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ORANGE COUNTY HEALTH CARE AGENCY: INN TECH SUITE (HELP@HAND) FINAL REPORT

Mental Health Technology Solutions
April 2018 – April 2023
Submitted April 2023

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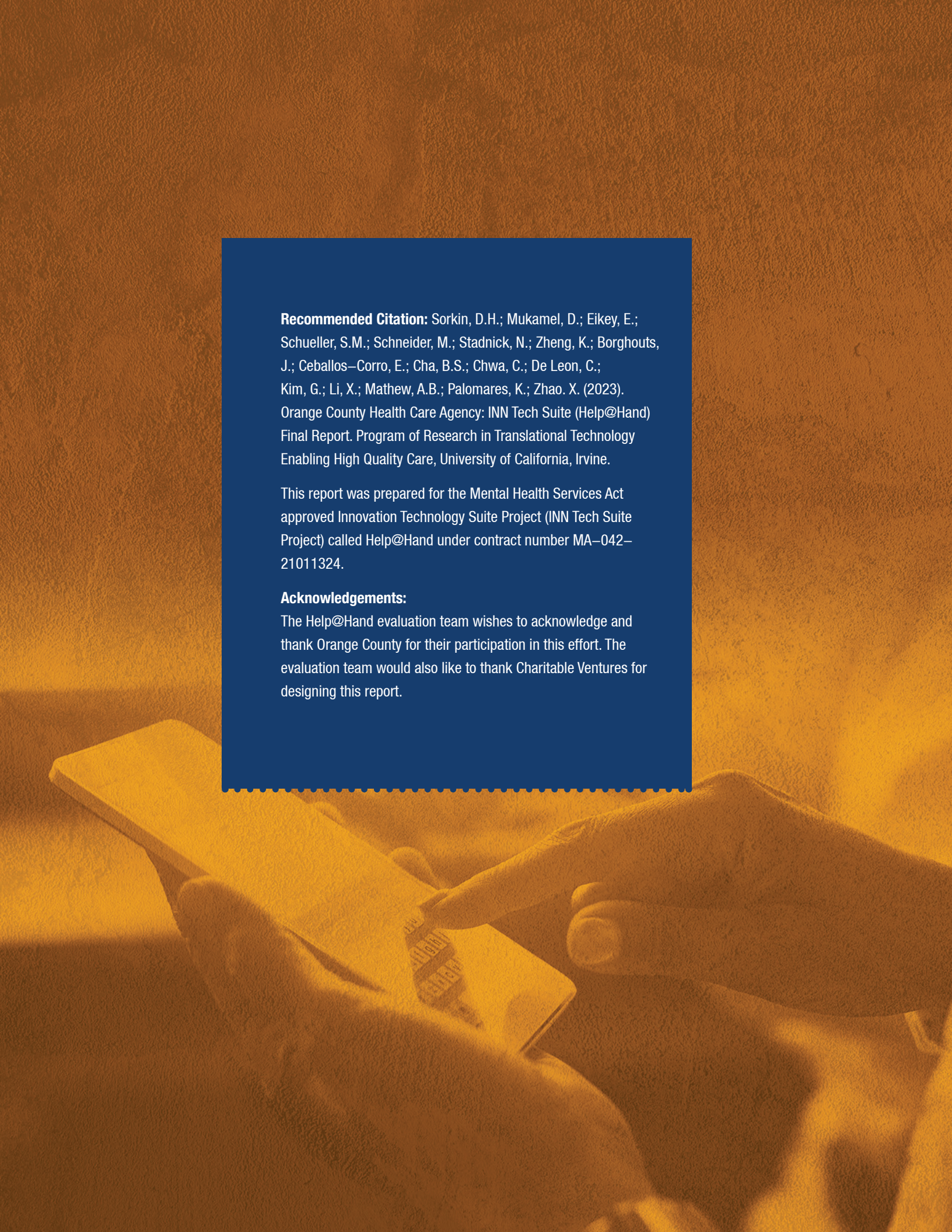

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The Orange County Health Care Agency (OCHCA) was approved to join the Help@Hand program in April 2018 and the program concluded in April 2023. OCHCA's Help@Hand program aimed to increase access to mental health services to underserved residents and introduce a new approach to the county mental health system.

This report presents program activities, evaluation findings, and learnings from April 2018 through April 2023.

PROGRAM ACTIVITIES

OCHCA's Help@Hand program included offering Mindstrong[1] to eligible county residents, providing digital literacy education to community members, planning two needs assessments, and planning a pilot of decision support dashboards.

Mindstrong Implementation
OCHCA launched Mindstrong with eligible psychiatry patients in a local healthcare system in May 2020. The county expanded the program by making it available to all Orange County residents through Mental Health America[2] and other departments in the local healthcare system in 2022.

Digital Literacy
Peers led digital literacy workshops in the community and created an information booklet aimed at building digital literacy skills and integrating technology to support mental health and wellness.

Needs Assessments
The county planned needs assessments with community college students and OCHCA behavioral health clients. However, the county paused the needs assessments in 2021 to focus on other county activities.

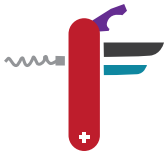
Decision Support Dashboards
OCHCA partnered with the Help@Hand evaluation team to serve as a pilot site for decision support dashboards, but discontinued it in 2020 to focus on other program activities.

EVALUATION

OCHCA's Mindstrong implementation evaluation involved a provider and a consumer evaluation. Key findings included:

Over 75% of providers felt that Mindstrong's care model was a significant innovation that may benefit patients

Providers reported challenges with program enrollment, rapport with Mindstrong therapists, and technology



About 90% of providers indicated that Mindstrong was a useful resource for their patients

[1] Mindstrong provides a digital phenotyping, artificial intelligence (AI) enabled, telemedicine network for outpatient management of behavioral health disorders that reduces resource utilization, increases access, and improves patient outcomes by diagnosing behavioral comorbidities early, detecting relapse early, and intervening early.
[2] Mental Heatlh America is a national website that offers various mental health screeners, educational materials, and behavioral health resources.

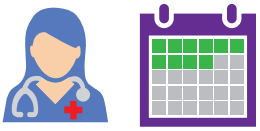
Over 70% of consumers had taken part in a therapy session and/or had sent patient messages through the app

Over 90% of consumers were satisfied with the sessions with their Mindstrong therapist

Consumers felt accepted by Mindstrong (77%) and felt that their Mindstrong therapist was on their side (81%)

Consumers experienced feeling better about taking care of their mental health (67%)

Common reasons to not use Mindstrong included being busy and/or thinking it would take up too much time



The most common reasons consumers stopped using Mindstrong were a bad experience with a provider and difficulties making an appointment

Consumers who had more therapy sessions had more improvement in their mental health than those who had fewer therapy sessions

Consumers experienced improvements in mental health symptoms and stigma. Their DSM, depression, and anxiety scores reduced by 1.9, 2.6, and 2.8 points, respectively. Their stigma scores improved by 0.3 points over time

Mindstrong consumers had more frequent and longer healthcare visits than comparison patients, but were less likely to visit the emergency department or be hospitalized due to a mental health diagnosis

Consumers who rated Mindstrong higher on perceived usefulness were more likely to continue using Mindstrong

Consumers who scored high on loneliness were less likely to continue using Mindstrong

Consumers' engagement with biomarkers did not predict improvement in their mental health

LEARNINGS

Many learnings emerged throughout OCHCA's Help@Hand program. Key learnings related to program planning and execution, working with partners, consumer recruitment and engagement, the eligibility and consent process, digital literacy training, consumer experience, evaluation, and learning collaboration with other counties/cities. These learnings are presented on page 36.

FUTURE DIRECTIONS

The Mindstrong program ended in March 2023. OCHCA will continue to provide digital literacy education to community members. The county will carry forward learnings from Help@Hand and apply them to other county projects.

help @ hand™ Evaluation

PRIORITY ISSUE

In Fall 2017, the Orange County Health Care Agency (OCHCA) met with stakeholders to identify behavioral health needs and gaps. Stakeholders identified the following needs and gaps: lack of comprehensive case management, lack of family support services, challenges with system navigation, and a need for mental health stigma reduction and linguistic competence.

A comprehensive needs assessment conducted by CalOptima[3] of its members in 2017 had similar findings. The assessment found the following key factors impacted access to and use of mental health services: challenges navigating the public mental health system, lack of understanding about available county behavioral health services, and discomfort with discussing personal problems.

OCHCA aimed to develop a large-scale approach for outreach, engagement, system navigation, and service delivery that addressed these needs and gaps.

PROGRAM DESCRIPTION

Help@Hand is a five-year statewide demonstration project funded by Prop 63 (now known as the Mental Health Services Act). It is designed to bring a set (or "suite") of mental health digital therapeutics into the public mental health system of care. Help@Hand intends to understand how digital therapeutics fit within the public mental health system of care and leads innovation efforts by integrating Peers[4] throughout the program.

OCHCA was approved to join the Help@Hand program in April 2018 and their program concluded in April 2023. OCHCA's Help@Hand program's goal and learning objectives are shown below.

Orange County's Help@Hand Program

Goal: Increase access to mental health services to underserved groups and introduce a new approach to the county mental health system.

Learning Objectives:

1. **Detect and acknowledge mental health symptoms sooner;**
2. **Reduce stigma associated with mental illness by promoting mental wellness;**
3. **Increase access to the appropriate level of support and care;**
4. **Increase purpose, belonging, and social connectedness of individuals served;**
5. **Analyze and collect data to improve mental health needs assessment and service delivery.**

[3] CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors, and people with disabilities through four major programs: Medi-Cal, One Care, OneCare Connect and PACE. CalOptima is the largest health insurer in Orange County.

[4] Help@Hand defines a Peer as a person who publicly self-identifies with having a personal lived experience of a mental health/co-occurring issue accompanied by the experience of recovery. A Peer has training to use that experience to support the people they serve.

OCHCA conducted the following activities to accomplish their goal:

- Offered Mindstrong, a mental health app that provided virtual therapy services, to eligible county residents between May 2020 and March 2023
- Hosted digital literacy workshops and developed a workbook to supplement the workshops
- Began to plan needs assessments with community members and behavioral health clients
- Began to plan a pilot of decision support dashboards

ABOUT THIS REPORT

This report presents OCHCA's Help@Hand program, evaluation findings, and learnings from April 2018 through April 2023. It is organized as follows:

- **Summary of Activities:** Reports program activities and milestones
- **Evaluation:** Presents evaluation activities and findings
- **Learnings:** Describes lessons learned from the program
- **Future Directions:** Discusses the future of the program

PARTICIPATION IN THE HELP@HAND COLLABORATIVE

The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved twelve counties and two cities across California to participate in Help@Hand. These counties/cities included: City of Berkeley, Kern County, Los Angeles County, Marin County, Modoc County, Mono County, Monterey County, Orange County, Riverside County, San Francisco County, San Mateo County, Santa Barbara County, Tehama County, and Tri-City.

In 2017, the approved counties/cities formed the Help@Hand Collaborative to develop a shared learning experience that expanded technology options, accelerated learning, and improved cost sharing. OCHCA joined the Help@Hand Collaborative in April 2018.

CalMHSA provided administrative oversight and program management for the Help@Hand Collaborative. In October 2019, CalMHSA contracted with Cambria Solutions,[5] a consulting firm that specialized in implementing innovative and transformative solutions within government agencies, to provide a dedicated program management team for OCHCA's Help@Hand program. Cambria Solutions developed processes, managed program meetings, developed communication materials for consumers and stakeholders, and identified issues and risks. In April 2021, OCHCA established a direct contract between the county and Cambria Solutions. In addition, OCHCA established a direct contract between the county and the University of California, Irvine to conduct their formative evaluation. In December 2021, OCHCA separated from the Help@Hand Collaborative to focus on their local Help@Hand program.

PROGRAM DESCRIPTION

OCHCA's Help@Hand program offered Mindstrong to eligible county residents, provided digital literacy education to community members, planned two needs assessments, and planned a pilot of decision support dashboards.

Mindstrong Implementation

Exploring Technologies

The Help@Hand Collaborative[6] identified three focus areas at the beginning of the program: (1) Peer chat and digital therapeutics; (2) virtual evidence-based therapy utilizing an avatar; and (3) digital phenotyping using passive data for early detection and intervention. A Request for Statement of Qualifications (RFSQ) process identified five qualified vendors in 2017. Vendors conducted demonstrations of their products to the Help@Hand Collaborative. The Collaborative selected 7Cups and Mindstrong as the initial Help@Hand technologies based on their qualifications, demonstrations, and testing by end-users and staff.

In early 2018, OCHCA gathered community feedback on 7Cups and Mindstrong through focus groups and stakeholder meetings. After the contract with 7Cups was terminated by the Help@Hand Collaborative in August 2019, OCHCA focused their program on implementing Mindstrong within the county.

Implementation Planning

OCHCA initially planned to launch Mindstrong with transitional age youth engaged in the Program for Assertive Community Treatment (PACT)[7] and individuals over the age of 13 engaged in the crisis services continuum.

[5] Cambria Solutions was acquired by Ernst & Young LLP in 2022.

[6] The Help@Hand Collaborative is comprised of counties and cities across California that are participating in Help@Hand. Counties/cities participating in the Collaborative develop a shared learning experience that expands technology options, accelerates learning, and improves cost sharing.

[7] PACT provides field-based outpatient services for transitional age youth and adults living with a serious emotional disturbance (SED) or serious mental illness (SMI).

PACT providers attended introductory sessions to learn about Mindstrong. However, initial feedback indicated that Mindstrong was not a good fit because the county's Electronic Health Record (EHR) system was not set up to implement a program like Mindstrong. The County also explored the use of Mindstrong with its programs serving first onset psychosis and postpartum target populations. However, it was determined programs within OCHCA were not prepared to implement digital mental health solutions. Thus, OCHCA explored alternative implementation sites outside of the county system and decided to focus their Mindstrong implementation on psychiatry patients at a local healthcare system.

OCHCA began planning their Mindstrong implementation at the local healthcare system in June 2019. Considerable work was done with Mindstrong and the local healthcare system to develop the referral process, incorporate the county-required informed consent, and establish a data sharing model.

LifeLine Phone Testing

In early 2020, OCHCA and the Help@Hand evaluation team developed a plan to test whether the Mindstrong app was compatible with phones provided through the California LifeLine Program. The California LifeLine Program provides discounted home phone and cell phone services to eligible households.

The plan was presented to Orange County stakeholders but it did not receive full stakeholder support. Since Mindstrong had already conducted similar testing with LifeLine phones, Mindstrong provided a list of compatible phones to OCHCA. The county updated the Mindstrong program's eligibility criteria to include the approved phones.

Implementation Launch

In May 2020, OCHCA launched Mindstrong at the local healthcare system. The launch began with only two psychiatry providers referring eligible patients. Eligible patients included patients who were over the age of 18, did not have an active psychotherapist, met the clinical eligibility criteria[8], and had access to their own compatible smartphone.

In September 2020, OCHCA, Mindstrong, and the local healthcare system trained psychiatry resident providers[9] on Mindstrong and the referral process. After receiving the training, resident providers began to refer patients to Mindstrong. The OCHCA program team repeated the training when new residents joined the local healthcare system in 2021.

OCHCA developed a "project playbook" that included lessons learned from the Mindstrong implementation to inform future projects. The "project playbook" was updated throughout the implementation. OCHCA documented their experience and early lessons learned from planning and launching the Mindstrong implementation in **Appendix B**.

Implementation Expansion

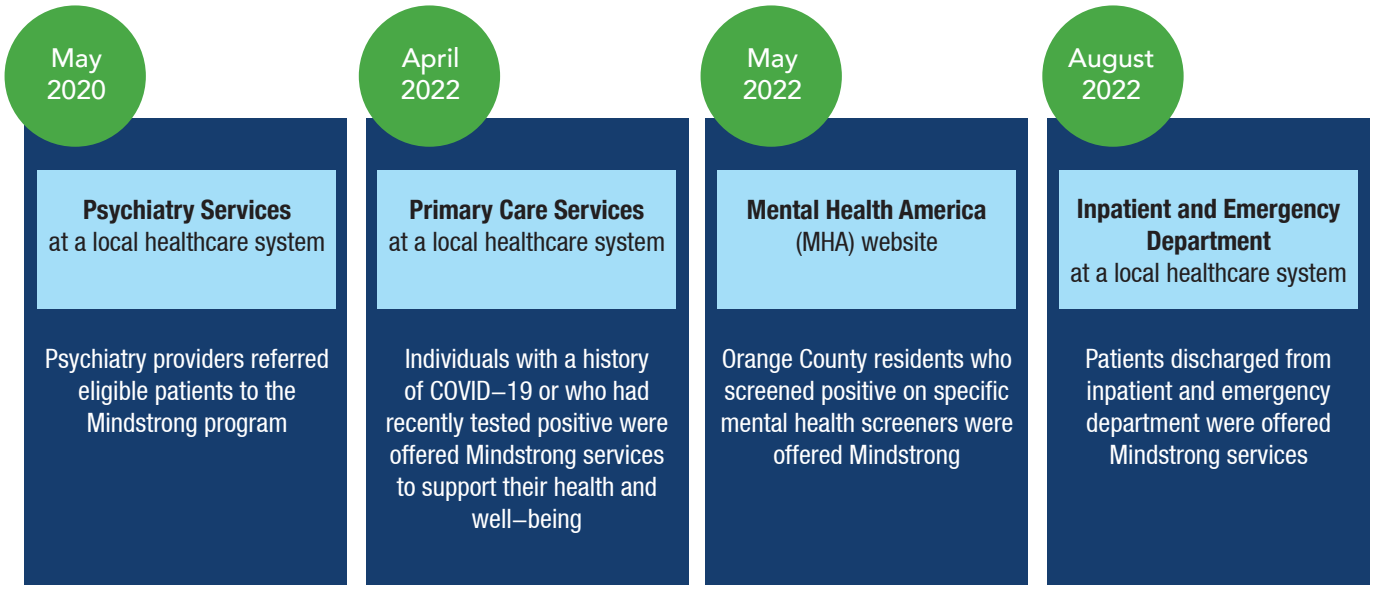
In 2021, OCHCA began discussions to broaden their marketing approach to reach more Orange County residents. The county developed outreach strategies and communication templates to connect with potential partners. OCHCA held presentations with various departments in the local healthcare system, Mental Health America (MHA), community colleges, and federally qualified health centers (FQHCs) to explore potential partnerships.

[8] The clinical eligibility criteria included diagnosis of major depressive disorder, bipolar disorder, schizophrenia, or schizoaffective disorder. In January 2021, the criteria was updated to include post-traumatic stress disorder and obsessive-compulsive disorder.

[9] Resident psychiatry providers are medical school graduates that are participating in a post-graduate training program. Residents provide care under the supervision of senior psychiatry providers.

In 2022, OCHCA expanded the Mindstrong program to more Orange County residents as shown in **Figure 1** below.

Figure 1. OCHCA's Mindstrong Program Expansion



OCHCA initially engaged with community colleges in 2019, but plans were paused in 2020 to focus on the implementation at the local healthcare system. OCHCA reconnected with community colleges in September 2021. Although interest remained high, community colleges required a Memorandum of Understanding between the county and participating community colleges. This created a significant barrier due to the limited time remaining on the Help@Hand program and staffing constraints within the county and colleges.

In March 2022, OCHCA met with FQHCs to discuss offering Mindstrong services to their patients. FQHCs determined that Mindstrong was not an appropriate fit due to the time-limited nature of this program and long-term therapy needs within FQHCs.

Mindstrong Transition

OCHCA's Mindstrong program ended in March 2023. The county discontinued new enrollments in December 2022. In January 2023, Mindstrong announced that the company had been acquired and would discontinue all clinical services on March 10, 2023. OCHCA communicated with consumers to inform and help transition them to other forms of care.

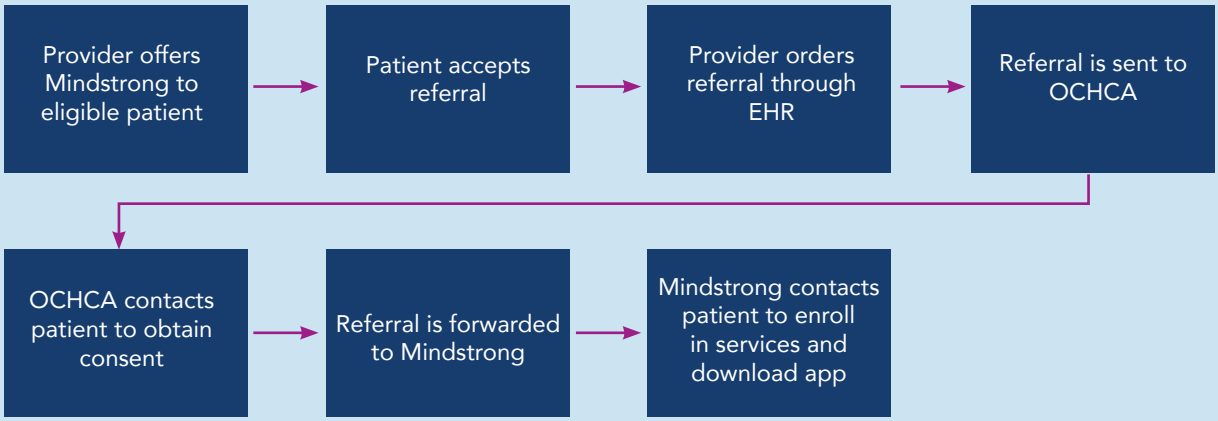
Processes Developed for OCHCA's Mindstrong Program

OCHCA developed the following key processes over time for their Mindstrong program.

