Administrative Office
1717 North Indian Hill Boulevard, Suite B
Claremont, CA 91711
Phone (909) 623-6131
Fax (909) 623-4073

Clinical Office / Adult
2008 North Garey Avenue
Pomona, CA 91767
Phone (909) 623-6131
Fax (909) 865-9281

Clinical Office / Child & Fam
1900 Royalty Drive, Suite 180
Pomona, CA 91767
Phone (909) 766-7340
Fax (909) 865-0730

MHSA Administrative Office
2001 North Garey Avenue
Pomona, CA 91767
Phone (909) 623-6131
Fax (909) 326-4690

Wellness Center
1403 North Garey Avenue
Pomona, CA 91767
Phone (909) 242-7600
Fax (909) 242-7691

TRI-CITY MENTAL HEALTH AUTHORITY

AGENDA

GOVERNING BOARD REGULAR MEETING

WEDNESDAY, APRIL 16, 2025 AT 5:00 P.M.
MHSA ADMINISTRATION BUILDING
2001 NORTH GAREY AVENUE, POMONA, CA 91767

To join the meeting on-line clink on the following link:
https://tricitymhs-org.zoom.us/j/84285684564?pwd=fHGFVqHZjWuHk7HObbRsmDxckrjVUy.1

Passcode: awFL+Wy4

Public Participation. *Section 54954.3 of the Brown Act provides an opportunity for members of the public to address the Governing Board on any item of interest to the public, before or during the consideration of the item, that is within the subject matter jurisdiction of the Governing Board. Therefore, members of the public are invited to speak on any matter on or off the agenda. If the matter is an agenda item, you will be given the opportunity to address the legislative body when the matter is considered. If you wish to speak on a matter which is not on the agenda, you will be given the opportunity to do so at the Public Comment section.* ***No action shall be taken on any item not appearing on the Agenda. The Chair reserves the right to place limits on duration of comments.***

In-person participation: *raise your hand when the Governing Board Chair invites the public to speak.*

Online participation: *you may provide audio public comment by connecting to the meeting online through the zoom link provided; and use the Raise Hand feature to request to speak.*

Please note that virtual attendance is a courtesy offering and that technical difficulties shall not require that a meeting be postponed.

Written participation: *you may also submit a comment by writing an email to molmos@tricitymhs.org. All email messages received by 3:00 p.m. will be shared with the Governing Board before the meeting.*

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by Tri-City Mental Health Authority to all or a majority of the Governing Board less than 72 hours prior to this meeting, are available for public inspection at 1717 N. Indian Hill Blvd., Suite B, in Claremont during normal business hours.

In compliance with the American Disabilities Act, any person with a disability who requires an accommodation in order to participate in a meeting should contact JPA Administrator/Clerk Mica Olmos at (909) 451-6421 at least 24 hours prior to the meeting.

GOVERNING BOARD CALL TO ORDER

Chair Leano calls the meeting to Order.

ROLL CALL

Board Members Lorraine Canales, Carolyn Cockrell, Sandra Grajeda, Paula Lantz, and Elizabeth Ontiveros-Cole; Vice Chair Wendy Lau; and Chair Jed Leano.

POSTING OF AGENDA

The Agenda is posted 72 hours prior to each meeting at the following Tri-City locations: Clinical Facility, 2008 N. Garey Avenue in Pomona; Wellness Center, 1403 N. Garey Avenue in Pomona; Royalty Offices, 1900 Royalty Drive #180/280 in Pomona; MHSA Office, 2001 N. Garey Avenue in Pomona; and on the TCMHA's website: http://www.tricitymhs.org

CONSENT CALENDAR

1. APPROVAL OF MINUTES OF THE MARCH 19, 2025 GOVERNING BOARD REGULAR MEETING

Recommendation: "A motion to approve the Minutes of the Governing Board Regular Meeting of January 15, 2025."

2. ONTSON PLACIDE, EXECUTIVE DIRECTOR MONTHLY REPORT

Recommendation: "A motion to receive and file."

3. DIANA ACOSTA, CHIEF FINANCIAL OFFICER MONTHLY REPORT

Recommendation: "A motion to receive and file."

4. LIZ RENTERIA, CHIEF CLINICAL OFFICER MONTHLY REPORT

Recommendation: "A motion to receive and file."

5. SEEYAM TEIMOORI, MEDICAL DIRECTOR MONTHLY REPORT

Recommendation: "A motion to receive and file."

6. DANA BARFORD, DIRECTOR OF MHSA AND ETHNIC SERVICES MONTHLY REPORT

Recommendation: "A motion to receive and file."

7. NATALIE MAJORS-STEWART, CHIEF COMPLIANCE OFFICER MONTHLY REPORT

Recommendation: "A motion to receive and file."

8. CONSIDERATION OF RESOLUTION NO. 775 APPROVING THE SECOND AMENDMENT TO AGREEMENT WITH JS RISK CONSULTING FOR RISK MANAGEMENT CONSULTING SERVICES, AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE THE AMENDMENT

Recommendation: "A motion to adopt Resolution No. 775 approving the Second Amendment to the Agreement with JS Risk Consulting; and authorizing the Executive Director to execute the Amendment."

9. CONSIDERATION OF RESOLUTION NO. 776 ADOPTING THE AUTHORITY'S REVISED POLICIES AND PROCEDURES NOS.: I.06, I.07, II.03, CL.III.04, CL.IV.03, CL.V.01, CL.V.02, AND CL.V.11, EFFECTIVE APRIL 16, 2025

Recommendation: "A motion to adopt Resolution No. 776 establishing the revised Policy and Procedures Nos.: I.06, I.07, II.03, CL.III.04, CL.IV.03, CL.V.01, CL.V.02, and CL.V.11, effective April 16, 2025."

10. CONSIDERATION OF RESOLUTION NO. 777 ADOPTING A REVISED MASTER CLASSIFICATION AND SALARY SCHEDULE AND REVISED JOB DESCRIPTION FOR SENIOR BEHAVIORAL HEALTH SPECIALIST CLASSIFICATION

Recommendation: "A motion to adopt Resolution No. 777 to approve the revised Job Description for the Senior Behavioral Health Specialist classification and the Master Classification and Salary Schedule to reflect the change."

11. CONSIDERATION OF RESOLUTION NO. 778 AUTHORIZING THE EXECUTIVE DIRECTOR TO PURCHASE TWO (2) VEHICLES FROM CROWN TOYOTA IN THE AMOUNT OF $110,141.30 FOR THE MCC PROGRAM

Recommendation: "A motion to adopt Resolution No. 778 authorizing the Executive Director to purchase two vehicles for the Mobile Crisis Care Program in the total amount of $110,141.30 from Crown Toyota."

NEW BUSINESS

12. CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE ROUND 5 GRANT WITHDRAWAL

Recommendation: "A motion to authorize the withdrawal from the CYBHI R5 grant program and reverts the $750,000 award."

13. CONSIDERATION OF RESOLUTION NO. 779 ADOPTING THE MENTAL HEALTH SERVICES ACT (MHSA) ANNUAL UPDATE FOR FISCAL YEAR 2025-26

Recommendation: "A motion to adopt Resolution No. 779 approving the Authority's MHSA Annual Update For Fiscal Year 2025-26, as recommended by the TCMHA Mental Health Commission."

14. CONSIDERATION OF RESOLUTION NO. 780 ADOPTING DECLARING AN EMERGENCY DUE TO DAMAGE TO AUTHORITY'S PROPERTY LOCATED IN THE CITY OF POMONA, CALIFORNIA AND AUTHORIZING THE EXECUTIVE DIRECTOR TO AWARD A CONTRACT TO REHABILITATE THE PROPERTY ON AN EMERGENCY BASIS AND WITHOUT GIVING NOTICE FOR BIDS TO LET CONTRACTS

Recommendation: "A motion to adopt Resolution No. 780 approving the Emergency Declaration and Authorize the Executive Director to award a contract to rehabilitate the Authority's Property due to damage, without giving notice to bids."

GOVERNING BOARD COMMENTS

Members of the Governing Board may make brief comments or request information about mental health needs, services, facilities, or special problems that may need to be placed on a future Governing Board Agenda.

PUBLIC COMMENT

The Public may at this time speak regarding any Tri-City Mental Health Authority related issue, provided that no action shall be taken on any item not appearing on the Agenda. The Chair reserves the right to place limits on duration of comments.

ADJOURNMENT

The Governing Board will meet next in a Regular Joint Meeting with the Mental Health Commission to be held on **Wednesday, May 21, 2025 at 5:00 p.m.** in the MHSA Administrative Office, 2001 North Garey Avenue, Pomona, California.

MICAELA P. OLMOS
JPA ADMINISTRATOR/CLERK

MINUTES

GOVERNING BOARD REGULAR MEETING

MARCH 19, 2025 – 5:00 P.M.

The Governing Board Meeting was held on Wednesday, March 19, 2025, at 5:03 p.m. in the MHSA Administrative Office located at 2001 North Garey Avenue, Pomona, California.

CALL TO ORDER Chair Leano called the meeting to order at 5:03 p.m.

ROLL CALL Roll call was taken by JPA Administrator/Clerk Olmos.

GOVERNING BOARD

PRESENT: Jed Leano, City of Claremont, Chair
Wendy Lau, City of La Verne, Vice-Chair
Lorraine Canales, City of Pomona, Board Member
Sandra Grajeda, City of Claremont, Board Member
Elizabeth Ontiveros-Cole, City of Pomona, Board Member

ABSENT: Carolyn Cockrell, City of La Verne, Board Member
Paula Lantz, City of Pomona, Board Member

STAFF:

PRESENT: Ontson Placide, Executive Director
Steven Flower, General Counsel
Diana Acosta, Chief Financial Officer
Elizabeth Renteria, Chief Clinical Officer
Seeyam Teimoori, Medical Director
Dana Barford, Director of MHSA & Ethnic Services
Natalie Majors-Stewart, Chief Compliance Officer
Mica Olmos, JPA Administrator/Clerk

Chair Leano pulled Consent Calendar out of order to allow recipient of award to arrive at the meeting.

CONSENT CALENDAR

Chair Leano opened the meeting for public comment; and there was no public comment.

There being no further comment, Board Member Lau moved, and Board Member Ontiveros-Cole seconded to approve the Consent Calendar. The motion was carried by the following vote: Board

Members Canales, Grajeda, and Ontiveros-Cole; Vice-Chair Lau; and Chair Leano. NOES: None. ABSTAIN: None. ABSENT: Board Members Cockrell and Lantz.

1. APPROVAL OF MINUTES FROM THE FEBRUARY 19, 2025, GOVERNING BOARD REGULAR MEETING

Recommendation: "A motion to approve the Minutes of the Governing Board Regular Meeting of January 15, 2025."

2. ONTSON PLACIDE, EXECUTIVE DIRECTOR MONTHLY REPORT

Recommendation: "A motion to receive and file."

3. DIANA ACOSTA, CHIEF FINANCIAL OFFICER MONTHLY REPORT

Recommendation: "A motion to receive and file."

4. LIZ RENTERIA, CHIEF CLINICAL OFFICER MONTHLY REPORT

Recommendation: "A motion to receive and file."

5. SEEYAM TEIMOORI, MEDICAL DIRECTOR MONTHLY REPORT

Recommendation: "A motion to receive and file."

6. DANA BARFORD, DIRECTOR OF MHSA AND ETHNIC SERVICES MONTHLY REPORT

Recommendation: "A motion to receive and file."

7. NATALIE MAJORS-STEWART, CHIEF COMPLIANCE OFFICER MONTHLY REPORT

Recommendation: "A motion to receive and file."

8. CONSIDERATION OF RESOLUTION NO. 772 APPROVING THE PURCHASE OF 15 LAPTOPS IN THE AMOUNT OF $30,351.69 FROM INTELLI-TECH; AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE ANY RELATED PURCHASE DOCUMENTS

Recommendation: "A motion to adopt Resolution No. 772 authorizing the purchase of 15 laptops from Intelli-Tech in the amount of $30,351.69; and authorizing the Executive Director to execute any related purchase documents."

9. CONSIDERATION OF RESOLUTION NO. 773 APPROVING THE SECOND AMENDMENT TO THE AGREEMENT WITH CAPSTONE SOLUTIONS CONSULTING GROUP, LLC FOR COMPLETION OF THE DRUG MEDI-CAL CERTIFICATION FROM THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (DHCS), AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE THE AMENDMENT

Recommendation: "A motion to adopt Resolution No. 773 approving the Second Amendment to the Agreement with Capstone Solutions Consulting Group, LLC; and authorizing the Executive Director to execute the Amendment."

NEW BUSINESS

10. CONSIDERATION OF RESOLUTION NO. 774 APPROVING AN AGREEMENT WITH YOUTH CREATING CHANGE IN THE AMOUNT OF $43,140.00 TO CONDUCT PROGRAMS AND ACTIVITIES THAT SUPPORT TCMHA'S PROGRAMMING CORE ACTIVITIES FOR YOUTH SUICIDE PREVENTION AND INTERVENTION EFFORTS

Director of MHSA & Ethnic Services Barford discussed the Directing Change Project, stating that the contract with Youth Creating Change would be to provide support for the year 2025. She explained that they help the youth create the programs, awareness, and provide technical support, workshops, and informational webinars, and also host and maintain content; and noted that it is a wonderful opportunity for the youth.

Board Member Ontiveros-Cole inquired if this is high school only. Lisa Naranjo said high school age up to college.

Board Member Canales asked what the deadlines were. Lisa Naranjo, MHSA Program Supervisor -PEI, stated the deadline was March 1, 2025, for this fiscal year 2024-25; however, the agreement is for next Fiscal Year 2025-26.

Chair Leano opened the meeting for public comment; and there was no public comment.

There being no further comment, Board Member Lau moved, and Board Member Canales seconded, to approve Resolution No. 774 approving an Agreement with Youth Creating Change in the amount of $43,140.00; and authorizing the Executive Director to execute the Agreement. The motion was carried by the following vote: Board Members Canales, Grajeda, and Ontiveros-Cole; Vice-Chair Lau; and Chair Leano. NOES: None. ABSTAIN: None. ABSENT: Board Members Cockrell and Lantz.

GOVERNING BOARD COMMENTS

There was no comment.

PUBLIC COMMENT

Sara Rodriguez, MHSA Projects Manager, announced the MHSA Annual Update for Fiscal Year 2025-26 was posted online and was under the 30-day public review, and that its Public Hearing will be held on April 8, 2025 at 3:30pm.

Director of MHSA & Ethnic Services Barford stated it was Green Ribbon Week and the month of March was Mental Health Awareness Month; and that flyers, ribbons, and wrist bands were available to promote mental health awareness.

PRESENTATION

AN AWARD OF RECOGNITION WAS PRESENTED TO OUTGOING GOVERNING BOARD MEMBER RONALD T. VERA, FOR HIS LEADERSHIP AND DEDICATED SERVICE TO TRI-CITY MENTAL HEALTH AUTHORITY FROM FEBRUARY 2017 – JANUARY 2025

Chief Financial Officer Acosta thanked Mr. Ron Vera for the years of service and dedication to TCMHA on the Governing Board; and commented that his questions were informative and kept staff on their toes.

Dr. Teimoori thanked him for being a relentless advocate for medical team and supporting the psychiatry team. Mr. Vera stated there was such a need for psychiatric doctors in community.

Chief Clinical Officer Renteria thanked Mr. Vera and his wife for keeping the board focused to serve the underserved and on severe mental illness and advocacy.

Chief Compliance Officer Majors thanked Mr. Vera for his years of service, stating that he championed the quality and compliance effort, and his questions always clarified and inspired. Mr. Vera commented that he remembers Chief Compliance Officer Majors when he started and expressed excitement for seeing her progress.

Director of MHSA & Ethnic Services Barford thanked him and his sense of humor and stated that he made her feel comfortable and confident and helped lighten the meeting, noting that his questions were important and needed to be asked.

JPA Administrator/Clerk Olmos thanked Mr. Vera for his support and stated that she appreciated his prompt responses and how his questions made everyone think; and that he will be missed. Mr. Vera stated JPA Administrator/Clerk Olmos kept him on his toes.

General Counsel Flower thanked Mr. Vera for bringing him on board and making him feel welcome and for demonstrating the qualities that made TCMHA a great organization, noting that Mr. Vera made it a joy to work here.

Executive Director Placide stated Mr. Vera was a part of his welcoming committee and thanked him for his time; and then stated that Mr. Vera led with purpose and that he was appreciated and will be missed. Mr. Vera stated his wife reminded him of why he served.

Board Member Canales thanked Mr. Vera and his wife for educating her and for their dedication to mental health, and pointed out that Mr. and Mrs. Vera been helpful.

Board Member Ontiveros-Cole stated she was amazed by his questions, even seeming minute but there was reason and purpose; and stated that she admired him and has appreciated knowing him and his wife and what they have done.

Board Member Grajeda stated she has big shoes to fill but will do her best and wants to meet with him to learn what she can. Mr. Vera commented on the importance of moving forward.

Vice-Chair Lau stated she and Mr. Vera have known each other for many years, and she had always looked forward to his commentary. She stated he served because he cared, and she found out that they both have similar lived experience and how difficult it is to translate that into service; and thanked him for everything he has done.

Chair Leano stated Mr. Vera was his partner in representing Claremont and that he set an example for the level of preparation; that his level of commitment was rare and was proud to tell the community they were represented by him. He commended Mr. Vera's ability to refocus on the central question of how the action helps the community and he hoped to uphold that.

Chair Leano then presented the plaque of recognition to Mr. Ron Vera.

Mr. Vera invited his wife Christina Vera to stand with him, and acknowledged that when their son was diagnosed with a mental health illness, she stepped in; and when they found TCMHA, it was going through Bankruptcy and he felt that if they helped TCMHA, it would help them. He stated Mrs. Vera was a part of a committee that rewrote the charter so every board would have a community representative.

Mrs. Christina Vera stated she saved TCMHA from being taken in by the county.

Mr. Vera stated he saw what TCMHA did for the community and when he volunteered for the board, he took his role seriously and he read everything the staff presented, wanting to know what was happening in the community, noting that he wanted to guarantee TCMHA never went through bankruptcy again. He also stated he was stepping down to dedicate more time to other boards, but he was not planning on completely going away; that not everyone knows what TCMHA does, but he wanted everyone to find out; and that he felt a connection to everyone and appreciated the award and recognition of him and his wife.

ADJOURNMENT

At 5:28 p.m., on consensus of the Governing Board its Regular Meeting of March 19, 2025, was adjourned. The next Regular Meeting of the Governing Board will be held on Wednesday, April 16, 2025, at 5:00 p.m., in the MHSA Administrative Office, 2001 North Garey Avenue, Pomona, California.

_____
Micaela P. Olmos, JPA Administrator/Clerk

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **April 16, 2025**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Ontson Placide, LMFT, Executive Director**

SUBJECT: **Executive Director's Monthly Report**

UPDATE ON THE MHSA to BHSA REVERSION AND TRANSFORMATION PLANNING

The MHSA Plan was posted in March for a 30-day public comment period, of which after, a presentation of the MHSA Plan during the Mental Health Commission's Public Hearing on 4/9/25. The prior recommendations were accepted with minimal public comment. This will now be brought forth to the Governing Board for approval. The Executive Team will construct a programming and financial MHSA plan that looks to future service delivery.

HUMAN RESOURCES

Staffing – Month Ending March 2025

- Total Staff is 212 full-time and 6 part-time plus 48 full-time vacancies 4 part-time vacancies for a total of 265 full-time equivalent positions.
- There were 8 new hires in March 2025.
- There were 3 separations in March 2025.

Workforce Demographics in March 2025

- American Indian or Alaska Native = 0.46%
- Asian = 7.80%
- Black or African American = 7.80%
- Hispanic or Latino = 62.84%
- Native Hawaiian or Other Pacific Islander = 0.46%
- Other = 1.83%
- Two or more races = 1.83%
- White or Caucasian = 16.97%

New Posted Positions in March 2025

- Behavioral Health Specialist – TCG (1 FTE)
- Clinical Program Manager – Adult FSP (1 FTE)
- Clinical Therapist I/II – FSP/TAY (1 FTE)
- Program Supervisor – Peer Support (1 FTE)

AB 2561

As mentioned in the November 2024 Board Report, as required by AB 2561, public agencies must now present an annual report on their vacancies, recruitment, and retention efforts during a public hearing before their governing body. This presentation, which must occur before the adoption of the fiscal year's final budget which is anticipated to happen at the May Governing Board meeting. The presentation will include changes to policies or recruitment activities that hinder vacancy reduction.

As a public employer, AB 2561 does apply to TCMHA and the Human Resources Department is actively preparing a presentation to be presented in an upcoming Governing Board meeting prior to Annual Budget Adoption. Preliminary plans involve a collaborative effort between Human Resources and the Finance Department to report on vacancies and recruitment efforts in conjunction with or before the adoption of the fiscal budget each July. Further details and updates will be provided in future reports

NATIONAL & STATEWIDE UPDATES IN BEHAVIORAL HEALTH

Federal Funding/Medicaid

California lawmakers approve $2.8 billion to sustain Medi-Cal health care program- California lawmakers voted Thursday to send $2.8 billion in additional funds to California's low-income health insurance plan, Medi-Cal, to cover higher-than-anticipated costs as the fiscal year ends. The move was part of a budget trailer bill, otherwise known as a "budget bill junior," that gets funds moving before the start of the new fiscal year in July. The bill also authorized spending to support local governments affected by the winter Los Angeles fires, and allocated $181 million in bond funds to nature conservancies for forest resilience. Sacramento Bee

California Mental Health/Homelessness

Riverside reaches major milestone in youth homeless crisis- Riverside officials announced a major milestone in their fight to end the homeless crisis, proclaiming that they have effectively reduced the number of unhoused youth to zero. The city undertook this initiative aimed at getting every young person off the street two years ago. "As a mother of three kids, I just felt very strongly that our youth needed our help, particularly our foster youth," Mayor Patricia Dawson said. CBS Los Angeles

California Officials Warn Proposition 36 May Drain Resources From Successful Community Programs

Ever since voters overwhelmingly approved Proposition 36 last fall, there's been a hot debate in Sacramento over how to pay for the new drug and mental health treatment programs outlined in the tough-on-crime ballot measure. Now, officials at one state agency say they have a pot of money available to help fund the voter-approved initiative, even as they warn that the funding will dry up in future years — because of Proposition 36. KQED

Mental health workers at Kaiser Permanente in Los Angeles go on hunger strike

Mental health workers at Kaiser Permanente in Los Angeles have been striking for nearly six months. In an effort to get their message to break through, some have now started a hunger strike. NPR

Here's how California's Prop 36 is working so far

Five months after California voters approved harsher punishments for repeat theft and drug crimes, an early snapshot of charging data reveals uneven implementation of the law across the state. Some counties have filed far more theft cases while others have focused on felony charges for drug possession. San Francisco lags behind its counterparts in the number of cases filed under Proposition 36 in both categories. Even among prosecutors who backed the law, approaches differ. Some instituted time limits for considering past crimes to avoid punishing people for decades-old offenses, while others have not. Some say they won't pursue felony charges against people who appear to be stealing to survive, while others are throwing the book at suspects regardless of what they're accused of taking. San Francisco Chronicle

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **April 16, 2025**

TO: **Governing Board of Tri-City Mental Health Authority**
Ontson Placide, LMFT, Executive Director

FROM: **Diana Acosta, CPA, Chief Financial Officer**

SUBJECT: **Monthly Finance and Facilities Report**

UNAUDITED FINANCIAL STATEMENTS FOR THE EIGHT MONTHS ENDED FEBRUARY 28, 2025 (2025 FISCAL YEAR-TO-DATE):

The financials presented herein are the PRELIMINARY and unaudited financial statements for the eight months ended February 28, 2025. These financial statements include the activities from the clinical outpatient operations as well as activities from the implemented MHSA programs under the CSS, PEI, INN, WET and CFTN plans.

The increase in net position (income) is approximately $9.7 million. MHSA operations accounted for approximately $8.1 million of the increase, which is primarily the result of recognizing MHSA revenues on hand at the beginning of the fiscal year. MHSA non-operating revenues are reflected when MHSA funds have been received and are eligible to be spent.

During fiscal 2024, Tri-City received MHSA funding of approximately $20.7 million, of which $13.2 million were for approved programs for fiscal 2024-25 MHSA operations and was reflected as MHSA Revenue Restricted for Future Period on the Statement of Net Position (balance sheet) at June 30, 2024. These restricted MHSA revenues have now been recorded as non-operating revenues in fiscal 2024-25. In addition, during this current fiscal year 2024-25 approximately $17.7 million in MHSA funding has been received of which $3.5 million was identified and approved for use in the current fiscal year 2024-25 and recorded as non-operating revenues, bringing the total MHSA non-operating revenues recognized to date up to approximately $16.7 million. Unlike the requirement to reflect all available and **approved** MHSA funding when received as non-operating revenues, MHSA operating costs are reflected when incurred. Therefore, the matching of revenue to expense is not consistent as the timing of expenditures will lag behind the timing of revenue recognition.

The increase in net position of approximately $1.6 million is from Clinic outpatient operations, which is the result of operations for the eight months ended February 28, 2025 which includes one-time payments made at the beginning of the year.

The total cash balance at February 28, 2025 was approximately $62.2 million, which represents an increase of approximately $14.4 million from the June 30, 2024 balance of

approximately $47.8 million. Outpatient Clinic operations, after excluding any intercompany receipts or costs resulting from MHSA operations, had an increase in cash of approximately $3.8 million primarily as a result timing of cash receipts from LADMH. MHSA operations reflected an increase in cash of approximately $10.7 million, after excluding intercompany receipts or costs resulting from clinic operations. Total increase in MHSA cash reflects the receipt of approximately $17.7 million in MHSA funds offset by the use of cash for MHSA operating activities.

Approximately $14.1 million in Medi-Cal cash receipts have been collected for both Outpatient Clinic Operations and MHSA Operations within the eight months ended February 28, 2025. As of the date of the report, approximately $1.6 million of additional receipts received are related to outstanding receivables.

UPCOMING, CURRENT EVENTS & UPDATES

Overall Financial Update

We continue to closely monitor for any new developments, changes to legislation and updated revenue projections from CBHDA, specifically with regard to MHSA as these revenues continually fluctuate and as evidenced in the past and as noted below, significantly differ from original projections as well as revised projections. As such, planning appropriately to ensure we meet the needs of our community, and having the ability to make changes as we go will be necessary in the upcoming years, especially if projections wind up being significantly different than currently projected.

Upcoming reporting deadlines

Now that the annual financial statement audit is behind us and has been issued, the finance department will now move onto the following reportable items and deadlines:

External

- State Controllers Financial Transactions Report due 01/31/2025, submitted 01/23/2025
- MHSA Annual Revenue and Expenditure Report due 01/31/2025, submitted 01/31/2025
    - DHCS has excepted the ARER and identified $0 subject to reversion as of 06/30/2024
- State Compensation Report due 04/30/2025

Internal

- MHSA Annual update due 04/30/2025
- Agency-wide Budget due 06/30/2025

MHSA Funding Updates

Estimated Current Cash Position – The following table represents a brief summary of the estimated (unaudited) current MHSA cash position as of the seven months ended January 31, 2025.

		MHSA	
Cash at June 30, 2024	$	36,745,684	
Receivables net of Reserve for Cost Report Settlements		2,435,962	
Prudent Reserves		(2,200,000)	*
Estimated Remaining Expenses for Operations FY 2024-25		(4,294,971)	**
Reserved for future CFTN Projects		(6,417,848)	
Total Estimated Adjustments to Cash		(10,476,857)	
Estimated Available at June 30, 2025	$	26,268,828	
Estimated remaining MHSA funds to be received in FY 2023-24	$	3,563,338	

* Per SB 192, Prudent Reserves are required to be maintained at an amount that does not exceed 33% of the average Community Services and Support (CSS) revenue received for the fund, in the preceding 5 years.

** Estimated based on to-date actuals projected through year-end June 30, 2025, net of estimated Medi-Cal revenue, including actual and estimated amounts to year end 06/30/2025.

MHSA EXPENDITURES AND MHSA REVENUE RECEIPTS

MHSA Reversion Update

Each remittance of MHSA funds received by Tri-City is required to be allocated among three of the five MHSA Plans, CSS, PEI and INN. The first 5% of each remittance is required to be allocated to INN and the remaining amount is split 80% to CSS and 20% to PEI. While the WET and the CapTech plans have longer time frames in which to spend funds (made up of one-time transfers into these two plans), the CSS, PEI and INN plans have three years.

Amounts received within the CSS and PEI programs must be expended within three years of receipt. INN amounts must be programmed in a plan that is approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) within three years of receipt, and spent within the life of the approved program. Upon approval by the MHSOAC, INN amounts have to be expended within the life of said program. For example, a program approved for a five-year period will have the full five years associated with the program to expend the funds.

The following tables are **excerpts** from DHCS's annual reversion report received by Tri-City on February 11, 2025 based on the fiscal year 2023-24 Annual Revenue and Expense Report (ARER).

CSS reversion waterfall analysis

CSS amounts received

	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24*	Total
	8,797,914	9,293,482	11,824,329	13,252,035	9,139,346	**16,870,739**	77,854,693
Expended in:							
2017-18							-
2018-19	-						939,014
2019-20	1,290,269	-					9,028,103
2020-21	7,507,645	3,546,924	-				11,054,569
2021-22		5,746,558	3,676,533	-			9,423,091
2022-23			8,147,796	5,723,324	-		13,871,120
2023-24				7,528,711	4,245,936	-	11,774,647
2024-25 **					**4,893,410**	**13,731,208**	**18,624,618**
2025-26							**-**
Total Expended	8,797,914	9,293,482	11,824,329	13,252,035	9,139,346	13,731,208	74,715,162
Unspent Balance	-	-	-	-	-	3,139,531	3,139,531

*=Based on latest revenue projections

**=Planned Expenditures based on approved MHSA Plan

PEI reversion waterfall analysis

PEI amounts received

	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24*	Total
	2,145,788	2,119,324	2,173,110	2,948,240	3,311,501	2,260,797	4,175,846	19,134,606
Expended in:								
2017-18	726,119							726,119
2018-19	1,419,669	387,017						1,806,686
2019-20	-	1,644,825	-					1,644,825
2020-21		87,482	1,746,984	-				1,834,466
2021-22			426,126	1,309,696				1,735,822
2022-23				1,638,544	1,718,632			3,357,176
2023-24					***1,592,869***	***1,840,888***		**3,433,757**
2024-25 **						***419,909***	***3,586,503***	4,006,412
2025-26 **								-
Total Expended	2,145,788	2,119,324	2,173,110	2,948,240	3,311,501	2,260,797	3,586,503	18,545,263
Unspent Balance	-	-	-	-	-	-	589,343	589,343

*=Based on latest revenue projections

**=Planned Expenditures based on approved MHSA Plan

The following table was copied directly from latest information provided from DHCS:

INN reversion waterfall analysis

INN	Reallocated AB 114	FY 17-18	FY 18-19	FY 19-20	FY 20-21	FY 21-22	FY 22-23	FY 23-24	
Encumbered Unspent Funds	799,187	302,889	580,471	550,879	784,114	874,536	620,101	926,070	
Unencumbered Unspent Funds	-	-	-	-	-	-	-	251,396	
Unspent Balance	**799,187**	**302,889**	**580,471**	**550,879**	**784,114**	**874,536**	**620,101**	**1,177,466**	
Encumbered Funds Starting Balance →	**799,187**	**302,889**	**580,471**	**550,879**	**784,114**	**874,536**	**620,101**	**926,070**	
Applied Expenditure ↓									**Applied Expenditure ↓**
FY 15-16									-
FY 16-17									-
FY 17-18	304,376	-							304,376
FY 18-19	131,206	-	-						131,206
FY 19-20	355,393	-	-	-					355,393
FY 20-21	8,212	-	-	-	-				8,212
FY 21-22	-	302,889	25,035	-	-	-			327,924
FY 22-23	-	-	555,436	179,342	-	-	-	-	734,778
FY 23-24	-	-	-	371,537	182,851	-	-	-	554,388
FY 24-25									
Encumbered Unspent Balance →	-	-	-	-	601,263	874,536	620,101	926,070	

Note that in fiscal year 2024, the INN *Community Planning Process for Innovation Project(s)* program was approved by the MHSAOAC in the amount of $675 thousand. Additionally, in fiscal year 2025, the INN PADs Phase II program was approved by the MHSAOAC in the amount of $1.5 million.

OVERALL FACILITIES UPDATE

The leases at the 1900 Royalty location are due to expire at the end of the current fiscal year, June 30, 2025. Additionally, the lease at 1717 North Indian Hill Blvd is set to expire at the end of September 2025. Management is actively considering all options to accommodate staff and client space needs.

Attachments:

Attachment 3-A: February 28, 2025 Unaudited Monthly Financial Statements

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF NET POSITION

	AT FEBRUARY 28, 2025			AT JUNE 30, 2024		
	TCMH	**MHSA**	**Consolidated**	**TCMH**	**MHSA**	**Consolidated**
	Unaudited	**Unaudited**	**Unaudited**	**Audited**	**Audited**	**Audited**
Current Assets						
Cash	$ 15,084,531	$ 47,160,982	$ 62,245,513	$ 11,061,930	$ 36,745,684	$ 47,807,614
Accounts receivable, net of reserve for uncollectible accounts $872,132 at February 28, 2025 and $1,028,867 at June 30, 2024	5,435,891	5,996,650	11,432,541	6,958,443	6,511,598	13,470,040
	20,520,421	53,157,632	73,678,054	18,020,372	43,257,282	61,277,654
Property and Equipment						
Land, building, furniture and equipment	4,138,920	10,194,941	14,333,861	4,100,520	10,766,682	14,867,203
Accumulated depreciation	(2,938,835)	(5,163,491)	(8,102,326)	(2,864,375)	(4,972,020)	(7,836,395)
Rights of use assets-building lease	1,753,343	-	1,753,343	1,753,343	-	1,753,343
Accumulated amortization-building lease	(1,634,013)	-	(1,634,013)	(1,395,366)	-	(1,395,366)
Rights of use assets-SBITA	1,298,467	-	1,298,467	1,298,467	-	1,298,467
Accumulated amortization-SBITA	(588,073)	-	(588,073)	(588,073)	-	(588,073)
Total Property and Equipment	2,029,808	5,031,451	7,061,259	2,304,516	5,794,663	8,099,179
Other Assets						
Deposits and prepaid assets	358,177	63,245	421,422	93,757	63,245	157,002
Note receivable-Housing Development Project	-	2,800,000	2,800,000	-	2,800,000	2,800,000
Total Noncurrent Assets	2,387,985	7,894,696	10,282,680	2,398,273	8,657,908	11,056,181
Total Assests	22,908,406	61,052,328	83,960,734	20,418,645	51,915,190	72,333,835
Deferred Outflows of Resources						
Deferred outflows related to the net pension liability	6,257,996	-	6,257,996	6,257,996	-	6,257,996
Total Deferred Outflows of Resources	6,257,996	-	6,257,996	6,257,996	-	6,257,996
Total Assets and Deferred Outflows of Resouces	**$ 29,166,402**	**$ 61,052,328**	**$ 90,218,730**	**$ 26,676,641**	**$ 51,915,190**	**$ 78,591,831**
LIABILITIES						
Current Liabilities						
Accounts payable	399,142	54,995	454,137	608,213	452,165	1,060,378
Accrued payroll liabilities	189,865	581,878	771,742	93,247	262,608	355,855
Accrued vacation and sick leave	608,323	1,263,028	1,871,350	636,668	1,264,537	1,901,206
Deferred revenue	1,270,711	-	1,270,711	496,724	-	496,724
Reserve for Medi-Cal settlements	3,894,036	3,560,688	7,454,724	3,673,280	3,201,942	6,875,222
Current portion of lease liability	119,330	-	119,330	357,977	-	357,977
Current portion of SBITA liability	308,979	-	308,979	308,979	-	308,979
Total Current Liabilities	6,790,386	5,460,588	12,250,973	6,175,088	5,181,252	11,356,340
Intercompany Acct-MHSA & TCMH	415,157	(415,157)	-	177,414	(177,414)	-
Long-Term Liabilities						
Lease liability	-		-	-	-	-
SBITA liability	401,415		401,415	401,415	-	401,415
Net pension liability	9,745,737	-	9,745,737	9,745,737	-	9,745,737
Unearned MHSA revenue	-	15,605,107	15,605,107	-	1,383,814	1,383,814
Total Long-Term Liabilities	10,147,152	15,605,107	25,752,259	10,147,152	1,383,814	11,530,966
Total Liabilities	17,352,695	20,650,537	38,003,232	16,499,654	6,387,651	22,887,305
Deferred Inflow of Resources						
MHSA revenues restricted for future period	-	-	-	-	13,188,357	13,188,357
Deferred inflows related to the net pension liability	156,688	-	156,688	156,688	-	156,688
Total Deferred Inflow of Resources	156,688	-	156,688	156,688	13,188,357	13,345,045
NET POSITION						
Invested in capital assets net of related debt	1,200,085	5,031,451	6,231,535	1,236,145	5,794,663	7,030,808
Restricted for MHSA programs	-	35,370,340	35,370,340	-	26,544,519	26,544,519
Unrestricted	10,456,934	-	10,456,934	8,784,153	-	8,784,153
Total Net Position	11,657,019	40,401,791	52,058,810	10,020,298	32,339,182	42,359,480
Total Liabilities, Deferred Inflows of Resources and Net Position	**$ 29,166,402**	**$ 61,052,328**	**$ 90,218,730**	**$ 26,676,641**	**$ 51,915,190**	**$ 78,591,831**

Definitions:
TCMH=Tri-City's Outpatient Clinic
MHSA=Mental Health Services Act (Proposition 63)

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET POSITION
EIGHT MONTHS ENDED FEBRUARY 28, 2025 AND 2024

	PERIOD ENDED 2/28/25			PERIOD ENDED 2/29/24		
	TCMH Unaudited	**MHSA Unaudited**	**Consolidated Unaudited**	**TCMH Audited**	**MHSA Audited**	**Consolidated Audited**
OPERATING REVENUES						
Medi-Cal FFP	$ 2,815,496	$ 3,904,837	$ 6,720,333	$ 3,232,121	$ 3,635,690	$ 6,867,811
Medi-Cal FFP FYE Prior Year	1,076,815	1,188,733	2,265,548	67,297	3,039	70,336
Medi-Cal SGF-EPSDT	704,770	1,306,161	2,010,931	671,741	696,947	1,368,688
Medi-Cal SGF-EPSDT Prior Year	174,562	174,613	349,175	3,379	25,813	29,192
Medicare	6,447	5,243	11,691	4,656	3,094	7,750
Contracts	-	21,550	21,550	10,000	20,571	30,571
Patient fees and insurance	-	-	-	446	180	626
Rent income - TCMH & MHSA Housing	8,624	58,115	66,740	7,392	49,393	56,785
Other income	490	587	1,077	540	436	975
Net Operating Revenues	**4,787,205**	**6,659,839**	**11,447,043**	**3,997,572**	**4,435,163**	**8,432,735**
OPERATING EXPENSES						
Salaries, wages and benefits	5,358,613	12,448,911	17,807,525	5,410,019	11,256,003	16,666,022
Facility and equipment operating cost	426,819	1,091,437	1,518,255	392,778	818,523	1,211,301
Client lodging, transportation, and supply expense	41,326	460,503	501,828	109,957	458,064	568,020
Depreciation & amortization	199,759	418,924	618,683	195,445	404,559	600,004
Other operating expenses	639,846	1,628,730	2,268,576	535,123	1,406,694	1,941,818
Total Operating Expenses	**6,666,363**	**16,048,504**	**22,714,867**	**6,643,322**	**14,343,844**	**20,987,165**
OPERATING (LOSS) (Note 1)	**(1,879,158)**	**(9,388,665)**	**(11,267,824)**	**(2,645,750)**	**(9,908,681)**	**(12,554,431)**
Non-Operating Revenues (Expenses)						
Realignment	2,436,900	-	2,436,900	2,465,756	-	2,465,756
MHSA funds	-	16,693,035	16,693,035	-	15,539,345	15,539,345
Grants and Contracts	742,196	-	742,196	605,238	-	605,238
Interest Income net with FMV	293,108	1,394,012	1,687,120	189,229	1,130,150	1,319,378
Gain/(Loss) on disposal of assets	-	(635,773)	(635,773)	-	-	-
Total Non-Operating Revenues (Expense)	3,515,879	17,451,274	20,967,153	3,260,222	16,669,495	19,929,717
INCOME (LOSS)	**1,636,720**	**8,062,609**	**9,699,329**	**614,472**	**6,760,814**	**7,375,286**
INCREASE (DECREASE) IN NET POSITION	**1,636,720**	**8,062,609**	**9,699,329**	**614,472**	**6,760,814**	**7,375,286**
NET POSITION, BEGINNING OF YEAR	10,020,298	32,339,182	42,359,480	8,639,329	28,506,858	37,146,187
NET POSITION, END OF MONTH	**$ 11,657,019**	**$ 40,401,791**	**$ 52,058,810**	**$ 9,253,801**	**$ 35,267,672**	**$ 44,521,474**

(**Note 1)** "Operating Loss" reflects loss before realignment funding and MHSA funding which is included in non-operating revenues.

Definitions:
Medi-Cal FFP= Federal Financial Participation Reimbursement
Medi-Cal SGF-EPSDT=State General Funds reimbursement for Medi-Cal services provided to children under the "Early and Periodic Screening, Diagnosis and Treatment" regulations.
TCMH=Tri-City's Outpatient Clinic
MHSA=Mental Health Services Act (Proposition 63)

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF CASH FLOWS
EIGHT MONTHS ENDED FEBRUARY 28, 2025 AND 2024

	PERIOD ENDED 2/28/25			PERIOD ENDED 2/29/24		
	TCMH Unaudited	MHSA Unaudited	Consolidated Unaudited	TCMH Audited	MHSA Audited	Consolidated Audited
Cash Flows from Operating Activities						
Cash received from and on behalf of patients	$ 6,282,930	$ 7,458,563	$ 13,741,493	$ 2,211,201	$ 2,449,844	$ 4,661,045
Cash payments to suppliers and contractors	(1,706,781)	(3,691,187)	(5,397,968)	(1,426,182)	(2,969,092)	(4,395,274)
Payments to employees	(5,290,341)	(12,131,151)	(17,421,492)	(5,276,774)	(10,849,608)	(16,126,382)
	(714,191)	(8,363,775)	(9,077,967)	(4,491,755)	(11,368,856)	(15,860,611)
Cash Flows from Noncapital Financing Activities						
MHSA Funding	-	17,725,439	17,725,439	-	17,361,698	17,361,698
CalHFA-State Administered Projects	-	532	532	-	30,266	30,266
Realignment	2,436,900	-	2,436,900	3,789,668	-	3,789,668
Grants and Contracts	1,755,437	-	1,755,437	946,356	-	946,356
	4,236,012	17,725,971	21,961,983	4,736,024	17,391,964	22,127,988
Cash Flows from Capital and Related Financing Activities						
Purchase of capital assets	(38,400)	(178,136)	(216,536)	(66,370)	(230,216)	(296,586)
Intercompany-MHSA & TCMH	237,743	(237,743)	-	(276,462)	276,462	-
	199,344	(415,879)	(216,536)	(342,832)	46,246	(296,586)
Cash Flows from Investing Activities						
Interest received	281,358	1,357,789	1,639,147	154,280	896,765	1,051,044
	281,358	1,357,789	1,639,147	154,280	896,765	1,051,044
Cash Flows from Reorganization Items						
Receipt of SB90 claims previously reserved and accrued	-	-	-	241,378	-	241,378
	-	-	-	241,378	-	241,378
Net Increase (Decrease) in Cash and Cash Equivalents	4,002,522	10,304,105	14,306,628	297,094	6,966,119	7,263,213
Cash Equivalents at Beginning of Year	11,061,930	36,745,684	47,807,614	8,976,643	30,118,745	39,095,388
Cash Equivalents at End of Month	**$ 15,064,452**	**$ 47,049,790**	**$ 62,114,242**	**$ 9,273,737**	**$ 37,084,864**	**$ 46,358,601**
Cash from the Balance Sheet	**15,084,531**	**47,160,982**	**62,245,513**	**9,313,216**	**37,328,064**	**46,641,279**
YTD Gain/(Loss) from GASB 31 Fair Market Value	**$ 20,079**	**$ 111,192**	**$ 131,271**	**$ 39,479**	**$ 243,199**	**$ 282,678**

Definitions:

TCMH=Tri-City's Outpatient Clinic
MHSA=Mental Health Services Act (Proposition 63)

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET POSITION
ACTUAL TO BUDGET COMPARISON
EIGHT MONTHS ENDING FEBRUARY 28, 2025
(UNAUDITED)

	TRI-CITY MENTAL HEALTH OUTPATIENT CLINIC (TCMH)			TRI-CITY MENTAL HEALTH SERVICES ACT (MHSA)			TRI-CITY MENTAL HEALTH AUTHORITY CONSOLIDATED		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
OPERATING REVENUES									
Medi-Cal FFP	$ 3,051,055	$ 3,935,941	$ (884,885)	$ 4,237,788	$ 7,358,025	$ (3,120,237)	$ 7,288,844	$ 11,293,966	$ (4,005,122)
Medi-Cal FFP Prior Year	929,855	-	929,855	1,097,687	-	1,097,687	2,027,542	-	2,027,542
Medi-Cal SGF-EPSDT	787,839	1,220,511	(432,672)	1,444,870	1,408,394	36,476	2,232,709	2,628,905	(396,196)
Medi-Cal SGF-EPSDT Prior Year	106,497	-	106,497	113,162	-	113,162	219,659	-	219,659
Medicare	6,447	3,333	3,114	5,243	1,733	3,510	11,691	5,067	6,624
Patient fees and insurance	-	667	(667)	-	333	(333)	-	1,000	(1,000)
Contracts	-	-	-	21,550	18,667	2,883	21,550	18,667	2,883
Rent income - TCMH & MHSA Housing	8,624	7,392	1,232	58,115	40,000	18,115	66,740	47,392	19,348
Other income	490	400	90	587	133	454	1,077	533	543
Provision for contractual disallowances	(318,628)	(515,645)	197,017	(471,661)	(876,639)	404,978	(790,289)	(1,392,284)	601,995
Provision for contractual disallowances prior year	215,025	-	215,025	152,497	-	152,497	367,522	-	367,522
Net Operating Revenues	**4,787,205**	**4,652,599**	**134,606**	**6,659,839**	**7,950,647**	**(1,290,809)**	**11,447,043**	**12,603,246**	**(1,156,203)**
OPERATING EXPENSES									
Salaries, wages and benefits	5,358,613	6,952,369	(1,593,756)	12,448,911	15,276,356	(2,827,445)	17,807,525	22,228,725	(4,421,200)
Facility and equipment operating cost	426,823	374,408	52,415	1,093,319	926,633	166,685	1,520,142	1,301,041	219,100
Client program costs	41,326	7,555	33,771	460,503	402,021	58,482	501,828	409,575	92,253
Grants	115,979	910,465	(794,486)	82,317	247,747	(165,430)	198,296	1,158,212	(959,916)
MHSA training/learning costs	-	-	-	79,597	47,815	31,783	79,597	47,815	31,783
Depreciation & amortization	199,759	131,653	68,107	418,924	416,208	2,716	618,683	547,861	70,822
Other operating expenses	523,864	346,512	177,352	1,464,933	1,840,775	(375,843)	1,988,796	2,187,287	(198,491)
Total Operating Expenses	**6,666,363**	**8,722,961**	**(2,056,598)**	**16,048,504**	**19,157,555**	**(3,109,051)**	**22,714,867**	**27,880,516**	**(5,165,649)**
OPERATING INCOME (LOSS)	**(1,879,158)**	**(4,070,362)**	**2,191,204**	**(9,388,665)**	**(11,206,908)**	**1,818,243**	**(11,267,824)**	**(15,277,270)**	**4,009,446**
Non-Operating Revenues (Expenses)									
Realignment	2,436,900	2,933,333	(496,433)	-	-	-	2,436,900	2,933,333	(496,433)
Contributions from member cities & donations	43,675	70,236	(26,561)	-	-	-	43,675	70,236	(26,561)
MHSA Funding	-	-	-	16,693,035	16,693,035	-	16,693,035	16,693,035	-
Grants and contracts	742,196	2,134,161	(1,391,965)	-	-	-	742,196	2,134,161	(1,391,965)
Interest (expense) income, net	293,108	129,947	163,161	1,394,012	913,335	480,677	1,687,120	1,043,281	643,838
Other income-loss on disposal of assets	-	-	-	(635,773)	-	(635,773)	(635,773)	-	(635,773)
Total Non-Operating Revenues (Expense)	**3,515,879**	**5,267,677**	**(1,751,798)**	**17,451,274**	**17,606,370**	**(155,096)**	**20,967,153**	**22,874,046**	**(1,906,893)**
INCREASE(DECREASE) IN NET POSITION	**$ 1,636,720**	**$ 1,197,315**	**$ 439,406**	**$ 8,062,609**	**$ 6,399,462**	**$ 1,663,147**	**$ 9,699,329**	**$ 7,596,776**	**$ 2,102,553**

Definitions:

Medi-Cal FFP= Federal Financial Participation Reimbursement

Medi-Cal SGF-EPSDT=State General Funds reimbursement for Medi-Cal services provided to children under the "Early and Periodic Screening, Diagnosis and Treatment" regulations.

TCMH=Tri-City's Outpatient Clinic

MHSA=Mental Health Services Act (Proposition 63)

TRI-CITY MENTAL HEALTH AUTHORITY
ACTUAL TO BUDGET VARIANCE EXPLANATIONS
EIGHT MONTHS ENDING FEBRUARY 28, 2025

COMMENT: PLEASE NOTE, THE DISCUSSION BELOW MAY USE THE FOLLOWING ABBREVIATIONS:
TCMH==TRI-CITY MENTAL HEALTH (OUTPATIENT CLINIC OPERATIONS)
MHSA==MENTAL HEALTH SERVICES ACT (ACTIVITIES INCLUDE CSS, PEI, INN, WET AND CFTN PROGRAMS)

Net Operating Revenues

Net operating revenues are lower than the budget by approximately $1.2 million for the following reasons:

1 **Medi-Cal FFP revenues for FY 2024-25** were approximately $4.0 million lower than the budget. Medi-Cal FFP revenues were $885 thousand lower for TCMH and approximately $3.1 million lower for MHSA. At TCMH, the adult program revenues were lower than budg by $721 thousand and the children program revenues were lower by $164 thousand. For MHSA, the adult and older adult FSP progran were lower than budget by $2.7 million and the Children and TAY FSP programs were lower by $415 thousand. Additionally, as a resul of higher than expected billing rates approved by the LACDMH for the fiscal year 2023-24, a total of $2 million from prior year Medi-Ca FFP revenues were recorded to the current year operations.

2 **Medi-Cal SGF-EPSDT revenues for fiscal year 2024-25** were lower than budget by $396 thousand of which $432 thousand lower were from TCMH and $36 thousand higher were from MHSA. As was mentioned above, additional $220 thousand in prior year Medi-C SGF-EPSDT revenues were recorded in the current year operations. SGF-EPSDT relates to State General Funds (SGF) provided to th for provision of qualifying Medi-Cal services for Early Prevention Screening and Diagnostic Testing (EPSDT) to children and youth und 21 years. These funds are in addition to the FFP reimbursed by the federal government.

3 **Medicare revenues** are $7 thousand higher than the budget. Tri-City records revenue when the services are provided and the claims are incurred and submitted.

4 **Contract revenues** are approximately $3 thousand higher than the budget.

5 **Rent Incomes** are higher than the budget by $19 thousand. The rental income represents the payments collected from Genoa pharma for space leasing at the 2008 N. Garey Avenue and from the tenants staying at the MHSA house on Park Avenue.

6 **Provision for contractual disallowances** for fiscal year 2024-25 was lower than budget by $602 thousand. Furthermore, due to the State's completion of FY15-16 cost report audit, the overall reserves were reduced by another $368 thousand. This prior year's reserve write off essentially helps increase the current year's net operating revenues.

Operating Expenses

Operating expenses were lower than budget by approximately $5.2 million for the following reasons:

1 **Salaries and benefits** are $4.4 million lower than budget and of that amount, salaries and benefits are $1.6 million lower for TCMH operations and are approximately $2.8 million lower for MHSA operations. These variances are due to the following:

TCMH salaries are lower than budget by $961 thousand due to vacant positions and benefits are lower than budget by $632 thousand. Benefits are budgeted as a percentage of the salaries. Therefore, when salaries are lower, benefits will also be lower.

MHSA salaries are lower than budget by $1.7 million. The direct program salary costs are lower by approximately $1.1 million due to va positions and the administrative salary costs are lower than budget by $592 thousand. Benefits are lower than the budget by another $ million. Of that, health insurance was lower than budget by $437 thousand, retirement insurance $525 thousand, state unemployment insurance $78 thousand, workers compensation $35 thousand, medicare tax $30 thousand. Group term life insurance and other employee benefits are all lower.

2 **Facility and equipment operating costs** were higher than the budget by $219 thousand of which $52 thousand higher was from TCMH and $167 thousand higher was from MHSA. Overall, building and facility costs were higher than the budget by $142 thousand due to repairs and maintenance costs at the 2008 N. Garey building and the Community Therapeutic Garden. The equipment costs were higher by another $77 thousand due to the replacement of agency wide laptop docking stations, some of the aging printer scanne projectors and the upgrading of the Wellness Center's computer lab all of which are funded by the CFTN plan.

3 **Client program costs** are higher than the budget by $92 thousand partly due to a payment of $396 thousand to the City of Pomona's Hope for Home Year-Round Emergency Shelter early in the year while the budget is evenly spread out over a fiscal year.

4 **Grants for fiscal year 2024-25** are $960 thousand lower than the budget. These are the sub-grants awarded under the TCMH Mental Health Student Services Act program, the community grants under the MHSA PEI Community Wellbeing project and the Student Loan Forgiveness program under the MHSA WET plan.

5 **MHSA learning and training costs** are approximately $32 thousand higher than the budget.

TRI-CITY MENTAL HEALTH AUTHORITY
ACTUAL TO BUDGET VARIANCE EXPLANATIONS
EIGHT MONTHS ENDING FEBRUARY 28, 2025

COMMENT: PLEASE NOTE, THE DISCUSSION BELOW MAY USE THE FOLLOWING ABBREVIATIONS:
TCMH==TRI-CITY MENTAL HEALTH (OUTPATIENT CLINIC OPERATIONS)
MHSA==MENTAL HEALTH SERVICES ACT (ACTIVITIES INCLUDE CSS, PEI, INN, WET AND CFTN PROGRAMS)

6 **Depreciation and amortization** are $71 thousand higher than the budget.

7 **Other operating expenses** were lower than the budget by $198 thousand of which $177 thousand higher were from TCMH offset by $376 thousand lower from MHSA. Overall, the higher costs were due to higher personnel recruiting fees, attorney fees, dues and subscriptions, and liability insurance costs. These higher costs are offset with lower professional fees.

Non-Operating Revenues (Expenses)

Non-operating revenues, net, are lower than budget by $1.9 million as follows:

1 **TCMH non-operating revenues** are approximately $1.8 million lower than the budget. Of that, realignment fund was lower than the budget by $496 thousand, contributions from member cities are lower by approximately $27 thousand due to timing, grants and contrac were lower by $1.4 million, interest income net with fair market value was higher by $163 thousand.

2 **MHSA non-operating revenue** is in line with the budget.
In accordance with Government Accounting Standards Board, MHSA funds received and available to be spent must be recorded as non-operating revenue as soon as the funds are received. Funds are available to be spent when an MHSA plan and related programs have been approved and the proposed expenditures for those programs have been approved through an MHSA plan, MHSA update, or State Oversight and Accountability Commission.

The differences in actual to budget are broken out as follows:

	Actual	Budget	Variance
CSS funds received and available to be spent	$ 12,056,637	$ 12,056,637	$ -
PEI funds received and available to be spent	4,006,412	4,006,412	-
WET funds received and available to be spent	-	-	-
CFTN funds received and available to be spent	-	-	-
INN funds received and available to be spent	629,986	629,986	-
Non-operating revenues recorded	$ 16,693,035	$ 16,693,035	$ -

CSS, PEI and INN recorded revenues are all in line with the budget.

Interest income net with Fair Market Value for MHSA is higher than budget by approximately $481 thousand.

Other Income-Loss on Disposal of Assets is approximately $636 thousand. This is due to the transferring of the Tri-City's property c 956 W. Baseline Rd. in Claremont to Restore Neighborhools LA, Inc. (RNLA) for the development and construction of a 15-unit of combined affordable and permanent supportive senior housing project, known as Claremont Gardens. The escrow was successfully closed on February 28, 2025.

TRI-CITY MENTAL HEALTH AUTHORITY
CONSOLIDATING STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET POSITION
EIGHT MONTHS ENDED FEBRUARY 28, 2025 AND 2024

	PERIOD ENDED 2/28/25			PERIOD ENDED 2/29/24		
	TCMH Unaudited	MHSA Unaudited	Consolidated Unaudited	TCMH Audited	MHSA Audited	Consolidated Audited
REVENUES						
Medi-Cal FFP, net of reserves	$ 2,815,496	$ 3,904,837	$ 6,720,333	$ 3,232,121	$ 3,635,690	$ 6,867,811
Medi-Cal FFP FYE Prior Year	1,076,815	1,188,733	2,265,548	67,297	3,039	70,336
Medi-Cal SGF-EPSDT	704,770	1,306,161	2,010,931	671,741	696,947	1,368,688
Medi-Cal SGF-EPSDT Prior Year	174,562	174,613	349,175	3,379	25,813	29,192
Medicare	6,447	5,243	11,691	4,656	3,094	7,750
Realignment	2,436,900	-	2,436,900	2,465,756	-	2,465,756
MHSA funds	-	16,693,035	16,693,035	-	15,539,345	15,539,345
Grants and contracts	742,196	21,550	763,745	615,238	20,571	635,808
Contributions from member cities & donations	43,675	-	43,675	-	-	-
Patient fees and insurance	-	-	-	446	180	626
Rent income - TCMH & MHSA Housing	8,624	58,115	66,740	7,392	49,393	56,785
Other income	490	587	1,077	540	436	975
Interest Income	293,108	1,394,012	1,687,120	189,229	1,130,150	1,319,378
Gain (Loss) on disposal of assets	-	(635,773)	(635,773)	-	-	-
Total Revenues	**8,303,084**	**24,111,113**	**32,414,196**	**7,257,794**	**21,104,658**	**28,362,452**
EXPENSES						
Salaries, wages and benefits	5,358,613	12,448,911	17,807,525	5,410,019	11,256,003	16,666,022
Facility and equipment operating cost	426,819	1,091,437	1,518,255	392,778	818,523	1,211,301
Client lodging, transportation, and supply expense	41,326	460,503	501,828	109,957	458,064	568,020
Depreciation & amortization	199,759	418,924	618,683	195,445	404,559	600,004
Other operating expenses	639,846	1,628,730	2,268,576	535,123	1,406,694	1,941,818
Total Expenses	**6,666,363**	**16,048,504**	**22,714,867**	**6,643,322**	**14,343,844**	**20,987,165**
INCREASE (DECREASE) IN NET POSITION	**1,636,720**	**8,062,609**	**9,699,329**	**614,472**	**6,760,814**	**7,375,287**
NET POSITION, BEGINNING OF YEAR	10,020,298	32,339,182	42,359,480	8,639,329	28,506,858	37,146,187
NET POSITION, END OF MONTH	**$ 11,657,019**	**$ 40,401,791**	**$ 52,058,810**	**$ 9,253,801**	**$ 35,267,672**	**$ 44,521,474**

NOTE: This presentation of the Change in Net Assets is NOT in accordance with GASB, but is presented only for a simple review of Tri-City's revenue sources and expenses.

Definitions:
Medi-Cal FFP= Federal Financial Participation Reimbursement
Medi-Cal SGF-EPSDT=State General Funds reimbursement for Medi-Cal services provided to children under the "Early and Periodic Screening, Diagnosis and Treatment" regulations.
TCMH=Tri-City's Outpatient Clinic
MHSA=Mental Health Services Act (Proposition 63)

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: April 16, 2025

TO: Governing Board of Tri-City Mental Health Authority (TCMHA)
Ontson Placide, LMFT, Executive Director

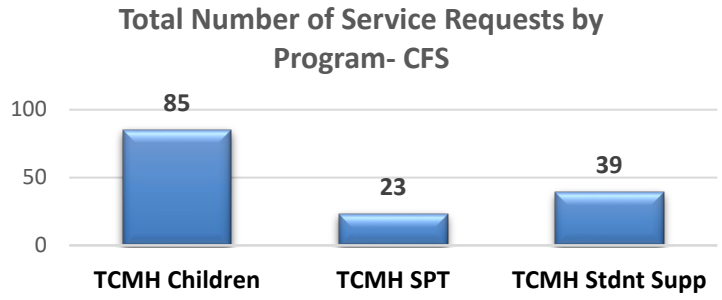
FROM: Elizabeth Renteria, LCSW, Chief Clinical Officer

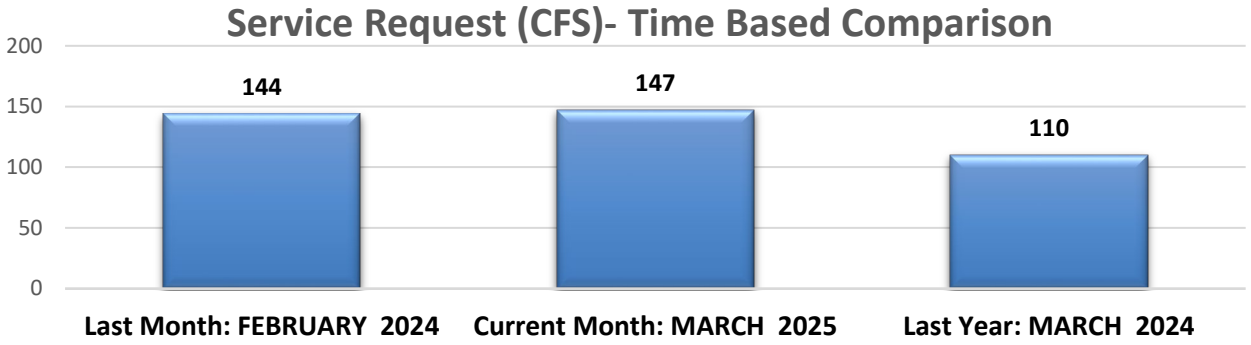
SUBJECT: Monthly Clinical Services Report

CLINICAL SERVICES DATA UPDATE

CFS March 2025 Data

Total Number of completed Service Requests
147
135 Unique





This graph above compares the number of services requests from last month, February 2024 and last year, March 2024 to the current month, March 2025. There was a 34% increase in the number of service requests from last month.
Note: This data includes MHSSA Services requests. All reports prior to May 2024 did not include MHSSA service requests data.

ATC REPORT

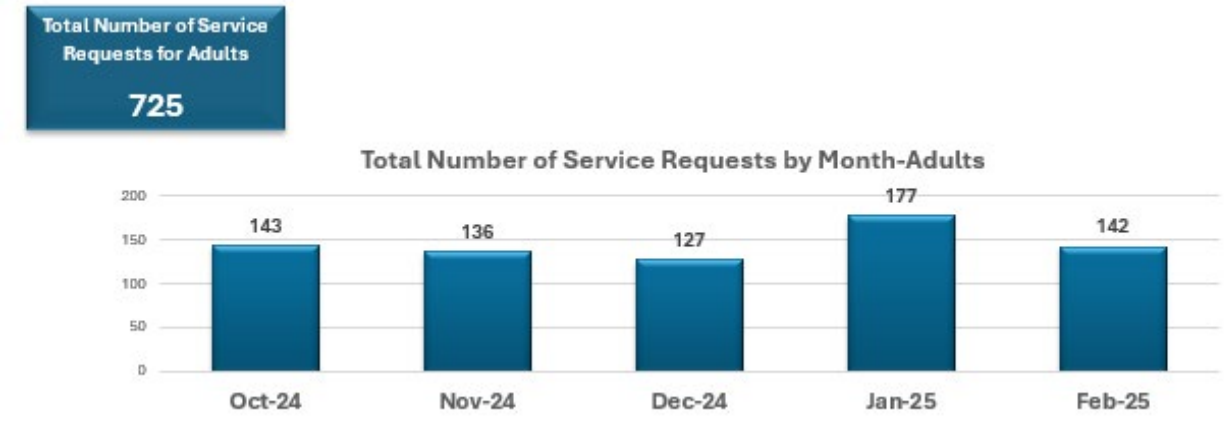
Service Requests

Adult Services:

The Access to Care department at Tri-City Mental Health continues to serve as the main entry point for those individuals seeking mental health services. The Access to Care department processes service requests, registrations and completes intake assessment. Having a centralized department that focuses on assisting individuals to access services at Tri-City Mental Health allows for easier access for those seeking services. The Access to care department plays a vital role as the entry point for individuals seeking support. We take pride in providing compassionate assistance and ensuring each person receives the help they need.

Below is the total number of service requests received for all ***adult programs*** from **October 1, 2024, to February 28, 2025.** There was a total of **725** adults over the age of 26 years of age that sought services from Tri-City Mental Health or who were referred into services. Each service request represents an individual seeking mental health support. A trained behavioral health specialist will assess their needs, process the request and provide appropriate resources based on their unique circumstances.

Graph 1: Total number of Service Requests for all Adult Programs. *

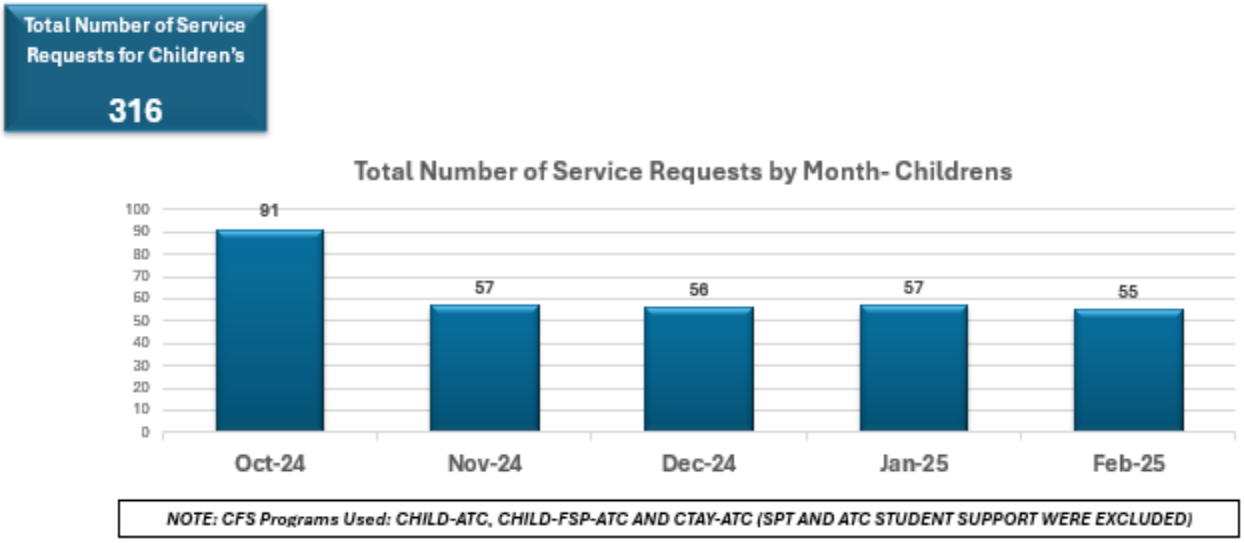


***Data above also includes service requests processed by adult FSP team.**

Children and Family Services:

From **October 1, 2024, to February 28, 2025,** there were approximately **316** individuals that sought services through our **Children and Family programs.** There was an average of approxiamtely **62** individuals per month aged 0-25 seeking services either on their own or with their caregivers and families. This data also includes service requests processed by the FSP department.

