allcove™ San Mateo FAQs

Staffing questions

1. **Given that the psychiatrist position and nurse practitioner positions are .4 FTE, can those roles be combined?**

NO, they cannot be combined because they provide two different functions and services.

2. **Regarding the required training for all staffing roles, does allcove™ have those curriculums and provide the training? Or are those topics that we have to source for?**

See question #15

3. **Is it possible to hire 8 part time therapists instead of 4 full time or a combo or F/T and P/T?**

The combination of P/T and F/T staff can be decided at a center level, however, there are considerations of continuity of team-based care and care coordination that are a central part of the model.

4. **Are these staffing RECOMMENDATIONS or staffing REQUIREMENTS? Suppose a 0.5 FTE is enough for SEE? In other words, can we bring our own experience to bear on the staffing model, keeping your guidelines in mind?**

Yes, certainly. The staffing model that's provided in the toolkit is an aspirational staffing profile. Think about the core service delivery and how you may be able to creatively deliver those services. It is important not to shortchange any of the service streams, we don't see any of them as less important than others. Often, I think what happens is the peer support and the non-clinical services tend to get a little neglected because they don't provide that clinical care but in this model they're just as important. You will need staff to deliver them, whether you start out at the baseline and then work up as more young people come through the door. Internationally this model has been very successful in opening the door to access. So, what typically happens is the minute you open the doors young people do come and they come quite willingly. At headspace right now the problem is demand. You need to have a solid staffing profile so that when you open the doors you can meet the demand at a low level and then plan to staff up.

5. **Given the county-wide hiring issues and depletion of clinical workforce, hiring four licensed clinicians to run the clinic may be a barrier. Would PHCD consider allowing a staffing structure with a licensed clinician to carry cases and supervise three clinical associates (post-graduate, registered with the BBS, collecting hours)?**

We are looking for permanent staff. If the budget just doesn't work don't feel shy contacting the Stanford team or Eddie and talking about the budget relatives. The district has the planned budget, but budgets can be changed. The budget is what is right now and that's

what we have to assume that's what it will be. But don't be afraid to back channel and ask the board about the budget.
Bringing in clinical associates can be a way to expand the capacity to care, but it can't be seen as providing your core staffing profile. The clinicians are the ones who are going to have to be providing supervision. With the center opening soon you want to have a pretty solid team to start off with so that they can provide care directly and in time certainly build towards your capacity through student programs.

Budget/Funding

6. **Many of the roles associated with this project are non-management positions. Will there be funding to support the supervision of these roles?**

See question #10

7. **You provide a rough budget with FTW requirements, a lot of training, but nothing is included for HR to recruit/train, Marketing to outreach, IT to wire and connect, Finance to audit, Compliance/Quality to monitor etc. These are startup and ongoing indirect costs, and they are substantial. How do you propose an agency pay for them, or do you have a ballpark amount on what you expect them to be? The answer could impact submissions contents considerably.**

Please refer to question 10, 11 and 35

8. **So, we don't have to apportion the salaries the way it was laid out on p. 18?**

What that is, is the yearly funding for staff per component. If you were doing the first-year budget you would probably not have all of that funding because you're ramping up and hiring people so you may only want to ask for a portion of that and devote some resources to the hiring process and the training process. So, then your budget for that may be different. So that first year you may use all that money and you may not depend on how many clients you get that first year. The staffing model numbers have come vetted and recommended by the Stanford Team.

9. **Do we only have this kind of budgetary flexibility with staff in the ramp-up period or can we adjust some of the other positions in later years?**

Look at the core service streams, you have to be able to deliver those services from the onset then you scale up staff according to young people coming in. When you open the doors, you need to be able to provide all those core services. It's not scaling up the core services, it's being able to deliver all of them as the minimum requirement.
We're going to go with what works, what's effective, what our partners at Stanford believe works. We want something that's sustainable.

10. **Will start-up costs be funded in excess of the core staff covered by the $2.52 annually?**

We will not go over the budget. For the year's budget we wouldn't go over that, but we would give you a certain amount to work with even if you do not have all the staff. So, you need to decide what that is. I would look at all those components, like training and onboarding.