Referral process at the local healthcare system

The county utilized a case-by-case referral to enroll patients in the Mindstrong program. The local healthcare system modified their EHR system to automate referrals. The referral process is displayed in **Figure 2**.

Figure 2. Referral Process at the Local Healthcare System



Recruitment materials

OCHCA created provider flyers and consumer postcards to inform and recruit providers and consumers for the program. Providers and consumers could also reference the materials as reminders of the processes for OCHCA's Mindstrong program. The provider flyer shared information on the Mindstrong program, eligibility criteria, and referral process. The consumer postcards provided consumers with information on the program and what to expect from the enrollment process. OCHCA obtained feedback on the postcard and flyers from Peers, the local healthcare system, and the Mindstrong team. **Figures 3** and **4** display the provider flyer and consumer postcard.

Figure 3. Provider Flyers for OCHCA's Mindstrong Program

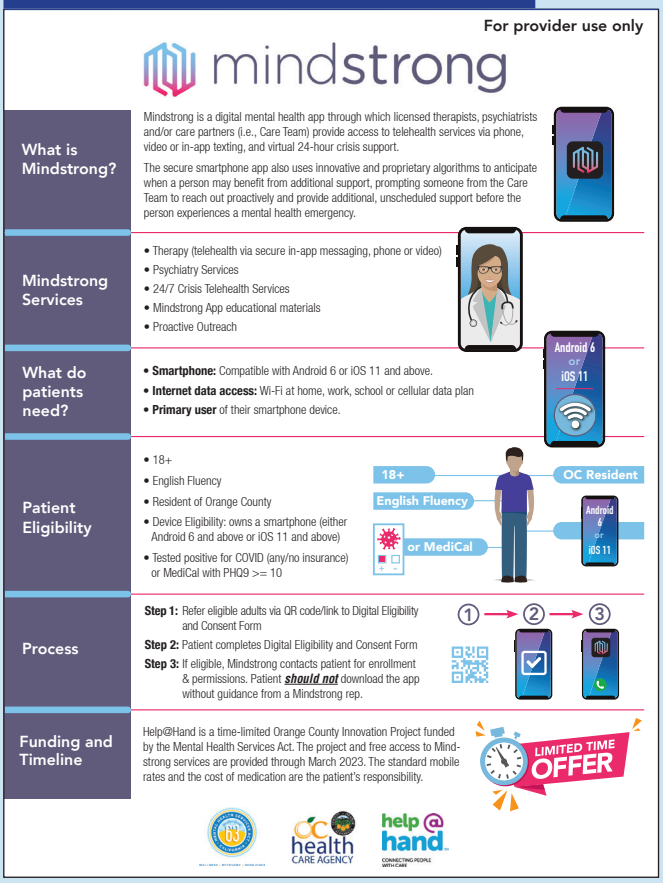
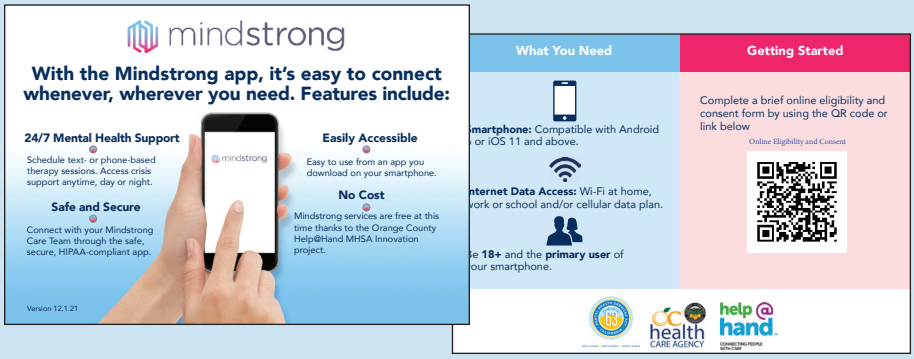


Figure 4. Consumer Postcards for OCHCA's Mindstrong Program



Informed consent

OCHCA obtained informed consent from all Mindstrong consumers to make them aware of the services offered, the duration of services, and security and privacy features related to the Mindstrong application. OCHCA's Peers reviewed the informed consent language to confirm that it was clear and understandable.

Initially, OCHCA planned to collect informed consent in person, but had to shift to a remote consent process to comply with COVID-19 safety measures. OCHCA created an online version of the informed consent form and prepared for Peers to contact referred patients. This involved procuring smartphones, obtaining secure emails, and signing business associate agreements (BAAs). After patients were referred, OCHCA's Peers contacted patients referred to the program and shared a link to the consent form via text message. Peers guided patients through the online form, confirmed eligibility, and obtained consent.

In Fall 2021, OCHCA began to modify their informed consent process to give consumers the ability to provide consent at their convenience through an automated process. The content from the original consent form was converted into a script and made into a series of short, informational videos. Peers spent many hours reviewing the voice and tone of the videos and testing the automated process. OCHCA consulted with program partners to identify appropriate eligibility questions and mental health screeners that would confirm consumers' eligibility. The county also generated a list of resources to provide consumers, particularly those ineligible for the Mindstrong program. OCHCA launched this new process in January 2022. **Appendix D** provides detailed information on the transition to the digital eligibility and consent process.

Data sharing model

OCHCA, Mindstrong, and the Help@Hand evaluation team held extensive conversations to understand the data that Mindstrong collected and what could be shared with OCHCA and the Help@Hand evaluation team for the evaluation. OCHCA and the evaluation team developed three broad areas to explore (see page 18) and worked with Mindstrong to identify the app data that could address these areas. In May 2021, Mindstrong and the Help@Hand evaluation team established a data use agreement (DUA) outlining the Mindstrong data that would be transferred to the Help@Hand evaluation team. Partners also collaborated to determine the method and frequency of data sharing. They also clarified the necessary personal identifiers required for Mindstrong enrollment that ensured consumer privacy. Data sharing began in August 2021. OCHCA facilitated several discussions between partners to understand the adoption and use of Mindstrong.

Expansion site referrals

In 2022, OCHCA updated the consumer flyer to include a QR code that linked to the digital eligibility and consent form. Updated flyers were provided to all implementation sites and direct links to the form were incorporated into the MHA website. Interested consumers could scan the QR code or click on the link to confirm their eligibility and provide consent for the Mindstrong program.

Digital Literacy

Digital literacy was an important component of OCHCA's Help@Hand program. Peers across the Help@Hand Collaborative identified the need to empower California communities to make informed decision about how they interact with technology.

The Help@Hand Collaborative held community sessions in eleven counties to better understand the local community needs around the use of technology to support well-being. A community session was held in Orange County in June 2019. The Help@Hand Collaborative created a digital literacy video series and curriculum to address common topics identified through the work sessions. Curriculum topics included understanding and managing digital identity and dealing with cyberbullying.

In April 2022, OCHCA's Peers kicked off a series of digital literacy workshops in the community using the digital literacy curriculum developed by the Help@Hand Collaborative. Peers created an information workbook aimed at building digital literacy skills and integrating technology to support mental health and wellness to supplement the curriculum. Excerpts from the workbook are displayed in **Figure 5**.

Figure 5. OCHCA's Digital Literacy Workbook

In late 2022, OCHCA developed promotional materials for digital literacy workshops and expanded the frequency of workshops offered to the community at the Recovery Education Institute (REI), wellness centers, club houses, and other locations throughout the county.

Appendix E presents additional information on OCHCA's Peer-led digital literacy efforts.

Needs Assessments

In addition to their Mindstrong program and digital literacy efforts, OCHCA partnered with the Help@Hand evaluation team to plan needs assessments with community college students and OCHCA Behavioral Health Services (BHS) clients.[10]

OCHCA and the Help@Hand evaluation team began to develop a survey to understand the unmet mental health needs of community college students and how apps may address these needs. The survey was to be distributed to students during an in-person event in May 2020, but the event and needs assessment were cancelled due to COVID-19.

A separate needs assessment was developed to learn about the experiences and challenges of BHS clients with telehealth services during COVID-19. OCHCA and the Help@Hand evaluation team developed a survey to identify current access to technology, general technology use, and use of technology to support mental health among BHS clients. Two versions of the survey were created: 1) a survey for clients over the age of 13; and 2) a survey for parents of clients under the age of 13. The needs assessment was paused in 2021 due to conflicting priorities within the county that emerged as a result of needing to attend to the COVID-19 crisis.

Decision Support Dashboards

In 2019, OCHCA partnered with the Help@Hand evaluation team to serve as a pilot site for decision support dashboards. Decision support dashboards were part of a larger effort to create a data repository for the overall Help@Hand program. The data repository was intended to be a large database infrastructure that would allow for the collection, storage, and management of datasets for data analysis, sharing, and reporting. The data repository would be utilized to develop decision support dashboards meant to support counties/cities with program planning activities and monitoring.

OCHCA and the Help@Hand evaluation team engaged in extensive discussions to understand OCHCA's dashboard-related needs and requirements. The Help@Hand evaluation team responded to OCHCA's Security Requirement Questionnaire to prepare for the data transfer from OCHCA to the Help@Hand data repository. This effort was discontinued in 2020 to allow OCHCA to focus on other program activities.

PROGRAM CHANGES

Over the course of their five years of participation, OCHCA's Help@Hand program pivoted and changed to adapt to internal and external factors. The following changes were made:

- **Program Components:** OCHCA initially planned to implement all five components of the Help@Hand program (e.g., peer chat and digital therapeutics, virtual evidence-based therapy utilizing avatar, digital phenotyping using data for early detection and intervention, community engagement and outreach, and outcome evaluation). Since OCHCA focused their program on implementing Mindstrong, they did not implement those components not in Mindstrong (e.g., peer chat and digital therapeutics or virtual evidence-based therapy utilizing an avatar).
- **Core audience:** OCHCA intended to make apps available to all county residents who owned a smartphone, tablet, computer or had access to computer devices (e.g., libraries, kiosks, etc.). Due to the nature of the Mindstrong program, individuals needed to have access to their own smartphone and had to meet clinical criteria. Those who did not have access to their own smartphone or did not meet the criteria were not eligible to participate.

[10] Behavioral Health Services (BHS) clients include children, youth, and adults that receive mental health services through OCHCA.

- **Implementation Site:** OCHCA initially planned to launch Mindstrong with programs serving first onset psychosis and postpartum target populations, transitional age youth engaged in the Program for Assertive Community Treatment (PACT), as well as individuals engaged in the crisis continuum. However, OCHCA later determined that Mindstrong was not a good fit within these programs. In May 2020, OCHCA launched Mindstrong at a local healthcare system.
- **Timeline:** OCHCA intended to make apps available to county residents in February 2018 but did not launch Mindstrong until May 2020. This delay was due to the contracting process, planning and readiness discussions, and diligent development and review of all program forms and materials.
- **Informed Consent:** Incorporating the OCHCA informed consent into the Mindstrong referral process required much planning and considerations. OCHCA planned to collect informed consent in-person at the local healthcare system. However, due to COVID-19 restrictions, the county shifted to a remote consenting process.
- **LifeLine Phone Testing:** The county developed a plan to test Mindstrong's compatibility with phones provided by the California LifeLine program. However, this effort was discontinued because the plan did not receive stakeholder support.
- **Planned Activities:** Some activities that were initially planned did not occur. For example, the county planned to implement 7Cups, but this work did not occur because 7Cups' contract was terminated by the Help@Hand Collaborative. Needs assessments and decision support dashboards pilot were discontinued to focus on other program activities.

TIMELINE

The timeline below includes activities, events, and milestones that occurred throughout OCHCA's Help@Hand program.

Year 1 (April 27, 2018 – April 26, 2019)

OCHCA's Help@Hand program was approved on April 27, 2018

Exploring Technologies

- Considered implementing 7Cups and Mindstrong throughout the county
- Conducted focus groups with the Wellness Center Central and the Orange County Recovery and Education Institute (REI) to obtain feedback about perceptions of 7Cups
- Completed series of onboarding events with Mindstrong and introductory sessions with providers to prepare for a tentative Mindstrong launch with transitional age youth in the Program for Assertive Community Treatment (PACT) and individuals 13+ engaged in the crisis services continuum

Decision Support Dashboards

- Held ongoing discussions with Help@Hand evaluation team about the data transfer from OCHCA to the Evaluation Data Repository
- Help@Hand evaluation team responded to OCHCA's Security Requirement Questionnaire as a first step in preparing for the data transfer of EHR and claims data from OCHCA to the Evaluation Data Repository

Year 2 (April 27, 2019 – April 26, 2020)

Implementation Planning

- Discontinued 7Cups implementation planning after 7Cups received 30–day notice of termination of contract in August 2019
- Shifted Mindstrong implementation site to a local healthcare system with psychiatry patients
- Began planning a tentative Mindstrong soft launch in community colleges for Fall 2020

- Developed several iterations of the informed consent process and held extensive conversations involving the program team, county compliance, Peers, local healthcare system, Mindstrong, and video production company
- Began creating a plan to test the compatibility of Mindstrong with California LifeLine phones

Digital Literacy

- Held Orange County Mental Health Services Act (MHSA) Steering Committee and Community Work Sessions to better understand the local community needs about how to effectively use digital devices in June 2019

Needs Assessments

- Began planning needs assessment with college students, but later discontinued due to COVID–19

Decision Support Dashboards

- Discontinued data repository efforts to focus on other program activities

Year 3 (April 27, 2020 – April 26, 2021)

Mindstrong Implementation

- Launched Mindstrong with psychiatry patients in a local healthcare system on May 14, 2020
- Expanded Mindstrong implementation to allow more clinicians to refer patients to Mindstrong on September 16, 2020
- Streamlined Mindstrong referral process using an EHR referral order
- Updated the clinical eligibility criteria to include post–traumatic stress disorder (PTSD) and obsessive–compulsive disorder (OCD)
- Peers began to support the informed consent process
- Developed digital consent videos to automate OCHCA informed consent process
- Created eligibility and referral guide for providers to assist with referral process and outreach materials (e.g., postcards) for providers to share Mindstrong information with consumers
- Held discussions on how to move to a broader marketing approach rather than a case–by–case referral and the feasibility of expanding Mindstrong to different core populations and programs
- Shared proposal for LifeLine Phone Testing with community stakeholders

Needs Assessments

- Began planning needs assessment with county behavioral health clients, but was later paused due to conflicting priorities within the county

Year 4 (April 27, 2021 – April 26, 2022)

Mindstrong Implementation

- Trained new referring psychiatry providers joining the local healthcare system
- Established a data sharing model between Mindstrong and the Help@Hand evaluation team
- Engaged with vendor (Qualtrics/Walker) to build the digital consent process, add a scheduling feature (e.g., Acuity), and add eligibility questions
- Deployed the digital eligibility and consent process with consumers at the local healthcare system
- Continued discussions on expansion to community colleges in 2021 and reestablished contact with community college stakeholders
- Developed outreach strategies and communication templates to engage a broader population (e.g., college students; adults who tested positive for COVID–19)

- Expanded the Mindstrong program to primary care services at the local healthcare system in April 2022
- Met with a regional FQHC about providing Mindstrong to the FQHC's patients
- Began discussions with MHA to offer Mindstrong to eligible individuals

Digital Literacy

- Developed and enhanced digital literacy content for community members and consumers (e.g., how to vet apps, use QR codes, cyberbullying, etc.)
- Identified outreach strategies and locations for digital literacy content
- Peers led "Managing your Digital Presence" workshop at the Annual Meeting of the Minds Conference

OCHCA separated from the Help@Hand Collaborative to focus on their local implementation in December 2021

Year 5 (April 27, 2022 – April 26, 2023)

Mindstrong Implementation

- Expanded the Mindstrong program to eligible adults referred from Mental Health America's web–based mental health support site in May 2022
- Expanded the Mindstrong program to eligible adults discharged from inpatient and emergency department at the local healthcare system in August 2022
- Facilitated discussions between program partners (OCHCA, Mindstrong, Help@Hand evaluation, local healthcare system) to understand the adoption and use of Mindstrong
- Planned for end of program (e.g., stopped new enrollments, identified transition plan)
- On January 31, 2023, Mindstrong announced that the company had been acquired and clinical services for all clients would end on March 10, 2023
- Notified Mindstrong consumers that clinical services were ending and provided additional resources for continued support

Digital Literacy

- Developed promotional outreach materials for digital literacy workshops
- Developed supporting materials (e.g., workbook) to facilitate learning at the digital literacy workshops
- Expanded frequency of digital literacy workshops and outreach efforts to community members (e.g., wellness centers, REI, etc.)

OCHCA's Help@Hand program ended on April 26, 2023

OCHCA worked with the Help@Hand evaluation team to evaluate their Mindstrong implementation. There were no formal evaluation activities associated with the digital literacy, needs assessments, and data support dashboard efforts.

EVALUATION OVERVIEW OF OCHCA'S MINDSTRONG IMPLEMENTATION

OCHCA's primary areas of exploration guided the evaluation of their Mindstrong implementation. The primary areas of exploration evolved over the course of the program and were adapted to the following:

- **Contextual Factors:** What factors make a setting ready for a product like Mindstrong, and influence providers/consumers to use it over time?
- **Service Delivery:** How is Mindstrong used? How do providers view Mindstrong?
- **Potential Benefits:** What are the potential benefits of using Mindstrong? What do providers perceive as the potential benefits of Mindstrong?

EVALUATION METHODOLOGY

OCHCA's evaluation of their Mindstrong implementation consisted of a **provider evaluation** and a **consumer evaluation**. It included multiple data sources to understand the provider and consumer perspectives as described below.[11]

The Provider Evaluation assessed the beliefs, practices, and structures that might impact the implementation of OCHCA's Mindstrong program.

Provider Surveys and Interviews: Providers referring patients to OCHCA's Mindstrong program were invited to complete bi-annual surveys and annual interviews with the Help@Hand evaluation team. This report presents survey and interview data collected between June 2020 and December 2022.

The Consumer Evaluation examined the factors influencing consumers to adopt, use, or abandon Mindstrong. It also provided insight into the consumer experience.

App Data: Mindstrong collected app enrollment, activity, engagement, and survey data and shared it with the Help@Hand evaluation team. This report presents data collected between May 2020 and March 2023.

Electronic Medical Record (EMR) Data: Health-related data documented by the healthcare system was collected from patients who participated in OCHCA's Mindstrong program and compared to those in the healthcare system who did not participate in the program. This report presents data collected between May 2020 and March 2023.

Consumer Surveys: All consumers participating in OCHCA's Mindstrong program were invited to complete surveys online or over the phone with the Help@Hand evaluation team. This report presents data collected between October 2020 and January 2023.

[11] This report uses the icons for the provider surveys and interviews, app data, electronic medical record data, and consumer surveys to indicate the data source for each finding in this section.

CULTURAL COMPETENCE AND STAKEHOLDER CONTRIBUTION IN THE EVALUATION

Peers and other stakeholders ensured that OCHCA's evaluation of their Mindstrong implementation was culturally competent and contributed in the following ways:

Participation in the statewide Help@Hand evaluation advisory board: An advisory board was convened early in the program to provide critical guidance and insight on the Help@Hand Collaborative evaluation.[12] To ensure a culturally competent evaluation, the board included a diverse team of stakeholders, such as program leaders; decisionmakers with practical experience in community, county/city, and large-scale evaluation efforts; behavioral health/social scientists; Peers with lived experience; consumer and family members who received mental health services; and people representing diverse communities (e.g., LGBTQ and racial/ethnic diversity). The board was initiated in 2018 and dismissed in 2022 due to financial restrictions.

Participation in a workgroup to conceptualize and measure mental health stigma: One of the shared learning objectives of the overall Help@Hand Collaborative was to reduce stigma associated with mental illness by promoting mental wellness. Evaluating this outcome required measuring mental health stigma prior to and after the implementation of the Help@Hand program. The Help@Hand evaluation team reviewed the literature and identified more than 400 measures of mental health stigma. In 2020, a workgroup of 11 Peer and academic experts was convened to recommend appropriate mental health stigma measures for the Help@Hand evaluation.

Peer review of evaluation instruments: Consumers completed surveys as part of OCHCA's Mindstrong program evaluation. Prior to beginning data collection, Peers reviewed and provided feedback on surveys that were developed by the Help@Hand evaluation team to ensure that survey wording was appropriate.

Stakeholder involvement: Evaluation findings were shared with Orange County's stakeholders during stakeholder meetings to inform and gather feedback on the program and the evaluation.

[12] The Help@Hand Collaborative is comprised of counties and cities across California that are participating in Help@Hand. Counties/cities participating in the Collaborative develop a shared learning experience that expands technology options, accelerates learnings, and improves cost sharing. The Collaborative evaluation provides feedback and learnings from all counties/cities participating in Help@Hand.

PROVIDER EVALUATION FINDINGS

Bi-annual surveys and annual interviews were conducted with psychiatry providers at the local healthcare system who referred their patients to the Mindstrong program between June 2020 and December 2022. The provider evaluation was designed to understand providers' perspectives on the contextual factors, service delivery, and potential benefits of OCHCA's Mindstrong implementation.

This section presents data from the second survey and the annual interview conducted in 2020, 2021, and 2022.

