to the benefit of each party's successors and assigns.

(e) The unenforceability, invalidity, or illegality of any provision of this Agreement shall not render the remaining provisions unenforceable or invalid.

* * *

In witness of and in agreement with this Agreement's terms, the parties, by their duly authorized representatives, affix their respective signatures:

PENINSULA HEALTH CARE DISTRICT

By: ____

Its: ____

Date: ______________________________________

[CONTRACTOR NAME]

____

Date: ______________________________________

ENCLOSURE 2 – STANDARD ADMINISTRATIVE REQUIREMENTS

The following language is an example of terms that may be incorporated into an agreement with the selected proposer. Enclosure 2 is the standard administrative contract language that will be incorporated into Exhibit A – Services, under the Administrative Requirements section. Applicants will be deemed to have agreed to each clause unless the proposal identifies an objection, sets forth the basis for the objection, and provides substitute language to make the clause acceptable to the applicant. Such objections and substitute language must be submitted with the proposal and approved by PHCD Counsel prior to finalizing an agreement.

Administrative Requirements Under Exhibit A - Services

A. Quality Management and Compliance

1. Quality Management Program and Quality Improvement Plan

   Contractor must have a Quality Management Program and submit a Quality Improvement Plan to Peninsula Health Care District (PHCD) annually by June 30. The Quality Improvement Plan should address 1) how the Contractor will comply with all elements of this Agreement, 2) the Contractor will participate in the allcove™ Learning Community meetings and activities, 3) the Contractor will participate in the allcove™ Community Consortium meetings and activities, 4) services that are requested through a referral process will be scheduled within 3 days from date of request, 5) drop-in hours are determined via a shared decision making process with key stakeholders and the Youth Advisory Group. PHCD will provide feedback if the submitted plan is missing critical components related to PHCD and/or allcove™ requirements. Additional feedback may be available if requested prior to the submission date.

2. Referring Individuals to Psychiatrist

   Contractor will have written procedures for referring individuals to a psychiatrist or physician when necessary, if a psychiatrist is not available.

3. Medication Support Services

   For Contractors that provide or store medications: Contractor will store and dispense medications in compliance with all pertinent state and federal standards. Policies and procedures must be in place for dispensing, administering and storing medications and include, at a minimum, the following:

   a. Medications are logged in, verified, counted and added to inventory sheets.

b. All medications obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so.

c. Medications intended for external use only are stored separately from medications intended for internal use; food and blood samples are stored in separate refrigerators.

d. All medications are stored at proper temperatures: room temperature drugs at 59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit.

e. Medications are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication.

f. Medications are disposed of after the expiration date and recorded.

g. Injectable multi-dose vials are dated and initialed when opened.

h. A medications log is maintained to ensure that expired, contaminated, deteriorated and abandoned medications are disposed in a manner consistent with state and federal laws.

i. "Stock" medications that are not prescribed by the client's physician may not be used (for example, Tylenol).

4. Documentation of Services
   Contractor shall provide all pertinent documentation required for state and federal reimbursement including but not limited to Consent Forms, assessments, treatment plans, and progress notes. Contractor agencies are required to provide and maintain record of regular documentation training to staff providing direct services. Proof of trainings including attendance by staff may be requested at any time during the term of this Agreement.

   Mild to moderate Behavioral Health providers will comply with state law that requires each service be documented in a stand-alone progress note that includes the following elements:

   a. Client Name and MediCal number or PHCD medical record number;
   b. Date of Service;
   c. CPT code;
   d. Location Code;

e. Diagnosis addressed;
f. Provider and Agency Name, if applicable;
g. Face to Face minutes (client present) – claimed minutes;
h. Service time (client not presents);
i. Language (if language services were provided);
j. Service Description: goal/behavior addressed, therapist interventions, client's response/outcome, and plan;
k. Signature, printed name, credentials, and date.

Mild to moderate Behavioral Health providers are required to complete a closing summary for the following reasons:

a. if client has achieved optimal improvement;
b. the treatment team determines that the client will not benefit from further therapy;
c. the client is no longer in therapy, does not show for services or has stopped engaging.

5. Evaluation Tools and Satisfaction Surveys

Contractor agrees to administer/utilize any and all evaluation and survey instruments through datacove and as directed by PHCD, including outcomes and satisfaction measurement instruments.