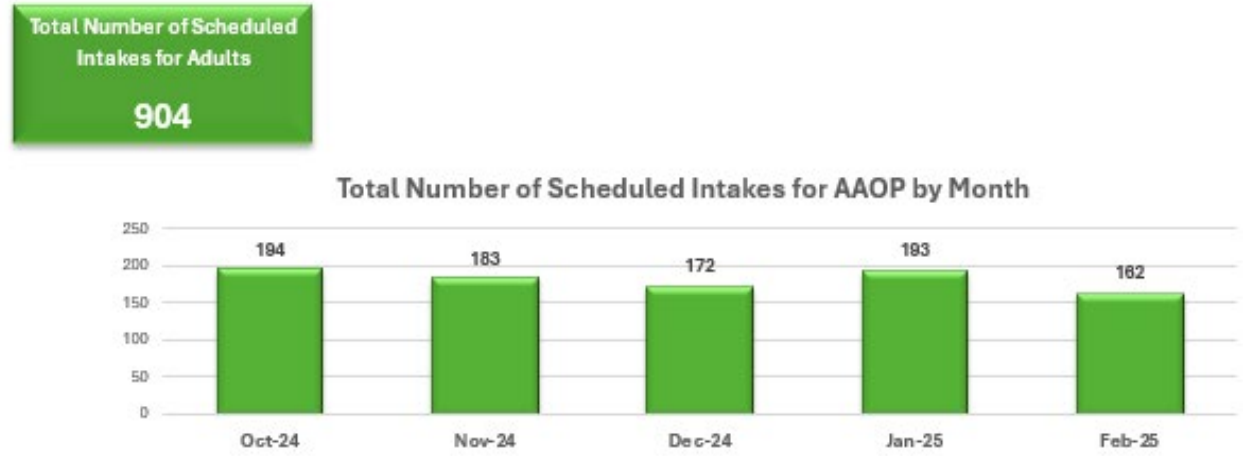
Graph 2: Total number of Service Requests for all Children's Programs. *



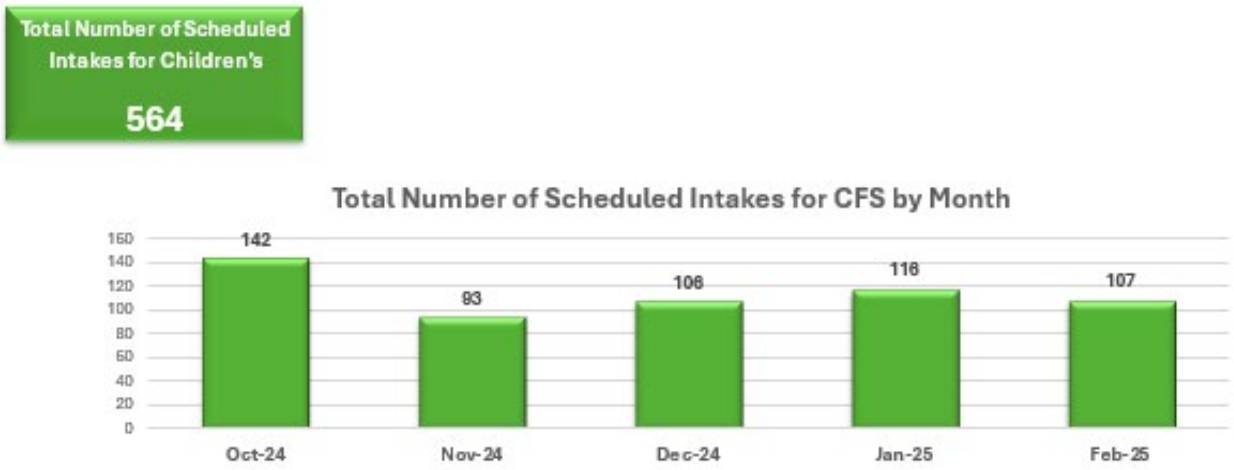
Intake Assessments Scheduled

After an individual has a service request processed, depending on their need, they will get scheduled for an intake assessment here at Tri-City Mental Health. Below is the data that reflects how many intake appointments were scheduled for both our adult program and our Children and Family Programs over the past 5 months. The total number of intakes scheduled in this past five months for adults and children is **1,468.**

Graph 3: Total Number of Scheduled Intake Appointments for all Adult Programs.



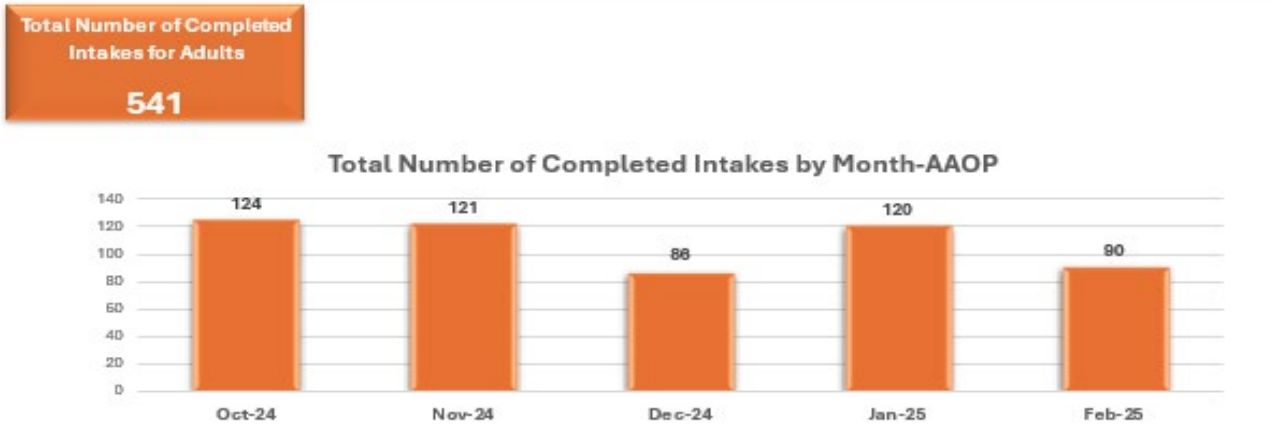
Graph 4: Total number of Scheduled Intake Appointments for all Children's Programs.



Intake Assessment Completed

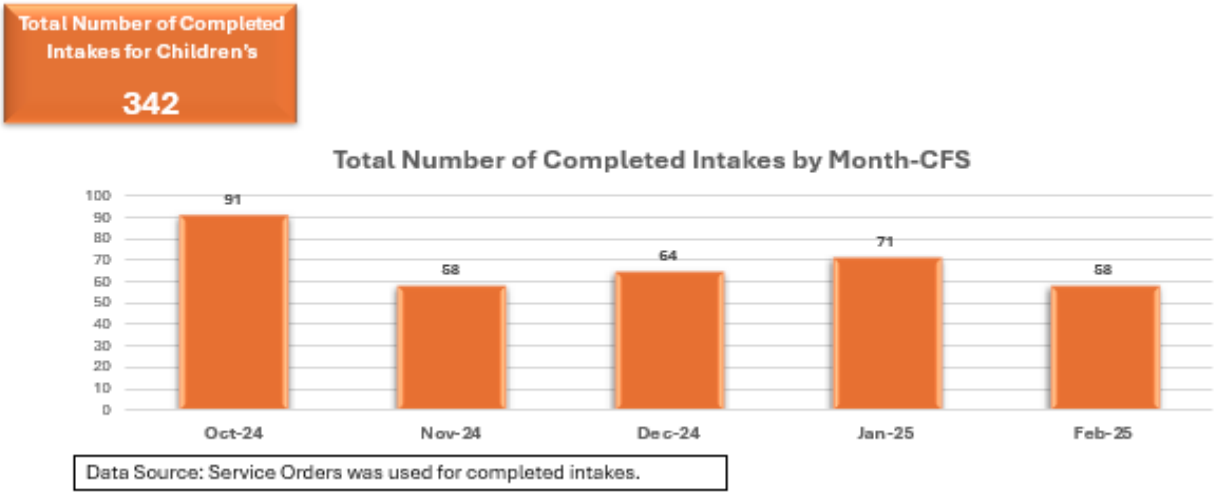
Data below reflects how many adult and children's intakes were completed between our Adult Programs and Children and Family programs from **October 1, 2024, to February 28, 2025**. During this 5-month period, there were approximately **883 intake assessments** completed, based on completed orders. This data is significant, as it represents individuals who have been assessed and evaluated, heard, and supported on their journey to receiving mental health care. Whether they receive services at our agency or are referred to a different level of care, we ensure they are connected to the appropriate support.

Graph 5: Total number of Completed Intakes for Adult Programs



*Data Source: Completed intake data is based on completed orders.

Graph 6: Total number of Completed Intakes for Children's Programs.



Intake timeliness

Per Los Angeles County, a standard service request for an individual seeking mental health services must receive an assessment appointment within 10 days, an individual discharging from the hospital or jail setting must receive an assessment appointment within 5 days, and individuals identified as urgent/high risk must receive an assessment appointment within 48 hours. The Access to Care department at Tri City has been able to maintain between 97-100% timely intake appointments since November 2023.

INTER-DEPARTMENT COLLABORATIONS

The Access to Care Department works very closely with many departments within the Tri-City system of care, regularly collaborating with one another to ensure everyone who makes contact with our agency is promptly connected to the support they need on their path to wellness.

Recently, Tri City has rolled-out a new Mobile Crisis Care team to assist with individuals who are experiencing a psychiatric crisis and are in need of stabilization support. The Access to Care team has already experienced several instances in which we were able to partner together with the Mobile Crisis Care team in order to further assess, stabilize, and link community members to the much-needed mental health support that they need.

Similarly, the Access to Care team has been working closely alongside our Adult Clinical Programs as well as our Child and Family Clinical Programs in order to provide shadowing and cross-training experiences for their newer staff members so that they may learn about what it takes to get started with services at our agency, how to conduct a thorough

biopsychosocial assessment in order to determine medical necessity, and to further our interdepartmental relationships with one another.

Lastly, the Access to Care team was recently invited by the Community Navigation team at Tri City to attend the Los Angeles Veteran Resource Expo on March 21, 2025 in order to provide resources to local veterans and to further our connections and enhance our working relationships with fellow supportive agencies throughout the county.

Whatever the ask may be, our team works diligently alongside our fellow colleagues in order to ensure that an individualized and whole person care approach is utilized to support the unique needs of each community member they come into contact with.

Support/Resources section

The Access to Care Department works in collaboration with the following departments/agencies in offering supportive services and resources to individuals:

- Pomona City Hall
- Pomona Valley Hospital
- Pomona College
- University of La Verne
- Starview Urgent Behavioral Health Center
- East Valley Community Clinic
- Volunteers of America
- Prototypes
- Pomona, Claremont & La Verne PD
- DPSS Office
- Parks/Rec centers in Pomona, La Verne and Claremont
- The Regional Center
- Co-Occurring Support Team (Tri-City)
- Full-Service Partnership Team (Tri-City)
- Children and Family Department (Tri-City)
- Community Navigators -referrals and resources (Tri-City)
- School Partnership team (Tri-City)
- Wellness Center (Tri-City)
- APS and CPS
- CTRI
- American Recovery Center (ARC)
- Hope for Homes
- Various psychiatric hospitals
- Local schools and colleges

Success Story

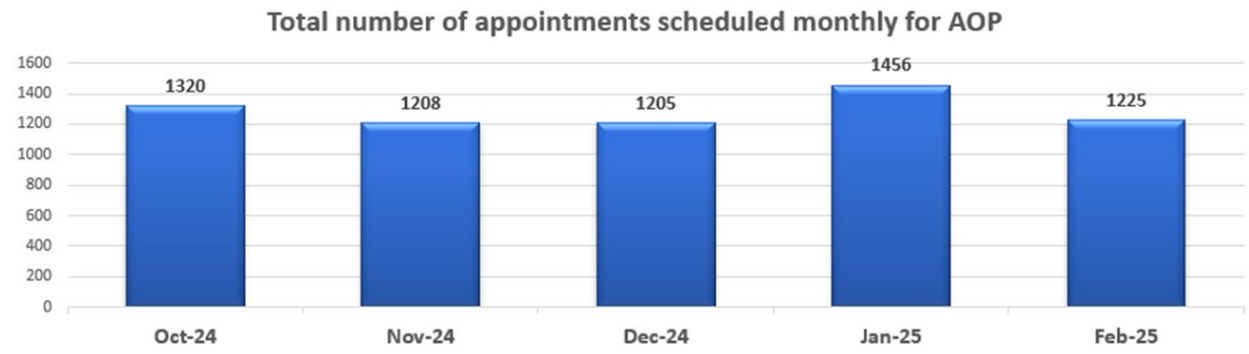
ATC Senior Behavioral Health Specialist) shares a success story of assisting an older individual that came in seeking services through the Access to Care department. This person was unhoused and unfortunately had private insurance. ATC staff membered worked closely with this individual to assess their needs. This person was assisted to connect back to their private insurance in addition to linking this individual to our Community Navigators for housing resources. The individual expressed gratitude to Rosa, stating she lifted their spirit and gave them hope stating others have not shown them professionalism and respect. Rosa found out the next day that this person was able to find shelter at Hope for Homes and was in the process of working on their insurance with the Community Navigators. This success story shows the impact we can have by offering excellent customer service, listening to the needs of those we serve and collaborating with our internal departments as well as external partners.

CENTRALIZED SCHEDULING

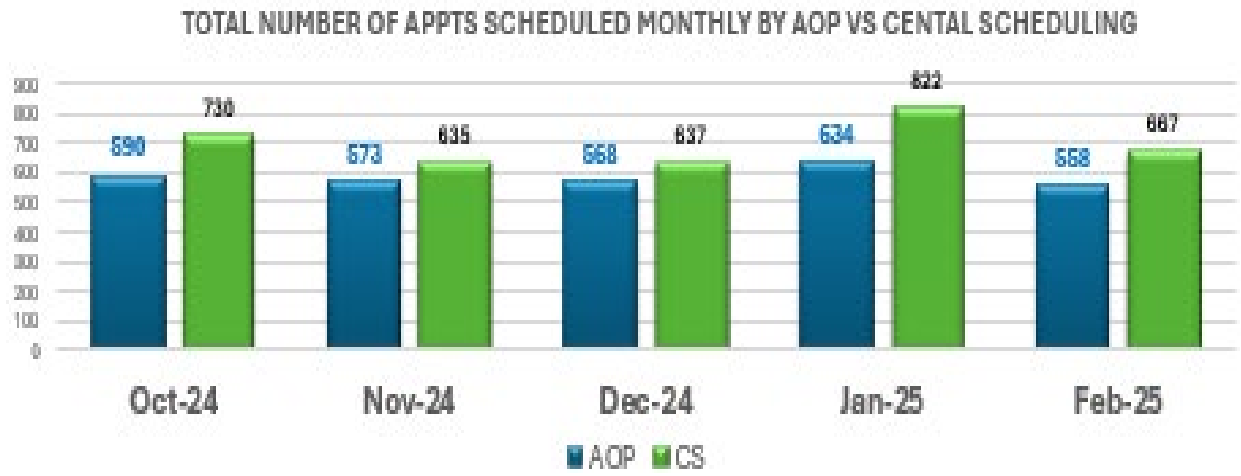
Over the past 5 months (October/2024 to February/2025), there have been a total of **6,414** appointments scheduled for the adult outpatient team **(see graph 1),** with **3,491** of those appointments being scheduled directly by the Centralized Scheduling team. Our Centralized Scheduling team plays a pivotal role in our clients having their scheduling/rescheduling needs handled in a streamlined and efficient manner, in addition to our providers feeling supported with managing these administrative tasks.

Adult outpatient providers will schedule their own follow-up appointments once a client has shown to their appointment. Therefore, seeing the high number of appointments scheduled by our providers over the past 5 months of **2,923 (see graph 2)** one can infer that clients are showing to their appointments and having a follow-up appointment scheduled. There is an average of approximately **1,282** appointments for the adult outpatient clients being scheduled per month.

Graph 1: Total number of appointments scheduled by month for the Adult Outpatient Program



Graph 2: Total number of appointments scheduled by CST team vs. Clinical Team



M.D. Appointments

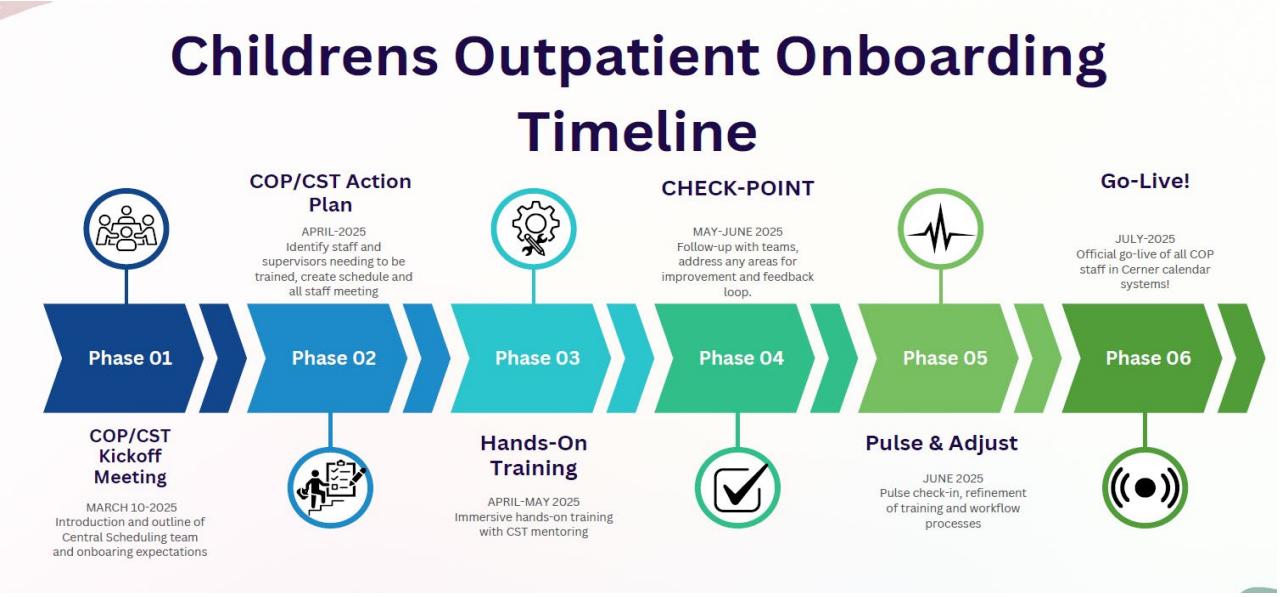
In July/2024, the Centralized Scheduling department took on the scheduling of appointments for our psychiatrists who work with our adult population. This includes managing all psychiatrist appointments, with the exception of the initial medication evaluations. Over the past 5 months (October/2024 to February/2025), the CST team scheduled approximately, **2,725** appointments for our psychiatrists. **(See graph 3 below).** One of the main goals of the Centralized Scheduling team is to allow for ease of access in terms of scheduling and to provide an additional layer of support for our providers to ensure their clients are scheduled. For our Centralized Scheduling department, each appointment scheduled represents an individual getting connected to the support they need to support their mental health wellness.

Graph 3: Total Number of appointments scheduled for psychiatrists by CST - October/2024-02/28/2025

NEXT STEP/PROGRAM DEVELOPMENT

In March 2025, we begun the process of onboarding out children's department by initiating meetings with CFS COP Leadership. We are now meeting weekly with our CFS COP Leadership and creating a plan to onboard 6 COP Clinicians and 1 Behavioral Health Specialist on to Centralized Scheduling. We will be holding a kickoff meeting with the children's department on 4/16/2025 to introduce them to the Centralized Scheduling Department. We have a tentative go live date for all COP providers as of 7/1/2025. Below in you can see our tentative onboarding plan for our children's department (see graph 4).

Graph 4: Tentative Children's Outpatient Onboarding Timeline



Inter-department collaborations

Central Scheduling (CS) has collaborated previously with Medication Support teams (MSS), our Adult Outpatient Services (AOP), and future onboarding of Children's Outpatient Programs (COP). CS collaborations with multiple programs has played a crucial role in enhancing client participation efforts and overall service efficiency. Without these collaborative efforts, the success of client engagement and continuity of care would not occur as frequently. By delegating administrative burdens to Central Scheduling, clinical programs can now dedicate more focused time to direct client care, improving service accessibility, appointment adherence, and treatment outcomes. This streamlined approach fosters a more cohesive system, ensuring that both adult and children's outpatient programs operate with greater efficient and client-centered care.

THERAPEUTIC COMMUNITY GARDEN

The cycle of unseasonably cold and wet weather, followed by an unusually warm spell over the past month, has created the perfect environment for weeds to thrive in the Therapeutic Community Garden (TCG). Our team members and group participants have been tirelessly battling an invasion of non-native weeds, including oxalis, filaree, burr clover, mallow, clover, wild lettuce, dandelions, weedy grasses, henbit, spurge, and, most daunting of all, the fast-spreading nutsedge. This relentless weed grows from its nuts, roots, and rhizomes, quickly taking over irrigated areas. Each team member commits at least one hour per week to digging out weeds from the gravel paths, the rocks beneath the raised beds, the decorative stream bed, and the mulch areas, all in an effort to preserve the health and vitality of the garden.

Fortunately, other cycles in the garden have been more uplifting and rewarding. Our wildflowers have started to bloom, and the critters that rely on them, along with the insects they attract, have been making their appearances. The beauty of the blossoming plants has been almost overshadowed by the lively presence of these creatures. The excitement of two Connect in the Garden participants as they observed the various life stages of lady beetles thriving within the protective fronds of the native scorpion weed was contagious. Their enthusiasm in sharing these discoveries with their fellow group members was truly heartwarming.

At the start of this month, the TCG groups chose the warm season crops that they wanted to grow in the Garden for the Summer Season. Then, to provide a strong foundation to ensure that the plants thrive, they amended the soil with compost and added slow-release organic fertilizer in preparation for planting. Participants have begun to plant starter plants of eggplant, cherry tomatoes, tomatillos and peppers, both sweet and hot in the lower growing beds. In the beginning of April vegetable and fruit seeds will be tucked into the warming soil to produce some of our favorite crops like, melons, cucumbers, squash, basil and watermelon.

Left : Nasturtium flowers spill from a Raised Bed; **Second from Left** : Orange blossoms scent the air; **Second from Right :** Native wildflowers growing in the decorative Swale; **Right :** Native Strawberry plant in bloom.


Above: *The weeds that have been keeping the TCG team busy.*

External Outreach

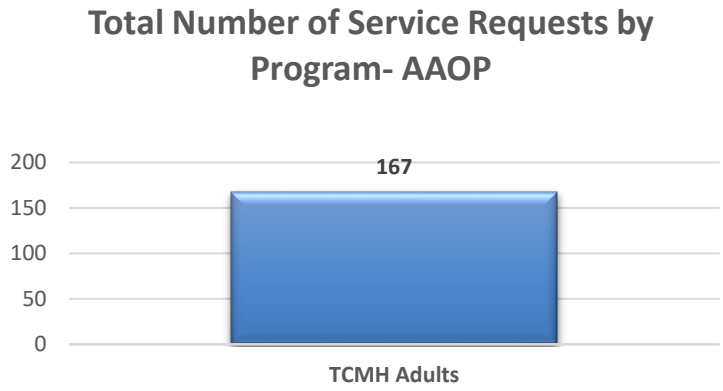
TCG Clinician Reconnects with Mount San Antonio Gardens:
The TCG clinician has reconnected with Mount San Antonio Gardens, presenting a valuable opportunity for the team to engage with the senior population. During previous meetings with this organization, the team discussed the potential for offering workshops aimed at educating seniors about the therapeutic benefits of gardening and nature. These workshops will not only provide valuable information but also encourage seniors to participate in hands-on activities, fostering social connections and promoting both physical and mental well-being.

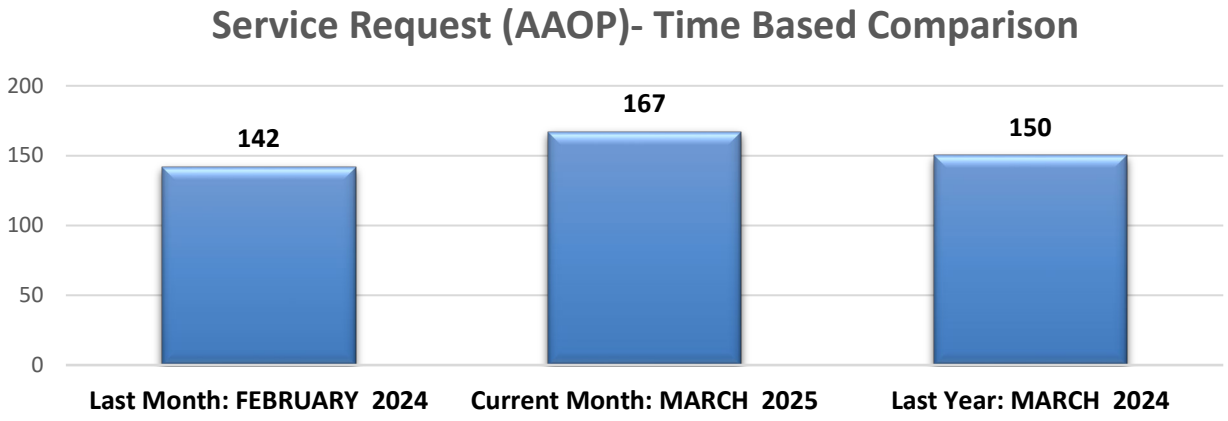
Casa Colina:
The team has built a successful partnership with Casa Colina Children's Services, as demonstrated by the opportunity to engage with their youth this summer. The TCG team has coordinated with Casa Colina staff to plan two workshops for their Youth Adventure Group, which targets children ages 8-17. These workshops will include activities designed to connect young people with nature while also teaching valuable coping and socialization skills. More details about these workshops will be shared as the dates approach.

Southern Counties Regional Partnership (SCRP):
On March 18, 2025, the TCG team attended the SCRP Conference to share information about Tri City's Therapeutic Garden. Attendees had the chance to ask questions about the program and learn about the use of therapeutic horticulture as a modality. Additionally, they were introduced to a common group activity, creating mindfulness sachets while practicing the 5-4-3-2-1 grounding technique. The TCG team successfully reached out to a total of 30 individuals during this event.

AAOP- March 2025 Data

Total Number of completed Service Requests 167





This graph above compares the number of services requests from last month, February 2025 and last year, March 2024 to the current month, March 2025. There was a 18% increase in the number of service requests from last month.

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **April 16, 2025**

TO: **Governing Board of Tri-City Mental Health Authority**
Ontson Placide, LMFT, Executive Director

FROM: **Seeyam Teimoori, M.D., Medical Director**

SUBJECT: **Medical Director's Monthly Report**

SERVICES PROVIDED BY OUR PSYCHIATRISTS AND NURSING TEAM IN THE MONTH OF MARCH 2025

The team of psychiatrists provides initial psychiatric evaluations and psychiatric follow ups to our clients. The initial psychiatric evaluations are scheduled based on the clients' severity of symptoms, recent hospital admissions and being currently on psychiatric medications, to ensure timely access to these services, based on the urgency of cases.

The nursing team provides medication monitoring services in our in-house medication room for our outpatient clients. In the field medication monitoring services are provided for our clients in full-service partnership program. This includes providing oral medications and administering long acting injectables, which are proven to improve treatment outcomes.

These services which are supervised by our psychiatrists, improve medication compliances, facilitate treatments by monitoring the efficacies of medications and early reporting of side effects and other concerns, which will be addressed by treating psychiatrists.

Here are some of the services provided in the month of March:

- Total number of initial psychiatric evaluations: 46
- Total number of appointments with our psychiatrists: 289
- Total number of medication monitoring services: 645
- Total number of long-acting injections: 105

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: April 16, 2025

TO: Governing Board of Tri-City Mental Health Authority
Ontson Placide, LMFT, Executive Director

FROM: Dana Barford, Director of MHSA and Ethnic Services

SUBJECT: MHSA and Ethnic Services Monthly Report

DIVERSITY, EQUITY, AND INCLUSION (DEI)

On Friday, March 28th, the ADELANTE Chair and DEI Coordinator had the privilege of attending the Latino & Latina Roundtable's 21st Annual César Chávez Breakfast. The event was a powerful reminder of the critical role collaboration and community-driven efforts play in addressing the needs of the Latino community. It provided a meaningful opportunity to connect with others, learn about impactful initiatives, and reflect on the collective responsibility we share in fostering positive change and supporting the well-being of all. We extend our gratitude to the Latino/a Roundtable for their tireless work and look forward to future collaborations aimed at continuing to strengthen our community.

UPCOMING EVENTS

For May Mental Health Month, we are excited to host a series of pop-up events centered around self-care and wellness, featuring an engaging bingo game format. The idea for these events was born out of a desire to support our community during uncertain times, aiming to foster connection and promote mental wellbeing. Through this interactive and fun activity, participants will not only learn positive coping strategies and practical self-care skills that can be integrated into their daily lives but will also have the chance to come together in a supportive, uplifting environment. These events are designed to break down the stigma surrounding mental health while empowering individuals to prioritize their wellbeing and build a sense of unity within the community.

COMMUNITY PLANNING PROCESS (CPP)

On April 8, Tri-City's Mental Health Commission convened the annual MHSA Public Hearing to review the MHSA Annual Update for FY 2025-26. During the presentation, the MHSA Projects Manager provided an overview of MHSA programming from FY 2023-24 which included outcomes, successes, challenges, and a projected budget. Several success stories were shared which focused on perseverance and continuing to support individuals throughout their recovery journey. At the conclusion of the public hearing, members of the Mental Health Commission unanimously voted to endorse the MHSA Annual Update for FY 2025-26 to Tri-City's Governing Board for approval and adoption.

Westmont Elementary School

Jan Lopez, Family Engagement Coordinator for Westmont Elementary School in Pomona, contacted the Tri-City Projects Manager requesting a presentation for their staff and parents. On March 19th, Sara Rodriguez presented to a group of parents and staff, introducing them to Tri-City services, along with information on relevant programming and current events. The school was also linked to the Therapeutic Community Garden to continue collaboration.

PREVENTION AND EARLY INTERVENTION (PEI)

Stigma Reduction

For the month of March, program staff facilitated weekly Courageous Minds workshop sessions, prepared and directed Green Ribbon Week activities, and provided a suicide prevention presentation. This year, the Courageous Minds cohort included four new speakers who completed their training program, with two participants sharing their mental health story during Green Ribbon Week 2025.

This year's Green Ribbon Week focused on the theme of "Thrive in Mind" and had a mixture of both virtual and in person activities. Some of the virtual options included the pledge drive, social media postings, and the Mental Health 101 Webinar. The rest of the Green Ribbon Week activities were held at various boba shops in the cities of Pomona, Claremont, and La Verne.

COMMUNITY NAVIGATORS (CN)

Outreach efforts for the Community Navigator Program consisted of tabling at the following events: Public Safety Fair hosted by Pomona PD, and LA County Veteran Expo Event hosted at the Pomona Fairplex. These collaborations have proven to be a valued method of support for our community partners.

In addition, the Community Navigators continue to support the participants at the Hope 4 Home shelter on the 2nd and 4th Thursday of the month. Their consistent presence at the shelter and wealth of resources, allow the Navigators to assist these individuals with their basic needs as well as housing recommendations to assist them in their transition to a more permanent home.

Success Story

A male veteran was referred to the Community Navigator Program by his property manager for rental assistance. He served numerous years in the service including time in Vietnam which he takes pride in. He shared his connection to Pomona as he ran a successful sober living home where he helped others get back on their feet. However, this individual lost his VA pension last year because he was collecting double benefits but was allowed to keep only his SSI benefits. With this drastic reduction in income, he had been struggling to pay for rent and food.

The Community Navigator utilizing Homeless Prevention Funds was able to assist him with his rent and late fees to help him maintain his housing. He had been served a 3-day notice to pay or quit and said he had gone hungry to be able to afford feeding his ESA dog and pay his rent. The Community Navigator assisting him also connected him to VPAN (Veteran Peer Access Network-LA County) to help him navigate all aspects of VA benefits and services. In addition, he was linked to the Inland Valley Humane Society where he can receive pet food at no cost. Lastly, he has been approved for CalFresh benefits, so he does not have to struggle with feeding himself and his dog.

WELLNESS CENTER (WC)

The Wellness Center continues to implement programming that is responsive to the needs of the community including employment assistance. For many struggling financially, the Center in partnership with Maxim Healthcare hosted another successful hiring event where nineteen participants attended the event and two were offered job placements on the spot. Five additional attendees were deemed hirable and have started the application process.

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **April 16, 2025**

TO: **Governing Board of Tri-City Mental Health Authority**
Ontson Placide, LMFT, Executive Director

FROM: **Natalie Majors-Stewart, LCSW, Chief Compliance Officer**

SUBJECT: **Monthly Best Practices Report**

BEHAVIORAL HEALTH SERVICES ACT (BHSA) TRANSFORMATION

Completion of Phase 2: Assessment of Needs and Capacity

The Tri-City BHSA Transformation Project Team is making great progress with the project plan and has completed Phase 2: *Assessment of Needs and Capacity*.

- Phase 1: Develop Plan & Orient to BHSA Guidelines, Regulations, and Requirements
- Phase 2: Assessment of Needs and Capacity
- Phase 3: Creation of Organization & Program Design/Re-Design Strategy
- Phase 4: Preparation for and Implementation of Design/Re-Design
- Phase 5: Go-Live/Launch BHSA Integrated Plan

The Phase 2: Assessment of Needs and Capacity was completed from December 2024 through March 2025, and was coordinated by the agency's quality improvement: data and outcomes team. During the *assessment of needs and capacity*, data was collected from various sources and analyzed to demonstrate our strengths and areas of need as we transition to the Behavioral Health Services Act (BHSA). Data from the *assessment of needs and capacity* will assist the agency in making data driven decisions on how to best implement programming for BHSA. Some highlights from the assessment include the following:

- When comparing the demographics of clients/participants to the demographics of Pomona, Claremont, and La Verne residents, the data showed that Tri-City is effectively reaching both African American and Latinx communities. Additionally, we have Spanish and Vietnamese speaking staff across programs to meet the language needs of the community.

- Direct feedback from the community and clients was also very positive. When asked "*How can we improve Tri-City's programs and services to better meet the needs of*

the community?" Comments included: "We are doing great and so much stuff we offer," "Tri City is doing a great job," and "Everything is fine the way it is."

- A review of the time it takes from requesting clinical services to the time of intake shows that Tri-City is consistently meeting the timeliness standards. More specifically, the percent of service requests meeting this goal ranged from 93-100% in the last fiscal year.

Internal presentations and discussions of the data from the *assessment of needs and capacity* have commenced and will continue to be shared internally over the next few months as we launch Phase 3: Creation of Organization & Program Design/Re-Design Strategy. As more guidance is released regarding BHSA and as program designs are being developed, additionally data will be collected and analyzed to help drive decision making and planning for the remaining phases of the BHSA Transformation Project.

Tri-City Mental Health Authority
AGENDA REPORT

DATE: **April 16, 2025**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Ontson Placide, LMFT, Executive Director**

BY: **Liz Renteria, LCSW, Chief Clinical Officer**

SUBJECT: **Consideration of Resolution No. 775 Approving the Second Amendment to Agreement with JS Risk Consulting for Risk Management Consulting Services, and Authorizing the Executive Director to Execute the Amendment**

Summary:

Staff is requesting approval from the Governing Board to authorize the Executive Director of Tri-City Mental Health Authority (TCMHA) to amend the existing agreement with JS Risk Consulting. The amendment would allow JS Risk Consulting to provide additional training for the Mobile Crisis Care Program staff. The enhanced training sessions are designed to improve field safety and strengthen client services. The sessions will focus on crisis intervention skills and will include interactive role-playing, tabletop exercises, and debriefings with the multidisciplinary teams.

Background:

In March 2022, Tri-City Mental Health Authority (TCMHA) was awarded a $200,000 planning grant from the California Department of Health Care Services to support the planning and design of Crisis Care Mobile Units. On March 16, 2022, the Governing Board approved Resolution No. 641, authorizing the Executive Director to execute Subcontract Agreement No. 7460-CA MOBILE CRISIS-TRICITY-01 with Advocates for Human Potential, Inc. This agreement supports the Behavioral Health Mobile Crisis and Non-Crisis Services Project No. 21-10349, in partnership with the California Department of Health Care Services and includes authorization for any subsequent amendments.

Between March 2022 and February 2023, TCMHA engaged in ongoing cross-sector collaboration with local and regional partners—including school districts, law enforcement agencies, and social service organizations. In conjunction with a review of community needs assessments, these efforts contributed to the development of an action plan for expanding mobile behavioral and mental health crisis response services in the cities of Pomona, Claremont, and La Verne. The action plan also included the training for staff involved in the Mobile Crisis Care Program in critical areas like risk management and crisis intervention and safety. In May 2023, TCMHA received a contract amendment providing an additional $300,000 to support the Crisis Care Mobile Unit Program. This amendment was fully executed in July 2023.

Fiscal Impact:

The funding source will be funds acquired for implementation through the Crisis Care Mobile Units grant and will not exceed $12,000.00.

Recommendation:

Staff recommends that the Governing Board adopt Resolution No. 775 approving the Second Amendment to the Agreement with JS Risk Consulting; and authorizing the Executive Director to execute the Amendment.

Attachments:

Attachment 8-A: Resolution No. 775 - Draft

Attachment 8-B: Second Amendment to Agreement with JS Risk Management Consulting Services

RESOLUTION NO. 775

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY APPROVING THE SECOND AMENDMENT TO AGREEMENT WITH JS RISK CONSULTING FOR RISK MANAGEMENT CONSULTING SERVICES, AND AUTHORIZING THE EXECUTIVE DIRECTOR TO EXECUTE THE AMENDMENT

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("Authority" or "TCMHA"), through its Executive Director, on August 1, 2024 entered into an agreement with JS Risk Consulting in an amount not to exceed $25,000.00, for Risk Management Consulting Services in connection with the Workplace Violence Prevention Plan/Program.

B. On October 23, 2024, the Governing Board adopted Resolution No.760, authorizing the Authority's Executive Director to execute the First Amendment to the Risk Management Consulting Services Agreement with JS Risk Consulting to: 1) extend the term of the Agreement to December 31, 2024; 2) increase the compensation for additional risk management services; and 3) modify the Scope of Services.

C. The Authority desires to execute the Second Amendment to the Risk Management Consulting Services Agreement with JS Risk Consulting to: 1) modify Scope of Services; 2) increase the compensation in a total amount not to exceed $12,000.00 for the added services; and 3) extend the term of the Agreement to June 30, 2025.

A. The Authority affirms that JS Risk Consulting is an independent contractor and not an employee, agent, joint venture or partner of TCMHA. The Agreement does not create or establish the relationship of employee and employer between JS Risk Consulting and TCMHA.

2. Action

The Authority's Executive Director is authorized to enter into and execute the Second Amendment to the Agreement with JS Risk Consulting extending the term of the Agreement to June 30, 2025; and increasing the total compensation in the amount of $12,000.00 for training in preparedness and response protocols for Mobile Crisis Care and Emergency Response Teams.

[Continues on Page 2]

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on April 16, 2025, by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

JED LEANO, CHAIR

APPROVED AS TO FORM:

STEVEN L. FLOWER, GENERAL COUNSEL

ATTEST:

MICAELA P. OLMOS, RECORDING SECRETARY

Founded in 1960
by the residents
of Pomona,
Claremont and La
Verne.

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SECOND AMENDMENT

TO

INDEPENDENT CONTRACTOR AGREEMENT

BETWEEN

TRI-CITY MENTAL HEALTH AUTHORITY

AND

JS RISK CONSULTING

DATED

APRIL 16, 2025

Administrative Office
1717 North Indian Hill
Boulevard, Suite B
Claremont, CA 91711
Phone (909) 623-6131
Fax (909) 623-4073

Clinical Office / Adult
2008 North Garey Avenue
Pomona, CA 91767
Phone (909) 623-6131
Fax (909) 865-9281

Clinical Office / Child & Family
1900 Royalty Drive, Suite 180
Pomona, CA 91767
Phone (909) 766-7340
Fax (909) 865-0730

MHSA Administrative Office
2001 North Garey Avenue
Pomona, CA 91767
Phone (909) 623-6131
Fax (909) 326-4690

Wellness Center
1403 North Garey Avenue
Pomona, CA 91767
Phone (909) 242-7600
Fax (909) 242-7691

ATTACHMENT 8-B

TABLE OF CONTENTS

SECOND AMENDMENT

INDEPENDENT CONTRACTOR AGREEMENT BY AND BETWEEN TRI-CITY MENTAL HEALTH AUTHORITY AND JS RISK CONSULTING

1. PARTIES AND DATE

This Second Amendment ("Second Amendment") is made and entered into as of April 16, 2025 ("Second Amendment Date"), by and between TRI-CITY MENTAL HEALTH AUTHORITY, a California joint powers authority ("TCMHA" or "Authority") and JS RISK CONSULTING, with its principal place of business at 29190 Ridgeline Court, Temecula, California 92590 (the "CONTRACTOR"). TCMHA and CONTRACTOR are sometimes individually referred to as a "Party" and collectively as "Parties."

2. RECITALS

a. TCMHA and CONTRACTOR entered into an Independent Contractor Agreement effective August 1, 2024 ("Agreement") for Risk Management Consulting Services.

b. On October 23, 2024, the Parties executed the First Amendment to the Agreement to: 1) extend the term of the Agreement to December 31, 2024; 2) increase the CONTRACTOR's compensation for additional risk management services; and 3) modify the Scope of Services; incorporated and made part of the First Amendment as 'Exhibit 1.'

c. The Parties desire to amend again the Agreement and execute the Second Amendment to: 1) modify Scope of Services to add training in preparedness and response protocols for Mobile Crisis Care and Emergency Response Teams; and 2) increase the compensation in a total amount not to exceed $12,000.00 for the added services; incorporated and made part of the Second Amendment as 'Exhibit 1.

d. In consideration of these Recitals and the performance by the Parties of the promises, covenants, and conditions herein contained, the Parties agree as provided in this Second Amendment.

3. AMENDMENT

a. Exhibit A (Scope of Services) to the Agreement is hereby amended by the addition thereto of Exhibit 1 to this Second Amendment; and the monthly compensation to $4,000.00 in an amount not to exceed $12,000 for the added services.

b. Section 7 (Term) of the Agreement is hereby amended and restated in its entirety to read as follows:

> "The Term of this Agreement shall be from August 1, 2024 to June 30, 2025, with an option to extend three additional months, unless earlier terminated in accordance with the provisions of Section 8 below; or renewed subject to an amendment to this Agreement."

4. REAFFIRMATION OF OTHER TERMS

Except as modified or changed herein, all of the terms and provisions of the Agreement, as amended by the Second Amendment, shall remain in full force and effect.

5. EXECUTION

The Parties have executed this Agreement as of the Second Amendment Date.

TRI-CITY MENTAL HEALTH AUTHORITY **JS RISK CONSULTING**

By: _____ By: _____
Ontson Placide, Executive Director Jiles Smith, Owner

Attest:

By: _____
Micaela P. Olmos, JPA Administrator/Clerk

Approved as to Form:
RICHARDS WATSON & GERSHON

By: _____
Steven L. Flower, General Counsel

EXHIBIT 1

JS Risk Consulting
29190 Ridgeline Court
Temecula, CA 92590

SOW ADDENDUM for agreement to perform consulting services to Tri-City Mental Health Authority

Date:	Services performed by:	Services performed for:
October 14, 2024, Addendum March 31, 2025	JS Risk Consulting 29190 Ridgeline Court Temecula, CA 92590	Tri-City Mental Health Authority 1717 N. Indian Hill Blvd. Claremont, CA 91711

Tri-City Mental Health Authority ("Client") and JS Risk Consulting ("Contractor"), effective October 1, 2024. This SOW Addendum is subject to the terms and conditions contained in the existing Agreement between the parties and is made a part thereof. Any term not otherwise defined herein shall have the meaning specified in the Agreement. In the event of any conflict or inconsistency between the terms of this SOW and the terms of this Agreement, the terms of the Agreement shall govern and prevail.

Period of performance

The Services identified in this SOW shall commence April 15, 2025, through June 30, 2025, with an option to extend for up to an additional three months as deemed necessary by TCMHA.

Background

Tri-City Mental Health Authority (Tri-City) aims to enhance staff safety and crisis response capabilities through advanced training for the Mobile Crisis Care (MCC) and Emergency Response Team (Dr. AID), including supervisors and managers. Building on the foundational CPI Nonviolent Crisis Intervention Training, this initiative focuses on managing higher-risk scenarios involving aggressive, violent, or suicidal individuals.

Scope of Work

As an addendum to the October 1, 2024 contract, JS Risk Consulting (Contractor) will research, design and deliver training through interactive tabletop exercises to improve preparedness and response protocols for MCC and Emergency Response Teams. The training will emphasize de-escalation techniques, nonviolent intervention strategies, and coordinated responses to critical incidents.

Deliverable materials

1. **Training Plan & Scenarios**
    - Document outlining learning objectives, exercise structure,
    - A set of 5-10 field-relevant crisis scenarios
2. **Interactive Training Sessions**
    - Minimum of 4 sessions for 5-10 staff members, each lasting 1-1.5 hours over 2 months from April 1, 2025 through June 15, 2025.
    - Interactive role-playing, tabletop exercise, and debriefings with multidisciplinary teams.
3. **Participant Materials**
    - Quick-reference guides and handouts on crisis response strategies
4. **Final Report & Recommendations**
    - Summary of training outcomes, participant feedback, and observed gaps.

Contractor responsibilities

- JS Risk Consulting (Contractor) will be responsible for the following:

1. **Research & Needs Assessment**
    - Review existing crisis intervention policies, past incidents, and best practices and identify any gaps.
    - Consult with Tri-City stakeholders (MCC, ERTs) to tailor training.
2. **Curriculum & Scenario Development**
    - Design advanced, realistic crises, scenario-based tabletop exercises that build on CPI training and align with trauma-informed and culturally sensitive practices.
3. **Training Delivery**
    - Facilitate interactive tabletop exercises for MCC, Emergency Response Teams, and supporting teams.
    - Facilitate role-playing, decision-making drills, and post-scenario debriefs to enhance learning.
4. **Evaluation & Reporting**
    - Assess staff competency through surveys, quizzes, or observer feedback.
    - Provide a final report with training outcomes, lessons learned, and recommendations.
    - Conduct post-training evaluation

5. **Coordination & Compliance**
    - Collaborate with Tri-City leadership to schedule sessions, secure resources, and ensure alignment with organizational standards.

Client responsibilities

To ensure the successful execution of this training project, the client agrees to:

1. Provide Access & Resources
    - Share relevant policies and past incident reports.
    - Grant access to key staff (MCC, FSP, Emergency Response Teams) for consultations.
    - Supply facility space, technology, or logistical support for training sessions.
2. Participant Coordination
    - Identify and schedule staff attendees for each session.
    - Communicate training expectations and objectives to participants.
3. Collaborate on Content
    - Review and approve training scenarios, materials, and learning objectives.
    - Provide relevant input on draft deliverables (exercises).
4. Support Implementation
    - Designate a point of contact for coordination.
    - Assist with incident debriefs or role-playing as needed.
5. Evaluate & Provide Feedback
    - Review incidents and share actionable insights on policy or procedural gaps.

Fee schedule

The Contractor will provide services at a rate of $4,000 per month, covering two training sessions each month. Invoices will be issued monthly, with Invoice #1 dated April 30, 2025 (covering services from April 1-30) and Invoice #2 dated June 15, 2025 (covering May 1-31), both payable within 15 days of receipt. The contract includes a total of four sessions (two per month), with each session lasting 1-1.5 hours as needed by the client. All sessions will be conducted in-person.

Out-of-pocket expenses/invoice procedures

Client will be invoiced monthly for the consulting services and T&L expenses. Standard Contractor invoicing is assumed to be acceptable. Invoices are due upon receipt. Any out-of-pocket expenses will be discussed and agreed upon by the Client before the Contractor incurs the expense.

Invoices shall be submitted monthly in arrears to the address indicated above. Each invoice will reflect charges for the time period being billed and cumulative figures for previous periods. Terms of payment for each invoice are due upon receipt by Client of a proper invoice. Contractor shall provide Client with sufficient details to support its invoices, including time sheets for services performed and expense receipts and justifications for authorized expenses, unless otherwise agreed to by the parties.

Completion criteria

Contractor shall have fulfilled its obligations when any one of the following first occurs:

- Contractor accomplishes the Contractor activities described within this SOW, including delivery to Client of the materials listed in the Section entitled "Deliverable Materials", and Client accepts such activities and materials without unreasonable objections.
- Contractor and/or Client has the right to cancel services or deliverables not yet provided with 10 working days advance written notice to the other party.

Tri-City Mental Health Authority
AGENDA REPORT

DATE: **April 16, 2025**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Ontson Placide, LMFT, Executive Director**

BY: **Natalie Majors-Stewart, LCSW, Chief Compliance Officer**

SUBJECT: **Consideration of Resolution No. 776 Adopting Revised Policies and Procedures Nos.: I.06, I.07, II.03, CL.III.04, CL.IV.03, CL.V.01, CL.V.02, and CL.V.11, Effective April 16, 2025**

Summary:

As part of our policy and procedure management plan, agency policies are reviewed and updated on an ongoing, or as needed basis to ensure that policies are up to date with the most current statutes, regulations, contract requirements, best practices, and internal procedures.

Background:

The following policies and procedures were reviewed and revised to ensure that policies remain relevant, effective, and compliant with current laws, regulations, standards of care, industry standards, as well as internal procedures.

Policy and Procedure No. I.06 – Keys, Key Card, and Key Code Issuance and Return: Standardizes and clarifies Key Issuance and Return requirements which supports that assurance of the security of the facilities, the security of equipment, the confidentiality of client and staff records, and the security of medications.

Policy and Procedure No. I.07 – Facilities and Ground Maintenance: To establish guidelines for the maintenance of facilities and grounds owned or operated by Tri-City Mental Health Authority.

Policy and Procedure No. II.03 – Licensure and Certification: To establish guidelines that ensure the proper and up to date credentialing of workforce members as required by federal or state law, and to maintain such credentials while providing client services on behalf of Tri-City Mental Health Authority.

Policy and Procedure No. CL.III.04 – Program Service Delivery: To describe Tri-City Mental Health Authority specialty mental health program services and how these services are delivered.

Policy and Procedure No. CL.IV.03 – Scope of Practice: To establish and define the permissible activities and limitations for workforce members based on applicable laws, professional regulations, and as defined by Tri-City Mental Health Authority.

Policy and Procedure No. CL.V.01 – Standards for Prescribing & Monitoring Medications: To establish a uniform standard for storing, administering, disposing and accountability of medications. This policy sets forth the principles for ensuring compliance with Federal, State, and County regulatory requirements.

Policy and Procedure No. CL.V.02 – Storing Administering Accountability of Medications: To establish a uniform standard for storing, administering, disposing and accountability of medications. This policy sets forth the principles for ensuring compliance with Federal, State, and County regulatory requirements.

Policy and Procedure No. CL.V.11 – Reporting Clinical Incidents Involving Clients: To establish uniform guidelines for prompt reporting of clinical incidents.

The revised draft policies are included for Governing Board review and approval. Also included are the current policy versions, with annotations of all revisions.

Funding:

None Required.

Recommendation:

Staff recommends that the Governing Board adopt Resolution No. 776 establishing the revised Policy and Procedures Nos.: I.06, I.07, II.03, CL.III.04, CL.IV.03, CL.V.01, CL.V.02, and CL.V.11, effective April 16, 2025.

Attachments:

Attachment 9-A: Resolution No. 776 - Draft
Attachment 9-B: Policy & Procedure I.06 – Keys, Key Card, and Key Code Issuance and Return
Attachment 9-C: Policy & Procedure I.07 – Work Orders
Attachment 9-D: Policy & Procedure II.03 – Licensure and Certification
Attachment 9-E: Policy & Procedure CL.III.04 – Program Service Delivery
Attachment 9-F: Policy & Procedure CL.IV.03 – Scope of Practice
Attachment 9-G: Policy & Procedure CL.V.01 – Standards for Prescribing & Monitoring Medications
Attachment 9-H: Policy & Procedure CL.V.02 – Storing Administering Accountability of Medications
Attachment 9-I: Policy & Procedure CL.V.11 – Reporting Clinical Incidents Involving Clients

RESOLUTION NO. 776

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY ADOPTING THE AUTHORITY'S REVISED POLICIES AND PROCEDURES NOS.: I.06, I.07, II.03, CL.III.04, CL.IV.03, CL.V.01, CL.V.02, AND CL.V.11, EFFECTIVE APRIL 16, 2025

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("TCMHA" or "Authority") desires to update its Policies and Procedures Nos. I.06, I.07, II.03, CL.III.04, CL.IV.03, CL.V.01, CL.V.02, and CL.V.11**,** respectively, to comply with current statues, regulatory requirements, contract requirements as well as the Authority's best practices and internal procedures.

B. TCMHA Policies and Procedures are routinely reviewed and updated to ensure they are relevant, effective, and compliant with current regulations, mandates, and processes.

2. Action

The Governing Board approves the Authority's revised Keys, Key Card, and Key Code Issuance and Return Policy & Procedure No. I.06; Work Orders Policy & Procedure No. I.07; Licensure and Certification Policy & Procedure No. II.03; Program Service Delivery Policy & Procedure No. CL.III.04; Scope of Practice Policy & Procedure No. CL.IV.03; Standards for Prescribing & Monitoring Medications Policy & Procedure No. CL.V.01; Storing Administering Accountability of Medications Policy & Procedure No. CL.V.02; and Reporting Clinical Incidents Involving Clients Policy & Procedure No. CL.V.11, effective April 16, 2025 respectively, replacing and superseding all previous versions.

[Continues on Page 2]

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on April 16, 2025 by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

JED LEANO, CHAIR

APPROVED AS TO FORM:

STEVEN L. FLOWER, GENERAL COUNSEL

ATTEST:

MICAELA P. OLMOS, RECORDING SECRETARY

TRI-CITY MENTAL HEALTH AUTHORITY
POLICY & PROCEDURE

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Facilities and Grounds Maintenance	**I.07**	**04/16/2025**	**1** of **4**
APPROVED BY: **Governing Board** **Executive Director**	**SUPERCEDES:** **09/21/2005**	**ORIGINAL ISSUE DATE:** **02/28/2002**	**RESPONSIBLE PARTIES:** **Facilities Department**

1. PURPOSE

1.1 To establish guidelines for the maintenance of facilities and grounds owned or operated by Tri-City Mental Health Authority.

2. DEFINITIONS

When used in this Policy, the following terms shall have the meanings hereinafter set forth unless the context indicates otherwise:

2.1 **Facilities:** Any building, office, place, grounds, equipment owned or operated for a particular purpose.

2.2 **Grounds:** Any land and outdoor areas surrounding a facility, including things like lawns, landscaping, and walkways.

2.3 **Workplace Hazard:** Any condition within a work environment that is dangerous and/or has the capacity to cause, harm, injury, illness or damage. Hazards can be physical, environmental, structural, biological, chemical, ergonomic, etc.

2.4 **Work Order:** A formal request for a task, project, maintenance, and/or repair.

3. POLICY

3.1 All Tri-City Mental Health Authority facilities and grounds shall be maintained in good condition to ensure safety and well-being of clients, workforce members, and visitors.

3.2 Facilities staff will conduct daily inspections of the building when conducting general cleaning and maintenance.

3.3 Workforce members are responsible for understanding and adhering to all Facilities and Safety guidelines.

3.4 Workforce members shall identify and report potential hazards, safety concerns, maintenance issues, damage within the facility.

3.5 Workforce members shall keep their work areas and common areas clean, organized and in good working condition.

4. PROCEDURES

General Maintenance

4.1 The property and structures are to be maintained in good and clean condition.

4.2 The buildings and grounds shall be free of environmental pollutants and such nuisances as may adversely affect the health and welfare of consumers, to the extent that such conditions are within the reasonable control of the Tri-City.

4.3 The building shall be maintained to ensure that the premises are free from vermin and rodents through pest control services.

4.4 The Facilities Department shall ensure that air filters for the heating and air conditioning system are routinely inspected, cleaned and replaced as necessary to maintain the system in normal operating condition.

4.5 The water supply and plumbing must be in operating condition. This includes plumbing, drainage facilities and drinking water supplies, which shall be maintained consistent with Part 5, Title 24 of the California Code of Regulations related to basic plumbing requirements. Restrooms must also be maintained in operating condition.

4.6 All rooms, passageways and other spaces used by workforce members, clients, and or visitors, must have artificial illumination. Auxiliary lighting must be provided to ensure sufficient lighting to handle emergency egress when needed. Flashlights shall always be available and ready for use, at designated locations.

4.7 All rooms will be labeled with a number. Treatment rooms are to remain unlocked. Staff rooms and rooms with restricted access must be locked.

Work Orders

4.8 A work order is required for all agency non-emergency facilities requests. Work Orders are to be maintained by the facilities manager.

4.8.1 For any major emergent facilities requests, (such as broken water pipes, flooding, power outage, major damage, fire, etc.) workforce members must immediately get to safety and then contact the Facilities Manager directly.

Safety Hazard – Reporting and Response

4.9 When a workplace hazard or potential workplace hazard is identified, Tri-City Mental Health Authority workforce members are responsible for immediately reporting the hazard to the Facilities Department.

4.9.1 Potential workplace hazards include spilled materials or liquids in any area where someone might fall, walkways that are unclean or littered, restrooms that are unsanitary or not in good working condition, etc.

4.10 The Facilities staff shall identify the hazard and take immediate corrective action to abate the hazard. The response time to identify a hazard called in to the Facilities Department is approximately within twenty-four (24) hours depending on the urgency and approval process.

4.11 While corrective action is in progress, necessary precautions are to be taken to protect or remove any individuals from exposure to the hazard. Workforce member shall not enter an imminent hazard area without specific approval.

4.12 Hazards shall be assessed and reviewed to determine if any safety awareness (i.e. safety emails or other communication) or corrective action is required.

4.12.1 Safety/Hazard assessments and abatement forms will be completed to identify the overall action plan to correct the hazard.

4.12.2 Safety/Hazard assessments and abatement forms are to be maintained by the facilities manager.

5. REFERENCES

5.1 California Code of Regulations Title 24

5.2 California Code of Regulations Title 9 Sections 787.00 to 787.27

5.3 TCMHA Emergency Operations Plan

5.4 TCMHA Injury and Illness Prevention Program

5.5 Occupational Safety and Health Administration Regulations (OSHA)

TRI-CITY MENTAL HEALTH AUTHORITY

POLICY & PROCEDURE

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
~~WorkOrders~~ Facilities and Grounds Maintenance	I.07	~~09/21/2005~~ 4/16/2025	1 of 3
APPROVED BY:	**SUPERCEDES:** 9/21/2025	**ORIGINAL ISSUE DATE:**	**RESPONSIBLE PARTIES:**
Governing Board Executive Director		02/28/2002	~~Director of Operations~~ Facilities Department

1. PURPOSE

To establish guidelines as to the order of work requests to maintain the integrity and safety of the Tri-City Mental Health Authority buildings.

2. DEFINITIONS

2.1 Facilities: Any building, office, place, grounds, equipment owned or operated for a particular purpose.

2.2 Grounds: Any land and outdoor areas surrounding a facility, including things like lawns, landscaping, and walkways.

2.3 Workplace Hazard: Any condition within a work environment that is dangerous and/or has the capacity to cause, harm, injury, illness or damage. Hazards can be physical, environmental, structural, biological, chemical, ergonomic, etc.

2.4 Work Order: A formal request for a task, project, maintenance, and/or repair.

3. POLICY

3.1 All Tri-City Mental Health Authority ~~employees shall maintain the physical facility~~ facilities and grounds shall be maintained in good condition to ensure safety and well-being of clients, workforce members, and visitors. ~~of consumer, staff and visitors. All workplace hazards are to be immediately reported to the Facilities Department as soon as the workplace hazard is discovered.~~

3.2 Facilities staff will conduct daily inspections of the building when conducting general cleaning and maintenance.

3.3 Workforce members are responsible for understanding and adhering to all Facilities and Safety guidelines.

3.4 Workforce members shall identify and report potential hazards, safety concerns, maintenance issues, damage within the facility

3.5 Workforce members shall keep their work areas and common areas clean, organized and in good working condition.

4. PROCEDURES

~~Safety Hazard – Reporting and Response~~ **General Maintenance**

4.1 The property and structures are to be maintained in good and clean condition.

4.2 The buildings and grounds shall be free of environmental pollutants and such nuisances as may adversely affect the health and welfare of consumers, to the extent that such conditions are within the reasonable control of the Tri-City.

4.3 The building shall be maintained to ensure that the premises are free from vermin and rodents through pest control services.

4.4 The Facilities Department shall ensure that air filters for the heating and air conditioning system are routinely inspected, cleaned and replaced as necessary to maintain the system in normal operating condition.

4.5 The water supply and plumbing must be in operating condition. This includes plumbing, drainage facilities and drinking water supplies, which shall be maintained consistent with Part 5, Title 24 of the California Code of Regulations related to basic plumbing requirements. Restrooms must also be maintained in operating condition.

4.6 All rooms, passageways and other spaces used by workforce members, clients, and or visitors, must have artificial illumination. Auxiliary lighting must be provided to ensure sufficient lighting to handle emergency egress when needed. Flashlights shall always be available and ready for use, at designated locations.

4.7 All rooms will be labeled with a number. Treatment rooms are to remain unlocked. Staff rooms and rooms with restricted access must be locked.

Work Orders

4.8 A work order is required for all agency non-emergency facilities requests. Work Orders are to be maintained by the facilities manager.

4.8.1 For any major emergent facilities requests, (such as broken water pipes, flooding, power outage, major damage, fire, etc.) workforce members must immediately get to safety and then contact the Facilities Manager directly.

~~**4.1** Potential workplace hazards include spilled materials or liquids in any area where someone might fall, walkways that are unclean or littered, restrooms that are unsanitary or not in good working condition, etc.~~

~~**4.2** Tri-City Mental Health Authority employees are responsible for immediately reporting any workplace hazards. When a workplace hazard or potential workplace hazard is identified, the employee must report the hazard to the Facilities Department, or, in their absence, the Director of Operations who will immediately contact the Facilities Department to address the workplace hazard. Either the Facilities Department staff or Director of Operations will complete a Hazard Assessment form, Investigation/Inspection & Abate Record, Work Order Request Form, and a Hazard Abatement form. (See Exhibits A, B, and C.)~~

~~**4.2.1** The Facilities staff will identify the hazard and take immediate corrective action to abate the hazard. A Hazard Abatement Form must be completed to identify the overall action plan to correct the hazard. The response time to identify a hazard called in to the Facilities~~

~~Department or Director of Operations is one hour.~~

~~**4.2.2** While corrective action is in progress, necessary precautions are to be taken to protect or remove employees and consumers from exposure to the hazard. Employees shall not enter an imminent hazard area without specific approval of the Director of Operations or designee.~~

~~**4.2.3** Hazard Assessment forms and the Abatement Correction forms are to be maintained by the Director of Operations. The assessment forms will be reviewed quarterly to determine if any safety or training courses need to be developed.~~

~~4.3 General Maintenance~~ Safety Hazard – Reporting and Response

4.9 When a workplace hazard or potential workplace hazard is identified, Tri-City Mental Health Authority workforce members are responsible for immediately reporting the hazard to the Facilities Department.

4.9.1 Potential workplace hazards include spilled materials or liquids in any area where someone might fall, walkways that are unclean or littered, restrooms that are unsanitary or not in good working condition, etc.

4.10 The Facilities staff shall identify the hazard and take immediate corrective action to abate the hazard. The response time to identify a hazard called in to the Facilities Department is approximately within twenty-four (24) hours depending on the urgency and approval process.

4.11 While corrective action is in progress, necessary precautions are to be taken to protect or remove any individuals from exposure to the hazard. Workforce member shall not enter an imminent hazard area without specific approval.

4.12 Hazards shall be assessed and reviewed to determine if any safety awareness (i.e. safety emails or other communication) or corrective action is required.

4.12.1 Safety/Hazard assessments and abatement forms will be completed to identify the overall action plan to correct the hazard.

4.12.2 Safety/Hazard assessments and abatement forms are to be maintained by the facilities manager.

~~**4.12.3** The property and structures are to be maintained in good and clean condition.~~

~~**4.12.4** The buildings and grounds shall be free of environmental pollutants and such nuisances as may adversely affect the health and welfare of consumers, to the extent that such conditions are within the reasonable control of the Tri-City.~~

~~**4.12.5** The building shall be maintained to ensure that the premises are free from vermin and rodents through operation of a pest control program.~~

~~**4.12.6** The Facilities Department shall ensure that air filters for the heating and air conditioning system are routinely inspected, cleaned and replaced as necessary to maintain the system in normal operating condition.~~

~~**4.12.7** The water supply and plumbing must be in operating condition. This includes plumbing, drainage facilities and drinking water supplies, which shall be maintained consistent with Part 5, Title 24 of the California Code of Regulations related to basic plumbing requirements. Restrooms must also be maintained in operating condition.~~

~~**4.12.8** All rooms, passageways and other spaces used by consumers or staff must have artificial illumination. Auxiliary lighting must be provided to ensure sufficient lighting to handle emergency egress when needed. Flashlights shall be in readiness for use at all times at designated locations.~~

~~**4.12.9** All rooms will be labeled with a number. Treatment rooms are to remain unlocked. Staff rooms and rooms holding medical records may be locked. The Facilities Department shall maintain duplicate keys for all offices.~~

5. LEGAL/REGULATORY REFERENCES

5.1 California Code of Regulations Title 24

5.3 TCMHA Emergency Operations Plan

5.4 TCMHA Injury and Illness Prevention Program
California Code of Regulations Title 9 Section 787.00 to 787.27 ~~787.15, 787.16, 787.17, 787.18, 787.19, 787.25~~

5.5 Occupational Safety and Health Administration Regulations (OSHA)

~~**5.1** Occupational Safety and Health Administration Regulations (OSHA)~~

~~6. FORMS~~

~~The forms associated with this Policy and Procedure may include but are not limited to:~~

~~**6.1 Exhibit A** - Hazard Assessment Form - Investigation/Inspection and Abate Record~~

~~**Exhibit B** - Work Request Form~~

~~**6.2 Exhibit C** - Hazard Abatement Form~~

EXHIBIT A

TRI-CITY MENTAL HEALTH AUTHORITY

HAZARD ASSESSMENT FORM
INVESTIGATION / INSPECTION & ABATEMENT RECORD

Date of Investigation / Inspection:

Reason for Inspection:

☐ New Equipment/Substance

Explain:

☐ New Process

Explain:

☐ New or Revised Procedure

Explain:

Name of person(s) conducting investigation:

Name of person(s) consulted:

Description of investigation: (attach additional sheets if necessary)

Findings – Including identification of hazard & severity: (attach additional sheets if necessary)

Steps taken to abate hazard & date of these steps: (attach additional sheets if necessary)

EXHIBIT B

TRI-CITY MENTAL HEALTH AUTHORITY

WORK ORDER REQUEST FORM

Send Completed Forms To: Nancy Day

Location	Description
Department: _____	☐ One Time Request ☐ Recurring Request
Describe where work is needed (i.e., suite, room number, address, piece of equipment, etc.):	Describe problem (i.e., leak, malfunction, paint, etc.):
Contact:	Needed By:

Comment(s)

_____

_____

Originator Signature: Date: Requesting Supervisor:Date:

Note: No guarantees will be made on when requested work will actually be completed.

For Office Use Only

Received By: _____ Date: _____

☐ Approved By: _____ Date: _____

☐ Denied By: _____ Date: _____

Reason: _____

For Facilities Staff Use Only

Comments: _____

Date Received: _____ Date Completed: _____

EXHIBIT C

TRI-CITY MENTAL HEALTH AUTHORITY

HAZARD ABATEMENT FORM

~~Safety/Health items identified during the (date) inspection/investigation will be submitted to the Health & Safety Committee for review, and an action plan will be developed to resolve each specific safety/health item (such as hazards, needed policies, etc.) by a fixed completion date, and by those assigned responsibility. This form will be used to document identified problems, steps to be taken, and completion deadline.~~

~~OVERALL ACTION PLAN~~

~~Action Steps to be Taken~~	~~Priority (assign each step a number)~~	~~Projected Completion Date~~	~~Date Completed~~
~~1.~~			
2.			
3.			
4.			
5.			

TRI-CITY MENTAL HEALTH AUTHORITY
POLICY & PROCEDURE

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Keys, Key Card, and Key Code Issuance and Return	**I.06**	**4/16/2025**	**1** of **6**
APPROVED BY: **Governing Board** **Executive Director**	**SUPERCEDES:** **9/18/2019**	**ORIGINAL ISSUE DATE:** **04/23/1998**	**RESPONSIBLE PARTIES:** **Facilities Manager** **Executive Team** **All Workforce Members**

1. PURPOSE

1.1 To provide a system which establishes and maintains the security of the facilities, the security of equipment, the confidentiality of client and staff records, and the security of medications.

2. DEFINITIONS

When used in this Policy, the following terms shall have the meanings hereinafter set forth unless the context indicates otherwise:

2.1 **Access:** Method of entry to a physical space that is restricted to certain individuals either on a permanent basis or during certain hours of the day.

2.2 **Electronic Access:** Use of an electronic access credential to open locked doors and other locked areas.

2.3 **Electronic Access Credential**: A method a method of proving identity and authorization to access specific areas, systems, or resources.

2.4 **Key:** A physical metal key used to access locked areas.

2.5 **Key Fob:** A small programmable device that contains electronic access credentials and provides electronic access to locked areas.

2.6 **Key Card:** A small card or id badge that contains electronic access credentials and provides electronic access to locked areas.

2.7 **Keypad Code**: A programmable numeric sequence that contains electronic access credentials and provides electronic access to locked areas

2.8 **Key Holder:** An individual authorized and issued a key or electronic access credential.

2.9 Lockable Key Cabinet or Lock Box: A controlled storage box, permanently affixed in some manner as approved by Facilities Management for the storage of keys to be shared by multiple users within a campus department or departments.

2.10 Master Key: A key or electronic credential that operates multiple locks of a given department.

2.11 Workforce: Any employee, volunteer, intern, consultant, locum tenens, trainee, contractor of TCMHA (whether paid or not paid by TCMHA). This includes individuals who provide services to clients and those who provide administrative, managerial, support services and/or other products, goods or services.