KEY FINDINGS

Over 75% of providers felt that Mindstrong's care model was a significant innovation that may benefit patients

Providers reported challenges with program enrollment, rapport with Mindstrong therapists, and technology

About 90% of providers indicated that Mindstrong was a useful resource for their patients

PROVIDER DEMOGRAPHICS

Respondents varied across surveys and interviews, but tended to be female, Asian American/Pacific Islander, and were most often either a 3rd or 4th year resident.[13]

	2022 N=16 (72% response rate)	2021[14] N=21 (87% response rate)	2022 N=13 (81% response rate)
Gender	**56%** Female **44%** Male	**67%** Female **33%** Male	**62%** Female **31%** Male **8%** I prefer not to answer
Race/Ethnicity	**56%** Asian American/ Pacific Islander **38%** White **6%** Multiracial	**62%** Asian American/ Pacific Islander **24%** White **5%** Hispanic or Latino **10%** I prefer not to answer	**54%** Asian American/ Pacific Islander **31%** White **8%** Hispanic or Latino **8%** I prefer not to answer
Role	**6%** 1st year resident **31%** 2nd year resident **31%** 3rd year resident **31%** 5th year resident	**33%** 2nd year resident **29%** 3rd year resident **38%** 4th year resident	**46%** 3rd year resident **54%** 4th year resident

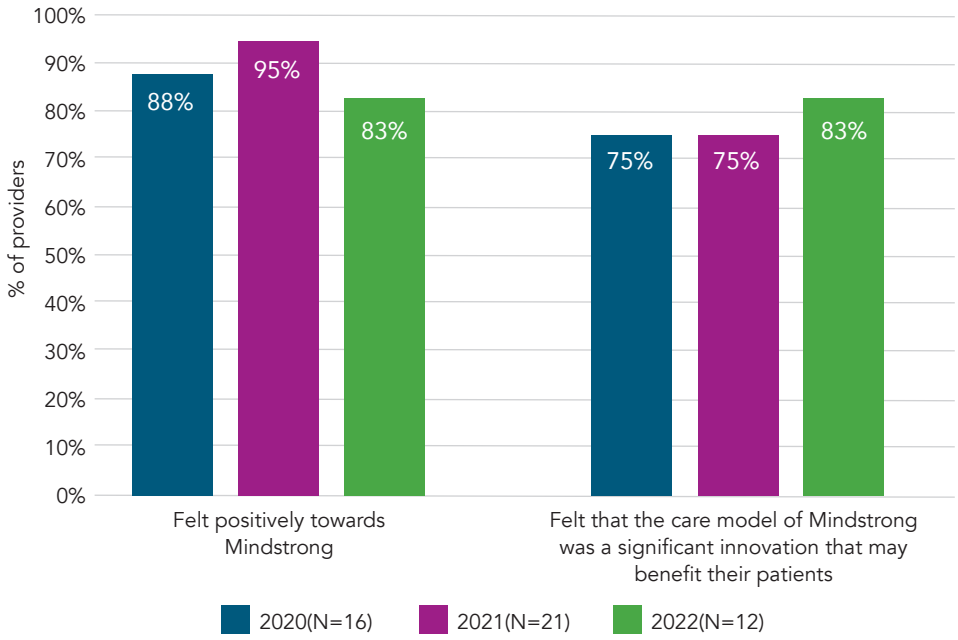
[13] Resident psychiatry providers are medical school graduates that are participating in a post-graduate training program. Residents provide care under the supervision of senior psychiatry providers.
[14] There were errors in 2021 provider race/ethnicity and role demographics in the previous report. The demographics presented here have been updated.

AREA OF EXPLORATION #1: CONTEXTUAL FACTORS

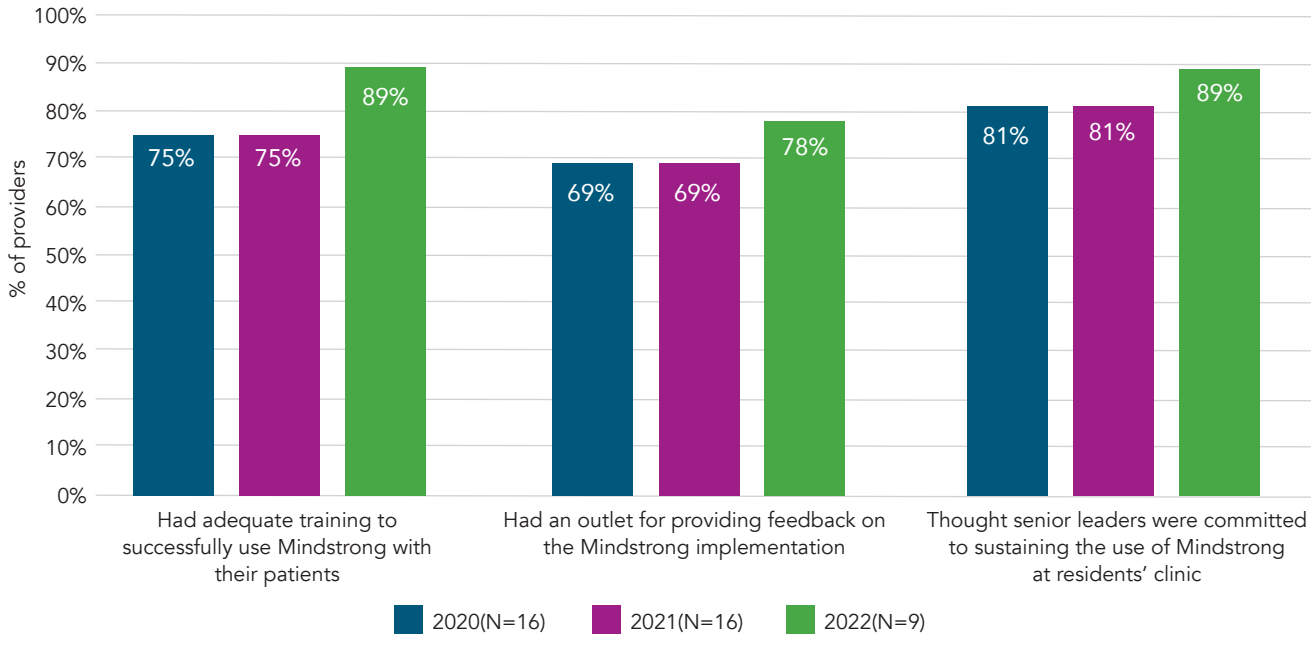
What factors make a setting ready for a product like Mindstrong, and influence providers to use it over time?

Provider Attitudes Toward Mindstrong

Providers had positive feelings toward Mindstrong. Over the years, the majority of provider respondents indicated feeling positively towards Mindstrong. Specifically, the innovation of the Mindstrong care model was perceived as likely to benefit their patients, with over 75% of respondents in each year reporting this sentiment.



Providers also felt their clinics were ready for Mindstrong implementation. The positive perception of training, feedback, and sustainability were highest in the third year of implementation, which may in part indicate that clinic environments grew in readiness over the years. Over 80% of providers in each year agreed that the Mindstrong implementation would be sustainable long-term.



Referring Patients to Mindstrong

Multiple factors facilitated providers' patient referrals to Mindstrong. In the surveys, providers reported several factors that facilitated their referrals, including patients' motivation to seek help, their ability to access therapy services virtually and in a timely manner, and that there were no financial costs for patients to participate. Providers also noted that the COVID-19 pandemic impacted availability of services.

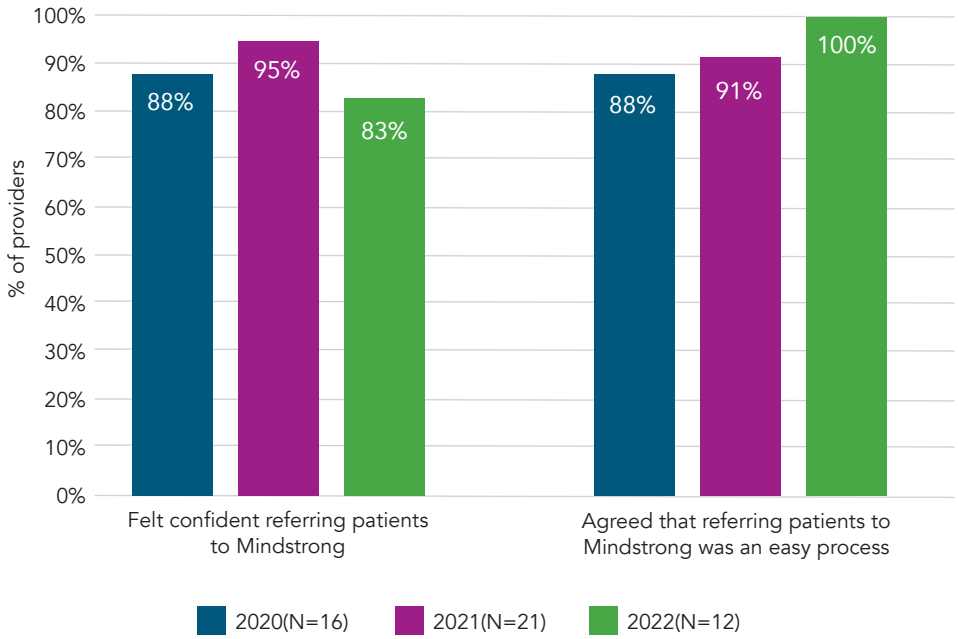
Patients were motivated to start therapy but had difficulty finding someone that was accepting patients, especially given the COVID-19 pandemic

Patients could conveniently participate in therapy virtually

Patients had timely access to therapy services

Patients did not have to pay for services

Providers reported high levels of confidence referring patients to Mindstrong. Over 80% of provider respondents over all three years reported they felt confident in making referrals to Mindstrong. An even higher percentage perceived that it was easy to make Mindstrong referrals.



AREA OF EXPLORATION #2: SERVICE DELIVERY

How do providers view Mindstrong?

Challenges Reported by Providers

Although the overall experience with Mindstrong was positive, providers reported several barriers. Challenges below are those reported by providers in the surveys. Providers did not have first-hand experience with the consumer-facing side of the application, so challenges reported by providers are largely based on patient feedback to providers.

Enrollment Barriers	Rapport Barriers
Patients were not contacted, or had a delay in contact, after being referred to Mindstrong	Mindstrong only offered brief therapy sessions
Patients were contacted but did not receive a message with callback information	Mindstrong therapists rotated between sessions
Enrollment process was too difficult for some patients	Mindstrong therapists frequently canceled sessions

Providers also reported enrollment and rapport barriers in the interviews.

"A lot of patients, you know, I've placed the referral and then they've said they were never contacted and, you know, they likely just didn't answer the phone. They got a call from an unknown number."

"So, a couple of patients would tell me that they start to develop some rapport with the therapist. But then that person had to leave and then they had to find someone to fill in."

Some providers commented on barriers related to technology.

"So, we have lots of elderly patients who are just like, 'Yeah, I mean, I can't do that.' Even if they get referred, they're like, 'I don't know how to use my smartphone. I don't know how to use zoom. I don't know how to figure it out.'"

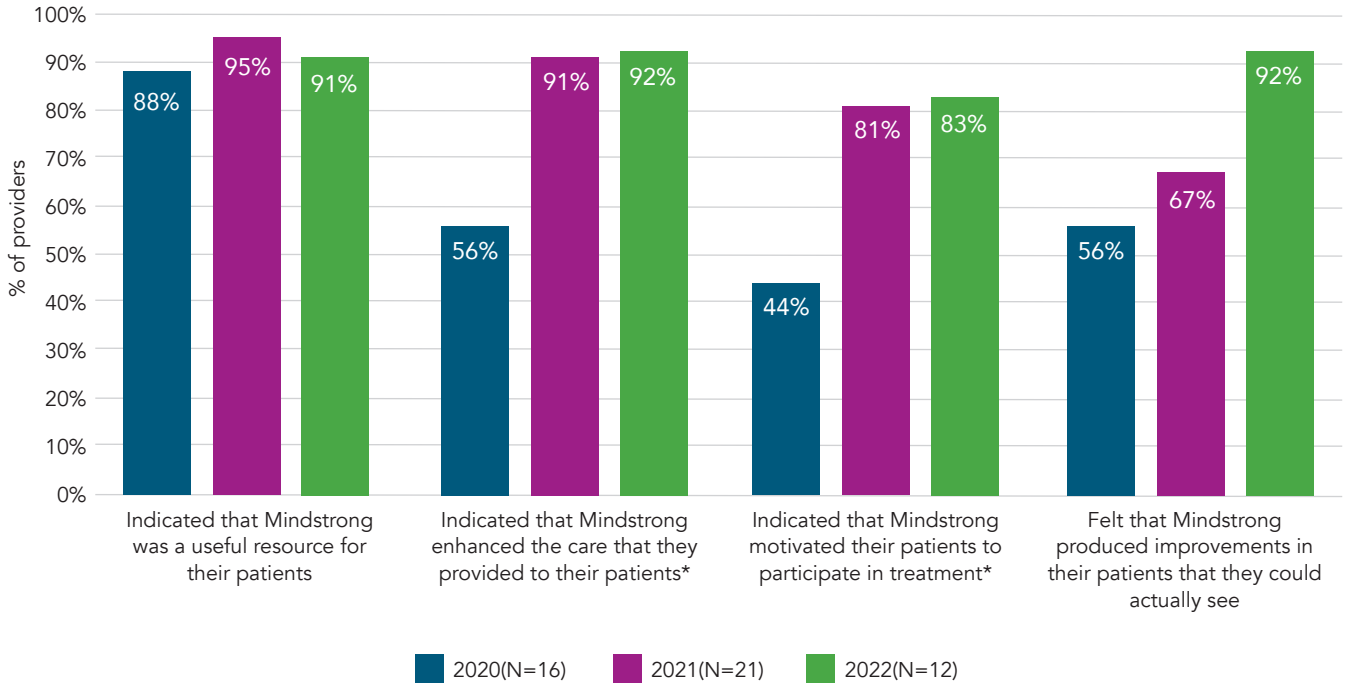
"Some had technical difficulties pretty frequently."

AREA OF EXPLORATION #3: POTENTIAL BENEFITS

What do providers perceive as the potential benefits of Mindstrong?

Mindstrong Benefits

Providers reported several perceived benefits of Mindstrong that motivated their referrals. Approximately 90% of providers in each year indicated that Mindstrong was a useful resource for their patients. In addition, providers' perception that Mindstrong enhanced their patient care, motivated patients to participate in treatment, and produced discernible patient improvements generally increased over the course of the Mindstrong implementation.



*There was a statistically significant increase in 2021 compared to 2020 with alpha = .05

CONSUMER EVALUATION FINDINGS

The consumer evaluation examined the consumer experience related to contextual factors, service delivery, and potential benefits of OCHCA's Mindstrong implementation.[15]

Providers referred **839 psychiatry patients** (e.g., individuals who received medical treatment at the local healthcare system) to OCHCA's Mindstrong program. A total of **377 consumers** (e.g., patients that enrolled in the Mindstrong program) enrolled.

839
Patients Referred
to OCHCA's Mindstrong program
by local healthcare system

377
Consumers Enrolled
in OCHCA's Mindstrong program

This section includes:

- **App data** on the use of Mindstrong and surveys completed within the Mindstrong app by the 377 psychiatry patients at the local healthcare system who used Mindstrong between May 2020 and March 2023.

- **Electronic Medical Record (EMR) data** on emergency department visits and hospitalizations at the local healthcare system of the 368 patients who used Mindstrong[16] between May 2020 and March 2023 compared to 368 patients who did not use Mindstrong.[17]

Patients are referred to as **Mindstrong consumers** and **comparison patients** depending on their use of Mindstrong

Mindstrong Consumers (N=368)
Patients at the local healthcare system that were enrolled in OCHCA's Mindstrong program.

Comparison Patients (N=368)
A sample of patients at the local healthcare system that were not enrolled in OCHCA's Mindstrong program.

- **Survey data** from 108 patients referred to Mindstrong by the local healthcare system who completed surveys outside of the Mindstrong app between October 2020 and January 2023. The surveys examined their decision to use (or not use) Mindstrong and their experience with Mindstrong.

Survey respondents are categorized as **users** and **non-users** depending on their participation in the program

Users (N=96)
Survey respondents who stated they downloaded Mindstrong. Users completed an initial survey and follow-up surveys.[18]

Non-Users (N=12)
Survey respondents who stated they did not download Mindstrong. Non-users completed a one-time survey.[19]

[15] The consumer evaluation assessed the experience of psychiatry patients at the local healthcare system. It did not include the Mindstrong expansion sites (e.g., inpatient, emergency department, and primary care services at the local healthcare system, Mental Health America website) due to low referral numbers, limited consumer contact information, and the limited time remaining on the program at the time of expansion.

[16] A total of 368 patients instead of 377 patients were included because it was not possible to find unique comparison patients for 9 of the 377 Mindstrong consumers.

[17] Patients in the comparison sample were selected on three inclusion criteria: 1) a patient's age, gender, and at least two behavioral health diagnoses (or one diagnosis if the Mindstrong consumer only had one diagnosis) matched with those of Mindstrong consumers; 2) the patient saw a mental health provider at the local healthcare system between May 14, 2020 and March 10, 2023; and 3) the patient was not enrolled in Mindstrong.

[18] Users completed an initial survey (e.g., Initial Survey (N = 96)) and five follow-up surveys (e.g., Follow-Up Survey 1 (N = 55), 2 (N = 45), 3 (N = 31), 4 (N = 19), 5 (N = 9)). Follow-up Surveys were completed 3, 6, 12, 18, and 24 months after completing the Initial Survey, respectively.

[19] Non-users completed a one-time survey (e.g., One-Time Survey (N = 12)).

KEY FINDINGS

Over 70% of consumers had taken part in a therapy session and/or had sent patient messages through the app

Over 90% of consumers were satisfied with the sessions with their Mindstrong therapist

Consumers felt accepted by Mindstrong (77%) and felt that their Mindstrong therapist was on their side (81%)

Consumers experienced feeling better about taking care of their mental health (67%)

Common reasons to not use Mindstrong included being busy and/or thinking it would take up too much time

The most common reasons consumers stopped using Mindstrong were a bad experience with a provider and difficulties making an appointment

Consumers who had more therapy sessions had more improvement in their mental health than those who had fewer therapy sessions

Consumers experienced improvements in mental health symptoms and stigma. Their DSM, depression, and anxiety scores reduced by 1.9, 2.6, and 2.8 points, respectively. Their stigma scores improved by 0.3 points over time.

Mindstrong consumers had more frequent and longer healthcare visits than comparison patients, but were less likely to visit the emergency department or be hospitalized due to a mental health diagnosis

Consumers who rated Mindstrong higher on perceived usefulness were more likely to continue using Mindstrong

Consumers who scored high on loneliness were less likely to continue using Mindstrong

Consumers' engagement with biomarkers did not predict improvement in their mental health

CONSUMER DEMOGRAPHICS

Age, Gender, Ethnicity, and Education

Similar to app data demographics, the majority of both Mindstrong consumers and comparison patients were female and between 26-59 years old.[20]

The demographics of survey respondents were also female, but slightly younger (e.g., a higher percentage in the 18-25 age category). Most survey respondents identified as White (53%) and the majority had an Associates, Bachelors, or graduate degree.

	Mindstrong Consumers (App Data, N=377)	Mindstrong Consumers (EMR Data, N=368)	Comparison Patients (EMR Data, N=368)	Subset of Mindstrong Consumers (Survey Users and Non-Users, N=108)
Gender 	**64%** Female **32%** Male **4%** Another Gender or Missing Data	**68%** Female **32%** Male	**68%** Female **32%** Male	**69%** Female **25%** Male **6%** Transgender Man/Woman or Missing Data
Age 	**14%** 18-25 years **70%** 26-59 years **17%** 60+ years	**17%** 18-25 years **66%** 26-59 years **17%** 60+ years	**22%** 18-25 years **61%** 26-59 years **17%** 60+ years	**24%** 18-25 years **57%** 26-59 years **13%** 60+ years **6%** Missing Data
Ethnicity 	Data Not Collected	Data Not Collected	Data Not Collected	**53%** Non-Hispanic White **21%** Hispanic/ Latino/a/x **8%** Asian **18%** Missing Data
Highest Education Level 	Data Not Collected	Data Not Collected	Data Not Collected	**11%** High school **29%** Some college **44%** Associates, Bachelors, or Graduate Degree **16%** Missing Data

[20] There was no statistically significant difference in the age and gender distribution between the 368 Mindstrong consumers and 368 comparison patients.

Mental Health

On average, EMR data showed that Mindstrong consumers (N = 368) had 3.7 mental health diagnoses (SD =2.5) and comparison patients (N = 368) had 2.9 mental health diagnoses (SD = 2.1) (p<0.001). Mindstrong consumers were significantly more likely to have anxiety, recurrent depressive disorders, and bipolar disorder diagnoses than comparison patients (p<0.05). Comparison patients were significantly more likely to have substance use related disorders than Mindstrong consumers (p<0.05).