11. **Curious about the integration/budget consideration between access to healthcare internationally and limited access -- so many of licensed clinicians get recruited by hospitals with ability to pay Bay Area wages … Using a model that's done internationally with lots more government funding that's sustainable because it's part of their culture and their financial makeup and then bringing it here which theoretically it's been seed funded by government agencies. But the sustainability of it is gigantic, the clinical portion is going to be the premier cost.**

We're going to try and be creative and work with the insurance companies and hospitals. But it's a work and progress. The difference between us as a special district and say Santa Clara County is we as a special district have much less red tape and our mission is different than the county.

12. **Can you please confirm that we are understanding these aspects of the budget correctly: a) that there is $884K each year for 4 clinicians, and that there is $498K per year for a .4 FTE psychiatrist?**

The budget is $884,000 for 4.0 FTE Clinicians (including benefits, insurance, and training); and $498,333 for 0.4 FTE Psychiatrists (including benefits, insurance and training).

Services

13. **What is the educational expectation for a Peer Support Specialist?**

The education expectation is a high school GED/diploma and lived experience receiving mental health support. Although a peer support specialist can have a college degree and higher levels of education, not having a 4-year degree should not be a barrier to holding a peer support role.

14. **Would mentoring services from mentors older than the Peer Support Specialist ages of 18-26 fall under any of the service categories?**

Mentoring as its own standalone approach to supporting the young people who attend your allcove could be a helpful corollary approach to supporting your youth community, but should be seen as a separate, "service stream," and not directly related to peer support work as youth/adult mentoring programs and relationship building are a different model of youth support. Mentoring programs that support young people through matching them with their adult allies, would require ongoing supervision and training of the mentors, as well as keeping in mind matching and maintaining a youth/adult mentoring relationship has its own set of best practices, which is separate from peer support and the other non-clinical services streams at allcove. I am happy to discuss more, as needed. -Jules Villanueva-Castano, julesvc@stanford.edu

15. **Which of the required staff training will CaT (Stanford) provide directly?**

Any training that is through the learning community about the model components is funded by the OSC so it's free of charge to any allcove™ partners.

Logistical

16. **Which sections are included in the 20-page narrative limit? Specifically, are any of these included: cover letter, org chart, board authorization letter, Sections H. (claims & HIPAA violations if any), and L. Statement of Compliance with Contractual Requirements?**

The sections that are included in the 20 page narrative are: C. Organizational Capacity and Experience; D. Philosophy and Service Model; E. Staffing Patterns and Training, F. Cultural Responsiveness and Customer Service; G.Quality Evaluation and Improvement;J. Cost Analysis/budget. You can add attachments for such things as an org chart, and that will not be counted towards the 20-page limit.

17. **On page 27 section C.1 to C.5, are any of the Supplemental Documents listed including Organizational Capacity included in the 20-page limit?**

No, attachments will not count towards the 20-page limit.

18. **Is there a page limit on Supplementary Documents?**

No.

19. **Letters of Recommendation: Does the limit of five: apply to all letters under Section K including the three business references? Or are five letters allowed beyond those three?**

We asked for at least 3 business references, there was no limit to how many references you can submit. However, the Letters of Recommendation were limited to 5.

20. **Page 97, in the timely access to services section, there is mention of an "authorized client". Please describe what an "authorized client" means- how is this defined? Does it have a term-limit?**

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. There is no other authorization process required. The language in Enclosure 2: Standard Administrative Requirements will be revised at time of contract to remove reference to "authorized client".

21. **The timely access to services on page 97 does not match what is outlined in the referral/intake process on page 17. Which is correct? Is this part of the distinction between a referral/new client and an "authorized client"?**

Page 17 of the RFP is correct. Page 97 of Enclosure 2: Standard Administrative Requirements will be revised at time of contract to remove reference to "authorized client".

22. **Should partners be submitting their own applications if they don't have an identified Coordinating Agency?**

Partnering agencies can certainly work to secure a coordinating agency but that should not prevent you from applying. If your proposal is great, then we can partner you with a coordinating agency that is selected.

23. If applying as a partner (not the main Coordinating Agency), would we need to identify partners to cover the remaining components?

The primary agency submitting the proposal, would have to identify partners for all components. But you as a partner would not have to do that.

24. As a smaller agency this is a huge project, we would be interested more in forming a partnership with a bigger agency. How do we go about that, do we put in a proposal? Will there be a list of other agencies applying?

Yes, I think if you are interested in partnering you can look at the list of agencies that are interested in applying and that are in attendance today. Connect with anybody who is on this attendee list today, especially with the services that you can provide. You could respond as an individual provider; however we are looking for someone through this RFP for a provider that can provide all the services.