3. POLICY

3.1 Safety and security of the building and its contents is controlled through the use of keys, electronic access credentials, motion detectors with security codes, and door lock combination codes. This includes doors, desks, cabinets and mailboxes.

3.2 Authorized and designated staff in the Facilities Department, maintain control tracking, and release of all keys and electronic access credentials (exceptions in 3.3), which include external master, internal master, office door keys, and other miscellaneous keys for cabinets, desks and file cabinets.

3.2.1 All keys will be stored in a locked cabinet in the Facilities Department. Only authorized and designated facilities staff have access to the key cabinet.

3.3 The Facilities Department does have direct access or control for the following areas:

3.3.1 Medication Cabinets: The Medical Director and Medication Support Services Manager maintain control tracking, and release of any keys, key cards, and/or key codes to medication storage cabinets. Medications are kept in locked cabinets within the Medication Room.

3.4 Restricted Areas – Keys and electronic access credentials require special approval as in 3.5.2.

3.4.1 Medication room and medication storage: Medications are maintained in a locked area with limited access. Keys, key cards, and/or key codes

are controlled by the Medication Services Support Manager, or his or her designee.

3.4.2 Medical records/chart room: Records containing PHI are maintained in a secured area with limited access. Only designated and authorized staff with special approval will have a key or electronic access. Cleaning/Janitorial service is not allowed in the medical records office at any time and only can access the chart room when Medical Records staff is present.

3.4.3 I.T. Equipment: I.T. Equipment Rooms/Storage Areas are maintained in a secured area with limited access. Only designated and authorized staff with special approval will have a key or electronic access.

3.4.4 Human Resource Files: Personnel records maintained in a secured area with limited access. Only designated and authorized staff with special approval will have a key or electronic access.

3.4.5 Departmental Restricted Areas: Departments may also have additional access controls for items such as file cabinets, desks, etc.

3.5 Requests for Keys:

3.5.1 Requests for the release of any keys and/or electronic access credentials must be requested by a supervisor and submitted to the Facilities Department.

3.5.2 Requests for Keys to Restricted Areas (3.4) : In addition to 3.5.1, supervisors must also obtain approval from both their Department Director or Program Manager as well as additional approval from the director overseeing the restricted areas, prior to release of keys or access permission. when making any keys, key cards, and/or key codes request for their staff.

3.6 Key Holder Responsibilities

3.6.1 Keys and electronic access credentials are the responsibility of the individual to whom they are issued and shall not be shared with any other person. The borrowing, lending, exchanging, or duplicating of any key (physical metal keys and electronic access credentials) is prohibited.

3.6.2 Key holders assume responsibility for the safekeeping of the key(s) and its use. When leaving a facility area or building, all doors must be secured as they were upon arrival.

3.6.3 Key holders or others shall not prop doors open or leave them unlocked during hours when the facility is normally closed.

3.6.4 Key holders shall not unlock buildings or rooms for others.

3.6.5 Workforce members separating from TCMHA must return any issued keys or electronic credential to Facilities Management. Upon notification from the department, Facilities Management will deactivate electronic access for separating employees.

4. PROCEDURES

4.1 Key and Electronic Access Credential Control

4.1.1 The Facilities Manager oversees the system of key and electronic access, monitoring, and control.

4.1.2 All unused keys will be stored in a locked cabinet in the facilities department. The Facilities staff has the only access to the key cabinet.

4.1.3 The Facilities Manager or authorized designee in the Facilities Department will maintain a Key Control Form on each staff member who has been issued keys. The form will show what keys have been released, exchanged or returned and the date. The staff member will initial each transaction.

4.1.4 The Facilities Manager or authorized designee in the Facilities Department will maintain an electronic access control system on each staff member who has granted key card or key code access. The system will track what key cards, and/or key codes have been active/deactivated, areas of access and dates of access.

4.2 Key Authorization / De-authorization

4.2.1 Supervisors will email the facilities department to request and authorize the specific keys or electronic key access credentials for their direct work force member reports.

4.2.2 Keys: the facilities department will provide the requested keys directly to the staff receiving the key and have them sign the Key Control Form.

4.2.2.1 Master keys will only be issued to authorized leadership members, by special request and permission.

4.2.3 Electronic Key Access: The facilities department designee will provide the electronic key access credentials directly to the staff which will be logged in the electronic access control system.

4.2.4 Upon termination, staff will return keys during their exit meeting on their last day of employment, prior to termination. Electronic access credentials will also be deactivated upon termination. Tri-City may also require that staff return keys or may deactivate electronic access credentials at any time during their employment.

4.2.4.1 Return of Keys/Deactivation for Medication Cabinets**:** Upon termination, staff will return keys to the Medical Director/Medication Support Services Manager, prior to receiving their final paycheck. Electronic access credentials will also be deactivated upon termination. Tri-City may also require that staff return keys or may deactivate electronic access credentials at any time during their employment.

4.2.5 Lost/missing/stolen keys shall be reported to the Facilities Department and the workforce members supervisor, as soon as possible after the key holder determines a key is missing. The Facilities Manager or designee will determine whether or not a re-keying of the affected building(s) and/or locks will be necessary as a result of any keys that are lost/missing/stolen.

4.2.6 If keys are lost or stolen in the workplace, workforce members will be responsible for the expenses involved in replacing keys and for re-keying of locks due to such loss and will sign a statement acknowledging this fact.

5. REFERENCES

5.1 Code of Federal Regulations Title 45 Sections 164.310(a)(1) and (2), HIPAA Security Rule

5.2 Code of Federal Regulations Title 45 Section 164.306

5.3 Welfare and Institutions Code: Code 5328 et. seq.

5.4 California Code of Regulations: 8 CCR § 3342 (Title 8>Division 1. Department of Industrial Relations>Chapter 4. Division of Industrial Safety>Subchapter 7. General Industry Safety Orders>Group 2. Safe Practices and Personal Protection>Article 7. Miscellaneous Safe Practices)

TRI-CITY MENTAL HEALTH AUTHORITY

POLICY & PROCEDURE

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Keys, Key Card, and Key Code Issuance and Return	**I.06**	~~**9/18/2019**~~ **4/16/2025**	**1 of 5**
APPROVED BY:	**SUPERCEDES:**	**ORIGINAL ISSUE DATE:**	**RESPONSIBLE PARTIES:**
Executive Director **Governing Board**	~~**11/16/2005**~~ **9/18/2019**	**04/23/1998**	~~Chief Operations Officer~~ Facilities Manager ~~HR Manager~~ ~~Medication Support Services Mngr~~ ~~IT Manager/Security Officer~~ ~~Support Systems Manager~~ Executive Team All workforce members

1. PURPOSE

To provide a system which establishes and maintains the security of the facilities, the security of equipment, the confidentiality of client and staff records, and the security of medications.

2. DEFINITIONS

When used in this Policy, the following terms shall have the meanings hereinafter set forth unless the context indicates otherwise:

2.1 Access: Method of entry to a physical space that is restricted to certain individuals either on a permanent basis or during certain hours of the day.

2.2 Electronic Access: Use of an electronic access credential to open locked doors and other locked areas.

2.3 Electronic Access Credential: A method a method of proving identity and authorization to access specific areas, systems, or resources.

2.4 Key: A physical metal key used to access locked areas.

2.5 Key Fob: A small programmable device that contains electronic access credentials and provides electronic access to locked areas.

2.6 Key Card: A small card or id badge that contains electronic access credentials and provides electronic access to locked areas.

2.7 Keypad Code: A programmable numeric sequence that contains electronic access credentials and provides electronic access to locked areas

2.8 Key Holder: An individual authorized and issued a key or electronic access credential.

2.9 Lockable Key Cabinet or Lock Box: A controlled storage box, permanently affixed in some manner as approved by Facilities Management for the storage of keys to be shared by multiple users within a campus department or departments.

2.10 Master Key: A key or electronic credential that operates multiple locks of a given department.

2.11 Workforce: Any employee, volunteer, intern, consultant, locum tenens, trainee, contractor of TCMHA (whether paid or not paid by TCMHA). This includes individuals who provide services to clients and those who provide administrative, managerial, support services and/or other products, goods or services.

3. POLICY

~~3.1~~ Safety and security of the building and its contents is controlled through the use of keys, electronic access credentials, motion detectors with security codes, and door lock combination codes. This includes doors, desks, cabinets and mailboxes. ~~Keys, key cards, and/or key codes are not to be copied or loaned under any circumstances. Master Keys are retained and controlled by the Facilities Department with the exception of medical records rooms and medication rooms.~~

3.2 Authorized and designated staff in the Facilities Department, maintain control tracking, and release of all keys and electronic access credentials (exceptions in 3.3), which include external master, internal master, office door keys, and other miscellaneous keys for cabinets, desks and file cabinets. ~~Keys, key cards, and/or key codes to the medical records department are limited. The Chief Operations Officer and the Department Director of the staff member must provide written authorization to the HR Department for the release of any keys, key cards, and/or key codes.~~

3.2.1 All keys will be stored in a locked cabinet in the Facilities Department. Only authorized and designated facilities staff have access to the key cabinet.

3.3 The Facilities Department does have direct access or control for the following areas:

3.3.1 Medication Cabinets: The Medical Director and Medication Support Services Manager maintain control tracking, and release of any keys, key cards, and/or key codes to medication storage cabinets. Medications are kept in locked cabinets within the Medication Room.

3.4 Restricted Areas – Keys and electronic access credentials require special approval as in 3.5.2. ~~Offices, cabinets and/or file door cabinets where medications are stored must be secured at all times. Keys, key cards, and/or key codes to medication room, cabinets and file doors are limited. The Medication Support Services Manager provides authorization, tracking, and release of any keys, key cards, and/or key codes to the medication room and/or medication storage cabinets.~~

3.4.1 Medication room and medication storage: Medications are maintained in a locked area with limited access. Keys, key cards, and/or key codes are controlled by the Medication Services Support Manager, or his or her designee.

3.4.2 Medical records/chart room: Records containing PHI are maintained in a secured area with limited access. Only designated and authorized staff with special approval will have a key or electronic access. Cleaning/Janitorial service is not allowed in the medical records office at any time and only can access the chart room when Medical Records staff is present.

3.4.3 I.T. Equipment: I.T. Equipment Rooms/Storage Areas are maintained in a secured area with limited access. Only designated and authorized staff with special approval will have a key or electronic access.

3.4.4 Human Resource Files: Personnel records maintained in a secured area with limited access. Only designated and authorized staff with special approval will have a key or electronic access.

3.4.5 Departmental Restricted Areas: Departments may also have additional access controls for items such as file cabinets, desks, etc. ~~Departments may have their own key/access controls for such things as file cabinets, desks, etc. Security codes are changed and doors may be re-keyed, as needed.~~

3.4.6

3.5 Requests for Keys:

3.5.1 Requests for the release of any keys and/or electronic access credentials must be requested by a supervisor and submitted to the Facilities Department.

3.5.2 Requests for Keys to Restricted Areas (3.4) : In addition to 3.5.1, supervisors must also obtain approval from both their Department Director or Program Manager as well as additional approval from the director overseeing the restricted areas, prior to release of keys or access permission. when making any keys, key cards, and/or key codes request for their staff.

3.6 Key Holder Responsibilities

3.6.1 Keys and electronic access credentials are the responsibility of the individual to whom they are issued and shall not be shared with any other person. The borrowing, lending, exchanging, or duplicating of any key (physical metal keys and electronic access credentials) is prohibited.

3.6.2 Key holders assume responsibility for the safekeeping of the key(s) and its use. When leaving a facility area or building, all doors must be secured as they were upon arrival.

3.6.3 Key holders or others shall not prop doors open or leave them unlocked during hours when the facility is normally closed.

3.6.4 Key holders shall not unlock buildings or rooms for others.

3.6.5 Workforce members separating from TCMHA must return any issued keys or electronic credential to Facilities Management. Upon notification from the department, Facilities Management will deactivate electronic access for separating employees.

4. PROCEDURES

4.1 Key and Electronic Access Credential Control

4.1.1 The Facilities Manager oversees the system of key and electronic access, monitoring, and control. ~~The Facilities Department maintains control of all keys, which include external master, internal master, office door keys, and other miscellaneous keys for cabinets, desks and file cabinets. The medical records rooms and medication rooms are the only exceptions.~~

4.1.2 All unused keys will be stored in a locked cabinet in the facilities department. The Facilities staff has the only access to the key cabinet.

4.1.3 The Facilities Manager or authorized designee in the Facilities Department will maintain a Key Control Form on each staff member who has been issued keys. The form will show what keys have been released, exchanged or returned and the date. The staff member will initial each transaction.

4.1.4 The Facilities Manager or authorized designee in the Facilities Department will maintain an electronic access control system on each staff member who has

granted key card or key code access. The system will track what key cards, and/or key codes have been active/deactivated, areas of access and dates of access.

~~**4.1.5** The Human Resources (HR) Department will maintain a Key Control Form (Exhibit A) on each staff member who has been issued keys. The form will show what keys, key cards, and/or key codes had been released, exchanged or returned and the date. The staff member will initial each transaction.~~

~~**4.1.5.1** Keys are controlled by the Facilities Department. Keys will be stored in a locked cabinet in the Facilities Department. The Facilities staff has the only access to the key cabinet.~~

~~**4.1.5.2** The Facilities Department controls master keys. Master keys are issued to the Executive Team, HR, IT Manager and Facilities staff.~~

~~**4.1.5.3** The Chief Operations Officer controls the issuance of keys, key cards, and/or key codes for the administrative offices. Keys and security codes are issued to the Executive Director, Chief Financial Officer, Chief Operations Officer, Chief Clinical Officer, Human Resources Manager, IT Manager/HIPAA Security Officer and Joint Powers Authority Administrator/Clerk. Except for the internal master key, all other keys open specific internal office doors.~~

~~**4.1.5.4** Clinical records are maintained in a secured area with limited key access. Only 3 authorized staff will have a key, key card, and/or key code to the medical records office. The Chief Operations Officer controls access to the medical records office. Medical records are kept on open shelving at 2008 N. Garey and locked cabinets at 1900 Royalty Drive. Consumer charts are picked up and deposited by authorized staff only. Cleaning/Janitorial service is not allowed in the medical records office at any time and only can access the chart room when Medical Records staff is present.~~

~~**4.1.5.5** Medication room and medication storage keys, key cards, and/or key codes are controlled by the Medication Services Support Manager, or his or her designee. Medications are kept in a locked area designated for medications.~~

~~**4.1.5.6** When a consumer brings in medication which needs to be taken at the time the consumer is involved in treatment, the authorized medication team personnel is responsible for ensuring that the medication is stored in a locked container and area.~~

~~**4.1.5.7** The HR Department controls personnel records. Staff records are kept in locked file cabinets in the HR Department.~~

~~**4.1.5.8** MIS / IT equipment is locked and controlled by the IT Manager/HIPAA Security Officer. MIS / IT staff have access to this area.~~

4.2 Key Authorization / De-authorization

~~Managers / supervisors will complete the Key Authorization Form (Exhibit B) and submit to the HR Department. The Facilities Department will provide the requested keys to HR for staff pick-up and completion of Key Control Form.~~

4.2.1 Supervisors will email the facilities department to request and authorize the specific keys or electronic key access credentials for their direct work force member reports. ~~Upon termination, staff will return keys to the HR Department prior to receiving their final paycheck. Key card/code access will also be deactivated upon termination. Tri-City may also require that staff return keys or may deactivate access card/code at~~

~~any time during their employment.~~

4.2.2 Keys: the facilities department will provide the requested keys directly to the staff receiving the key and have them sign the Key Control Form.~~Medical Records: Upon termination, staff will return keys to the Chief Operations Officer, prior to receiving their final paycheck. Key card/code access will also be deactivated upon termination. Tri-City may also require that staff return keys or may deactivate access card/code at any time during their employment.~~

4.2.3 Electronic Key Access: The facilities department designee will provide the electronic key access credentials directly to the staff which will be logged in the electronic access control system.Medication Room/Cabinets: Upon termination, staff will return keys to the Medication Services Support Manager, prior to receiving their final paycheck. Key card/code access will also be deactivated upon termination. Tri-City may also require that staff return keys or may deactivate access card/code at any time during their employment.

4.2.4 Upon termination, staff will return keys during their exit meeting on their last day of employment, prior to termination. Electronic access credentials will also be deactivated upon termination. Tri-City may also require that staff return keys or may deactivate electronic access credentials at any time during their employment.

4.2.4.1 Return of Keys/Deactivation for Medication Cabinets: Upon termination, staff will return keys to the Medical Director/Medication Support Services Manager, prior to receiving their final paycheck. Electronic access credentials will also be deactivated upon termination. Tri-City may also require that staff return keys or may deactivate electronic access credentials at any time during their employment.

4.2.5 Lost/missing/stolen keys shall be reported to the Facilities Department and the workforce members supervisor, as soon as possible after the key holder determines a key is missing. The Facilities Manager or designee will determine whether or not a re-keying of the affected building(s) and/or locks will be necessary as a result of any keys that are lost/missing/stolen.

4.2.6 If keys are lost or stolen in the workplace, workforce members will be responsible for the expenses involved in replacing keys and for re-keying of locks due to such loss, and will sign a statement acknowledging the fact.

~~4.3 Lost Keys~~

~~If keys are lost or stolen in the workplace, staff will be responsible for the expenses involved in replacing keys and for re-keying of locks due to such loss, and will sign a statement acknowledging the fact.~~

5. REFERENCES

5.1 Welfare and Institutions Code 5328 et. seq.

5.2 California Code of Regulations, Title 22

6. FORMS

The forms associated with this Policy and Procedure may include but are not limited to:

6.1 **Exhibit A** - Key Control Form

6.2 **Exhibit B** - Key Authorization Form

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Keys, Key Card, and Key Code Issuance and Return	I.06	9/18/2019	2 of 5

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Keys, Key Card, and Key Code Issuance and Return	I.06	9/18/2019	3 of 5

TRI-CITY MENTAL HEALTH AUTHORITY

POLICY & PROCEDURE

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Licensure and Certification	**II.03**	**04/16/2025**	**1** of **3**
APPROVED BY: **Governing Board** **Executive Director**	**SUPERCEDES:** 09/21/2005	**ORIGINAL ISSUE DATE:** 02/04/1997	**RESPONSIBLE PARTIES:** Chief Compliance Officer Chief Clinical Officer Medical Director Human Resources

1. PURPOSE

1.1 To provide a system that ensures the proper and up to date credentialing of workforce members as required by federal or state law, and to maintain such credentials while providing client services on behalf of Tri-City Mental Health Authority (TCMHA).

2. DEFINITIONS

When used in this Policy, the following terms shall have the meanings hereinafter set forth unless the context indicates otherwise:

2.1 **Client:** Any individual who has been referred for, has requested, or has received mental health and/or substance use services or programs. The term "client" includes those who meet the above criteria and may also be referred to as beneficiaries, clients, consumers, members, participants, survivors, patients, or ex-patients.

2.2 **Credentials:** A document that identifies and attests to qualifications, competence, or authority in a particular field or practice. Credentials can include, but are not limited to a license, registration, waivers, certifications, certificates, DEA number, furnishing number, degree, diploma, etc.

2.3 **Credentialing:** The process of verifying and assessing a service provider's professional records, education, training, skills, and experience to confirm that the services is qualified to provide and claim for services in their stated discipline.

2.4 **Rendering Service Provider:** An individual service provider who is credentialed to provide healthcare services.

2.5 **Workforce member:** Any TCMHA employee, volunteer, intern, consultant, locum tenens, trainee, or contractor, whether or not they are paid by TCMHA. This includes individuals who provide services to clients and those who provide administrative, managerial, support services and/or other products, goods or services.

3. POLICY

3.1 All workforce members with a job description, payroll title, or job duties that has a particular credential requirement must maintain valid and active status for that credential, at all times.

3.2 Workforce members must provide proof of their credentials upon hire, when going through the credentialing process, at each period of renewal, and as otherwise requested or required.

3.3 Workforce members who materially falsify their employment record as it relates to credentials, education, examination status will be subject to disciplinary action.

3.4 Workforce members that will render treatment services as part of their job description and duties, must be approved by the TCMHA credentialing team to ensure that the provider is eligible and qualified to provide and claim for treatment services.

3.5 Workforce members are responsible for renewing their credentials, prior to the expiration date.

3.5.1 Workforce members are responsible for meeting any requirements in sufficient time, such as: obtaining continuing education, completing exams, paying fees, and updating statuses, etc., so that their credentials are continuously in force.

3.6 It is the responsibility of the workforce remember to maintain adequate knowledge and skills to perform their duties as well as to ensure they are free of any legal or disciplinary actions to ensure the delivery of safe, legal, and professional services to clients.

3.7 Workforce members who fail to renew their credentials prior to the expiration date will be prohibited from providing services, if that particular credential is required to perform services.

3.8 Workforce members who fail to renew their credentials prior to the expiration date, may be subject to disciplinary action.

3.9 Any Workforce member who misrepresents or fails to make a timely report of any change of status to his/her license may be subject to disciplinary action,

3.10 Workforce members will only function within the scope of their respective credential.

3.11 Workforce members shall avoid misrepresentation of their own professional credentials, qualifications, affiliations, and purposes, or those of the colleagues, institutions, and organization with which the staff member is associated.

3.12 It is the responsibility of the workforce member to disclose to their Program Manager or supervisor, in writing, immediately should the workforce member become excluded, suspended or debarred from providing direct or indirect services under any federally funded health care program during the course of their appointment as a workforce member.

3.13 Any workforce member suspected or confirmed to be excluded, suspended, debarred from providing services, or has been charged with a criminal offense related to health care, will be subject to investigation and discipline procedures in accordance with Policy II-18.

4. PROCEDURES

4.1 Workforce members whose job description, payroll title, or job duties require specific credentials must submit valid proof of the required credentials.

4.2 Workforce members must ensure that Human Resources has a copy of their current credentials on file, as all times.

4.3 Human Resources will pre-screen applicant credentials prior to an offer for employment. If the pre-screening indicates issues, notification will be sent to the hiring director, manager or supervisor.

4.4 Copies of workforce member licenses and credentials will be requested and maintained by Human Resources and stored in the workforce member's personnel file.

4.5 Copies of Rendering Service Providers credentials will be stored and maintained in the workforce member's credentialing file.

4.6 Workforce members must immediately report to their supervisor, if their credentials have expired or have been suspended or revoked by the issuing agency.

4.7 At approximately 30 days in advance of the renewal date, a reminder will be sent to any Rendering Service Provider of their upcoming credential expiry.

4.8 Credentials are reviewed in accordance with Policy II-18. However, workforce members credentials may be reviewed at any time during the course of

employment.

5. LEGAL/REGULATORY REFERENCES

5.1 California Code, Business and Professions Code > Division 2

5.2 By the authority of the Governing Board as outlined in the TCMHA Personnel Rules & Regulations.

5.3 TCMHA Policy II-18: Workforce Members Ability to Provide Goods and Services Under Federally Funded Health Care Programs

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Licensure and Certification	11.03	**04/16/2025**	**5 of 5**

TRI-CITY MENTAL HEALTH AUTHORITY

POLICY & PROCEDURE

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Licensure and Certification	11.03	~~09/21/2005~~ 04/16/2025	1 of 3
APPROVED BY: Governing Board Executive Director	SUPERCEDES: 09/21/2005	ORIGINAL ISSUE DATE: 02/04/1997	RESPONSIBLE PARTIES: Human Resources ~~Program Chief~~ Chief Compliance Officer Chief Clinical Officer Medical Director

1 1. PURPOSE

1.1 To provide a system of ensuring the proper and ~~current~~ up to date credentialing of ~~staff and subcontract personnel~~ workforce members ~~who are~~ as required by federal or state law, ~~to be credentialed,~~ and to maintain such credentials while providing client services ~~in the employ of the Tri-City~~ on behalf of Tri-City Mental Health Authority (TCMHA).

2. DEFENITIONS

When used in this Policy, the following terms shall have the meanings hereinafter set forth unless the context indicates otherwise:

2.1 Workforce member – Any TCMHA employee, volunteer, intern, consultant, locum tenens, trainee, or contractor, whether or not they are paid by TCMHA. This includes individuals who provide services to clients and those who provide administrative, managerial, support services and/or other products, goods or services.

2.2 Credentialing – The process of verifying and assessing a service provider's professional records, education, training, skills, and experience to confirm that the services is qualified to provide and claim for services in their stated discipline

~~1.2~~2.3 Rendering Service Provider – A individual service provider who is credentialed to provide renders healthcare services.

2.4 Client- Any individual who has been referred for, has requested, or has received mental health and/or substance use services or programs. The term "client" includes those who meet the above criteria and may also be referred to as beneficiaries, clients, consumers, members, participants, survivors, patients, or ex-patients.

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POLICY

3.1 It is the policy of TCMHA ~~Tri-City to hire certain staff who must possess current licensure or certification, clear of legal and/or disciplinary actions, in order to provide legal, safe and professional services to clients.~~ that all workforce members with a job description, payroll title, or job duties that require a particular license, certification, or certificate, must provide proof and maintain valid and active license/certification status, at all times. Workforce members are responsible for renewing their license/certification, prior to the expiration date as well as maintaining adequate knowledge and skills to perform their duties. They must also be free of any legal or disciplinary actions to ensure the delivery of safe, legal, and professional services to clients.

3.2 Workforce members will only function within the scope of practice of their respective license, certificate, or job title/ role. If their role requires additional or specific certification, the workforce member is required to obtain and maintain current and valid certification to perform required job duties.

~~2.3~~3.3 Workforce members shall avoid misrepresentation of their own professional qualifications, affiliations, and purposes, or those of the colleagues, institutions, and organization with which the staff member is associated.

~~2.4~~3.4 Workforce members that intend to be a Rendering Services Provider, must be approved by the TCMHA credentialing team to ensure that the provider is eligible and qualified to provide and claim for services.

~~2.5~~3.5 Rendering service Providers who fail to renew their license or certification prior to the expiration date will be prohibited from providing services were said license or certification is required.

~~2.6~~3.6 All Workforce members who fail to renew their license or certification prior to the expiration date, may be subject to disciplinary action.

~~2.7~~3.7 Failure of supervisors to ensure that their ~~employee's~~ Rendering provider licenses or certifications are renewed prior to their expiration dates will result in disciplinary action of the supervisor.

~~2.8~~3.8 It is the responsibility of the workforce member to disclose to their Program Manager or supervisor, in writing, immediately should the employee become excluded, suspended or debarred from providing direct or indirect services under any federally funded health care program during the course of their appointment as a workforce member.

~~2.9~~3.9 Any workforce member suspected or confirmed to be excluded, suspended, debarred from providing services, or has been charged with a criminal offense related to health care, will be subject to investigation and discipline procedures in accordance with Policy II-18.

3 PROCEDURES

~~3.1 **General**~~

4.1 Workforce members whose roles require licensure and are pre-licensed, must be registered with their respective licensing board or have an approved waiver. These workforce members may may perform their duties for which they have been appropriately trained for under the supervision of a licensed professional in the same discipline and are subject to the following conditions

4.1.1 Clinical Social Worker, Marriage and Family Therapist, and Professional Clinical Counselor who are acquiring the experience required for licensure must be registered with the Board of Behavioral Sciences and subject to regulations of that Board. No waiver is needed, nor can one be obtained. Proof of licensure must be provided to Human Resources when it is obtained. The Board of Behavioral Sciences requires that licensure be obtained no longer than six years from the date of initial registration application to the Board, and that registration be renewed annually. Failure to maintain active registration with the Board or to obtain licensure within the six-year period may result in restriction of practice, demotion or termination.

4.1.2 For Psychologists, waivers from the State Department of Mental Health are required and will be requested prior to employment. Human Resources will forward the request and keep a copy of the State's determination in the employee's file. Proof of Licensure must be provided once it is obtained. A waiver may not exceed five years from the date it is granted. Failure to acquire California licensing by the end of the waivered period may result in restriction of practice, demotion or termination.

4.1.3 Licensed Workforce members who have been recruited for employment from outside the State of California and whose experience is sufficient to gain admission to a licensing examination may apply for waivers from the State Department of Mental Health. A waiver granted under these circumstances may not exceed three years. Failure to acquire California licensing by the end of the waivered period may result in restriction of practice, demotion or termination.

4.2 Human Resources will pre-screen workforce members licenses and certification status prior to employment. If an applicant has any pending action, notification will be sent to the hiring manager.

4.3 Copies of workforce member licenses and certifications will be requested and maintained by Human Resources and stored in the workforce member's personnel file. ~~Human Resources (HR) will maintain a copy of all employee licenses and certifications showing the name, type, identification number and expiration date.~~

4.4 Copies of Rendering Service Providers licenses and certifications will be stored and maintained in their credentialing file.

4.5 At ~~least~~ approximately 30 days ~~in~~ advance of the renewal date, a reminder will be sent to the Rendering Service Provider of their upcoming licensure or credentials expiry. ~~if the employee fails to provide proof of application in a timely manner, HR will issue a final notification to the employee's supervisor and Program Chief.~~

4.6 Credentials are generally reviewed on a monthly basis. However, rendering service providers credentials may be reviewed at any time during the course of employment. ~~HR~~

may check on an employee's credentials (with the credentialing body) at any time during the course of their employment with Tri-City Mental Health Center.

Credentialed applicants must, prior to hire, present current credentials clear of legal and/or disciplinary actions showing authorization to perform client services in positions for which they are being considered. Applications of applicants with actions pending against their licenses will be rejected until the license is cleared by the licensing body. Subsequent to hire, the following will be required:

3.1.14.1.1 The credentialed person must maintain and renew the credential prior to its expiration date.

3.1.24.1.2 Employees without proof of updated licenses or certifications will be prohibited from billing Medi-Cal or Medicare where service provided requires such licensure.

3.1.34.1.3 A Scope of Practice Authorization form will be completed on all clinical employees by the Program Chief. Such document will remain in effect until rescinded or revised by the Program Chief, and must be reviewed upon promotion or reassignment of duties.

3.24.2 **Renewal**

3.2.14.2.1 At approximately 60 days in advance of the renewal date, HR will request from the credentialed employee proof of application for the renewal of the credential. Proof shall consist of a copy of the renewal notice from the licensing board, and a copy of the employee's renewal fee check to the licensing board. A copy of HR's request will also be sent to the employee's supervisor and the Program Chief.

3.2.24.2.2 If no proof of a renewed credential is provided to HR by the renewal date, steps may be taken to initiate disciplinary action including, suspension without pay for five working days, in accordance with applicable agency procedures. If no proof or explanation of mitigating circumstances is provided within five working days from the date of suspension, the employee will be subject to discharge.

3.2.34.2.3 Reinstatement of an employee who was suspended or discharged for failure to renew his/her credential on time will be at the sole discretion of the Executive Director.

~~3.3~~4.3 ~~**Ongoing Verification**~~

~~3.3.1~~4.3.1 ~~Should HR receive information indicating that there has been legal and/or disciplinary action against the employee's professional license, such information will be provided to administration and may result in immediate discharge of the employee, without rights of notice or appeal.~~

~~3.4~~4.4 ~~**Responsibilities**~~

~~3.4.1~~4.4.1 ~~Employees will present a clear and current clinical license and maintain and renew required credentials prior to expiration dates. They will only function within their *Scope of Practice Authorization* when performing client services.~~

~~3.4.2~~4.4.2 ~~Supervisors will ensure that all credentialed staff function within their *Scope of Practice Authorization* and are properly credentialed while performing client services. Interviewing of candidates by supervisors will only be permitted following the clearance of the applicant's clinical license through HR. (See Operational Guideline 2.1700.01, B, 3.)~~

~~3.4.3~~4.4.3 ~~HR will pre-screen licenses with the licensing body. Applicants with pending actions against their license will be referred to the Program Chief. HR will maintain records indicating the credential and expiration date of each credentialed employee. HR will provide sufficient notification of upcoming credential expiration to the employee, supervisor and Program Chief.~~

4 LEGAL/REGULATORY REFERENCES

~~4.1~~5.1 By federal and state regulation and the authority of the Governing Board as outlined in the Personnel Rules & Regulations, Sec. 1600.

TRI-CITY MENTAL HEALTH AUTHORITY
POLICY & PROCEDURE

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Program Service Delivery	**CL.III.04**	**4/16/2025**	**1** of **4**
APPROVED BY: **Governing Board** **Executive Director**	**SUPERCEDES:** 04/21/2010	**ORIGINAL ISSUE DATE:** 05/08/1998	**RESPONSIBLE PARTIES:** Chief Clinical Officer Medical Director

1. PURPOSE

1.1 To describe Tri-City Mental Health Authority (TCMHA) specialty mental health program services and how these services are delivered.

1.1.1 Tri-City Mental Health Authority (TCMHA) provides Specialty Mental Health Services (SMHS), which are rehabilitative services designed to address significant mental, emotional, and/or behavioral conditions.

2. DEFINITIONS

When used in this Policy, the following terms shall have the meanings hereinafter set forth unless the context indicates otherwise:

2.1 **Assessment:** A service activity to evaluate the client's mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are necessary, recommending or updating a course of treatment.

2.2 **Crisis Intervention:** An expedited, unplanned service to help clients cope with a crisis and stabilize their status within a community or clinical setting. Crisis intervention is aimed at restoring the client to their functional community role.

2.3 **Mental Health Services:** These include individual, group, or family interventions designed to reduce mental or emotional disability, improve functioning, and support community integration aligned with recovery goals.

2.4 **Therapy**: Therapeutic interventions focusing on symptom reduction, restoration of functioning, and enhancing personal and community coping abilities.

2.5 **Psychosocial Rehabilitation**: Focuses on recovery and resiliency, addressing mental health needs by enhancing functional, social, communication, and daily living skills.

2.6 Medication Support Services: Services related to the prescribing, administering, monitoring, and educating about psychiatric medications.

2.7 Referral and Linkages: Activities aimed at connecting clients to necessary services, including healthcare, education, and social support.

2.8 Peer Support Services: Culturally competent individual and group services that foster recovery and self-advocacy through coaching, engagement, and identification of strengths by provided by a certified peer support specialists with lived experience.

2.9 Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS): Services for children and youth under 21, delivered via a Child and Family Team (CFT), ensuring coordinated planning and service delivery.

2.10 Treatment Planning: Developing, updating, and monitoring a client's treatment course to ensure effective care.

3. POLICY

3.1 Program and services shall be provided in accordance with all applicable laws, regulations, plans, manuals, and policies enacted at the Federal, California State, Los Angeles County Mental Health Plan, and TCMHA levels.

3.2 Programs and services shall be designed to provide the maximum reduction of mental disability and restoration or maintenance of function consistent with the requirements for learning, development, independent living, and enhanced self-sufficiency.

3.3 Programs and services shall be directed at assessing, identifying, and providing treatment modalities directed toward achieving the Individual's goals.

3.4 Programs and services shall focus on client needs, strengths, choices, and involvement in care planning and implementation.

3.5 Programs and services shall be provided in the least restrictive setting and shall be consistent with the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency.

3.6 Programs and services shall be multi-disciplinary and shall reflect the cultural, linguistic, ethnic, age, gender, sexual orientation, and other social characteristics of the community that the program serves.

3.7 Programs and services shall be multi-disciplinary and shall reflect the cultural, linguistic, ethnic, age, gender, sexual orientation, and other social characteristics of the community that the program serves.

3.8 TCMHA will ensure that cultural and linguistic competence is upheld at all levels programs and service delivery.

3.9 Programs and services shall ensure the following service availability requirements:

3.9.1 Timely access to services

3.9.2 Availability of crisis services 24 hours a day, 7 days a week

3.9.3 Availability of services in the clients' preferred language

3.9.4 Ability to request a change of provider

4. PROCEDURES

4.1 Programs and services may include assessment, treatment planning, psychotherapy, rehabilitation services, peer support, medication, case management, laboratory tests, diagnostic procedures, and other appropriate services.

4.2 Access to Programs and Services shall be maintained in accordance with the TCMHA Access to care Policy.

4.3 Clients enrolled in SMHS will be assigned to a primary services provider (and possibly other services providers) to provide relevant and necessary services.

4.4 SMHS must always be provided under the direction of a licensed professional. In the event services are provided by an unlicensed service provider or a licensed non AMHD (Authorized Mental Health Discipline), services will be supervised by a licensed AMHD (Psychiatrist, LCSW, MFT, or Psychologist).

4.5 The licensed professional directing a service assumes ultimate responsibility for the Rehabilitative Mental Health Service and Targeted Case Management service provided.

4.6 All workforce members providing specialty mental health services must inform clients and their legal guardians (if applicable) that acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services.

5. REFERENCES

5.1 Title 9, Division 2, Chapter 11

5.2 Los Angeles County Department of Mental Health Short Doyle/ Medi-Cal Provider's Manual

5.3 State DHCS Mental Health Services Division Medi-Cal Billing Manual (Medi-Cal Billing Manual)

5.4 Relevant LACDMH Policies and Procedures

5.5 Relevant TCMHA Authority Policies and Procedures

TRI·CITY Mental Health Services

Policy & Procedure

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Programs Service Delivery	CL.III.04	~~04/21/2010~~ 4/16/2025	1 of 9
APPROVED BY:	**SUPERCEDES:**	**ORIGINAL ISSUE DATE:**	**RESPONSIBLE PARTIES:**
Executive Director	4/21/2010 ~~All Others~~ ~~(Including Service Delivery Definition)~~	05/08/1998	Chief Clinical Officer Medical Director

PURPOSE

2.1 ~~This purpose of this policy is~~ To describe Tri-City Mental Health Authority (TCMHA) ~~Center (TCMHC)~~ specialty mental health program services and how these services are delivered.

2.2 Tri-City Mental Health Authority (TCMHA) provides Specialty Mental Health Services (SMHS), which are rehabilitative services designed to address significant mental, emotional, and/or behavioral conditions.

~~POLICY STATEMENT~~

~~TCMHC interventions are designed to provide the maximum reduction of mental disability and restoration or maintenance of function consistent with the requirements for learning, development, independent living and enhanced self-sufficiency. In order to achieve this goal, services are directed at assessing, identifying and providing treatment modalities directed toward achieving the Individual's goals.~~

2. DEFINITIONS

~~Service definitions are presented based on Mode of Service. Medi-Cal services are defined in accordance with Title 9, Chapter 11.~~ When used in this Policy, the following terms shall have the meanings hereinafter set forth unless the context indicates otherwise:

2.1 Assessment: A service activity to evaluate the client's mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are necessary, recommending or updating a course of treatment.

~~2.2~~ **Crisis Intervention.** An expedited, unplanned service to help clients cope with a crisis and stabilize their status within a community or clinical setting. Crisis intervention is aimed at restoring the client to their functional community role. ~~Crisis Intervention is a quick emergency response service, lasting less than 24 hours to, or on behalf of, the~~

~~client for a condition that requires more timely response than a regularly scheduled visit. The services enable the client to cope with a crisis, while maintaining his/her as a functioning community member to the greatest extend possible. Crisis Intervention services are limited to stabilization of the presenting emergency. This service does not include Crisis Stabilization.~~

~~2.3~~ Mental Health Services. These include individual, group, or family interventions designed to reduce mental or emotional disability, improve functioning, and support community integration aligned with recovery goals. ~~Mental Health Services are those individual and group therapies and interventions designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhances self-sufficiency and **are not provided** as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation or day treatment intensive. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. Service activities include:~~

2.4 Therapy: Therapeutic interventions focusing on symptom reduction, restoration of functioning, and enhancing personal and community coping abilities. ~~Therapy. Therapy is a service activity that is a psychotherapeutic intervention focusing primarily on symptom reduction as a means to improve functioning. This service activity may be delivered to a client or group of clients and may include family therapy.~~

2.5 Psychosocial Rehabilitation: Focuses on recovery and resiliency, addressing mental health needs by enhancing functional, social, communication, and daily living skills. ~~Rehabilitation Services. Rehabilitative Services are activities that include assistance in improving, maintaining or restoring a client's functioning skills, daily living skills, social~~

~~and leisure skills, grooming and personal hygiene skills, meal preparation skills and support resources and/or medication education.~~

2.6 Medication Support Services: Services related to the prescribing, administering, monitoring, and educating about psychiatric medications.

2.7 Referral and Linkages: Activities aimed at connecting clients to necessary services, including healthcare, education, and social support.

2.8 Peer Support Services: Culturally competent individual and group services that foster recovery and self-advocacy through coaching, engagement, and identification of strengths by provided by a certified peer support specialists with lived experience.

2.9 Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS): Services for children and youth under 21, delivered via a Child and Family Team (CFT), ensuring coordinated planning and service delivery.

2.10 Treatment Planning: Developing, updating, and monitoring a client's treatment course to ensure effective care.

~~2.11 Individual Therapy. Individual therapy is a MHS activity (other than psychological testing) that is delivered to or on behalf of one client. Family members and other collaterals may be present; however, for billing purposes, only one service claim can be submitted. Services "on behalf" of the client may include such activities as paperwork, case conferences, etc.~~

~~.11.1 Group Therapy. Group therapy is a face-to-face MHS activity delivered to more than one client at the same time. This service is always face-to-face.~~

.11.2 ~~Collateral. A collateral service is a face-to-face or telephone contact with a significant support person to the client. The client may or may not be present. If may involve any number of members of the family/families or significant support persons. Services may include, but are not limited to: consultation and~~

~~training (such as intra or inter-agency conferences/consultations) to assist in the better utilization of services; involvement in the planning and implementation of service plans; increasing understanding of mental illness in general; increasing understanding and acceptance of a client's specific condition; and counseling for the benefit of the client even if the client is not present.~~

~~2.12~~ **~~Medication Support Services.~~** ~~Medication Support Services are those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of service and/or assessment of the client.~~ **~~Services are provided by a staff person with the scope of practice of his/her profession.~~**

~~2.13 Community Outreach Services~~

~~3.4.1. **Mental Health Promotion.** Mental Health Promotion is an activity directed toward:~~

~~.13.1.1 Enhancing or expanding an agency or organization's knowledge and sills in the mental health field for the benefit of the community-at-large or special population groups; and~~

~~.13.1.2 Providing education and/or consultation to individuals and communities regarding mental health service programs in order to prevent the onset of mental health problems.~~

~~3.4.2 **Community Client Services.** Community Client Services include activities and projects directed toward:~~

~~3.4.2.1 Assisting individuals and families for whom there is no open case record, to achieve adaptive level of functioning through a single or occasional contact; and~~

~~3.4.2.2 Enhancing or expanding an organization's mental health knowledge and skills in relation to the community-at-large or special population groups.~~

~~2.14 **Case Management Support.** Case Management Support services are designed to be system-oriented and not directed to specific clients. Examples of activities under this service include: coordinating services provided by local agencies; establishing specific linkages with local agencies; providing consultation and education; establishing systems of planning and monitoring; providing case management services to clients and their families~~

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Programs Service Delivery	CL.III.04	~~04/21/2010~~ 4/16/2025	6 of 9
APPROVED BY:	**SUPERCEDES:**	**ORIGINAL ISSUE DATE:**	**RESPONSIBLE PARTIES:**
Executive Director	4/21/2010 ~~All Others~~ ~~(Including Service Delivery Definition)~~	05/08/1998	Chief Clinical Officer Medical Director

~~when there is no open case; facilitating development and utilization of appropriate resources.~~

3. POLICY

3.1 Program and services shall be provided in accordance with all applicable laws, regulations, plans, manuals, and policies enacted at the Federal, California State, Los Angeles County Mental Health Plan, and TCMHA levels.

3.2 Programs and services shall be designed to provide the maximum reduction of mental disability and restoration or maintenance of function consistent with the requirements for learning, development, independent living, and enhanced self-sufficiency.

3.3 Programs and services shall be directed at assessing, identifying, and providing treatment modalities directed toward achieving the Individual's goals.

3.4 Programs and services shall focus on client needs, strengths, choices, and involvement in care planning and implementation.

3.5 Programs and services shall be provided in the least restrictive setting and shall be consistent with the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency.

3.6 Programs and services shall be multi-disciplinary and shall reflect the cultural, linguistic, ethnic, age, gender, sexual orientation, and other social characteristics of the community that the program serves.

3.7 Programs and services shall be multi-disciplinary and shall reflect the cultural, linguistic, ethnic, age, gender, sexual orientation, and other social characteristics of the community that the program serves.

3.8 TCMHA will ensure that cultural and linguistic competence is upheld at all levels programs and service delivery.

3.9 Programs and services shall ensure the following service availability requirements:

3.9.1 Timely access to services

3.9.2 Availability of crisis services 24 hours a day, 7 days a week

3.9.3 Availability of services in the clients' preferred language

3.9.4 Ability to request a change of provider

4. PROCEDURES

4.1 Programs and services may include assessment, treatment planning, psychotherapy, rehabilitation services, peer support, medication, case management, laboratory tests, diagnostic procedures, and other appropriate services.

4.2 Access to Programs and Services shall be maintained in accordance with the TCMHA Access to care Policy.

4.3 Clients enrolled in SMHS will be assigned to a primary services provider (and possibly other services providers) to provide relevant and necessary services.

4.4 SMHS must always be provided under the direction of a licensed professional. In the event services are provided by an unlicensed service provider or a licensed non AMHD (Authorized Mental Health Discipline), services will be supervised by a licensed AMHD (Psychiatrist, LCSW, MFT, or Psychologist).

4.5 The licensed professional directing a service assumes ultimate responsibility for the Rehabilitative Mental Health Service and Targeted Case Management service provided

4.6 All workforce members providing specialty mental health services must inform clients and their legal guardians (if applicable) that acceptance and participation in the mental health

system is voluntary and shall not be considered a prerequisite for access to other community services.

AUTHORITY

4.1 Title 9, Chapter 11, ~~Section 1810.350~~

5.1 Los Angeles County Department of Mental Health Short Doyle/ Medi-Cal Provider's Manual

5.2 State DHCS Mental Health Services Division Medi-Cal Billing Manual (Medi-Cal Billing Manual)

5.3 Relevant LACDMH Policies and Procedures

5.4 Relevant TCMHA Authority Policies and Procedures

TRI-CITY MENTAL HEALTH AUTHORITY
POLICY & PROCEDURE

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Reporting Clinical Incidents Involving Clients	**CL.V.11**	**04/16/2025**	**1** of **4**
APPROVED BY: **Governing Board** **Executive Director**	**SUPERCEDES:** 8/1/2019	**ORIGINAL ISSUE DATE:** 04/21/2010	**RESPONSIBLE PARTIES:** Chief Clinical Officer Medical Director

1. PURPOSE

1.1 To establish uniform guidelines for prompt reporting of clinical incidents.

2. DEFINITIONS

When used in this Policy, the following terms shall have the meanings hereinafter set forth unless the context indicates otherwise:

2.1 **Client:** An existing client with activity in the past 180 days.

2.2 **Critical Clinical Event:** An event that has generated or may generate governmental and/or immediate community-wide attention and may require a notification by DMH to the Board of Supervisors.

2.3 **Clinical Event:** An event involving a client, whether or not the event occurred while receiving services.

2.4 **Clinical event categories** reportable to Los Angeles County Department of Mental Health Clinical Risk Management (CLRM) include the following:

2.4.1 Death – Unknown Cause;

2.4.2 Death – Suspected or Known Cause Other than Suicide;

2.4.3 Death – Suspected or Known Suicide;

2.4.4 Suspected or Known Suicide Attempt Requiring Emergency Medical Treatment (EMT);

2.4.5 Client Self-Injury Requiring EMT (Not Suicide Attempt);

2.4.6 Client Injured Another Person Who Required EMT;

2.4.7 Suspected or Alleged Homicide by Client;

2.4.8 Medication Error/Medication-related Event;

2.4.9 Suspected or Alleged Inappropriate Interpersonal Relationships with Client by Staff;

2.4.10 Threat of Legal Action;

2.4.11 Client Assault by another Client Requiring EMT;

2.4.12 Adverse Drug Reaction Requiring EMT;

2.4.13 Alleged Assault by Staff Member to Client; and

2.4.14 Inaccurate, Absent, or Unchecked Laboratory Data, Resulting in a Client Requiring EMT

3. POLICY

3.1 All clinical programs shall report clinical events, identified in the Clinical Event definition to both the TCMHA Incident Reporting System and The Los Angeles County Department of Mental Health (LACDMH) Safety Intelligence (SI) Event Reporting System.

3.2 TCMHA Incident Reports shall be used by for evaluating and improving safety measures, preventing future occurrences of incidents, and for improving the quality of mental health services rendered.

4. PROCEDURES

4.1 If a clinical event as defined in this policy occurs at a program site or during delivery of a clinical service at any location, the physical well-being and safety of persons involved shall be the primary consideration. Referrals shall be made immediately to appropriate life-saving and/or safety agencies (e.g., paramedics and/or law enforcement).

4.1.1 If an event occurs that is not defined as a clinical event in this policy, do not enter the event into the Safety Intelligence (SI) Reporting System. Events considered to be non-clinical events must continue to be reported internally in accordance with TCMHA internal reporting protocols.

4.2 Workforce members shall immediately report clinical events to their direct supervisor or permissible designee.

4.3 Clinical Program Managers or their permissible designee, shall enter critical clinical events immediately, and enter non-critical clinical events in the Safety Intelligence (SI) Reporting System within two (2) business days.

4.3.1 The Clinical Program Manager or designee shall notify their Department Director of the critical clinical event and when the event report was entered into SI.

4.3.2 The Department Director shall determine appropriate notification to the Executive Team according to the Clinical Incident Process.

4.4 Manager Review of Clinical Events: Clinical Program Managers shall review clinical events reported online within three (3) business days from the report date and take/plan immediate action(s) as indicated, in order to resolve any outstanding concerns, as well as plan department-wide system revisions or additions that may prevent the reoccurrence of a similar clinical event.

4.5 Maintaining the Confidentiality of Clinical Events and Incident Reporting. Clinical Events and Incident Reports and related correspondence shall be treated as privileged, confidential communication between TCMHA and DMH, Los Angeles County's Third-Party Administrator, County Counsel, and TCMHA legal counsel in the areas of risk management and medical malpractice. Clinical Events and Incident Reports shall not be made available to anyone other than designated and permitted TCHMA workforce members, designated and permitted Los Angeles DMH County Agents and designated and permitted Department of Health Care Services - California.

3.3 All reportable incidents that occur at TCMHA facilities, ground, events, or in course of performing TCMHA duties, including clinical events, are still required to be reported through TCMHA internal reporting process.

3.3.1 Clinical event reporting in the LACDMH Safety Intelligence (SI) Event Reporting System does not preclude the proper TCMHA incident reporting.

4.6 Quality Improvement. Program Managers, along Department Directors shall review incident reports for risk mitigation and quality improvement purposes in accordance with the Clinical Incident Reporting Process.

5. REFERENCES

5.1 Patient Safety and Quality Improvement Act 2005

5.2 Welfare and Institutions Code: 5328

5.3 California Government Code Section 6254(c)

5.4 County of Los Angeles – Department of Mental Health: Policy 303.05 Reporting Clinical Events Involving Clients

TRI-CITY MENTAL HEALTH AUTHORITY

POLICY & PROCEDURE

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Reporting Clinical Incidents Involving Clients	CL.V.11	~~08/01/2019~~ 04/16/2025	1 of 3
APPROVED BY: Executive Director Governing Board	**SUPERCEDES:** All previous versions	**ORIGINAL ISSUE DATE:** 04/21/2010	**RESPONSIBLE PARTIES:** Chief Clinical Officer Medical Director

1. PURPOSE

To establish uniform guidelines for prompt reporting of clinical incidents ~~to the Chief Clinical Officer and the Medical Director. The Los Angeles County Department of Mental Health Safety Intelligence (SI) Event Reporting System will be used by Tri-City Mental Health Authority (TCMHA) staff for submitting Clinical Incident Reports. Clinical Event Reports (CERs) shall be used by Tri-City Mental Health Authority (TCMHA) for evaluating and improving the quality of mental health services rendered in the Tri-Cities.~~

2. DEFINITIONS

2.1 Client: An existing client with activity in the past 180 days.

2.2 Critical Clinical Event: An event that has generated or may generate governmental and/or immediate community-wide attention and may require a notification by DMH to the Board of Supervisors.

2.3 Clinical Event: An event involving a client, whether or not the event occurred while receiving services.

2.4 Clinical event categories reportable to Clinical Risk Management (CLRM) include the following:

2.4.1 Death – Unknown Cause;

2.4.2 Death – Suspected or Known Cause Other than Suicide;

2.4.3 Death – Suspected or Known Suicide;

2.4.4 Suspected or Known Suicide Attempt Requiring Emergency Medical Treatment (EMT);

2.4.5 Client Self-Injury Requiring EMT (Not Suicide Attempt);

2.4.6 Client Injured Another Person Who Required EMT;

2.4.7 Suspected or Alleged Homicide by Client;

2.4.8 Medication Error/Medication-related Event;

2.4.9 Suspected or Alleged Inappropriate Interpersonal Relationships with Client by Staff;

2.4.10 Threat of Legal Action;

2.4.11 Client Assault by another Client Requiring EMT;

2.4.12 Adverse Drug Reaction Requiring EMT;

2.4.13 Alleged Assault by Staff Member to Client; and

2.4.14 Inaccurate, Absent, or Unchecked Laboratory Data, Resulting in a Client Requiring EMT

3. POLICY

3.1 All clinical programs shall report clinical events, identified in the Clinical Event definition to both the Tri-City Incident Reporting System and The Los Angeles County Department of Mental Health ~~through the online~~ Safety Intelligence Event Reporting System.

3.2 Clinical Incident Reports shall be used by Tri-City Mental Health Authority (TCMHA) for evaluating and improving the quality of mental health services rendered in the Tri-Cities.

4. PROCEDURES

4.1 Reporting Clinical Events

4.1.1 If a clinical event as defined in this policy occurs at a program site or during delivery of a clinical service at any location, the physical well-being and safety of persons involved shall be the primary consideration. Referrals shall be made immediately to appropriate life-saving and/or safety agencies (e.g., paramedics and/or law enforcement).

4.1.1.1 If an event occurs that is not defined as a clinical event in this policy, do not enter the event into the Safety Intelligence (SI) Reporting System. Events considered to be non-clinical events must continue to be reported internally in accordance with TCMHA internal reporting protocols. ~~Clinical Risk Management (CLRM), Countywide Resource Management (CRM) if a CRM provider or Community Reintegration Program (CRP-AB109) may be contacted for consultation at the telephone numbers listed in the first section of the Frontline Reporter page, the first page of the Safety Intelligence Event Report.~~

4.1.2 Staff shall immediately report clinical events to their direct supervisor or permissible designee.

4.1.3 Clinical Program Managers or their permissible designee, shall enter critical clinical events immediately, and enter non-critical clinical events in the Safety Intelligence (SI) Reporting System within two (2) business days.

4.1.3.1 The Clinical Program Manager or designee shall notify their Department Director of the critical clinical event and when the event report was entered into SI.

4.1.3.2 The Department Director shall determine appropriate notification to the Executive Team according to the Clinical Incident Process.

4.2 Manager Review of Clinical Events. Clinical Program Managers shall review clinical events reported online within three (3) business days from the report date and take/plan immediate action(s) as indicated, in order to resolve any outstanding concerns, as well as plan department-wide system revisions or additions that may prevent the reoccurrence of a similar clinical event.

4.3 Maintaining the Confidentiality of Clinical Incident Reporting. ~~Event Reporting (CER).~~ Clinical Incident ~~Event~~ Reports and related correspondence shall be treated as privileged, confidential communication between TCMHA and DMH, Los Angeles County's Third-Party Administrator, County Counsel, and TCMHA legal counsel in the areas of risk management and medical malpractice. Clinical Incident Reports shall not be made available to anyone other than designated and permitted Tri City Staff, designated and permitted DMH County Agents and designated and permitted Department of Health Care Services - California.

4.4 Clinical Incident reporting does not preclude the proper ~~reporting on other~~ TCMHA reporting. All incidents, including clinical incidents, are still required to be reported through TCMHA internal reporting process. ~~forms to appropriate TCMHA departments/staff such as: Human Resources for alleged employee misconduct; the Chief Operations Officer for serious incidents, the Chief Operations Officer/Chief Compliance Officer for subpoenas/medical record events; the Chief Operations Officer/ Chief Clinical Officer for client/visitor injuries on TCMHA property or property damage; and Human Resources for Return to Work status for employee illnesses or injuries.~~

4.5 Quality Improvement. Program Managers, along Department Directors shall review CERs for risk mitigation and quality improvement purposes in accordance with the Clinical Event Reporting Process.

5. REFERENCES

5.1 Los Angeles Department of Mental Health Policy 303.05 Reporting Clinical Events Involving Clients

5.2 California Government Code Section 6254(c)

5.3 Patient Safety and Quality Improvement Act 2005

5.4 Welfare and Institutions Code Section 5328

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Reporting Clinical Incidents Involving Clients	CL.V.11	08/1/2019	3 of 3

TRI-CITY MENTAL HEALTH AUTHORITY
POLICY & PROCEDURE

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Scope of Practice	**CL.IV.03**	**04/16/2025**	**1** of **4**
APPROVED BY: **Governing Board** **Executive Director**	**SUPERCEDES:** **05/20/2009**	**ORIGINAL ISSUE DATE:** **05/20/2009**	**RESPONSIBLE PARTIES:** Human Resources Chief Clinical Officer Medical Director

1. PURPOSE

1.1 To establish and define the permissible activities and limitations for workforce members based on applicable laws, professional regulations, and as defined by Tri-City Mental Health Authority (TCMHA).

2. DEFINITIONS

When used in this Policy, the following terms shall have the meanings hereinafter set forth unless the context indicates otherwise:

2.1 **Lead Case Authority:** Includes but is not limited to acting as a clinical team leader, providing direct or functional supervision of service delivery, or approving of client plans.

2.2 **Rendering Service Provider:** An individual service provider who is credentialed to provide healthcare services.

2.3 **Scope of Competency:** The range of tasks, services, and interventions that a workforce member is qualified to perform based on their formal education, training, and experience.

2.4 **Scope of Practice:** The specific tasks, responsibilities, and activities that a workforce member is legally and ethically allowed to preform based on their education, training, license, certification, or job title/role.

2.5 **Workforce member:** Any TCMHA employee, volunteer, intern, consultant, locum tenens, trainee, or contractor, whether or not they are paid by TCMHA. This includes individuals who provide services to clients and those who provide administrative, managerial, support services and/or other products, goods or services.

3. POLICY

3.1 Workforce members must only perform duties and provide services allowable within the scope of practice of their respective license, registration, certificate, and job description.

3.1.1 The scope of practice requirements must be consistent with the mandates of their licensing board, standards of care, legal mandates and agency guidelines.

3.2 Workforce members must only provide services within their scope of competency, training, experience and skill.

3.3 Workforce members must receive the required and adequate clinical supervision and oversight consistent with the mandates of their licensing board, standards of care, legal mandates and agency guidelines.

3.4 Workforce members must perform services under the supervision and direction of a licensed service provider, as indicated on the ____.

3.5 Workforce members are responsible for maintaining adequate knowledge and skills to perform their duties.

3.6 Workforce members providing services in a language other than English must be classified as certified bilingual employees as per policy CL. IV07 Language Interpretation and Translation.

3.7 Only workforce members who are Lanterman-Petris-Short Act (LPS) Certified designated by Los Angeles County and TCHMA can write 5150 or 5185 holds.

4. PROCEDURES

Clinical Supervision and Lead Case Authority

4.1 Workforce members must perform services under the appropriate clinical supervision and case direction, based on the outline below:

Service Provider Discipline	Supervision
Licensed Marriage and Family Therapy, Social Worker, Psychologist, Psychiatric Mental Health Nurse Practitioner, or	Authorized and expected to provide services independently within their discipline and professional scope. May consult with supervisors and colleagues and needed.

Psychiatrist	Has lead case authority.
Pre-Licensed (Registered) Marriage and Family Therapy, Social Worker or Psychologist	Must be supervised by a licensed mental health professional in accordance with laws and regulations governing the registration and professional standards of care. Has lead case authority (only when being supervised by a licensed mental health professional in accordance with laws and regulations governing the registration and professional standards of care.
Other Licensed Mental Health Professional	Services must be provided under the direction of a practitioner with lead case authority. Supervision must be provided in accordance with laws and regulations governing the license and professional standards of care.
Unlicensed Mental Health Professional	Services must be provided under the direction of a practitioner with lead case authority. Supervision must be provided in accordance with laws, regulations, and professional standards of care.
Student Intern	Services must be provided under the direction and supervision of a practitioner with lead case authority Supervision must be provided in accordance with laws, regulations, and professional standards of care. Clinical documentation must be co-signed by the licensed practitioner. The co-Signature affirms review, approval, and clinical responsibility for the documented service Workforce members assigned to this level include

5. REFERENCES

5.1 California Board of Behavioral Sciences

5.2 California Board of Psychology

5.3 California Board of Nursing

5.4 Medical Board of California

5.5 Board of Medical Quality Assurance

5.6 Welfare and Institutions Code Sect. 5150, and 571.2

5.7 Business and Professional Code

5.8 CCR. Tit. 9, § 1840.314 - Claiming for Service Functions-General

5.9 Department of Mental Health, Los Angeles County

TRI·CITY Mental Health Services

Policy & Procedure

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Scope of Practice	CL.IV.03	04/16/2025	1 of 3
APPROVED BY:	**SUPERCEDES:**	**ORIGINAL ISSUE DATE:**	**RESPONSIBLE PARTIES:**
Governing Board Executive Director		05/20/2009	Human Resources Chief Clinical Officer Medical Director ~~Executive Director~~ ~~Dir. of Clinical Program Services~~ ~~Chief Program Officer~~ ~~Human Resources Staff~~ ~~Clinical Supervisors~~ ~~Service Providers~~

1 PURPOSE

1.1 To establish and define the permissible activities and limitations for workforce members based on applicable laws, professional regulations, and as defined by Tri-City Mental Health Authority (TCMHA). ~~Mental Health Center (TCMHC) is a municipal Joint Powers Authority of the State of California. The Director of Clinical Program Services at TCMHC is mandated to define the scope of practice for public mental health service providers in the participating cities. Licensing law does not fully and completely define scope of practice for all clinical activities, and some clinical activities do not require Licensure. Therefore, a policy is necessary to insure quality of care to the public and to clarify for clinical staff which services they are authorized to perform at this agency.~~

2 2. DEFENITIONS

When used in this Policy, the following terms shall have the meanings hereinafter set forth unless the context indicates otherwise:

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2.1 Workforce member – Any TCMHA employee, volunteer, intern, consultant, locum tenens, trainee, or contractor, whether or not they are paid by TCMHA. This includes individuals who provide services to clients and those who provide administrative, managerial, support services and/or other products, goods or services.

2.2 Scope of Competency- The range of task, services, and interventions that a workforce member is qualified to preform based on their formal education, training, and experience

2.3 Scope of Practice- The specific tasks, responsibilities, and activities that a workforce member is legally and ethically allowed to preform based on their education, training, license, certification, or job title/role

3 POLICY ~~STATEMENT~~

3.1 It is the policy of TCMHA that all workforce members operate within the scope of practice of their respective license, certificate, or job title/ role as defined by TCMHA, their respective licensing boards, and applicable federal and state laws.

3.2 Where required, workforce members must be licensed in their discipline(s) by the State of California. Workforce members with an out-of-state license must apply for and obtain a California license in a specified time period.

3.3 Workforce members must only provide services within their role, licensure, or certification.

3.4 Workforce members must only provide services within their scope of competency.

3.5 ~~Students. All students~~ Student interns who will be rendering services on behalf of TCHMA must have their scope of practice defined by their clinical supervisor, must receive clinical supervision on all treatment services for clients, and all their clinical documentation must be co-signed by their supervisor. A supervisor may co-sign only for service procedures that they are authorized to provide.

3.6 Workforce members providing services in a language other than English must be classified as certified bilingual employees as per policy CL. IV07 Language Interpretation and Translation.

3.7 2.10 Only Lanterman-Petris-Short Act (LPS) Certified workforce members who are designated by Los Angeles County and TCHMA can write 5150 or 5185 holds.

~~3.8 Tri-City will determine the scope of practice for all clinical activities provided by clinical staff of this agency as well as contracted clinical staff. No clinical staff may perform procedures with consumers at Tri-City without written approval of the Director of Clinical Program Services, or designee. All clinical staff must show appropriate training, qualified supervision, and/or current licenses for specific procedures. All procedures defined as "clinical" in the activity codes require authorization by management.~~

3.9 The scope of this policy is limited to those services delivered under the ShortDoyle Medi-Cal Manual and is not meant to be exhaustive for all programs at Tri-City Mental Health Center. Those programs, such as Medicare and Drug Medi-Cal, will have program-specific policy-specific addenda to this policy.

4 PROCEDURE

4.1 **Licensing / Certification.** Clinical staff must show proof of training, licensing, or certification for review by the Program Manager prior to actual employment or when requesting authorization for additional practice privileges. Clinicians must be licensed in their discipline(s) by the State of California and may not perform clinical procedures outside the scope of practice of the respective license. Clinicians with an out-of-state license must apply for and obtain a California license in a specified time period. Procedures not addressed by licensure will require acceptable proof of training, experience, or certification. Physicians must provide to Human Resources a copy of their current license to practice medicine, DEA card, and a copy of controlled prescription blanks issued by the State.

4.2 **Waivers.** Clinicians who are registered with their respective licensing boards may perform specific clinical procedures for which they have been trained under supervision of a licensed professional in that discipline, subject to the following conditions:

4.2.1 **Clinical Social Workers and Marriage and Family Therapists**. Clinical Social Workers and Marriage and Family Therapists who are acquiring the experience required for licensure must be registered with the Board of Behavioral Sciences and subject to regulations of that Board. No waiver is needed, nor can one be obtained. Proof of licensure must be provided to Human Resources when it is obtained. The Board of Behavioral Sciences requires that licensure be obtained no longer than six years from the date of initial registration application to the Board, and that registration be renewed annually. Failure to maintain active registration with the Board or to obtain licensure within the six-year period may result in restriction of practice, demotion or termination.

4.2.2 **Psychologists.** Waivers from the State Department of Mental Health are required and will be requested upon hiring. Human Resources will forward the request and keep a copy of the State's determination in the employee's file. Proof of licensure must be provided to Human Resources when it is obtained. A waiver may not exceed **five** years from the date it is granted. Failure to acquire California licensing by the end of the waivered period may result in restriction of practice, demotion or termination.

~~Psychologists, Clinical Social Workers and Marriage and Family Therapists who have been recruited for employment from outside the State of California and whose experience is sufficient to gain admission to a licensing examination may apply for waivers from the State Department of Mental Health. A waiver granted under these circumstances may not exceed three years. Failure to acquire California licensing by the end of the waivered period may result in restriction of practice, demotion or termination.~~

~~4.3 **Clinicians.** The following classifications perform services that are considered to be clinical and require clinical privileges at this agency:~~

~~4.3.1 Psychologists~~

~~4.3.2 Social workers~~

~~4.3.3 Marriage and family therapists~~

~~4.3.4 Psychiatrists~~

~~4.3.5 Psychiatric technicians~~

~~4.3.6 Mental health rehabilitation specialists~~

~~4.3.7 Case managers~~

~~4.3.8 Clinical supervisors~~

~~Volunteers are not considered to be clinical and will not be scoped to provide any billable services.~~

~~4.4 **Clinical Privileges.** Practice privileges for specific clinical procedures will be authorized by the Program Manager and approved by the Director of Clinical Program Services (or designee) based on proof of licensure, certifications, and/or training in the Human Resources record. Clinical privileges granted by another agency, county, or service area do not automatically transfer to Tri-City Mental Health. Clinicians may request additional clinical privileges if they provide information verifying appropriate training or an authorization for clinical privileges. All amendments will be kept in Human Resources for all clinicians. Any clinician performing clinical procedures for which he/she **has not been approved** may be subject to disciplinary actions up to and including termination.~~

~~**Privilege Levels.** Practice privileges are granted at the levels described below:~~

3.1 Case Oversight Levels

Case oversight level define the degree in which a workforce member is authorized to provide services based on their professional Licensure, certification, role, and taxonomy.

4.4.1 **Independent Case Oversight:** ~~The clinician discusses the activity during regular clinical supervision.~~ Workforce members assigned to this level are typically fully licensed or certified and authorized to provide services independently within their discipline and professional scope. These workforce members may consult during regular clinical supervision.

4.4.2 **Supervised Case Oversight**: Workforce members assigned to this level are typically associates or pre- licensed. These workforce members are permitted to provide their services under the direction of a fully licensed practitioner with appropriate supervisor authority. ~~The clinician discusses the activity with a Licensed Practitioner of the Healing Arts (LPHA) prior to or as soon as possible after the service takes place.~~

4.4.3 **Supervised and Co-signature Case Oversight:** Workforce members assigned to this level typically not possess a license or certification. These workforce members must perform all services under the direction of a fully licensed practitioner with appropriate supervisor authority. Any clinical documentation must be co-signed by the licensed practitioner. The co-Signature affirms review, approval, and clinical responsibility for the documented service ~~The progress note for the activity is reviewed by an LPHA. The progress note is co-signed by an LPHA if the staff is a "trainee", "student volunteer", or intern / licensed staff under review by the Program Manager / Clinical Supervisor. A discussion of the activity does not need to take place.~~

~~4.5 **Appeals.** Clinicians may appeal the determination of privileges to the Director of Clinical Program Services or designee. Determinations made by the Executive Director are considered final.~~

~~4.6 **Language Certification.** Clinicians must be authorized to provide therapy or translation services in languages other than English. Certification of competence or testing may be requested. Specific language privileges are required to receive bilingual pay benefits.~~

~~4.7 **Transportation.** Clinicians must be authorized by Tri-City in order to transport consumers. Proof of current California Driver's License and current insurance coverage on the vehicle to be used must be on file with Human Resources. Also,~~

completion of Tri-City's Driver Registration Request Form must be completed and processed. A vehicle used to transport more than seven people requires a Class B license.