	Mindstrong Consumers (EMR Data, N=368)	**Consumer Patients** (EMR Data, N=368)
Mental Health Diagnosis	**89%** Anxiety **20%** Recurrent Depressive Disorders **17%** Substance Use Related Disorders **16%** Bipolar **11%** Eating and Sleeping Disorders **8%** Personality Disorders **8%** Schizophrenia and Related Psychotic Disorders	**82%** Anxiety **12%** Recurrent Depressive Disorders **26%** Substance Use Related Disorders **8%** Bipolar **11%** Eating and Sleeping Disorders **5%** Personality Disorders **6%** Schizophrenia and Related Psychotic Disorders

Data from the initial surveys showed that 40% of Mindstrong users felt ashamed for having a mental illness and 40% felt inferior to others without a mental illness.

40% felt ashamed for having a mental illness

40% felt inferior to others without a mental illness

AREA OF EXPLORATION #1: CONTEXTUAL FACTORS

What factors make a setting ready for a product like Mindstrong, and influence consumers to use it over time?

Key Factors Considered When Deciding to Use Mental Health Technology

Consumer survey data found privacy, price, and the effect on their device to be key factors that users considered in mental health technology. (Initial Survey, N = 84)[21]

89%

Personal information is kept private

76%

The app is free

61%

The app will not have a negative effect on device (e.g., drain phone battery)

Five non-users (42%) were eligible for Mindstrong, but chose not to sign up for the program. Seven non-users (58%) had started the onboarding process, but never downloaded the app on their phone. **The three most common reasons that non-users did not sign up for or download Mindstrong were because they were busy, had other strategies in place to support their mental health, and didn't think Mindstrong would be useful. (One-Time Survey, N=12)**

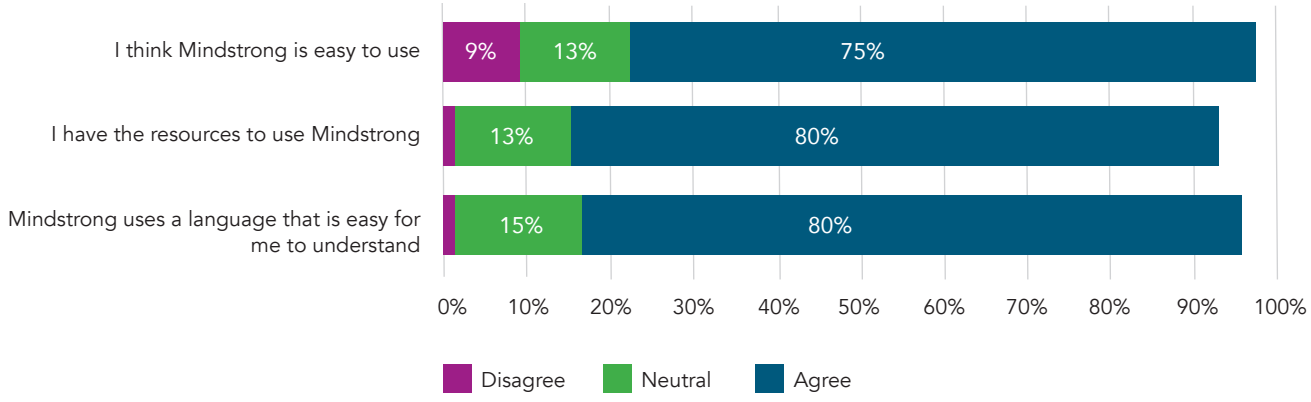
Busy / no time

Use of other strategies to support mental health

Didn't think it would be useful / wanted to handle problem myself

Ease of Using Mindstrong

The majority of users (the subset of Mindstrong consumers who completed consumer surveys) thought Mindstrong was easy to use (75%), had the resources to use Mindstrong (80%), and felt Mindstrong used a language that was easy to understand (80%). (Follow-up Survey 1, N = 55)



[21] Sections that compare findings from the initial, follow-up, and one-time surveys will refer to these as Initial Survey, Follow-Up Survey 1-5, and One-Time Survey and only include data from those survey respondents.

Challenges Experienced by Consumers

Users who continued to use Mindstrong shared the following most common challenges they experienced. Similar challenges were found across Follow-up Surveys.

Said they experienced difficulties using Mindstrong

Did not understand biomarkers

Had a bad experience with Mindstrong providers

Had difficulties making an appointment for a therapy session / felt they had too little time during therapy session

Users shared the following most common reasons for no longer using Mindstrong. Similar reasons were given across Follow-up Surveys.

Felt Mindstrong was not useful

Said they experienced difficulties using Mindstrong

Did not understand biomarkers

Had difficulties making an appointment for a therapy session / felt they had too little time during therapy session

Had a bad experience with Mindstrong providers

Said they wanted to use traditional mental health services

AREA OF EXPLORATION #2: SERVICE DELIVERY

How is Mindstrong used?

Mindstrong Enrollment and Activity (as of 1/31/2023)

The table below defines the terms used in this section.

	Definitions
Consumers discharged	Consumers who formally requested to be released from Mindstrong services
Stayed enrolled	Consumers who stayed enrolled in the Mindstrong program
Active users	Consumers that had at least one meaningful app activity
Therapy session	A therapy session that consumers had with a licensed Mindstrong therapist (these included chat, phone, and video sessions)
Patient message	Consumers could send patient messages to connect with their care team
Urgent session	Consumers could request an urgent session through the Mindstrong app to meet with a Mindstrong therapist
Crisis Assessment Team (CAT)	The CAT consisted of licensed professionals trained to serve individuals that were experiencing a behavioral health crisis. Clinicians performed evaluations and risk assessments to link individuals to an appropriate level of care.

App data indicated the majority of consumers had taken part in a therapy session, and/or had sent patient messages through the Mindstrong app. A small subset of consumers made an urgent session request after hours.

377
Consumers Enrolled in OCHCA's Mindstrong Program

43
Consumers Discharged from OCHCA's Mindstrong Program

509
Average Number of Days Consumers Stayed Enrolled in OCHCA's Mindstrong Program

308
Average Number of Days Consumers Were Active in OCHCA's Mindstrong Program

75%
of consumers had at least one **therapy session**; each consumer had an average of **14.3 therapy sessions**

74%
of consumers had Phone Therapy Sessions with a Mindstrong Clinical Specialist

14%
of consumers had Chat Therapy Sessions with a Mindstrong Clinical Specialist

11%
of consumers had Video Therapy Sessions with a Mindstrong Clinical Specialist

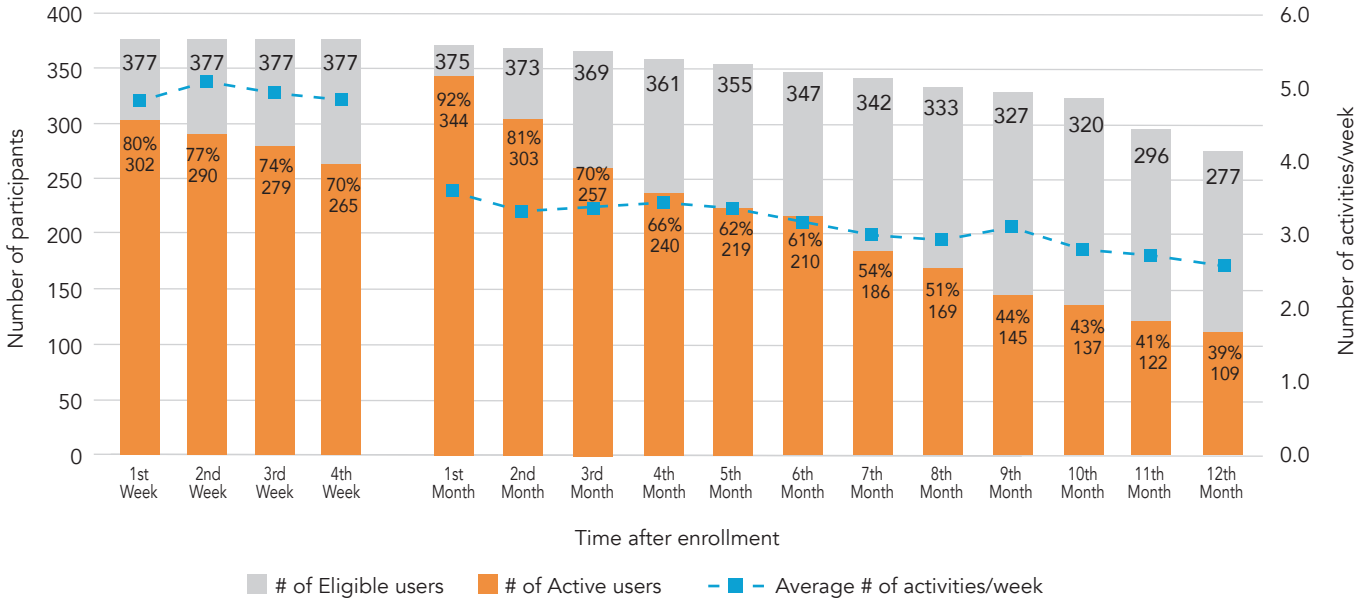
86%
of consumers had sent a **patient message**

11%
of consumers made an **urgent session request** after hours and/or the weekend

CAT 9
referrals were made to the **Crisis Assessment Team (CAT)**

Mindstrong App Engagement

App data showed that the percentage of active users decreased over time, but engagement remained largely stable among consumers engaged with Mindstrong. Consumers were most active in the first month of enrollment, with 92% of eligible users remaining active in the first month. After the first month, the total number of active users declined. Potentially, consumers were more active in the beginning of enrollment to explore the app. After the first month, the number of activities remained largely stable, and active users completed on average between 2.5 and 3.5 activities per week. (N=377)[22]



Almost all consumers used Mindstrong for more than a day (92%) and a majority used Mindstrong for more than 30 days (85%).

92%
used Mindstrong for more than a day (N=377)

323 Days
Average length of time on app among the 347 consumers who used Mindstrong for more than a day (SD = 236 days)

112 Days
Average number of unique days among the 347 consumers who used Mindstrong for more than a day (SD = 120 days)

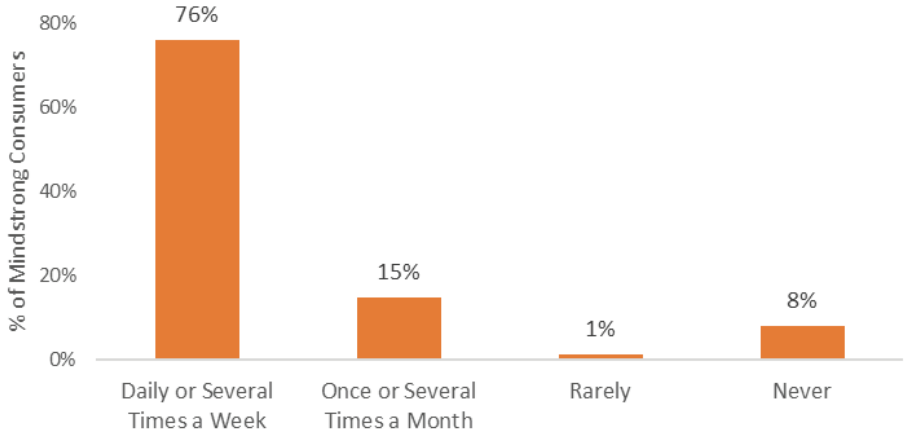
85%
used Mindstrong for more than 30 days (N=377)

349 Days
Average length of time on app among the 320 consumers who used Mindstrong for more than 30 days (SD = 227 days)

121 Days
Average number of unique days among the 320 consumers who used Mindstrong for more than 30 days (SD = 121 days)

[22] App activities are defined as 1) viewing biomarkers, 2) taking part in therapy sessions, 3) completing surveys, 4) sending patient messages, and 5) taking part in care partner sessions.

The majority of all consumers enrolled in OCHCA's Mindstrong program (76%) interacted with Mindstrong daily or several times a week. (N=377)



Predictors of Mindstrong App Engagement

People who thought Mindstrong would be useful when they first started using it[23] tended to use the app longer. Those who were lonelier at the beginning of the program tended not to use the app long. (Initial Survey of those consumers who downloaded Mindstrong, N=84)[24]

The More Useful consumers thought Mindstrong would be at the start of the program → **More** likely to use Mindstrong longer

Lonelier consumers at the start of the program → **Less** likely to use Mindstrong longer

Confidence in Using Technology[25] → **Not related** to how long consumers used Mindstrong

Privacy Concerns[26] → **Not Related** to how long consumers used Mindstrong

Confidence in using technology and privacy concerns were not related to length of time on the app. Various factors may impact adoption and engagement of mental health apps, such as experience using technology and privacy concerns (Balaskas et al, 2022). Overall, consumers were confident using technology. While privacy was important to consumers (see page 29), this may not have been a significant concern impacting Mindstrong use. (Initial Survey of those consumers who downloaded Mindstrong, N=84)

[23] Consumers were asked to rate 3 statements related to Mindstrong's usefulness (e.g. 'I believe Mindstrong will be useful in my daily life') on a 5-point Likert scale ranging from Strongly disagree (1) to Strongly agree (5). The survey items were based on the Unified Theory of Acceptance and Use of Technology questionnaire, which is used to evaluate technology acceptance and adoption. The ratings were combined as a single mean usefulness score that could range from 1-5.

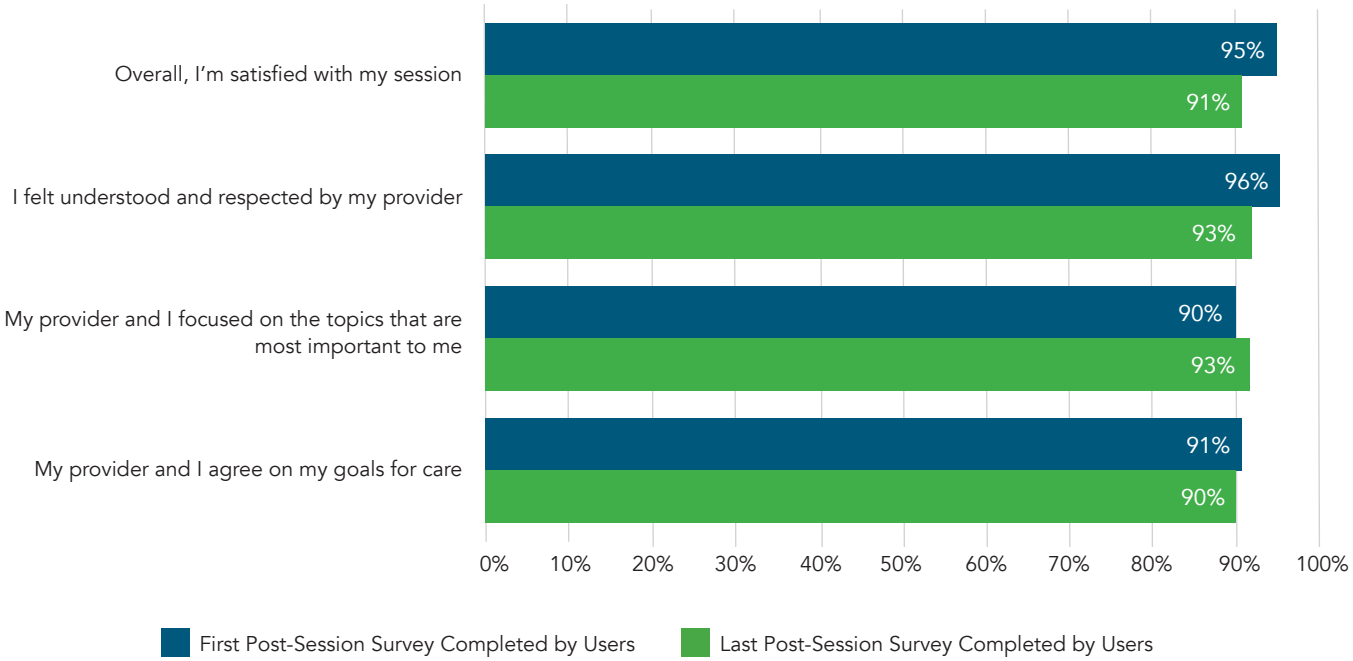
[24] The cox proportional hazard model was used to estimate the likelihood of leaving Mindstrong. Analysis indicated that lower perceived usefulness and higher loneliness both increased the likelihood of leaving Mindstrong early. (The coefficient for perceived usefulness=0.57, p-value <0.01, and the coefficient for loneliness = 1.80, p-value=0.04, where the coefficient represents the likelihood of leaving Mindstrong early and a coefficient > 1 indicated a higher likelihood of leaving Mindstrong early.) Other variables were examined and determined not to be significant, including stigma scores, the therapeutic alliance with their psychiatrist at the local healthcare system, DSM-5 scores, digital literacy, privacy concerns, access to care, mental health detection, interest in using mental health technology, and the onboarding experience with Mindstrong.

[25] Consumers were asked to rate one statement related to digital literacy ('I am confident using technology to look up information') taken from the Mental Health Literacy Scale on a 5-point Likert scale ranging from Strongly disagree (1) to Strongly agree (5).

[26] Participants were asked to rate one statement related to privacy ('I feel that as a result of my using technology, others know more about me than I am comfortable with') taken from the Scale on Mobile Users' Information Privacy Concerns on a 5-point Likert scale ranging from Strongly disagree (1) to Strongly agree (5).

Satisfaction with Sessions

App data showed that satisfaction was high both on the first and last in-app survey (e.g., the surveys consumers completed after their first and last session with a provider, respectively) consumers completed (N = 167), indicating a consistently positive experience over time.[27] Over 90% of consumers were satisfied with their session with a provider and had positive sentiments toward the provider they saw.



A majority of users felt their Mindstrong therapist was on their side and found talking with a Mindstrong therapist useful. 77% felt Mindstrong accepted them no matter how they responded. (Follow-Up Survey 1, N = 55)

81%

Agreed their **Mindstrong therapist was on their side** and tried to help them

71%

Found talking with a **Mindstrong therapist very or extremely useful**; this was rated as **the most useful Mindstrong feature**

77%

Felt accepted by Mindstrong no matter how they responded

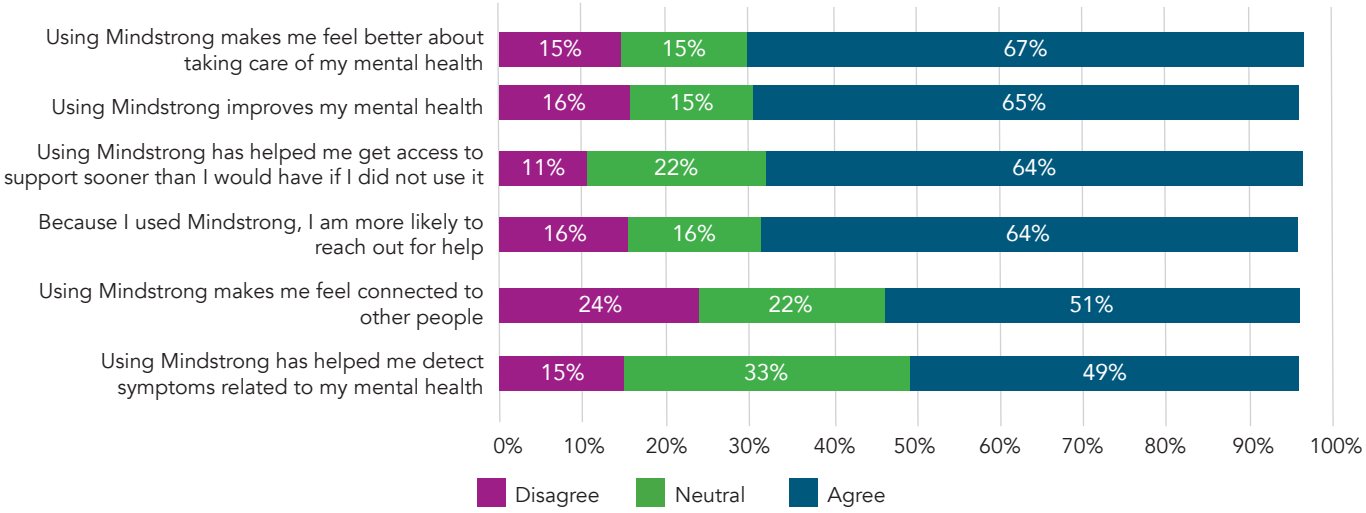
[27] The average time between the first and last post-session survey that consumers completed was 240 days.

AREA OF EXPLORATION #3: POTENTIAL BENEFITS

What are the potential benefits of using Mindstrong?

Perceived Benefits of Mindstrong among Consumers

The majority felt using Mindstrong made them feel better about taking care of their mental health (67%) and improved their mental health (65%). (Follow-Up Survey 1, N=55)



Changes in Mental and Physical Health Symptoms

Mental health symptoms improved over time among Mindstrong consumers who took a mental health assessment at least twice.[28, 29]

Mental Health Symptoms

Improved

-1.9

DSM-5 scores were reduced by 1.9 points over time, on average. This indicates that mental health symptoms improved for consumers. **(N=164, p=0.05)[30]**

Number of Unhealthy Days

Improved

-1.3

The number of unhealthy days was reduced by 1.3 days, on average. This indicates that consumers had more healthy days. **(N=126, p=0.01)[31]**

Depression and Anxiety Symptoms

Improved

-2.6 and -2.8

Depression and Anxiety symptoms were reduced by 2.6 and 2.8 points, respectively, over time, on average. This indicates depression and anxiety symptoms improved for consumers. **(N=97, p=0.01; N=104, p<0.01)[32]**

General Health

Not changed

0

General Health did not change over time, on average. **(N=126; p=0.84)[33]**

[28] Of the 377 Mindstrong consumers, 236 took at least one mental health assessment twice in the Mindstrong app. The average time between the first and last assessment that consumers completed was 192 days.