6. Site Certification

Contractor will comply with all site certification requirements. Contractor shall maintain all applicable certifications through San Mateo County to provide any of the following reimbursable services: Short-Doyle Medi-Cal, MediCal, Medicare, or Drug MediCal.

7. Compliance with HIPAA, Confidentiality Laws, and PHI Security

Contractor must implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Protected Health Information (PHI), including electronic PHI that it creates, receives, maintains, uses or transmits, in compliance with 45 C.F.R and to prevent use or disclosure of PHI other than as provided for by this Agreement.

Contractor shall implement reasonable and appropriate policies and procedures to comply with the standards. Contractor is required to report any security incident or breach of confidential PHI to PHCD Clinical Lead within twenty–four (24) hours.

a. Contractor will develop and maintain a written Privacy and Security Program that includes administrative, technical and physical

safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities.

b. Contractor agrees to comply with the provisions of 42 C.F.R. Part 2 as described below if records contain or contract possesses any PHI covered under 42 C.F.R Part 2:

   1) Acknowledge that in receiving, storing, processing, or otherwise using any information from PHCD about the clients in the program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Behavioral Health and Recovery Services Patient Records, 42 C.F.R. Part 2;

   2) Undertake to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the federal confidentiality regulations, 42 C.F.R. Part 2; and

   3) Agree to use appropriate safeguards to prevent the unauthorized use or disclosure of the protected information.

d. Training Requirements
Contractor is required to conduct, complete and maintain record of annual confidentiality training by all staff serving or accessing PHI of PHCD clients. Contractor may utilize BHRS Confidentiality trainings located at http://smchealth.org/bhrs/providers/ontrain.

The following trainings must be completed on an initial and then annual basis:

   i. allcove™ Model Integrity
   ii. Staff Onboarding to allcove™ Model – at date of hire
   iii. allcove™ Clinical Model
   iv. Confidentiality
   v. HIPAA
   vi. Compliance
   vii. Fraud, Waste, and Abuse
   viii. Critical Incident Management
   ix. Cultural Humility
   x. Interpreter training (if using interpreter services)

8. Minimum Staffing Requirements
Contractor shall have on file job descriptions (including minimum qualifications for employment and duties performed) for all personnel whose salaries, wages, and benefits are reimbursable in whole or in

part under this Agreement. Contractor agrees to submit any material changes in such duties or minimum qualifications to PHCD prior to implementing such changes or employing persons who do not meet the minimum qualifications currently on file. Contractor service personnel shall be direct employees, contractors, volunteers, or training status persons.

9. Availability and Accessibility of Services
   Contractor shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees, if the Contractor also serves enrollees of a commercial plan, or that are comparable to the hours the Contractor makes available for Medi-Cal services that are not covered by the PHCD or another Mental Health Plan, if the Contractor serves only Medi-Cal clients.

10. Timely Access to Services
    The Contractor shall ensure compliance with the timely access requirements as referenced in 42 C.F.R. § 438.206(c)(1)(iv).

    a. Contractor shall return phone calls to an authorized client within **one (1) business day**. Contractor shall offer an available initial visit with an authorized client within **three (3) business days of the client's request for an appointment**. The client must be seen within **ten (10) business days** of the request for an appointment.

       Contractor must notify PHCD Director of Youth Behavioral Programswhen unable to meet this standard.

    b. The PHCD shall monitor Contractor regularly to determine compliance with timely access requirements. (42 C.F.R. § 438.206(c)(1)(v).

    c. The PHCD shall work with the Contractor to improve timely access and/or take corrective action if there is a failure to comply with timely access requirements. (42 C.F.R. § 438.206(c)(1)(vi).

11. Record Retention
    Paragraph 14 of the Agreement notwithstanding, Contractor shall maintain medical records required by the California Code of Regulations. Notwithstanding the foregoing, Contractor shall maintain beneficiary medical and/or clinical records for a period of ten (10) years, except the records of persons under age eighteen (18) at the time of treatment shall be maintained: a) until ten (10) years beyond the person's eighteenth (18th) birthday or b) for a period of ten (10)

years beyond the date of discharge, whichever is later. This rule does not supersede professional standards. Contractor may maintain records for a longer period of time if required by other regulations or licenses.