4.8 **Lanterman-Petris-Short (LPS) Certification.** Clinicians must have LPS Certification Training and designation by Los Angeles County and Tri-City Mental Health to write 5150s.

4.9 **Responsibilities**

4.9.1 **Clinicians.** Provide Human Resources with proof of education and training, California Clinical License/renewals, Driver's License, auto insurance coverage, certifications, and proof of supervision as needed; use only Activity Codes for which they are authorized.

4.9.2 **Clinical Supervisors.** Provide clinical supervision on service procedures for which they have clinical privileges; co-sign all documentation by students assigned to them; may provide Director of Clinical Program Services or designee with a letter of professional recommendation for eligibility for a clinician to perform specific services at this agency.

4.9.3 **Program Managers.** Reviews training, licenses, and certifications of all clinicians assigned to the program; authorizes clinical service procedures that each clinician may use; insures scope of practice is program specific, develops program specific policies on scope of practice.

4.9.4 **Director of Clinical Program Services.** Establishes scope of practice parameters for Tri-City and its contracted agency. Responsible for all clinical procedures / practices within the clinic. Reviews and approves practice privileges authorized by the Program Manager.

4.9.5 **Human Resources.** Maintains Scope of Practice authorizations for all clinicians in their personnel files; prepares and faxes waiver requests to Department of Mental Health; maintains copies of all pertinent training, licenses (including updates), and auto insurance coverage.

5 LEGAL/REGULATORY REFERENCES

5.1 California Board of Behavioral Sciences

5.2 California Board of Psychology

5.3 Department of Mental Health, Los Angeles County

5.4 Welfare and Institutions Code Sect. 5150, and 571.2

5.5 Board of Medical Quality Assurance

5.6 Business and Professional Code 2570.185.

~~6 FORMS~~

~~Forms associated with this Policy may include, but are not limited to the following:~~

~~6.1 Scope of Practice Form~~

~~6.2 State DMH Professional Licensing Waiver Request~~

TRI·CITY Mental Health Services

ATTACHMENT I

State of California – Health and Human Services Agency Department of Mental Health

MENTAL HEALTH PROFESSIONAL LICENSING WAIVER REQUEST MH 12 (Rev 01/08) Page 1 of 2 *(Please fill-in all boxes below. See reverse side for completion instructions.)*

APPLICANT'S FULL NAME (Include aliases and maiden names):	
TYPE OF WAIVER REQUEST **(Please check appropriate box)**	
WITHIN CALIFORNIA/NOT LICENSE ELIGIBLE PSYCHOLOGIST: (5 years maximum)	OUT-OF-STATE/LICENSING-EXAM-READY: (3 years maximum) PSYCHOLOGIST LCSW MFT
DATE OF DEGREE OR DATE ALL DEGREE REQUIREMENTS MET:	EMPLOYMENT START DATE (in the position requiring the waiver):
REQUEST SUBMITTED BY: (SIGNATURE---MENTAL HEALTH DIRECTOR/DESIGNEE) PRINTED NAME:	
DATE:	COUNTY:
DO NOT COMPLETE THE FOLLOWING - FOR STATE DEPARTMENT OF MENTAL HEALTH USE ONLY	
DATE COMPLETE WAIVER APPLICATION RECEIVED:	DATE WAIVER BEGINS:
COMMENTS:	DATE WAIVER ENDS:
Approved by: Program Administrator, Program Compliance OR Chief, Medi-Cal Oversight—North	
Signature:	Date:
This waiver is granted pursuant to Welfare and Institutions Code Section 5751.2 and with the stipulation that the employer and the applicant assume responsibility for meeting all applicable statutory and regulatory requirements during the approved waiver period.	

ATTACHMENT I

7 State of California – Health and Human Services Agency Department of Mental Health

8 MENTAL HEALTH PROFESSIONAL LICENSING WAIVER REQUEST MH 12 (Rev 01/08)

PROFESSIONAL LICENSING WAIVER REQUEST

Instructions for Completing This Form

Applicant's Full Name. Include Aliases and Maiden Names: DMH staff need this information, when applicable, to track accurately the applicant's waiver history. At the option of the county, a waiver granted in one county is valid in another county for the life of the waiver. Rather than requesting a new waiver, when applicable, a county may obtain a copy of the previous waiver.

Type of Waiver Request: Clearly indicate the type of waiver request. To be eligible for the Out-of-State/License-Ready category, an applicant must be both license-ready and recruited from out-of-State.

Date of Degree or Date all Degree Requirements Were Met: Attach a copy of the applicant's degree or a letter from the applicant's post-baccalaureate institution specifying the date the applicant met all the requirements for the degree. This is important in determining the commencement of the waiver period. For psychologists accruing hours to make them eligible to sit for the licensing examination, a waiver cannot be granted prior to the date on which the degree was awarded or the date on which the applicant met all the requirements for the doctoral degree.

4) *Employment Start Date (In the Position Requiring the Waiver):* Specify the date the applicant started or will start employment in the position requiring a waiver.

In order for the DMH to determine if the applicant has been previously employed in a position requiring a waiver, **it is necessary to attach a copy of the applicant's post-degree employment history**. This can take the form of a current, complete resume or recent employment application. In addition, the DMH will check for a previously issued waiver.

5) *Request Submitted By (Mental Health Director/Designee):* All waiver requests must be submitted, signed and dated by the local county mental health director or the director's designee.

For additional information on the professional licensing waiver process, see DMH Letter No. 02-09.

TRI·CITY Mental Health Services

ATTACHMENT II

GENERIC CLINICAL PRIVILEGES

I=INDEPENDENT S=SUPERVISED C=CO-SIGNATURE REQUIRED

CODE	GENERAL SERVICE PROCEDURES	PSYCHIATRIST	LCSW	MFT	PRE-LICENSED MSW/MFT	MHRS 1	MHRS 2	MHRS 3	LICENSED PSYCH TECH (LTP)	CASE MANAGER	INTERNS / STUDENTS	ADMIN / CLERK
1531	INITIAL ASSESSMENT	**I**	I	**I**	**I**	**C**	**C**	**C**	**C**		**C**	
1532	PSYCHIATRIC EVALUATION	**I**										
1540	INDIVIDUAL PSYCHOTHERAPY		I	**I**	**I**						**C**	
1550	GROUP PSYCHOTHERAPY		I	I	I						C	
1510	FAMILY THERAPY		I	I	I						C	
1535	OUTCOMES	I	I	I	I	I	I	I	I	I	I	I
1560	MEDICATION PRESCRIPTIONS	I										
1560	MEDICATION INJECTIONS	I							I			
4205	MEDICATION PEER REVIEW	I										
1570	CRISIS INTERVENTION	I	I	I	S	S	S	S	I	S/C	C	
1571	WRITE 5150s *	*	*	*					*			
1575	MENTAL HEALTH SUPPORT SERVICES	I	I	I	I	I	I	I	I	I	C	
4201	CASE CONSULTATION	I	I	I	I	I	I	I	I	I	C	
4203	SERVICE PLANS	I	I	I	I	C	C	C	C	C	C	
4204	COORDINATED CARE PLANS	I	I	I	I	C	C	C	C	C	C	
5013	CASE MANAGEMENT		I	I	I	S	I	I	I	I	C	
4206	CLOSING CHARTS	I	I	I	S	C	C	C	C	C	C	

Key: **Independent** (I) – The clinician discusses the activity during regular clinical supervision. **Supervised** (S) – The clinician discusses the activity with an LPHA prior to or as soon as possible after the activity (intervention) takes place. **Co-signature Required** (C) – The progress note for the activity is reviewed and co-signed by an LPHA. A discussion of the activity does not need to take place.

BLANK=PROCEDURE IS NOT APPLICABLE OR ADDITIONAL VERTIFICATION NEEDED.

***Documentation of relevant training and experience is required. Level of privileges (I, S, or C) determined based on prior experience.**

TRI-CITY MENTAL HEALTH AUTHORITY
POLICY & PROCEDURE

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Standards For Prescribing Medications	**CL.V.01**	**4/16/2025**	**1** of **5**
APPROVED BY: **Governing Board** **Executive Director**	**SUPERCEDES:** **8/1/2019**	**ORIGINAL ISSUE DATE:** **04/21/2010**	**RESPONSIBLE PARTIES:** Medical Director

1. PURPOSE

1.1 To provide guidelines for clinical policy regarding standards for prescribing and managing psychoactive medications and to provide a foundation for quality management relating to the use of the major classes of psychoactive medications.

2. DEFINITIONS

When used in this Policy, the following terms shall have the meanings hereinafter set forth unless the context indicates otherwise:

2.1 **Furnish:** Order of medication or device by a Psychiatric Mental Health Nurse Practitioners (PMHNP); the act of making a pharmaceutical agent or agents available to the client in accordance with a standardized procedure (BPC § 2836).

2.2 **Furnishing Supervision:** A periodic review of the PMHNP furnishing practice conducted by a DMH physician that supports professional collaboration.

2.3 **Order:** An instructional directive mandating the delivery of specific patient care services from a licensed physician or other licensed health care professional authorized to do so.

2.4 **Prescriber**: A licensed physician or other authorized licensed health care practitioner with legal authority to order or prescribe medication

2.5 **Prescription Medication**: An order for medications by a physician or other licensed health care professional with authority to write prescriptions.

2.6 **Psychiatric Mental Health Nurse Practitioners (PMHNP) Scope of Practice:** Advanced Practice Registered Nurse (APRN) specialized in Psychiatric Mental Health Nursing who possesses additional preparation and skills beyond the Registered Nurse (RN) scope of practice which includes physical diagnosis,

assessment and management of health-illness needs, the provision of psychotherapy and consultation services, and prescriptive or furnishing authority. PMHNPs utilize education, training, experience, and established standardized procedures to provide care beyond the RN's usual scope to perform the overlapping medical furnishing functions.

2.7 Standardized Procedures: Policies and protocols developed through collaboration among administrators and health professionals, including physicians, nurses, and pharmacists.

3. POLICY

3.1 The prescribing, ordering, and furnishing of medications must be compliant with all applicable federal and State regulations, Licensing Boards, and Standards of Care. Prescribing, ordering, and furnishing must be consistent with generally accepted professional and community standards.

3.2 The following licensed medical staff can prescribe dispense, and administer medication (including any required supervision):

Medical Staff and Requirements:	Allowable Activity
Physician **Must have: 1) An active Medical License from the Medical Board of California; 2) A Federal Drug Enforcement Administration (DEA) Number.*	– Prescribe, dispense, and administer medications. – Provide Medication Training and Support.
Psychiatric Mental Health Nurse Practitioner (PMHNP) **Must have: 1 An active Nurse Practitioner License from the California Board of Registered Nursing (BRN); 2) A Nurse Practitioner Furnishing Number from the California Board of Registered Nursing (BRN); and 3) A Federal Drug Enforcement Administration (DEA) Number.*	Under the supervision of a TCMHA physician: – Prescribe, dispense and administer medication – Provide Medication Training and Support.
All Trained Personnel	Administer intranasal Naloxone

3.3 Documentation regarding the prescribing, ordering, and furnishing of medications must be consistent with legal regulations, practice standards, as well as TCMHA documentation policies, guidelines and standards.

3.4 TCMHA workforce members authorized to prescribe, order, and furnish medications shall refer to the Los Angeles County DMH Parameters regarding medication as needed.

3.4.1 The parameters apply to treatment of all individuals accessing outpatient mental health services at TCMHA, regardless of the funding source for the prescribed medication/treatment.

3.4.2 The parameters are not absolute, and it is understood that the clinical condition of the client ultimately will dictate the course of action to be followed by the physicians. However, the specific reasons for deviation from these parameters should be clearly documented in the consumer's clinical record.

3.4.3 The parameters are designed to encourage consultation and monitoring at TCMHA clinical sites and to encourage departmental education and training.

3.4.4 Changes in the current medication regimens made for the purpose of conformity with these treatment parameters should be initiated only after careful consideration of the original reasons for the current medication regimen.

3.4.5 These parameters reflect current interpretations of best practices and change as new information and medications become available.

4. PROCEDURES

4.1 Guidelines for medical examination and medical monitoring should be in accordance with American Psychiatric Association, Professional Practice Standards and LACDMH Practice Parameters.

4.2 Prescribing and monitoring of individuals taking any medication should be determined by the unique clinical situation and condition of the individual and should be done in accordance with American Psychiatric Association, Professional Practice Standards and LACDMH Practice Parameters.

4.3 Refusal to undergo a medical examination and / or appropriate medical monitoring is a special situation that must be addressed by the prescribing physician. Risks and benefits of prescribing medication shall be discussed with the individual being treated. The physiologic dangers inherent in this situation

must be considered and the nature and outcomes of such deliberations must be clearly documented in the clinical record.

4.4 Relevant information contained in progress notes from other clinical disciplines and staff should be reviewed and considered by the treating physician/PMHNP in formulating medication treatment planning. Factors influencing the physician's treatment decisions obtained from other treating clinicians should be documented.

4.5 Treatment of individuals known to the facility but not to the physician/PMHNP (i.e., cross coverage situations) should include a review of the relevant parts of the clinical record to appropriately prescribe/furnish.

4.6 Physicians/PMHNPs should be capable of utilizing the full spectrum of psychotropic agents available for the specific population being treated and consistent with the physician's background, training, and scope of practice.

4.7 In circumstances where multiple service providers are involved in the treatment, physicians//PMHNP should review and discuss medication treatment plans with other disciplines, as needed, and document this activity in the clinical record.

Medication Review and Informed Consent

4.8 The prescribing physician/PMHNP must document the review of medications with the client or authorized legal representative when:

4.8.1 A new medication is prescribed; or there is a change in dosage or dosage range.

4.8.2 The client resumes taking medication following documented withdrawal of consent for treatment.

4.9 The agency approved medication consent form(s) shall be used for all prescribers at all clinical sites. These forms shall be filed in the client's clinical record.

4.10 For clients who are dependents or wards of the juvenile court, the following must be done in addition to the agency approved medication consent (4.9).

4.10.1 The prescribing practitioner must complete as submit to the court for review and approval the Physician's Statement Attachment JV-220 (A) or the Physician's Request to Continue Medication Attachment JV-220 (B).

4.10.2 In response to physician attachments submitted by the prescribing practitioner, an official court order for psychotropic medication must be obtained from the Court (JV-223).

Supervision for Psychiatric Mental Health Nurse Practitioners (PMHNP)

4.1 Any psychiatrist furnishing supervision for PMHNP must meet minimum legal, practice, and regulatory requirements, and be approved by the TCMHA Medical Director or Lead Psychiatrist, in order to function as a Furnishing Supervisor.

4.2 Any furnishing supervisor must provide input into any PMHNP's performance evaluations.

4.3 Any furnishing supervisor must attest at least yearly to the continued clinical competence of the PMHNP based upon regular review of cases.

4.4 Supervision of the frequency and duration of furnishing must comply legal, ethical guidelines and practice standard requirements.

Monitoring and Quality Improvement

4.5 TCMHA's Medical Director or designee shall regularly measure performance against important components of standard clinical parameters. Monitoring and analysis will be used to improve practitioner performance, revise the guidelines, and enhance clinical decision-making.

4.6 All parameters related to the use of psychoactive medications shall be incorporated into existing medication monitoring standards and procedures.

4.7 Existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring, peer review, and site visits.

5. REFERENCES

5.1 LACDMH Parameters for Medication Use

5.2 LACDMH Guidelines for the Use of DMH Parameters

5.3 LACDMH Psychiatric Mental Health Nurse Practitioner (PMHNP) Standard Procedures

TRI-CITY MENTAL HEALTH AUTHORITY

POLICY & PROCEDURE

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Standards For Prescribing ~~and Monitoring~~ Medications	CL.V.01	~~08/01/2019~~ 4/16/2025	1 of 6
APPROVED BY: Executive Director Governing Board	**SUPERCEDES:** ~~All previous versions~~ ~~8/1/2019~~	**ORIGINAL ISSUE DATE:** 04/21/2010	**RESPONSIBLE PARTIES:** Medical Director

1. PURPOSE

To provide guidelines for clinical policy regarding standards for prescribing and managing psychoactive medications and to provide a foundation for quality management relating to the use of the major classes of psychoactive medications.

2. DEFINITIONS

When used in this Policy, the following terms shall have the meanings hereinafter set forth unless the context indicates otherwise: ~~Furnishing or ordering of drugs or devices by nurse practitioners is the act of making a pharmaceutical agent or agents available to the patient in accordance with a standardized procedure pursuant to California (CA) Business & Professions Code Section 2836.2. (See Authority)~~

2.1 Furnishing: Ordering of medication or devices by a Psychiatric Mental Health Nurse Practitioners (PMHNP); the act of making a pharmaceutical agent or agents available to the client in accordance with a standardized procedure (BPC § 2836).

2.2 Furnishing Supervision: A periodic review of the PMHNP furnishing practice conducted by a DMH physician that supports professional collaboration.

2.3 Order: An instructional directive mandating the delivery of specific patient care services from a licensed physician or other licensed health care professional authorized to do so.

2.4 Prescriber: A licensed physician or other authorized licensed health care practitioner with legal authority to order or prescribe medication

2.5 Prescription Medication: An order for medications by a physician or other licensed health care professional with authority to write prescriptions.

2.6 Psychiatric Mental Health Nurse Practitioners (PMHNP) Scope of Practice: Advanced Practice Registered Nurse (APRN) specialized in Psychiatric Mental Health Nursing who possesses additional preparation and skills beyond the Registered Nurse (RN) scope of practice which includes physical diagnosis, assessment and management of health-illness needs, the provision of psychotherapy and consultation services, and prescriptive or furnishing authority. PMHNPs utilize education, training, experience, and established standardized procedures to provide care beyond the RN's usual scope to perform the overlapping medical furnishing functions.

2.7 Standardized Procedures: Policies and protocols developed through collaboration among

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administrators and health professionals, including physicians, nurses, and pharmacists within DMH.

~~**1.1 Standardized Procedures:** refers to policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code. California (CA) Business & Professions Code Section 2725. (See Authority)~~

~~**1.2** Standardized Procedures: for furnishing are the content of the DMH Parameters for the Prescribing of Psychoactive Medications. (See References 1 and 2)~~

~~**1.3** Patient Specific Furnishing Protocols: are developed in consultation with the furnishing supervisor that permit patient specific furnishing that is not permitted within the standardized procedure and are documented in the clinical record. (See Reference 1 and Attachment 1)~~

~~2.~~1. POLICY

The prescribing, ordering, and furnishing of medications must be compliant with all applicable federal and State regulations, Licensing Boards, **and** Standards of Care. ~~DMH PMHNP Standardized Procedures, and DMH Policies and Parameters. (See References 1 and 2)~~

~~2.1~~ Prescribing, ordering, and furnishing must be consistent with generally accepted professional and community standards.

The following licensed medical staff can prescribe, dispense, and administer medication (including any required supervision):

TCMHA Worfkforce Classification	Allowable Activity
Physician *Must have active California Medical License and a Drug Enforcement Administration (DEA) Number.*	- Prescribe, dispense, and administer medications. - Provide Medication Training and Support.
Psychiatric Mental Health Nurse Practitioners (PMHNP) **Must have: 1 An active Nurse Practitioner License from the California Board of Registered Nursing (BRN); 2) A Nurse Practitioner Furnishing Number from the California Board of Registered Nursing (BRN); and 3) A Federal Drug Enforcement Administration (DEA) Number.*	Under the supervision of a TCMHA physician: - Prescribe, dispense and administer medication - Provide Medication Training and Support.
All Trained Personnel	Administer intranasal Naloxone

3.3 Documentation regarding the prescribing, ordering, and furnishing of medications must be consistent with DMH Policy No. 401.02 Clinical Records Maintenance, Organization, and Contents. (See Reference 3)

3.4. TCMHA workforce members authorized to prescribe, order, and furnish medications prescribers will refer to the Los Angeles County DMH Parameters regarding medication as needed.

3.4.1 The parameters apply to treatment of all individuals accessing outpatient mental health services at TCMHA, regardless of the funding source for the prescribed medication/treatment.

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3.4.2 The parameters are not absolute and it is understood that the clinical condition of the client ultimately will dictate the course of action to be followed by the physicians. However, the specific reasons for deviation from these parameters should be clearly documented in the consumer's clinical record.

3.4.3 The parameters are designed to encourage consultation and monitoring at TCMHA clinical sites and to encourage departmental education and training.

3.4.4 Changes in the current medication regimens made for the purpose of conformity with these treatment parameters should be initiated only after careful consideration of the original reasons for the current medication regimen.

~~3.4.5 Prescribing and furnishing must be consistent with generally accepted professional and community standards.~~

~~3.4.6~~3.4.5 These parameters reflect current interpretations of best practices and change as new information and medications become available.

4. PROCEDURE

~~Physical Examination and Medical Monitoring~~

4.1 Guidelines for medical monitoring are should be in accordance with American Psychiatric Association, Professional Practice Standards and LACDMH Practice Parameters. ~~Monitoring of individuals taking any medication should be determined by the unique clinical situation and condition of the individual, including type of medication(s), health risk factors, duration of treatment, concurrent general medical conditions and associated medications and laboratory monitoring of serum levels. All such activity and results shall be documented in the clinical record.~~

4.2 Prescribing and monitoring of individuals taking any medication should be determined by the unique clinical situation and condition of the individual and should be done in accordance with American Psychiatric Association, Professional Practice Standards and LACDMH Practice Parameters.

4.3 Refusal to undergo a medical examination and / or appropriate medical monitoring is a special situation that must be addressed by the prescribing physician. Risks and benefits of prescribing medication shall be discussed with the individual being treated. The physiologic dangers inherent in this situation must be considered and the nature and outcomes of such deliberations must be clearly documented in the clinical record.

4.4 Relevant information contained in progress notes from other clinical disciplines and staff should be reviewed and considered by the treating physician/PMHNP in formulating medication treatment planning. Factors influencing the physician's treatment decisions obtained from other treating clinicians should be documented.

4.5 Treatment of individuals known to the facility but not to the physician/PMHNP (i.e., cross coverage situations) should include a review of the relevant parts of the clinical record to appropriately prescribe/furnish.

4.6 Physicians/PMHNPs should be capable of utilizing the full spectrum of psychotropic agents available for the specific population being treated and consistent with the physician's background, training, and scope of practice.

4.7 In circumstances where multiple service providers are involved in the treatment, physicians//PMHNP should review and discuss medication treatment plans with other disciplines, as needed, and document this activity in the clinical record.

Medication Review and Informed Consent

4.8.1. The prescribing physician/PMHNP must document the review of medications with the client or guardian when:

4.8.1.1 A new medication is prescribed; or there is a change in dosage or dosage range.

~~**4.8.1.2** At least annually even in the absence of medication changes;~~

~~**4.8.1.3**~~**4.8.1.2** The client resumes taking medication following documented withdrawal of consent for treatment.

4.9 The agency approved ~~Consent for~~ medication~~" (Attachment 1) issued by TCMHA~~form(s) ~~and process~~ shall be used for all prescribers at all clinical sites.~~in all clinical sites~~. These forms shall be ~~chronologically~~ filed in the client's clinical record.

~~**4.9.1.** The "Psychotropic Medication Authorization Form" issued by Juvenile Court must be used when applicable.~~

4.10 For clients who are dependents or wards of the juvenile court, the following must be done in addition to the agency approved medication consent (4.9).

4.10.1. The prescribing practitioner must complete as submit to the court for review and approval the Physician's Statement Attachment JV-220 (A) or the Physician's Request to Continue Medication Attachment JV-220 (B).

4.10.2. In response to physician attachments submitted by the prescribing practitioner, an official court order for psychotropic medication must be obtained from the Court (JV-223).

5. ~~Furnishing~~ Supervision for Psychiatric Mental Health Nurse Practitioners (PMHNP)

5.1 Any psychiatrist ~~In circumstances where multiple clinicians are involved in the treatment, physicians should periodically review and discuss medication treatment plans with other disciplines and document this activity in the clinical recoAnyone~~ furnishing supervision for PMHNP must meet minimum legal, practice, and regulatory requirements, and be approved by the TCMHA Medical Director or Lead Psychiatrist, in order to function as a Furnishing Supervisor.

5.2 Any furnishing supervisor must provide input into any PMHNP's performance Annual Performance Evaluation.

5.3 Any furnishing supervisor must attest at least yearly to the continued clinical competence of the PMHNP based upon regular review of cases.

5.4 Supervision of the frequency and duration of furnishing must comply legal, ethical guidelines and practice standard requirements

6. Monitoring and Quality Improvement

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6.1 TCMHA's Medical Director shall regularly measure performance against important components of standard clinical parameters. Monitoring and analysis is used to improve practitioner performance, revise the guidelines, and enhance clinical decision-making.

6.2 All parameters related to the use of psychoactive medications shall be incorporated into existing medication monitoring standards and procedures.

6.3 Existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to: supervision, medication monitoring, peer review, and site visits.

7. REFERENCES

~~7.1~~ LAC~~Los Angeles Department of Mental Policy 306.02 Standards for Prescribing and Furnishing of Psychoactive Medications.~~

~~7.2~~7.1 DMH Parameters for Medication Use

~~7.3~~7.2 LACDMH Guidelines for the Use of DMH Parameters

~~7.4~~7.3 LACDMH Psychiatric Mental Health Nurse Practitioner (PMHNP) Standard Procedures

~~8. RESPONSIBLE PARTY~~

~~8.1 Tri City Mental Health Medical Director~~

~~2.1.1. Information to be provided to the client/guardian shall include:~~

~~2.1.1.1 An explanation of the nature of the illness and the proposed treatment.~~

~~2.1.1.2 The name and dose (range) of the medication~~

~~2.1.1.3 The type, range of frequency and amount, method (oral or injection), and duration of taking the medication.~~

~~2.1.1.4 The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff.~~

~~2.1.1.5 A disclosure of the reasonable alternative procedures or courses of treatment, if any.~~

~~2.1.1.6 A description of anticipated benefits.~~

~~2.1.1.7 Special instructions regarding food, drink or lifestyles.~~

~~2.1.1.8 A description of any reasonable foreseeable material risks, interactions with other medications, or discomforts;~~

~~2.1.1.9 The probable side effects of these drugs known to commonly occur and any particular side effects likely to occur with the particular patient.~~

~~2.1.1.10 The possible additional side effects which may occur to patients taking such medications beyond three months. The patient shall be advised that such side effects may include persistent involuntary movement of the hands and feet and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued.~~

~~2.1.1.11 Additional requirements for informed consent for antipsychotic medications include: "A voluntary patient shall be treated with antipsychotic medications only after such person has been informed of his or her right to accept or refuse such medications and has consented to the administration of such medications.~~

~~2.2 Associated Assessment~~

~~2.2.1. Relevant information contained in progress notes from other clinical disciplines and staff should be reviewed and considered by the treating physician/PMHNP in formulating medication treatment planning. Factors influencing the physician's/PMHNP's treatment decisions obtained from other treating clinicians should be documented.~~

~~Treatment of individuals known to the facility but not to the physician/PMHNP (i.e., cross coverage situations) should include a review of the clinical record to assess for medication history, adverse side effects, allergies and other special circumstances or considerations required to appropriately prescribe/furnish.~~

~~Physicians/PMHNPs should be capable of utilizing the full spectrum of psychotropic agents available for the specific population being treated and consistent with the physician's background, training, and scope of practice~~

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Standards For Prescribing and Monitoring Medications	CL.V.01	08/1/2019	6 of 6

TRI-CITY MENTAL HEALTH AUTHORITY

POLICY & PROCEDURE

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Storing, Administering, Disposing, and Accountability of Medications	**CL.V.02**	**04/16/2025**	**1** of **8**
APPROVED BY: **Governing Board** **Executive Director**	**SUPERCEDES:** **8/1/2019**	**ORIGINAL ISSUE DATE:** **04/21/2010**	**RESPONSIBLE PARTIES:** **Medical Director**

1. PURPOSE

1.1 To establish a uniform standard for storing, administering, disposing and accountability of medications. This policy sets forth the principles for ensuring compliance with Federal, State, and County regulatory requirements.

2. DEFINITIONS

2.1 Authorized Medication Room Personnel: Workforce members members who are authorized to have access to the medication room and who are authorized to handle medication.

2.2 Medication: A substance taken into (or applied to) the body for the purpose of prevention, treatment, relief of symptoms, or cure.

2.3 Medication Administration: The act of administering a single dose of a prescribed medication, whether by injection, inhalation, ingestion, application, or other means into (or applied to) the body of the individual by an individual legally authorized to do so. Medication administration requires making a written record of each medication administered.

2.4 Medication Training and Support: The following activities are included in medication monitoring training and support: 1) Communicating the prescriber's order to a client in such a manner that the client self-administers his/her medication properly; 2) Reminding or coaching a client to take medication at the time ordered; 3) Observing a client to ensure medications were taken; 4) Providing/delivering to a specific client a package or container of medication that was lawfully prepared and/or labeled by a person authorize to prescribe/dispense medication. Medication Training and Support requires making a written record of each medication, training, and support intervention.

2.5 Medication Dispensing: Dispensing is the act of interpreting an order for a medication and, pursuant to that order, the proper selection, measuring, packaging, labeling, and insurance of the medication for a client.

2.6 Prescriber: A licensed physician or other authorized licensed health care practitioner with legal authority to order or prescribe medication.

2.7 Prescription Medication: Medications that must be ordered by a physician or other licensed health care professional with authority to write prescriptions.

2.8 Sample Medication: Pre-boxed medication that is provided to prescribers by pharmaceutical manufacturers to be order for and provided to specific clients. Pharmaceutical samples are not intended for sale or resale.

2.9 Terminated Medication: Any expired, obsolete, unused, damaged, contaminated or deteriorated or otherwise unusable or unwanted medication.

3. POLICY

3.1 Clinic and facility standards shall conform to Federal, State, and County regulatory requirements, as well as policy requirements

3.2 The Medical Director of Tri-City Mental Health Authority (TCMHA), or permissible designee, shall be responsible for overall control, access and accountability of medications and supplies at TCMHA.

3.3 The responsibility and implementing standards and for ensuring compliance at TCMHA clinical facilities is assigned to the Medical Director of TCMHA.

3.4 TCMHA must have a medication inventory control system that is approved by the Medical Director, which includes a secure medication storage area and logging system.

3.5 Only the following medication types can be stored at TCMHA/by TCMHA workforce members:

3.5.2 Medication orders and/or prescriptions written by TMCHA prescribers.

3.5.3 Sample Medication from pharmaceutical manufacturers.

3.5.2.1 Receipt of any sample medication must be authorized and signed for by a TCMHA psychiatrist.

3.6 Any medication received on behalf of TCMHA, stored at TCMHA, or handled by TCMHA workforce members shall only be used for prescribed clients.

3.6.1 Medications indicated in 3.6 shall never be used by TCMHA staff or other individuals/purposes.

3.7 All medications (ordered/prescribed medications and sample medications) that are stored at TCMHA or by TCMHA workforce shall only be stored designated locked medication cabinet(s), which shall be located inside of designated locked medication room(s).

3.7.1 Medication must be stored in accordance with Federal, State, and County regulatory requirements, as well as policy requirements to promote security as well as health and client safety.

3.8 Medications shall only be accessible to licensed medical, nursing, or pharmacy personnel authorized by the Medical Director and Medication Support Manager.

3.9 The medication support program shall have specific key control policies, procedures and protocols delineating which authorized staff members have access to the keys.

3.10 The following licensed medical staff can perform activities related to medication:

Workforce Member	Allowable Activities:
Physician **Must have: 1) An active Medical License from the Medical Board of California; 2) A Federal Drug Enforcement Administration (DEA) Number.*	– Prescribe, dispense, and administer medications. – Provide medication training and support. – Classified as authorized medication room personnel
Psychiatric Mental Health Nurse Practitioner (PMHNP) **Must have: 1 An active Nurse Practitioner License from the California Board of Registered Nursing (BRN); 2) A Nurse Practitioner Furnishing Number from the California Board of Registered Nursing (BRN); and 3) A Federal Drug Enforcement Administration (DEA) Number.*	Under the supervision of a TCMHA physician: – Prescribe, dispense, and administer medications – Provide medication training and support services – Classified as authorized medication room personnel
Registered Nurse (RN) **Must have: 1) An active Nurse License from the California Board of Registered Nursing (BRN);*	Under the supervision and order of a TCMHA physician and/or PMHNP: – Dispense Non-Controlled Medication – Administer Medication – Provide medication training and support services – Classified as authorized medication room personnel

License Psychiatric Technician (P.T.) **Must have: 1) An active California Psychiatric Technician License from the Board of Vocational Nursing,*	Under the supervision and order of a TCMHA physician and/or PMHNP: – Administer Medication – Provide medication training and support services – Classified as authorized medication room personnel
All Trained Personnel	Administer intranasal Naloxone in accordance with training and agency policy

3.11 All medications administered must be done in accordance with a written order and under the direct supervision an authorized TMCHA prescriber.

3.12 Only authorized workforce members, delineated in 3.6, are permitted to administer medications.

3.12.1 Workforce members administering medication shall inform the client and/or authorized legal representative of the intended benefit and potential clinically significant side effects of the medications.

3.13 Terminated medications shall immediately be removed from inventory and disposed of onsite in the proper disposal bin. Terminated medication shall be disposed of/destroyed by a designated and qualified medication destruction vendor.

3.14 Upon discovery of medication errors or near-miss events, TCMHA workforce members shall act in accordance with policies, procedures and protocols regarding incident reporting.

4. PROCEDURES

4.1 The overall medication acquisition, administration, disposal, and accountability is the direct responsibility of the medical director. Medication storage at each clinic is the direct responsibility of the Medication Support Program Manager or permissible designee.

Medication Logging

4.2 Any medication entering or exiting the medication cabinets, must be logged in or out officially, (This includes, but is not limited to prescriptions for individual clients, special request/orders for medications, sample medications).

4.3 Elements on the medication logs must be congruent with applicable regulatory standards, as well as State of California & Los Angeles Department of Mental Health certification/recertification standards.

4.4 Medication logs must be kept a minimum of three (3) years.

4.5 The Medical Director or his/her designee must review the medication log for accuracy on a monthly basis.

Medication Storage

4.6 Medications must be stored in a locked, secure area, not accessible to clinic client's, visitors, or unauthorized staff.

4.7 Medications shall be accessible only to licensed medical, nursing, or pharmacy personnel designated in accordance with key control policies and protocols.

4.8 Medications shall be stored in an orderly manner in cabinets, drawers, or carts of sufficient size to prevent crowding.

4.9 Containers that are cracked, soiled, or without secure closures shall not be used. Medication labels shall be legible.

4.10 All medications shall be kept and stored in their originally received containers. No drug shall be transferred between containers.

4.11 Internal use medication in liquid, tablet, capsule, or powder form shall be stored separately from medication for external use.

4.12 Look-alike/sound-alike medication shall be separated and identified by Tall Man lettering and warning labels

4.13 Medications shall not be stored in the same refrigerator with food or beverages.

4.14 Test reagents, germicides, disinfectants, and other household substances shall be stored separately from medications.

4.15 Medications shall not be kept in stock after the expiration date on the label; and no contaminated or deteriorated medications shall be available for use. The Medical Director or his/her designee will dispose of such medications in a manner prescribed by law.

Labeling

4.16 All medications shall be labeled in compliance with State and Federal laws.

4.17 No person other than a pharmacist or a licensed prescriber shall label a prescription or alter any prescription labels.

4.18 All multi-dose vials shall be clearly initialed, marked with the date the first draw is taken and discarded 30 days from that date or manufacturer expiration date if earlier.

Temperature Monitoring in the Medication Storage Area

4.19 Medications shall be stored at appropriate temperatures.

4.20 All facilities must have a thermometer to monitor the room and refrigerator temperature in their medication storage area.

4.21 The temperature of the storage area shall be entered into a log on a weekly basis with each entry signed by the person responsible for monitoring.

4.22 Medications required to be stored at room temperature shall be stored at a temperature between 59 °F (15 °C) and 86 °F (30 °C)

4.23 Medications requiring refrigeration shall be stored in a refrigerator between 36 °F (2 °C) and 46 °F (8 °C).

Sample Medication

4.24 Receipt of Sample medication must be immediately logged in the medication inventory control system and stored in the locked medication area, in accordance with this policy.

4.25 Sample medication must be ordered by a licensed prescriber, in order for the sample to be provided to a client.

4.26 All sample orders must be documented in the client's medical record, along with documentation of client education and informed consent.

4.27 The ordering prescriber of the sample shall affix medication label with information required under Business and Professional Code 4076 and all packaging requirements of good pharmaceutical practice, including the use of childproof containers.

4.27.2 Sample medications shall be provided in the original manufacturer's packaging with ample directions on how to take the medication.

4.27.3 Sample medications shall only be provided when the date of expiration of

the sample is prior to the date provided to the client.

4.28 Sample medication must be logged out of the medication inventorying control system before being provides to the client.

4.29 Once ordered and labeled and signed-out of the inventory control system, the sample medication can be provided to or delivered to the intended client by a physician, PMHNP, registered nurse, or psychiatric technician.

Medication and Medication Supply Disposal/Destruction

4.30 TCMHA workforce members shall follow all laws, regulations, standards, policies, procedures, and protocols regarding disposal/destructions of terminated medication.

4.31 All terminated medications shall be immediately removed from of inventory, by an authorized and licensed medication workforce member.

4.32 To remove a terminated medication from inventory, an authorized and licensed medication workforce member, with an accompanying authorized witness, must complete the following:

Remove the medication from inventory

Count the remaining inventory

Log the medication out of inventory

Prepare the medication for disposal/destruction

Place the medication in the designated disposal container in the medication room.

4.33 Terminated medications shall be picked up by a qualified contracted vendor for destruction on a regular basis. The Medication Services Program Manager must ensure expeditious transfer of the expired medication.

4.34 Sharps and used syringes and needles shall be disposed in the onsite sharps container provided through a qualified contracted vendor.

Compliance

4.35 Every six months, the program Medication Services Program Manager or permissible designee shall inspect the medication storage area and process of the program for compliance with the applicable standards and regulations.

5. REFERENCE

5.1 California Business and Professions Code Division 2 Chapter 9 – California Pharmacy Law

5.2 Los Angeles Department of Mental Health Policy Policy 352.10 Medication Administration (306.16)

5.3 Los Angeles Department of Mental Health Policy 352.19 Sample Medication

5.4 Los Angeles Department of Mental Health Policy 352.15 Patient's Own Medication

5.5 Los Angeles Department of Mental Health Policy 352.14 Medication Storage

5.6 Los Angeles Department of Mental Health Policy 352.08 Expired Medication and Device Disposal

TRI-CITY MENTAL HEALTH AUTHORITY
POLICY & PROCEDURE

SUBJECT:	POLICY NO.:	EFFECTIVE DATE:	PAGE:
Storing, Administering, Disposing, and Accountability of Medications	**CL.V.02**	~~**08/01/2019**~~ **4/16/2025**	**1 of 5**
APPROVED BY: **Executive Director Governing Board**	**SUPERCEDES:** ~~**All previous versions**~~ **08/11/2019**	**ORIGINAL ISSUE DATE:** **04/21/2010**	**RESPONSIBLE PARTIES:** **Medical Director**

1. PURPOSE

To establish a uniform standard for storing, administering, disposing and accountability of medications. This policy sets forth the principles for ensuring compliance with Federal, State, and County regulatory requirements.

2. DEFINITIONS

2.1 Authorized Medication Room Personnel: Workforce members members who are authorized to have access to the medication room and who are authorized to handle medication.

2.2 Medication: A substance taken into (or applied to) the body for the purpose of prevention, treatment, relief of symptoms, or cure.

2.3 Medication Administration: The act of administering a single dose of a prescribed medication, whether by injection, inhalation, ingestion, application, or other means into (or applied to) the body of the individual by an individual legally authorized to do so. Medication administration requires making a written record of each medication administered.

2.4 Medication Training and Support: The following activities are included in medication monitoring training and support: 1) Communicating the prescriber's order to a client in such a manner that the client self-administers his/her medication properly; 2) Reminding or coaching a client to take medication at the time ordered; 3) Observing a client to ensure medications were taken; 4) Providing/delivering to a specific client a package or container of medication that was lawfully prepared and/or labeled by a person authorize to prescribe/dispense medication. Medication Training and Support requires making a written record of each medication, training, and support intervention.

2.5 Medication Dispensing: Dispensing is the act of interpreting an order for a medication and, pursuant to that order, the proper selection, measuring, packaging, labeling, and insurance of the medication for a client.

2.6 Prescriber: A licensed physician or other authorized licensed health care practitioner with legal authority to order or prescribe medication.

2.7 Prescription Medication: Medications that must be ordered by a physician or other licensed health care professional with authority to write prescriptions.

2.8 Sample Medication: Pre-boxed medication that is provided to prescribers by pharmaceutical manufacturers to be order for and provided to specific clients. Pharmaceutical samples are not intended for sale or resale.

2.9 Terminated Medication: Any expired, obsolete, unused, damaged, contaminated or deteriorated or otherwise unusable or unwanted medication.

3. POLICY

3.1 Clinic and facility standards shall conform to Federal, State, and County regulatory requirements, as well as policy requirements

3.2 The Medical Director of Tri-City Mental Health Authority (TCMHA), or permissible designee, shall be responsible for the overall control, access and accountability of medications and supplies at TCMHA. ~~medication supply and for how the supply will be obtained, monitored, and administered within the agency.~~

3.3 The responsibility for developing and implementing standards and for ensuring compliance at TCMHA clinical facilities is assigned to the Medical Director of TCMHA ~~who has a direct services responsibility.~~

3.4 TCMHA must have a medication inventory control system that is approved by the Medical Director, which includes a secure medication storage area and logging system.

3.5 Only the following medication types can be stored at TCMHA/by TCMHA workforce members:

3.5.2 Medication orders and/or prescriptions written by TMCHA prescribers.

3.5.3 Sample Medication from pharmaceutical manufacturers.

3.5.4 Receipt of any sample medication must be authorized and signed for by a TCMHA psychiatrist.

3.6 Any medication received on behalf of TCMHA, stored at TCMHA, or handled by TCMHA workforce members shall only be used for prescribed clients.

3.6.2 Medications indicated in 3.6 shall never be used by TCMHA staff or other individuals/purposes.

3.7 All medications (ordered/prescribed medications and sample medications) that are stored at TCMHA or by TCMHA workforce shall only be stored designated locked medication cabinet(s), which shall be located inside of designated locked medication room(s).

3.7.2 Medication must be stored in accordance with Federal, State, and County regulatory requirements, as well as policy requirements to promote security as well as health and client safety.

3.8 Medications shall only be accessible to licensed medical, nursing, or pharmacy personnel authorized by the Medical Director and Medication Support Manager.

3.9 The medication support program shall have specific key control policies, procedures and protocols delineating which authorized staff members have access to the keys.

3.10 The following licensed medical staff can perform activities related to medication:

Workforce Member	Allowable Activities:
Physician **Must have: 1) An active Medical*	– Prescribe, dispense, and administer medications. – Provide medication training and

License from the Medical Board of California; 2) A Federal Drug Enforcement Administration (DEA) Number.	support. – Classified as authorized medication room personnel
Psychiatric Mental Health Nurse Practitioner (PMHNP) **Must have: 1 An active Nurse Practitioner License from the California Board of Registered Nursing (BRN); 2) A Nurse Practitioner Furnishing Number from the California Board of Registered Nursing (BRN); and 3) A Federal Drug Enforcement Administration (DEA) Number.*	Under the supervision of a TCMHA physician: – Prescribe, dispense, and administer medications – Provide medication training and support services – Classified as authorized medication room personnel
Registered Nurse (RN) **Must have: 1) An active Nurse License from the California Board of Registered Nursing (BRN);*	Under the supervision and order of a TCMHA physician and/or PMHNP: – Dispense Non-Controlled Medication – Administer Medication – Provide medication training and support services – Classified as authorized medication room personnel
License Psychiatric Technician (P.T.) **Must have: 1) An active California Psychiatric Technician License from the Board of Vocational Nursing,*	Under the supervision and order of a TCMHA physician and/or PMHNP: – Administer Medication – Provide medication training and support services – Classified as authorized medication room personnel
All Trained Personnel	Administer intranasal Naloxone in accordance with training and agency policy

3.11 All medications administered must be done in accordance with a written order and under the direct supervision an authorized TMCHA prescriber.

3.12 Only authorized workforce members, delineated in 3.6, are permitted to administer medications.

3.12.2 Workforce members administering medication shall inform the client and/or authorized legal representative of the intended benefit and potential clinically significant side effects of the medications.

3.12.3 Workforce members administering medication shall remain with the client and report observations to the ordering prescriber or supervising psychiatrist.

3.13 Terminated medications shall immediately be removed from inventory and disposed of onsite in the proper disposal bin. Terminated medication shall be disposed of/destroyed by a designated and qualified medication destruction vendor.

3.14 Upon discovery of medication errors or near-miss events, TCMHA worforce members shall act in accordance with policies, procedures and protocols regarding incident reporting.

~~**3.15** Clinic and facility standards shall conform to County, State, and Federal Regulatory agency requirements. (LACDMH Policy No. 1100.01, Quality Improvement Program;~~

~~California Business and Professions Code Division 2 Chapter 9 - California Pharmacy Law)~~

4. PROCEDURES

~~General~~

4.1 The overall medication acquisition, administration, disposal, and accountability, is the direct responsibility of the medical director. The medication storage at each clinic is the direct responsibility of the Medication Support Program Manager or permissible designee.

Medication Logging

4.2 Any medication entering or exiting the medication cabinets, must be logged in or out officially, (This includes, but is not limited to prescriptions for individual clients, special request/orders for medications, sample medications).

4.3 Elements on the medication logs must be congruent with applicable regulatory standards, as well as State of California & Los Angeles Department of Mental Health certification/recertification standards.

4.4 Medication logs must be kept a minimum of three (3) years.

4.5 The Medical Director or his/her designee must review the medication log for accuracy on a monthly basis.

~~**4.1.2** No medications shall be administered or dispensed except on the order of a person lawfully authorized to prescribe for and treat human illness. All such orders shall be in writing and signed by the person giving the order. The name, quantity or duration of therapy, dosage and time of administration of the drug, the route of administration, other than oral; and the site of injection, when indicated, shall be specified.~~

~~**4.1.3** All medications that are stored on site shall only be stored in the medication room in a locked cabinet, or other locked storage container.~~

~~**4.1.4** Medications shall be accessible only to licensed medical, nursing, or pharmacy personnel designated in writing by the facility. The medication support program shall have a specific key control policy delineating which authorized staff members have access to the keys.~~

~~**Pharmaceutical Samples** Pharmaceutical samples may be used and stored at TCMHA clinical facilities under the following conditions:~~

~~**4.1.5** The pharmaceutical samples shall be stored only in the medication room in locked cabinet or other storage container under lock and key.~~

~~**4.1.6** Any program in which sample medications are dispensed must have a medication control system that is approved by the Medical Director and includes a secure medication storage area and logging system.~~

~~**4.1.7** Sample medications must be logged into the program's medication control system before they are dispensed to client.~~

~~**4.1.8** Sample medications can be dispensed only by a California licensed Physician, Nurse Practitioner, or Physician Assistant.~~

~~**4.1.9** Sample medications may be dispensed only with appropriate documentation in the client medical record.~~

~~**4.1.10** Sample medications may be dispensed only when the date of dispensing is prior to the expiration date.~~

~~**4.1.11** Medication samples shall be dispensed in the original manufacturer's packaging with ample directions on how to take the medication.~~

~~**4.1.12** When medication samples are dispensed, it must be under the direct supervision of the prescribing physician.~~

~~**4.1.13** This policy does not authorize the storage of pharmaceutical samples at any location other than the locked medication area noted above.~~

~~**Storage & Labeling**~~ **Medication Storage**

4.6 Medications ~~shall~~ must be stored in a locked, secure area, not accessible to clinic consumers or unauthorized staff.

4.7 Medications shall be accessible only to licensed medical, nursing, or pharmacy personnel designated ~~in writing by the facility.~~ in accordance with key control policies and protocols.

4.8 Medications shall be stored in an orderly manner in cabinets, drawers, or carts of sufficient size to prevent crowding.

4.9 Containers that are cracked, soiled, or without secure closures shall not be used. Medication labels shall be legible.

4.10 All medications shall be kept and stored in their originally received containers. No drug shall be transferred between containers.

4.11 Internal use medication in liquid, tablet, capsule, or powder form shall be stored separately from medication for external use.

4.12 Look-alike/sound-alike medication shall be separated and identified by Tall Man lettering and warning labels

4.13 Medications shall not be stored in the same refrigerator with food or beverages.

4.14 Test reagents, germicides, disinfectants, and other household substances shall be stored separately from medications.

4.15 Medications shall not be kept in stock after the expiration date on the label; and no contaminated or deteriorated medications shall be available for use. The Medical Director or his/her designee will dispose of such medications in a manner prescribed by law.

~~Medication labels shall be legible.~~

Labeling

4.16 All medications ~~obtained by prescription~~ shall be labeled in compliance with State and Federal laws ~~governing prescription dispensing.~~

4.17 No person other than a pharmacist or licensed prescriber ~~physician~~ shall label any prescription or alter any prescription labels.

4.18 All multi-dose vials shall be clearly initialed, marked with the date the first draw is taken and discarded 30 days from that date or manufacturer expiration date if earlier.

- ~~Non-legend medication shall be labeled in conformance with State and Federal food and drug laws.~~

~~**4.2 Medication Logging**~~

~~**3.4.1** Any medication entering or exiting the medication room, must be logged in or out officially, (This includes, but is not limited to prescriptions for individual clients, special request/orders for medications, sample medications).~~

~~**3.4.2** Log elements must be congruent with applicable regulatory standards, as well as State of California & Los Angeles Department of Mental Health certification/recertification standards.~~

~~**3.4.3** The medication logs must be kept a minimum of three (3) years.~~

~~**3.4.4** Each time the clinic stock is replenished, it needs to be entered onto the ongoing medication log. The completed log shall be kept for at least three (3) years after the date of the last entry made.~~

~~**3.4.5** The Medical Director or his/her designee must review the medication log for accuracy on a monthly basis and report any significant discrepancies to the Chief Compliance Officer at TCMHA.~~

~~**3.4.6** Medication administered in an outpatient clinical facility shall be done only under the direct supervision of the prescribing physician.~~

Temperature Monitoring in the Medication Storage Area

4.19 Medications shall be stored at appropriate temperatures.

4.20 All facilities must have a thermometer to monitor the room and refrigerator temperature in their medication storage area.

4.21 The temperature of the storage area shall be entered into a log on a weekly basis with each entry signed by the person responsible for monitoring.

4.22 Medications required to be stored at room temperature shall be stored at a temperature between 59 °F (15 °C) and 86 °F (30 °C)

4.23 Medications requiring refrigeration shall be stored in a refrigerator between 36 °F (2 °C) and 46 °F (8 °C).

Sample Medication

4.24 Receipt of Sample medication must be immediately logged in the medication inventory control system and stored in the locked medication area, in accordance with this policy.

4.25 Sample medication must be ordered by a licensed prescriber, in order for the sample to be provided to a client.

4.26 All sample orders must be documented in the client's medical record, along with documentation of client education and informed consent.

4.27 The ordering prescriber of the sample shall affix medication label with information required under Business and Professional Code 4076 and all packaging requirements of good pharmaceutical practice, including the use of childproof containers.

4.27.2 Sample medications shall be provided in the original manufacturer's packaging with ample directions on how to take the medication.

4.27.3 Sample medications shall only be provided when the date of expiration of the sample is prior to the date provided to the client.

4.28 Sample medication must be logged out of the medication inventorying control system before being provides to the client.

4.29 Once ordered and labeled and signed-out of the inventory control system, the sample medication can be provided to or delivered to the intended client by a physician, PMHNP, registered nurse, or psychiatric technician.

Medication and Medication Supply Disposal/Destruction ~~Medication Disposal~~

4.30 ~~Tri-City Mental Health Services shall properly dispose of unused, out-of-date, damaged or otherwise unusable or unwanted Controlled Substances, including samples and medication.~~ TCMHA workforce members shall follow all laws, regulations, standards, policies, procedures, and protocols regarding disposal/destructions of terminated medication.

4.31 All terminated medications shall be immediately removed from of inventory, by an authorized and licensed medication workforce member.

4.32 To remove a terminated medication from inventory, an authorized and licensed medication workforce member, with an accompanying authorized witness, must complete the following:

Remove the medication from inventory

Count the remaining inventory

Log the medication out of inventory

Prepare the medication for disposal/destruction

Place the medication in the designated disposal container in the medication room.

4.33 Terminated medications shall be picked up by a qualified contracted vendor for destruction on a regular basis. The Medication Services Program Manager must ensure expeditious transfer of the expired medication.

4.34 Sharps and used syringes and needles shall be disposed in the onsite sharps container provided through a qualified contracted vendor. ~~by the ASB.~~

~~4.34.2~~ ~~The Program Manager or their designee shall follow all laws, regulations, standards, and protocols regarding medication disposal.~~

~~4.34.3~~ ~~When a medication has expired, the disposal of the medication must be logged. The log elements must be congruent with applicable regulatory standards, as well as State of California & Los Angeles Department of Mental Health certification/recertification standards.~~

4.34.4 Expired medications shall be logged out, placed in a sealable container, sealed by the program manager or permissible designee.

4.34.5 Expired medications shall be picked up by and eligible contracted vendor for destruction no later than one month after the expiration date. The program manager must ensure expeditious transfer of the expired medication.

4.34.6 Medications shall not be kept in stock after the expiration date on the label, and no contaminated or deteriorated medications shall be available.

Compliance

3.7.1 Every six months, the program Medication Services Program Manager or permissible designee shall inspect the medication storage area and process of the program for compliance with the applicable standards and regulations. ~~The documentation shall be submitted to the Manager of Best Practices.~~

5. REFERENCE

~~**5.1** Los Angeles Department of Mental Health Policy 306.03 Storage, Administration, Disposing, and Accountability, of Medication~~

5.2 California Business and Professions Code Division 2 Chapter 9 - California Pharmacy Law

5.3 Los Angeles Department of Mental Health Policy Policy 352.10 Medication Administration (306.16)

5.4 Los Angeles Department of Mental Health Policy 352.19 Sample Medication

5.5 Los Angeles Department of Mental Health Policy 352.15 Patient's Own Medication

5.6 Los Angeles Department of Mental Health Policy 352.14 Medication Storage

5.7 Los Angeles Department of Mental Health Policy 352.08 Expired Medication and Device Disposal

~~6. RESPONSIBLE PARTY~~

~~**6.1** Tri City Mental Health Medical Director~~

Tri-City Mental Health Authority
AGENDA REPORT

DATE: **April 16, 2025**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Ontson Placide, LMFT, Executive Director**

BY: **Kitha Torregano, Human Resources Director**

SUBJECT: **Consideration of Resolution No. 777 Adopting a Revised Master Classification and Salary Schedule and Revised Job Description for the Senior Behavioral Health Specialist Classification**

Summary:

This report seeks the adoption of a revised job description for the Senior Mental Health Specialist classification to align with TCMHA's commitment to terminology consistency with the broader behavioral health profession. The revision changes the title from "Senior Mental Health Specialist" to "Senior Behavioral Health Specialist" to match the statewide and national movement toward the use of "behavioral health" terminology. This change aligns the agency's job description with current professional standards without altering the role's essential functions or pay grade.

Background:

In the course of TCMHA's Classification and Compensation Study implemented through Resolution No. 724 (adopted by the Governing Board on September 20, 2023), various job titles were updated to reflect the shift in the mental health field towards "behavioral health" terminology. While most classifications were updated at that time, the Senior Mental Health Specialist classification was not. This agenda item seeks to update the title to "Senior Behavioral Health Specialist." This is a straightforward title change to bring the job description in alignment with state and professional standards and does not involve any changes to job duties, compensation, or qualifications.

Fiscal Impact:

None applicable. The administrative title change has no impact on compensation, benefits, or staffing levels.

Recommendation:

Staff recommends that the Governing Board adopt Resolution No. 777 to approve the revised job description for the Senior Behavioral Health Specialist classification and update the Master Classification and Salary Schedule to reflect the change.

Attachments:

Attachment 10-A: Resolution No. 777 - Draft
Exhibit A: Master Classification and Salary Schedule Effective 01012025

Attachment 10-B: Senior Behavioral Health Specialist Job Description

RESOLUTION NO. 777

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY APPROVING THE REVISED JOB DESCRIPTION OF THE SENIOR BEHAVIORAL HEALTH SPECIALIST CLASSIFICATION; AND REVISING THE AUTHORITY'S MASTER CLASSIFICATION AND SALARY SCHEDULE EFFECTIVE RETROACTIVE JANUARY 1, 2025 TO INCLUDE THIS CHANGE

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. The Tri-City Mental Health Authority ("TCMHA" or "Authority") desires to change the title of the Senior Mental Health Specialist Job Description to *Senior Behavioral Health Specialist* to match the statewide and national use of "behavioral health" terminology; and update the Authority's Master Classification and Salary Schedule to reflect this change effective January 1, 2025.

B. The Authority's Governing Board has previously approved job descriptions, classifications, salary ranges, and benefits for the Authority's employees through the adoption of Resolutions.

2. Action

The Governing Board approves the revised job description of Senior Behavioral Health Specialist Classification without altering the pay grade; and adopts the Authority's Revised Master Classification and Salary Schedule effective retroactively to January 1, 2025, attached herein as 'Exhibit A.', replacing and superseding all previous versions.

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on April 16, 2025, by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

JED LEANO, CHAIR

APPROVED AS TO FORM:

STEVEN L. FLOWER, GENERAL COUNSEL

ATTEST:

MICAELA P. OLMOS, RECORDING SECRETARY

EXHIBIT A

TRI-CITY MENTAL HEALTH AUTHORITY
MASTER CLASSIFICATION AND SALARY SCHEDULE
EFFECTIVE JANUARY 1, 2025
ADOPTED APRIL 16, 2025

Classification	Salary Range
Accountant	31
Accounting Manager	52
Accounting Technician	22
Administrative Assistant	26
Administrative Services Manager	46
Behavioral Health Advocate I	15
Behavioral Health Advocate II	17
Behavioral Health Program Supervisor	43
Behavioral Health Specialist	22
Behavioral Health Specialist Coordinator	30
Behavioral Health Worker	19
Chief Clinical Officer	70
Chief Compliance Officer & Privacy Officer	65
Chief Financial Officer	70
Chief Information Officer	65
Chief Operating Officer/HIPAA Privacy Officer	70
Clinical Program Manager	53
Clinical Supervisor I	45
Clinical Supervisor II	49
Clinical Therapist I	37
Clinical Therapist II	41
Communications Coordinator	32
Community Behavioral Health Trainer	37
Community Capacity Organizer	37
Community Navigator	19
Compliance Administrator	37
Controller	57
Counselor	31
Crisis Intervention & Medication Support Manager	52
Crisis Intervention & Medication Support Supervisor	37
Data Analyst	42
Data Specialist	38
Data Supervisor	46
Deputy Chief Clinical Officer	61
Director of MHSA & Ethnic Services	65
Diversity, Equity & Inclusion Coordinator	37
Electronic Health Reocrds Specialist	37
Executive Director	93
Facilities and Safety Manager	46
Facilities Coordinator	42
Facilities Maintenance Worker	19
Grants Manager	47
Housing Manager	52
Housing Outreach Specialist	26
Housing Supervisor	46
Human Resources Analyst	38
Human Resources Assistant	19
Human Resources Director	60
Human Resources Technician	25
Information Technology Service Desk & Project Supervisor	46
Information Technology Specialist I	30
Information Technology Specialist II	34
Information Technology Systems Administrator & Security Officer	52
Joint Powers Authority (JPA) Administrator/Clerk	52
Manager of Best Practices	52
Master of Social Work Intern	15
Medical Assistant	15

Medical Director	93
MHSA Program Coordinator	42
MHSA Projects Manager	52
Nurse Practitioner I	56
Nurse Practitioner II	60
Occupational Therapist	50
Office Assistant	15
Office Specialist	19
Peer Support Specialist I	15
Peer Support Specialist II	19
Program Analyst	42
Program Manager	52
Program Supervisor	46
Program Support Supervisor	31
Psychiatric Technician I	22
Psychiatric Technician II	26
Psychiatrist I	82
Psychiatrist II	86
Psychiatrist III	90
Psychologist	46
Quality Assurance Specialst I	38
Quality Assurance Specialst II	42
Quality Assurance Supervisor	46
Residential Services Coordinator	18
Revenue/Billing Manager	52
Senior Accountant	37
Senior Facilities Maintenance Worker	23
Senior Human Resources Analyst	42
Senior Information Technology Specialist	52
Senior Behavioral Health Specialist	26
TCG Gardener	15
WET Supervisor	46

TRI-CITY MENTAL HEALTH AUTHORITY
MASTER CLASSIFICATION AND SALARY SCHEDULE
EFFECTIVE JANUARY 1, 2025
ADOPTED APRIL 16, 2025