[29] Paired t-tests were used to determine whether the means were significantly different between the first and last scores (alpha=0.05).

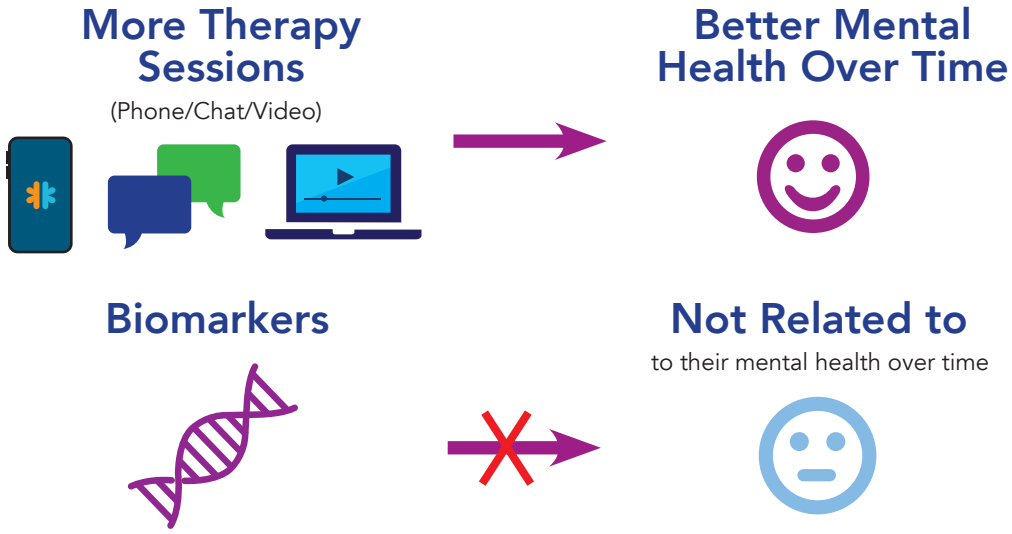
[30] Mental health symptoms were measured using the DSM-5 Cross-Cutting Symptom Measure, a self-rated measure that assesses symptoms across psychiatric diagnoses. A higher score indicates more severe symptoms.

[31] Consumers were asked to report the number of unhealthy days they experienced.

[32] Depression was measured by 8 items (e.g., I felt worthless; I felt I had nothing to look forward to; I felt helpless; I felt sad; I felt like a failure; I felt depressed; I felt unhappy; I felt hopeless) with total scores ranging from 8 to 40. Anxiety was measured by 7 items (e.g., In the past SEVEN days, I felt fearful; I felt anxious; I felt worried; I found it hard to focus on anything other than my anxiety; I felt nervous; I felt uneasy; I felt tense) with total scores ranging from 7 to 35.

[33] Consumers were asked to rate their general health on a scale ranging from 1 to 5.

Among Mindstrong consumers who completed at least one DSM-5 survey in the app, those who had more therapy sessions with a Mindstrong Clinical Specialist had a significantly better improvement in their mental health (e.g., DSM-5 scores) over time, compared to those who had less therapy sessions. Biomarker engagement did not predict significantly better improvement in mental health over time. **(N=258)**[34]



Changes in Access to Appropriate Levels of Support and Care

Mindstrong consumers had significantly more healthcare visits[35] within the healthcare system than comparison patients. Those using Mindstrong stayed longer for each healthcare visit ($p < 0.05$).[36]

	Mindstrong Consumers (N=368)	Comparison Patients (N=368)
Average Number of Healthcare visits	27.8 visits (SD = 32.7 visits)	15.1 visits (SD = 27.1 visits)
Average Number of Minutes for Each Healthcare Visit	33.6 minutes (SD = 8.6 minutes)	28.4 minutes (SD = 13.4 minutes)
Average Number of Behavioral Health Visits[37]	14.2 visits (SD = 11.9 visits)	4.6 visits (SD = 13.5 visits)

[34] A multilevel regression model was used. The model controlled for the number of days since the first survey, age, and gender. (b = -0.2, p= .01)

[35] Healthcare visits included office visits, telemedicine, nurse only visits, urgent care, and hospital encounters. It did not include emergency department visits or hospitalization via the emergency department.

[36] T-tests were used to determine if the means were significantly different between Mindstrong consumers and comparison patients (alpha=0.05).

[37] Behavioral health visits followed the ICD-10 classification for mental and behavioral health disorders by the World Health Organization (e.g., ICD-10 codes with visit diagnosis beginning with F). These included F10-F19: Substance Use Related Disorders; F20-F29: schizophrenia and related psychotic disorders; F30-F39: major mood disorders; F40-F49: anxiety, stress-related, dissociative, and somatoform disorders; F50-F59: eating and sleep disorders, and sexual dysfunction; F60-F69: personality disorders; F70-F79: intellectual disability; F80-F89: specific learning disability and autisms spectrum disorders; F90-F99: ADHD, conduct disorders, childhood anxiety disorders, and tic disorders.

Although Mindstrong consumers had more healthcare visits, they had significantly fewer emergency department (ED) visits and were less likely to have behavioral health related ED visits and hospitalizations compared comparison patients ($p < 0.05$).[38]

	Mindstrong Consumers (N=368)		Comparison Patients (N=368)	
	Average Number	Percent of Consumers	Average Number	Percent of Patients
 ED Visits[39]	0.5+ (SD = 2.0 visits)	21.5%	1.2+ (SD = 4.9 visits)	27.2%
 Hospitalizations	0.2 (SD = 0.8 visits)	11.4%	0.2 (SD = 0.6 visits)	16.3%
 Behavioral Health Related ED Visits and Hospitalizations[40]	0.1 (SD = 0.6 visits)	8.7%+	0.2 (SD = 0.8 visits)	14.4%+

+: Statistically different at the 5% level

[38] T-tests were used to determine if the means were significantly different between Mindstrong consumers and comparison patients. Chi-square tests were used to determine if the distributions were different between the Mindstrong consumers and comparison patients. (alpha=0.05).

[39] ED visits included visits to the ED that did not result in a hospitalization.

[40] Behavioral health related ED visits and hospitalizations were combined for this analysis due to small sample sizes.

Changes in Mental Health Stigma

Mindstrong consumers felt less mental health stigma as they used the app over time. Specifically, consumers felt less internalized stigma related to feeling alienation (e.g., feelings of embarrassment or shame), and more personal resilience (e.g., willingness to ask for help and having fewer symptoms interfere with life). There were no changes in internalized sigma related to social withdrawal (e.g., avoiding social situations). (Initial Survey and Follow-Up Surveys 1-5 of those consumers who downloaded Mindstrong and completed at least two surveys, N=68)[41]

Internalized Stigma: Alienation

Improved

-0.3

Stigma alienation scores were reduced by 0.3 points over time, on average. This indicates less stigma.

(p=0.03)[42]

Internalized Stigma: Social withdrawal

Not changed

-0.1

Social withdrawal stigma scores were reduced by 0.1 points over time, on average. However, this did not indicate a statistically significant change.

(p=0.3)[43]

Resilience: Willingness to ask for help

Improved

0.3

Willingness to ask for help improved by 0.3 points over time, on average. This indicates an improvement.

(p<0.01)[44]

Resilience: Not dominated by symptoms

Improved

0.3

Not dominated by symptoms improved by 0.3 points over time, on average. This indicates an improvement.

(p<0.02)[45]

Changes in Purpose, Belonging, and Social Connectedness

There was no change in loneliness over time. (Initial Survey and Follow-Up Surveys 1-5 of those consumers who downloaded Mindstrong and completed at least two surveys, N=68)[46,47]

Loneliness

Not changed

0.1

Loneliness scores were reduced by 0.1 points over time, on average. However, this change was not statistically significant.

(p=0.4)

[41] Paired t-tests were used to determine if the means were significantly different between the score on the first survey and the last survey. (alpha=0.05)

[42] Internalized stigma related to alienation reflected the average scores of six items: 1) I feel out of place in the world because I have a mental illness; 2) Having a mental illness has spoiled my life; 3) People without mental illness could not possibly understand me; 4) I am embarrassed or ashamed that I have a mental illness;5) I am disappointed in myself for having a mental illness; and 6) I feel inferior to others who don't have a mental illness.

[43] Internalized stigma related to social withdrawal reflected the average scores of six items: 1) I don't talk about myself much because I don't want to burden others with my mental illness; 2) I don't socialize as much as I used to because my mental illness might make me look or behave "weird"; 3) Negative stereotypes about mental illness keep me isolated from the "normal" world; 4) I stay away from social situations in order to protect my family or friends from embarrassment; 5) Being around people who don't have a mental illness makes me feel out of place or inadequate; and 6) I avoid getting close to people who don't have a mental illness to avoid rejection.

[44] Resilience related to willingness to ask for help reflected the average scores of three items: 1) I know when to ask for help; 2) I am willing to ask for help; and 3) I ask for help when I need it.

[45] Resilience related to not being dominated by symptoms reflected the average scores of three items: 1) Coping with my mental illness is no longer the main focus of my life; 2) My symptoms interfere less and less with my life; and 3) My symptoms seem to be a problem for shorter periods of time each time they occur.

[46] Loneliness related to the average score of three questions: 1) How often do you feel that you lack companionship?; 2) How often do you feel left out?; and 3) How often do you feel isolated from others?

[47] Paired t-tests were used to determine whether the means were significantly different between the first and last loneliness scores. (alpha=0.05)

Listed below are the key learnings that were identified across Orange County's participation in Help@Hand. This list is not meant to be comprehensive, but rather highlights important learnings that might be useful for others' planning on implementing digital mental health products into their systems of care. Some learnings were based on activities that were planned for and found to be successful to recommend to others. Other learnings were based on challenges learned along the way and suggested to be considered by others as well.

Program Planning and Execution

- **Identify key collaborators and involve them at all stages.** Building a digital system of care requires input, guidance, and sign-off from key collaborators involved in the program management, implementation, and evaluation of the program. These collaborators include, but are not limited to, providers, staff, Peers, potential consumers and/or patients, county leadership, information technology security and privacy, and compliance.
- **Obtain leadership support.** Implementing changes meant to transform the system requires support, communication, and guidance from leadership, as decisions made on such programs can impact other programs across the county system.
- **Include staff with clinical experience as part of the implementation team.** Apps with clinical integration require implementation staff with clinical experience.
- **Allocate sufficient staffing resources.** The staff time required to implement the program was higher than anticipated. While the county identified opportunities to expand the program's reach, activities were limited by staffing resources.
- **Consider the trade-offs between building a product versus adopting an existing product.** Even turn-key products require many resources to implement. In some cases, it may be more efficient build a product with the required functionality instead of adopting an existing product and molding it to fit the county and consumers' needs.
- **Make critical program elements a priority throughout implementation.** Consumer safety, privacy, and product quality are critical program elements that should remain an ongoing priority throughout implementation. These elements can also guide the implementation plan and launch date.
- **Consider whether the technology is a good fit for your audience.** When selecting a technology product, consider what the product was meant to do and who it was meant to serve. Identify whether your population has the skills and resources necessary to use the product.
- **Establish effective communication and decision-making processes.** It is important to identify strategies for effective communication and decision-making processes across the entire system. Maintain transparent communication throughout the implementation with all identified partners and collaborators.
- **Create clear processes to prevent program delays.** Establish clear processes with task lists and defined start and end dates. Assign these tasks to the appropriate people who are resourced to accomplish them. Identify potential bottlenecks and resolve them to prevent delays and misunderstandings.
- **Tailor training materials to fit the audience.** The content, format, and length of information will differ based on the training audience (e.g., referring providers, potential partners, or new program staff).
- **Allow for the opportunity to course-correct and shift when needed.** Specific elements, such as digital consent, website development, and vendor security requirements, require collaboration with program partners and may create unanticipated issues or delays.

Working with Partners

- **Consult with key players early on.** Contracting with technology vendors and private entities required special considerations around contract language and payment structures. Internal subject matter experts (e.g., county counsel) was needed to be involved early in the vetting process.
- **Partner with a vendor specializing in organizational change management (OCM).** Implementing technology and making it fit within the current county space is a challenge. Contracting with a vendor specializing in OCM helped the county adapt to this change.
- **Maintain communication with all program partners.** Communicate regularly with program partners to ensure information, messaging, and shared vision is accurate.
- **Define terms frequently.** Partners may not have a shared definition of terms (e.g., serious mental illness, Peers). Define terms constantly, especially early on, to develop a shared understanding.
- **Be informed on changes to digital products.** Digital solutions are frequently updated. Updates may cause misalignment within previously established processes. It is important to regularly communicate and understand product changes that may impact implementation.
- **Develop a shared tracking system for referral and enrollment data across partners.** A consistent data tracking process can ensure alignment of referral and enrollment data (e.g., documentation of all referrals and enrollments between partners). Maintaining a shared database would have been helpful.
- **Grant access to protected health information (PHI)/personal identifying information (PII) to boost productivity.** It was difficult for partners to identify and resolve issues around referral and enrollment data when they were unable to access PHI/PII to address specific issues. Establishing a Business Associate Agreement to allow certain partners to access PHI/PII would have supported data review and analysis.
- **Consider the possibility of the technology vendor being acquired.** When establishing vendor contracts, specify what should happen if a vendor is to be acquired or go out of business (e.g., specify who owns and manages the data, and what support will be provided during the transition).
- **Discuss the program timeline, duration, and staffing resources, as these may impact partnerships.** Organizations may not be able to implement the program within the given timeframe or may be hesitant to offer clients a resource that will later be discontinued. Even when interest in the program is high, lack of staffing resources can prevent the partnership from moving forward.

Consumer Recruitment and Engagement

- **Incorporate a variety of communication strategies.** Consumers' communication preferences will vary. Some may prefer to receive information via email, text messaging, phone calls, dashboards, etc. Developing a communication plan that supports a variety of strategies may increase engagement.
- **Provide consumers and referring providers easy access to program information.** Consumers and providers benefit from having access to materials (e.g., postcards and flyers) that share information about the program. These materials need to be tailored for each implementation site to ensure accurate information.
- **Track the referral source to shed light on effective outreach strategies.** Appropriate tracking may help identify the most effective outreach strategies when there are different ways for consumers to enroll in the program.
- **Keep the onboarding process as simple as possible for the consumer.** Lengthy referral, eligibility and consent processes with multiple steps and hand-offs between different parties created opportunities for consumers to discontinue the enrollment process.
- **Incorporate Peer feedback when developing program content.** Program content should be developed with Peers to prevent issues that may create a disconnect with the consumer (e.g., confusing process, unclear terminology, trigger words, etc.).

Eligibility and Consent Process

- **Consider challenges associated with an automated digital eligibility and consent process.** The shift from the phone consent to the automated digital consent process created new challenges. The digital eligibility and consent process allowed consumers to fill out a form multiple times or alter their responses. This may have allowed ineligible consumers to access services.
- **Provide access to live support.** While some consumers appreciate the ability to complete the digital process at their convenience, others may prefer to speak with a Peer. Consumers should have the ability to request live support during the process.
- **Allocate time to test and update processes.** Developing a digital consenting process requires thorough testing and updates to internal processes before launching with consumers.
- **Determine the minimal level of consumer information to be collected that is necessary for the program.** Less information was collected from consumers referred through the automated digital eligibility and consent process compared to the case-by-case referrals.

Digital Literacy Training

- **Provide digital literacy training as part of technology programs.** Digital literacy needs to be addressed to ensure that consumers can use the technology. Community partners and participants can provide useful feedback on the community's technology-related needs.
- **Consider the audience when developing materials and promoting workshops.** When developing materials or marketing digital literacy sessions, the needs of the audience should be considered to determine the best methods (e.g., physical materials, digital materials, location, etc.).
- **Allocate sufficient time to build a digital literacy curriculum.** Peers recognized that creating digital literacy resources to address the community's needs required extensive time and effort. The audience's background, location, attendance expectations, and resources impacted the curriculum.
- **Determine deadlines and requirements to host digital literacy workshops at community centers.** Community centers have deadlines and requirements to promote and host digital literacy workshops. Communicate with community centers in advance to ensure that workshops are added to event calendars and schedules.

Consumer and Provider Experiences

- **Consider reasons for not using Mindstrong.** Common reasons for deciding not to use Mindstrong included being too busy and/or thinking it would take up too much time. Future programs should clarify to consumers the anticipated time commitment, and offer support and suggestions for more easily integrating mental health support into their daily lives.
- **App engagement stayed stable over time.** Though the number of active users declined over time, those who remained engaged with Mindstrong continued to complete 2.5-3.5 activities per week, on average.
- **Consumers valued the ability to speak to a therapist.** The majority of consumers found connecting (e.g. chatting) with a Mindstrong therapist to be very or extremely useful, and rated this feature the highest among the Mindstrong features.
- **Consider challenges when offering digital tools.** Challenges included technical issues, bad experiences with Mindstrong providers, and/or sessions being unavailable or too short. For some consumers, these challenges were sufficient reasons to stop using Mindstrong.

- **Providers felt prepared and knowledgeable about Mindstrong.** Providers felt that they had supervisory support for Mindstrong, that there was sufficient provider training, and that they could readily provide feedback regarding the implementation.
- **Over the course of implementation, providers generally increased in the perceived benefits of referring patients to Mindstrong.** Providers were most likely to indicate that they felt Mindstrong enhanced patient care, motivated patents to participate in treatment, and produced discernible patient improvements in the last year of implementation.
- **Providers referred patients to Mindstrong due to the cost, convenience, and timely access to services.** Reasons for referring patients to Mindstrong remained consistent throughout the implementation.
- **Providers identified areas for improvement.** Providers reported that some patients wanted longer sessions and improved communication during the enrollment process and throughout receiving services (e.g., follow-up after sessions). Some patients also informed providers that they had significant gaps in their therapy due to frequent therapist turnover.
- **Mindstrong consumers experienced improved mental health symptoms over time.** Mindstrong consumers who completed mental health surveys repeatedly within the app evidence a significant improvement in mental health symptoms, anxiety, depression, and healthy days over time.
- **Mindstrong consumers experienced improvements in mental health stigma over time.** Mindstrong consumers who completed mental health surveys showed that Mindstrong consumers felt less stigma as they used the app over time.
- **Mindstrong consumers showed a different pattern in healthcare utilization from comparison patients.** Data extracted from electronic medical records comparing Mindstrong participants to a comparison sample of similar patients indicated that during the same period of time, Mindstrong participants had more frequent and longer healthcare visits (e.g. well checks, office visits, urgent care) than the comparison sample. However, on average Mindstrong participants visited the Emergency Department less frequently and were less likely to be hospitalized due to a mental health diagnosis than comparison patients.
- **Perceived usefulness of Mindstrong and loneliness predicted continued use.** Consumer survey data showed that those who scored Mindstrong higher on perceived usefulness were more likely to continue using Mindstrong over time, while consumers who scored higher on loneliness were less likely to continue using Mindstrong.
- **There were specific activities within Mindstrong that contributed to improved mental health symptoms.** The more therapy sessions Mindstrong consumers engaged in, the better their mental health symptoms. There was no effect of engagement with Mindstrong's biomarker information on mental health outcomes over time.

Evaluation

- **Discuss key data elements to be collected at the beginning of the program.** Vendors may not provide key data elements in the appropriate format if they are not discussed ahead of time.
- **Build in time when planning to use evaluation findings to make data-driven decisions.** Timing of the evaluation was dependent on multiple factors. It took time to establish data use agreements, identify needs, reach required enrollments for data sharing, and interpret preliminary data analysis.
- **Reflect on milestones, lessons learned, and recommendations throughout the program.** Documenting this information on a quarterly basis helped identify successes and areas for improvement.

Learning Collaboration with other Counties/Cities Implementing Help@Hand

- **Prior to engaging with other Counties/Cities in a collaborative effort, establish expectations around shared objectives, program management, spending/finances, and expected deadlines and deliverables.** Decisions to work in parallel versus in partnership need to be negotiated prior to initiating any shared programmatic decisions.
- **Maintain ongoing communication.** When working within a multi-county/city collaborative, regular communication and coordination is important, especially in the beginning. Ongoing meetings and post-meeting summaries were especially helpful in keeping collaborators informed.
- **Allow time for collaborators to reach common ground.** Counties/cities are familiar with their own processes and requirements. It takes time to understand others' processes and establish a common vision and goal for the program.

FUTURE DIRECTIONS FOR OCHCA'S HELP@HAND PROGRAM

Although the Mindstrong program ended in March 2023, the county will continue the digital literacy component of the program and carry forward lessons learned from the Help@Hand program to other county projects.

Mindstrong

In January 2023, Mindstrong announced that the company had been acquired and clinical services for all consumers would end on March 10, 2023. OCHCA communicated with consumers to inform and help transition them to other forms of care.

OCHCA's Mindstrong program ended in March 2023. While Mindstrong was generally well received by consumers, low enrollment rates and the company's closure influenced the county's decision to discontinue the program. The low uptake was in part due to the county's implementation approach at the local healthcare system (e.g., providers referring individual patients instead of broader marketing approach). OCHCA considered moving to a broader marketing approach with community colleges, but time and resource constraints within the county impacted their ability to implement Mindstrong in community colleges.