12. Critical Incident Reporting

Contractor is required to submit Critical Incident reports to PHCD Director of Youth Behavioral Programswhen there are unusual events, accidents, errors, violence or significant injuries requiring medical treatment for clients, staff or members of the community. (45 C.F.R. § 164, subpart C, in compliance with 45 C.F.R. § 164.316.)

The incident reports are confidential however discussion may occur with the Contractor regarding future prevention efforts to reduce the likelihood of recurrence. Contractor is required to participate in all activities related to the resolution of critical incidents.

13. Consumer Grievance Process
Contractor is required to develop and implement a resolution process for clients, that includes preparation and distribution of materials concerning client rights and how to initiate grievances appeals. It also provides ongoing outreach to inform and educate clients and their families about how they can participate in that process. It includes mechanisms to monitor and act as warranted to resolve disputes between clients and providers and observes defined timelines and legal parameters to assure fair and equal treatment for all.

14. Professional Standards and Credentialing
Contractor is responsible to perform yearly credentialing checks on all professional staff whose work requires licensing by a state regulatory board.

a. Physicians
Contractor's physicians or medical staff shall maintain the appropriate licensure and perform their duties under this Agreement in accordance with the rules of ethics of the medical profession. Contractor's staff shall also perform their duties under this Agreement in accordance with the appropriate standard of care for their medical profession and specialty.

b. Behavioral Health
Contractor's Behavioral Health staff shall maintain appropriate licensure and/or be certified by the appropriate State recognized Board in California (or eligible for certification by such Board by

virtue of having successfully completed all educational and residency requirements required to sit for the Board examinations).

c. Notification Requirement
Contractor shall notify PHCD upon the occurrence of any and/or all of the following:

1) Contractor's license to practice medicine in any jurisdiction is suspended, revoked, or otherwise restricted;

2) A complaint or report concerning Contractor's competence or conduct is made to any state medical or professional licensing agency;

3) Contractor's participation as a Medicare or Medi-Cal provider is under investigation or has been terminated;

4) There is a material change in any of the information the Contractor has provided to PHCD concerning Contractor's professional qualification or credentials;

Contractor must also notify the PHCD within thirty (30) days of:

1) any breach of this Agreement;

2) any material violation of PHCD's rules or regulations by the Contractor himself/herself; or

3) if the Contractor is subject to or participates in any form of activity which would be characterized as discrimination or harassment.

15. Ineligible Employees (PROVIDERS WITH EMPLOYEES)

PHCD requires that Contractors identify the eligibility status to bill for Medi-Cal services of ALL employees, interns or volunteers prior to hiring and on an annual basis thereafter. These records should be maintained in the employee files. This process is meant to ensure that any person involved with delivering services to clients of PHCD or involved in Medi-Cal billing or oversight are not currently excluded, suspended, debarred or have been convicted of a criminal offense as described below.

The Contractor must notify PHCD Director of Youth Behavioral Programs(by completing the PHCD Critical Incident Reporting form and faxing to _______) should a current employee, intern or volunteer

be identified as ineligible to bill Medi-Cal services. Contractors are required to screen for ineligible employees, interns and volunteers by using the following websites:

a. Office of Inspector General

Contractor may not employ any persons deemed an Ineligible Person by the Office of the Inspector General in the provision of services for the County through this Agreement. Any employee(s) of Contractor determined to be an Ineligible Person will be removed from responsibility for, or involvement with Peninsula Health Care District clients or operations. An "Ineligible Person" is an individual who (1) is currently excluded, suspended, debarred or otherwise ineligible to participate in Federal health care programs, or (2) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in the Federal health care programs after a period of exclusion, suspension, debarment or ineligibility. Ineligibility may be verified by checking: http://exclusions.oig.hhs.gov/.

b. California Department of Health Care Services

Contractor providing state funded health services may not employ any persons deemed an Ineligible Person by the California Department of Health Care Services (DHCS) in the provision of services for the County through this Agreement. Any employee(s) of Contractor determined to be an Ineligible Person will be removed from responsibility for, or involvement with County clients or operations. An "Ineligible Person" is an individual who has been (1) convicted of a crime involving fraud or abuse of the Medi-Cal program, or (2) suspended from the federal Medicare program for any reason. Ineligibility may be verified by checking:
http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

Once there, scroll down to the bottom of the page and click on Medi-Cal Suspended and Ineligible Provider List (Excel format). The list is in Alphabetical order. Search by the individual's last name.