One of the main core areas of allcove™ is service integration and collaboration and I think it starts here by reaching out to another partnering agency.

25. Does the statement of compliance need to be signed? Does the statement regarding disputes need to be signed?

No, when you put in the cover letter that is signed by whoever is authorized to sign for the proposal, they are signing for all the information included in the proposal. What we do need is a statement saying, “yes we will comply”.

26. The ability to solidify MOU's by the submission deadline is too tight . It almost presents as if the expectation is that MOU's should have been established long before the RFP dropped in order to realistically be ready and integrated into budgeting by 9/9.. Thanks -Our org would like to contract for medical services but we do not have time prior to submission to secure/vet a vendor. Thank you - respectfully

It’s not technically necessary to have the MOU finalized by 9/9. But applying agencies do risk themselves by applying with the intention of fulfilling the MOU and being unable to fulfill it by the due date. There will be additional time to secure the MOU before being fully selected.

27. Where do we place the (1) project schedule, (2) info on transition to new contractor, (3) financial audit?

a. Place it in the budget section, because that would show any start up costs you need
b. Need more info - That is in the section that was enclosure #2, you do not address anything there, that will be at time of contract. At time of contract we will say you need to have a plan or process so that if you decide you’re not going to be a contractor that you have a plan for that. You will need to maintain services during the transition to the other provider.
c. Place it in the budget section

28. Are we required to submit Supplementary Documents? (p. 27)

No, you are not required to. If you have documents that outline your organization, like an organization chart or a plan for quality assurance you could include that. You are not required to.

29. What is the address for proposal submission? May we deliver by hand?
Yes, you could deliver by hand, the address is 1819 Trousdale Dr, Burlingame, CA 94010, the address is also included in the RFP. You do need to have your electronic copy as well as your paper copies submitted by the due date to be considered for the RFP.

30. medical malpractice as part of insurance? The RFP states cost include INSURANCE, benefits and salary
Because there will be medical services and other professional services provided. They will have to have professional negligence insurance appropriate to whatever services the applying agencies are going to be providing.

31. Several of us have concerns about the deadline. Can it be pushed back so we have more time to establish partnerships?
The new deadline is September 16th, 2022.

32. Will allcove™ have to compensate Stanford for some integrity or clinical training?
All technical assistance and training available through the learning community is funded by the MHSOAC and free of charge to any allcove™ partners.

33. For medication, who would pay for medication if a youth does not have Medi-Cal or other insurance?
Currently that's what the seed funding from the commission will be utilized, to initially be able to pay for those kinds of expenses. The work around for financial sustainability and creating funding streams that the commission along with their associates and our team will be looking at further on after those grant funds run out what getting reimbursements is what that's going to look like. So initially those costs will be covered through the grant.

34. If we bill Medi-Cal or private insurance, would the resulting revenue be offset with a corresponding reduction in the award amount from Peninsula or would we still receive the $2.5M annually?

The corresponding revenue will be offset as PHCD will equally be involved in the reimbursement of insurance and Medi-Cal services.

35. On p. 18. the RFP notes that the budget ought to reflect insurance costs. Would we receive reimbursement for the cost of insurance or ought we to reduce the amounts allocated to salary, benefits, and training to create space in our budget to pay for this item?

The budget provided in the RFP for yearly staff costs includes insurance, training and benefits. Your budget should reflect the total amount for staffing that includes these items

and does not exceed the amount listed in Section II.2.5 Funding for yearly staff costs. PHCD would not reimburse you for insurance, per se, as that should be included in your staffing budget.

36. If we were to get the award, would we bill each month for 1/12th of the costs or would we need to share a GL + timesheets + subcontractor costs?

All of the information regarding billing and costs will be further outlined and negotiated in the full contract that will be executed by PHCD and contractor/subcontractors that are selected for this project.

Questions to PHCD

37. Under what circumstances might PHCD consider multiple primary contractors?
See question #22 and #83

38. The target community area is the PHCD service area. Is there an expectation that the allcove™ center would primarily focus on serving youth from this specific area? Would there be an impact to funding if the center serves youth from outside the target community area?

allcove™ centers do not have a service catchment and provide services to all youth who come in. Practically speaking, however, centers typically draw youth from about 1 hour's distance depending on transport flows. Youth who come to allcove™ and who are not able to continue access services at center because of geographical distance should be assisted initially and then be linked with services that are closer to their home base. AS an example some youth who attended allcove™ San Jose transitioned to being seen at allocve Palo Alto when the center closed.