Digital Literacy

Digital literacy was an important part of OCHCA's Help@Hand program. In June 2019, stakeholders provided feedback on the community's needs around the use of technology. OCHCA's Peers used this feedback to develop digital literacy materials and delivered trainings to community members.

OCHCA will continue digital literacy trainings as part of the Multi-County Psychiatric Advance Directives (PAD) Innovation Project. Part of this project involves creating a digital cloud-based platform to store PADs. OCHCA will continue digital literacy trainings in the Program for Assertive Community Treatment (PACT) to equip consumers with the skills needed to access and store PADs on the cloud-based platform.

Lessons Learned

OCHCA's initial goal for Help@Hand was to use technology to support mental health. Through this experience, the county discovered invaluable learnings about the process of integrating technology into the public behavioral health system and working within a multi-county collaborative. OCHCA will carry forward these lessons learned and apply them to other county projects.

DISSEMINATION OF RESULTS

Project updates were provided in MHSA Innovation Annual Reports and included as part of MHSA Annual Plan Updates.

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OCHCA completed the following tables describing their program information, accomplishments, lessons learned, and recommendations during the reporting period.

September 2018 – December 2019

Orange County	Quarter 1 (Sept 2018 – Feb 2019)	Quarter 2 (March 2019 – May 2019)	Quarter 3 (Jun 2019 – Sept 2019)	Quarter 4 (Oct 2019 – Dec 2019)
Tech Lead(s)	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT
Implementation Site	• CYBH PACT • County/City Crisis Assessment Teams	• CYBH PACT • County/City Crisis Assessment Teams	• Large medical center	• Large medical center • OC Community Colleges (initial communications begun to explore interest and feasibility of being implementation site)
Team Composition	• Peer Lead, 2 Peers, 2 staff to facilitate community feedback meetings	• Peer Lead, 2 Peers at 7 Cups, 2 staff to facilitate community feedback meetings	• Peer Lead, 2 Peers, IT, Compliance, Contracts, PIO, Cambria (3.5 FTE) to support Mindstrong launch	• Peer Lead, 2 Peers, Compliance, PIO, AQIS, Cambria (3.5 FTE) to support Mindstrong Launch
Core Audiences	Mindstrong: • Transitional age youth (ages 13-25) engaged in the Program for Assertive Community Treatment (PACT) • Individuals 13+ engaged in the crisis services continuum • Additional programs to be added later (Full Service Partnerships, Recovery Centers, etc.) 7 Cups: • To be determined	Mindstrong: • Transitional age youth (ages 13-25) engaged in PACT • Individuals 13+ engaged in the crisis services continuum • Additional programs to be added later (Full Service Partnerships, Recovery Centers, etc.) 7 Cups: • To be determined	Mindstrong: • Adults 18+ • Severe mental illness diagnosis • English speaking • Individuals who own a smartphone with unlimited data, talk and text o May be expended depending on research on Lifeline phones and Mindstrong data usage 7 Cups: • To be determined	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder o Anxiety disorders, substance use disorders or other co-occurring diagnoses are ok o May have a history of psychiatric hospitalization and/or 1+ crisis evaluations within last 12 months • Device eligibility: owns a smartphone with unlimited data, talk and text o May be expended depending on research on Lifeline phones and Mindstrong data usage
Products in Use/Planned	• Mindstrong: Health, Health Services and Care (Planned) • 7 Cups (Planned; contingent upon addressing issues identified during soft launch)	• Mindstrong: Health, Health Services and Care (Planned) • 7 Cups – Growth Paths only (Planned) • 7 Cups (Planned; contingent upon addressing issues identified during soft launch)	• Mindstrong Crisis Prevention Services (Planned) • 7 Cups—Growth Paths only (Planned)	• Mindstrong Crisis Prevention Services (Planned)
Implementation Approach	• Mindstrong (not in use yet) • 7 Cups (not in use yet)	• Mindstrong (not in use yet) • 7 Cups (not in use yet)	• Mindstrong (not in use yet) • 7 Cups (not in use yet)	• Mindstrong (not in use yet)
Other Unique Qualities	• Serving individuals regardless of insurance type/status	• Serving individuals regardless of insurance type/status	• Serving individuals regardless of insurance type/status • Began discussions on how to meaningfully address informed consent	• Serving individuals regardless of insurance type/status • Creating plan to pilot/test Lifeline phones • Extensive conversations and iterative refinement around informed consent process involving project team, compliance, peers, large medical center, Mindstrong and video production company; including digitization of consent form and creating companion video/audio

Continued on next page

Orange County	Quarter 1 (Sept 2018 – Feb 2019)	Quarter 2 (March 2019 – May 2019)	Quarter 3 (Jun 2019 – Sept 2019)	Quarter 4 (Oct 2019 – Dec 2019)
Milestones	Mindstrong: • PACT: Pre-implementation; tentative MS launch date in April • Crisis services continuum pre-implementation	Mindstrong: • PACT: Pre-implementation; tentative MS launch date in Spring 2020 • Crisis services continuum pre-implementation	Mindstrong: • Tentative pilot launch date in January 2020 • (Pending guidance from Manatt and County/City Counsel on FDA)	Mindstrong: • Tentative pilot launch at large medical center in Spring 2020 (pending finalized informed consent form/process & referral) • Implementation planning for Community Colleges, with preliminary soft pilot launch in Fall 2020
Lessons Learned	• Shared vision and support from executive leadership • Prioritize system prep, program prep and implementation planning over launching • Involve tech experts in the planning, development and management at the overall collaborative and local level • Communication w/vendors, checking in to ensure information, messaging, and shared vision is accurate • Tech vendors should be held to equitable standards • Create a checklist of pre-launch activities (i.e., coordinate meetings w/Compliance, IT, County/City Counsel, QI) • Ability to course correct, shift/change when needed • Frequently define terms, especially in the beginning, to ensure shared understanding • Collaborate/communicate with the program managers and staff in programs where app will be launched • Obtain feedback from clinicians/peers early on to assess interest/readiness to use the app services • Continually manage expectations at all levels (i.e., community, programs, vendors) • Risk and Liability workgroup, legal counsel, and crisis response protocols are critical elements to the project • Acknowledge challenges such as managing details with a small team and creating an environment where Counties/Cities and vendors can openly discuss challenges, concerns and issues • Shared messaging that the Help@Hand project is not about implementing apps, it's about developing a sustainable digital mental health system of care for CA (i.e., infrastructure building) • Apps that involve clinical integration require implementation support staff with clinical experience • With an ever expanding team, needed to identify strategies for effective communication and decision-making process			
Recommendations	• Flow of communication (i.e., within/between/among CalMHSA, Counties/Cities, vendors) • Plans and frequency of coordinated calls between Counties/Cities • Status update following the Cambria meetings • Systematic process for testing/vetting apps, including user safety • Process for procuring and demoing new apps/vendors, as well as for adding new components to the Suite • Planning, development and implementation process be streamlined and sustainable in the future (e.g., security vetting, compliance, etc.) • Meaning for Counties/Cities to collaborate • Consider risk and liability as part of County/City planning and readiness • Clinical integration should be the primary focus when planning launch of mental health treatment-focused apps and should include implementation staff with clinical experience • Before engaging program implementation partners, prepare an effective work plan that prioritizes necessary/required preconditions to have in place prior to launch (i.e., roadmap of involved parties and logical order/priorities for IT, data sharing, Compliance, clinical integration, etc.) • Consider use of DARCI model as a strategy for effective and expedited communication and decision-making • Existing Tech is not necessarily geared with the County/City mental health plan consumer in mind so when exploring and procuring technology, be very clear in including the type of tech the core audience will likely have access to, as well as language capabilities (should be included in RFA language, criteria)			

January 2020 – December 2020

Orange County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT
Implementation Site	• Large medical center • OC Community Colleges (initial communications begun to explore interest and feasibility of being implementation sites)	• Large medical center • Community Colleges implementation delayed • Re-started conversations with County-operated programs (PACT, esp. CYBH) about MS implementation	• Large medical center • Continued conversations with County-operated programs (Adult Mental Health) about feasibility of MS implementation • Explored opportunities for MS expansion	• Large medical center • Determined County-operated programs (Adult Mental Health) may not be feasible at this time • Re-started internal discussions about feasibility of MS implementation in Community Colleges • Explored opportunities for MS expansion
Team Composition	• Peer Lead, 2 Peers, Compliance, PIO, AQIS, Cambria (3.5 FTE) to support Mindstrong Launch	• Peer Lead, 2 Peers, Compliance, PIO, AQIS, Cambria (2.5 FTE) to support Mindstrong Launch; 2 HCA INN Staff to support Informed Consent process; re-initiation of discussions with County managers to determine interest in MS (modified model) for their programs	• Peer Lead, 2 Peers, Compliance, Cambria (2.5 FTE) to support Mindstrong implementation; 2 HCA INN Staff to support Informed Consent process • Engaged new vendor, Charitable Ventures for marketing collateral and website	• Peer Lead, 2 Peers, Compliance, Cambria (2.5 FTE) to support Mindstrong implementation; 2 HCA INN Staff to support Informed Consent process, Charitable Ventures to support marketing collateral and website updates
Core Audiences	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder • Anxiety disorders, substance use disorders or other co-occurring diagnoses are ok • May have a history of psychiatric hospitalization and/or 1+ crisis evaluations within last 12 months • Device eligibility: owns a smartphone with unlimited data, talk and text • May be expanded depending on research on Lifeline phones and Mindstrong data usage	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder • Anxiety disorders, substance use disorders or other co-occurring diagnoses are ok • May have a history of psychiatric hospitalization and/or 1+ crisis evaluations within last 12 months • Device eligibility: owns a smartphone with unlimited data, talk and text • May be expanded depending on research on Lifeline phones and Mindstrong data usage	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder • Co-occurring anxiety disorders, substance use disorders or other secondary diagnoses are ok as long as a qualifying diagnosis is present • Use of a smartphone (Android 6/iOS 11 or newer) • Internet access: Wi-Fi at home, work, school and/or cellular data plan • Primary user of their smartphone device • Does not currently have a psychotherapist Exclusion Criteria: • Consistent attendance at scheduled psychotherapy sessions provided by a licensed MFT/LCSW/LPCC or intern, or license-waivered clinician • Client only receiving non-clinical ancillary supports (i.e., case management, peer support, housing support, etc.) is **NOT** excluded from this program May be expanded depending on research on Lifeline phones and Mindstrong data usage	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder, Post Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD) • Co-occurring anxiety disorders, substance use disorders or other secondary diagnoses are ok as long as a qualifying diagnosis is present • Use of a smartphone (Android 6/iOS 11 or newer) • Internet access: Wi-Fi at home, work, school and/or cellular data plan • Primary user of their smartphone device Exclusion Criteria: • Does not currently have a psychotherapist • Consistent attendance at scheduled psychotherapy sessions provided by a licensed MFT/LCSW/LPCC or intern, or license-waivered clinician • Client only receiving non-clinical ancillary supports (i.e., case management, peer support, housing support, etc.) is NOT excluded from this program Mindstrong is continuing to explore the expansion of qualifying diagnoses
Products in Use/Planned	• Mindstrong Crisis Prevention Services (Planned)	• Mindstrong Crisis Prevention Services (In Use as part of soft launch)	• Mindstrong Crisis Prevention Services (In Use as part of soft launch)	• Mindstrong Health
Implementation Approach	• Mindstrong (Not in use yet)	• Mindstrong launched May 14, 2020	• Expanded Mindstrong referring providers at the large medical center to include residents • Revisited Mindstrong eligibility criteria to ensure appropriate referrals (i.e., clarified qualifying diagnoses; defined psychotherapist/psychotherapy)	• Started discussions on how to move to a broader marketing approach rather than a case by case referral • Developed digital consent videos to automate HCA informed consent process

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Orange County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
			• Updated HCA Informed Consent document to address Apple/Android privacy alerts • Continued discussions on clarity of continuity of care • Increased emphasis on sustainability planning • UCI Evaluation initiated interviews with referring providers and shared results recommendations with HCA • Several provider recommendations were implemented to improve and streamline the referral process • Established necessary activities to allow Peers to conduct outreach to complete consumer informed consent (smartphone, BAA's, secure emails, FTP site) • Conducted provider training to support full deployment to large medical center • OC Peer developed Mindstrong consumer information sheet	• Created an eligibility and referral guide to help providers with referral process • Created physical outreach materials (postcard) to be used when referring providers want to share Mindstrong information with consumers • UCI Evaluation conducted interviews with referring providers and consumers to gather their feedback and perspectives on the referral process and to identify potential areas for improvement • Increased Peer involvement through participation in tech lead calls and development of outreach materials (brochures, flyers, MS video, FAQs)
Other Unique Qualities	• Serving individuals regardless of insurance type/status • Creating plan to pilot/test Lifeline phones • Extensive conversations and iterative refinement around informed consent process involving project team, compliance, Peers, large medical center, Mindstrong and video production company; including digitization of consent form and creating companion video/audio	• Proposal for Mobile Innovation and Lifeline Testing going through community planning	• Continuous assessment and adjustment of the rapid deployment response	• Evaluated referral flow and numbers and adjusted the process for improvements • Started discussions on feasibility of expanding Mindstrong to different target populations and programs
Milestones	Mindstrong: • Tentative pilot launch at large medical center in Spring 2020 (depending on impact of COVID-19 public health emergency response) • Implementation planning for Community Colleges, with preliminary soft pilot launch in Fall 2020 (possibly sooner in response to increased need for telehealth support due to impact of COVID-19 on school closures)	• Launched Mindstrong with large medical center Outpatient Psychiatry on 5/14/2020 • As of June 30, 2020 (end of Q2) large medical center Psychiatry referral statistics indicate: o 2 Referring providers o 16 consumers referred o 10 completed Mindstrong enrollments o 4 consumers could not be contacted by HCA-INN to complete Informed consent. o 2 consumers in-process	• Fully launched at large medical center on 9/16/2020 • Streamlined Mindstrong training referral process using an Epic referral order • Contracted with marketing vendor (through CalMHSA) to convert informed consent into video format, convert trifold brochures into webpages and update OC Help@Hand webpages • Referral Statistics provided below table	• Trained Peers in referral/consent process • Began process for converting informed consent into digital format
Lessons Learned	• Communication with vendors, checking in to ensure information, terminology, messaging, and shared vision is accurate and determine appropriate data sharing is transparent • Risk, liability, legal counsel, and crisis response protocols are critical elements to the project and must remain an ongoing priority throughout implementation • Consumers and providers need easy access to County-specific and Help@Hand project information to learn about the product and what to expect • Identify and maintain strategies for effective, transparent communication and decision-making throughout implementation			
Recommendations	• Collaborate and prepare early with key stakeholders to support alignment in approaches, definitions, terminology, etc. and continuously revisit throughout implementation or when considering program expansion • Involve various subject matter experts (compliance, legal, fiscal, contracts, etc.) to support all stages of project implementation • Develop a streamlined process for training providers and project staff about the product to support consistency in communication about the product and with eligible consumers • Maintain ongoing and transparent communication between all project partners • Determine data access and ownership prior to execution of contracts • Actively engage Peers in all project activities • Maintain adaptable strategies and workplans; anticipate shifts and be flexible and prepared for changes • To the extent possible, maintain consistency in project staff for historical knowledge and continuity • Utilize parallel workstreams to more efficiently accomplish project activities			

January 2021 – December 2021

Orange County	Quarter 1 (Jan – Mar 2021)	Quarter 2 (Apr – Jun 2021)	Quarter 3 (Jul – Sept 2021)	Quarter 4 (Oct – Dec 2021)
Tech Lead(s)	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Same as Quarter 1	• Same as Quarter 1	• Same as Quarter 1
Implementation Site	• Large medical center	• Same as Quarter 1	• Same as Quarter 1	• Same as Quarter 1
Team Composition	• Peer Lead, 2 Peers, Cambria (2.5 FTE) to support Mindstrong implementation; 2 HCA INN Staff to support Informed Consent process, Charitable Ventures to support marketing collateral and website updates	• Two Peers, Cambria (2.5 FTE) to support Mindstrong implementation; 2 HCA INN Staff to support Informed Consent process, HCA Technical Team to support the development of the Digital Informed Consent, Charitable Ventures to support marketing collateral and website updates	• 2 Peers, Cambria (2.5 FTE) to support Mindstrong implementation; 4 HCA INN Staff to support Informed Consent process, HCA Technical Team to support the development of the Digital Informed Consent, HCA Compliance for consultation, Charitable Ventures to support marketing collateral and website updates, Walker to complete the HCA digital consent build in Qualtrics.	• 2 Peers, Cambria (2.5 FTE) to support Mindstrong implementation; 4 HCA INN Staff to support Informed Consent process, HCA Technical Team to support the development of the Digital Informed Consent, HCA Compliance for consultation, Charitable Ventures to support marketing collateral and website updates, Walker to complete the HCA digital consent build in Qualtrics.
Core Audiences	• Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder, Post Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD) • Co-occurring anxiety disorders, substance use disorders or other secondary diagnoses are ok as long as a qualifying diagnosis is present • Owns a smartphone (Android 6/iOS 11 or newer) • Internet access: Wi-Fi at home, work, school and/or cellular data plan • Primary user of their smartphone device • Exclusion Criteria: • Does not currently have a psychotherapist • Consistent attendance at scheduled psychotherapy sessions provided by a licensed MFT/LCSW/LPCC or intern, or license-waivered clinician • Client only receiving non-clinical ancillary supports (i.e., case management, peer support, housing support, etc.) is NOT excluded from this program	• Same as Quarter 1	• No changes to the diagnosis or exclusion criteria • Potential expansion to community colleges • Potential expansion to include adults (18 and older) who tested positive for COVID-19 and scored 12+ on Kessler 6	• Same as Quarter 3
Products in Use/Planned	• Mindstrong Health	• Same as Quarter 1	• Same as Quarter 1	• Same as Quarter 1
Implementation Approach	• Started discussions on how to move to a broader marketing approach rather than a case by case referral • Identified changes needed on the OC Help@Hand website and began internal discussions to update information • Developed digital consent videos in Qualtrics to automate HCA informed consent process • Distributed an eligibility and referral guide to help providers with referral process • Distributed physical outreach materials (postcard) to be used when referring providers want	• Continued discussions on marketing expansion to Community Colleges in 2021 • Began contact reestablishment of communications with primary Community College stakeholders • Continued to develop digital consenting in Qualtrics to automate HCA informed consent process • Assessed the existing Consenting process and areas of opportunity • Help@Hand Evaluation increased the number of conducted interviews with referring providers and consumers to gather their feedback and per	• Engaged vendor (Qualtrics/Walker) to finish building the digital consent process and add a scheduling feature • Continued communications with Community College stakeholders • Explored expanding to adults who have tested positive for COVID-19 • Discussed adding an additional screening tool (i.e., Kessler-6) to the digital consent process and appropriate cut off score to refer eligible participants	• Continued work with (Qualtrics/Walker) to finish building the digital consent process and scheduling feature and tested with Peers • Continued conversations about expanding to adults who have tested positive for COVID-19 from Primary Care • In preparation for expansion, included an additional screening tool (i.e., Kessler-6) to the digital consent process to screen eligibility of participants. • Created new and updated outreach materials

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Orange County	Quarter 1 (Jan–Mar 2021)	Quarter 2 (Apr – Jun 2021)	Quarter 3 (Jul – Sept 2021)	Quarter 4 (Oct – Dec 2021)
	to share Mindstrong information with consumers • Help@Hand evaluation team conducted interviews with referring providers and consumers to gather their feedback and perspectives on the referral process and to identify potential areas for improvement • Increased Peer involvement through participation in tech lead calls, development of outreach materials (brochures, flyers, MS video, FAQs) and the Consenting process. • Collaborated with Mindstrong to develop a dashboard for enrollment details, demographic information and referral tracking	spectives on the referral process and to identify potential areas for improvement • Optimized the Consenting process related to Peer involvement • Developed Policies and Procedures for the Consenting process • Initiated Mindstrong dashboard reconciliation • Conducted an HCA tracking log review and reconciliation		
Other Unique Program Qualities	• Evaluated referral flow and numbers and adjusted the process for improvements	• Established that physical outreach materials were effective in supporting consumer referrals • Identified that providing a call-back number for potential consumers improved opportunities for consumer contact • Explored the benefits of providing multiple avenues to initiate consenting • Assessed ways to provide project information while maintaining confidentiality	• Trained HCA Office Support staff to support the referral and consent process • Began building a scheduling feature (i.e., Acuity) in the HCA digital consent survey	• Continued building a scheduling feature (i.e., Acuity) in the HCA digital consent survey • Trained new HCA support staff to support the consent process
Milestones	• Peers were trained in and began supporting the informed consent process • Trained Outpatient Psychiatry clinicians • Updated the clinical eligibility criteria and expanded the core audience	• Reached a critical number of consumers enrolled in the program to allow for optimal data sharing between Mindstrong and Help@Hand Evaluation • Trained 2021 incoming residents • Established a data sharing model between Mindstrong and Help@Hand Evaluation • Distributed outreach materials to support referrals • Finalized OCHCA Innovation website Mindstrong content	• Added eligibility questions in the digital consent process to help automate the referral process • Developed outreach strategies and communication templates to engage a broader core audience (e.g., college students; adults who tested positive for COVID-19) • Began data sharing between Mindstrong and Help@Hand evaluation team, per data use agreement • Established an expansion to increase enrollments • Shared Help@Hand progress and project updates with OC community stakeholders	• Tested, reviewed and prepared to launch the digital consent process. • Reviewed Mindstrong Consumer Utilization Data.
Lessons Learned	• Marketing and Outreach Activities: o Consumers access information in multiple ways and have different levels of comfort and/or ability o Project informational trainings to referring providers, potential partners or new internal staff differ based on the core audience (e.g., content, length and delivery style) • Project Planning (ideally prior to implementation) o Lack of clear processes and identified project staff responsible to address the issues may result in miscommunication, delayed work o Changes to license management and/or monitoring are challenging during project implementation o Online elements such as digital consent, website development, vendor security requirements, and other web-based policies and processes require collaboration, scheduling and communication with IT, Compliance and project partners, which creates unanticipated issues or delays. • Project implementation: o Expanding the eligibility criteria of qualifying diagnoses introduces unique and challenging scenarios during the informed consent process. • Client or Project Partner Engagement: o *Potential partners:* Project expansion efforts and target timelines may be impacted or delayed due to internal timelines, processes and requirements of potential partners (e.g., Community Colleges) o *Clients:* an automated/digital process does not take in to account or have the ability to adjust to the person's preferred communication style or needs.			