16. Section 504 Compliance
Service Providers that will provide services on behalf of the PHCD must have disabled access and agree that it will comply with Section 504 of the Rehabilitation Act of 1973, as amended, all requirements

imposed by the applicable DHHS regulation, and all guidelines and interpretations issued pursuant thereto.

17. allcove™ Model Integrity
The licensing program (granting rights to use the allcove™ name and logo) is overseen by the Mental Health Services Oversignt and Accountability Commission with technical support and model integrity support provided directly to centers by the Central allcove™ Team at the Stanford Center.

Contractor is required to annually participate in a collaborative oversight review, and attend allcove™ trainings and conferences to maintain model integrity and to ensure a consistent, high quality experience for youth.

Contractor and subcontractors will represent themselves (as allcove™, not as their respective agencies).

18. Fingerprint Compliance
Contractor certifies that its employees, trainees, and/or its subcontractors, assignees, volunteers, and any other persons who provide services under this agreement, who have direct contact with any client will be fingerprinted in order to determine whether they have a criminal history which would compromise the safety of individuals with whom the Contractor's employees, trainees and/or its subcontractors, assignees, or volunteers have contact. Contractor shall have a screening process in place to ensure that employees who have positive fingerprints shall adhere to CCR Title 9 Section 13060 (Code of Conduct) when providing services to individuals with whom they have contact as a part of their employment with the contractor.

An attestation of fingerprinting certification is attached hereto and incorporated by reference herein as Attachment E.

19. Child Abuse Reporting
Required of all service providers that will be working with children under the age of 21. Service Provider must agree to ensure that all known or suspected instances of child abuse or neglect are reported to a child protective agency. Contractor agrees to fully comply with the Child Abuse and Neglect Reporting Act, Cal Pen Code 11164 et seq. Contractor will ensure that all known or suspected instances of child abuse or neglect are reported to an agency (police department, sheriff's department, county probation department if designated by the county to receive mandated reports, or the county welfare department) described in Penal Code Section 11165.9. This responsibility shall include:

a. A requirement that all employees, consultants, or agents performing services under this contract who are required by the Penal Code to report child abuse or neglect, sign a statement that he or she knows of the reporting requirement and will comply with it.

b. Establishing procedures to ensure reporting even when employees, consultants, or agents who are not required to report child abuse under the Penal Code gain knowledge of, or reasonably suspect that a child has been a victim of abuse or neglect.

c. Agrees to comply with Fingerprinting and Background checks as shown in Exhibit A, Section II. A.17 above.

B. Cultural Competency

Implementations of these guidelines are based on the National Culturally and Linguistically Accessible Services (CLAS) Standards issued by the Department of Health and Human Services. For more information about these standards, please contact go to: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf.

1. Contractor will submit an annual cultural competence plan that details on-going and future efforts to address the diverse needs of clients, families and the workforce. This plan will be submitted to the PHCD Director of Youth Behavioral Programs by September of the fiscal year.

   The annual cultural competence plan will include, but is not limited to the following:

   a. Implementation of policies and practices that are related to promoting diversity and cultural competence such as ongoing organizational assessments on disparities and needs, client's rights to receive language assistance.
   b. Contractor forum for discussing relevant and appropriate cultural competence-related issues (such as a cultural competence committee, grievance, or conflict resolution committee).
   c. Ongoing collection of client cultural demographic information, including race, ethnicity, primary language, gender and sexual orientation in health records to improve service provision and help in planning and implementing CLAS standards.
   d. Staffing objectives that reflect the cultural and linguistic diversity of the clients. (Contractor will recruit, hire and retain clinical staff members who can provide services in a culturally and linguistically appropriate manner).

e. Staff training plan related to cultural competency. Contractor will ensure that all program staff receive at least eight (8) hours of external training per year (i.e. sponsored by San Mateo County Behavioral Health and Recovery Services or other agencies) on how to provide culturally and linguistically appropriate services including the CLAS and use of interpreters.

2. Contractor will establish the appropriate infrastructure to provide services in San Mateo County identified threshold languages. Currently the threshold languages are: Spanish, Tagalog and Chinese (Mandarin and Cantonese). If contractor is unable to provide services in those languages or if other languages are needed, the contractor is expected to contact PHCD Director of Youth Behavioral Programs for consultation.