39. Is there an example of how decisions are made about programming with the various inputs, including YAG, the Community Consortium, the Stanford CYMHW, the Central allcove™ Team, PHCD Director of Youth Behavioral Programs and PHCD Clinic lead, and the coordinating agency?

The lead agency is responsible for the operational and clinical governance of the center therefore decision making is guided by the organization's governance structures and advisory bodies. The Stanford Central allcove™ Team provides technical assistance to implement the model adherence to model integrity.

40. On page 103, there's an expectation for providers to have the infrastructure to provide services in four threshold languages. Does "appropriate infrastructure" include access to a third-party interpretation service?

Yes, it does.

41. Is it possible to get an example of the rate schedule from other current allcove™ providers?

There isn't a rate schedule as of yet since the Santa Clara centers have not been billing.

42. What is the expectation of the timeline for the coordinating agency to work towards certification for drug Medi-Cal?

See question #44

43. On page 14, there is mention of "drop-in mental health counseling services". What does this look like?

Drop-in services is a modality to deliver brief face to face short-term Interventions with longer term, or more intensive care, being accessed through scheduled appointments. It addresses young people's need to have support in a timely way and has been very successful internationally.

44. Are there restrictions to serving youth who are publicly or privately insured?

No, as of now there are no restrictions. Further conversations with private and public insurance carriers will occur once the coordinating agency comes on board.

45. Who determines which health, mental health and other screenings and assessments will be used?

The allcove™ data collection system, the datacove, has screening tools/outcome measures built in. See Toolkit resource:https://stanfordmedicine.box.com/s/6u4azsnov96ajyn4gritu2edgx42nlgt Additional tools can be used locally but consideration should be given to youth survey fatigue.

46. I don't see the FT project manager on the FTE list. Does Peninsula expect us to fund this ourselves or do we just designate one of the licensed clinicians as the project manager? Who would pay for security?

We do have a Peninsula Health Care District Clinical Lead; the Lead will be the clinical liaison. They will be the direct overseer of interacting with licensed clinicians. This is a position paid by and covered by Peninsula Health Care District that will also be a part of the clinical team and will also be having their own caseload of patients as well. For the administration and support Eddie will be serving as the site director.

YAG questions

47. How many members are on the YAG? How does recruitment, training, and engagement work for the SM YAG?

There are currently 17 members on the YAG. Recruitment, training and engagement are overseen by the Youth Outreach Specialist. Recruitment is done yearly and members on the YAG can stay on for two terms (each term accounts for one calendar year).

48. Why are no young people presenting?
For our Youth Advisors, a lot of them have just started school, I have both high school and college young people. Youth have started school and we are big supporters of them doing school and we adjust according to their school schedules

49. How do folk sign up to be in the YAG?
We recruit for our YAG once a year and just recently went through recruitment. Youth between the ages of 16-25 are eligible to apply via an online form. Once they submit an application there is an interview process. Following the interview process the Youth Outreach Specialist and the YAG members will discuss who will be accepted into the YAG. After deliberation acceptances will be sent out.

50. Are there currently any current YAG members who have lived experience with living unhoused? (Understanding that the model targets mild to moderate challenges - I was just curious)
We do not currently have representation from youth with lived experience of living unhoused. We are always looking to ensure that all lived experiences are represented and constantly looking to expand our networks for outreach.

Datacove

51. Is it possible to link the datacove with other EHRs for collective data gathering?
No, datacove will not be able to link to other EHR's there will be double data entry

52. What technical support is available for datacove users?
The central allcove™ team will be the main technical support for datacove

53. Can you share any metrics from other allcove™ locations that show what good might look like? (i.e. encounters by service provision, job development, educational supports, physical medicine, etc.)
We are evaluating the allcove™ model on a number of domains, across a number of groups. The five domains we are collecting outcomes on are: increased access, mental health equity, youth partnership. efficient and effective use of resources, and improved youth mental health…
Some of the outcomes we are collecting are youth health is collected through our minimum data set, and looks at mental health tools, progression of goals, a flourishing measure. we intend for the intended outcomes to be a holistic view of a youth's wellbeing
Our evaluation framework is quite robust. We are collecting domains across a number of different groups ie: increased access, mental health equity, youth partnership. efficient and effective use of resources, and improved youth mental health. Through the datacove we are really collecting data on youth wellbeing and health and some of the specific tools and

measures that we've been collecting from Santa Clara County include specific mental health screeners like the YAD which measure anxiety. We also wanted to measure some strength-based outcomes by asking youth to complete a flourishing measure which gives more of a holistic measure of a youth's relationships, friendships, goals. This is just a sneak peek at what we were measuring.