Salary Range	Annually						Monthly						Per Pay Period						Hourly					
	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
15	[redacted]	[redacted]	48,546.58	50,973.94	53,522.77	56,198.90	[redacted]	[redacted]	4,045.55	4,247.83	4,460.23	4,683.24	[redacted]	[redacted]	1,867.18	1,960.54	2,058.57	2,161.50	[redacted]	[redacted]	23.33970	24.50670	25.73210	27.01870
16	[redacted]	[redacted]	49,760.26	52,248.35	54,860.83	57,603.73	[redacted]	[redacted]	4,146.69	4,354.03	4,571.74	4,800.31	[redacted]	[redacted]	1,913.86	2,009.55	2,110.03	2,215.53	[redacted]	[redacted]	23.92320	25.11940	26.37540	27.69410
17	48,575.49	51,004.30	53,554.59	56,232.38	59,043.92	[redacted]	4,047.96	4,250.36	4,462.88	4,686.03	4,920.33	[redacted]	1,868.29	1,961.70	2,059.79	2,162.78	2,270.92	[redacted]	23.35360	24.52130	25.74740	27.03480	28.38650	
18	49,790.00	52,279.55	54,893.49	57,638.05	60,520.10	[redacted]	4,149.17	4,356.63	4,574.46	4,803.17	5,043.34	[redacted]	1,915.00	2,010.75	2,111.29	2,216.85	2,327.70	[redacted]	23.93750	25.13440	26.39110	27.71060	29.09620	
19	48,604.40	51,034.67	53,586.42	56,265.66	59,079.07	62,033.09	4,050.37	4,252.89	4,465.53	4,688.81	4,923.26	5,169.42	1,869.40	1,962.87	2,061.02	2,164.06	2,272.27	2,385.89	23.36750	24.53590	25.76270	27.05080	28.40340	29.82360
20	49,819.54	52,310.54	54,926.14	57,672.37	60,556.08	63,583.73	4,151.63	4,359.21	4,577.18	4,806.03	5,046.34	5,298.64	1,916.14	2,011.94	2,112.54	2,218.17	2,329.08	2,445.53	23.95170	25.14930	26.40680	27.72710	29.11350	30.56910
21	51,065.04	53,618.24	56,299.15	59,114.22	62,069.90	65,173.47	4,255.42	4,468.19	4,691.60	4,926.19	5,172.49	5,431.12	1,964.04	2,062.24	2,165.35	2,273.62	2,387.30	2,506.67	24.55050	25.77800	27.06690	28.42030	29.84130	31.33340
22	52,341.74	54,958.80	57,706.69	60,592.06	63,621.58	66,802.74	4,361.81	4,579.90	4,808.89	5,049.34	5,301.80	5,566.89	2,013.14	2,113.80	2,219.49	2,330.46	2,446.98	2,569.34	25.16430	26.42250	27.74360	29.13080	30.58730	32.11670
23	53,650.27	56,332.85	59,149.38	62,106.93	65,212.16	68,472.77	4,470.86	4,694.40	4,929.11	5,175.58	5,434.35	5,706.06	2,063.47	2,166.65	2,274.98	2,388.73	2,508.16	2,633.57	25.79340	27.08310	28.43720	29.85910	31.35200	32.91960
24	54,991.46	57,741.01	60,628.05	63,659.44	66,842.46	70,184.61	4,582.62	4,811.75	5,052.34	5,304.95	5,570.21	5,848.72	2,115.06	2,220.81	2,331.85	2,448.44	2,570.86	2,699.41	26.43820	27.76010	29.14810	30.60550	32.13580	33.74260
25	56,366.34	59,184.53	62,143.74	65,251.06	68,513.54	71,939.30	4,697.19	4,932.04	5,178.65	5,437.59	5,709.46	5,994.94	2,167.94	2,276.33	2,390.14	2,509.66	2,635.14	2,766.90	27.09920	28.45410	29.87680	31.37070	32.93920	34.58620
26	57,775.54	60,664.24	63,697.50	66,882.40	70,226.42	73,737.66	4,814.63	5,055.35	5,308.13	5,573.53	5,852.20	6,144.81	2,222.14	2,333.24	2,449.90	2,572.40	2,701.02	2,836.06	27.77670	29.16550	30.62380	32.15500	33.76270	35.45080
27	59,219.89	62,180.77	65,289.95	68,554.30	71,982.14	75,581.17	4,934.99	5,181.73	5,440.83	5,712.86	5,998.51	6,298.43	2,277.69	2,391.57	2,511.15	2,636.70	2,768.54	2,906.97	28.47110	29.89460	31.38940	32.95880	34.60680	36.33710
28	60,700.43	63,735.36	66,922.13	70,268.22	73,781.55	77,470.64	5,058.37	5,311.28	5,576.84	5,855.69	6,148.46	6,455.89	2,334.63	2,451.36	2,573.93	2,702.62	2,837.75	2,979.64	29.18290	30.64200	32.17410	33.78280	35.47190	37.24550
29	62,217.79	65,328.64	68,595.07	72,024.99	75,626.10	79,407.54	5,184.82	5,444.05	5,716.26	6,002.08	6,302.17	6,617.29	2,392.99	2,512.64	2,638.27	2,770.19	2,908.70	3,054.14	29.91240	31.40800	32.97840	34.62740	36.35870	38.17670
30	63,773.22	66,961.86	70,310.03	73,825.65	77,516.82	81,392.69	5,314.43	5,580.15	5,859.17	6,152.14	6,459.73	6,782.72	2,452.82	2,575.46	2,704.23	2,839.45	2,981.42	3,130.49	30.66020	32.19320	33.80290	35.49310	37.26770	39.13110
31	[redacted]	[redacted]	72,067.84	75,671.23	79,454.75	83,427.55	[redacted]	[redacted]	6,005.65	6,305.94	6,621.23	6,952.30	[redacted]	[redacted]	2,771.84	2,910.43	3,055.95	3,208.75	[redacted]	[redacted]	34.64800	36.38040	38.19940	40.10940
32	67,001.79	70,351.84	73,869.54	77,562.99	81,441.15	85,513.17	5,583.48	5,862.65	6,155.79	6,463.58	6,786.76	7,126.10	2,576.99	2,705.84	2,841.14	2,983.19	3,132.35	3,288.97	32.21240	33.82300	35.51420	37.28990	39.15440	41.11210
33	68,676.82	72,110.69	75,716.16	79,501.97	83,477.06	87,650.99	5,723.07	6,009.22	6,309.68	6,625.16	6,956.42	7,304.25	2,641.42	2,773.49	2,912.16	3,057.77	3,210.66	3,371.19	33.01770	34.66860	36.40200	38.22210	40.13320	42.13990
34	70,393.86	73,913.42	77,609.17	81,489.62	85,564.13	89,842.27	5,866.15	6,159.45	6,467.43	6,790.80	7,130.34	7,486.86	2,707.46	2,842.82	2,984.97	3,134.22	3,290.93	3,455.47	33.84320	35.53530	37.31210	39.17770	41.13660	43.19340
35	72,153.54	75,761.30	79,549.39	83,526.77	87,703.20	92,088.26	6,012.79	6,313.44	6,629.12	6,960.56	7,308.60	7,674.02	2,775.14	2,913.90	3,059.59	3,212.57	3,373.20	3,541.86	34.68920	36.42370	38.24490	40.15710	42.16500	44.27320
36	73,957.52	77,655.34	81,538.08	85,615.09	89,895.73	94,390.61	6,163.13	6,471.28	6,794.84	7,134.59	7,491.31	7,865.88	2,844.52	2,986.74	3,136.08	3,292.89	3,457.53	3,630.41	35.55650	37.33430	39.20100	41.16110	43.21910	45.38010
37	75,806.43	79,596.82	83,576.48	87,755.41	92,143.17	96,750.37	6,317.20	6,633.07	6,964.71	7,312.95	7,678.60	8,062.53	2,915.63	3,061.42	3,214.48	3,375.21	3,543.97	3,721.17	36.44540	38.26770	40.18100	42.19010	44.29960	46.51460
38	77,701.52	81,586.54	85,666.05	89,949.18	94,446.77	99,168.99	6,475.13	6,798.88	7,138.84	7,495.77	7,870.56	8,264.08	2,988.52	3,137.94	3,294.85	3,459.58	3,632.57	3,814.19	37.35650	39.22430	41.18560	43.24480	45.40710	47.67740
39	79,644.03	83,626.40	87,807.62	92,198.08	96,807.98	101,648.35	6,637.00	6,968.87	7,317.30	7,683.17	8,067.33	8,470.70	3,063.23	3,216.40	3,377.22	3,546.08	3,723.38	3,909.55	38.29040	40.20500	42.21520	44.32600	46.54230	48.86940
40	81,635.22	85,717.01	90,002.85	94,502.93	99,228.06	104,189.49	6,802.93	7,143.08	7,500.24	7,875.24	8,269.01	8,682.46	3,139.82	3,296.81	3,461.65	3,634.73	3,816.46	4,007.29	39.24770	41.21010	43.27060	45.43410	47.70580	50.09110
41	83,676.11	87,859.82	92,252.78	96,865.60	101,708.88	106,794.27	6,973.01	7,321.65	7,687.73	8,072.13	8,475.74	8,899.52	3,218.31	3,379.22	3,548.18	3,725.60	3,911.88	4,107.47	40.22890	42.24030	44.35230	46.57000	48.89850	51.34340
42	85,767.97	90,056.30	94,559.30	99,287.14	104,251.47	109,464.16	7,147.33	7,504.69	7,879.94	8,273.93	8,687.62	9,122.01	3,298.77	3,463.70	3,636.90	3,818.74	4,009.67	4,210.16	41.23460	43.29630	45.46120	47.73420	50.12090	52.62700
43	87,912.24	92,307.70	96,923.22	101,769.41	106,857.71	112,200.61	7,326.02	7,692.31	8,076.93	8,480.78	8,904.81	9,350.05	3,381.24	3,550.30	3,727.82	3,914.21	4,109.91	4,315.41	42.26550	44.37870	46.59770	48.92760	51.37390	53.94260
44	90,109.97	94,615.46	99,346.21	104,313.66	109,529.26	115,005.70	7,509.16	7,884.62	8,278.85	8,692.81	9,127.44	9,583.81	3,465.77	3,639.06	3,821.01	4,012.06	4,212.66	4,423.30	43.32210	45.48820	47.76260	50.15080	52.65830	55.29120
45	92,362.82	96,980.83	101,829.94	106,921.36	112,267.38	117,880.88	7,696.90	8,081.74	8,485.83	8,910.11	9,355.61	9,823.41	3,552.42	3,730.03	3,916.54	4,112.36	4,317.98	4,533.88	44.40520	46.62540	48.95670	51.40450	53.97470	56.67350
46	94,671.82	99,405.49	104,375.65	109,594.37	115,074.13	120,827.82	7,889.32	8,283.79	8,697.97	9,132.86	9,589.51	10,068.99	3,641.22	3,823.29	4,014.45	4,215.17	4,425.93	4,647.22	45.51530	47.79110	50.18060	52.68960	55.32410	58.09030
47	97,038.66	101,890.46	106,985.01	112,334.35	117,950.98	123,848.61	8,086.55	8,490.87	8,915.42	9,361.20	9,829.25	10,320.72	3,732.26	3,918.86	4,114.81	4,320.55	4,536.58	4,763.41	46.65320	48.98580	51.43510	54.00690	56.70720	59.54260
48	99,464.56	104,437.84	109,659.68	115,142.56	120,899.79	126,944.69	8,288.71	8,703.15	9,138.31	9,595.21	10,074.98	10,578.72	3,825.56	4,016.84	4,217.68	4,428.56	4,649.99	4,882.49	47.81950	50.21050	52.72100	55.35700	58.12490	61.03110
49	101,951.20	107,048.66	112,401.12	118,021.28	123,922.24	130,118.35	8,495.93	8,920.72	9,366.76	9,835.11	10,326.85	10,843.20	3,921.20	4,117.26	4,323.12	4,539.28	4,766.24	5,004.55	49.01500	51.46570	54.03900	56.74100	59.57800	62.55690
50	104,500.03	109,724.99	115,211.20	120,971.76	127,020.40	133,371.26	8,708.34	9,143.75	9,600.93	10,080.98	10,585.03	11,114.27	4,019.23	4,220.19	4,431.20	4,652.76	4,885.40	5,129.66	50.24040	52.75240	55.39000	58.15950	61.06750	64.12080
51	107,112.51	112,468.10	118,091.38	123,996.08	130,195.94	136,705.71	8,926.04	9,372.34	9,840.95	10,333.01	10,849.66	11,392.14	4,119.71	4,325.70	4,541.98	4,769.08	5,007.54	5,257.91	51.49640	54.07120	56.77470	59.61350	62.59420	65.72390
52	109,790.30	115,279.84	121,043.73	127,095.90	133,450.72	140,123.36	9,149.19	9,606.65	10,086.98	10,591.33	11,120.89	11,676.95	4,222.70	4,433.84	4,655.53	4,888.30	5,132.72	5,389.36	52.78380	55.42300	58.19410	61.10380	64.15900	67.36700
53	112,535.07	118,161.68	124,069.92	130,273.31	136,787.04	143,626.29	9,377.92	9,846.81	10,339.16	10,856.11	11,398.92	11,968.86	4,328.27	4,544.68	4,771.92	5,010.51	5,261.04	5,524.09	54.10340	56.80850	59.64900	62.63140	65.76300	69.05110
54	115,348.48	121,115.90	127,171.62	133,530.18	140,206.77	147,216.99	9,612.37	10,092.99	10,597.63	11,127.51	11,683.90	12,268.08	4,436.48	4,658.30	4,891.22	5,135.78	5,392.57	5,662.19	55.45600	58.22880	61.14020	64.19720	67.40710	70.77740
55	118,232.19	124,143.76	130,350.90	136,868.37	143,711.78	150,897.55	9,852.68	10,345.31	10,862.57	11,405.70	11,975.98	12,574.80	4,547.39	4,774.76	5,013.50	5,264.17	5,527.38	5,803.75	56.84240	59.68450	62.66870	65.80210	69.09220	72.54690
56	121,187.87	127,247.33	133,609.63	140,290.18	147,304.56	154,669.84	10,098.99	10,603.94	11,134.14	11,690.85	12,275.38	12,889.15	4,661.07	4,894.13	5,138.83	5,395.78	5,665.56	5,948.84	58.26340	61.17660	64.23540	67.44720	70.81950	74.36050
57	124,217.60	130,428.48	136,949.90	143,797.47	150,987.20	158,536.56	10,351.47	10,869.04	11,412.49	11,983.12	12,582.27	13,211.38	4,777.60	5,016.48	5,267.30	5,530.67	5,807.20	6,097.56	59.72000	62.70600	65.84130	69.13340	72.59000	76.21950
58	127,323.04	133,689.30	140,373.58	147,392.34	154,761.98	162,500.00	10,610.25	11,140.77	11,697.80	12,282.69	12,896.83	13,541.67	4,897.04	5,141.90	5,398.98	5,668.94	5,952.38	6,250.00	61.21300	64.27370	67.48730	70.86170	74.40480	78.12500
59	130,506.06	137,031.44	143,882.96	151,077.06	158,630.99	166,562.66	10,875.51	11,419.29	11,990.25	12,589.75	13,219.25	13,880.22	5,019.46	5,270.44	5,533.96	5,810.66	6,101.19	6,406.26	62.74330	65.88050	69.17450	72.63320	76.26490	80.07820
60	133,768.75	140,457.20	147,480.11	154,854.13	162,596.72	170,726.61	11,147.40	11,704.77	12,290.01	12,904.51	13,549.73	14,227.22	5,144.95	5,402.20	5,672.31	5,955.93	6,253.72	6,566.41	64.31190	67.52750	70.90390	74.44910	78.17150	82.08010
61	137,112.98	143,968.66	151,167.12	158,725.42	166,661.66	174,994.77	11,426.08	11,997.39	12,597.26	13,227.12	13,888.47	14,582.90	5,273.58	5,537.26	5,814.12	6,104.82	6,410.06	6,730.57	65.91970	69.21570	72.67650	76.31030	80.12580	84.13210
62	140,540.82	147,567.89	154,946.27	162,693.65	170,828.32	179,369.63	11,711.73	12,297.32	12,912.19	13,557.80	14,235.69	14,947.47	5,405.42	5,675.69	5,959.47	6,257.45	6,570.32	6,898.83	67.56770	70.94610	74.49340	78.21810	82.12900	86.23540
63	144,054.35	151,256.98	158,819.86	166,760.88	175,098.98	183,853.90	12,004.53	12,604.75	13,234.99	13,896.74	14,591.58	15,321.16	5,540.55	5,817.58	6,108.46	6,413.88	6,734.58	7,071.30	69.25690	72.71970	76.35570	80.17350	84.18220	88.39130
64	147,655.66	155,038.42	162,790.37	170,929.82	179,476.34	188,450.29	12,304.64	12,919.87	13,565.86	14,244.15	14,956.36	15,704.19	5,679.06	5,963.02	6,261.17	6,574.22	6,902.94	7,248.09	70.98830	74.53770	78.26460	82.17780	86.28670	90.60110
65	151,347.04	158,914.50	166,860.10	175,203.18	183,963.31	193,161.49	12,612.25	13,242.87	13,905.01	14,600.27	15,330.28	16,096.79	5,821.04	6,112.10	6,417.70	6,738.58	7,075.51	7,429.29	72.76300	76.40120	80.22120	84.23230	88.44390	92.86610
66	155,130.77	162,887.30	171,031.74	179,583.25	188,562.40	197,990.62	12,927.56	13,573.94	14,252.65	14,965.27	15,713.53	16,499.22	5,966.57	6,264.90	6,578.14	6,907.05	7,252.40	7,615.02	74.58210	78.31120	82.22680	86.33810	90.65500	95.18780
67	159,009.14	166,959.52	175,307.39	184,072.93	193,276.51	202,940.40	13,250.76	13,913.29	14,608.95	15,339.41	16,106.38	16,911.70	6,115.74	6,421.52	6,742.59	7,079.73	7,433.71	7,805.40	76.44670	80.26900	84.28240	88.49660	92.92140	97.56750
68	162,984.22	171,133.46	179,690.16	188,674.72	198,108.35	208,013.73	13,582.02	14,261.12	14,974.18	15,722.89	16,509.03	17,334.48	6,268.62	6,582.06	6,911.16	7,256.72	7,619.55	8,000.53	78.35780	82.27570	86.38950	90.70900	95.24440	100.00660
69	167,058.94	175,411.81	184,182.34	193,391.54	203,061.04	213,214.14	13,921.58	14,617.65	15,348.53	16,115.96	16,921.75	17,767.85	6,425.34	6,746.61	7,083.94	7,438.14	7,810.04	8,200.54	80.31680	84.33260	88.54920	92.97670	97.62550	102.50680
70	171,235.38	179,797.07	188,787.04	198,226.29	208,137.70	218,544.56	14,269.61	14,983.09	15,732.25	16,518.86	17,344.81	18,212.05	6,585.98	6,915.27	7,261.04	7,624.09	8,005.30	8,405.56	82.32470	86.44090	90.76300	95.30110	100.06620	105.06950
71	175,516.22	184,291.95	193,506.56	203,181.89	213,341.02	224,008.10	14,626.35	15,357.66	16,125.55	16,931.82	17,778.42	18,667.34	6,750.62	7,088.15	7,442.56	7,814.69	8,205.42	8,615.70	84.38280	88.60190	93.03200	97.68360	102.56780	107.69620
72	179,904.19	188,899.36	198,344.22	208,261.46	218,674.56	229,608.29	14,992.02	15,741.61	16,528.69	17,355.12	18,222.88	19,134.02	6,919.39	7,265.36	7,628.62	8,010.06	8,410.56	8,831.09	86.49240	90.81700	95.35780	100.12570	105.13200	110.38860
73	184,401.78	193,621.79	203,302.94	213,468.11	224,141.42	235,348.46	15,366.81	16,135.15	16,941.91	17,789.01	18,678.45	19,612.37	7,092.38	7,446.99	7,819.34	8,210.31	8,620.82	9,051.86	88.65470	93.08740	97.74180	102.62890	107.76030	113.14830
74	189,011.68	198,462.37	208,385.42	218,804.77	229,744.94	241,232.16	15,750.97	16,538.53	17,365.45	18,233.73	19,145.41	20,102.68	7,269.68	7,633.17	8,014.82	8,415.57	8,836.34	9,278.16	90.87100	95.41460	100.18530	105.19460	110.45430	115.97700
75	193,737.02	203,424.00	213,595.20	224,274.96	235,488.66	247,263.12	16,144.75	16,952.00	17,799.60	18,689.58	19,624.05	20,605.26	7,451.42	7,824.00	8,215.20	8,625.96	9,057.26	9,510.12	93.14280	97.80000	102.69000	107.82450	113.21570	118.87650
76	198,580.51	208,509.60	218,934.98	229,881.81	241,375.89	253,444.67	16,548.38	17,375.80	18,244.58	19,156.82	20,114.66	21,120.39	7,637.71	8,019.60	8,420.58	8,841.61	9,283.69	9,747.87	95.47140	100.24500	105.25720	110.52010	116.04610	121.84840
77	203,545.06	213,722.29	224,408.29	235,628.85	247,410.18	259,780.77	16,962.09	17,810.19	18,700.69	19,635.74	20,617.51	21,648.40	7,828.66	8,220.09	8,631.09	9,062.65	9,515.78	9,991.57	97.85820	102.75110	107.88860	113.28310	118.94720	124.89460
78	208,633.57	219,065.39	230,018.67	241,519.62	253,595.47	266,275.36	17,386.13	18,255.45	19,168.22	20,126.63	21,132.96	22,189.61	8,024.37	8,425.59	8,846.87	9,289.22	9,753.67	10,241.36	100.30460	105.31990	110.58590	116.11520	121.92090	128.01700
79	213,849.38	224,542.03	235,769.04	247,557.44	259,935.31	272,932.19	17,820.78	18,711.84	19,647.42	20,629.79	21,661.28	22,744.35	8,224.98	8,636.23	9,068.04	9,521.44	9,997.51	10,497.39	102.81220	107.95290	113.35050	119.01800	124.96890	131.21740
80	219,195.81	230,155.54	241,663.34	253,746.48	266,433.86	279,755.42	18,266.32	19,179.63	20,138.61	21,145.54	22,202.82	23,312.95	8,430.61	8,852.14	9,294.74	9,759.48	10,247.46	10,759.82	105.38260	110.65170	116.18430	121.99350	128.09320	134.49780
81	224,675.57	235,909.44	247,704.91	260,090.06	273,094.64	286,749.42	18,722.96	19,659.12	20,642.08	21,674.17	22,757.89	23,895.79	8,641.37	9,073.44	9,527.11	10,003.46	10,503.64	11,028.82	108.01710	113.41800	119.08890	125.04330	131.29550	137.86030
82	230,292.40	241,807.07	253,897.49	266,592.35	279,922.03	293,918.14	19,191.03	20,150.59	21,158.12	22,216.03	23,326.84	24,493.18	8,857.40	9,300.27	9,765.29	10,253.55	10,766.23	11,304.54	110.71750	116.25340	122.06610	128.16940	134.57790	141.30680
83	236,049.84	247,852.38	260,244.82	273,257.09	286,919.98	301,265.95	19,670.82	20,654.37	21,687.07	22,771.42	23,910.00	25,105.50	9,078.84	9,532.78	10,009.42	10,509.89	11,035.38	11,587.15	113.48550	119.15980	125.11770	131.37360	137.94230	144.83940
84	241,951.01	254,048.70	266,751.06	280,088.64	294,093.07	308,797.63	20,162.58	21,170.73	22,229.25	23,340.72	24,507.76	25,733.14	9,305.81	9,771.10	10,259.66	10,772.64	11,311.27	11,876.83	116.32260	122.13880	128.24570	134.65800	141.39090	148.46040
85	247,999.86	260,399.78	273,419.74	287,090.75	301,445.25	316,517.55	20,666.65	21,699.98	22,784.98	23,924.23	25,120.44	26,376.46	9,538.46	10,015.38	10,516.14	11,041.95	11,594.05	12,173.75	119.23070	125.19220	131.45180	138.02440	144.92560	152.17190
86	254,199.92	266,909.76	280,255.25	294,268.00	308,981.50	324,430.50	21,183.33	22,242.48	23,354.60	24,522.33	25,748.46	27,035.87	9,776.92	10,265.76	10,779.05	11,318.00	11,883.90	12,478.10	122.21150	128.32200	134.73810	141.47500	148.54880	155.97620
87	260,554.74	273,582.61	287,261.73	301,624.75	316,706.00	332,541.25	21,712.89	22,798.55	23,938.48	25,135.40	26,392.17	27,711.77	10,021.34	10,522.41	11,048.53	11,600.95	12,181.00	12,790.05	125.26670	131.53010	138.10660	145.01190	152.26250	159.87560
88	267,068.67	280,422.06	294,443.14	309,165.38	324,623.73	340,854.80	22,255.72	23,368.51	24,536.93	25,763.78	27,051.98	28,404.57	10,271.87	10,785.46	11,324.74	11,890.98	12,485.53	13,109.80	128.39840	134.81830	141.55920	148.63720	156.06910	163.87250
89	273,745.47	287,432.70	301,804.26	316,894.45	332,739.26	349,376.14	22,812.12	23,952.73	25,150.35	26,407.87	27,728.27	29,114.68	10,528.67	11,055.10	11,607.86	12,188.25	12,797.66	13,437.54	131.60840	138.18880	145.09820	152.35310	159.97080	167.96930
90	280,589.09	294,618.48	309,349.46	324,816.96	341,057.81	358,110.69	23,382.42	24,551.54	25,779.12	27,068.08	28,421.48	29,842.56	10,791.89	11,331.48	11,898.06	12,492.96	13,117.61	13,773.49	134.89860	141.64350	148.72570	156.16200	163.97010	172.16860
91	287,603.68	301,983.97	317,083.10	332,937.28	349,584.14	367,063.42	23,966.97	25,165.33	26,423.59	27,744.77	29,132.01	30,588.62	11,061.68	11,614.77	12,195.50	12,805.28	13,445.54	14,117.82	138.27100	145.18460	152.44380	160.06600	168.06930	176.47280
92	294,793.82	309,533.54	325,010.19	341,260.82	358,323.89	376,239.97	24,566.15	25,794.46	27,084.18	28,438.40	29,860.32	31,353.33	11,338.22	11,905.14	12,500.39	13,125.42	13,781.69	14,470.77	141.72780	148.81420	156.25490	164.06770	172.27110	180.88460

TRI-CITY MENTAL HEALTH AUTHORITY
MASTER CLASSIFICATION AND SALARY SCHEDULE
EFFECTIVE JANUARY 1, 2025
ADOPTED APRIL 16, 2025

Salary Range	Annually						Monthly						Per Pay Period						Hourly					
	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
93	302,163.68	317,271.97	333,135.50	349,792.35	367,281.82	385,645.94	25,180.31	26,439.33	27,761.29	29,149.36	30,606.82	32,137.16	11,621.68	12,202.77	12,812.90	13,453.55	14,126.22	14,832.54	145.27100	152.53460	160.16130	168.16940	176.57780	185.40670
94	309,717.82	325,203.63	341,463.82	358,537.09	376,463.98	395,287.15	25,809.82	27,100.30	28,455.32	29,878.09	31,372.00	32,940.60	11,912.22	12,507.83	13,133.22	13,789.89	14,479.38	15,203.35	148.90280	156.34790	164.16530	172.37360	180.99230	190.04190
95	317,460.83	333,333.73	350,000.56	367,500.43	385,875.57	405,169.23	26,455.07	27,777.81	29,166.71	30,625.04	32,156.30	33,764.10	12,210.03	12,820.53	13,461.56	14,134.63	14,841.37	15,583.43	152.62540	160.25660	168.26950	176.68290	185.51710	194.79290
96	325,397.28	341,667.04	358,750.50	376,688.00	395,522.40	415,298.62	27,116.44	28,472.25	29,895.87	31,390.67	32,960.20	34,608.22	12,515.28	13,141.04	13,798.10	14,488.00	15,212.40	15,973.02	156.44100	164.26300	172.47620	181.10000	190.15500	199.66280
97	333,532.16	350,208.77	367,719.25	386,105.20	405,410.51	425,680.94	27,794.35	29,184.06	30,643.27	32,175.43	33,784.21	35,473.41	12,828.16	13,469.57	14,143.05	14,850.20	15,592.71	16,372.34	160.35200	168.36960	176.78810	185.62750	194.90890	204.65430
98	341,870.46	358,964.11	376,912.22	395,757.86	415,545.73	436,323.06	28,489.21	29,913.68	31,409.35	32,979.82	34,628.81	36,360.25	13,148.86	13,806.31	14,496.62	15,221.46	15,982.53	16,781.66	164.36080	172.57890	181.20780	190.26820	199.78160	209.77070
99	350,417.18	367,938.06	386,335.04	405,651.79	425,934.29	447,231.20	29,201.43	30,661.51	32,194.59	33,804.32	35,494.52	37,269.27	13,477.58	14,151.46	14,859.04	15,601.99	16,382.09	17,201.20	168.46980	176.89330	185.73800	195.02490	204.77610	215.01500
100	359,177.73	377,136.66	395,993.31	415,793.04	436,582.64	458,411.82	29,931.48	31,428.05	32,999.44	34,649.42	36,381.89	38,200.99	13,814.53	14,505.26	15,230.51	15,992.04	16,791.64	17,631.22	172.68160	181.31570	190.38140	199.90050	209.89550	220.39030

SENIOR BEHAVIORAL HEALTH SPECIALIST

Classification specifications are only intended to present a descriptive summary of the range of duties and responsibilities associated with specified positions. Therefore, specifications *may not include all* duties performed by individuals within a classification. In addition, specifications are intended to outline the *minimum* qualifications necessary for entry into the class and do not necessarily convey the qualifications of incumbents within the position.

FLSA STATUS: Non-Exempt

DEFINITION:

Under supervision, to plan and provide a variety of rehabilitative support services to individuals experiencing behavioral health conditions to attain, restore, or improve physical, behavioral, or emotional functioning; provide assistance to clinical staff; participate in group and perform individual support in programs; serve as a participant advocate; and provide case management services. Train and support Behavioral Health Specialists in specific Behavioral Health Specialist duties. Perform other duties as required.

DISTINGUISHING CHARACTERISTICS:

This single-position class is the senior level of the Behavioral Health Specialist series and requires additional years of experience in the behavioral health field. Incumbents in this class series provide skilled assistance to other Behavioral Health Specialists and provide crisis response to clients in acute psychiatric need at a level not requiring licensure as a Behavioral health professional. The incumbent in this classification reports to the Program Supervisor in the Department/Program assigned.

EXAMPLES OF ESSENTIAL DUTIES: Essential duties include, but are not limited to, the following:

- Provide skilled assistance and training to other Behavioral Health Specialists in direct service organization, client care, and other Behavioral Health Specialist duties.
- Evaluate the needs of participants experiencing behavioral health challenges; plan, develop, and implement individual and group rehabilitation activities under the guidance of licensed professional staff; as assigned, be responsible for developing and implementing specific rehabilitation group activities.
- Participate in staff conferences with other disciplines to link clients with housing, providers, outside agencies, organizations, or departments as appropriate. Perform as client's primary case manager.
- Perform crisis intervention counseling at a level not requiring licensure as a Behavioral health professional; and assist professional staff in planning the range of care needed to deal with participant's care.
- Develop and determine appropriate referrals for the continuation of care.

- Document and maintain records as required and as credentialed, include attendance records, daily visit logs, daily and/or weekly interdisciplinary notes.
- As needed, document participation in consultation with outside agencies, housing providers and other services providers.
- Ensure records are in compliance with federal, state, local and agency regulations for records including Health Insurance Portability and Accountability Act (HIPAA) and The Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH Act").
- Transport participants as necessary or assigned.
- Provide advocacy for participants as needed to ensure inclusion in all aspects of the community including education, socialization, employment and housing.
- Plan, implement and facilitate groups and individual sessions.
- Performs related duties as required.

QUALIFICATIONS:

Any combination of education, training, and experience that provides the required knowledge, skills, and abilities to perform the essential duties of the position is qualifying. Incumbents will possess the most desirable combination of education, training, skills, and experience, as demonstrated in their past and current employment history. A typical example includes:

Education, Training, and Experience:

Bachelor's degree in psychology, sociology, social work, or similar human service-oriented degree plus 2 years working in the behavioral health field as a specialist in behavioral modification, physical restoration, social adjustment, or vocational adjustment.

OR

Associates degree with 4 years of experience working in the behavioral health field as a specialist in behavioral modification, physical restoration, social adjustment, or vocational adjustment.

OR

6 years of experience working in the behavioral health field as a specialist in the fields of behavioral modification, physical restoration, social adjustment, or vocational adjustment.

Licenses and Certifications:

Possession of a valid California Driver's License, a satisfactory driving record, and a properly registered and insured vehicle, to be maintained throughout employment.

Language Skills:

Depending on the position, bilingual skills may be required or preferred.

Knowledge of:

- Skills and tasks related to the Behavioral Health Specialist's duties including the below.
- Needs assessment and crisis intervention techniques.
- Case management techniques.
- Interviewing techniques.
- Fundamental psychiatric care.
- Laws, rules, and regulations relevant to the delivery of rehabilitation services/activities.
- Principles, procedures, techniques, and trends in providing rehabilitation services for individuals experiencing behavioral health conditions.
- Behavioral characteristics associated with individuals experiencing behavioral health challenges.
- Various rehabilitation and educational activities effective when working with individuals experiencing behavioral health conditions in a group setting.
- Principles and techniques of case management.
- Cultural and social-economic factors and influences affecting behavioral health.
- Family and group dynamics.
- Techniques of crisis intervention.
- Socio-economic conditions and trends of behavioral illnesses and the impact on family and community.
- Behavioral Health symptoms and behavior and hygiene principles,
- Techniques in the care and treatment of individuals or groups experiencing behavioral health conditions.
- Principles and practices of record keeping.
- Community resources, including other behavioral health and social service agencies.

Skill to:

- Operate a computer and utilize a variety of software programs.

Ability to:

- Recognize crisis situations accurately and take effective action.
- Understand, interpret, and apply the laws, rules, and regulations governing the Agency and rehabilitation services.
- Communicate and interact effectively in group situations requiring instruction or motivation of others.
- Keep complete and accurate records.
- Communicate clearly, both verbally and in writing in group settings.
- Understand and follow verbal and written instructions.
- Establish and maintain effective professional relationships with participants, families, physicians, social agencies, and others.

- Work effectively with staff, participants, families, community agencies, and the public.
- Relate to participants with diverse cultural, ethnic, and socio-economic backgrounds.
- Operate a computer and utilize a variety of software programs.
- Handle confidential matters with discretion.

PHYSICAL DEMANDS (ADA)

When assigned to an office environment, must possess mobility to work in a standard office setting and use standard office equipment, including a computer; vision to read printed materials and a computer screen; and hearing and speech to communicate in person and over the telephone; ability to stand and walk between work areas may be required. Finger dexterity is needed to access, enter, and retrieve data using a computer keyboard or calculator and to operate standard office equipment. Positions in this classification occasionally bend, stoop, kneel, reach, push, and pull drawers open and closed to retrieve and file information.

When performing field work, must possess mobility to work in changing site conditions; to sit, stand, and walk on level, uneven, or slippery surfaces; to reach, twist, turn, kneel, and bend; and to operate a motor vehicle and visit various sites throughout the Tri-Cities; vision to observe client behavior, signs of illness, and potential hazards. The job involves frequent walking to locate, assist, and deliver services to clients, with exposure to hazardous materials and waste in some locations. Employees must possess the ability to lift, carry, push, and pull materials and objects averaging a weight of 15 pounds, or heavier weights, in all cases with the use of proper equipment and/or assistance from other staff.

ENVIRONMENTAL CONDITIONS

Employees work in an office environment with moderate noise levels, controlled temperature conditions, and no direct exposure to hazardous physical substances. Employees also work in the field and are exposed to loud noise levels, cold and hot temperatures, inclement weather conditions, and may be exposed to blood and bodily fluids, and other hazardous physical substances and fumes. Employees interact with clients with behavioral disorders who may display erratic and assaultive behavior, including those who require emergency crisis intervention. Employees may also interact with upset staff and/or public and private representatives in interpreting and enforcing departmental policies and procedures.

WORKING CONDITIONS

In accordance with California Government Code Section 3100, Tri-City Mental Health Authority employees, in the event of a disaster, are considered disaster service workers and may be asked to protect the health, safety, lives, and property of the people of the State.

Employees serve as members of the Authority's on-call crisis intervention team and may be required to be available and respond to crisis situation 24/7 during on-call rotation.

Receive satisfactory results from a background investigation, which includes fingerprinting; a preemployment physical examination, which includes a drug/alcohol test; and an administrative review.

SENIOR ~~MENTAL~~BEHAVIORAL HEALTH SPECIALIST

Classification specifications are only intended to present a descriptive summary of the range of duties and responsibilities associated with specified positions. Therefore, specifications *may not include all* duties performed by individuals within a classification. In addition, specifications are intended to outline the *minimum* qualifications necessary for entry into the class and do not necessarily convey the qualifications of incumbents within the position.

FLSA STATUS: Non-Exempt

DEFINITION:

Under supervision, to plan and provide a variety of rehabilitative support services to ~~mentally ill and emotionally disturbed persons~~individuals experiencing behavioral health conditions to attain, restore, or improve ~~individual~~ physical, ~~mental~~behavioral, or emotional functioning; provide assistance to clinical staff; participate in group and perform individual support in programs; serve as a participant advocate; and provide case management services. Train and support ~~Mental~~Behavioral Health Specialists in specific ~~Mental~~Behavioral Health Specialist duties. Perform other duties as required.

DISTINGUISHING CHARACTERISTICS:

This single-position class is the senior level of the ~~Mental~~Behavioral Health Specialist series and requires additional years of experience in the ~~mental~~behavioral health field. Incumbents in this class series provide skilled assistance to other ~~Mental~~Behavioral Health Specialists and provide crisis response to clients in acute psychiatric need at a level not requiring licensure as a ~~mental~~Behavioral health professional. The incumbent in this classification reports to the Program Supervisor in the Department/Program assigned.

EXAMPLES OF ESSENTIAL DUTIES: Essential duties include, but are not limited to, the following:

- Provide skilled assistance and training to other ~~Mental~~Behavioral Health Specialists in direct service organization, client care, and other ~~Mental~~Behavioral Health Specialist duties.

- Evaluate the needs of ~~mentally ill and emotionally disturbed~~ participants experiencing behavioral health challenges; plan, develop, and implement individual and group rehabilitation activities under the guidance of licensed~~,~~ professional staff; as assigned, be responsible ~~to develop/implement~~for developing and implementing specific rehabilitation group activities.

- Participate in staff conferences with other disciplines to link clients with housing, providers, outside agencies, organizations, or departments as appropriate. Perform as client's primary case manager.

- Perform crisis intervention counseling at a level not requiring licensure as a ~~mental~~Behavioral health professional; and assist professional staff in planning the range of care needed to deal with participant's care.

- Develop and determine appropriate referrals for the continuation of care.

- Document and maintain records as required and as credentialed, include attendance records, daily visit logs, daily and/or weekly interdisciplinary notes.
- As needed, document participation in consultation with outside agencies, housing providers and other services providers.
- Ensure records are in compliance with federal, state, local and agency regulations for records including Health Insurance Portability and Accountability Act (HIPAA) and The Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH Act").
- Transport participants as necessary or assigned.
- Provide advocacy for participants as needed to ensure inclusion in all aspects of the community including education, socialization, employment and housing.
- Plan, implement and facilitate groups and individual sessions.
- ~~Perform janitorial and reception~~Performs related duties as ~~needed and assigned~~required.

QUALIFICATIONS:

Any combination of education, training, and experience that provides the required knowledge, skills, and abilities to perform the essential duties of the position is qualifying. Incumbents will possess the most desirable combination of education, training, skills, and experience, as demonstrated in their past and current employment history. A typical example includes:

Education, Training, and Experience:

Bachelor's degree in psychology, sociology, social work, or similar human service~~-~~ oriented degree plus 2 years working in the ~~mental~~behavioral health field as a specialist in behavioral modification, physical restoration, social adjustment, or vocational adjustment.

OR

Associates degree with 4 years of experience working in the ~~mental~~behavioral health field as a specialist in behavioral modification, physical restoration, social adjustment, or vocational adjustment.

OR

6 years of experience working in the ~~mental~~behavioral health field as a specialist in the fields of behavioral modification, physical restoration, social adjustment, or vocational adjustment.

Licenses and Certifications:

Possession of a valid California Driver's License, a satisfactory driving record, and a properly registered and insured vehicle, to be maintained throughout employment.

Language Skills:

~~Bilingual Spanish strongly~~Depending on the position, bilingual skills may be required or preferred.

Knowledge of:

- Skills and tasks related to the ~~Mental~~Behavioral Health Specialist's duties including the below.
- Needs assessment and crisis intervention techniques.
- Case management techniques.
- Interviewing techniques.
- Fundamental psychiatric care.
- Laws, rules, and regulations relevant to the delivery of rehabilitation services/activities.
- Principles, procedures, techniques, and trends ~~of~~in providing rehabilitation services for ~~mentally ill and emotionally disturbed participants.~~ individuals experiencing behavioral health conditions.
- Behavioral characteristics ~~of the mentally ill and emotionally disturbed.~~ associated with individuals experiencing behavioral health challenges.
- Various rehabilitation and educational activities ~~useful~~effective when working with ~~the mentally ill~~individuals experiencing behavioral health conditions in a group setting.
- Principles and techniques of case management.
- Cultural and social-economic factors and influences affecting ~~mental~~behavioral health.
- Family and group dynamics.
- Techniques of crisis intervention.
- Socio-economic conditions and trends of ~~mental~~behavioral illnesses and the impact on family and community.
- ~~Mental~~Behavioral Health symptoms and behavior and hygiene principles,
- Techniques in the care and treatment of individuals or groups ~~of mentally ill participants.~~ experiencing behavioral health conditions.
- Principles and practices of record keeping.
- Community resources, including other ~~mental~~behavioral health and social service agencies.

Skill to:

- Operate a computer and utilize a variety of software programs.

Ability to:

- Recognize crisis situations accurately and take effective action.
- Understand, interpret, and apply the laws, rules, and regulations governing the Agency and rehabilitation services.

- Communicate and interact effectively in group situations requiring instruction or motivation of others.
- Keep complete and accurate records.
- Communicate clearly, both verbally and in writing in group settings.
- Understand and follow verbal and written instructions.
- Establish and maintain effective professional relationships with participants, families, physicians, social agencies, and others.
- Work effectively with staff, participants, families, community agencies, and the public.
- Relate to participants with diverse cultural, ethnic, and socio-economic backgrounds.
- Operate a computer and utilize a variety of software programs.
- Handle confidential matters with discretion.

~~**Special Requirements:**~~

~~Possess~~**PHYSICAL DEMANDS (ADA)**

When assigned to an office environment, must possess mobility to work in a ~~current valid Driver's License, a satisfactory driving record~~standard office setting and ~~meet~~use standard office equipment, including a computer; vision to read printed materials and a computer screen; and hearing and speech to communicate in person and over the ~~Agency's~~ telephone; ability to stand and walk between work areas may be required. Finger dexterity is needed to access, enter, and retrieve data using a computer keyboard or calculator and to operate standard office equipment. Positions in this classification occasionally bend, stoop, kneel, reach, push, and pull drawers open and closed to retrieve and file information.

When performing field work, must possess mobility to work in changing site conditions; to sit, stand, and walk on level, uneven, or slippery surfaces; to reach, twist, turn, kneel, and bend; and to operate a motor vehicle ~~insurance standards.~~ and visit various sites throughout the Tri-Cities; vision to observe client behavior, signs of illness, and potential hazards. The job involves frequent walking to locate, assist, and deliver services to clients, with exposure to hazardous materials and waste in some locations. Employees must possess the ability to lift, carry, push, and pull materials and objects averaging a weight of 15 pounds, or heavier weights, in all cases with the use of proper equipment and/or assistance from other staff.

~~Receive satisfactory results from a background investigation, which includes fingerprinting; a pre-employment physical examination, which includes a drug/alcohol test; and an administrative~~

ENVIRONMENTAL CONDITIONS

Employees work in an office environment with moderate noise levels, controlled temperature conditions, and no direct exposure to hazardous physical substances. Employees also work in the field and are exposed to loud noise levels, cold and hot temperatures, inclement weather conditions, and may be exposed to blood and bodily fluids, and other hazardous physical substances and fumes. Employees interact with clients with behavioral disorders who may display erratic and assaultive behavior, including those who require emergency crisis intervention.

Employees may also interact with upset staff and/or public and private representatives in interpreting and enforcing departmental policies and procedures.

WORKING CONDITIONS

- ~~review.~~

In accordance with California Government Code Section 3100, Tri-City Mental Health ~~Center~~ Authority
employees, in the event of a disaster, are considered disaster service workers and may be asked to protect the health, safety, lives, and property of the people of the State.

Employees serve as members of the Authority's on-call crisis intervention team and may be required to be available and respond to crisis situation 24/7 during on-call rotation.

Receive satisfactory results from a background investigation, which includes fingerprinting; a preemployment physical examination, which includes a drug/alcohol test; and an administrative review.~~**ESSENTIAL JOB FUNCTIONS:**~~

~~The position requires prolonged sitting, reaching, twisting, turning, bending, stooping, lifting, and carrying paper and documents weighing up to 15 pounds in the performance of daily activities; body mobility to move from one work area to another, and operate a vehicle; grasping, repetitive hand movement and fine coordination in recording information, preparing reports and data, and using a computer keyboard; near and far vision in observing activities, reading correspondence and reports, statistical data, and using a computer; and communicating with others on the phone, in person, and in meetings.~~

Tri-City Mental Health Authority
AGENDA REPORT

DATE: **April 16, 2025**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Ontson Placide, LMFT, Executive Director**

BY: **Liz Renteria, LCSW, Chief of Clinical Services**

SUBJECT: **Consideration of Resolution No. 778 Authorizing the Executive Director to Purchase Two (2) Vehicles from Crown Toyota in the Amount of $110,141.30 for the Mobile Crisis Care Unit Program**

Summary:

Staff is seeking approval to authorize the Executive Director of Tri-City Mental Health Authority (TCMHA) to purchase two vehicles for the Mobile Crisis Care Unit program. This action will allow TCMHA to purchase two more vehicles for the mobile crisis response for clients in accordance with the approved Action Plan that was submitted to the Department of Health Care Services. The cost of each vehicle is $55,070.65 for a total of $110,141.30.

Background:

In March of 2022 TCMHA was awarded a $200,000 planning grant by the California Department of Health Care Services for planning and design of a Mobile Crisis Care Program also referred to as the CCMU Grant. On March 16, 2022, Resolution No. 641 for the Subcontract Agreement No. 7460-CA MOBILE CRISIS-TRICITY-01 with the Advocates for Human Potential, Inc. for Behavioral Health Mobile Crisis and Non-Crisis Services Project No. 21-10349 with the California Department of Health Care Services was approved by the board authorizing the Executive Director to execute the agreement and any amendments thereafter.

From March 2022 to February 2023, TCMHA engaged in ongoing and cross-sector collaboration with local and regional organizations (e.g., school districts, law enforcement, social service agencies, etc.) and reviewed community needs assessments, for the creation of an action plan for an expanded mobile behavioral and mental health crisis response program for residents of Pomona, Claremont, and La Verne. The plan included the development of field capable mobile response vehicles for crisis response.

In May of 2023 TCMHA received a contract amendment for an additional $300,000 for the purchase of vehicles and other supplies for Crisis Care Mobile Unit program, bringing the grant award amount to a total of $500,000. The amendment was fully executed in July 2023.

A total of three quotes were obtained from local vendors as follows:

- Toyota of Glendora $67,558.12 per vehicle
- Crown Toyota $55,070.65 per vehicle
- Claremont Toyota $57.389.15 per vehicle

Due to the need to assess and view the vehicle in person by Tri-City Mental Health Authority staff members, it was necessary for local vendors to be contacted.

Fiscal Impact:

The purchase of these vehicles will be funded by the Department of Health Care Services Crisis Care Mobile Units (CCMU) Grant administered by Advocates for Human Potential. The total cost of these vehicles is $110,141.30.

Recommendation:

Staff recommends that the Governing Board adopt Resolution No. 778 authorizing the Executive Director to purchase two vehicles for the Mobile Crisis Care Program from Crown Toyota in the total amount of $110,141.30.

Attachments:

Attachment 11-A: Resolution No. 778 - Draft

RESOLUTION NO. 778

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY AUTHORIZING ITS EXECUTIVE DIRECTOR TO PURCHASE TWO (2) VEHICLES FROM CROWN TOYOTA IN THE AMOUNT OF $110,141.30 FOR THE CRISIS CARE MOBILE UNIT PROGRAM

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("TCMHA" or "Authority") was awarded in March 2022 a planning grant in the amount of $200,000 by the California Department of Health Care Services (CDHCS) for the planning and design of a Crisis Care Mobile Unit (CCMU) Program. In July 2023 TCMHA received from CDHCS an additional $300,000 for the purchase of vehicles and other supplies for TCMHA's CCMU program.

B. The Authority desires to purchase two (2) vehicles using CCMU grant funds for the CCMU program. Accordingly, TCMHA's Facilities Division obtained three (3) Bids, and the Bid submitted by Crown Toyota was selected in the amount of $110,141.30.

2. Action

The Authority's Executive Director is authorized to purchase two (2) vehicles from Crown Toyota in the total amount of $110,141.30 for TCMHA's Crisis Care Mobile Unit Program.

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on April 16, 2025 by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

JED LEANO, CHAIR

APPROVED AS TO FORM:

STEVEN L. FLOWER, GENERAL COUNSEL

ATTEST:

MICAELA P. OLMOS, RECORDING SECRETARY

Tri-City Mental Health Authority
AGENDA REPORT

DATE: April 16, 2025

TO: Governing Board of Tri-City Mental Health Authority

FROM: Ontson Placide, LMFT, Executive Director

BY: Elizabeth Renteria, LCSW, Chief Clinical Officer
Erin Sapinoso, Grants Manager

SUBJECT: Children and Youth Behavioral Health Initiative Round 5 Grant Withdrawal

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Summary:

Staff respectfully request governing board approval for withdrawal from the Children and Youth Behavioral Health Initiative (CYBHI) Round 5 (R5): Early Intervention Programs and Practices grant from the California Department of Health Care Services (DHCS) as managed by third party administrators California Institute for Behavioral Health Services (CIBHS) and Heluna Health (Heluna). The contract reflects an award amount of $750,000 for Tri-City Mental Health Authority's (TCMHA) Mobile Crisis Care (MCC) program under the CYBHI "Other Implementation Track (Start-Up)".

Background:

The CYBHI is a multi-year, multi-department package of investments that support behavioral health and wellness for California children, youth, and their families. Efforts focus on promoting social and emotional well-being, preventing behavioral health challenges, and providing equitable, appropriate, timely, and accessible services for emerging and existing behavioral health needs for children and youth ages 0-25. The CYBHI aims to improve access to, and the quality of, behavioral health services for all children and youth in California, regardless of payer. The focus of CYBHI R5 is Early Intervention Programs and Practices, which includes Youth Mobile Crisis Response.

In November 2023, TCMHA submitted an application for a CYBHI R5 grant award to support the development of its MCC program. At the time, the only other source of dedicated funding for MCC was the Crisis Care Mobile Units (CCMU) grant. This solicitation occurred prior to the formal decision to allocate Behavioral Health Services Act to support MCC.

In March 2024, TCMHA received notice that it had been selected for a CYBHI R5 award in the amount of $750,000 under the CYBHI "Other Implementation Track (Start-Up)" for TCMHA's MCC program. CYBHI R5 funds will be used towards salaries of TCMHA's MCC personnel that include a Peer Support Specialist, a Psychiatric Technician, Clinical Therapist, Clinical Supervisor, and Clinical Manager.

On May 15, 2024, the TCMHA governing board approved acceptance of the $750,000 CYBHI R5 grant award for TCMHA's MCC program.

After nearly six months of contract negotiations with Heluna Health regarding revisions in language and change of authorized signatory (due to interim executive director position), the CYBHI contract became fully executed on November 4, 2024.

In January 2025, TCMHA submitted a request for a no-cost extension to prolong the grant period of performance one year from the original end date of June 30, 2025 to June 30, 2026. At the end of February 2025, TCMHA received notice that the no-cost extension request was approved.

As a result of the delays in executing the original contract and subsequent request for extending the grant period of performance, the time frame to spend CYBHI funding has significantly decreased making it difficult to use the funds to recruit and hire positions for the MCC program as originally planned.

Consequently, TCMHA will plan to focus use of Mental Health Services Act (MHSA) Community Services and Supports (CSS) funding as an alternative to the CYBHI grant award and proceed with MCC programming.

Fiscal Impact:

At this time, funding previously received and collected by TCMHA in the amount of $450,000 is being returned. In addition, TCMHA is relinquishing the remaining and available (however not collected) $300,000 grant award balance.

Recommendation:

Staff recommends that the Governing Board approves withdrawal from the CYBHI R5 grant program and reverts the $750,000 award.

Attachments:

None.

Tri-City Mental Health Authority
AGENDA REPORT

DATE: **April 16, 2025**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Ontson Placide, LMFT, Executive Director**

BY: **Dana Barford, Director of MHSA and Ethnic Services**

SUBJECT: **Consideration of Resolution No. 779 Adopting the Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2025-26 as Recommended by the TCMHA Mental Health Commission**

Summary:

The Welfare and Institutions Code Section (WIC) 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan followed by Annual Updates for all Mental Health Services Act (MHSA) programs and expenditures. The MHSA Projects Manager presented an overview of the MHSA Annual Update for Fiscal Year 2025-26 for the Tri-City Mental Health Commission during the Public Hearing held on April 8, 2025.

Background:

This MHSA Annual Update for Fiscal Year 2025-26 was posted on March 7, 2025, and the required minimum 30-day review process ended on April 8, 2025. Staff circulated a draft of the Annual Update by making electronic copies available on TCMHA 's website as well as circulating hard copies throughout the community. The plan was also promoted on social media including Facebook, X, and Instagram. Several methods of collecting feedback were available such as phone, fax, email, mail, and comment cards. All comments received regarding this plan were shared during the Public Hearing on April 8, 2025.

Stakeholder involvement is a critical component to the decade-long success of the MHSA process for Tri-City and staff continue to value and empower them throughout the community planning process. In preparation of this Annual Update, community members were invited to participate in stakeholder meetings, community forums and workgroups as well as invited to share their thoughts during the public comment period of the Public Hearing.

Fiscal Impact:

The Agency has funds available under MHSA to support the MHSA Annual Update for Fiscal Year 2025-26.

Recommendation:

Staff recommends that the Governing Board adopt Resolution No. 779 approving the Authority's Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2025-26 as recommended by the TCMHA Mental Health Commission.

Attachments:

Attachment 13-A: Resolution No. 779 - DRAFT

Attachment 13-B: Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2025 – 2026.

RESOLUTION NO. 779

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY ADOPTING ITS MENTAL HEALTH SERVICES ACT (MHSA) ANNUAL UPDATE FOR FY 2025-26

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. Tri-City Mental Health Authority ("TCMHA" or "Authority") wishes to adopt the Authority's Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2025-26, as recommended by the Authority's Mental Health Commission.

B. The Welfare and Institutions Code Section (WIC) 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan followed by Annual Updates for all Mental Health Services Act (MHSA) programs and expenditures.

C. The MHSA Annual Update was developed through a Community Planning Process wherein stakeholders and community members participate in reviewing and recommending programming and services.

2. Action

The Governing Board approves the Authority's MHSA Annual Update for Fiscal Year 2025-26; and authorizes the Executive Director, or designee, to prepare and submit any and all reports related thereto.

3. Adoption

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on April 16, 2025, by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

JED LEANO, CHAIR

APPROVED AS TO FORM:

STEVEN L. FLOWER, GENERAL COUNSEL

ATTEST:

MICAELA P. OLMOS, RECORDING SECRETARY

ATTACHMENT 13-A

TRI·CITY
Mental Health

Mental Health Services Act (MHSA)

ANNUAL UPDATE

FY 2025-26

ATTACHMENT 13-B

Table of Contents

MHSA County Compliance Certification

County: TRI-CITY MENTAL HEALTH AUTHORITY

Local Mental Health Director
Ontson Placide, Executive Director
Telephone Number: (909) 623-6131
E-mail: oplacide@tricitymhs.org

Program Lead
Dana Barford, Director of MHSA and Ethnic Services
Telephone Number: (909) 326-4641
E-mail: dbarford@tricitymhs.org

County Mental Health Mailing Address
1717 N. Indian Hill Boulevard Suite B, Claremont, CA 91711

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three- Year Program and Expenditure Plan or Annual Update, including stakeholder participation and non-supplantation requirements.

This MHSA Annual Update Plan has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft MHSA Annual Update Plan was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The MHSA Annual Update FY 2025-26, attached hereto, was adopted by the Tri-City Governing Board on April 16, 2025.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached MHSA Annual Update FY 2025-26 are true and correct.

Local Mental Health Director/Designee County: TRI-CITY MENTAL HEALTH AUTHORITY	Signature	Date

MHSA County Fiscal Accountability Certification

County/City: TRI-CITY MENTAL HEALTH AUTHORITY
___Three-Year Program and Expenditure Plan _X_ Annual Update ___ Annual Revenue and Expenditure Report

Local Mental Health Director
Ontson Placide, Executive Director
Telephone Number: (909) 623-6131
E-mail: oplacide@tricitymhs.org

County Auditor-Controller/ City Financial Officer
Diana Acosta, Chief Financial Officer
Telephone Number: (909) 451-6434
E-mail: dacosta@tricitymhs.org

Local Mental Health Mailing Address
1717 N. Indian Hill Boulevard Suite B, Claremont, CA 91711

I hereby certify that the MHSA Annual Update FY 2025-26 is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Local Mental Health Director/Designee County: TRI-CITY MENTAL HEALTH AUTHORITY	Signature	Date

I hereby certify that for the fiscal year ended June 30, 2024, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/ City's financial statements are audited annually by an independent auditor and the most recent audit report is dated November 15, 2024 for the fiscal year ended June 30, 2024. I further certify that for the fiscal year ended June 30, 2024, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund. I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

County Auditor Controller / City Financial Officer	Signature	Date

Executive Summary

Community Program Planning Process

The Community Program Planning process began in the fall of 2024 and continued throughout the fiscal year utilizing both in person and virtual platforms. Community members were invited to attend multiple stakeholder meetings and the MHSA Public Hearing. In addition, the community was presented with the annual Community Program Planning Survey which provided an opportunity for participants to share their feedback regarding possible gaps in service or unmet needs of community members.

MHSA Event	Dates
Community Program Planning Survey	Fall 2024
MHSA Community Forums (i.e. Stakeholder Meetings)	9/4/2024 9/5/2024 9/30/2024 11/7/2024 11/21/2024 1/28/2025 1/28/2025 1/29/2025 2/5/2025 (2 meetings)
30-Day Posting of the MHSA Annual Update FY 2025-26	3/7/2025 – 4/8/2025
MHSA Public Hearing and Meeting of the Tri-City Mental Health Commission	4/8/2025
Tri-City Governing Board Approval and Adoption	4/16/2025

MHSA Plan Highlights & Actions Since Previous Annual Update

Community Services and Supports (CSS)

CSS Program	Total Number Served FY 2023-24	Projected Number to be Served FY 2024-25
Full-Service Partnerships	787	608
Community Navigators	1,283	1,073
Wellness Center	1,630	898
Supplemental Crisis Services	592	No projections due to program sunsetting on June 30, 2024
Field Capable Clinical Services for Older Adults	52	35
Permanent Supportive Housing	211	231
Access to Care	2,793	2,793

Prevention and Early Intervention (PEI)

PEI Program	Total Number Served FY 2023-24	Projected Number to be Served FY 2024-25
Community Wellbeing	5,723	5,890
Community Mental Health Trainings	768	921
Stigma Reduction and Suicide Prevention	722	435
Older Adult & Transition Age Youth Wellbeing (Peer Mentor Program)	26	62
Wellness Center PEI /TAY and Older Adults	1,317	1,029
Family Wellbeing	878	519
NAMI: Community Capacity Building Program	176	181
Housing Stability Program	61	78
Therapeutic Community Gardening	330	277
Early Psychosis Program	24	54
School-Based Services	201	289

Introduction to Tri-City Mental Health Authority

On June 21, 1960, Tri-City Mental Health Authority (referred to as Tri-City throughout this document) was formed and established through a Joint Powers Authority Agreement (JPA) between the cities of Pomona, Claremont and La Verne. This union established Tri-City as a "county" and mental health authority for these three cities. Since 2008, Tri-City has benefited from funding under the Mental Health Services Act and expanded from a "treatment-only service" agency to a full system of care based on the Recovery Model.

For more than 60 years, Tri-City has provided services that are clinically, culturally, and linguistically appropriate for community members. Tri-City's commitment and belief in wellness and recovery for each of our clients has guided our service delivery and program development. By treating each individual based on their own identified cultural, language and health beliefs, Tri-City is able to demonstrate cultural humility while delivering services that are sensitive to both the customs and cultures of our clients.

Demographics

The total population for the Tri-City area is approximately 213,619 residents. Pomona has more than twice the population of the other two cities combined.

Table 1: Population by City

TOTAL POPULATION BY CITY				
	La Verne	**Claremont**	**Pomona**	**Tri-City Area**
Total population	31,239	36,891	145,489	**213,619**

Source: U.S. Census data from 2023 ACS 1-Year Estimates

The following tables indicate the total population by age group and race/ethnicity:

Table 2: Total Population by Age Group

TOTAL POPULATION BY AGE GROUP					
City: **Age group:**	**La Verne**	**Claremont**	**Pomona**	**Tri-City Area**	**% by Age**
0-14	4,771	4,844	25,340	34,955	16.4%
15-24	4,017	7,371	16,997	28,385	13.3%
25-59	12,756	114,746	75,183	102,685	41.8%
60+	9,695	9,930	26,135	47,594	22.3%
Totals	**31,239**	**36,891**	**145,489**	**213,619**	**100.00%**

Source: U.S. Census data from 2023 ACS 5-Year Estimates

Table 3: Total Population by Race/Ethnicity

TOTAL POPULATION BY RACE/ETHNICITY					
Race	**La Verne**	**Claremont**	**Pomona**	**Tri-City Area**	**% by ethnicity**
African American	1,029	2,006	10,384	13,419	6.3%
Asian Pacific Islander	3,255	5,666	17,599	26,520	12.4%
Native American	80	18	264	362	0.2%
White	14,116	17,631	14,186	45,933	21.5%
Hispanic or Latino/a/x	11,349	8,983	99,600	119,932	56.1%
Another Race	178	284	19,980	1,755	0.8%
Two or more races	1,232	2,303	2,163	5,698	2.7%
Race Totals:	**331,239**	**36,891**	**145,489**	**213,619**	**100.00%**
Ethnicity					
Hispanic/Latino/a/x (if any race)	11,349	8,983	99,600	119,932	56.1%
Not Hispanic or Latino/a/x	19,890	27,908	45,899	93,678	43.9%
Ethnicity Totals:	**31,239**	**36,891**	**145,489**	**213,619**	**100.00%**

Source: U.S. Census data from 2023 ACS 5-Year Estimates

Mental Health Service Act (MHSA)

The Mental Health Services Act (MHSA), also known as Proposition 63, has served as the primary source of funding for all MHSA programs for Tri-City Mental Health Authority since 2008. Passed in 2004, MHSA is funded through a tax imposed on Californians whose income exceeds 1 million dollars. Known as the "millionaire's tax" this initiative is designed to expand and transform California's county mental health system to provide more comprehensive care for those with serious mental illness, specifically in unserved and underserved populations.

With the passing of Proposition 1 in March 2024, MHSA will transition to the Behavioral Health Services Act (BHSA) on July 1, 2026. This current Annual Update plan will remain in effect through fiscal year 2025-26. Any changes will be reflected in the Behavioral Health Services Act Three-Year Plan, which under BHSA, will be called the County Integrated Plan for Behavioral Health Services and Outcomes. Tri-City is committed to continue providing quality, diverse and accessible programming to the community, under the new BHSA guidelines and policy.

Five Components of the Mental Health Services Act

Plan Component	Focus	Year Approved
Community Services and Supports (CSS)	Provides intensive treatment and transition services for people who suffer with serious and persistent mental illness	2009
Prevention and Early Intervention (PEI)	Implement services that promote wellness and prevent suffering from untreated mental illness	2010
Workforce Education and Training (WET)	Goal is to develop a diverse workforce and provide trainings for current staff	2012
Innovation	Develop new projects to increase access and quality of services to underserved groups	2012
Capital Facilities and Technological Needs	Supports the creation of facilities and technology infrastructure used for the delivery of MHSA services	2013

MHSA Community Program Planning Process

The success of the MHSA Community Program Planning process is built on a strong and effective community partnership. Per the Welfare and Institution Code section 5848, counties are required to collaborate with constituents and stakeholders throughout the planning and development process for any MHSA program or plan.

One critical component to the stakeholder process is the partnership and collaboration between TCMHA staff and stakeholders throughout the community planning process that includes meaningful stakeholder involvement on: mental health policy, monitoring, quality improvement, evaluation, and budget allocations. (Welfare and Institutions Code (W&I) section 5848).

Stakeholder involvement and opportunities for participation regarding specific areas of the community program planning process are listed below:

Mental Health Policy Public comments during Mental Health Commission meetings, Governing Board meetings and other stakeholder events	**Program Planning and Implementation** Stakeholder and Orientation meetings, MHSA workgroups, Community Program Planning Survey, and Wellness Collaboratives	**Monitoring** Stakeholder/Orientation Meetings, MHSA Workgroups, review outcomes for programs, 30-Day comment period for MHSA plans and updates, comments made during MHSA Public Hearing
Quality Improvement Annual Community Program Planning Survey, surveys completed following trainings, webinars, and presentations, l Wellness Collaboratives	**Evaluation** Stakeholder and Orientation Meetings, opportunity for questions, MHSA workgroups, review outcomes for programs, 30-day postings and public comments, Public Hearing public comments	**Budget Allocations** Stakeholder/Orientation Meetings, MHSA workgroups, 30-day plan postings and Public Hearing

Community involvement and representation matters, and Tri-City continues to seek the involvement of local community partners, consumers, and stakeholders as we strive to achieve diversity, equity, and inclusion in all aspects of this agency.

Stakeholder perspectives include individuals who receive services; consumers with serious mental illness and/or serious emotional disturbance; family members; community providers, leaders of community groups in unserved and underserved communities, persons recovering from severe mental illness, seniors, adults and families with children with serious mental illness; representatives from the tree cities of Claremont, La Verne and Pomona; veterans; representatives from the local school districts, colleges and universities; primary health care providers; law enforcement representatives, mental health, physical health, and drug/alcohol treatment providers; faith-based community representatives; representatives from the LGBTQ community; representatives from the Los Angeles County Department of Mental Health (LACDMH) and other county agencies.

Opportunities for collaboration include the following stakeholder engagement activities:

Tri-City Event	Description
MHSA Stakeholder Orientation (Virtual)	This presentation, offered in-person and virtually, encompasses the history of community mental health leading up to the passage of the Mental Health Services Act. Also includes an overview of all MHSA Plans and programs currently implemented through Tri-City's system of care.
MHSA Staff Orientation (Virtual)	These presentations during new employee orientation includes the history of community mental health leading up to the passage of the Mental Health Services Act. Also includes an overview of all MHSA Plans and programs currently implemented through Tri-City's system of care. Staff are also invited to attend stakeholder meetings where additional information is provided.
Community Program Planning Survey	This annual online survey is shared with stakeholders and community partners where they are invited to provide Tri-City staff their thoughts and concerns regarding mental health support services in the cities of Pomona, Claremont, and La Verne. From these responses, future community workgroups and Tri-City staff work in collaboration to develop or expand programs and services based on MHSA guidelines and funding.
Innovation Idea Survey (Online)	The Innovation Idea Survey was created to help community members and stakeholders develop new ideas to be considered for Innovation Projects. Ideas submitted through the survey are discussed during Innovation focus/workgroups.
Community Meetings	Tri-City staff attend multiple community meetings and events to learn first-hand about the needs of the community as well as providing them an opportunity to discuss issues or concerns directly with Tri-City staff.
Informal Interviews with Community Members/Partners	Community members are often interviewed (key informant interviews) and engage in dialogues with Tri-City staff and consultants when community input is critical to informing the decision process. Examples include providing input in the development of Tri-City's new branding campaign and the desired qualifications of a new Executive Director.
Mid-Year Stakeholder Meeting (Virtual)	Stakeholders and community partners are invited to participate in a mid-year stakeholder meeting where they have the opportunity to hear MHSA program updates, review any new MHSA projects or programs, and provide feedback regarding allocation of MHSA funding.
30-Day Posting of 3-Year Plan and Annual Update	All MHSA Three-Year Program and Expenditure Plans and Annual Updates are posted on Tri-City's website and social media for a 30-day review period. In addition, paper copies of the plans are distributed throughout the three cities at local venues such as city halls, libraries, and community centers.
Public Hearing and Mental Health Commission	The Mental Health Commission hosts an MHSA Public Hearing where community members are invited to join and review a presentation on program updates summarized in the most recent MHSA Three-Year Program and Expenditure plan or Annual Update. Participants can provide feedback to staff which is reviewed and incorporated into the Plan or Update.
Governing Board Meeting/Approval	Community members and stakeholders are invited to all Governing Board meetings and are provided the opportunity to share feedback and ask questions during the public comment period.

The following table reflects specific community program planning activities and collaboration impacting the development of this MHSA Annual Update FY 2025-26:

MHSA Event	Dates	Purpose
MHSA Community Forum at Tri-City	9/4/2024	Orientation to MHSA and introduction to current programs, evaluations, and budgets (Hybrid morning meeting).
MHSA Community Forum at Tri-City	9/5/2024	Orientation to MHSA and introduction to current programs, evaluations, and budgets (Hybrid evening meeting).
MHSA Community Forum *Stakeholder meeting at community location*	9/30/2024	Meeting aimed at children, TAY, families and schools in the service area.
MHSA Community Forum *Stakeholder meeting at community location*	11/7/2024	This stakeholder meeting focused on service providers of children, TAY, families, and Hispanic/Latino/a/x individuals.
MHSA Community Forum *Stakeholder meeting at community location*	11/21/2024	MHSA orientation and introduction with program overview for community group of religious organizations, law enforcement, and other non-profits.
MHSA Community Forum *Stakeholder meeting at community location*	1/28/2025	Meeting presented to university alumni group with graduates, staff, and students representing various concentrations and degrees.
MHSA Community Forum *Stakeholder meeting at community location*	1/28/2025	Meeting presented to a community group with local clinics, government agencies, school district staff and insurance groups, among others.
MHSA Community Forum *Mid-Year Stakeholder Update Meeting*	1/29/2025	During this mid-year stakeholder update, attendees were provided with an update on the potential fiscal impact of Proposition 1 (AB 531 and SB 326) in addition to a discussion and vote related to how to spend excess CSS dollars.
MHSA Community Forum *Stakeholder meeting at community location*	2/5/2025 (Two Meetings)	Presentation provided to school district employees, parents of k-12 children and various community partners. A morning in-person meeting and evening virtual meeting were provided.
30-Day Posting for Amendment to MHSA Annual Update FY 2025-26	3/7/2025 through 4/8/2025	The MHSA Annual Update FY 2025-2026 was posted on Tri-City's website and social media for a 30-day review period. In addition, paper copies of the Annual Update were distributed throughout the three cities at local venues such as city halls, libraries, and community centers.
MHSA Public Hearing and Mental Health Commission Meeting	4/8/2025	The Mental Health Commission will host the MHSA Public Hearing where community members are invited to join and review a presentation regarding program updates summarized in the most recent MHSA Annual Update FY 2025-26. Feedback from participants will be reviewed and incorporated into this plan. The Mental Health Commission will potentially endorse the plan for submission to Governing Board for consideration of approval and adoption.
Tri-City Governing Board Approval	4/16/2025	Tri-City's Governing Board will meet to approve and adopt the MHSA Annual Update FY 2025-26.

Proposals Approved During the FY 2024-25 Community Program Planning Process

Psychiatric Advanced Directives, (PADs) Phase II Multi-County Collaborative Innovation Project for Tri-City Mental Health Authority

During the MHSA Community Forums held on September 4th and 5th, 2024, stakeholders were provided updates on PADs Phase I, as well as the plan and budget developed to potentially implement PADs Phase II. Stakeholders were given the opportunity to make comments, ask questions and provide feedback on PADs Phase II. Attendees voted on whether they were in favor of moving forward with PADS Phase II and the majority of attendees voted in favor of moving forward with the project.

Voting Results - Are you in favor of moving forward with approving PADS phase II?

Yes	No	Maybe/unsure
87.5%	0%	12.5%

The plan was posted for a 30-day comment period from September 6, 2024, through October 8, 2024. On October 8, 2024, a Public Hearing pertaining to PADs Phase II was held during the regular Tri-City Commission meeting. Following presenting on PADS Phase I background, goals of PADs Phase II, and budget; the Commission moved to endorse the plan. On October 23, 2024, the Tri-City Governing Board met and approved PADs Phase II. With this approval, the plan was added to the Mental Health Services Oversight and Accountability Commission (MHSOAC) consent calendar and was approved on November 21, 2024. With this approval, the Innovations PADs project can continue to Phase II beginning on July 1, 2025.

MHSA Annual Update FY 2024-25 Mid-Year Update: Claremont Gardens Senior Housing Project

Tri-City Mental Health Authority proposed to update its FY 2024-25 MHSA Program Annual Update to utilize existing unspent CSS funding to support the completion of the Claremont Gardens Senior Housing Project at 956 W. Baseline Road, Claremont, California 91711 under the Mental Health Services Act (MHSA) Community Services and Supports (CSS) Plan in an amount not to exceed three million dollars ($3,000,000). Under the Mental Health Services Act, Counties may use General System Development funds under their CSS plan for costs associated with purchasing, renovating, or constructing of Project-Based Housing (9 C.C.R. § 3630.05). The proposed plan amendment will support the cost of the final renovation of this property.

Under the State MHSA Regulations (9 C.C.R. § 3315(b)), any update to the MHSA Program, other than the required annual update, must undergo a local review process that includes a 30-day public comment period however no public hearing is expressly required. This plan amendment was posted for a 30-day public comment period beginning November 8, 2024, until December 7, 2024, on Tri-City's website as well as all social media sites including Facebook, Instagram, and Twitter. In addition, this amendment was distributed to numerous locations including city halls, libraries, and community

centers. No feedback was received and there were no substantive changes made to the plan. This plan was presented to the Mental Health Commission on November 12, 2024. The Tri-City Governing Board reviewed this amendment on December 18, 2024, approving and adopting the amendment.

Allocate $5,200,000 in Community Services and Supports (CSS) Funds for the Purpose of Expanding Temporary Supportive Housing Options for Tri-City Clients Within the Cities of Pomona, Claremont, and La Verne.

Under California Code of Regulations § 3420.50 Counties are required to spend or transfer Community Services and Supports (CSS) monies within three fiscal years of receiving those funds from the State Controller. If the County fails to spend or transfer these funds out of CSS within that period, the funds become subject to reversion to the Mental Health Services Fund Reversion Account.

Based on the following receipts Tri-City has identified CSS funds that are at risk of reversion by June 30, 2027.

- Average annual CSS amounts received range from $9 to $11 million.
- Fiscal year 23/24 receipts were $16.3 million.
- Fiscal Year 24/25 receipts estimated to be $16.2 million.
- Total amount at risk of reversion at 6/30/27 is estimated to be $5.2 to $8.0 million.

With these funds available, Tri-City engaged community stakeholders, city officials, mental health commissioners, and governing board members, to identify the priority needs and gaps in services for the three cities. The results indicated an overwhelming desire to support the unhoused and homeless individuals located within the Tri-City catchment area.

A recent point-in-time count for homeless individuals revealed the following information indicating a high need for temporary supportive housing specifically in the city of Pomona:

City	Number of Homeless Individuals 2024
Pomona	545
Claremont	18
La Verne	22

Tri-City Mental Health Authority is proposing to expend an estimated $5.2 million dollars in Community Services and Supports (CSS) funds for the purpose of expanding temporary housing options and supportive services for unhoused individuals that are struggling with finding and maintaining housing. [1]

[1]Under the Mental Health Services Act, Counties may use General System Development funds under their CSS plan for costs associated with purchasing, renovating, or constructing of Project-Based Housing (9 C.C.R. § 3630.05).

(C.C.C. § 3420.50) Reversion for Counties: County shall spend CSS Account monies within three (3) fiscal years of receiving those funds from the State Controller, or within three (3) fiscal years of transferring funds from the Prudent Reserve to its CSS Account pursuant to sections 3420.30(g) or 3420.35. If a County fails to spend such funds within three (3) fiscal years, the funds shall revert to the Mental Health Services Fund for deposit into the Reversion Account.