3. Contractor will translate relevant and appropriate behavioral health-related materials (such as forms, signage, etc.) in San Mateo County identified threshold languages in a culturally and linguistically appropriate manner. PHCD strongly encourages its contractors to use PHCD-sponsored forms in an effort to create uniformity within the system of care. Contractor shall submit to PHCD by March 31st, copies of Contractor's health-related materials in English and as translated.

4. Should Contractor be unable to comply with the cultural competence requirements, Contractor will meet with the PHCD Director of Youth Behavioral Programs to plan for appropriate technical assistance.

Administrative Requirements Under Exhibit B - Payment

A. Payment

1. Maximum Obligation

The maximum amount that PHCD shall be obligated to pay for all services provided under this Agreement shall not exceed the amount stated in Paragraph 3 of this Agreement. Furthermore, PHCD shall not pay or be obligated to pay more than the amounts listed below for each component of service required under this Agreement.

In any event, the maximum amount county shall be obligated to pay for all services rendered under this contract shall not exceed DOLLARS ($___).

2. Rates

Subject to specific rates of services as agreed upon with provider and itemized per year of contract term.

B. Contractor will be responsible for all expenses incurred during the performance of services rendered under this Agreement.

C. Modifications to the allocations in Paragraph A of this Exhibit B may be approved by the PHCD Chief Executive Officer or designee, subject to the maximum amount set forth in Paragraph 3 of this Agreement.

D. The PHCD Chief Executive Officer or designee is authorized to execute contract amendments which modify the PHCD's maximum fiscal obligation by no more than $25,000 (in aggregate), and/or modify the contract term and/or services so long as the modified term or services is/are within the current or revised fiscal provisions.

E. In the event that funds provided under this Agreement are expended prior to the end of the contract period, Contractor shall provide ongoing services under the terms of this Agreement through the end of the contract period without further payment from PHCD.

F. In the event this Agreement is terminated prior to December XX, 2026, Contractor shall be paid on a prorated basis for only that portion of the contract term during which Contractor provided services pursuant to this Agreement. Such billing shall be subject to the approval of the PHCD Chief Executive Officer or designee.

G. Monthly Invoice and Payment

Contractor shall invoice the PHCD on or before the tenth (10th) working day of each month prior to the service month. Payment by PHCD to Contractor shall be monthly. Invoices that are received after the tenth (10th) working day of the month are considered to be late submissions and may be subject to a delay in payment. PHCD reserves the right to deny payment of invoices if Contractor does not meet contract deliverables. Invoices and reports are to be sent to:

Attn: Vickie Yee, CFO
invoices@peninsulahealthcaredistrict.org

H. PHCD anticipates revenues from various sources to be used to fund services provided by Contractor through this Agreement. Should actual revenues be less than the amounts anticipated for any period of this Agreement, the maximum payment obligation and/or payment obligations for specific services may be reduced at the discretion of the PHCD Chief Executive Officer or designee.

I. PHCD May Withhold

Contractor shall provide all pertinent documentation requested by PHCD. The PHCD may withhold payment for any and all services for which the required documentation is not provided, or if the documentation provided does not meet professional standards as determined by the PHCD Program Manager. Contractor shall meet at least quarterly with the PHCD Program Manager, to review the service delivery, documentation, and billing reports and to take appropriate corrective action, as needed, to resolve any discrepancies.

J. Inadequate Performance

If PHCD or Contractor finds that performance is inadequate, at the PHCD's discretion, a meeting may be called to discuss the causes for the performance problem, to review documentation, billing and/or other reports, and to take appropriate corrective action, as needed, to resolve any identified discrepancies. This Agreement may be renegotiated, allowed to continue to end of term, or terminated pursuant to Paragraph 5 of this Agreement. Any unspent monies due to performance failure may reduce the following year's agreement, if any.