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Orange County	Quarter 1 (Jan–Mar 2021)	Quarter 2 (Apr – Jun 2021)	Quarter 3 (Jul – Sept 2021)	Quarter 4 (Oct – Dec 2021)
Recommendations	• Marketing and Outreach Activities: o Develop a referral/client communication plan that supports a variety of strategies (e.g., via email, SMS, mail, and phone). o Collaborate with project champion for material development (e.g., content, training format, messaging, etc.) • Project Planning (ideally prior to implementation) o Create policies and procedures, process flows and utilize a RACI chart to clearly outline responsibilities and serve as a reference guide for project staff o During vendor negotiations and contract development, establish an agreement with the technology vendor that includes regular reporting of user activity and license availability. o Plan digital elements design build and revisions in advance with IT to ensure timely updates to security requirements and site content. • Project implementation: o Schedule weekly/ongoing calls with project staff to monitor progress and resolve implementation concerns (e.g., case reviews, documentation/tracking issues, etc.) • Client or Project Partner Engagement: o *Potential partners:* identify internal approval processes and timelines to determine whether implementation is feasible and/or the timeline is reasonable. o *Clients:* Create a digital consent process which allows a consumer to watch readily accessible informed consent videos and/or read associated text, depending on their preference.			
Cross County/City Sharing	• Riverside and OC: OC shared details about their implementation process, specifically related to the digital consent development. o Discussion included content development and language/phrasing to consider, potential topics to include, recommendations on voiceover, tips and strategies for video development, peer involvement, etc. • Marin and OC: Shared activities related to peer job descriptions, hiring and important considerations during the process			

January 2022 – December 2022

Orange County	Quarter 1 (Jan – Mar 2022)	Quarter 2 (Apr – Jun 2022)	Quarter 3 (Jul – Sept 2022)	Quarter 4 (Oct – Dec 2022)
Tech Lead(s)	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT
Team Composition	• Cambria (2.5 FTE) to support Mindstrong implementation • 4.25 FTE Health Care Agency (HCA) INN Staff to support Informed Consent process • The OC Health Care Agency (HCA) Technical Team to support the development of the Digital Informed Consent • HCA Compliance for consultation • Charitable Ventures to support marketing collateral and website updates • Walker to complete the HCA digital consent build in Qualtrics • Mental Health America to support expansion of MS using their External web-based mental health support site	• Cambria (2.5 FTE) to support Mindstrong implementation • 4.25 FTE Health Care Agency (HCA) INN Staff to support Informed Consent process • The OC Health Care Agency (HCA) Technical Team to support the development of the Digital Informed Consent • HCA Compliance for consultation, as needed • Charitable Ventures to support marketing collateral and website updates • Mental Health America (MHA) to support expansion of MS using their External web-based mental health support site	• Cambria (2.5 FTE) to support Mindstrong implementation • 4.25 FTE Health Care Agency (HCA) INN Staff to support Informed Consent process • The OC Health Care Agency (HCA) Technical Team to support the development of the Digital Informed Consent • HCA Compliance for consultation, as needed • Charitable Ventures to support marketing collateral and website updates • Mental Health America (MHA) to support expansion of MS using their External web-based mental health support site	• EY (formerly Cambria; 3.5 FTE) to support Mindstrong implementation • 4.25 FTE Health Care Agency (HCA) INN Staff to support Informed Consent process • The OC Health Care Agency (HCA) Technical Team to support the development of the Digital Informed Consent • HCA Compliance for consultation, as needed • Charitable Ventures to support marketing collateral and website updates • Mental Health America (MHA) to support expansion of MS using their External web-based mental health support site
Core Audiences	• No changes to the diagnosis or exclusion criteria • Expansion to include adults (18 and older) who tested positive for COVID (any/no insurance) or MediCal with PHQ9 >= 10 and a score of 9+ on Kessler 6 [Regional medical centers] • Potential expansion to include adults (18 and older) who screened positive for Depression, PTSD, Post-partum depression, and Anxiety) [Web based mental health support site]	• No changes to the diagnosis or exclusion criteria • Expansion to adults (18 and older) who tested positive for COVID (any/no insurance) or MediCal with PHQ9 >= 10 and a score of 9+ on Kessler 6 [Regional medical centers] • Expansion to adults (18 and older) who screened positive for Depression, PTSD, Post-partum depression, and Anxiety) [Web based mental health support site]	• No changes to the diagnosis or exclusion criteria • Continued expansion from previous quarters • Expansion to adults (18 and older) from the same large medical center discharged from inpatient and emergency department	• No changes to the diagnosis or exclusion criteria • Continued implementation with identified partners from previous quarters
Products in Use/Planned	• Mindstrong Health	• Mindstrong Health	• Mindstrong Health	• Mindstrong Health
Implementation Site	• Large medical center (i.e. Outpatient Psychiatry) • Regional medical centers (i.e. Primary Healthcare Centers) • Web based mental health support site	• Large medical center (i.e. Outpatient Psychiatry) • Regional medical centers (i.e. Primary Healthcare Centers) • Web based mental health support site	• Large medical center o Outpatient Psychiatry o Inpatient o Emergency Department o Regional medical centers (Primary Healthcare Centers) • Web based mental health support site	• Large medical center o Outpatient Psychiatry o Inpatient o Emergency Department o Regional medical centers (Primary Healthcare Centers) • Web based mental health support site
Implementation Approach	• Continued work with (Qualtrics/Walker) to finish building the digital consent process to include a Kessler 6 threshold and a digital consent process without the Kessler 6 threshold • Continued conversations with Primary Care physicians on expanding to adults who have tested positive for COVID-19 • Started conversations with Mental Health America (MHA) about expanding to adults who use the web based mental health support site and screen for mental health	• Initiated discussions between project partners (Mindstrong, HCA, UCI Evaluation) regarding understanding the impact of Mindstrong service on consumers. • Analyzed referral data sent from all referring sources (MHA, Primary Healthcare Centers, Outpatient Psychiatry, etc.). • Analyzed digital eligibility and consent data from Qualtrics. • Using analytical data, reviewed and revised HCA outreach content on the MHA resource page to increase referrals. • Expanded scope of Digital Literacy content from information sharing to interactive activities that	• Developed workbook for Digital Literacy workshops • Expanded frequency of Digital Literacy workshops and outreach efforts to community members (e.g., wellness centers, REI, etc.) • Began preliminary evaluation of Mindstrong adoption and use • Modified digital consent processes to support more accurate data collection (i.e., clarification question to clarify origin of referral)	• Expanded frequency of Digital Literacy workshops and outreach efforts to community members (e.g., wellness centers, REI, etc.) • Continued evaluation of Mindstrong adoption and use • Began planning for end of project (i.e., stopped new enrollments, identified transition plan)

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Orange County	Quarter 1 (Jan – Mar 2022)	Quarter 2 (Apr – Jun 2022)	Quarter 3 (Jul – Sept 2022)	Quarter 4 (Oct – Dec 2022)
		promote consumers' independent search for information within the digital space (e.g., how to vet apps, use QR codes, etc).		
Other Unique Qualities	• Trained new HCA support staff to support the digital consent process • Developed multiple workflows associated with each implementation site and core audience • Trained OCHCA staff on process workflows and potential scenarios • Continuously improved processes to track referrals received via physical and electronic channels, and data shared between project partners (Mindstrong, HCA, UCI Evaluation) • Leveraged web-based platforms (Lucidchart) to create process workflows and facilitate team collaboration • Utilized automated data reports that can be downloaded from Qualtrics for reconciliation and consumer data sharing	• HCA staff training for back-up protocols to ensure task continuity. • Developed Digital Literacy content and identified outreach strategies and locations. • Facilitated the ongoing information exchange of data for maximum analysis outcomes for project partners (Mindstrong, HCA, UCI Evaluation). • Improved processes to track digital referrals and consents.	• Continued facilitation of data exchange for maximum analysis outcomes. • Expanded outreach strategies and locations for Digital Literacy. • Improved processes to track and analyze digital referrals and consents.	• Continued development of project playbook (formerly Supplemental Document) to inform future projects of general and specific lessons learned • Began planning of close-out processes in anticipation of project conclusion at the end of Q1 2023
Milestones	• Built a scheduling feature (i.e., Acuity) in the Healthcare (HCA) digital consent survey • Identified strategies to address the issue of duplicate eligibility and consent entries within Qualtrics • Created two Digital Eligibility and Consent processes which includes a Kessler 6 threshold and one without • Deployed the Digital Eligibility and Consent process with large and regional medical centers • Collaborated with MHA to identify specific criteria/parameters and offer Mindstrong to eligible adults seeking mental health resources through the web based mental health support site • Updated and distributed existing materials to include the digital eligibility and consenting link • Created and distributed site-based provider informational materials • Initiated expansion discussion to regional Federally Qualified Health Centers	• Completed two digital consent processes: one with a Kessler 6 threshold and one without, to support the implementation plan at specific sites • Launched MS expansion at Primary Care site • Launched MS expansion to eligible consumers screened and referred through MHA's website	• Launched MS expansion to eligible consumers being discharged from inpatient and emergency department of large medical center. • Began Digital Literacy workshops.	• Developed promotional outreach materials for Digital Literacy workshops (swag) • Finalized and printed workbook for Digital Literacy workshops • Began planning for end of project • Reviewed preliminary data of consumer adoption and use from evaluation team
Lessons Learned	• Different implementation sites require specific tailored information or materials for consumers to access the Mindstrong Digital Eligibility and Consent form • Different referral approaches (e.g. virtual vs. in-person) require their own methods of communicating and distributing Mindstrong outreach materials to eligible consumers • Using a digital, easy to understand process for eligibility and consent still requires access to live support • There are a variety of ways a consumer can access the Digital Eligibility and Referral process and without appropriate tracking it is difficult to identify the most effective outreach approach (QR code vs. link) • Different levels of information are gathered from the consumer at the various points of entry • In a digital space consumers have the ability to fill out a form more than once or change their responses. This creates multiple versions of a consent form and may allow ineligible consumers to continue access to services. • Lengthy referral, eligibility, and consenting processes impact consumer engagement and may result in incomplete or abandonment consents. • Layout and visibility of service offer on 3rd party site (MHA) is not generating consumer interest. • 3rd party (MHA) eligibility process integration may result in otherwise eligible consumers being disqualified for eligibility. • There are multiple points where the consumers may abandon the referral, eligibility, and consent process prior to completion.			

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Orange County	Quarter 1 (Jan – Mar 2022)	Quarter 2 (Apr – Jun 2022)	Quarter 3 (Jul – Sept 2022)	Quarter 4 (Oct – Dec 2022)
	• Content design, without review by those with first-hand experience as a consumer, may create a disconnect with the consumers (e.g. confusing process, unclear terminology, trigger words, etc.) • When marketing digital literacy sessions, it is not always clear what outreach methods and materials are best (digital, physical, location, etc.) • Developing curriculum requires taking a variety of factors into account: audience background and needs, expectations of attendance, location, and available resources. • Expansion to additional referral sites impacted process-data gathering logistics. • Consumer engagement drops with lengthy periods between hand-offs (referral to consent and consent to enrollment). • Community centers have specific deadlines and requirements for promoting and hosting Digital Literacy workshops. • Data tracking is challenging between multiple partners managing their own systems. • Issues may arise with promotional outreach materials • Third party evaluations were delayed due to multiple factors (e.g., reaching optimal enrollment numbers for analyses, establishing data use agreements, identifying needs and interpreting preliminary data analysis). • Workarounds to support limitations of who accesses PHI/PII can impact productivity and delay identification of issues and concerns in data collection processes. • Digital solutions are frequently changed and updated for improvement (e.g., eligibility prerequisites, enrollment processes), which may cause misalignment within previously established processes (e.g., consumer referrals, eligibility screener)			
Recommendations	• Develop materials best suited for the core audience • Create multiple options to reach core audience (website, postcards, web-based messaging) • Utilize a digital scheduling platform (Acuity) that allows consumers access to live support • Identify methods to track and report referral sources • Design processes that keep the consumer experience in mind • Work with the digital platform specialists (Qualtrics) to identify strategies that prevent an individual from completing duplicate forms, changing answers, or accessing services when they are not eligible. • Ensure consumer experience is as quick and easy as possible by eliminating redundancy and unnecessary questions/processes. • Review messaging and layout with Peers and collaborate with partnering organization to achieve optimal visibility. • Carefully review MHA eligibility process/screener to ensure consumers are not inadvertently disqualified. • Regularly review data to understand where consumers "fall out" of the process and mitigate (through adjusting language, removing or rewording questions/steps, removed eligibility thresholds, etc.), • In addition to reviewing referral, eligibility, and consenting language with Peers, ensure that the Peers review the process (beginning to end) themselves to identify areas for improvement. • Collaborate with wellness center and Recovery Education Institute staff to understand consumer needs and best outreach strategies regarding digital literacy efforts. • Consult with those who work directly with the consumers to understand specific timing, context, and audience needs. • Adjust the referral process to include required questions that allow for more accurate reporting • Monitor the data of the hand-off process (e.g., average time between hand-offs) and communicate with vendor to address issues. • Start communications regarding events at community centers well in advance to be included in event calendars and schedules for consumer visibility and awareness. • Discuss and maintain a consistent data tracking process to minimize potential issues; establish process to ensure alignment of referral and enrollment data (e.g., assure consumer hand-off is acknowledged and documented between Mindstrong and HCA). Consider a shared database between partnering entities where possible. • Conduct preliminary research of available vendors to understand industry standards. Request sample products to verify quality. Test functionality of products before public distribution. • Build in adequate time when planning for data-driven decisions, when possible. • Extend access (BAA) to key team members to support data review and analysis. • Include product updates as standing agenda item to regularly communicate and understand changes that may impact implementation.			
Cross County/City Sharing				

January 2023 – March 2023

Orange County	Quarter 1 (Jan – Mar 2023)
Tech Lead(s)	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT
Implementation Site	• Large medical center o Outpatient Psychiatry o Inpatient o Emergency Department o Regional medical centers (Primary Healthcare Centers) • Web based mental health support site
Team Composition	• EY (formerly Cambria; 3.5 FTE) to support Mindstrong implementation • 4.25 FTE Health Care Agency (HCA) INN Staff to support Informed Consent process • The OC Health Care Agency (HCA) Technical Team to support the development of the Digital Informed Consent • HCA Compliance for consultation, as needed • Charitable Ventures to support marketing collateral and website updates • Mental Health America (MHA) to support close-out from their External web-based mental health support site
Core Audiences	• No changes to the diagnosis or exclusion criteria • Began offboarding consumers from technology services
Products in Use/Planned	• Mindstrong Health
Implementation Approach	• Continued planning for end of project o Aligned close-out communication efforts (message content, alternative support resources and communication channels) to consumers o Started discussions to clarify data required for post close-out evaluation • Expanded frequency of Digital Literacy workshops and outreach efforts to community members (e.g., wellness centers, REI, etc.) • Established close-out processes and responsibilities to ensure clients have additional resources for continued support if needed • Planned close-out early because it involves multiple work streams (e.g., referral, collateral) and other activities with all stakeholders involved
Other Unique Qualities	• Continued development of project playbook (formerly Supplemental Document) to inform future projects of general and specific lessons learned • Revised Digital Literacy workbook
Milestones	• Completed referral process close-out • Commensed close-out communication to consumers (established messages, identified alternative support resources and defined communication channels) • Developed additional promotional outreach materials for Digital Literacy workshops (swag) • Finalized and printed revised workbook for Digital Literacy workshops
Lessons Learned	• County may not receive data in appropriate format from the vendor if key data points and associated tracking methods are not discussed ahead of time
Recommendations	• Define key data points and understand how the vendor tracks them before the start of the project
Cross County/City Sharing	• Digital literacy efforts expanded beyond H@H project to other efforts within the county system

SPOTLIGHT: ORANGE COUNTY

Orange County Health Care Agency's Mindstrong Implementation

Since their approval to join the Help@Hand Program in 2018, Drs. Flor Yousefian Tehrani, MHSA Innovation Projects Program Manager, and Sharon Ishikawa, MHSA Coordinator, have been systematically following and maintaining an organizational change management plan to guide Orange County Health Care Agency's (HCA) implementation of Mindstrong. In June 2020, Mindstrong officially enrolled its first member from Orange County as part of this program.

Along the road to implementing their plan, Orange County has learned a number of lessons. Below Dr. Sharon Ishikawa highlighted three major lessons learned. Appendix B on page 79 provides more detailed lessons learned.

Lesson #1: *It takes a village to make changes to a County/City Behavioral Health System*

Building a digital system of care within a County/City Behavioral Health System requires the input, guidance, and sign-off of many people both within the system and across the diverse team of people designed to support project management, implementation, and evaluation. Orange County's village included:

- **Project Leadership (Tech Leads, Behavioral Health Director, and, as needed, Directors from Behavioral Health and different systems of care)** was responsible for local stewardship and decision-making, especially on clinical integration, risk management, privacy concerns, prioritization of efforts and use of funds.

- **Project Team (Orange County staff)** was responsible for executing different aspects of the project (i.e., informed consent, etc.).
- **Project Management Vendor (Cambria Solutions, Inc.)** was responsible for developing the business processes, managing the project meetings, developing collateral materials and project information for consumers and stakeholders, and identifying issues and risks.
- **HCA's Help@Hand Peers** were responsible for providing insight and feedback on business processes, collateral materials, and information developed for consumers. They will consent referred consumers as soon as all equipment and access/permissions related to personal health information (PHI) and personal identifiable information (PII) are in place.
- **HCA's Compliance** was responsible for providing guidance, input, and direction on informed consent, business associate agreement (BAA), privacy and security issues, and business process.
- **HCA's Public Information Officer (PIO)** was responsible for reviewing public-facing documents, collateral materials, and the Informed Consent website.
- **HCA's Information Technology (IT) Security** was responsible for vetting IT security of the Mindstrong platform, as well as providing solutions and ideas for technical issues such as capturing informed consent records that contain PHI/PII.
- **HCA's AQIS (Authority and Quality Improvement Services)** offered guidance on HCA's grievance policy, which was used to inform the development of CalMHSA's Help@Hand grievance policy.
- **HCA's Purchasing** was responsible for assisting with review of scope of work (SOWs) and procurement of services and vendors.
- **HCA's Peer Employee Advisory Committee (PEACe)** provided feedback and insight in selecting an appropriate voiceover for the Mindstrong video.
- **HCA's Chief Information Officer (CIO)** was responsible for guidance and direction on technical solutions.
- **Providers (local healthcare system)** were responsible for referring eligible consumers and helping to coordinate the business process integration into their systems and processes.
- **Mindstrong** was responsible for the technology and corresponding support services delivered to consumers, providing technical assistance for the process development, and ensuring implementation works with the application/services and the business model.
- **Outside Vendors** supported services such as video production, web design, etc.

As a village, the group worked collaboratively on a number of vital areas and issues. For example, early discussion and engagement with the local healthcare system Project Sponsor was critical in getting them to pilot Mindstrong and be an advocate for the implementation. Also, multiple parties, including project leadership from HCA, HCA Compliance, HCA IT, Cambria, local healthcare system, and Mindstrong, conferred to develop the rapid deployment process of referral, informed consent, and enrollment. Another noteworthy example of collaboration was engaging HCA Compliance and HCA IT to brainstorm and address informed consent issues, such as content, process, and technology-based solutions. The team also spent much time crafting language that was easy to understand for the target audience.

Lesson #2: *"Perfection is the enemy of progress." -Winston Churchill*

It is important to figure out the best time to launch. Launching too soon or too early may jeopardize overall implementation because critical issues are not identified and/or do not have an appropriate level of contingency planning. Alternatively, there are always issues or barriers that can impede progress, and a perfect or flawless implementation plan is not achievable. To balance these, it is critical that Counties identify their core values and use those to guide the decision to launch a product. Orange County's core values included:

- Consumer safety, privacy, and product quality were top priority.
- **A hierarchy of safety and privacy** that consisted of: 1) Compliance/IT work to identify risks/potential risks; 2) eliminate known risks; 3) guard against unknown risks; and 4) advise users of identified risks so they can make an informed choice about whether to use.
- Ensure **product quality** by fully understanding the product, evaluating evidence of potential impact, and working closely with Mindstrong and the evaluator to identify appropriate metrics.