Stakeholder Process

On January 29, 2025, Tri-City Mental Health Authority held a mid-year MHSA Community Forum for stakeholders, staff, and community members. During this meeting, attendees were advised by staff that Tri-City has an excess of CSS funds in the estimated amount of $5.2 million dollars that needs to be spent or transferred prior to June 30, 2027, or be subject to reversion back to the State. Participants were then presented with a list of projects that would meet the criteria for funding with CSS dollars. Participants were asked to rank the options in the order of their top choices. The top two choices that met the criteria for CSS funding were: 1) Purchase an existing building to create a form of bridge housing; and 2) Purchase Scattered Site Housing.

This feedback from stakeholders was then presented to Tri-City's Governing Board on February 19, 2025. The Executive Director for Tri-City then met with city leaders for Pomona, Claremont, and La Verne independently to solicit their input for this project. In addition to the shared consensus and advocacy for supportive housing, these discussions brought forth a secondary list of recommendations which Tri-City will consider as part of its behavioral health transformation process under BHSA in 2026.

After careful consideration of all recommendations, the final decision was made to allocate the unspent CSS funds as follows:

1. To purchase an existing commercial building or residential property, renovating, if necessary, with the goal of creating additional housing options and support services.
2. Partner with local landlords and property managers to purchase individual units in apartment complexes located throughout the cities of Pomona, Claremont, and La Verne for the purpose of providing additional housing options.
3. Increase the number of reserved beds with Hope for Home Shelter located in Pomona.

Once the property(s) have been identified for acquisition, Tri-City staff will seek final approval from the Tri-City Governing Board before proceeding with the purchase(s). In addition, a new contract will be presented for approval to reserve additional beds from the Hope for Home Shelter.

This request is hereby incorporated in this MHSA Annual Update FY 2025-26 to the Three-Year Program and Expenditure Plan FY 2023-24 – 2025-26. This action will also prevent the potential reversion of CSS funds.

Transfer $3,000,000 from the Community Services and Supports plan to Workforce Education and Training and Capital Facilities and Technological Needs plans.

Request for transfer of funds in the amount of $3,000,000 from Community Services and Supports (CSS) to be allocated as follows:

Capital Facilities and Technological Needs (CFTN)	$1,500,000.00
Workforce Education and Training (WET)	$1,500,000.00
Total	**$3,000,000.00**

The Community Service and Supports (CSS) plan, which receives the largest portion of MHSA funding at 76%, provides intensive treatment and transition services for people who experience serious and persistent mental illness or severe emotional disturbances or who are at risk of SMI/SED. In addition, the California Code of Regulations § 3420.10 allows for the transfer of excess funds from the Community Services and Supports (CSS) account to Prudent Reserve, CFTN account and WET account.

This ability to reallocate funds is critical to the sustainability of the Capital Facilities and Technological Needs (CFTN) and Workforce Education and Training (WET) plans since each received only a one-time allocation at the time of approval.

Capital Facilities and Technological Needs (CFTN) focuses on improvements to facilities, infrastructure, and technology of the local mental health system.

Therefore, the $1.5 million dollars in CSS funding from this proposal will be allocated to CFTN to 1) strengthen the technological infrastructure of Tri-City, 2) purchase or lease existing building(s) to create needed office space for staff and 3) reduce the risk of reversion of CSS funds.

Workforce Education and Training (WET) which also received a one-time allocation at the time of approval focuses on strengthening and supporting existing staff and caregivers through trainings while also concentrating on attracting new staff and volunteers to ensure future mental health personnel.

Therefore, the $1.5 million dollars in CSS funding from this proposal will be used to expand Tri-City's training programs, both internal and external (community), as well as provide incentives for recruitment and retention of staff.

This request is hereby incorporated in this MHSA Annual Update FY 2025-26 to the Three-Year Program and Expenditure Plan FY 2023-24 – 2025-26. This action will prevent the potential reversion of CSS funds.

MHSA Community Program Planning Survey

Beginning in July 2024, stakeholders and community partners were invited to participate in Tri-City's MHSA Community Program Planning Survey, which provides an opportunity for stakeholders to share their thoughts and concerns regarding the availability of support services. MHSA Projects Manager partnered with Innovations to update the survey (such as utilize tablets for survey completion and

update the language to be more inclusive) and distribute the Community Program Planning survey (for example station staff where surveys were available for 1:1 support and provide small incentives for completing surveys). Survey results were also collected via QR codes, email, and community meetings.

Pop-Up Tables at Community Centers: Staff set up tables at community centers across the service area to directly engage with community members and assist with completing the survey on-site. To further support this, staff enlisted Community Navigators, who were stationed within these centers, to help individuals take the survey. For older adults who needed additional assistance, one-on-one support was provided to navigate the tablets. This personalized approach made the experience more accessible and comfortable for participants, especially for those who might not be familiar with virtual platforms.

Outreach at High-Engagement Events: In October 2024, staff attended high-traffic community events such as trunk-or-treat in October 2024, which drew significant attendance. Booths were set up where with the QR code and attendees were able to take the survey on their personal devices. For those without a personal phone, tablets were available to facilitate survey completion. This outreach method proved successful, allowing the ability to engage with people in a fast-paced environment and encourage survey participation.

Incentives: To further encourage participation, the incentives such as custom tote bags and other give-away items were provided. These giveaways helped attract more people to take the survey and provided a tangible reward for their time.

Real-Time Feedback: During outreach, staff documented comments and concerns raised by participants. For example, some noted that the survey was too long or that the language used was too advanced. This feedback led to adjustments in the survey to ensure it was easier for responders to understand and complete.

Integration with Focus Groups: To further boost participation, the survey was integrated into focus group sessions facilitated by the Innovations team. At the start of each focus group, participants were introduced to the survey's purpose and completed it during the session. This strategy assisted in reaching more individuals and gather additional insights from focus group participants.

The Community Program Planning Survey

This annual survey is used to identify the needs and priorities of the three cities. Survey results were then incorporated into this MHSA Annual Update FY 2025-26. This survey is just one of many opportunities where stakeholders can share their voice regarding the needs of the communities.

Survey Results

Surveyed participants were asked to identify improvements that Tri-City could make to its programs and services to better meet the needs of the community.

The following chart outlines the specific themes identified based on responses received.

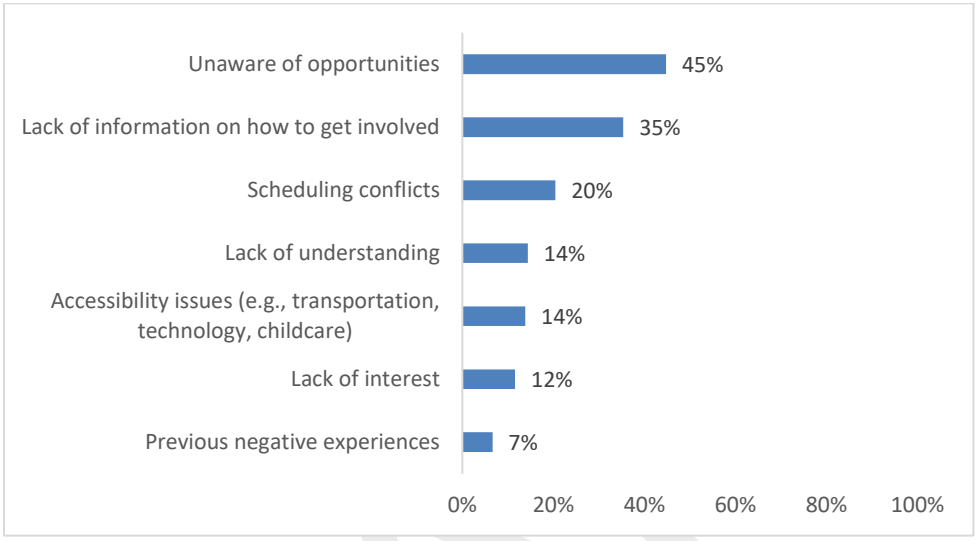
Themes	Count	Percentage
Increased Advertising & Outreach	50	28%
Expanded Services	33	18%
Better Communication & Information	32	18%
Improved Access to Services	9	5%
Community Collaboration & Support	1	1%
Community Feedback	2	1%
Unaware of services offered	5	3%
Satisfaction	18	10%
Uncertain	10	6%
Not Applicable/None	21	11%
Grand Total	**181**	**100%**

The following are a few examples of comments in the highest theme identified, "Increased Advertising & Outreach," made by 28% of survey participants regarding how Tri-City's programs and services can improve to better meet the needs of the community. These comments will be addressed by staff in future MHSA stakeholder meetings and workgroups:

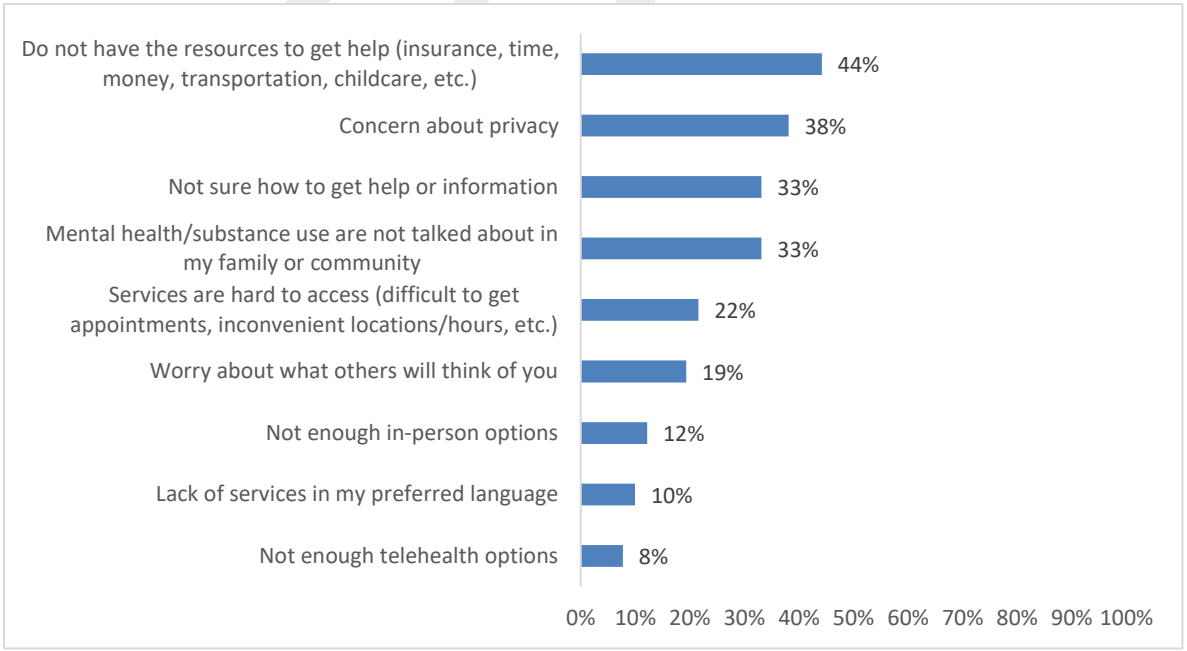
- "More/vast broad communication of your organization's service. I live across the street from your office…and see very little about the organization and services."
- "I think with more advertising and marketing we could be more aware of the resources offered."
- "Connect more with the community."
- "I think more outreach and more advertisement of services/programs."
- "Finding the area that will have the most engagement."
- "Increased community field outreach"
- "Keep showing up to community events"
- "Visit our departments more often and share what your do/what services are available that officer[s] can utilize in the field when dealing with patients."

The following examples show other questions presented to in the Community Program Planning Survey, as well as the results:

1. What obstacles have affected your participation in the mentioned Tri-City Mental Health's activities*, whether in the past or currently? *(Select all that apply)*



2. Please identify the top 3 barriers that you or someone you know face when looking for mental health support. *(Select all that apply)*



* Complete survey results are included in the Appendix

California Proposition 1:
Behavioral Health Services Act (BHSA) and Bond Measure

In March 2024, California voters passed Proposition 1. The two-bill package, Senate Bill (SB) 326 and Assembly Bill (AB) 531 proposed statewide efforts to reform and expand California's behavioral health system and was put on the ballot by the California State Legislature and the Governor. Proposition 1 is Governor Newsom's attempt to Modernize the Mental Health Services Act (MHSA) and increase supportive housing and access to treatment facilities. This will also modify how MHSA funds are allocated, and introduce changes related to oversight, accountability, and the community planning process. Proposition 1 also includes a $6.4 billion bond that would create mental health and substance use treatment beds, and housing with supportive services for unhoused Californians with behavioral health challenges.

30-Day Public Comment and MHSA Public Hearing

The MHSA Annual Update FY 2025-26 to the Three-Year Program and Expenditure Plan for FY 2023-24—FY 2025-26 provides a comprehensive overview of the MHSA projects and programs funded through the Mental Health Services Act, based on data collected during FY 2023-24. An electronic draft of this Annual Update was posted on Tri-City's website on March 7, 2025, for a 30-day public comment period ending April 8, 2025. In addition, hard copies were circulated throughout the three cities and distributed to public locations including city hall, libraries, community centers and cultural gatherings. Tri-City also utilized social media to circulate the document on four different digital platforms.

On April 8, 2025, the Tri-City Mental Health Commission will host the MHSA Public Hearing where community members will be invited to join and review a presentation regarding program updates summarized in the most recent MHSA Annual Update FY 2025-26. Participant feedback to staff will be reviewed and incorporated into this plan. The Mental Health Commission will have the opportunity to endorse the plan for submission to Tri-City's Governing Board for consideration of approval and adoption. The Tri-City Governing Board will be presented this recommendation of the MHSA Annual Update FY 2025-26 on April 16, 2025.

MHSA Programs

The following pages contain descriptions of each MHSA funded program. The descriptions include updates to the program's development; performance outcomes; and cost per participant calculations for programs that provide direct services.

The services provided for Fiscal Year 2023-24 are highlighted in each program summary by age group, number of clients served, projected number to be served and average cost per person.

Community Services and Supports (CSS)

The Community Services and Supports (CSS) Plan provides intensive treatment and transition services for people who suffer with serious and persistent mental illness or severe emotional disturbances, or who are at risk of SMI/SED.

Full-Service Partnerships
Community Navigators
Wellness Center
Supplemental Crisis Services | Intensive Outreach & Engagement Team
Field Capable Clinical Services for Older Adults
Permanent Supportive Housing
Access to Care

Full-Service Partnerships

Program Description

Full-Service Partnership (FSP) programs are designed for individuals who are experiencing serious emotional disturbance (SED) or severe mental illness (SMI) who would benefit from an intensive service program including housing support. The program uses a "whatever it takes" approach to help individuals achieve their goals. The Mental Health Service Act requires that fifty-one percent or more of the Community Services and Supports funds be used for Full-Service Partnerships programs.

Target Population

Unserved and underserved individuals with serious emotional disturbance (SED) or a severe mental illness (SMI) including children and youth ages 0-15, transition age youth ages 16-25, adults ages 26-59 and older adults ages 60 and over.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Total Served
Number Served FY 2021-22	98	162	454	73	**787**
Projected Number to be Served FY 2024-25	110	134	308	56	**608**
Cost Per Person	$17,040	$14,854	$11,670	$10,927	**$54,491**

Program Update

The FSP programs foster a collaborative relationship between Tri-City Mental Health and the client. This may also include the client's family members when appropriate. Through this collaboration, a plan is developed to provide a full spectrum of therapeutic and community services where the client can achieve their identified goals. These support services may be mental health specific or non-mental health specific, and can include housing, employment, education, and integrated treatment of co-occurring mental illness and substance use disorders. Personal service coordination/case management is available to assist the client with accessing needed medical, educational, social, vocational rehabilitative and/or other community services.

During FY 2023-24, The FSP program has continued to adapt to California Advancing and Innovating Medi-Cal (CalAim) billing reform while ensuring that the clients with the highest needs are effectively served. Staff have prioritized providing field-based services in an efficient manner and continue to provide quality outreach when clients are disengaged.

This fiscal year also displayed an increase in collaboration with school partners. FSP staff have regularly consulted and participated in various school meetings and Individualized Education Plan (IEP) meetings to support client progress. Building and maintaining these connections with the schools in our service area increases the likelihood that we can make our resources known to our districts, communicate referral processes, and support individuals who are in need of services.

There was also a noticeable increase in crises prevention and wrap around support that has been provided for clients. This was evident upon reviewing the data related to crisis occurrences and hospitalizations. The data indicated a small portion of clients served required a higher level of crises intervention service, as well as low numbers related to hospitalizations. This is an ongoing topic of discussion during meetings and supervision, and as a result staff have become better equipped to assess, manage, and incorporate prevention techniques. We can see this work directly impacting our FSP clients in a positive manner.

To enhance quality of care, a support drop-in hour was created in the FSP program for staff who need to consult on cases that may require additional support, feedback on clinical technique or additional wrap around services. It is very beneficial for staff to have a designated time, outside of their regularly scheduled supervision, to bring up questions or seek guidance. That additional staff support directly impacts the quality of care received by the client.

Challenges and Solutions

The FSP program experienced an increase of complex medical conditions reported by clients. To ensure that the individual is being addressed from the perspective of whole person care, linkage to a higher level of care and/or medical attention were indicated. To ease this process of referrals and linkage, staff were educated on Medi-Cal Managed Care Plan, CalAim, Enhanced Care Management (ECM) & other community supports during FSP team meetings, 1:1 supervision, and group supervision. Additionally, training on assessing, evaluating, and managing crisis for medical concerns was offered during team meetings and supervisions.

Release of Information (ROI) documents were revised and that presented a new learning curve regarding how to gather the appropriate information for the document, as well as how to complete the form. FSP teams attended trainings established by the Quality Assurance team to assist in the new documentation process with clients.

Diversity, Equity and Inclusion

Cultural barriers and challenges are regularly discussed in group supervision, individual supervision, and staff meetings. When conceptualizing cases, efforts are made to consider how culture may impact and influence how individuals conceptualize mental health. With the support of supervisors, staff are encouraged to educate themselves on the cultures that they are servicing and familiarize themselves with resources available. FSP programs attempt to hire a diverse group of staff that include bilingual abilities to expand our range of services to monolingual communities. We have seen great success with cases when we have been able to assign providers who match cultural and language preferences of clients. To reduce language barriers, the program has utilized a language line, which supports staff

by providing direct access to translation when providing services in the language of the clients we serve.

Additionally, trainings and themes during meetings focus on addressing topics around LGBTQ+ communities. Staff are also provided with access to resources within the community that could support LGBTQ+ clients, including Peer Support Specialists, Peer Mentors, and the Pomona Valley Pride. To support equity efforts, FSP referrals and documentation materials are translated to Spanish, one of the most prominent languages used in this community.

Community Partners

The FSP team and Housing Division team communicate often to discuss available internal and external resources and how to support families who are insufficiently housed. FSP collaborates regularly with internal and external substance use disorder (SUD) programs as well. The Tri-City SUD provider joins FSP meetings to streamline communication and provide feedback when discussing high risk cases. Staff regularly hold treatment team meetings, both with and without family, to make sure that everyone is efficiently and effectively supporting clients in their treatment goals. FSP programs closely work with the three cities' police departments to support clients in crisis as well as with Pomona Valley Hospital Medical Center when Tri-City clients need a higher level of care. Partnering with our local schools within the three cities to provide the younger population with crisis management and support during school hours ensures clients have a safe space at school to receive mental health services. FSP child and TAY programs work with organizations such as San Gabriel Pomona Regional Center to provide clients with specific services including Applied Behavioral Analysis (ABA) and Respite which target behavioral and developmental needs. FSP Programs that work with adults and older adults will partner with organizations such as the Social Security Administration or our internal Wellness Center for groups that target the adult and older adult demographic.

Treatment teams regularly collaborate with the Department of Child and Family Services (DCFS) and probation. The purpose of this collaboration is to highlight progress, strengths, and potential needs that clients and families may have that can impact meeting their recovery goals (i.e., needing SUD services). Collaboration is done through child and family team meetings, treatment team meetings, and regular collateral contact.

Success Story

FSP Adult

An individual was referred to Adult FSP due to several mental health symptoms, substance use, housing, and other healthcare needs. Keeping a person-centered and the whole system of care approach, an array of programs and services were provided to assist the individual meet their goals. Through FSP they obtained a clinical therapist, behavioral health specialist (BHS), peer support specialist (PSS), substance use counselor (COST), psychiatrist, housing specialist (TCMH Housing Dept), healthcare providers, and Enhanced Care Management (ECM) for a Care Management Team (CMT). Through this multidisciplinary support, the client was able to address building independent living skills, process their experiences in therapy, improve money management skills, address substance

use, improve self-care and prioritize medical conditions. Ultimately, the individual was placed in permanent housing and is currently maintaining their sobriety. This is one of many cases that displays FSP's "whatever it takes" approach in supporting community members in need of the types of support that FSP can provide.

FSP Child and Transition Age Youth (TAY)

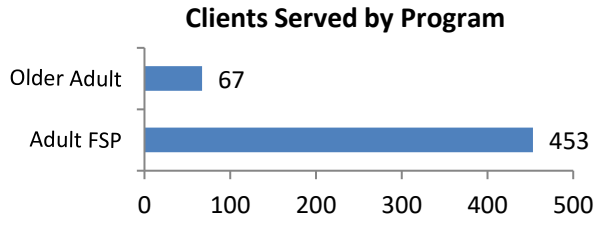
A TAY individual entered services experiencing severe symptoms of psychosis and difficulty completing daily activities without the family's assistance. Since being consistently engaged with all services and utilizing resources outside of session, the individual's activities of daily living have greatly improved. Among reported and observed improvements were increased communication skills, improved boundaries, and ability to express their needs in an appropriate manner. Additionally, the client has been known to actively practice their grounding skills when needed and in various settings. Lastly, the individual has consistently participated in groups, which has led to a sense of community with other TAYs who have experienced similar challenges. As a result, the client has not only felt a decrease in isolation but has been able to offer valuable insight to their peers and be a consistent form of support for them.

Program Summary

How Much Did We Do?

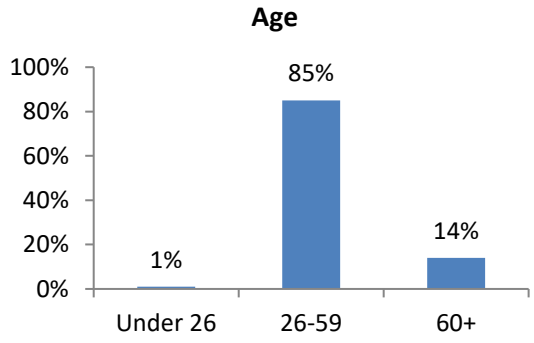
Full-Service Partnership (FSP) – Adult and Older Adult

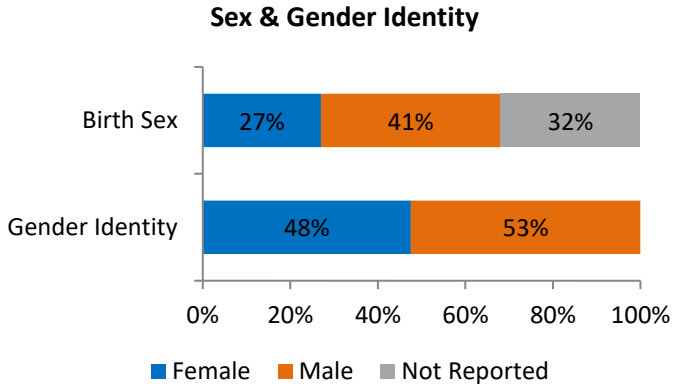
520
Individuals Served

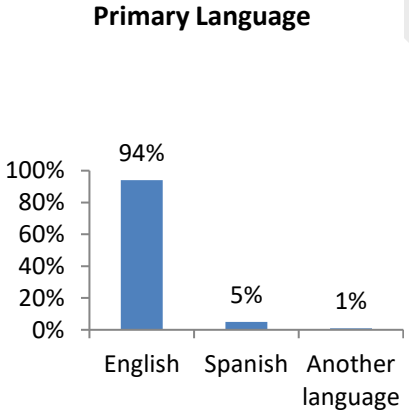


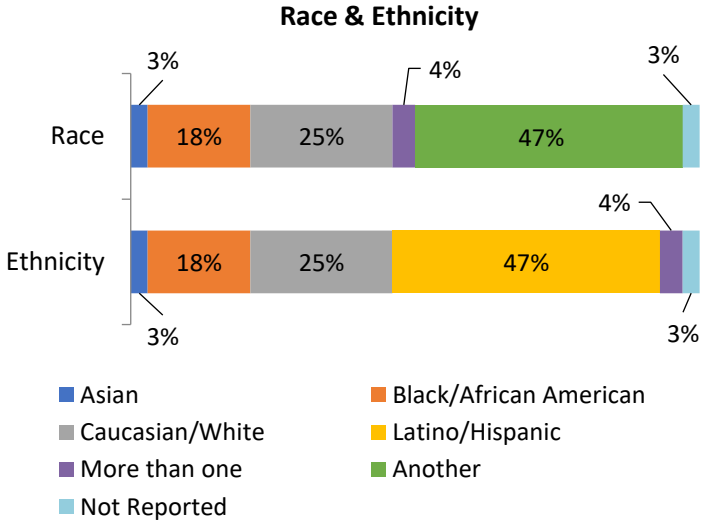
The number of individuals served **increased** from **265** in FY 2022-23 to **520** in FY 2023-24

89% of Adult/Older Adult clients lived in Pomona,
while 3% of clients lived in Claremont, 3% lived in La Verne, and 6% of clients came from other cities

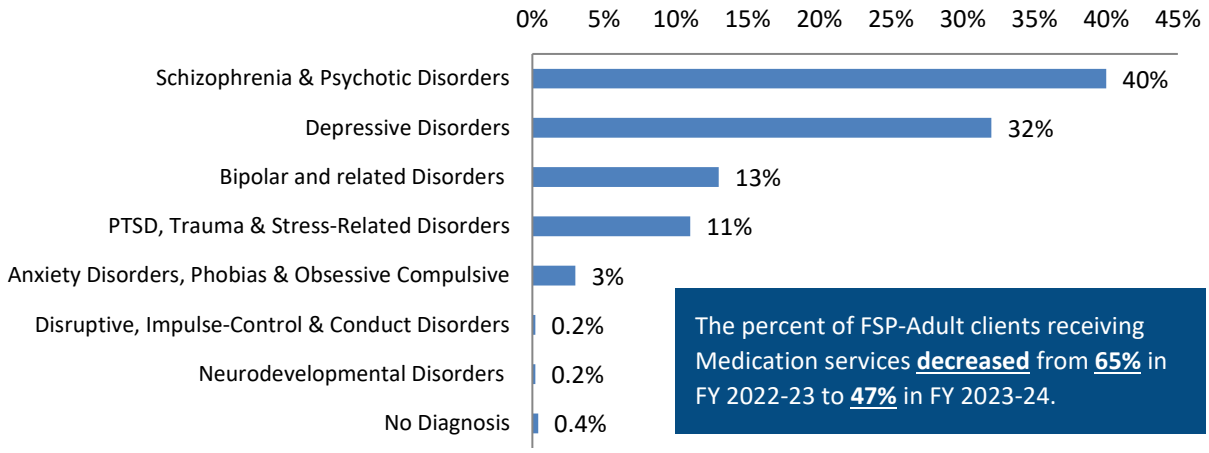






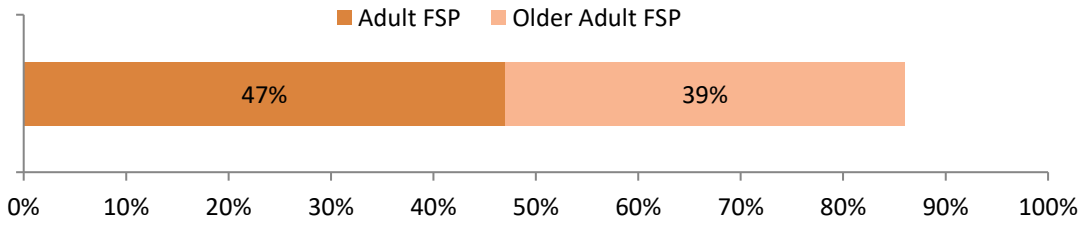


Primary Diagnosis by FSP Adult/Older Adult Clients

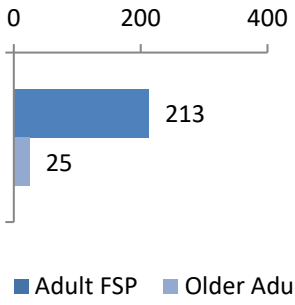


The percent of FSP-Adult clients receiving Medication services **decreased** from **65%** in FY 2022-23 to **47%** in FY 2023-24.

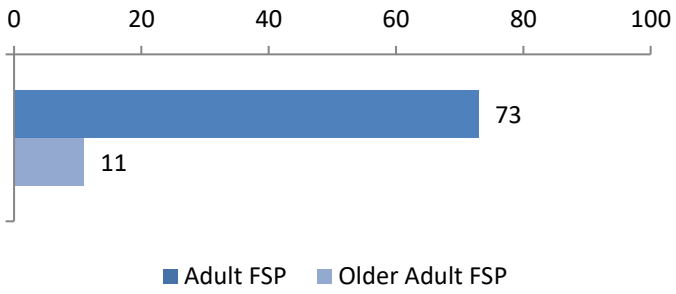
Percent of Clients Receiving Medication Services by Program



Number of Crisis Episodes

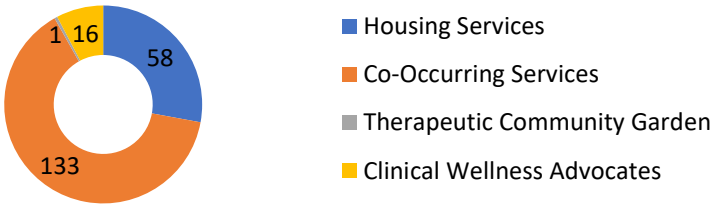


Number of Unique Clients w/ at least 1 Crisis Episodes



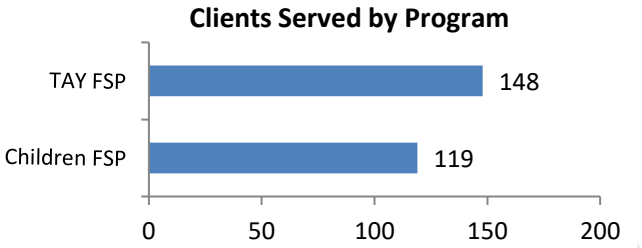
Number of FSP Adult/Older Adult Clients Connected to Other Services

***40%** of FSP clients are connected to other Tri-City*



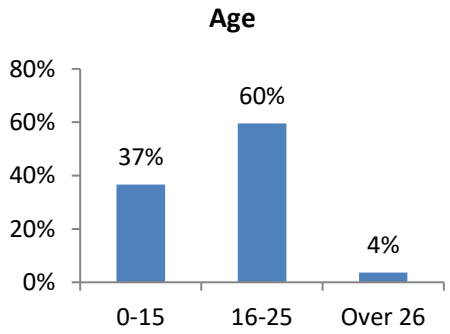
Full-Service Partnership (FSP) – Children and TAY

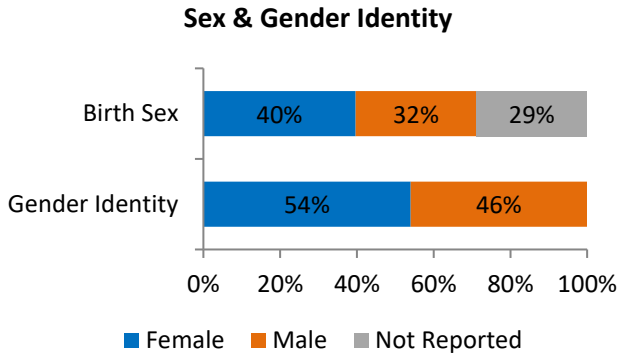
267
Individuals Served

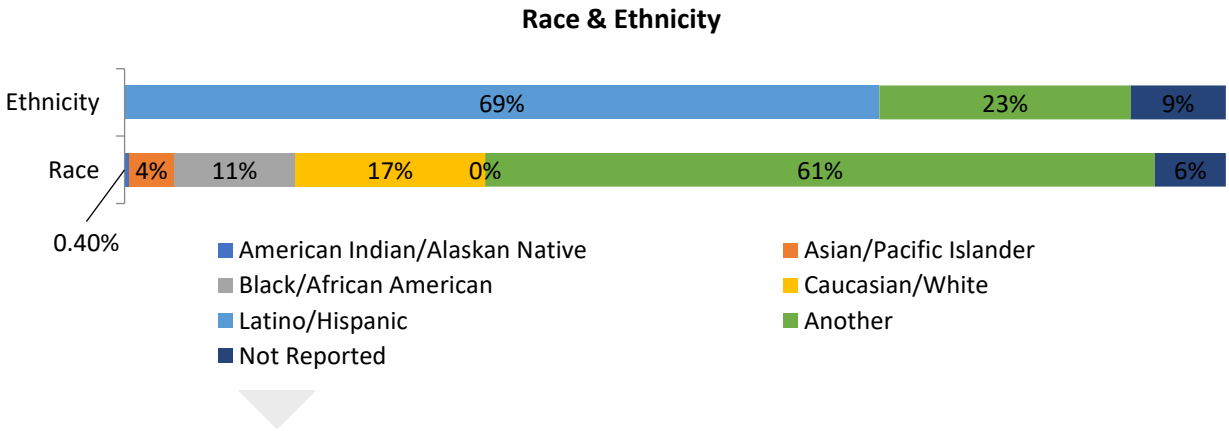


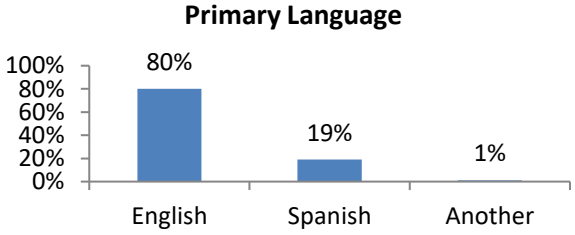
The number of individuals served increased from 225 in FY 2022-23 to 267 in FY 2023-24

84% of FSP CTAY clients lived in Pomona,
while 8% of clients lived in Claremont, 7% lived in La Verne, and 1% of clients came from other cities

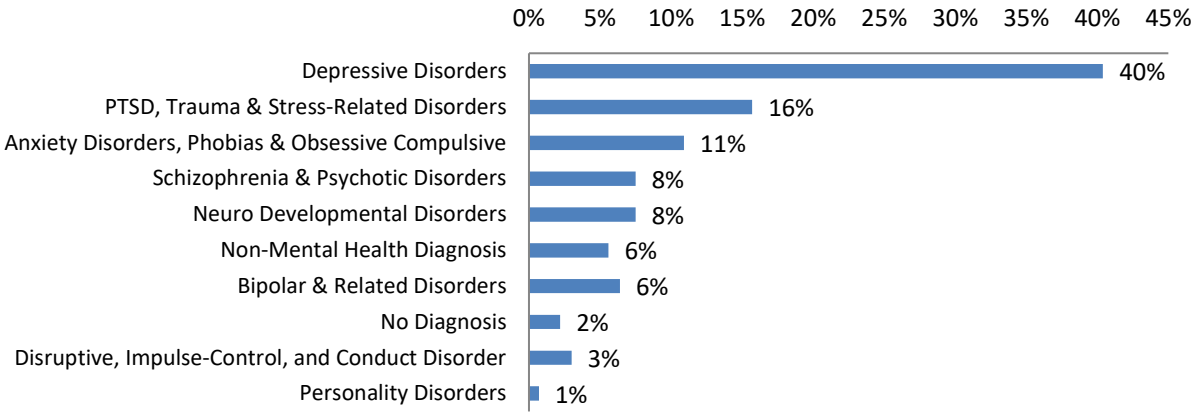




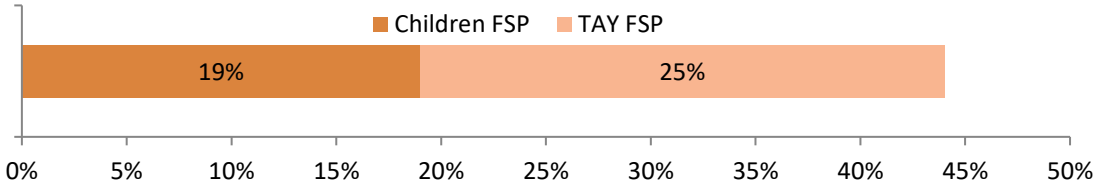




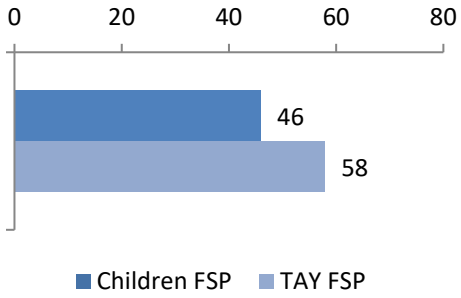
Primary Diagnosis by FSP CTAY Clients



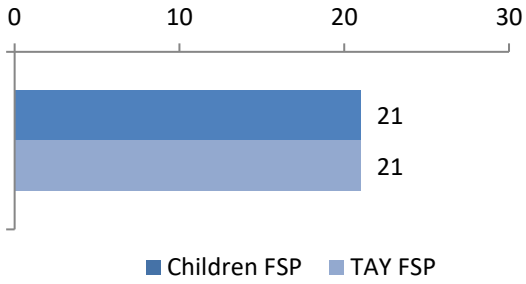
Clients Receiving Medication Services by Program



Number of Crisis Episodes

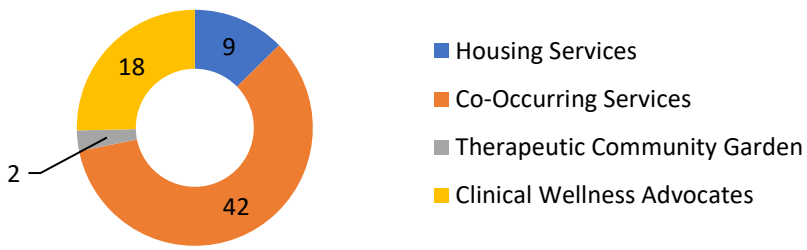


Number of Unique Clients w/ at least 1 Crisis Episodes



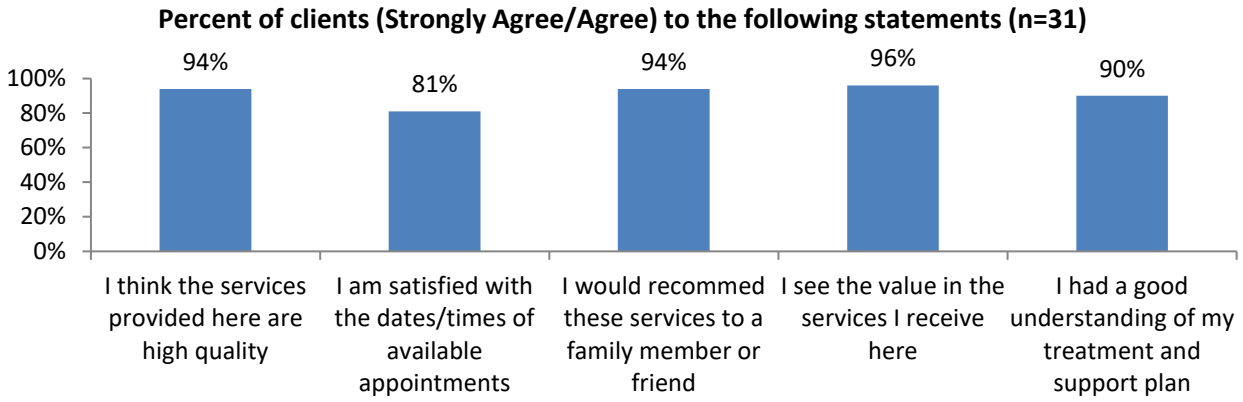
Number of FSP CTAY Clients Connected to Other Services

***27%** of FSP clients are referred to other Tri-City*



How Well Did We Do It?

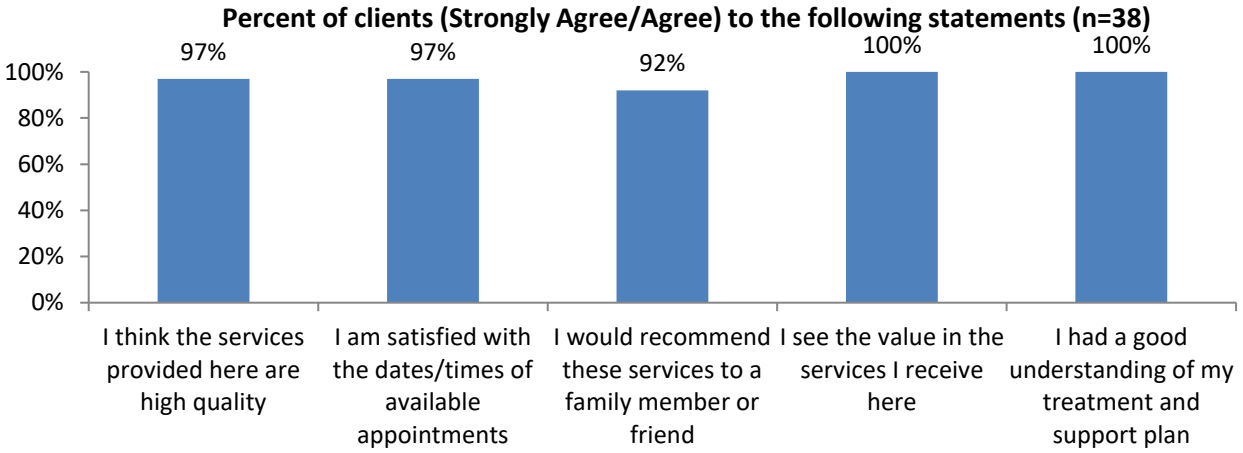
Full-Service Partnership (FSP) – Adult and Older Adult



On average, FSP Adult/Older Adult clients were enrolled for 11 months.

The average time enrolled in FSP Program **decreased** from **17 months** in FY 2022-23 to **11 months** in FY 2023-24.

Full-Service Partnership (FSP) – Children and TAY

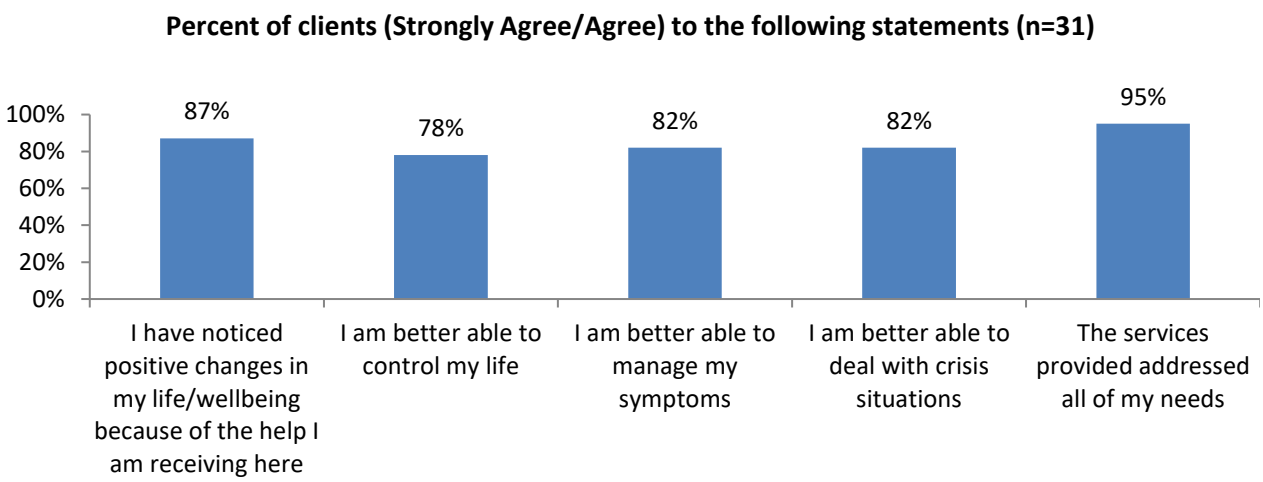


On average, FSP CTAY clients were enrolled for 9 months.

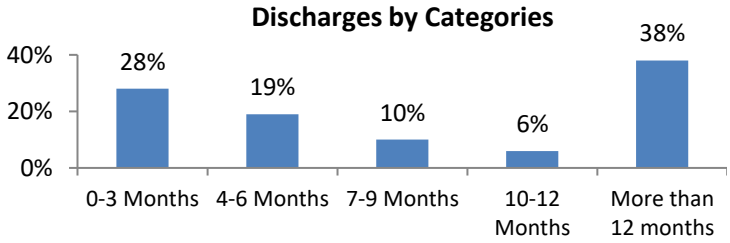
Is Anyone Better Off?

Full-Service Partnership (FSP) – Adult and Older Adult

As a direct result of the services I received:



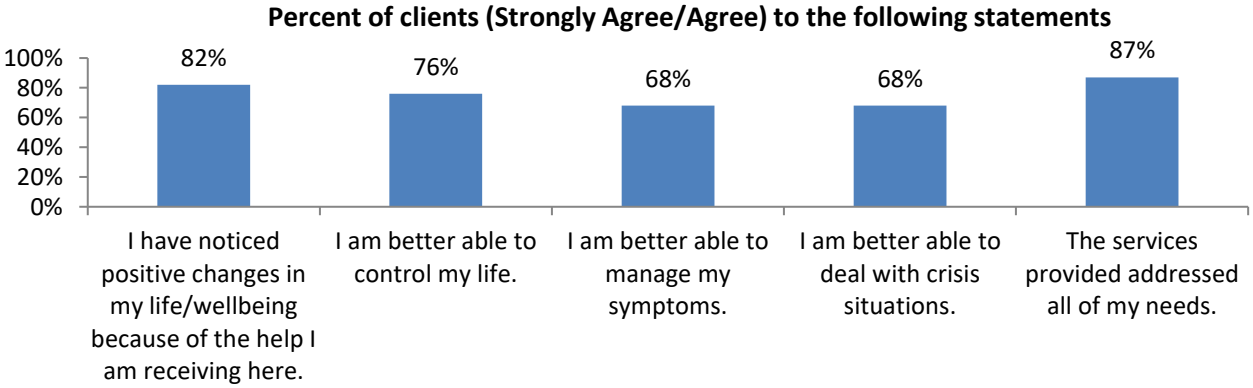
215 Discharges during FY 2023-24



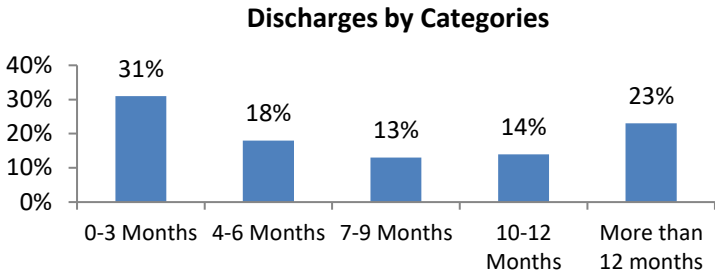
The number of discharges **increased** from **123** in FY 22-23 to **215** in FY 23-24.

Full-Service Partnership (FSP) – Children and TAY

As a direct result of the services I received:



171 Discharges during FY 2023-24



OMA Outcomes for FSP CTAY (n=69)			
OMA Reductions	**Pre-Intake & Intake**	**During FSP Enrollment (Key Event Tracking)**	**Reduction**
Homelessness	7% (n=5)	7% (n=5)	No
Hospitalizations	41% (n=28)	7% (n=2)	Yes
Justice Involvement	10% (n=7)	0% (n=0)	Yes
Expulsions/Suspensions from School	1% (n=1)	0% (n=0)	Yes

OMA Outcomes for FSP Adult/Older Adult (n=216)			
OMA Reductions	**Pre-Intake & Intake**	**During FSP Enrollment (Key Event Tracking)**	**Reduction**
Homelessness	49% (n=106)	47% (n=103)	Yes
Hospitalizations	48% (n=105)	2% (n=5)	Yes
Justice Involvement	10% (n=22)	1% (n=1)	Yes

Community Navigators

Program Description

Since 2009, the Community Navigators have served as the primary connection for community members to local resources, including informal community supports and available formal services. In addition, Community Navigators work closely with community partners, non-profit organizations, agencies, community food banks, and faith-based organizations who often contact Community Navigators for assistance. Resources include mental health services, substance use treatment, support groups and parenting classes. Community Navigators also collaborate with local advocacy groups in an effort to build a localized system of care that is responsive to the needs of the clients and community members we serve.

Target Population

Tri-City clients, community members and local organizations who request referrals and linkage to clinically and culturally appropriate resources and services.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	32	95	357	189	N/A	**1,283**
Projected Number to be Served FY 2024-25	27	79	299	158	**510**	**1,073**
Cost Per Person	$706	$706	$706	$706	$706	**$706**

Program Update

The Community Navigator (CN) Program received grant funds for the Homeless Implementation Grant which was approved for use between February 1, 2023 through January 31, 2024. Navigators began spending these funds in July 2023 and utilized the remaining funds during this fiscal year 2023-24. This grant provided funding for short-term motel vouchers, rental and move-in assistance, and furniture assistance.

The Community Navigator program recently applied to the San Gabriel Valley Council of Governments (SGVCOG) for the Housing Solutions Fund (HSF) for homeless prevention funds. The grant was approved in April 2024 and funding should be available next fiscal year 2024-25.

The Community Navigator Program is currently collaborating with the University of La Verne's Accessibility and Student Outreach and Support Services. The University requested a Community Navigator who could be available to assist the students with resources. Currently, one of the Navigators is stationed at the University once a month and available to assist students who may need to meet in person. However, students at the University can contact a CN through the 888 number at any time to schedule a virtual appointment if needed. A flyer with this information has also been distributed to students who attend the University.

Challenges and Solutions

Limited housing and shelter resources are an on-going challenge. There continues to be a high number of families and individuals that experience homelessness in the community. Additionally, resources for emergency shelters, especially for families is very limited in the service area. Issues with finding psychiatrist that take Medi-Cal health plans, and clinicians who do not have long waiting periods has also continued to be a challenge.

The approval of SGVCOG for The Housing Solutions Fund will support in countering these challenges. This program provides cities and service providers flexible funds that will assist individuals experiencing, or at-risk of homelessness, with expenses related to housing, rehousing, and stabilization. These funds will enhance the services that the Community Navigator Program provides, since the program often receives calls from individuals and families who are on a limited income, experiencing homelessness or at risk of homelessness.

Diversity, Equity and Inclusion

The Community Navigator program consists of highly trained individuals who are bilingual and can provide services in English, Spanish and Vietnamese. This has been helpful since there is a high population of Spanish speaking individuals in Pomona as well as a Vietnamese population. In addition, some of the CNs identify with lived experience so they can better connect with clients they serve. Flyers and documents are also provided in other languages requested.

The Community Navigator staff receive ongoing cultural inclusion training to better assist the populations that they serve. In addition, the CNs are trained to identify and research any resources that can help further support the mental well-being of individuals who may experience additional cultural barriers. The CNs are well versed in identifying services internally, and externally via community partner connections including but not limited to sliding scale mental health services, support groups and faith-based counseling. Community Navigators also work closely with local senior centers in the three cities, with some CN staff being stationed at the local community senior centers so that the program can assist older adults with support and resources when needed. The CNs also work closely with community partners whose services are geared towards LGBTQ+ individuals as well as monolingual Spanish speakers.

Community Partners

The Community Navigators collaborate closely with agencies such as Hope for Home Service Center, Los Angeles Centers for Alcohol and Drug Abuse (LACADA), Volunteers of America, Family Solutions, and the Los Angeles Homeless Services Authority (LAHSA) to link individuals to an array of services and resources geared towards those who are experiencing homelessness or housing insecurity.

The CNs also collaborate with the three cities of Pomona, Claremont, and La Verne, with a CN stationed in each city to address that community's specific needs. Additionally, the police departments regularly contact CNs when they encounter individuals in need of resources or homeless assistance.

When individuals are seeking lower level of care services, medical needs or services geared towards specialty populations, CNs collaborate with agencies such as Los Angeles Centers for Alcohol & Drug Abuse (L.A. CADA), Community Translational Research Institute (CTRI), East Valley Medical Center, Pomona Pride Center, House of Ruth, Volunteers of America and Just Us 4 Youth.

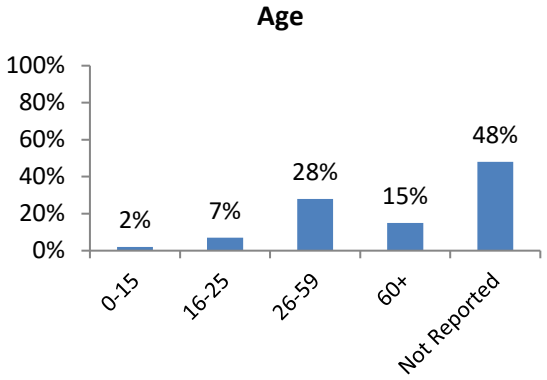
Success Story

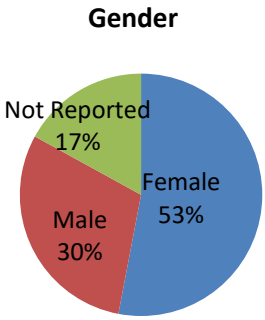
A Community Navigator worked with a single parent who had been unhoused for the past several years with their child. The CN program was able to house them in a motel for a month through the Homeless Prevention Grant. When the voucher expired, the Community Navigator connected the participant to a different crises housing program. The Navigator continued assisting the participant with multiple resources, as well as supporting them in gathering all the documents needed for a section 8 voucher that they had qualified for. Ultimately, the individual submitted all the documents needed, was approved for the section 8 voucher, and was recently housed in their own 2-bedroom apartment. The individual expressed gratitude, excitement, and happiness in being able to finally have their own place with their child, after being unhoused for so many years. With an essential need met, with the support of CNs, the participant was finally able to shift their focus to designing their space and making it a home.

Program Summary

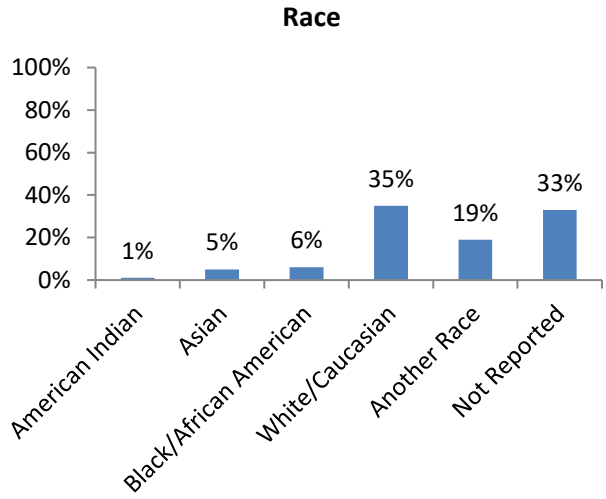
How Much Did We Do?

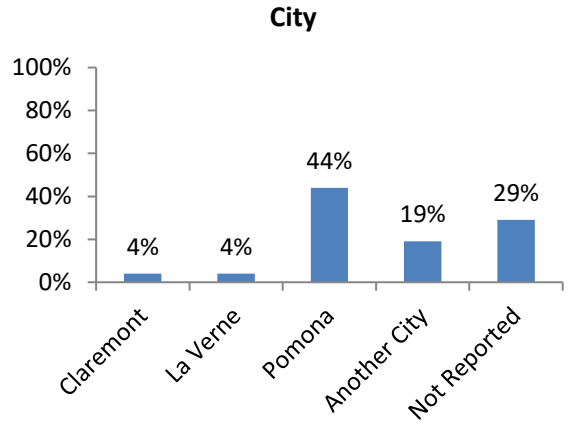
1,283 Individuals Served

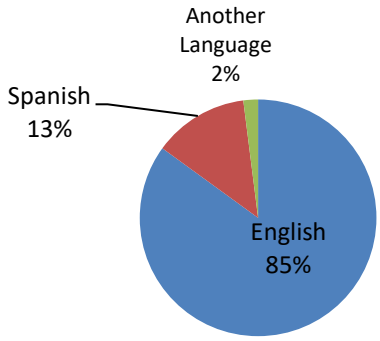




The number of individuals served **increased** from **969** in FY 2022-23 to **1,283** in FY 2023-24.





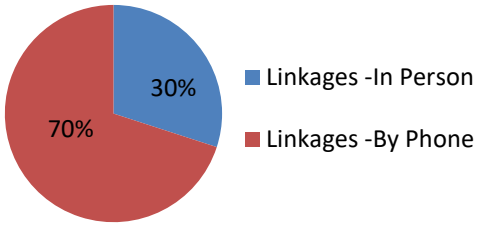


The number of homeless individuals who contacted the community navigators **increased** from **240** in FY 2022-23 to **280** in FY 2023-24.

280

Homeless Individuals who contacted the community navigators

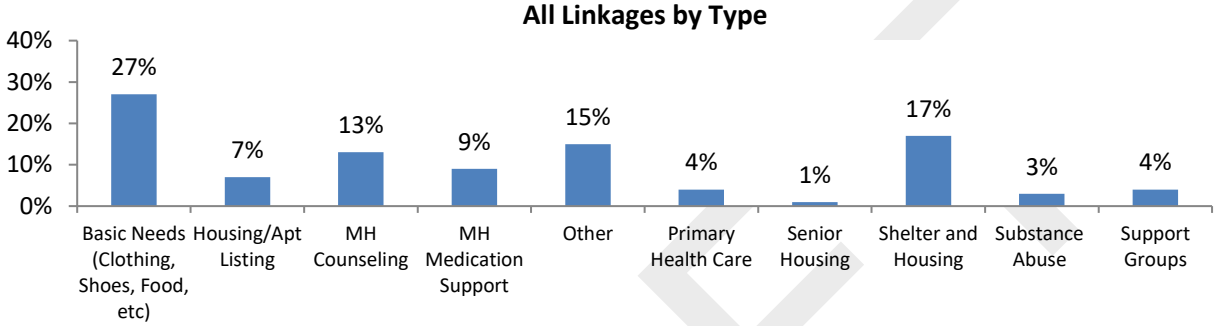
Linkages by Type



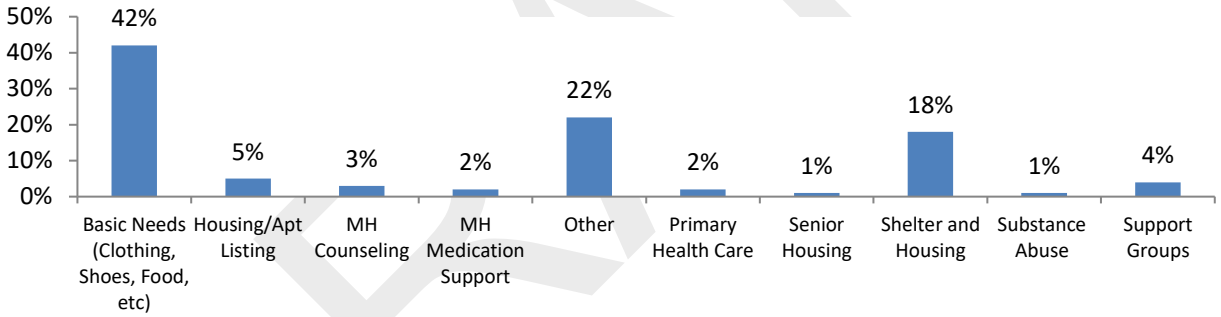
1,888 Linkages made by Community Navigators

The number of linkages made by the community navigators **increased** from **1,371** in FY 2022-23 to **1,888** in FY 2023-24.

All Linkages by Type



In-Person Linkages by Type

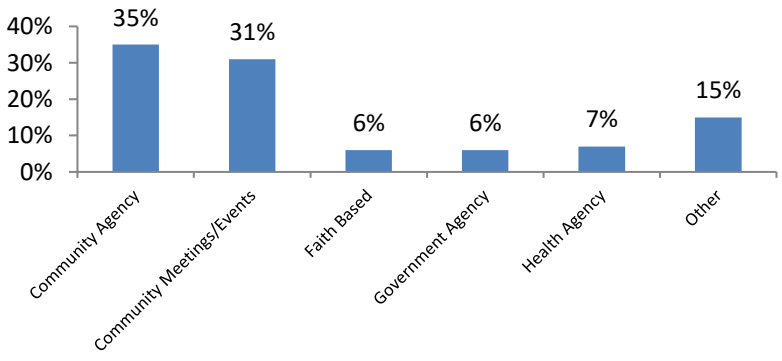


The number of events/locations outreached, and community members engaged **increased** from **31 and 670** in FY 2022-23 to **54 and 981** in FY 2023-24.

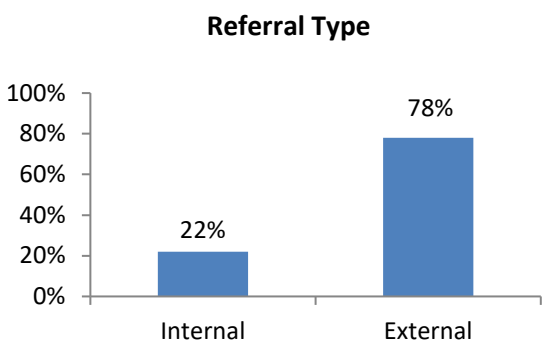
54 Events/Locations Outreached by Navigators

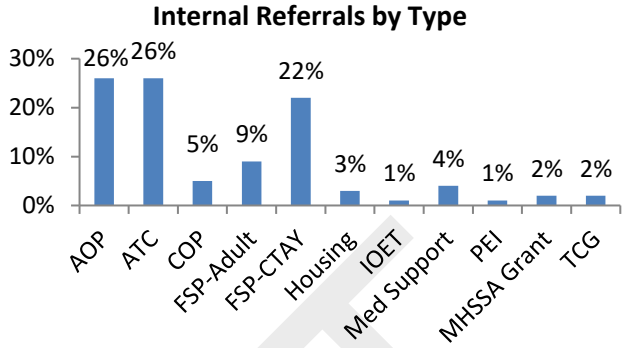
981 Total Community Members engaged by Navigators through Outreach

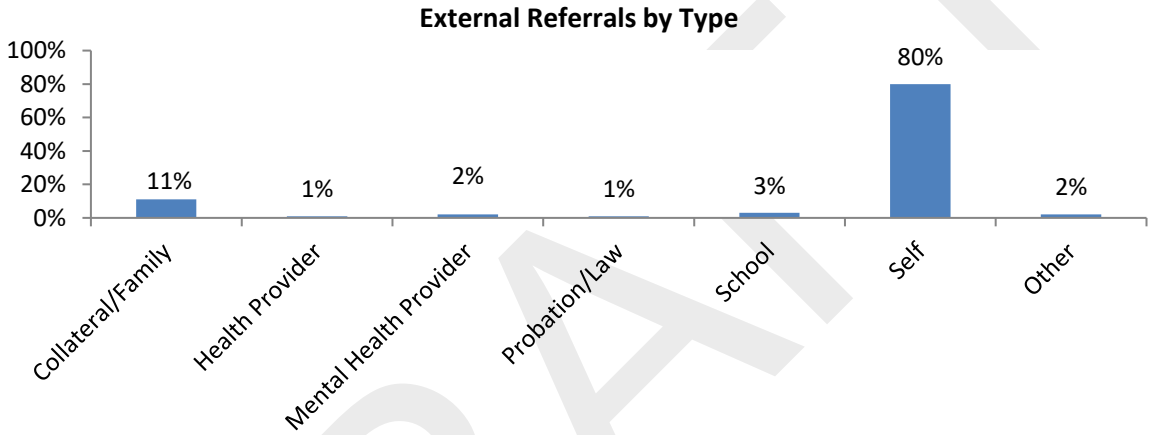
Locations by Type



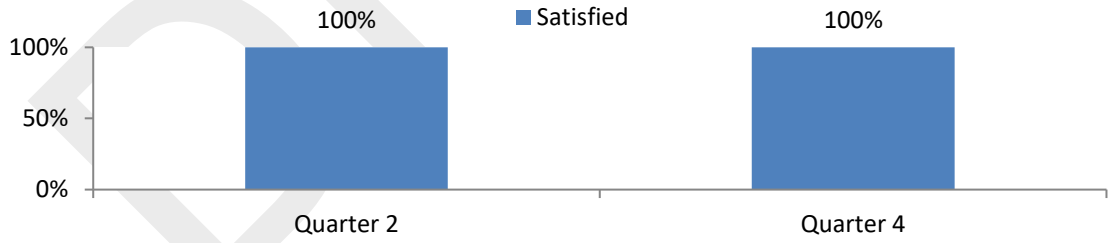
How Well Did We Do It?





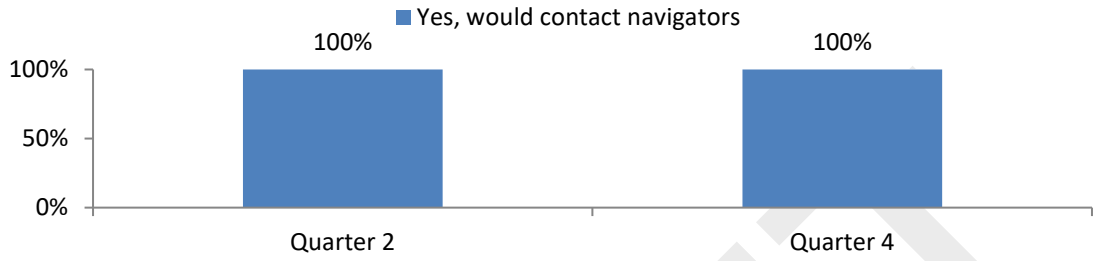


Percentage of Participants Reporting Satisfaction with Services Provided (n=135)



Is Anyone Better Off?

Percentage of Community Partners Reporting that if needed to find community resources again, would you contact the community navigators? (n=28)



How did you benefit from talking with a navigator?

The top three benefits were:

1. Mental Health Counseling/Treatment Assistance: 33% of respondents
2. Housing Assistance: 29% of respondents
3. Social Service Assistance 16% of respondents

Wellness Center

Program Description

The Wellness Center serves as a community hub that sponsors support groups and provides an array of holistic services through collaboration with other community partners. Specialized services include activities focused on TAY, older adults, and employment support. Services include support groups, educational resources and workshops, job fairs, hiring events, recreational activities, and vocational support. Wellness Center staff includes peer advocates, volunteers and clinical staff who can help participants engage in support services designed to increase wellbeing.

Target Population

The Wellness Center promotes recovery, resiliency, and wellness for residents of the Tri-City area. The Wellness Center is open to people of all ages, focusing especially on people in recovery and their families.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	55	229	972	265	109	**1,630**
Projected Number to be Served FY 2024-25	30	126	535	146	60	**898**
Cost Per Person	$1,645**	$1,645**	$1,645**	$1,645**	$1,645**	**$1,645****

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

Program Update

The Wellness Center experienced an increase in individuals served, from 1,009 in FY 2022-23 to 1,630 in FY 2023-24. Multiple hiring events were provided to the community to support those who are actively searching for employment and, combined with other employment supports, 75 individuals obtained employment.

Challenges and Solutions

One challenge faced by the staff during FY 2023-24 was the shift back to in-person appointments and discovering that many individuals still prefer to meet virtually. While some services are still offered as hybrid options, the Employment and Vocational support services encouraged those who were ready, to meet in person for their appointment. The reasoning behind this was that often, interviews are in-person, so practicing face-to-face would replicate an actual interview environment while still providing interview practice that would benefit them in a virtual environment as well.

In the next fiscal year, staff also hope to resume its basic, intermediate, and advanced computer classes at the Wellness Center. COVID restrictions led to significant limitations regarding room capacity, and the computer lab was limited on the number of individuals that could be in the room at the same time. With those limitations reduced, we hope to bring back this resource that has proven to be valuable in the past.

Diversity, Equity and Inclusion

The Wellness Center holds groups that have been created to target specialty populations such as LGBTQ+, Spanish monolingual, older adults, children, and transition age youth. Additionally, vocational and employment services provide support regardless of an individual's age, race, or culture for them to be able to reach their goals of obtaining employment. Wellness Center staff are bilingual, and services can be offered in Spanish and Tagalog. If needed, services also include linguistic support in several other languages.

Groups and services are offered at a range of times throughout the day to increase accessibility and materials are offered in threshold languages. The Wellness Center strives to create a space where individuals can feel safe and heard regardless of any cultural barriers. Additionally, Staff participate in ongoing training to increase cultural competence and gain knowledge about implicit bias.

Community Partners

The Wellness Center works closely with both internal programs and external community organizations to strengthen their network of support. Examples include Generation Her, a teen parent support group, AlaNon for family AA support, Master of Social Work (MSW) Consortium for workforce development and other local community-based organizations for specific age-related services.

Additionally, the Wellness Center has partnered with several external businesses and organizations during hiring events (focusing on a single employer presenting multiple job opportunities they have at their agency or business) and job fairs (feature multiple employers seeking potential candidates). Partners include the United States Postal Service, California Highway Patrol, Employment Development Department, San Bernardino County, On-Time Staffing and FedEx Ground.