K. Quarterly Data Reporting Timeline

Contractor will collaborate with the PHCD Director of Youth Behavioral Programs to complete quarterly data forms on the following schedule:

1. Year One
    a. Quarter 1 – due date 4/30/22 completed by PHCD
    b. Quarter 2 – due date 9/30/22 completed by PHCD
    c. Quarter 3 – due date 3/31/23 completed by Contractor
    d. Quarter 4 – due date 6/30/23 completed by Contractor

2. Year Two
    a. Quarter 1 – due date 9/30/23 completed by Contractor
    b. Quarter 2 – due date 12/31/23 completed by Contractor
    c. Quarter 3 – due date 3/31/24 completed by Contractor
    d. Quarter 4 – due date 6/30/24 completed by Contractor

3. Year Three
    a. Quarter 1 – due date 9/30/24 completed by Contractor
    b. Quarter 2 – due date 12/31/24 completed by Contractor

c. Quarter 3 – due date 3/31/25 completed by Contractor
d. Quarter 4 – due date 6/30/25 completed by Contractor

4. Year Four
    a. Quarter 1 – due date 9/30/25 completed by Contractor
    b. Quarter 2 – due date 12/31/25 completed by Contractor
    c. Quarter 3 – due date 3/31/26 completed by Contractor
    d. Quarter 4 – due date 6/30/26 completed by Contractor

L. Annual Fiscal Report and Unspent Funds

1. Contractor shall submit to PHCD a year-end annual fiscal report no later than thirty (30) days after the end of each fiscal year. Annual fiscal reports shall include accounting for all services provided through the Agreement for each applicable period. Format shall be determined by the PHCD Director of Youth Behavioral Programs and is subject to change based upon funding source requirements. Contractor shall annually have its books of accounts audited by a Certified Public Accountant and a copy of said audit report shall be submitted along with the Annual Fiscal Report.

2. If the Annual Fiscal Report provided to PHCD shows that total payment to Contractor exceeds the total actual costs for all of the services rendered by Contractor to eligible patients during the reporting period, a single payment in the amount of the contract savings shall be made to PHCD by Contractor, unless otherwise authorized by the PHCD Chief Executive Officer or designee. By mutual agreement of PHCD and Contractor, contract savings or "unspent funds" may be retained by Contractor and expended the following year, provided that these funds are expended for services approved by PHCD and are retained in accordance with the following procedures.

    a. Contractor shall submit a summary calculation of any savings ninety (90) days after end of the fiscal year. The summary calculation will be a separate report from the year-end Annual Fiscal Report. With the summary calculation Contractor shall return the amount of the savings.

    b. At the time of the submission of the summary calculation Contractor may request to rollover some or all of any savings. The request must be made in writing to the PHCD Chief Executive Officer or designee. The request shall identify specifically how the rollover funds will be spent, including a detailed budget. Savings shall not be spent until Contractor receives a written approval of the request. Approved rollover funds shall be spent only for the succeeding fiscal year and only for the specific purpose(s) requested and approved.

c. Contractor shall submit an accounting report of the rollover savings. This report shall include copies of the detailed expenses. The report is due ninety (90) days after the specific purpose has been completed, or ninety (90) days after the end of the fiscal year, whichever comes first. Any unspent rollover funds shall be returned to the PHCD with the accounting report.

d. If the specific purpose is not yet complete as of the end of the succeeding fiscal year, contractor may request to rollover the unspent funds to the succeeding second fiscal year by submitting a written request with the accounting report. The unspent rollover funds shall not be spent until the request is approved by the PHCD Chief Executive Officer or designee.

e. A final accounting of the rollover funds shall be submitted ninety (90) days after the specific purpose has been completed, or ninety (90) days after the end of the second fiscal year, whichever comes first. Any unspent rollover funds shall be returned to the PHCD with the accounting report.

M. Claims Certification and Program Integrity

Anytime Contractor submits a claim to the PHCD for reimbursement for services provided under Exhibit A of this Agreement, Contractor shall certify by signature that the claim is true and accurate by stating the claim is submitted under the penalty of perjury under the laws of the State of California.

The claim must include the following language and signature line at the bottom of the form(s) and/or cover letter used to report the claim.