One example of demonstrating these principles was implementing a modified informed consent process, which allowed immediate implementation while the team continued to develop a long-term informed consent process. Originally, the team planned for Help@Hand Peers to consent a referred consumer in-person following their appointment. However, the plan was interrupted due to COVID-19. A modified informed consent process was developed, which involved the HCA team calling consumers to review a brief "Introducing Mindstrong" video and informed consent form before referring them to Mindstrong. This process helped to protect consumer safety by explaining services, the timeframe, and costs. The video was recommended by an HCA peer and communicates standard information. It also provides an opportunity for the team to answer any questions. The multi-modal delivery of information (visual, audio, written) helped ensure consumers received information in a mode that worked best for them.

Another example is that the pilot process soft-launched with two providers to gauge and understand process impacts and make necessary adjustments before opening up referral process to all local healthcare system providers.

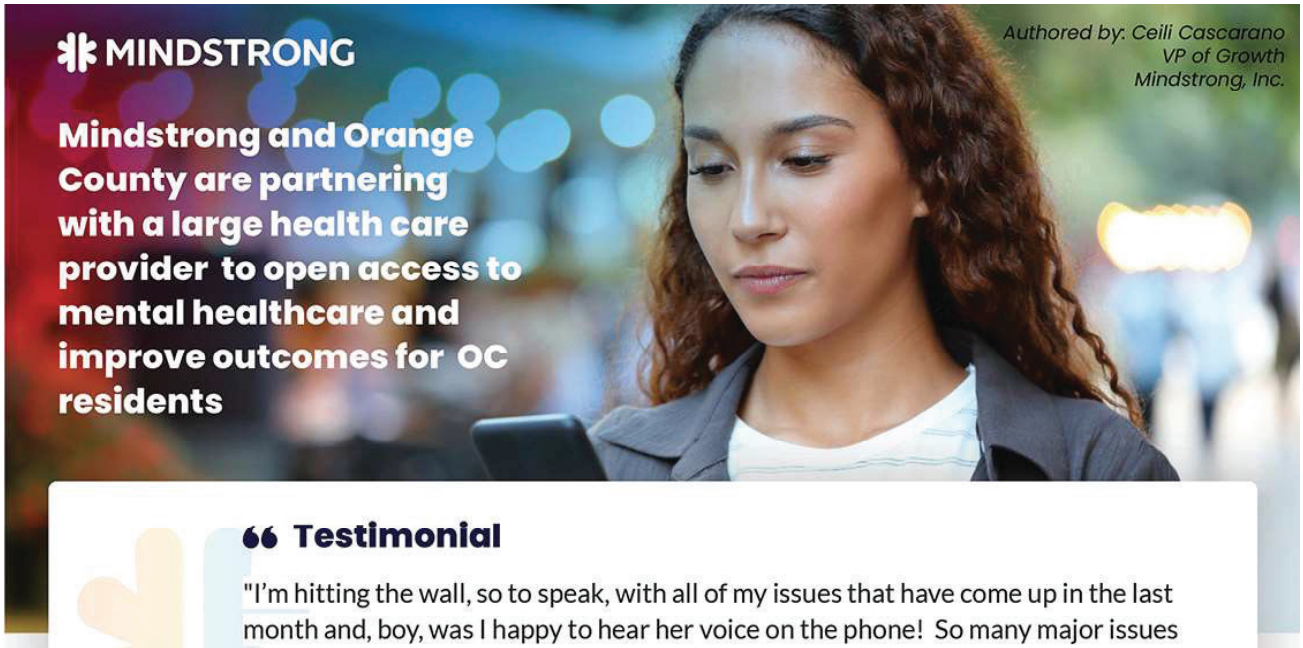
Lesson #3: *The journey is as important as the destination*

The learnings that have been extracted to date have been critical for building the foundation for continual organizational change for Orange County HCA. These deep learnings required time, patience, and a commitment to adhere to a general path and process, while maintaining flexibility to accommodate and address barriers as they arose. Ultimately, established processes to support the Mindstrong implementation will live beyond the lifetime of any single product and the Help@Hand project period by moving Orange County HCA closer to building a framework for a sustainable digital mental health system of care.

Examples of the types of processes addressed include:

#	Description	Contributors (in alphabetical order)[4]
1	Vet the safety and functionality of the vendor as well as tech–nology used (or being considered) to support implementation (i.e., Qualtrics,secure file transfer protocol, secure email, etc.) or privacy issues of methods (i.e., phones to call referred consumers – privacy of vmail/texting, etc.)	Cambria Project Team, Help@Hand Peers, Project Team, **HCA Compliance, HCA Leadership**, local healthcare system, Mindstrong Important to note that while this activity is specific to Quarter 2, one of OC's first activities nearly two years ago was to have IT conduct a robust Information/Data Security vetting when Mindstrong was initially identified as a vendor
2	Engage stakeholders for outreach material support and digital literacy training support	**CalMHSA**, HCA Leadership, HCA Project Team, **Help@ Hand Peers**
3	Develop targeted Mindstrong outreach materials (materials tailored for providers and consumers)	**Cambria Project Team**, HCA Leadership, HCA Project Team, Help@Hand Peers, Mindstrong, **Outside Vendors**, PEACe, local healthcare system
4	Develop an informed consent document that describes Mind–strong services and standardizes information reviewed with consumers. The document explains Mindstrong services, care coordination, data collection, privacy, security, crisis response, and consumer participation in the project (i.e., duration, cost, etc.)	Cambria Project Team, **HCA Compliance, HCA Lead-ership, Help@Hand Peers**, Mindstrong, PEACe, local healthcare system
5	Develop an introduction to Mindstrong video to ensure review of product description and privacy (including, but not limited to, content, phrasing, actor selected for voice over, etc.)	**Cambria Project Team**, HCA Compliance, HCA Leadership, HCA Project Team, **Help@Hand Peers**, Mindstrong, **Out-side Vendors**, PEACe
6	Conduct change readiness assessment of programs/partners	**Cambria Project Team**, HCA Leadership, HCA Project Team
7	Consult with stakeholder groups for compliance review and crisis response	CalMHSA, Cambria Project Team, **HCA Leadership**, **HCA Compliance**, HCA Project Team, Mindstrong
8	Plan sustainability beyond the project period if implementation is successful	AQIS, Cambria Project Team, **HCA Leadership**, HCA Project Team, HCA IT, Help@Hand Peers, Mindstrong, Help@Hand Evaluation, local healthcare system
9	Twice weekly (15–30 mins) touchpoint calls with HCA Tech Leads for decision making (esp. when COVID–19 dramatically decreased their availability for Help@Hand project)	**Cambria Project Lead**, HCA Tech Leads
10	Daily working meetings for Cambria project team to discuss project activity updates, scheduling, issue review and resolu–tion, project documentation update, risk analysis	**Cambria Project Team**
11	Weekly planning meetings with Cambria project, HCA project team and Help@Hand peers to plan ahead for the following week	**Cambria Project Team**, HCA Leadership, HCA Project Team, Help@Hand Peers
12	Regular project status meetings with partnering organizations, vendors, the Help@Hand Collaborative, and local project team	**Cambria Project Team**, HCA Leadership, HCA Project Team, Help@Hand Peers, Mindstrong, Help@Hand Evaluation, local healthcare system
13	Document of meeting minutes, decisions, accomplishments, issues, risks and mitigation strategies for tracking and monitoring implementation status and maintaining records for current and future project decision-making	**Cambria Project Team**, HCA Project Team, Mindstrong, Help@Hand Evaluation, local healthcare system

[4] Bolded contributors were the lead for the corresponding category.



Testimonial

"I'm hitting the wall, so to speak, with all of my issues that have come up in the last month and, boy, was I happy to hear her voice on the phone! So many major issues have come all at once and it is really putting my antidepressants to the test. I truly appreciated hearing her voice and getting [my therapist's] feedback on these issues....and she was there to tell me I have every right to feel stretched thin. I needed her yesterday and she was right there having my back! "

— *Mindstrong Member, Orange County, CA*

Mindstrong is a mental health app for Orange County residents that combines proven science, state-of-the-art technology, and dedicated care teams to deliver outstanding experiences and outcomes for members in need.

4,500+ **Sessions Completed**
Therapy Sessions

High Satisfaction
4.72 out of 5 post session rating

100% **Training in Cultural Competence**
100% of clinicians trained in culturally responsible care

44% **Diverse Clinical Team**
Clinical team that identifies as non-white

Mindstrong App & Platform

24/7 access
In addition to personalized care plans and scheduled sessions, member can always contact us.

Overlooked populations
Specialize in overlooked and underserved communities and help members living with serious mental illness find care

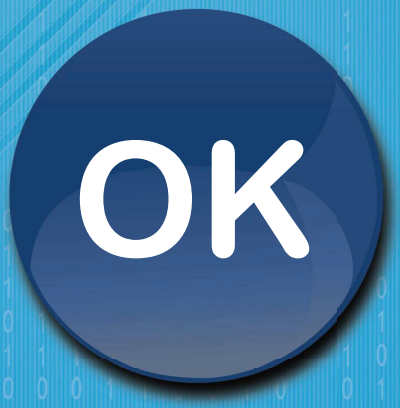
Measurement-based, continuous care
Our care team blends therapy, case management, medication management and psychosocial resources, all delivered through innovative formats and mediums.

State-of-the art technology
The Mindstrong app calculates a running, "Biomarker" score based on the member's natural phone interactions.

Targeted clinical interventions
Expert clinicians intervene at the right time with evidence-based interventions, to provide personalized support and therapy.

SPOTLIGHT

Orange County: Developing a Digital Informed Consent Process



Author: Flor Yousefian Tehrani, Psy.D., MFT,
Orange County Health Care Agency

In recent years, mental healthcare has been slowly moving into a digital space. However, with the onset of COVID-19, health care systems responded to the need for a rapid transition to telehealth and other digital healthcare solutions. Orange County's participation in the Help@Hand Innovation Project (OC H@H) provided a unique and timely opportunity to implement Mindstrong Telehealth Services. The transition to technology also allowed Orange County to transform its traditional informed consent process into a modern and efficient digital format.

Obtaining Informed Consent: Necessary Steps

The purpose of the OC H@H/Mindstrong Informed Consent is to ensure the consumer understands the Mindstrong services offered through the H@H project, is aware of the time-limited nature of the project and acknowledges the security and privacy features related to their interactions within the Mindstrong application.

A crucial aspect in the development of the OC H@H/Mindstrong Informed Consent was tailoring the language and content to the target audience. The OC H@H Peers assisted in identifying topics to include and clarifying services and technology features.

What is Informed Consent?

Informed consent is the principle that healthcare consumers should have sufficient information before making decisions about their care, treatment, and/or involvement in services. Informed consent requires that appropriate and clear information has been shared with the consumer in a way that allows them to form a judgement based on how their decision will affect them. Finally, the consumer must be able to freely exercise their decision without undue influence. Ultimately, informed consent is designed to protect consumers and build trust between the provider and the consumer by honoring the consumer's right and ability to make their own decisions. It is also important to keep in mind that informed consent is often required in order to be in compliance with county/city regulations.

Citation: https://www.hhs.gov/ohrp/regulations-and-policy/guidance/faq/informed-consent/index.html

Digital Evolution

The initial plan for the consenting process included H@H Peers meeting with potential participants directly after provider referral – a live and in-person handoff at the clinic to support the consumer in making an informed decision. Just before project rollout, public health orders and safety measures put in place due to COVID-19, removed the ability to meet the potential participants in person. The first effort to go digital started with placing the PDF of the Informed Consent online. When HCA received a referral from the provider, a H@H Peer called a potential participant, and initiated the process by sending an SMS text message containing an access link to this document. The H@H Peer would then guide the potential participant through the document, answer any questions, and conclude with obtaining verbal consent.

The next evolution in the digital consent process was automation. OC H@H wanted to give the potential participants the ability to complete the process at their convenience and provide a more engaging platform with a variety of ways to receive information (text, audio, or video) that would support, guide, and motivate them through informed consent completion. Potential participants now have the choice to read text, watch a series of short videos, or engage with a H@H Peer at a time convenient for them, to review and provide their informed consent. During the development of this new automated process, the OC H@H team identified the following key elements:

- include questions in advance of the digital consent process to screen for eligibility
- a series of short videos would be easier to navigate and follow the information
- simple and accessible language should be used to accommodate a broad audience
- animation would be more engaging and remain relevant longer than live action
- a friendly and approachable "look and feel" of the video and voiceover are critical to communicating the right message
- requiring participants to acknowledge understanding after each video would support individuals in being better informed
- including an Acuity scheduler in each stage of the consenting process would allow individuals access to a H@H Peer with questions or concerns at their time and date of choice

This ability to access the automated digital consent process included postcards that a provider shares with the consumer. These postcards, aside from providing necessary at-a-glance information about the services and the process, also contain a QR code. When the potential participant scans the QR code with their smartphone, they are taken to the automated digital eligibility and consent process.

Once again, the OC H@H Peer contributions were essential to the success of the project. They were part of the creation and review process throughout the evolution of the informed consent. For example, they reviewed and edited the postcards for clarity and comprehension of language and visual appeal. The Peers helped convert the informed consent text into a simple and accessible video script language. Their knowledge and experience guided the voice and tone of the videos: they spent countless hours reviewing the script content and listening to a variety of voiceovers. In addition, they tested and navigated the automated process to provide recommendations for an optimal consumer experience.

Challenges & Concerns

The entire process of developing, approving, and implementing the digital informed consent process surfaced multiple challenges and concerns, each of which were addressed. One of the biggest concerns was that the digital/automated informed consent process meant removing the immediate person-to-person connection between an OC H@H Peer and the potential participant. To mitigate this, OC H@H ensured the option to request a Peer to reach out to them during business hours was just a click away.

Additionally, the ability for a potential participant to fill out the same digital eligibility and consent form multiple times was raised as a potential problem. In a manual process where an individual can fill out a form one time, those answers and consent are registered as complete and final. However, because the digital process allows for multiple entries by the same individual, it was not immediately clear how to mark an entry as 'correct and final'. In response, the OC H@H team made adjustments to the process back-end database to allow only one entry per person based on unique identifiers in order to avoid duplicate entries, as well eliminate an individual's ability to give different answers to the same questions potentially causing confusion in the participant's eligibility.

Additionally, in order to manage the outreach workload, OC H@H made staffing adjustments to ensure the OC H@H team members were cross-trained on specific duties and responsibilities. A set of frequently asked questions were developed to ensure consistency and continuity for the potential participant.

As the project continues to evolve and the number of Orange County consumers of Mindstrong increases, having a digital informed consent process has the potential to ease staffing needs while reaching an even greater number of people in the County.

Sharing

In a prime example of knowledge sharing between counties in the Help@Hand project, Riverside County reached out to Orange County with the hopes of learning more about Orange County's informed consent process, and how to apply any learnings to their own work around improving the informed consent process in Riverside. Orange County shared valuable learnings such as those mentioned above, as well as ways to further improve the informed consent process, including a shift to a digital informed consent. Riverside County then created their own informed consent process, with the work expedited and efforts reduced based on the insight and lessons learned from Orange County.

SPOTLIGHT

OC Help@Hand Peers

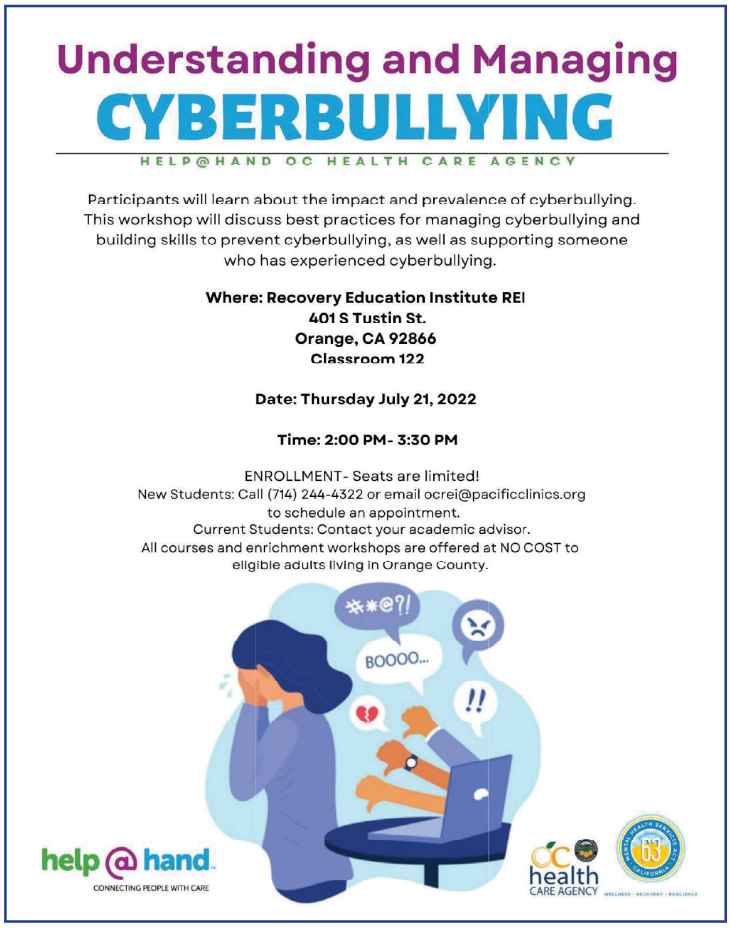
Orange County's Peers have been an integral part of the OC Help@Hand team since the beginning of project. Peers have contributed to the project in meaningful ways, including the development of digital literacy resources and supporting the implementation of Mindstrong in the county.

OC Help@Hand Peers developed digital literacy workshops and curated digital literacy educational and communication materials.

There are many digital technologies available to support mental health and wellness, but familiarity and comfort with technology will impact the likelihood of community members' use of such resources. An important component of OC Help@Hand is to increase the digital literacy capacity within the community. However, due to the COVID-19 pandemic digital literacy efforts were refocused.

"Even though it was hard to go out and engage the community, to share information, or to teach skills, we also know that the last two and a half years have been a really tough time for a lot of people in the community, so the need was even greater."
– Min Suh, OC Help@Hand Peer Lead

OCHCA was excited to resume their outreach efforts and engage the community in 2022. Peers utilized a digital literacy curriculum covering several topics, such as understanding and managing digital identity and footprint and dealing with cyberbullying. Peers kicked off a series of digital literacy workshops in April 2022. OC Help@Hand Peers Jackie Salagubang and Maria Gonzalez led the "Managing your Digital Presence" workshop at the Orange County Annual Meeting of the Minds Conference, and later led a second workshop, "Understanding and Managing Cyberbullying." A third workshop focusing on digital footprint/identity will be held later this year.



To the right: *Flyer developed to market digital literacy workshop*
Source: *Pacific Clinics Advancing Behavior Health Care Recovery Education Institute (N.D.) Retrieved from http://www.pcrei.org/*

Above: *OC Help@Hand Peers Jackie and Maria leading digital literacy workshops*
Source: *Orange County Health Care Agency*

Peers began developing an informative booklet aimed at building digital literacy skills and integrating technology to support mental health and wellness. The workbook includes QR codes to various resources, such as the One Mind PsyberGuide website. On this website, community members can browse through expert reviews of digital mental health technologies and select one that is right for them. Once the workbook is finalized, Peers will develop a workshop covering similar topics. Peers will also deliver a collage activity driven workshop to introduce digital literacy in a more visual way. Digital literacy events have been promoted through local organizations and Peers will continue to engage with community members at upcoming community events.

OC Help@Hand Peers have continued to support the Mindstrong implementation

Earlier this year, OCHCA automated their digital informed consent process and Peers played an instrumental role reviewing and testing the form and workflow. Prior to the launch of the digital consent process, Peers were tasked with calling and consenting consumers into the Mindstrong program. Now that the county has launched the automated digital consent process, Peers have been able to focus their time on developing digital literacy content. Daniel Gibbs, an OC Help@Hand Peer, continues to call consumers to enroll them into the Mindstrong program.

This year, OCHCA began to offer Mindstrong as a resource on Mental Health America's (MHA) web based mental health support site. Peers reviewed and provided meaningful feedback on the wording and tone of the program description on the MHA site to make sure that it was clear, appropriate, and relevant to potential consumers.

"For those who don't go through digital consent, I reach out to them and make sure their questions are answered."
– Daniel Gibbs,
OC Help@Hand Peer

OC Help@Hand Peers provide invaluable support and an important perspective

"Having Peers roll out these workshops has been important because they're able to connect well with other Peers, and it really helps establish trust with the community. We're all also very familiar with these places including the staff and members. We are actually, in many ways, part of that same community that we're outreaching to."
– Min Suh, OC Help@Hand Peer Lead

"We identify ourselves as Peer Specialists, but we have done the vast majority of our direct services in different organizations, so we all have our expertise with the community that we serve and the county clinics that we used to work with."
– Jackie Salagubang,
OC Help@Hand Peer

"It gives the digital literacy program more validity and credibility because we're endorsing it, we're talking about it, and we've been in some of the places they have been or are."
– Daniel Gibbs,
OC Help@Hand Peer

Tech for your Well-Being: Your Feedback

Meeting Date: June 24, 2019

Orange County

MHSA Stakeholder Meeting

CalMHSA
California Mental Health Services Authority

California Mental Health Services Authority
www.calmhsa.org

help @ hand™ Evaluation

OC health CARE AGENCY

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