Success Story

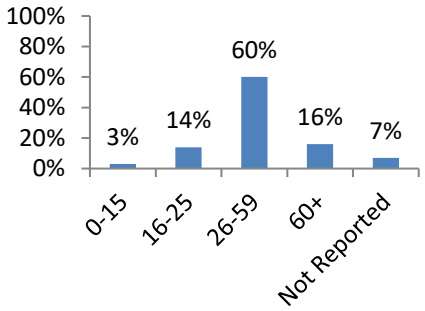
A participant came to the Wellness Center in 2023 to attend the Anxiety Relief group. Participant was experiencing eviction, homelessness and symptoms of anxiety and depression. They started attending groups consistently and gained confidence in their recovery, reporting benefits to their wellbeing and overall ability to socialize. After attending groups at the Wellness Center, they learned about resilience and identified that their current situation was temporary. The groups became a primary source of hope and positivity for them. Soon after, the individual chose to add vocational and employment services to support their goals of increasing income and obtaining housing. Staff supported with job searching, applications, and interviewing. Eventually, the participant successfully received job placements at multiple locations, securing reliable income and making possible the next step of obtaining permanent housing.

Program Summary

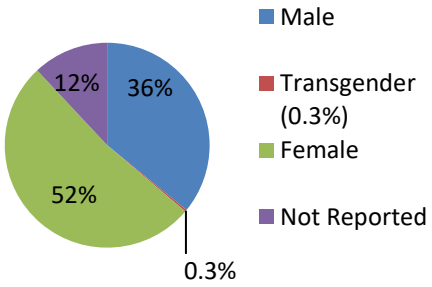
How Much Did We Do?

1,630 Unique Individuals attending Wellness Center

Age Group

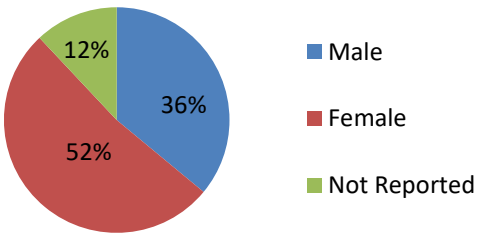


Current Gender Identity

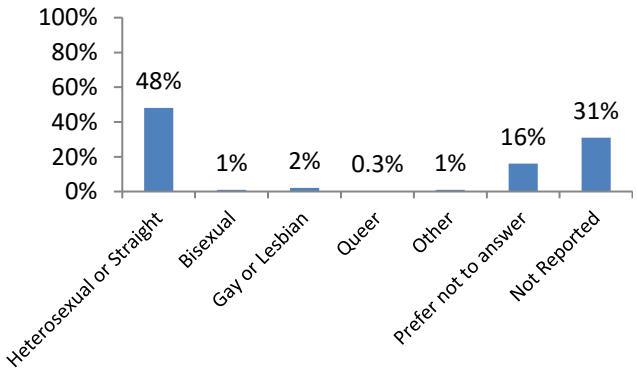


The number of individuals attending Wellness Center **increased** from **1,009** in FY 2022-23 to **1,630** in FY 2023-24.

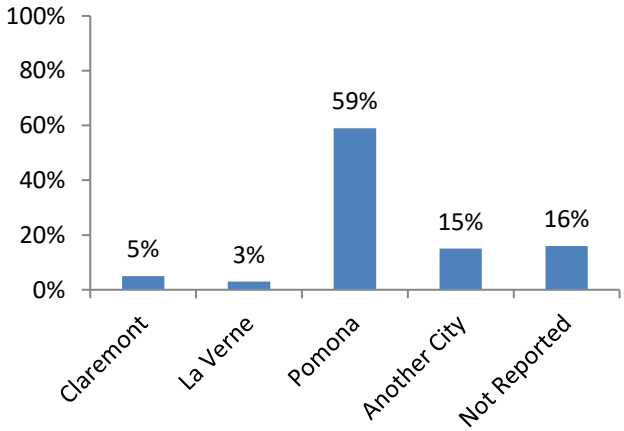
Assigned Gender at Birth



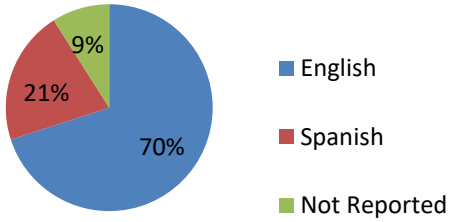
Sexual Orientation

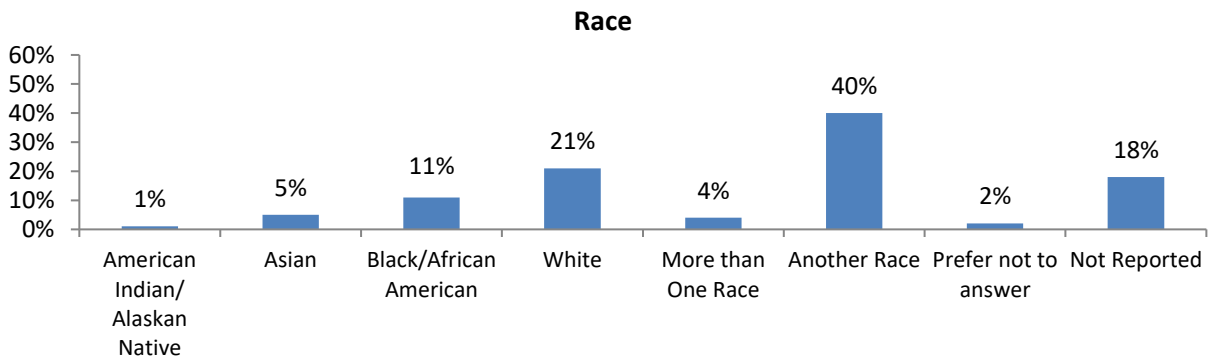


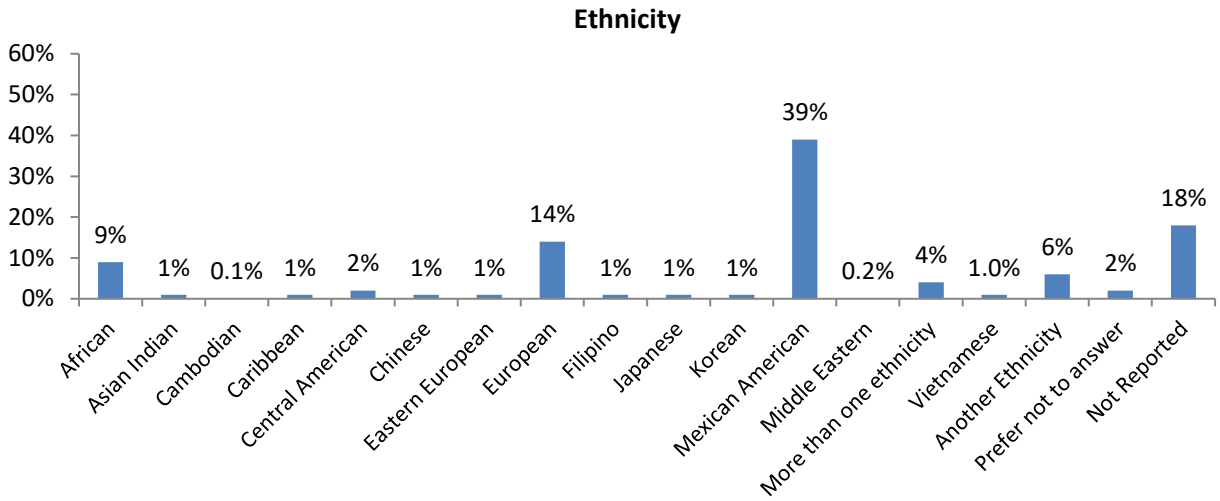
City

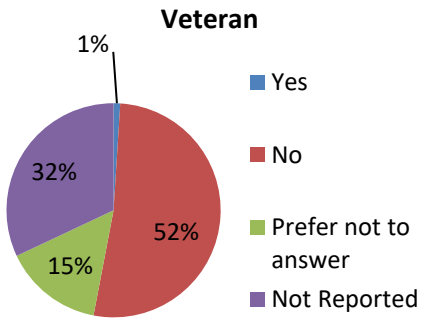


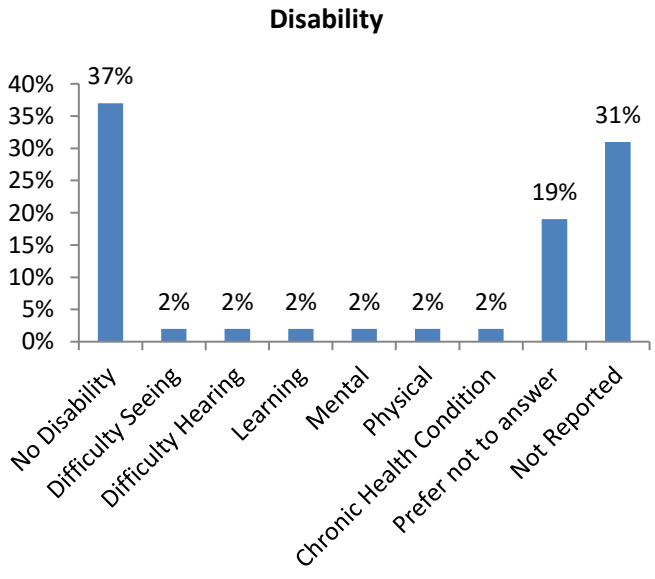
Primary Language




Race
60%
50%
40%
30%
20%
10%
0%
1%
5%
11%
21%
4%
40%
2%
18%
American Indian/ Alaskan Native
Asian
Black/African American
White
More than One Race
Another Race
Prefer not to answer
Not Reported


Ethnicity
60%
50%
40%
30%
20%
10%
0%
9%
1%
0.1%
1%
2%
1%
1%
14%
1%
1%
1%
39%
0.2%
4%
1.0%
6%
2%
18%
African
Asian Indian
Cambodian
Caribbean
Central American
Chinese
Eastern European
European
Filipino
Japanese
Korean
Mexican American
Middle Eastern
More than one ethnicity
Vietnamese
Another Ethnicity
Prefer not to answer
Not Reported

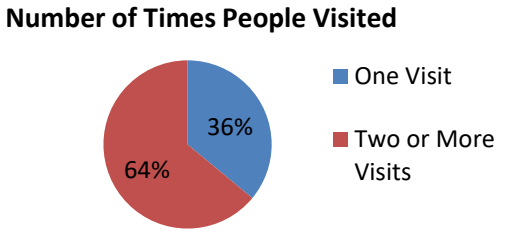

Veteran
1%
32%
52%
15%
Yes
No
Prefer not to answer
Not Reported


Disability
40%
35%
30%
25%
20%
15%
10%
5%
0%
37%
2%
2%
2%
2%
2%
2%
19%
31%
No Disability
Difficulty Seeing
Difficulty Hearing
Learning
Mental
Physical
Chronic Health Condition
Prefer not to answer
Not Reported

How Well Did We Do It?

16,184 Number of Wellness Center Events

(Duplicate Individuals)



Support Group Name	Number of Times Group Was Held	Average Number of Attendees at a Group
Group – Ageless and Unstoppable	29	2
Group – Anger Management	56	10
Group – Anxiety Relief	51	5
Group – Bore no More	12	2
Group – College Wellbeing	5	2
Group – Dual Recovery Anonymous	45	4
Group – Freedom through Reality	50	4
Group – Lose the Blues	43	3
Group – Men's Depression	49	2
Group – One-on-One	14	1
Group – Socialization	49	4
Group – Strong Women	50	7
Group – Women's Self-Esteem	17	2
Group Spanish – Corazón a Corazón	48	2
Group Spanish – Sobrellevando la Ansiedad	10	2
Group Spanish – Socialization	7	1
Group Vocational – Literacy Group	47	2

Contacts/Events by Type	Number of Individuals
Attendance Letter	261
Other	1,313
PC Lab	1,571
Tour	481
Phone Call/Email – Wellness Calls	2,005
Adult Orientation	9
Vocational – Job Search	1.689
Vocational – Computer classes	69
Vocational – Employment/Resume/Interview/Hiring	281

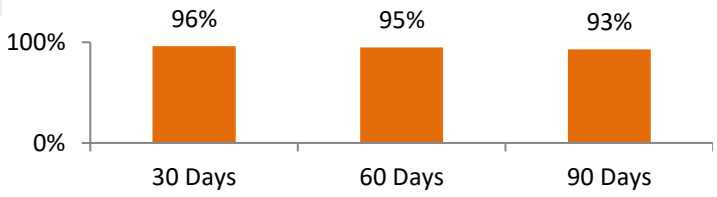
The number of available support groups at Wellness Center **increased** from **16** in FY 2022-23 to **18** in FY 2023-24.

75 Individuals Secured Employment

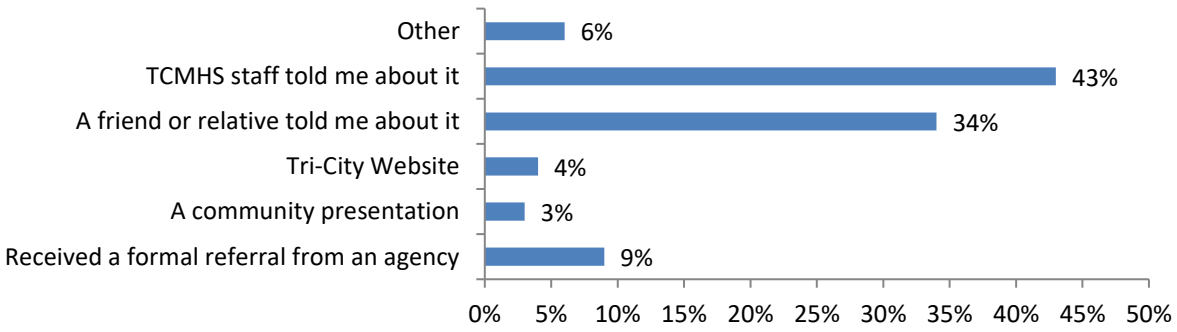
The number of individuals securing employment **increased** from **60** in FY 2022-23 to **75** in FY 2023-24.

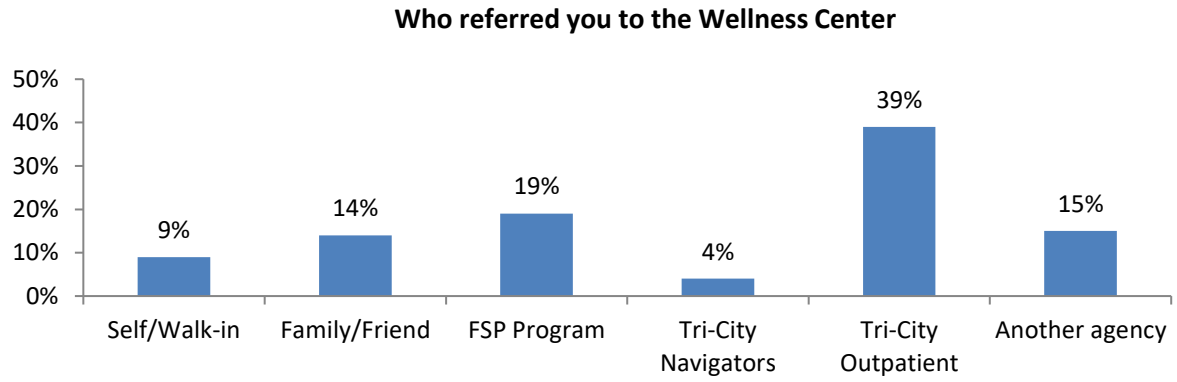
95% Satisfied with the help they get at Wellness Center Programs

Percent of Individuals who Maintain Employment at 30 Days · 60 Days · 90 Days



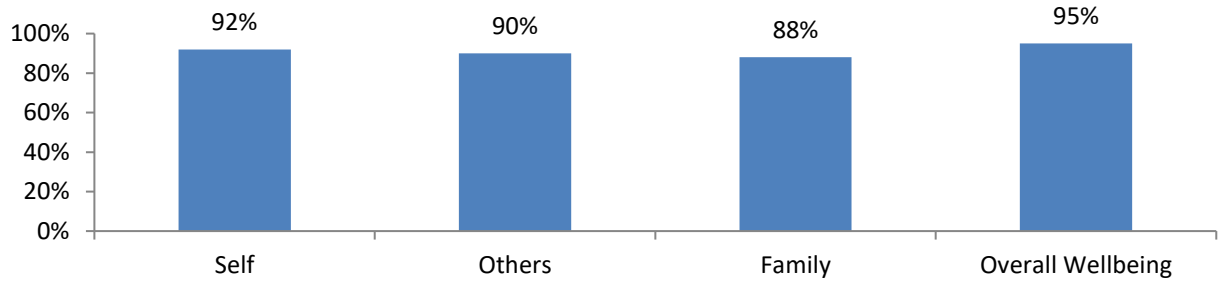
How Did You Learn About the Wellness Center Programs? (Choose All that Apply)





Is Anyone Better Off?

Percent of people who report improved relationships with the following because of the help they get from the Wellness Center Programs:



Supplemental Crisis Services & Intensive Outreach and Engagement Team

Program Description

The Supplemental Crisis Services (SCS) program provides after-hours and weekend phone support to individuals who are experiencing a crisis and who currently are not receiving TCMHA services. Crisis walk-in services are also available during business hours at Tri-City's clinic location. Through follow-up efforts by the Intensive Outreach and Engagement Team (IOET), individuals located in the community who are having difficulty connecting with and maintaining mental health support can receive services in an effort to help reduce the number of repeat hospitalizations and guide these individuals to the most appropriate care.

Target Population

The SCS targets individuals in crisis and currently not enrolled in Tri-City for services. The program is geared towards serving those who are seeking mental health support after-hours and individuals located in the community who are having difficulty connecting with and maintaining mental health support.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Supp Crisis Number Served FY 2023-24	0	6	50	8	40	**104**
Cost Per Person	$1,056**	$1,056**	$1,056**	$1,056**	$1,056**	**$1,056****
IOET Number Served FY 2023-24	22	45	267	77	77	**488**
Cost Per Person	$1,056**	$1,056**	$1,056**	$1,056**	$1,056**	**$1,056****

*No projections for number to be served were provided due to the program sunsetting on June 30, 2024.

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

Program Update

The IOET team provided community outreach which included linkage to formal services, medical services and other resources that those in need were struggling to obtain independently. Referrals from external partners remained consistent, with the highest number of referrals coming from Hope for Homes at 52%. The number of individuals outreached in FY 2023-24 decreased from the previous fiscal year, reducing from 714 in FY 2022-23 to 488. There was also a decrease in crisis calls, from 202 in FY 2022-23 to 104 in FY 2023-24.

On February 13, 2024, the team was notified that IOET will sunset as of June 30, 2024. In its place, the Mobile Crisis Care program will be implemented and have a designated staff to respond to crisis in the community with allocated vehicles fully equipped to respond to an array of crisis situations.

Challenges and Solutions

One challenge was balancing the range of crisis situations and clinically appropriate responses. Some individuals required support with obtaining identification cards or eyeglasses while others required more intensive support, such as linkage to services and obtaining assistance for complex medical issues. These requests from community members occurred often, and part of the solution-focused approach to these requests was having appropriate referrals/resources available, linkage support and follow up.

Diversity, Equity and Inclusion

Multiple staff members are bilingual, and brochures are in both English and Spanish. Staff incorporates literature regarding resources and referrals for underserved groups, providing culturally relevant information for those seeking it. Formal and informal services are identified based on need and resources/referrals are provided that meet individuals' preference (such as in-person sessions or phone/virtual). Additionally, all staff complete training related to Diversity, Equity, and Inclusion on a reoccurring basis to be mindful of culture, implicit biases, and to enhance their ability to provide fair and equable service to those in need.

Community Partners

The Supplemental Crisis Services engaged with several community partners with the goal of providing support, referrals, and resources. A few examples of this extensive network of support includes partnerships with the cities of Claremont, La Verne, and Pomona Police Departments, Mission Community Hospital, Pomona Valley Hospital Medical Center, Charter Oak Hospital, Tri-City clinical staff, Tri-City nonclinical staff, Los Angeles Department of Mental Health (LADMH), East Valley Community Health Center, Hope for Homes, local city councils, the Department of Motor Vehicles (DMV), Los Angeles Homeless Services Authority (LAHSA), Project Sister and House of Ruth.

Success Story

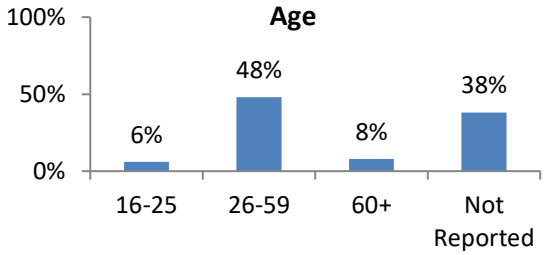
A notable success was the ability to continue receiving steady referrals from our partners in the community. Additionally, calls that were made to the crisis line saw a 16% increase from the previous fiscal year in regard to individuals calling the line due to being a previous client. This displayed a willingness to return to Tri-City as individuals who had been connected previously.

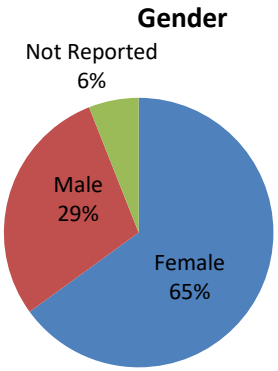
Program Summary

How Much Did We Do?

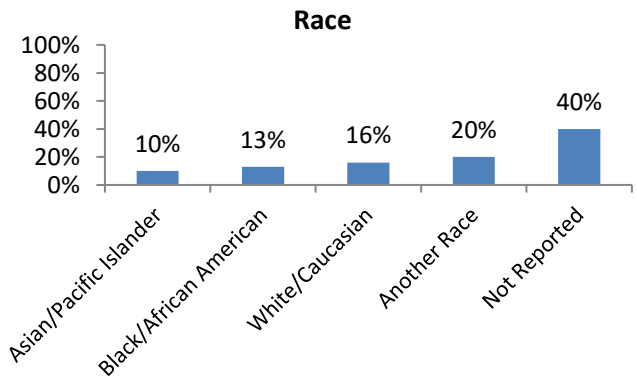
Supplemental Crisis Calls

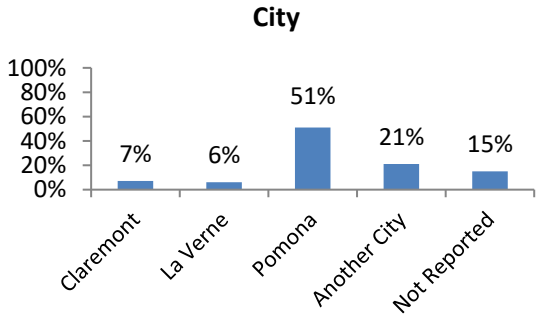
104 Supplemental Crisis Calls

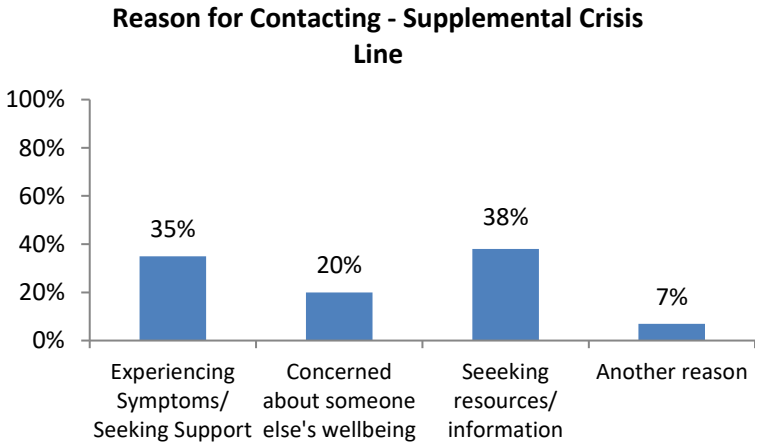


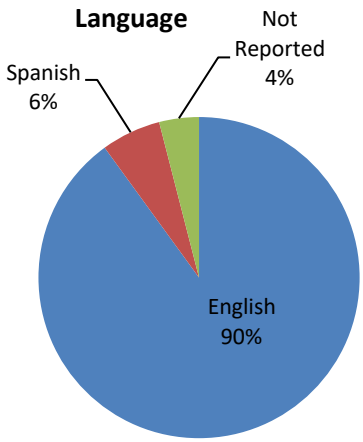


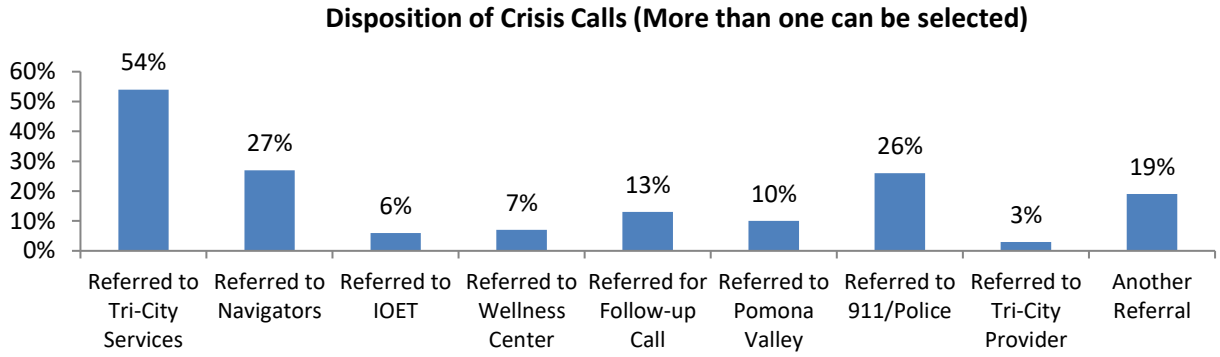
The number of crisis calls **decreased** from **202** in FY 2022-23 to **104** in FY 2023-24.









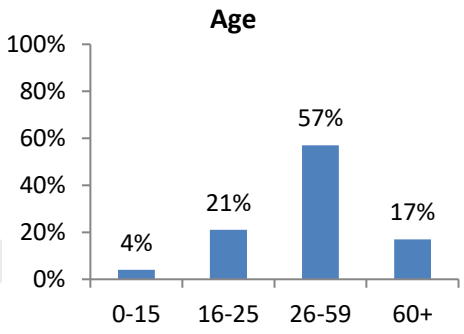


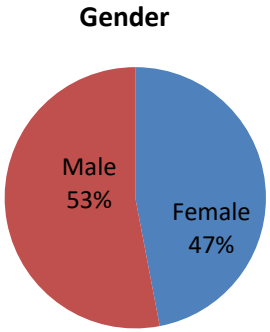
The percent of crisis calls referred to Tri-City Services **increased** from **45%** in FY 2022-23 to **54%** in FY 2023-24.

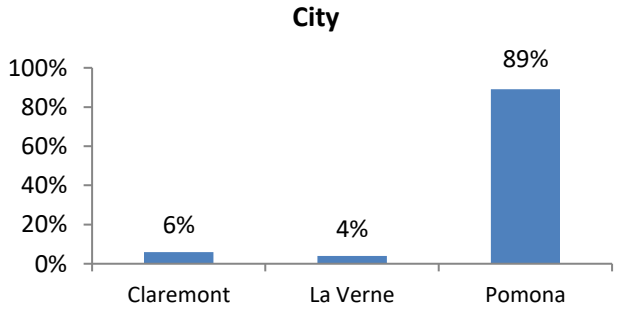
Supplemental Crisis Walk-Ins

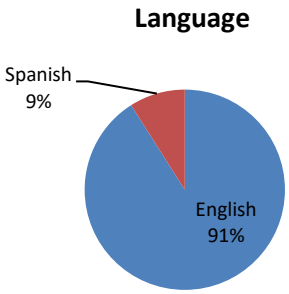
47
Crisis Walk-ins

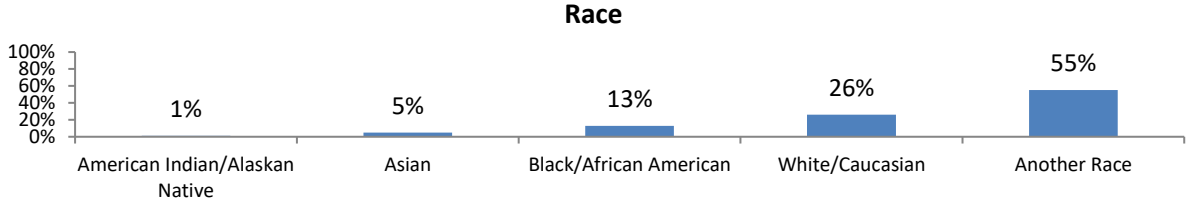
The number crisis walk-in **increased** from **45** in FY 2022-23 to **47** in FY 2023-24.







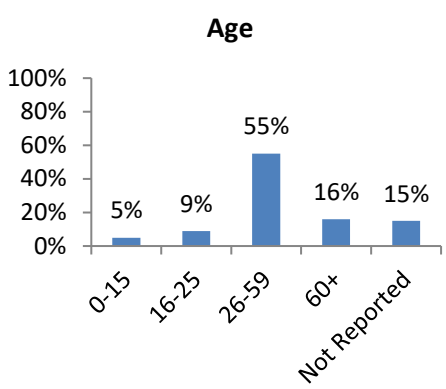


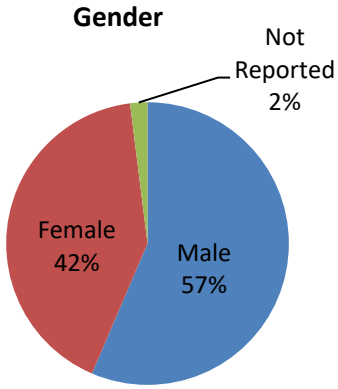


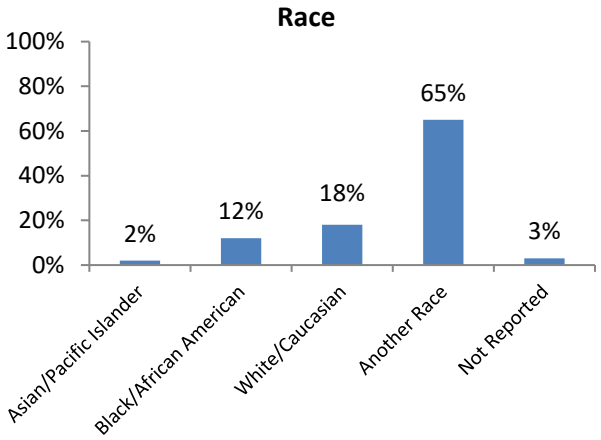
Intensive Outreach and Engagement

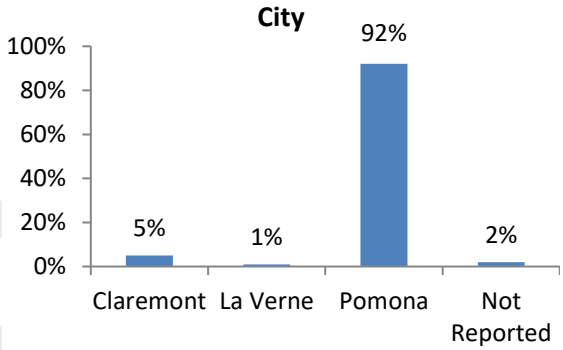
488 Individuals Outreached

The number of individuals outreached **decreased** from **714** in FY 2022-23 to **488** in FY 2023-24.

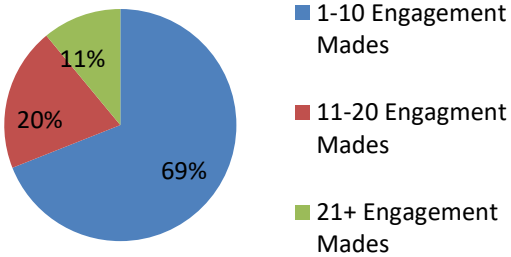




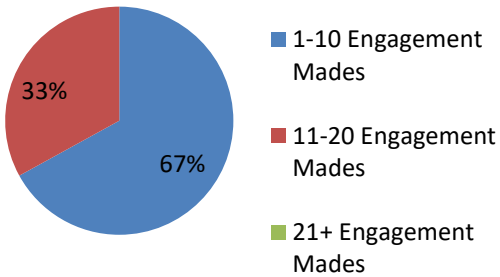




Percent of Engagement Attempts Made by IOET for Closed Individuals



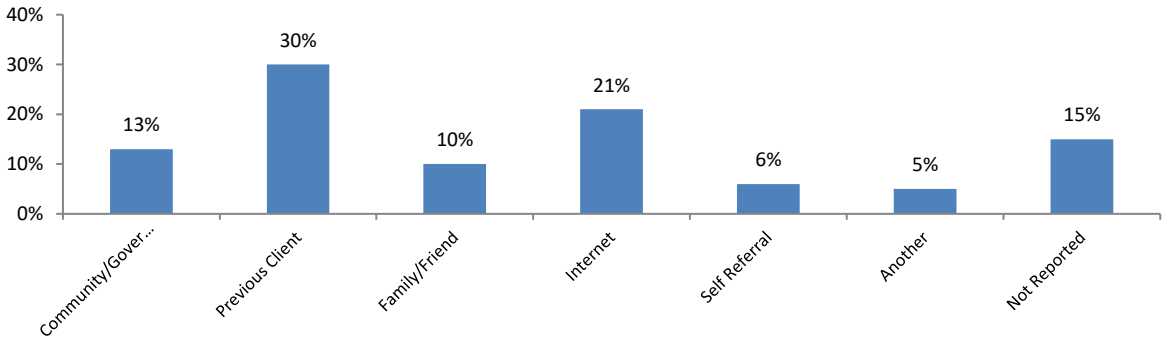
Percent of Engagement Attempts Made by IOET for Individuals currently being Engaged:



How Well Did We Do It?

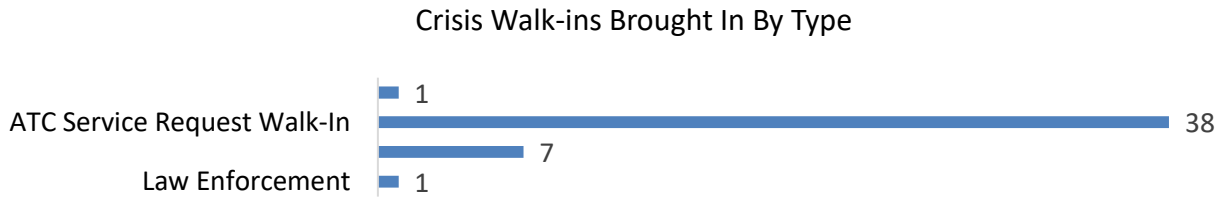
Supplemental Crisis Calls

How did you hear about the Supplemental Crisis Line:

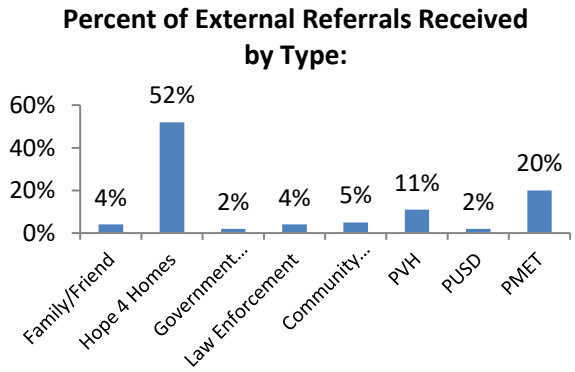


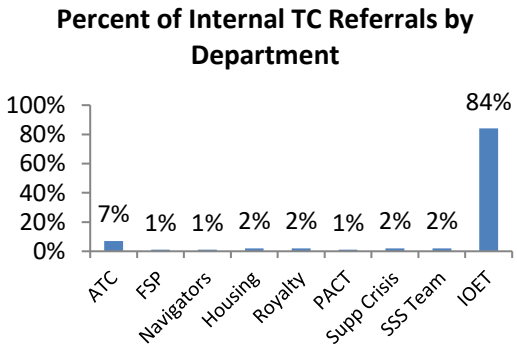
The percent of clients hearing about crisis line from being a previous client **increased** from **16%** in FY 2022-23 to **30%** in FY 2023-24.

Supplemental Crisis Walk-Ins



Intensive Outreach and Engagement





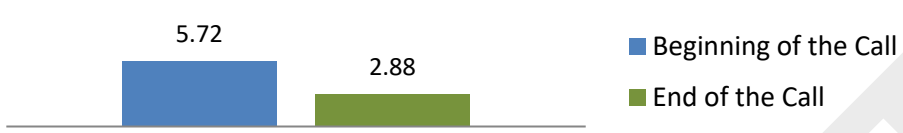
The number of external referrals remained constant with Hope for Homes and PMET-Pomona as the top 2 referrals sources.

Is Anyone Better Off?

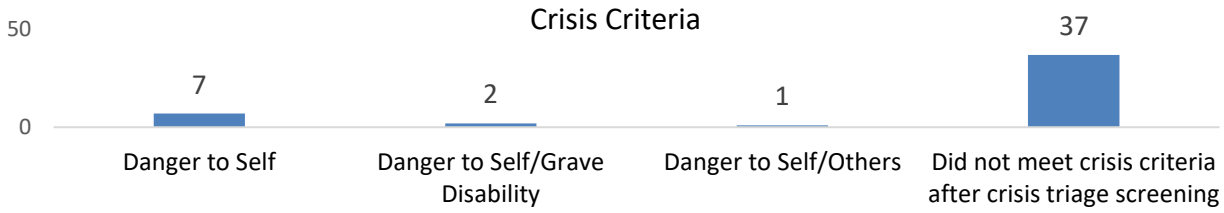
Supplemental Crisis Calls

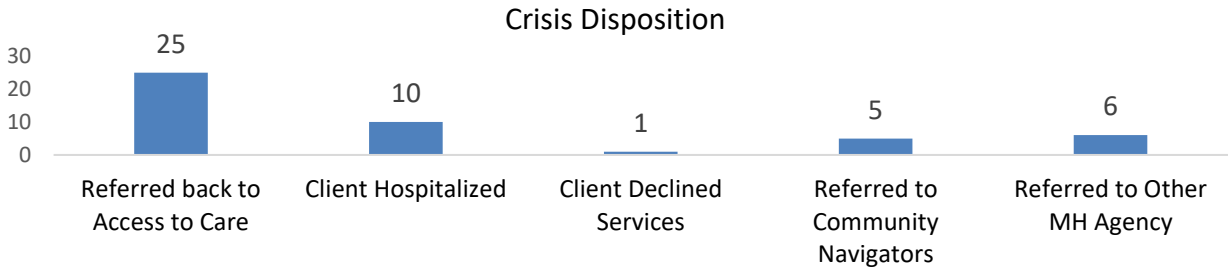
Level of Distress for Crisis Callers

Callers rated their level of distress at the beginning of the phone call and at the end on a 1 to 10 scale where 1 = mild and 10 = severe (higher rating means greater level of distress).



Supplemental Crisis Walk-Ins



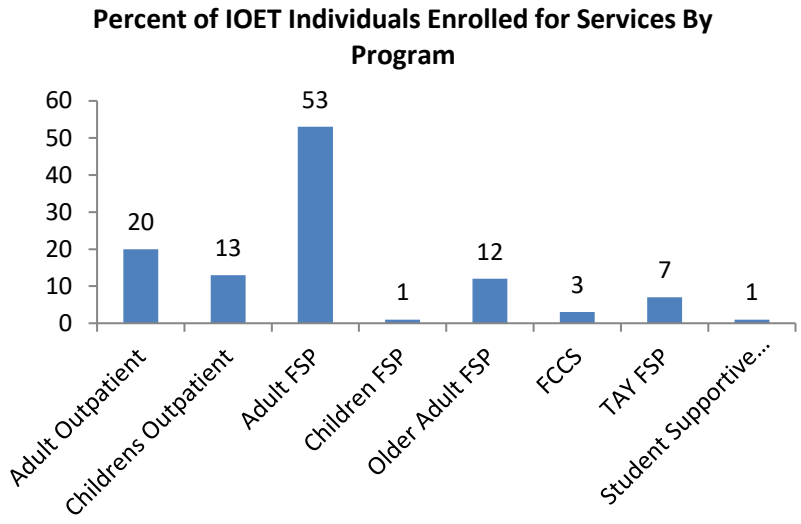


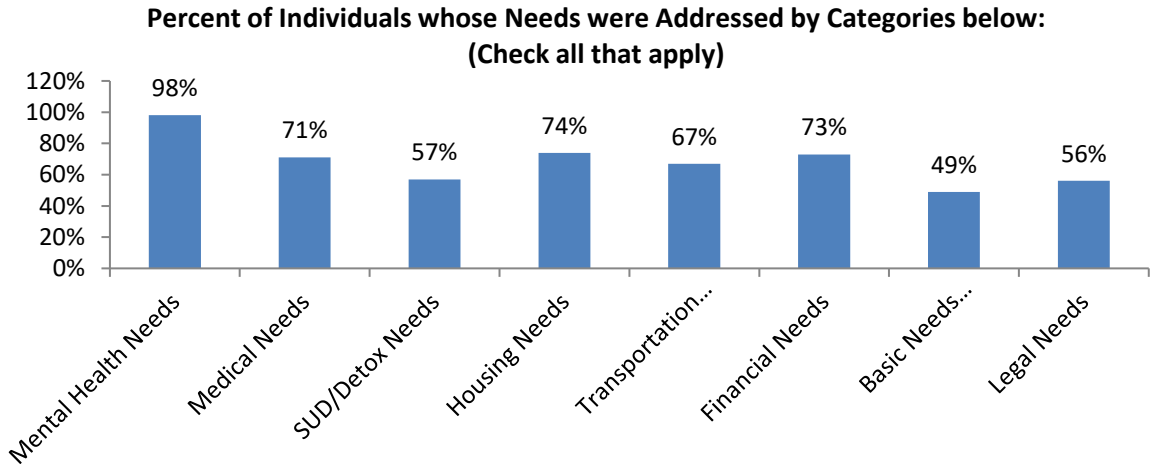
The number crisis walk-ins hospitalized **decreased** from **17** in FY 2022-23 to **10** in FY 2023-24.

51% Crisis Walk-ins were scheduled for intake

Intensive Outreach and Engagement

110 IOET Individuals Were Enrolled for Services at Tri-City





Field Capable Clinical Services for Older Adults

Program Description

Through the Field Capable Clinical Services for Older Adults (FCCS) program, TCMHA staff members provide mental health services to older adults ages 60 and above. FCCS offers an alternative to traditional mental health services for older adults who may be unable to access services due to impaired mobility, lack of transportation, stigma, or other limitations. Available services include but are not limited to 1) bio-psycho-social assessment 2) individual and group counseling 3) psychiatric and medication follow-up 4) case management and 5) referrals to appropriate community support services. These services are provided at locations convenient to older adults, including in-home, senior centers, medical facilities, and other community settings depending on the individual's preference.

Target Population

Older adults, ages 60 and over, who are experiencing barriers to mental health service due to a variety of issues including lack of transportation, stigma, or isolation.

Age Group	Older Adults 60+
Number Served FY 2023-24	52
Projected Number to be served FY 2024-25	35
Cost Per Person	$5,005

Program Update

During FY 2023-24, Field Capable Clinical Services for Older Adults (FCCS) served 52 unique individuals, a significant increase from the 37 individuals served in FY 2022-23. This increase supported the general upward trend that FCCS has experienced in recent years. To support staff and their growing caseloads, a Support Drop-In Hour was created to address complex and high-risk cases.

Additionally, FCCS witnessed an increase in complex medical conditions experienced by clients. This mirrored similar trends that occurred in other MHSA programs. Accordingly, staff was equipped to refer, provide resources, support with case management, and maintain/obtain relationships with external partners who may be able to offer relevant services to meet client's needs.

Challenges and Solutions

A change in the electronic health system (EHR) Care Plan component led to a new learning curve for FCCS staff. The team was supported in this transition by attending ongoing EHR and Quality Assurance (QA) training. Training included 1:1 support regarding how to add goals in the Care Plan as well as obtaining training materials and a components page for the EHR reflecting the recent changes and expectations.

With an increase in complex medical conditions, many individuals required linkage and referrals to higher levels of care and medical supports. To ease the challenge, staff are versed in reliable community partners to address medical concerns and work with internal Community Navigators when additional support is needed to identify resources available.

Diversity, Equity and Inclusion

The FCCS program continues to be led by a bilingual (Spanish speaking) clinician. In addition, all program brochures are available in both English and Spanish and an approved language line is also available. Community Navigators are available to provide culturally appropriate resources for clients as needed. The FCCS team also supports undocumented individuals in targeted case management, resource identification and linkage to services supporting issues related to immigration, legal support, social services, shelters, medical care, and support with the application process for Medi-Cal benefits.

Ongoing training is provided to FCCS staff regarding cultural competence and implicit bias. Depending on the need, FCCS is also able to refer to the appropriate supports should a client be experiencing physical or mental disability, require assistance with assisted living/senior housing, or obtain waivers for in-home living. Being aware of these resources in the community and partners who work specifically with the older adult population is vital in supporting this underserved demographic.

Community Partners

The Field Capable Clinical Services team collaborates regularly with internal as well as external partners for the purposes of referrals, resources, adjunct services, housing, and transitions, among other purposes. Examples of these collaborations are Los Angeles County Department of Health Services Medical Center for referrals, Pomona Housing Authority and Volunteers of America (VOA) for housing needs, Park Tree (a local pop-up clinic) for medical support, Police Departments in Pomona, Claremont and La Verne for referrals and collaboration, Prototypes and American Recovery Center for substance use treatment, The Department of Public Social Services, and Social Security Administration.

Success Story

An individual was connected to FCCS due to depression, anxiety, isolating behaviors and reducing social interactions with others. Through FCCS, they learned to connect with the community by increasing social interactions and addressing social behaviors. As medication support services were indicated, the individual was linked to the internal medication support services to assist with managing symptoms of depression. Ultimately, they were able to build interpersonal relationships, increase community engagement, and improve overall wellbeing. Some evidence of these improvements experienced were demonstrated in the individual's ability to become an active participant in their community center, host social events in their home, attend the Wellness Center, and attend various senior centers. As goals were met and improvements made in symptoms and impairments, they are now working towards graduation from the FCCS program.

Program Summary

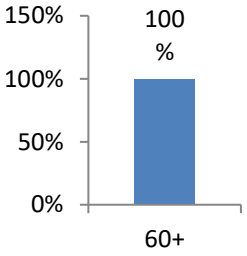
How Much Did We Do?

52
Individuals Served

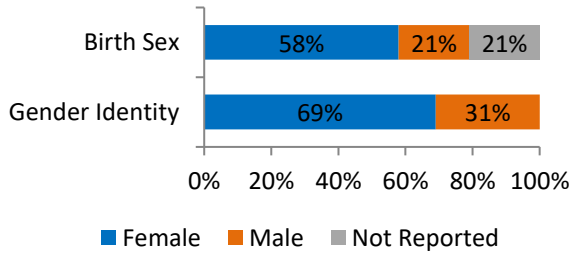
The number of individuals served **increased** from **37** in FY 2022-23 to **52** in FY 2023-24.

83% of FCCS clients lived in Pomona, while 15% of clients lived in Claremont.

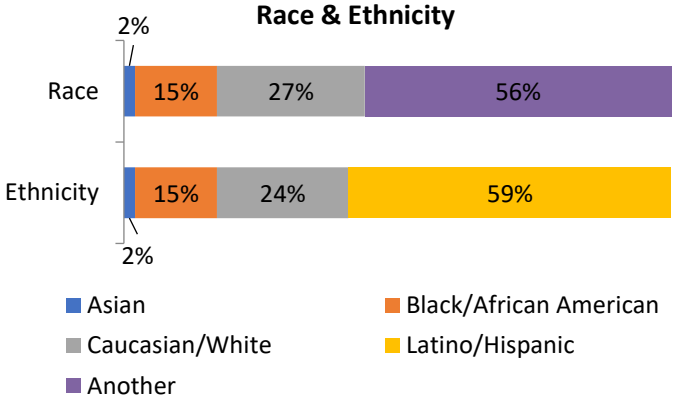
Age



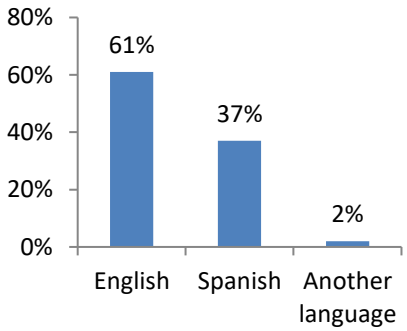
Sex & Gender Identity



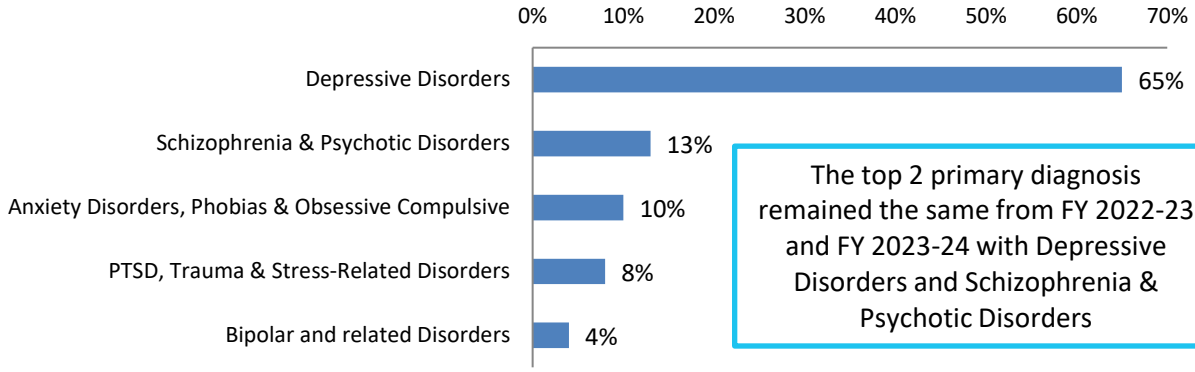
Race & Ethnicity



Primary Language

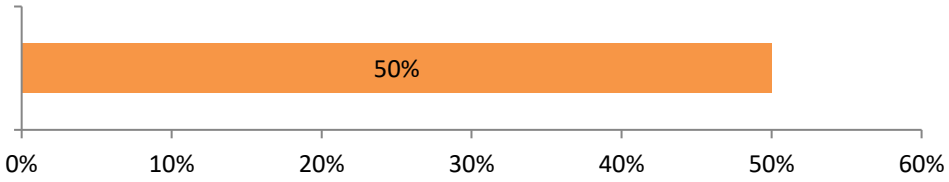


Primary Diagnosis by FCCS Clients

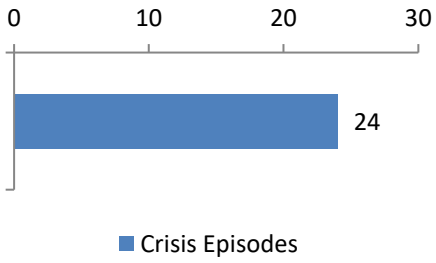


The top 2 primary diagnosis remained the same from FY 2022-23 and FY 2023-24 with Depressive Disorders and Schizophrenia & Psychotic Disorders

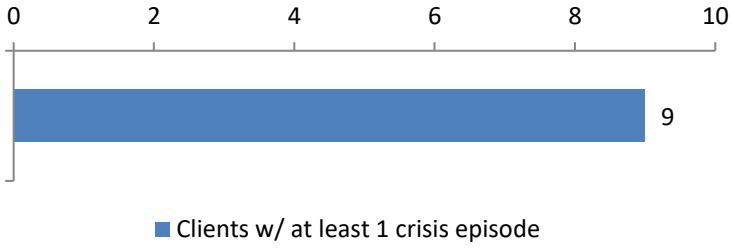
Percent of FCCS Clients Receiving Medication Services



Number of Crisis Episodes

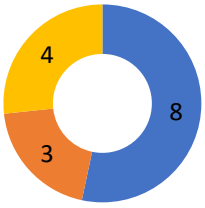


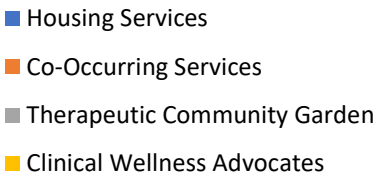
Number of Unique Clients w/ at least 1 Crisis Episodes



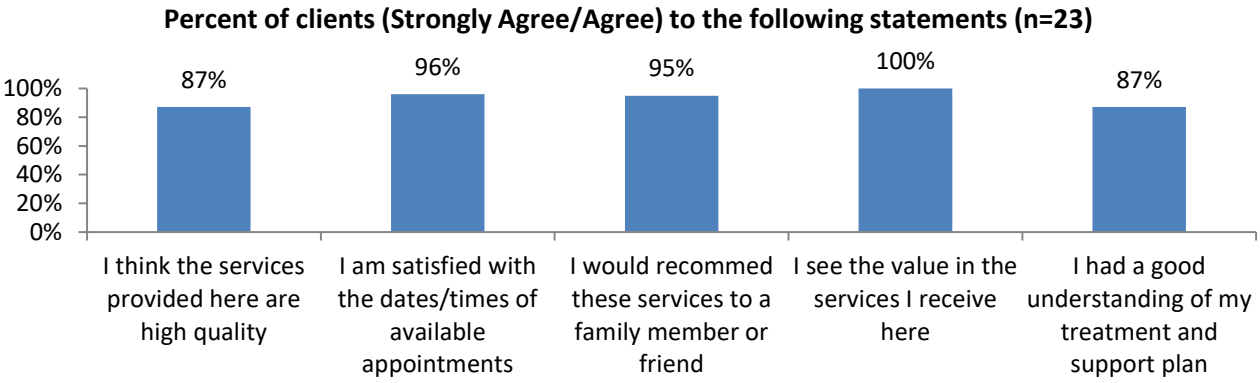
Number of FCCS Clients Connected to Other Services

***29%** of FCCS clients are connected to other Tri-City Services.*





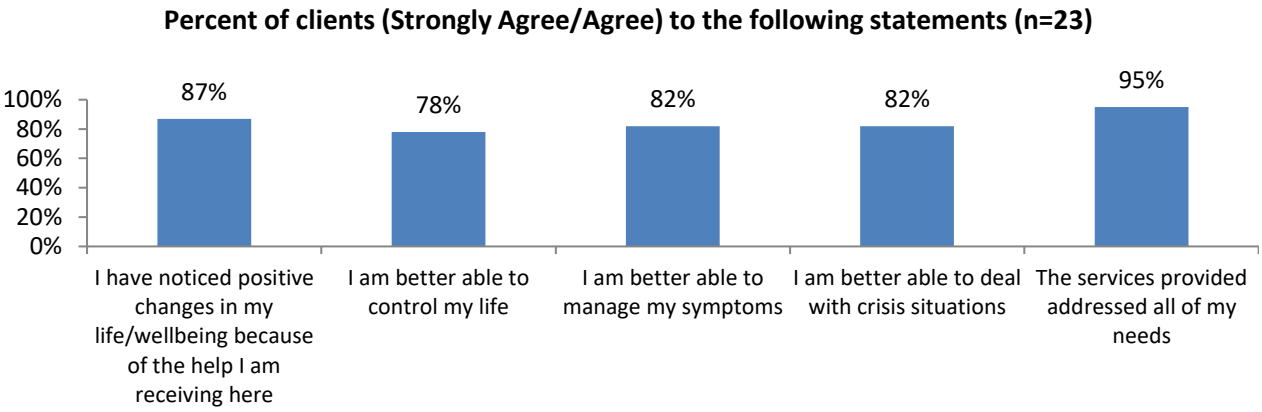
How Well Did We Do It?



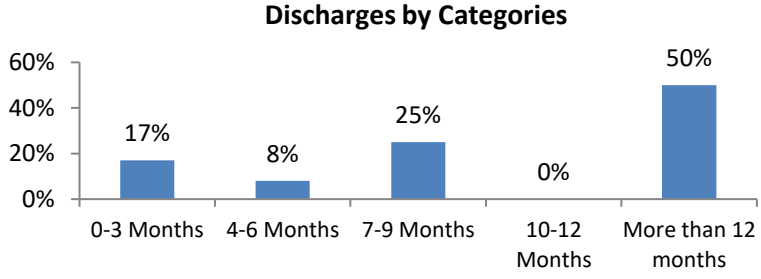
On average, FCCS clients were enrolled for 16 months.

The average enrollment (in months) of FCCS individuals **increased** from **14** in FY 2022-23 to **16** in FY 2023-24.

Is Anyone Better Off?



12 Discharges during FY 2022-23



Permanent Supportive Housing

Program Description

Permanent Supportive Housing units offer living spaces for Tri-City clients and their families in the cities of Claremont, La Verne and Pomona. Residential Service Coordinators (RSCs) are located at these sites to offer support and act as a liaison between tenants and the property staff. Permanent supportive housing has proven to be a significant part of successful recovery plans for many people with serious mental illness. Such housing enables successful pathways to recovery and, ultimately, can reduce the cost of other services such as emergency room visits and incarceration.

Target Population

Tri-City clients living with severe and persistent mental illness and their family members.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Total Served
Number Served FY 2023-24	6	18	138	49	**211**
Projected Number to be Served FY 2024-25	7	20	151	54	**231**

Program Update

On September 14, 2023, the Villa Esperanza hosted its Grand Opening. During the event, two MHSA tenants shared with attendees their story of battling through housing instability and their new outlook on life. Throughout the fiscal year, events and groups become available to tenants such as a biweekly anxiety support group called Color Me Calm, the Good Tenant Curriculum, a gardening group created with the Therapeutic Community Garden, a biweekly food bank in collaboration with Volunteers of America, and an on-site resource fair. A collaboration was also formed with the Step Fund which provides no-interest micro loans to LA County residents who are at imminent risk of homelessness. Another housing location, Holt Family Apartments, added solar panels in June to assist with reducing client's electricity bill.

Permanent Supportive Housing had previously partnered with the Therapeutic Community Garden (TCG) in prepping garden beds at Cedar Springs, one of our housing locations aimed at serving TAY and their families. The RSC at the site has since overseen the gardening group and the beds have flourished. This past fiscal year, the beds have consistently produced, and tenants are able to harvest sunflowers, peppers, corn, broccoli, carrots, beets, anise, kale, green beans, tomatoes, onions, cucumber, cilantro, lemon grass, parsley, jalapenos, habaneros, and basil depending on the season.

The Housing Division began to host Case Conferencing meetings with the clinical teams. Every month, the Housing Division holds an open meeting where clinical teams can ask questions about the process of a referral, inquire on the status of a referral, seek housing resources and present situations they are encountering with client related to housing. By providing this space, clinical staff can get their questions answered in a timely manner, while helping other staff learn about something that may come up later with a client.

Challenges and Solutions

One of the Permanent Supportive Housing locations, Villa Esperanza did not have a permanent property manager at the start of the fiscal year. The previous manager left as FY 2022-23 was ending and in the property management company rotated temporary mangers to oversee the applications and day-to-day business at the site. Towards the end of the fiscal year 2023-24, one manager became permanently placed, which was very positive for the residents to experience consistency and build relationships with one person as opposed to rotating individuals

There were also gaps and inconsistencies in assigned property managers at Cedar Springs, Holt Family Apartments and Parkside Apartments. After some time, new management was assigned to all locations. The RSCs worked closely with new staff and the clients to address any lease violations, rent tracking, any corrections of files, and general support as clients built rapport and new working relationships with incoming staff on the property.

With all properties obtaining stable property managers, the RSCs are working towards bringing back tenant meetings at their respective sites. These meetings allow a space for property management to explain how they are addressing concerns at their sites and build a stronger community as it involves the tenants as part of the solution.

Diversity, Equity and Inclusion

Tri-City's Housing programs offer fair housing to clients and their families regardless of status, culture, ethnicity, sex, gender, religion, or otherwise. Housing Division staff are trained in cultural competency, stigma reduction, and implicit bias. Staff make ongoing efforts to work with clients in identifying their rights regarding housing, including education about tenant rights and legal referrals if needed. For optimal accessibility, all activities at the sites are on the ground floor and have doors wide enough for wheelchairs. Activities vary to include an array of topics that may interest different groups, such as coffee chats, coloring, community game days, gardening activities, and stress relief. RSCs also provide in-home services for tenants and offer computer access/support which has been well received with older adults and Spanish speaking tenants. In addition, Pride Month is celebrated with monthly activities and stigma reduction is addressed through webinars.

Housing Division staff are bilingual in English and Spanish, while other staff identify as having lived experience. Flyers and information are also provided in multiple languages. Reasonable accommodations are always considered, and Housing works with property managers to make accommodations for someone with a disability to ensure they have fair and equitable use of their unit.

Community Partners

Every Tri-City department is highly involved and act as a source of referrals for Permanent Supportive Housing. High volume of referrals consistently come from Community Navigators, Adult Outpatient, Full-Service Partnership, Child and Family Services, Therapeutic Community Garden, Access to Care, Wellness Center, Employment Specialists, Clinical Wellness Advocates, and the Co-Occurring Support Team.

Additionally, several external agencies provide supplemental resources to clients to help them obtain and maintain housing, identify resources in the community, address overall wellbeing, support basic needs, promote safety, provide education, inform on tenant rights, address finances, and identify opportunities for select housing expenses to be covered. Some of these external entities include Pomona Housing Authority, APS/CPS Social Workers, Corporation for Supportive Housing, Department of Mental Health, law enforcement, faith community/church leaders, LA County Department of Public Social Services (DPSS), and National Alliance on Mental Health (NAMI).

Success Story

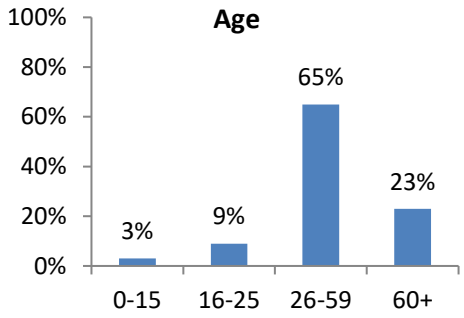
A transition age youth moved into Cedar Springs in 2016 and have continued to maintain a successful tenancy. They recently shared that a roommate was negatively impacting their mental health. While this information had been shared with RSCs before, the tenant was not ready to make a change related to their living environment and the roommate who was negatively affecting them. The RSC supported the tenant in having conversations with the roommate and the clinical team. The conversations took time but eventually a plan was identified for roommate to locate their own housing, allowing the tenant to size down to a one-bedroom apartment and live independently for the first time. The tenant has continued to maintain their housing and noted an improved quality of life since advocating for themselves, making a plan, and executing the plan with all parties involved.

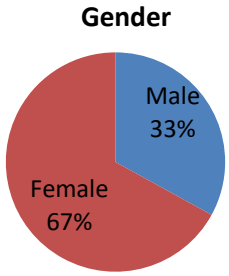
Program Summary

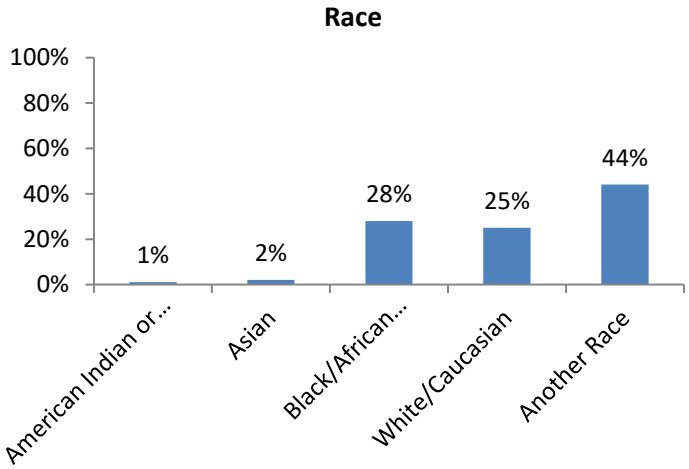
How Much Did We Do?

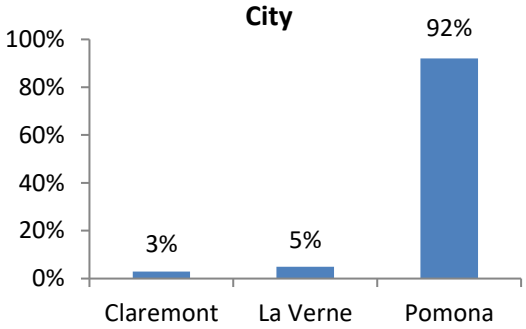
211
Individuals served with Housing needs

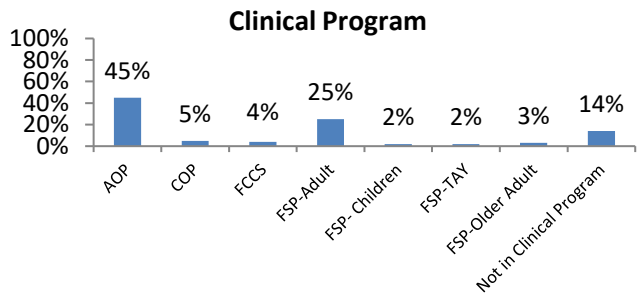
The number of individuals served with housing needs **decreased** from **226** in FY 2022-23 to **211** in FY 2023-24.

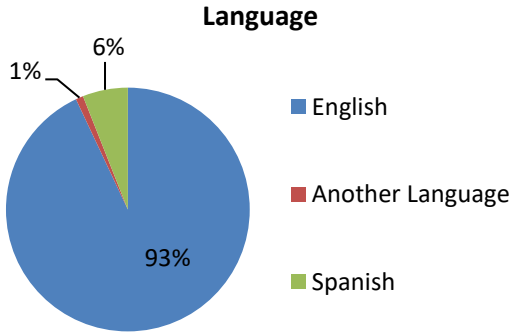








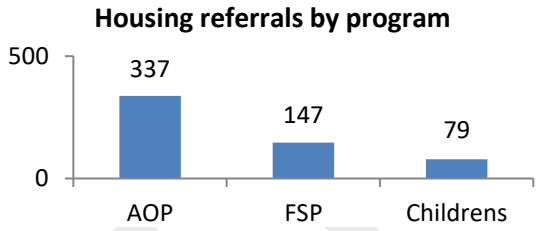




17
Housing Clients Discharged due to "No Further Care Needed"

25
Individuals with Continuum of Care Certificates

563
Housing Referrals Received



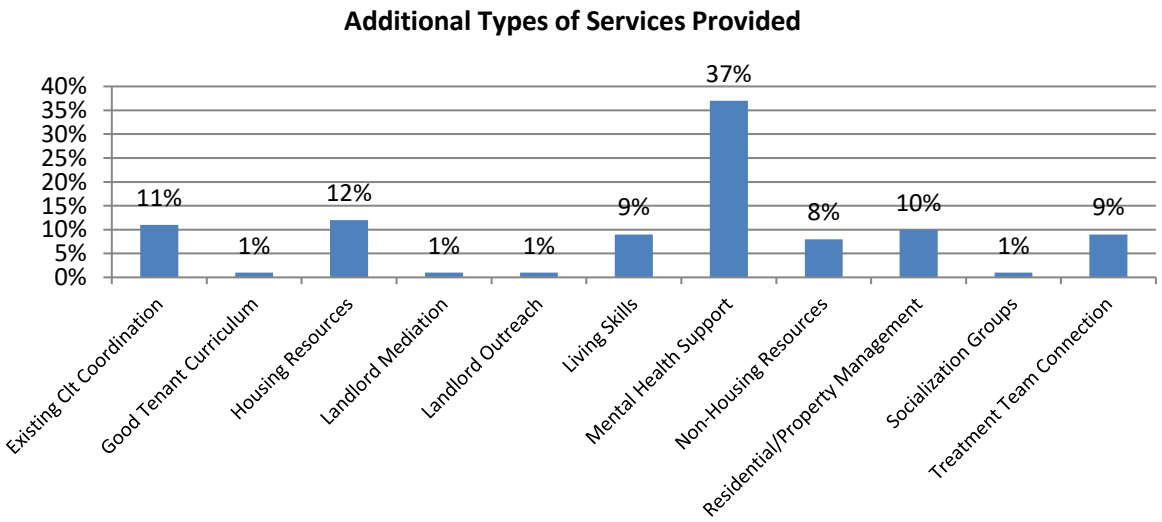
The number of housing referrals **increased** from **353** in FY 2022-23 to **563** in FY 2023-24.

How Well Did We Do It?

1,872
Housing Actions

3.2 years
Average Length of Time Housing Clients Living in Housing Unit

The number of housing actions provided to clients **increased** from **886** in FY 2022-23 to **1,872** in FY 2023-24.



Is Anyone Better Off?

40	102	17	69	100
Unique Individuals Assisted with Eviction Prevention	Unique Individuals Assisted with Maintaining Their Housing	Unique Individuals Secured Housing Either in Tri-City or Elsewhere	Unique Individuals Assisted with Obtaining Housing	Unique Individuals Connected to Housing Resources

Access to Care

Program Description

The Access to Care (ATC) program serves as the main entry point for individuals interested in receiving specialty mental health services from Tri-City Mental Health. Individuals seeking services can access care either by calling, walk-in, or via referral. The inquiring individual will discuss the presenting problems and needs with a mental health professional before scheduling an intake appointment to determine medical necessity. If needs are better served through another Tri-City program, or with a community provider, ATC staff will provide referrals and a warm hand-off to ensure linkage to the services that are appropriate. ATC's overall goal is to support recovery and assist community members in accessing mental health services to best meet their needs.