54. Would the coordinating agency and sub-contractors, if applicable, have access to reports and raw data from datacove?

See question #52

Miscellaneous/Unsure

55. In the attachments section, Attachment IV is a document from the Indigo Project. What is the role of the Indigo Project in this model?

The Indigo Project has worked with Stanford on developing the evaluation process and components of the datacove system to be used across the allcove™ program.

56. How will these two allcove™ program goals be measured?

a. **A. Provide education to the public about the importance of mental health to increase early help seeking and increase mental health literacy.**
b. **Reduce negative stereotypes, bias and stigma around mental illness (i.e. in schools, other community entities).**

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.

See page 78 of RFP document.

57. What is the allcove clinical model? Can we get an overview of what this is?

The allcove™ clinical model is based on creating a space where young people at risk of or facing mental health, substance use, or health concerns can come in for early support and intervention. The clinical model is short term and solution focused, but also prioritizes linking those needing a higher level of care to appropriate services. The frame is really a public mental health model creating early assessment and intervention opportunities that also link school mental health programs to allcove™ centers to early psychosis programs in a community-based continuum of early intervention care. The substance use component is based on an SBIRT early identification and intervention model as well. The behavioral health-primary care model focuses on an integrated care framework, where primary care providers and mental health providers cross refer, train, and support each other.

58. **Do the physical or mental health services have to end after 8 sessions? Is the maximum 8 sessions for both? For instance, could a youth get 8 sessions of physical health services and 8 sessions of mental health services?**

The mental health services are for mild to moderate cases, if a therapist believes a patient needs to continue after 8 sessions there will be referral pathways for more severe cases. The physical health services do not need to end after 8 visits, however, this is why a strong integration of wrap-around services with our external partnerships will be encouraged so that clients are transferred over to more permanent long-term physical and mental health, should they need it.

59. **Would it be possible to find out the number of youth served over time for each of the allcove™ centers?**

We currently have palo alto open and they're collecting data on young people coming in at a local level. We haven't deployed the data collection system yet so we would have to connect with the team at Santa Clara County to get statistics on the number of young people they're seeing. Something along the lines of 300 young people was something Vicki Harrison saw in a board report that they submitted. We're not entirely sure if it was unique users.

60. **Will this presentation be available to view after the meeting? Thanks!**

We will be sharing the allcove™ presentation slide deck to all RSVP'd attendees via email

61. **What is SEE?**

SEE is an acronym that stands for Supported Education and Employment, which is the workforce component that we will have at our allcove™ center.

62. **Will there be a list of who is attending today?**

Yes, we have sent out a list to all RSVP'd Proposers Conference attendees

63. **How do youth get to allcove™ centers?**

One of the Key concepts of allcove™ center is accessibility. Our center in San Mateo will be easily accessible through public transportation. There's a bus stop at the front entrance of the center and CalTrain is very close by.

64. **One Life is passionate about teen and young adult mental health, and has a major presence and great track record in this space in the mid-peninsula, currently employing 95 therapists. One Life would like to apply for the behavioral health/substance use portion of allcove™, and have even identified the providers interested in taking on these roles. <u>Can One Life apply just for this portion of the funding?</u>**

See question #22

<u>QUESTIONS FROM AUGUST 19TH SITE VISIT</u>

65. What is the COVE meant to be used for?

The cove is meant to represent the protective and safe space that allcove™ provides to all its visitors. At an allcove™ center the cove is typically used for youth who come in and want to hang out at a center. It can be used for activities such as game night or if a young person wants to come into the center to play video games. It is meant to be a flex area that can be used for many different activities.

66. Are there any safety concerns with the balcony? Can plexiglass be used as an option?

The outside terrace will only be utilized under strict supervision and will not be open for regular access unless an activity is being conducted in coordination with center staff. Alternative usages of the space will be considered on a case-by-case basis. Additional discussions and requests will happen between PHCD staff and the selected agency(s).

67. Are animals allowed onsite?

California law requires most public places to admit service dogs and psychiatric service dogs but not emotional support animals. California law allows persons with disabilities to bring trained service dogs and psychiatric service dogs, but not emotional support animals, to all public places. The center will follow in accordance with these laws.