> "Under the penalty of perjury under the laws of the State of California, I hereby certify that this claim for services complies with all terms and conditions referenced in the Agreement with Peninsula Health Care District. I understand that payment for these services may be from Federal and/or State funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and/or State laws.
>
> Executed at __________________ California, on _________, 20__
>
> Signed ______________________ Title _________________
>
> Agency _____________________"

ENCLOSURE 3
Attachment H
Health Insurance Portability and Accountability Act (HIPAA) Business Associate Requirements

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DEFINITIONS

Terms used, but not otherwise defined, in this Schedule shall have the same meaning as those terms are defined in 45 Code of Federal Regulations section 160.103 164.304 and 164.501. (All regulatory references in this Schedule are to Title 45 of the Code of Federal Regulations unless otherwise specified.)

a. ***Designated Record Set***. "Designated Record Set" shall have the same meaning as the term "designated record set" in Section 164.501.
b. ***Electronic Protected Health Information***. "Electronic Protected Health Information" ("EPHI") means individually identifiable health information that is transmitted or maintained in electronic media, limited to the information created, received, maintained or transmitted by Business Associate from or on behalf of Covered Entity.
c. ***Individual***. "Individual" shall have the same meaning as the term "individual" in Section 164.501 and shall include a person who qualifies as a personal representative in accordance with Section 164.502(g).
d. ***Privacy Rule***. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations Part 160 and Part 164, Subparts A and E.
e. ***Protected Health Information***. "Protected Health Information" shall have the same meaning as the term "protected health information" in Section 164.501 and is limited to the information created or received by Contractor from or on behalf of PHCD.
f. ***Required By Law***. "Required by law" shall have the same meaning as the term "required by law" in Section 164.501.
g. ***Secretary***. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his or her designee.
h. ***Security Incident***. "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system, but does not include minor incidents that occur on a daily basis, such as scans, "pings", or unsuccessful random attempts to penetrate computer networks or servers maintained by Business Associate
i. ***Security Rule***. "Security Rule" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Part 164, Subparts A and C.

OBLIGATIONS AND ACTIVITES OF CONTRACTOR

a. Contractor agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as required by law.

b. Contractor agrees to use appropriate safeguards to prevent the use or disclosure of the Protected Health Information other than as provided for by this Agreement.
c. Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of Protected Health Information by Contractor in violation of the requirements of this Agreement.
d. Contractor agrees to report to PHCD any use or disclosure of the Protected Health Information not provided for by this Agreement.
e. Contractor agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Contractor on behalf of PHCD, agrees to the same restrictions and conditions that apply through this Agreement to Contractor with respect to such information.
f. If Contractor has protected health information in a designated record set, Contractor agrees to provide access, at the request of PHCD, and in the time and manner designated by PHCD, to Protected Health Information in a Designated Record Set, to PHCD or, as directed by PHCD, to an Individual in order to meet the requirements under Section 164.524.
g. If Contractor has protected health information in a designated record set, Contractor agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the PHCD directs or agrees to make pursuant to Section 164.526 at the request of PHCD or an Individual, and in the time and manner designed by PHCD.
h. Contractor agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Contractor on behalf of, PHCD available to the PHCD, or at the request of the PHCD to the Secretary, in a time and manner designated by the PHCD or the Secretary, for purposes of the Secretary determining PHCD's compliance with the Privacy Rule.
i. Contractor agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for PHCD to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.
j. Contractor agrees to provide to PHCD or an Individual in the time and manner designated by PHCD, information collected in accordance with Section (i) of this Schedule, to permit PHCD to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.
k. Contractor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Contractor creates, receives, maintains, or transmits on behalf of PHCD.
l. Contractor shall conform to generally accepted system security principles and the requirements of the final HIPAA rule pertaining to the security of health information.
m. Contractor shall ensure that any agent to whom it provides EPHI, including a subcontractor, agrees to implement reasonable and appropriate safeguards to protect such EPHI.
n. Contractor shall report to PHCD any Security Incident within 5 business days of becoming aware of such incident.
o. Contractor shall makes its policies, procedures, and documentation relating to the security and privacy of protected health information, including EPHI, available to the Secretary of the U.S. Department of Health and Human Services and, at PHCD's request,

to the PHCD for purposes of the Secretary determining PHCD's compliance with the HIPAA privacy and security regulations.

PERMITTED USES AND DISCLOSURES BY CONTRACTOR

Except as otherwise limited in this Schedule, Contractor may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, PHCD as specified in the Agreement; provided that such use or disclosure would not violate the Privacy Rule if done by PHCD.