68. If there is a youth that has children, can they bring the children to the center if they do not have childcare?

Currently there will not be childcare provided at the center. However, if there are newly mothers who are nursing, there will be a lactation (mothers' room)/wellness room available.

69. Are the services only for those that have MediCal, or is it regardless of insurance?
See question #33

70. Is there a possibility to fund the center with another grant after this existing grant term is over?

Yes, certainly the possibility of future funding with supplemental and additional grant funds does exist. It is an area that PHCD with its coordinating agency selected will work together to ensure that whenever grant opportunities arise that they are vetted and considered.

71. Will there be cubicles for service staff in the workspace area?

The workspace area will not have cubicles. It's an open concept workspace at allcove™ centers. Each employee will have their own workspace and there will be desks set up next to each other but there will not be cubicles.

72. Where do youth check in?

Youth will check into the center at the reception desk.

73. I thought there wasn't going to be a reception area, where is the space for the "moment of pause"?

The moment of pause in our center will be the public lobby. This is the first space you walk into once you exit the elevator. The reception will be through the double doors following the moment of pause.

74. Are you planning a living space out on the balcony?

At this moment nothing is finalized for the balcony. We are currently in discussion with our YAG to figure out what they would like to see in our center

75. Are all the windows going to be frosted for privacy and confidentiality?

All of the windows in confidential areas will be frosted for privacy. Including all of the counseling rooms.

76. Does youth have access to the workspace area? How do you prevent access to confidential records?

Youth will not have access to the staff workspace area. We plan on having secure badge entry to all places with confidential records such as the staff workspace area and the clean and soiled rooms and only exclusive access to the medication room or medical supply room.

77. If repairs need to be done, who do we contact?

Peninsula Health Care District (PHCD) and the three full time staff will be part of the center and work directly at the center. They will handle all building/landlord issues and operational logistics regarding the site, parking, supplies or utilities.

78. Will there be service information available in the "moment of pause" space?

The moment of pause is designed to give youth a moment to breathe. It's built to acknowledge that moment of vulnerability of walking into a center for the first time. Because this is the concept of the moment of pause we will not include service information in this specific location. We will have service information available at the reception desk.

79. Are you open to extending the service area to other areas in the county and/or to out-of-county youth? How will the funding work for those areas?

allcove™ centers do not have a service catchment and provide services to all youth who come in. Practically speaking, however, centers typically draw youth from about 1 hour's distance depending on transport flows. Youth who come to allcove™ and who are not able to continue access services at center because of geographical distance should be assisted

initially and then be linked with services that are closer to their home base. As an example some youth who attended allcove™ San Jose transitioned to being seen at allcove™ Palo Alto when the center closed.

80. Agencies rely on being able to use interns, who are supervised, to provide services. However, this isn't typically reimbursed under Mild to Moderate MediCal. How will these services be financially covered?

See question #5 and #33

81. Will there be a possibility to use other data systems other than datacove, or in conjunction with datacove?

Each allcove™ center will have their own EHR system on top of the datacove. At this moment Datacove will not be able to sync with EHR systems.

82. Where are the other allcove™ locations?
There's currently one open in Palo Alto and previously one in San Jose (temporarily stopped delivering services due to building infrastructure remodeling). These two centers although part of the allcove™ network, are directly funded by the Santa Clara County and not MHSOAC. The 4 other locations funded through the state grant are in Beach Cities, Irvine, Sacramento, and Los Angeles. You can visit allcove.org to learn more.

83. Is there a plan for multiple providers to occupy this allcove™ space?
Yes, integration is at the key of our service delivery model. Multiple agencies and subcontractors will all be housed in the staff workspace and be expected to work as a team to deliver the allcove™ fidelity model.

84. When are services slated to begin?

The hope right now is to open at the end of March or early April. Once the center is open services will begin to be provided

85. Is there freedom for providers to be out in the community (providing services, and/or outreach) or only in the center?

Part of allcove™ is doing outreach. In Palo Alto, the Peer Support Specialists will go out and conduct outreach within the community. We will most likely do something similar as we want to outreach within our community. All outreach will have to meet strict allcove™ marketing and branding standards and therefore will be channeled through our Youth Outreach Specialist.

86. Is telehealth an option for services?
Yes, but not exclusively. In other words, we welcome models that incorporate telehealth as an option but not the only means of providing services to clients.