OBLIGATIONS OF PHCD

a. PHCD shall provide Contractor with the notice of privacy practices that PHCD produces in accordance with Section 164.520, as well as any changes to such notice.
b. PHCD shall provide Contractor with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, if such changes affect Contractor's permitted or required uses and disclosures.
c. PHCD shall notify Contractor of any restriction to the use or disclosure of Protected Health Information that PHCD has agreed to in accordance with Section 164.522.

PERMISSABLE REQUESTS BY PHCD

PHCD shall not request Contractor to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by PHCD, unless the Contractor will use or disclose Protected Health Information for, and if the Agreement provides for, data aggregation or management and administrative activities of Contractor.

DUTIES UPON TERMINATION OF AGREEMENT

a. Upon termination of the Agreement, for any reason, Contractor shall return or destroy all Protected Health Information received from PHCD, or created or received by Contractor on behalf of PHCD. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Contractor. Contractor shall retain no copies of the Protected Health Information.
b. In the event that Contractor determines that returning or destroying Protected Health Information is infeasible, Contractor shall provide to PHCD notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Contractor shall extend the protections of the Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Contractor maintains such Protection Health Information.

MISCELLANEOUS

a. Regulatory References. A reference in this Schedule to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required.
b. Amendment. The Parties agree to take such action as is necessary to amend this Schedule from time to time as is necessary for PHCD to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.
c. Survival. The respective rights and obligations of Contractor under this Schedule shall survive the termination of the Agreement.
d. Interpretation. Any ambiguity in this Schedule shall be resolved in favor of a meaning that permits PHCD to comply with the Privacy Rule.
e. Reservation of Right to Monitor Activities. PHCD reserves the right to monitor the security policies and procedures of Contractor

FINGERPRINTING CERTIFICATION

Contractor hereby certifies that its employees, trainees, and/or its subcontractors, assignees, volunteers, and any other persons who provide services under this agreement, who have direct contact with any client will be fingerprinted in order to determine whether they have a criminal history which would compromise the safety of individuals with whom the Contractor's employees, trainees and/or its subcontractors, assignees, or volunteers have contact. Additionally, Contractor's employees, volunteers, consultants, agents, and any other persons who provide services under this Agreement and who has/will have supervisory or disciplinary power over a child (Penal Code Section 11105.3) (the "Applicant") shall be fingerprinted in order to determine whether each such Applicant has a criminal history which would compromise the safety of children with whom each such Applicant has/will have contact.

Contractor's employees, volunteers, consultants, agents, and any other persons who provide services under this Agreement will be fingerprinted and: (check a or b)

____ a. do NOT exercise supervisory or disciplinary power over children (Penal 11105.3).

____ b. do exercise supervisory or disciplinary power over children (Penal 11105.3).

____
Name of Contractor

____
Signature of Authorized Official

____
Name (please print)

____
Title (please print)

____
Date

Revised 10/5/2017 S.Reed

Enclosure 5. Attachment I: Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, as Amended

Please review this document and state in proposal if you will comply with Section 504 requirements.

The undersigned (hereinafter called the "Contractor(s)") hereby agrees that it will comply with Section 504 of the Rehabilitation Act of 1973, as amended, all requirements imposed by the applicable DHHS regulation, and all guidelines and interpretations issued pursuant thereto.

The Contractor(s) gives/give this assurance in consideration of for the purpose of obtaining contracts after the date of this assurance. The Contractor(s) recognizes/recognize and agrees/agree that contracts will be extended in reliance on the representations and agreements made in this assurance. This assurance is binding on the Contractor(s), its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Contractor(s).

The Contractor(s): (Check a or b)

☐ a. Employs fewer than 15 persons.

☐ b. Employs 15 or more persons and, pursuant to section 84.7 (a) of the regulation (45 C.F.R. 84.7 (a), has designated the following person(s) to coordinate its efforts to comply with the DHHS regulation.

____
Name of 504 Person - Type or Print

____
Name of Contractor(s) - Type or Print

____
Street Address or P.O. Box

____
City, State, Zip Code

I certify that the above information is complete and correct to the best of my knowledge.

____
Signature

____
Title of Authorized Official

____
Date

*Exception: DHHS regulations state that:

"If a recipient with fewer than 15 employees finds that, after consultation with a disabled person seeking its services, there is no method of complying with (the facility accessibility regulations) other than making a significant alteration in its existing facilities, the recipient may, as an alternative, refer the handicapped person to other providers of those services that are accessible."