Target Population

The ATC serves community members seeking mental health services including children, TAY, adult, and older adults.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	429	529	1,646	189	**0**	**2,793**
Projected Number to be Served FY 2024-25	429	529	1,646	189	**0**	**2,793**
Cost Per Person	$544	$544	$544	$544	N/A	**$544**

Program Update

FY 2023-24 expanded the ATC team by adding a Clinical Supervisor and a Senior Behavioral Health Specialist. The program was also able to fully staff the Office Assistant roles. A variety of methods to complete intake appointments were offered, including face-to-face, video and telephone options. ATC was also able to consistently offer timely appointments to those who were seeking and qualified for intake assessments.

The program also became more efficient in reviewing and approving custody and legal representative documentation. This was accomplished by attending weekly custody documentation consultation meetings with the Chief Compliance Officer and Compliance Administrator, and due to staff meeting knowledge and efficiency goals, these meetings concluded in the same fiscal year.

In the next fiscal year, ATC intends to add two new clinical therapists to the program to assist in maintaining network adequacy guidelines. To accomplish this, ATC will begin to engage in the recruiting and hiring process for these two new positions.

Challenges and Solutions

ATC struggled with a high rate of no-shows to intake assessment appointments in FY 2023-24. As a solution, intake appointments were scheduled with back-up intakes which enable ATC the ability to offer some individuals sooner appointments and give the program the ability to render services even when no-shows occur. Another challenge was the inability to accept verbal consents for obtaining electronic signatures on enrollment documents. The program implemented the use of GETACCEPT in order to obtain signatures and worked alongside the Compliance Administrator and Chief Compliance Officer to ensure appropriate utilization. Lastly, individuals requesting services who did not have Medi-Cal or had another type of healthcare coverage was a challenge this fiscal year. To address this, ATC identified other resources for mental health support when individuals did not have Medi-Cal coverage or had private insurance.

Diversity, Equity and Inclusion

ATC is equipped to link individuals, if needed, to resources related to transportation, food, clothing, shelter, phones, language services (bilingual staff, a language line), as well as provide services offered via a variety of options (in-person, over the phone). The program accommodates individual's work and school schedules to complete service requests at times that work for the potential client.

Staff complete training and webinars related to cultural competency and implicit bias, as well as focus on these areas in supervision. Barriers related to seeking/adhering to mental health services due to culture or stigma are regularly discussed in individual and group supervision. Staff also work with their supervisors to address issues relevant to the LGBTQ+ population during intake and service requests and are equipped to provide community supports geared towards the LGBTQ+ community.

ATC regularly collaborates with the Community Navigators and Field Capable Clinical Services regarding referrals and support for older adults and veterans in the community. The program staff are also able to complete intakes for all ages to qualify for an intake assessment if indicated.

Community Partners

While ATC collaborates with several internal departments, the highest amount of collaboration in relation to intakes, resources and referrals is with the Adult Outpatient Team, Co-Occurring Support Team, Full-Service Partnership, Children and Family Department, Intensive Outreach and Engagement Team, Crisis Department, Community Navigators, and the School Partnership Team. External partnerships are another source for referrals, resources, substance use treatment, reporting mandates, and housing support. Some examples of external partnerships are: multiple local hospitals, Department of Public Social Services, local colleges, East Valley Community Clinic/Behavioral Department, Park Tree Community Clinic, Prototypes, Pacific Clinics, David & Margaret Youth and Family Services, Department of Child and Family Services, Five Acres, primary care physicians,

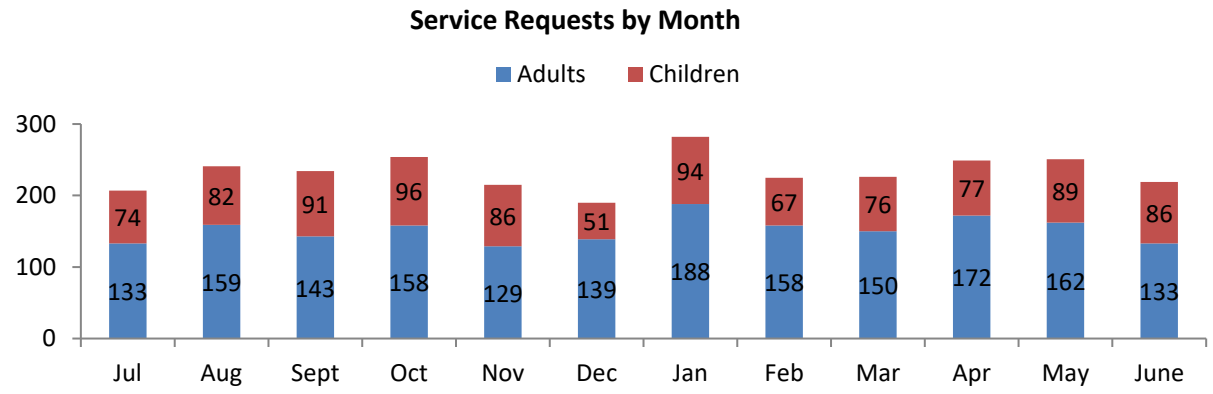
Adult/child Protective Services, Crisis and Trauma Resource Institute, American Recovery Center, Hope for Home and Volunteers of America.

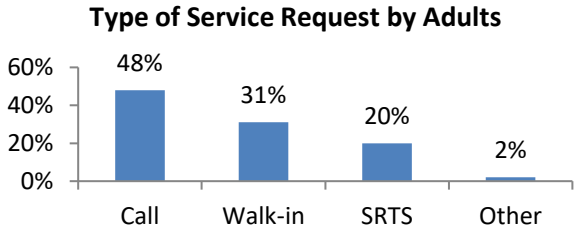
Success Story

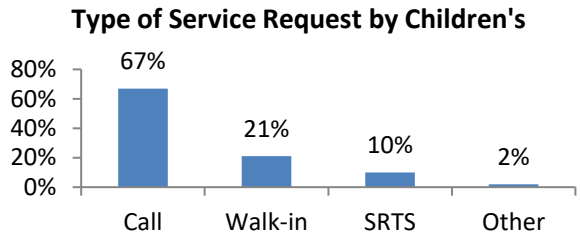
A potential client completed an intake assessment and following the assessment, the determination was made that they did not meet medical necessity for specialty mental health services with Tri City. However, the family had needs pertaining to their young child who was recently diagnosed with Autism and required behavioral support. The intake clinician was able to connect the family to a Peer Support Specialist, and a team member was assigned to help support the family with accessing further resources that would better fit their needs. As a result, the family was connected to the San Gabriel Pomona Regional Center and the caregivers developed the knowledge to advocate for themselves and their child. This is an example of how ATC goes above and beyond to ensure that individuals who come to us in need are supported, even if that means connecting them to another type of agency that may better suit their needs.

Program Summary

How Much Did We Do?





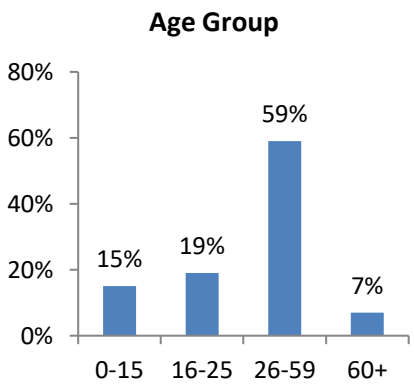


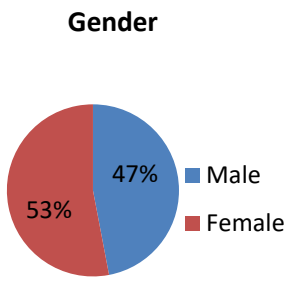
2,793

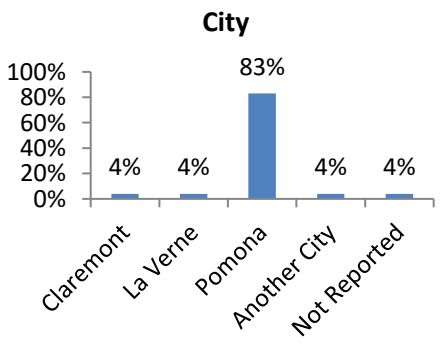
Service Requests

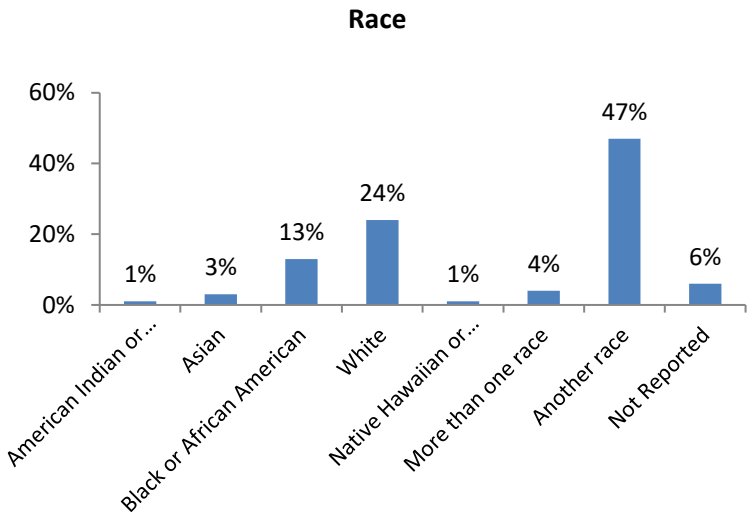
The number of service requests **increased** from **2,517** in FY 2022-23 to **2,793** in FY 2023-24.

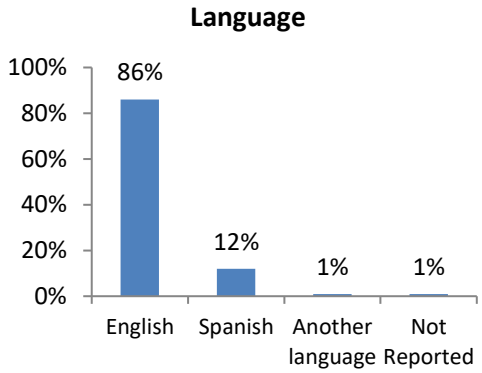
Demographics from All Service Requests











357

Services Request from Hospital Discharges Adults

106

Services Request from Hospital Discharges Children's

2,167

Intake Appointments Scheduled with Individual

The number of hospital discharges for both sites and intake appointments **increased** from **281, 76, and 1,942** in FY 2022-23 to **357, 106, and 2,167** in FY 2023-24.

Prevention and Early Intervention (PEI)

The Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services and supports, in addition to stigma reduction and suicide prevention efforts.

Community Wellbeing Program
Community Mental Health Trainings
Stigma Reduction and Suicide Prevention
Older Adult Wellbeing/Peer Mentor Program
Transition Age Youth Wellbeing/ Peer Mentor Program
Family Wellbeing Program
NAMI – Ending the Silence and NAMI 101
Housing Stability
Therapeutic Community Gardening
Early Psychosis Program
School-Based Services

MHSA Regulations for Prevention and Early Intervention

"The County shall identify each Program funded with Prevention and Early Intervention funds as a Prevention Program, Early Intervention Program, Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Stigma and Discrimination Reduction Program, Suicide Prevention Program, Access and Linkage to Treatment Program, or Program to Improve Timely Access to Services for Underserved Populations".

Prevention and Early Intervention Regulations/July 1, 2018
(Title 9 California Code of Regulations, Division 1, Chapter 14 MHSA)

Per the Regulations stated above, Counties are required to identify each program funded under their Prevention and Early Intervention Plan by one or more of the following categories:

Prevention and Early Intervention Plan Required Categories/Programs

1. **Prevention Program**
   a. Housing Stability Program
   b. Therapeutic Community Gardening
2. **Early Intervention Program**
   a. Early Psychosis Program
   b. TAY and Older Adult Wellbeing (Peer Mentor Program)
   c. Therapeutic Community Gardening
   d. School-Based Services
3. **Access and Linkage to Treatment Program**
   a. Early Psychosis Program
   b. Family Wellbeing Program
   c. Housing Stability Program
   d. TAY and Older Adult Wellbeing (Peer Mentor Program)
   e. Therapeutic Community Gardening
   f. Wellness Center (TAY and Older Adults)
4. **Stigma and Discrimination Reduction**
   a. Community Mental Health Trainings
   b. Community Wellbeing Program
   c. Early Psychosis Program
   d. Family Wellbeing Program
   e. Housing Stability Program
   f. TAY and Older Adult Wellbeing (Peer Mentor Program)
   g. Therapeutic Community Gardening
   h. Wellness Center (TAY and Older Adults)
5. **Outreach for Increasing Recognition for Early Signs of Mental Illness Program**
   a. Community Mental Health Trainings
   b. Community Wellbeing Program
   c. Early Psychosis Program
   d. Family Wellbeing Program
   e. Housing Stability Program
   f. TAY and Older Adult Wellbeing (Peer Mentor Program)
   g. Therapeutic Community Gardening
   h. Wellness Center (TAY and Older Adults)
6. **Suicide Prevention**
   a. Stigma Reduction/Suicide Prevention
   b. NAMI: Ending the Silence and NAMI 101
   c. TAY and Older Adult Wellbeing (Peer Mentor Program)

Community Capacity Building Programs

Community Capacity Building is comprised of three programs: Community Wellbeing Program, Community Mental Health Trainings and Stigma Reduction/Suicide Prevention Program

Community Capacity Building (Prevention)

Community Wellbeing Program

Program Description

The Community Wellbeing (CWB) program provides grants to local communities and groups in Tri-City's service area to assist them in strengthening their capacity to increase social connection and wellbeing. Through grants totaling up to $10,000, community projects are funded to increase awareness of mental health and wellbeing in addition to providing opportunities for these communities to network and build collaboration with other local organizations. Tri-City provides technical assistance including collecting data, outcome measures, and helping grantees evaluate the impact of their projects.

Target Population

The Community Wellbeing (CWB) program has dedicated its efforts to improving the wellbeing of children and transition-age youth ages 0 to 25. The CWB program serves communities and groups located in the cities of Claremont, La Verne and Pomona who are either comprised of youth or fund projects that directly benefit them.

Community Grants Awarded	Community Members Represented
13	12,209

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	3,967	911	640	205	N/A	**5,723**
Projected Number to be Served FY 2024-25	4,083	938	659	211	N/A	**5,890**

Program Update

In FY 2023-24, a total of 13 Community Wellbeing Grants were awarded. The community members served as a result of these grants represented 12,209 individuals, which was a significant increase from 10,809 in FY 2022-23. Notably, the communities being served by these projects provide services to underserved, unserved, and at-risk youth.

During this fiscal year, CWB staff partnered with other Tri-City staff and the Kennedy Austin Foundation to organize an event called "Box of Hope." This event was held at the Tri-City Wellness Center for families in Pomona, Claremont, and La Verne who were grieving the loss of loved ones. The aim was to create a supportive environment where families could feel cared for, heard, and connected to mental health services if necessary. Young members of the Kennedy Austin Foundation crafted and decorated beautiful boxes, each dedicated to the memory of loved ones, which families were able to take home. Additionally, program staff and other Tri-City personnel provided an overview of the services and programs available at Tri-City to assist youth and families in need, and several resource tables with information about Tri-City's programs and services were set up for attendees.

Program staff increased the number of in-person meetings in FY 2023-24 and attended events hosted by grantees and their organizations. This shift has fostered greater community engagement, as grantees can now meet face-to-face. A notable example of this was the final cohort meeting, which was hosted at a grantee's site. During this meeting, recipients of the grant were able to present their projects, share success stories, and discuss challenges they faced throughout the fiscal year. Additionally, they had the chance to network with one another and expressed their appreciation for the opportunity to meet and connect with their peers.

Challenges and Solutions

Grantees reported facing challenges in recruiting participants, both through outreach efforts and adjustments to project delivery. They expressed difficulties in retaining current participants as well as obtaining and attracting new ones. Furthermore, while some participants prefer in-person meetings, there are still many who prefer to connect virtually, and unfortunately, some do not attend either format. Grantees were able to address these challenges by adapting the delivery of their projects based on feedback from their communities. They offered both in-person and virtual options, utilized incentives, provided resources, and leveraged social media to promote a wider range of their services.

Additionally, grantees collaborated with other members of their cohort to promote their services reciprocally and seek advice on effective outreach and service delivery strategies.

Diversity, Equity and Inclusion

CWB staff consists of a bilingual staff member and all materials and presentations are available in English and Spanish. Additionally, a program staff member serves as the Chair for the ¡Adelante! Hispanic & Latino Wellness Committee. Members of ¡Adelante! share ideas and discuss barriers to improving the wellbeing of Latino and Hispanic families and communities. The program also works with community entities that provide services to underserved, unserved and at-risk communities, focusing on ages 0-25.

Additionally, grantees network and collaborate with each other to serve marginalized populations. Training resources related to cultural competence are disseminated to grantees, and the grantees distribute them to their participants. All 13 grantees are offered a diverse range of services, resources and activities, including hygiene products, meals, support groups, creative arts programs, clothing for teens, mental health workshops, afterschool programming, transportation for young mothers, grief and loss support, special needs basketball clinics for self-esteem and team building, art initiatives in open spaces, and an LGBTQ+ Youth Health & Education Wellbeing program. These efforts are aimed at enhancing the well-being of their communities and underserved populations.

Community Partners

In addition to collaborating with several internal programs, CWB works in partnership with several agencies such as: Bithiah's Family Services, Character Champions Foundation, City of Knowledge, City of Pomona, Draper Center for Community Partnerships, 4Kids WorldWide, House of Ruth, Kennedy Austin Foundation, La Verne Youth & Family Action Committee, Pomona Valley Pride, Purpose Church, Sowing Seeds for Life, and The Youth and Family Club of Pomona Valley. These organizations represent an array of services and supports for our community and individuals in the 0-25 age range.

Program staff facilitated connections between various grantees and our Mental Health Trainer, enabling mental health training sessions for their communities to further promote mental health and wellbeing. Grantees also exchanged resources and events from their own communities, and program staff circulated these resources among the cohort and Tri-City staff. Additionally, some grantees reported collaborating with other grant recipients in the cohort.

Success Story

Grantee, Purpose Church Rise Up Program, focuses on transition age youth (16-25) who reside in the Del Rosa and Angela Chanslor neighborhoods in Pomona. Rise Up provides weekly programming centered around social-emotional development via restorative circles, character building and mentorship. A total of 60 youth participates in this program. The Renacimiento Teen Center, where they have their central meeting location, is safe and conducive for this program. Per program staff and leadership, transformations have occurred within some of their attendees. One example is the story of a youth, who for the first year of receiving services, displayed difficulty with concentration,

disruptive behaviors and struggles with the authority figures. Upon entering year two, there was a noticeable change in the attendee. Currently, youth attend the program weekly, actively leads elements of the gathering among their peers, and has become close with his leaders. When leaders at the Rise Up Program approached the individual, inquiring on the change, the response included feedback highlighting staff persistence, accessibility, and genuine empathy for all who entered the program.

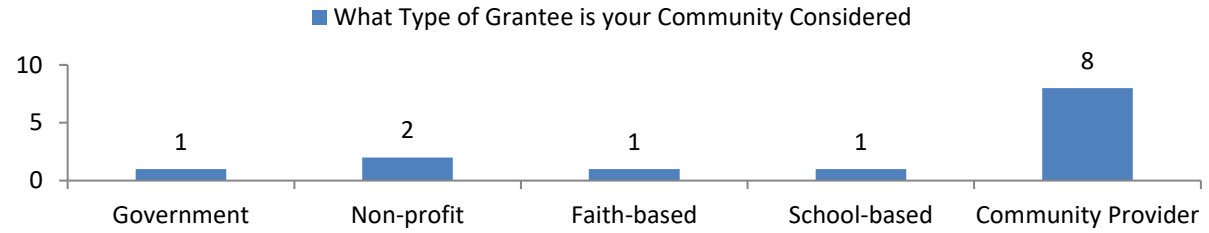
Program Summary

How Much Did We Do?

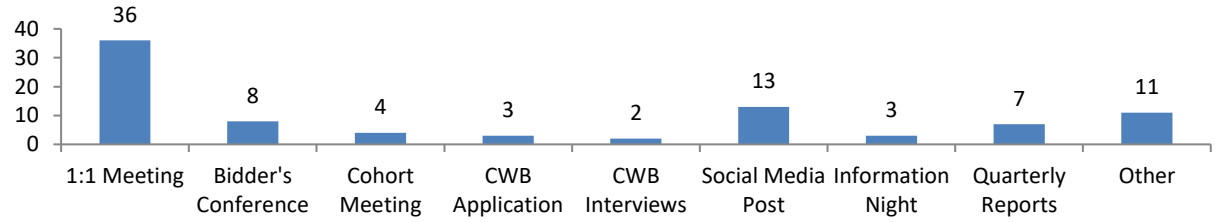
35 Application Reviews → **21 Application Interviews** → **13 Community Grantees Awarded**

12,209 Community Members Represented in all of Grantee Communities

The number of community members represented in all grantee communities **increased** from **10,809** in FY 2022-23 to **12,209** in FY 2023-24.



Number of Events Held by Community Capacity Organizer

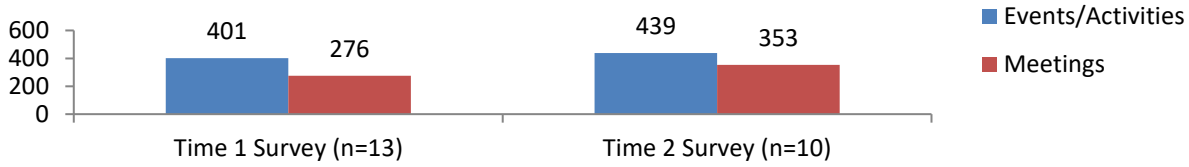


391 Event Attendees

The number of events held **increased** from **81** in FY 2022-23 to **87** in FY 2023-24.

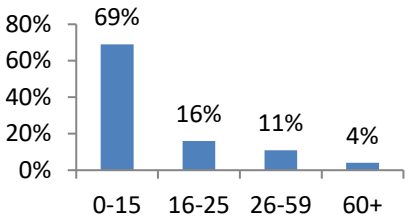
Number of Events/Activities and Meetings Hosted by Grantees

11,506 Attendees for Events/Meetings

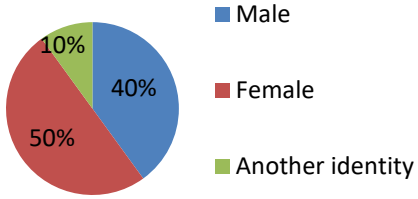


Grantee Community PEI Demographics (13 grantees completed Time 1 Survey)

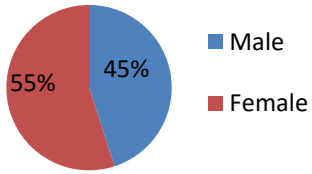
Age Group



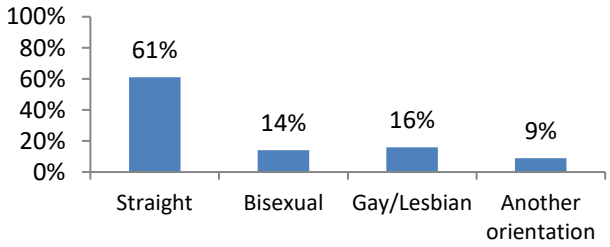
Current Gender Identity



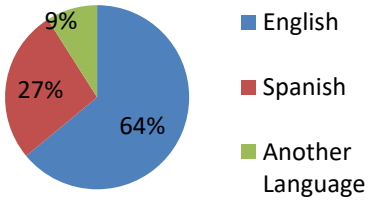
Assigned Gender at Birth



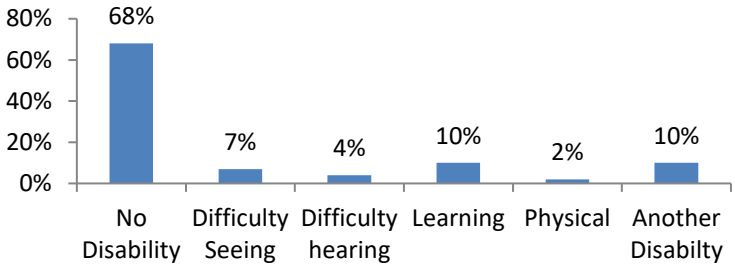
Sexual Orientation



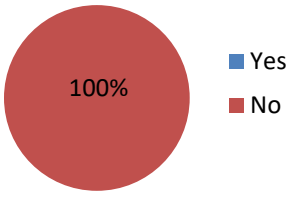
Language

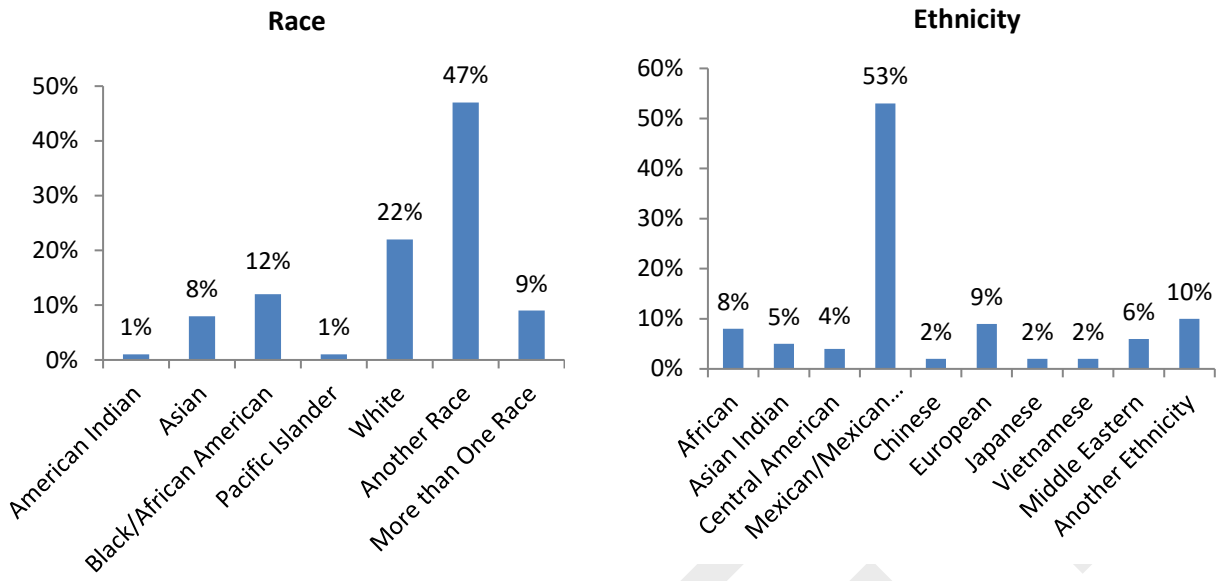


Disability



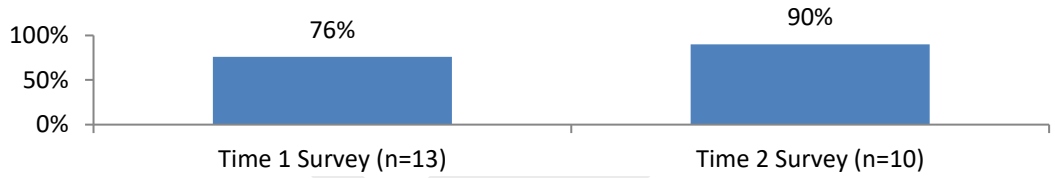
Veteran



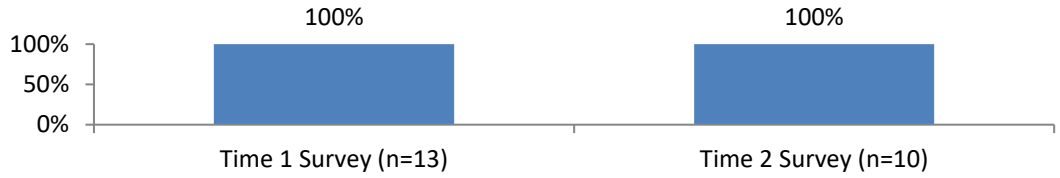


How Well Did We Do It?

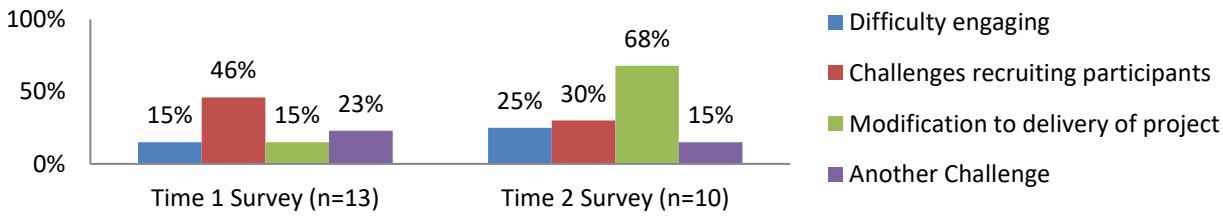
Percentage of Grantees who Report Successful in their Community's Activities:



Percent of Grantees who report they have a better understanding of the services at Tri-City and its mission:

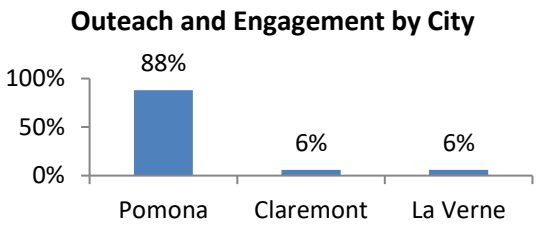


Percent of Grantees who report challenges their communities faced? (Check all that apply)



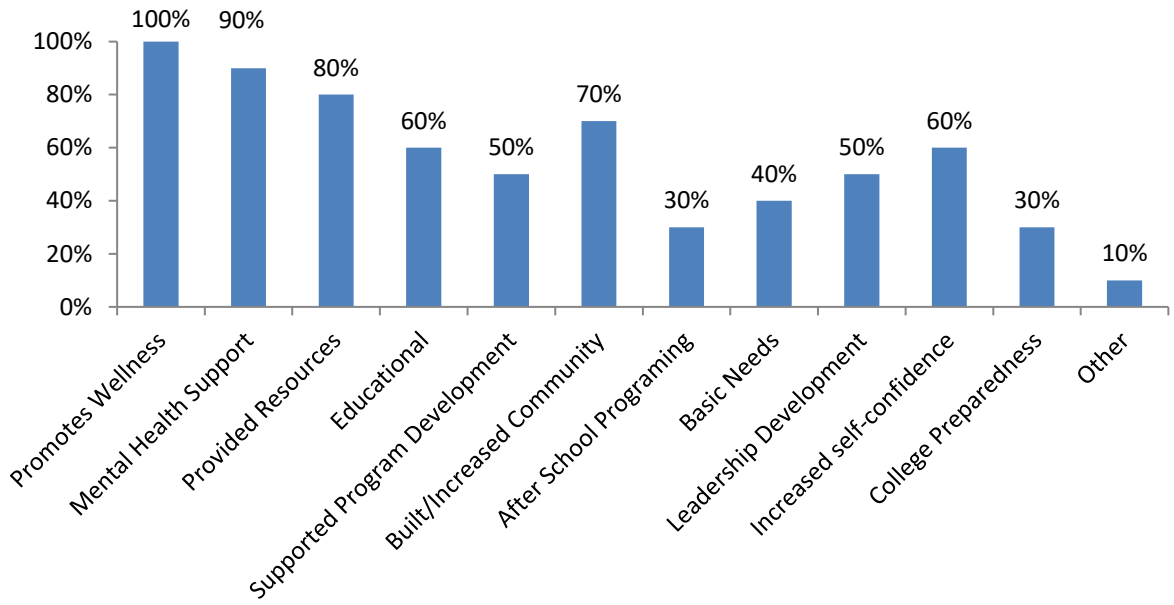
17
Outreach and Engagement Events

29
Individuals Outreached and Engaged

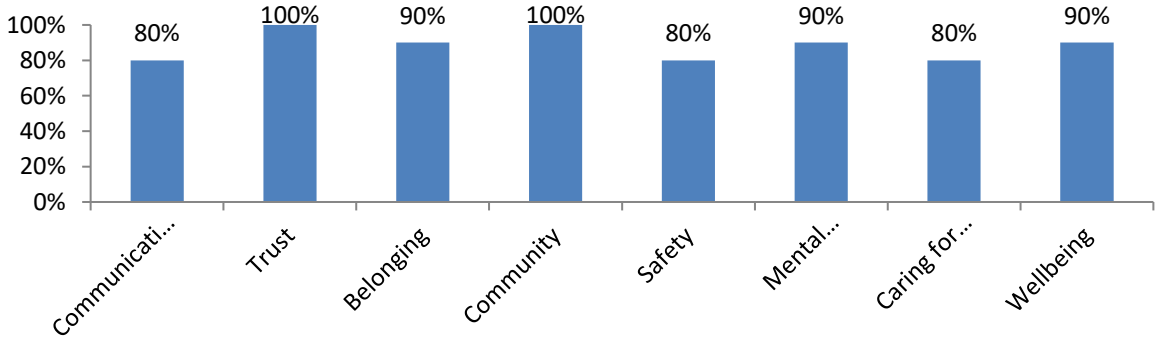


Is Anyone Better Off?

In what ways did your community benefit from this project? (Select all that apply)



As a result of your project efforts, members of the community now have a better sense of: (Select all that apply)



What was the most successful outcome of this project:

- Being able to transport mothers to their appointments, therapy and work!
- Music is proven to empower us, teach us calmness, heal us, and to help us create communities with those around us. Seeing these effects occur in real time was amazing, and I truly feel that the most successful outcome of this project was from the weekly, genuine connections made between mentees and mentors in their lessons.
- That students felt better about themselves (especially those who are unhoused) interacted more with others and were more accepting of other services that improved their lives such as attending our food pantries off campus.
- The CC Kids project has made early childhood wellbeing education more accessible and engaging, and taught that every child, indeed every person, is valuable, lovable and capable (VLC).
- The most successful continues to be the opportunity for our children to socialize and be encouraged in a positive atmosphere.
- The most successful outcome of this project has been our participants' improved well-being. We see a significant change in the lives of many members in less tears and more smiles. As well as new jobs, relationships and community involvement.
- The ultimate aim of the Teen Center project is to empower our teenagers to envision a brighter future and strive toward achieving their individual goals. We believe that this project will attract a significant increase in teen participation.
- We were able to ensure that kids at risk and need had a meal each weekday of the summer

Number of Potential Responders	12,209
Setting in Which Responders were Engaged	Community, Schools, Workplace, Virtual Platforms (e.g. Zoom), and Phone (e.g. conference calls)
Type of Responders Engaged	TAYs, teachers, LGTBQ+, families, students, service providers, faith-based individuals, and those with lived experience.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

Timely Access to Services for Underserved Populations Strategy

There were 0 MHSA referrals to Community Wellbeing Program.

Community Capacity Building (Prevention)

Community Mental Health Trainings

Program Description

Tri-City offers free Community Mental Health Trainings (CMHT) to individuals, groups and community partners in the Tri-City service area of Claremont, La Verne and Pomona. These trainings are designed to provide participants with the skills and information they need to support themselves, friends, families, and others in mental wellness. These free trauma-informed and evidence-based trainings include Mental Health First Aid (MHFA), Youth Mental Health First Aid (YMHFA), Adverse Childhood Experiences (ACEs), Community Resiliency Model™ (CRM), Motivational Interviewing (MI), Everyday Mental Health (EMH), Stress Management, Self-Esteem/Mental Health, and Wellness Recovery Action Plan. These trainings are offered virtually and in-person.

Target Population

Community members, community-based organizations, local schools, agencies, and Tri-City staff who are interested in learning how to recognize the early warning signs of mental illness and appropriately intervene to provide support.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	0	98	252	22	396	**768**
Projected Number to be Served FY 2024-25	0	118	302	26	475	**921**

Program Update

The Community Mental Health Training (CMHT) program created and implemented an annual community calendar of trainings offered to the public (cities of Pomona, La Verne, Claremont). Trainings are offered every second Friday of the month. Due to the success of the annual calendar, there has been an increase of community members registering to be a part of the Community Mental Health Trainings Contact List. Through this list, individuals are notified via monthly emails regarding current and upcoming mental health trainings, workshops, and presentations. Sixty-four community members (comprised of school districts, service providers, individual community members, community groups and organizations), are currently registered to receive updates on the Community Mental Health Training program. Additionally, having multiple options available for trainings

continues to be useful, accordingly, CMHT still provides and will continue to provide virtual and in-person training options for accessibility and inclusivity purposes.

Challenges and Solutions

The CMHT program has resumed in-house trainings for Tri-City staff. When scheduling and planning trainings for the community, staff must carefully consider scheduling options and make time available to support not only community members and groups, but also in-house staff. CMHT staff tracks and stays up to date on providing mandatory trainings to agency staff, while supporting the community and their training needs.

To support the organization and administration of trainings, CMHT staff created an In-House Trainings calendar for Tri-City staff to register for mandatory trainings. This allows the CMHT staff to properly organize and schedule for the Tri-City agency, while supporting requests from the community. This also supports in balancing the pre-designated monthly trainings offered to the general public on a monthly basis. Tracking requests also continues to be effective when scheduling trainings, and a vital source in managing organization and efficiency for the program.

Diversity, Equity and Inclusion

The Community Mental Health Training team consists of bilingual staff who are available to offer trainings in both English and Spanish. In addition, materials and brochures are available in both English and Spanish, while training also targets service providers that serve and support underserved communities. Continuing to offer trainings virtually supports efforts in eliminating barriers related to lack of transportation or physical mobility and provides easier access allowing everyone to participate and gain knowledge in a safe environment from their preferred location.

Additionally, CMHT trainers complete cultural competence trainings and these concepts are incorporated in the trainings provided to the community. The CMHT program recognizes that cultural backgrounds, gender identities, sexual orientations, languages, ages, and religious beliefs can shape perceptions of mental illness. These factors may hinder some individuals from openly discussing their mental health challenges or seeking necessary support and services. Therefore, CMHT emphasizes in its marketing materials that trainings are available to all residents, service providers, community organizations, and groups in Pomona, Claremont, and La Verne.

Community Partners

Community engagement is key to the success of the CMHT. Partners include local colleges, school districts, law enforcement, community-based organizations, and faith-based organizations. Some examples of external partners include Pomona Unified School District and Bonita Unified School District. While examples of internal partners include Tri-City's Mental Health Student Services Act, recipients of the Community Wellbeing Grant Program, interns, Housing Program and the Peer Mentor Program. These partnerships provide consumers of trainings for the CMHT program, support of landlords to increase their understanding of the intersection of mental health and housing needs, and support of school district staff and families.

Success Story

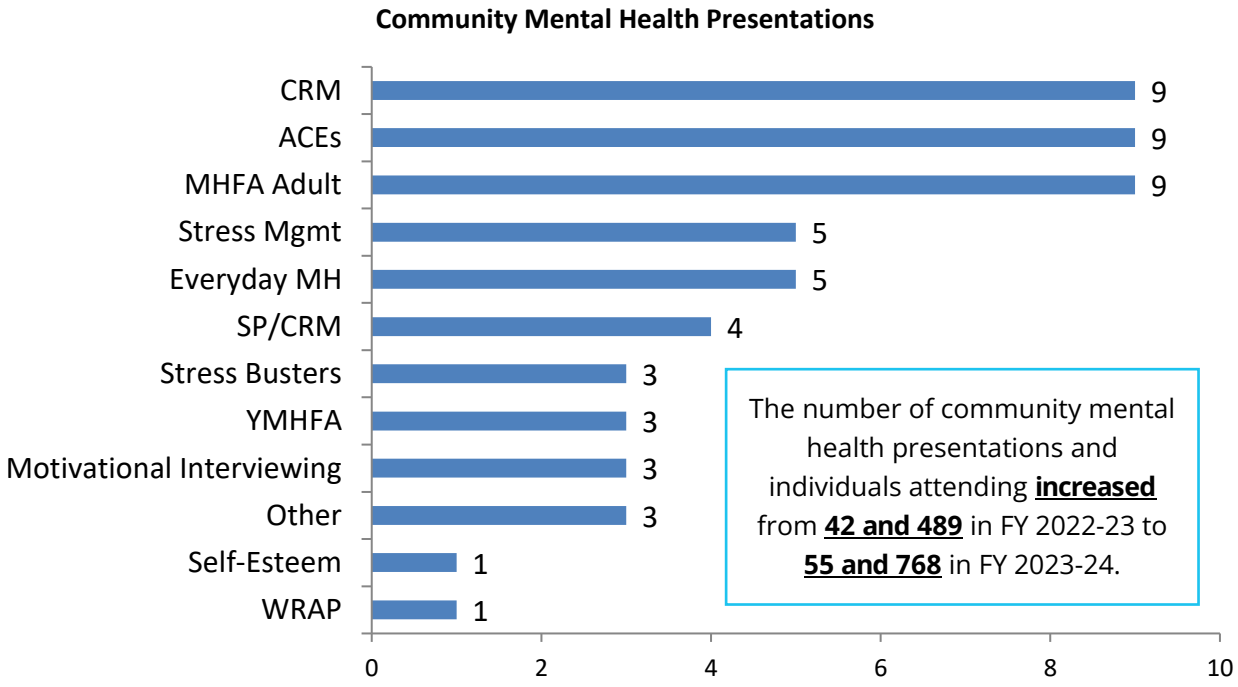
Staff delivered a Mental Health First Aid (MHFA) training to counselors at California Polytechnic University, Pomona. A few weeks after the training, CMHT staff was approached by one of the attendees in the community. The attendee shared their experience with staff, discussing their stepchild's mental health struggles at home. The individual expressed that the training had enabled them to recognize the signs and symptoms of her stepchild's challenges and was able to offer the MHFA action plan to provide the necessary support. As a result, they were able to ensure that the child received the appropriate resources to cope effectively. This community member's feedback emphasized that the MHFA course had been incredibly informative and beneficial in helping them engage with a loved one when they were facing mental health challenges.

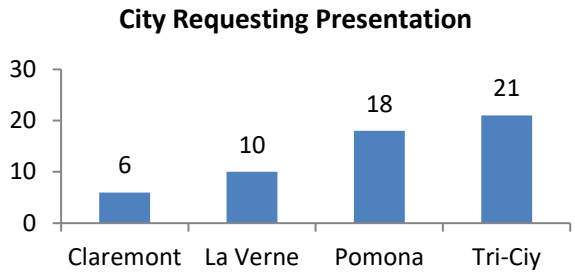
Program Summary

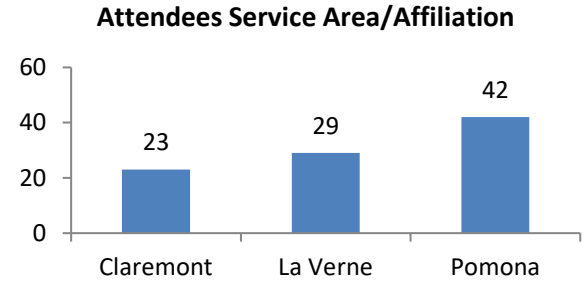
How Much Did We Do?

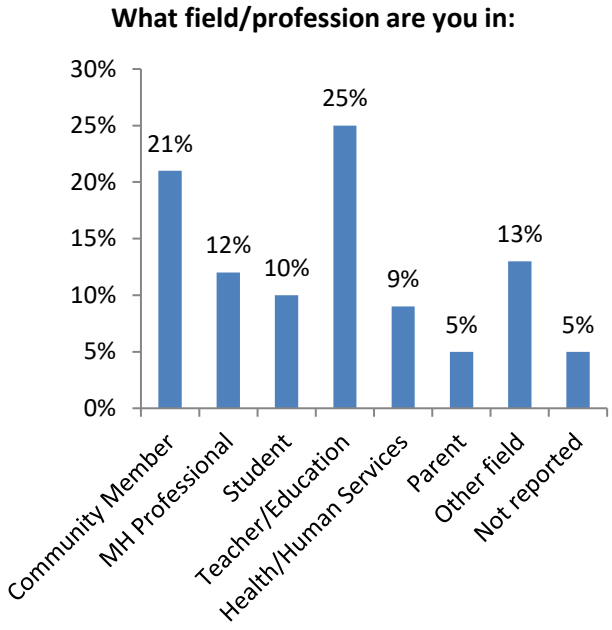
768
Individuals attending Presentations

55
Community Mental Health Presentations Conducted





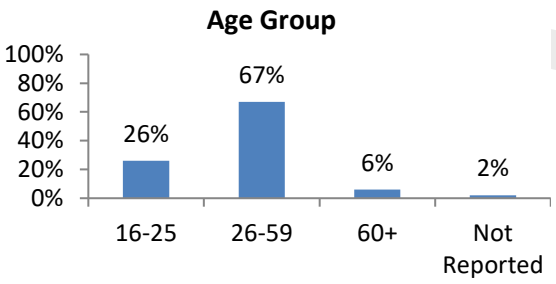


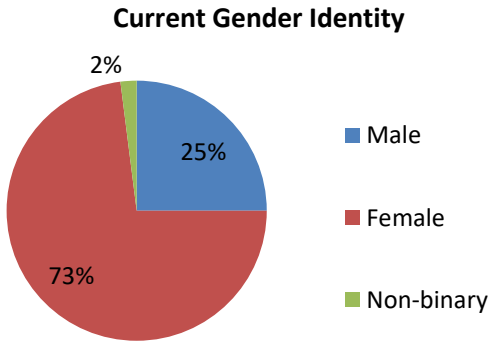


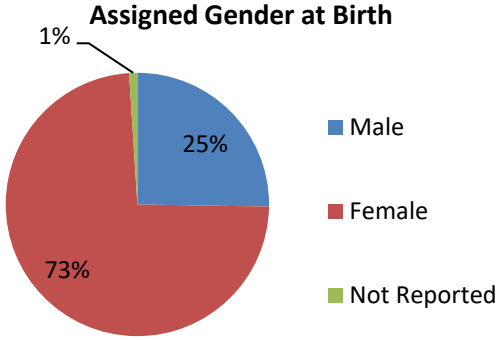
PEI Demographics from Surveys (n= 378)

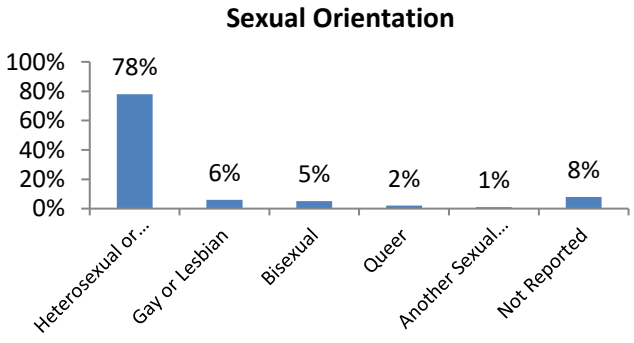
** PEI Demographics only completed by Adults 18+

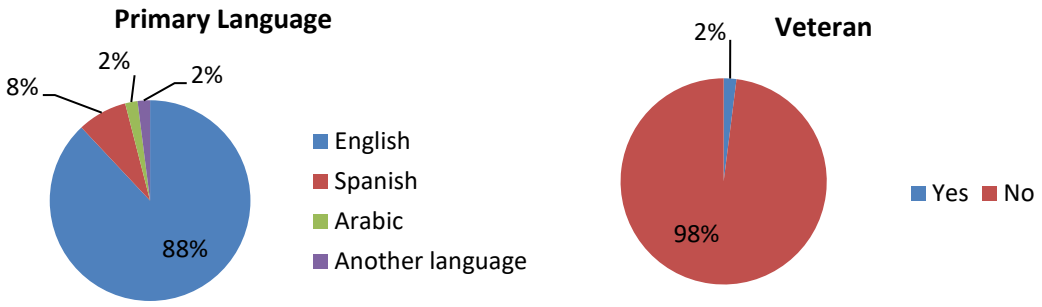
The number of surveys completed **increased** from **72** in FY 2022-23 to **378** in FY 2023-24.

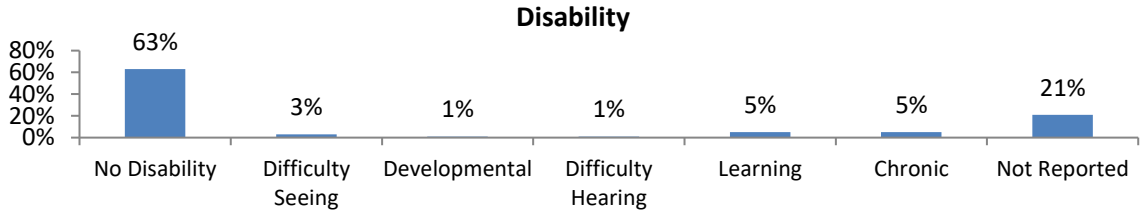


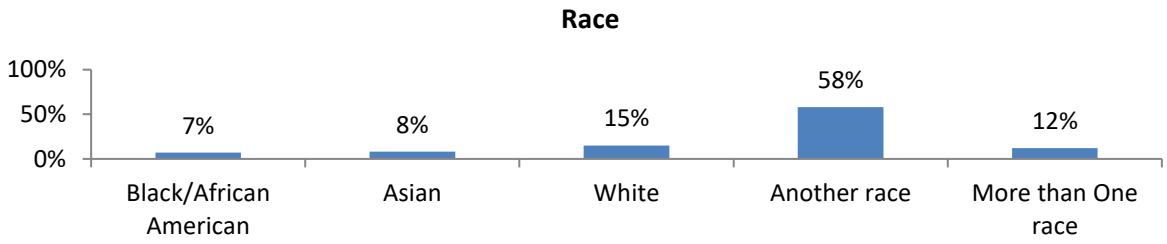


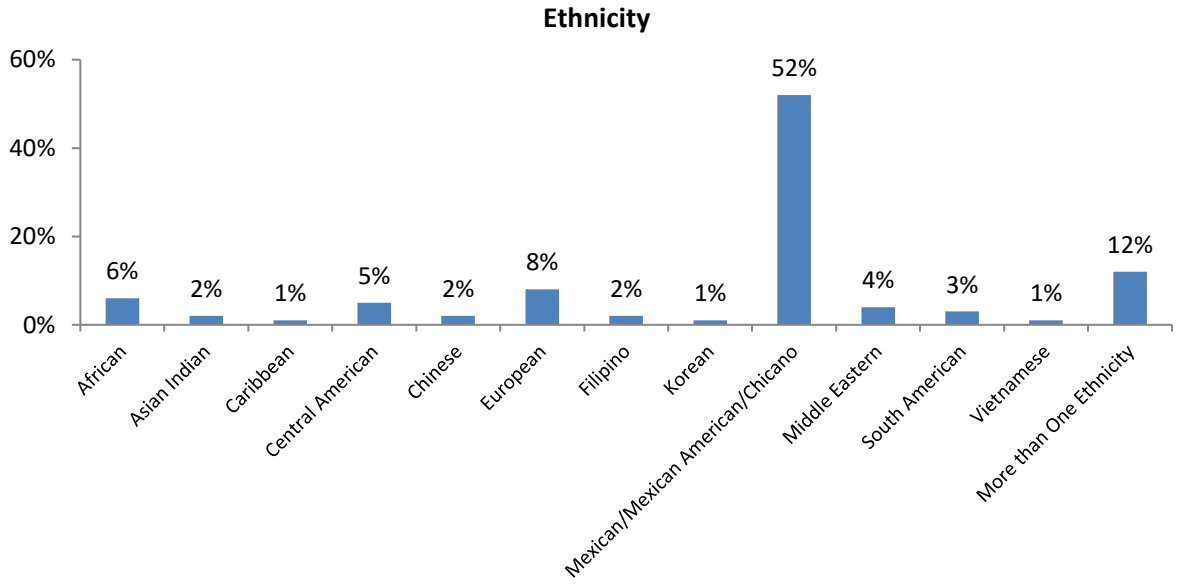





Primary Language
2%
8%
2%
88%
English
Spanish
Arabic
Another language
Veteran
2%
98%
Yes
No

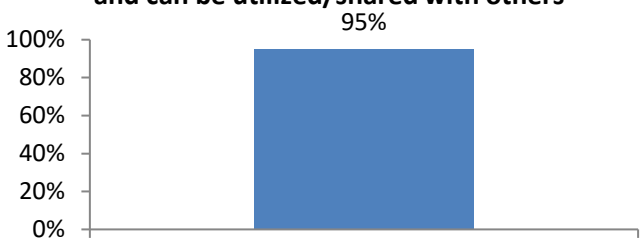

Disability
80%
60%
40%
20%
0%
63%
3%
1%
1%
5%
5%
21%
No Disability
Difficulty Seeing
Developmental
Difficulty Hearing
Learning
Chronic
Not Reported


Race
100%
50%
0%
7%
8%
15%
58%
12%
Black/African American
Asian
White
Another race
More than One race

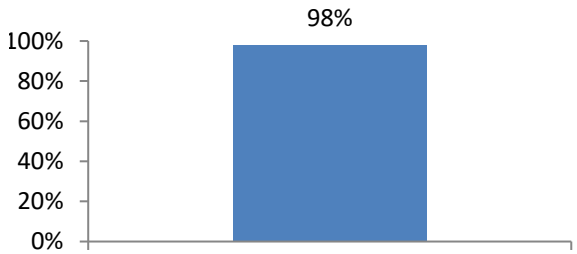

Ethnicity
60%
40%
20%
0%
6%
2%
1%
5%
2%
8%
2%
1%
52%
4%
3%
1%
12%
African
Asian Indian
Caribbean
Central American
Chinese
European
Filipino
Korean
Mexican/Mexican American/Chicano
Middle Eastern
South American
Vietnamese
More than One Ethnicity

How Well Did We Do It?

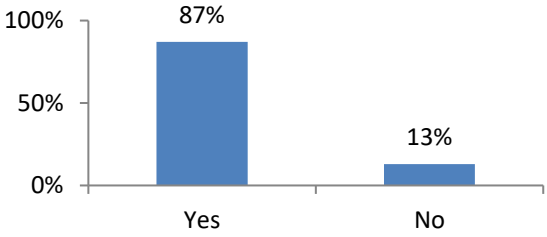
Percentage of participants who report the presentation provided helpful information and can be utilized/shared with others



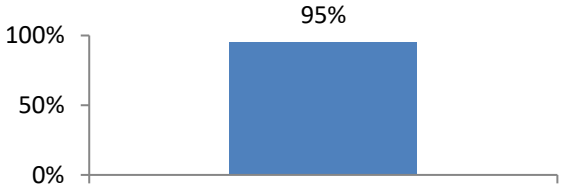
Percentage of participants who rated the presentation as good or excellent:



At any time in your life, have you experienced a traumatic event or mental health challenge?

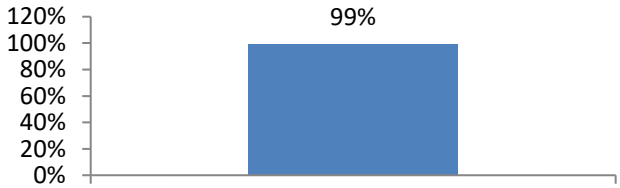


If so, has this presentation provided the support to manage your wellness or recovery?

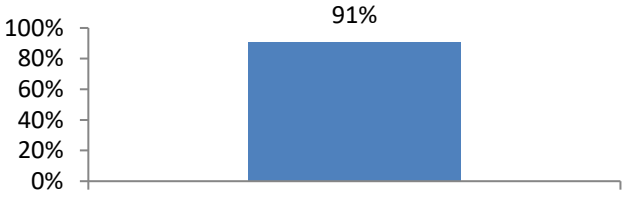


Mental Health First Aid

Percentage of participants who report increased knowledge about recognizing the signs and symptoms of mental health or substance use challenges

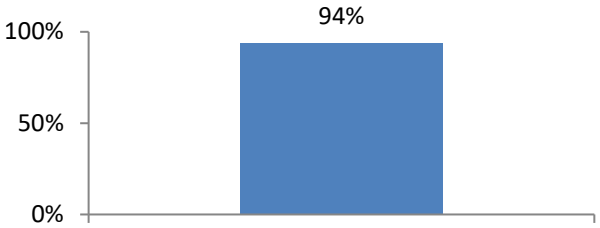


Percentage of participants who can express concerns to any person about mental health signs and symptoms to help that person to seek timely support

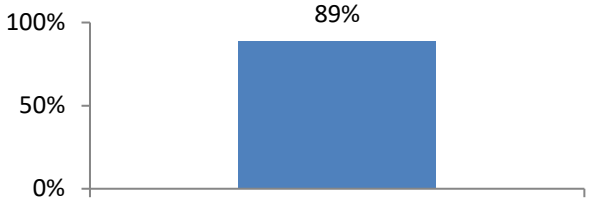


Is Anyone Better Off?

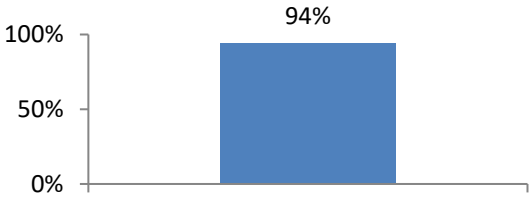
Percentage of participants who report feeling confident in using or applying the information they learned in the presentation



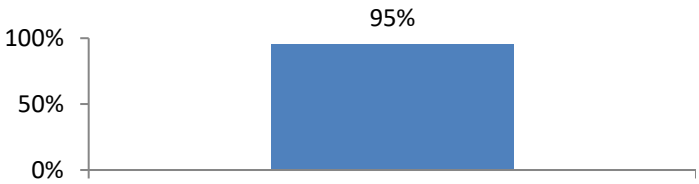
Percent of participants who report feeling more confident reaching out to someone who may be dealing with a mental health /substance use challenge or crisis:



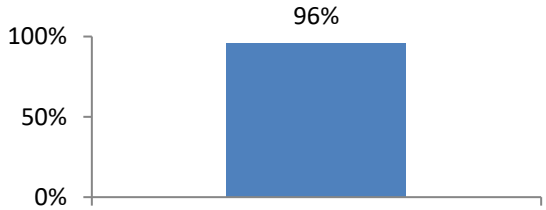
Percentage of participants who would recommend presentation to someone else



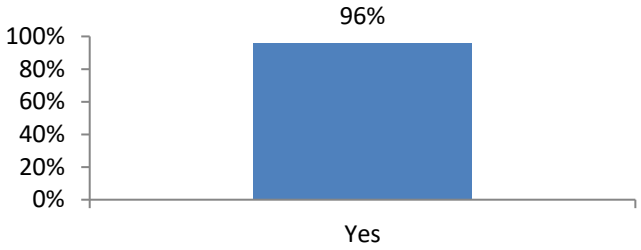
Use ALGEE action plan to connect an adult experiencing signs and symptom(s) of a mental health or substance use challenge or crisis to appropriate help or resources



Have a supportive conversation with anyone about mental health or substance use challenges.



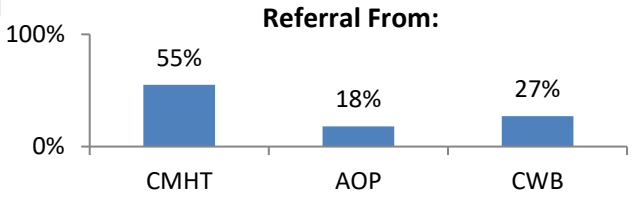
Would you take another MHFA course



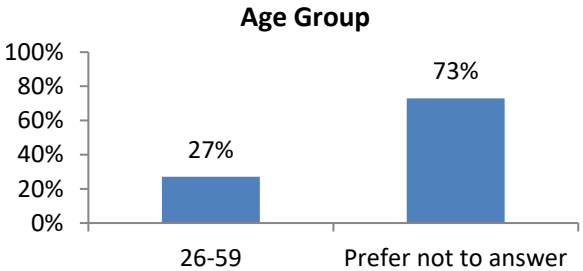
Number of Potential Responders	768
Setting in Which Responders were Engaged	Virtual platforms, Community, Healthcare, Schools, Local Business, Churches, Colleges, Rehabilitation, Regional Centers, Professional Associations, Law Agencies (probation/public defender's office), Department of Mental Health
Type of Responders Engaged	TAYs, Adults, Seniors, Landlords, Parents, Residents, Consumers, Faith Based Organizations, Community Based Organizations, Service Providers and Students.
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

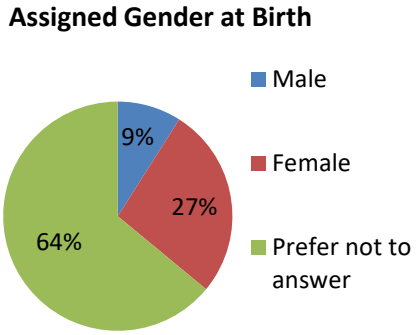
Timely Access to Services for Underserved Populations Strategy

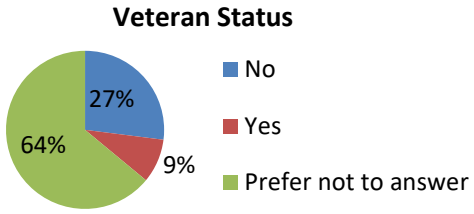
There were 11 MHSA referrals to the CMHT Program

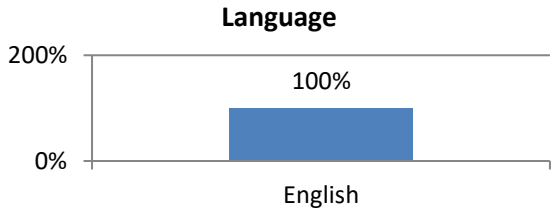


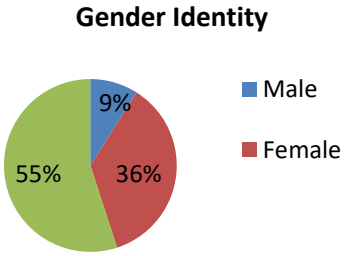
PEI Demographics Based on Referrals

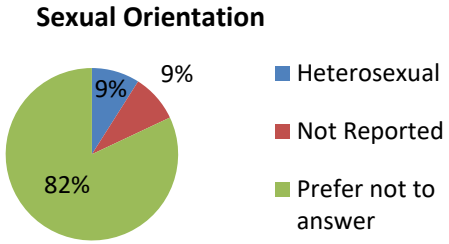


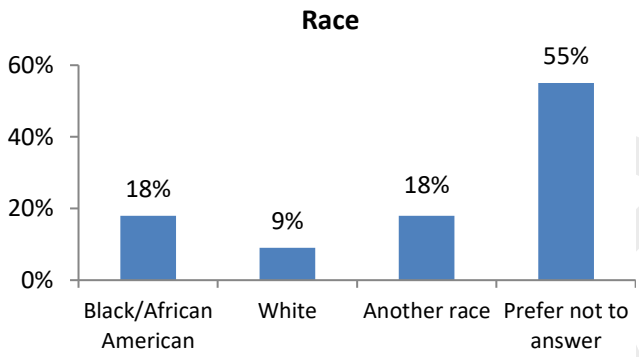


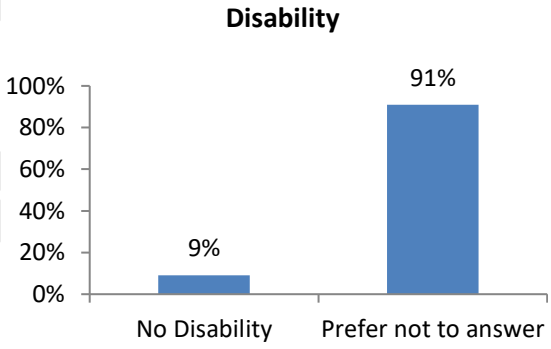

Veteran Status
27%
64%
9%
No
Yes
Prefer not to answer

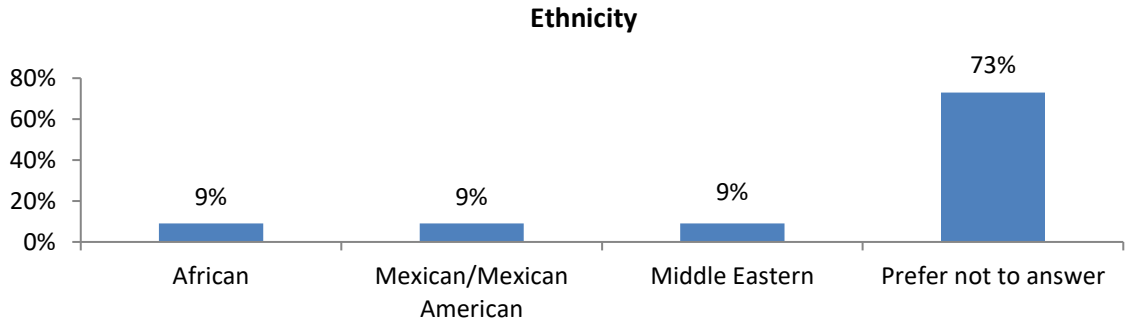

Language
200%
0%
100%
English


Gender Identity
9%
55%
36%
Male
Female


Sexual Orientation
9%
9%
82%
Heterosexual
Not Reported
Prefer not to answer


Race
60%
40%
20%
0%
18%
9%
18%
55%
Black/African American
White
Another race
Prefer not to answer


Disability
100%
80%
60%
40%
20%
0%
9%
91%
No Disability
Prefer not to answer


Ethnicity
80%
60%
40%
20%
0%
9%
9%
9%
73%
African
Mexican/Mexican American
Middle Eastern
Prefer not to answer

Community Capacity Building (Prevention)

Stigma Reduction and Suicide Prevention

Program Description

Tri-City is committed to supporting the strengths of each individual participant in their journey of recovery. Tri-City stigma reduction efforts on our website, via workshops and various community events are designed to empower individuals experiencing mental health challenges while generating awareness to the stigma associated with mental illness. Some efforts of the program include Green Ribbon Week, as well as state and nationally recognized campaigns including Mental Health Awareness Month, Black Indigenous and People of Color (BIPOC) Mental Health Awareness Month and Suicide Prevention Awareness Month.

Through a series of activities designed to support changes in attitudes, knowledge and behavior around the stigma related to mental illness, participants can have a voice in supporting not only their own recovery, but also influence the attitudes and beliefs of those who are touched by their stories.

These activities include:

1. **Courageous Minds Speakers Bureau**: Individuals with lived experience can share their personal stories of recovery through community presentations hosted throughout the year.
2. **Creative Minds**: Provides a unique opportunity for consumers and community members, both with and without a mental health condition, to create artwork that connects with their wellness, recovery and mental wellbeing. Art workshops and events are hosted in the community and virtually.
3. **Directing Change Program and Film Contest**: A statewide program with the mission to educate young people about suicide prevention, mental health and social justice through short films and art projects. Tri-City has a dedicated landing page where community members can view youth short film submissions from students in Pomona, Claremont and La Verne. Past award winners are listed here as well.
4. **Green Ribbon Week**: Each year, during the third week of March, Tri-City hosts stigma reduction presentations and collaborative community activities and distributes posters and green ribbons to promote mental health awareness in Pomona, Claremont and La Verne.

For each of these activities, consumer feedback is captured through program surveys which are administered several times per year as well as surveys specific to each event or presentation. In addition, TCMH suicide prevention efforts include offering suicide awareness trainings which provide participants with the skills needed to recognize the signs of suicide and connect individuals quickly and safely to appropriate resources and support services.

Target Population

Community members and partners including local colleges, schools, agencies, organizations, and Tri-City staff.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	0	65	39	16	602	**722**
Projected Number to be Served FY 2024-25	0	39	23	10	363	**435**

Program Update

Suicide Prevention Week was held from September 10-16,2023. Program staff launched a social media campaign to bring suicide prevention awareness to the community and distributed toolkits to local school sites, Tri-City, and community members. Each toolkit included a suicide prevention resource poster, pens, informational cards about Know the Signs, coasters, and stickers.

Additionally, Green Ribbon Week (GRW) was celebrated with a week of events and activities for the public. GRW is an annual recognition that aligns with Tri-City's stigma reduction campaign, encouraging the community to end mental health stigma. Courageous Minds Speakers Bureau, where individuals with lived experience can share their recovery journeys through community presentations, was also hosted during GRW.

During May 2024, Tri-City highlighted May Mental Health Awareness Month. During this month program staff hosted interactive lunch activities at elementary schools, middle schools, high schools and colleges to help promote mental health awareness and Tri-City mental health services. There were also virtual workshops hosted in collaboration with community partners to talk about mental health. In the next fiscal year, the program intends to implement a new suicide prevention training and recruit two cohorts per year for Courageous Minds.

Challenges and Solutions

A challenge experienced by the Stigma Reduction and Suicide Prevention program was engaging with transition age youth (TAY) and getting them involved in stigma reduction events. Lack of TAY attendance was due to barriers such as transportation, lack of parental/guardian support, conflict in scheduling, and/or stigma. Another challenge was that program staff received an overwhelming number of requests to attend or support community events in order to facilitate a stigma reduction activity or promote resources. Unfortunately, some of these requests were declined due to the program being booked frequently. Part of the solution was to provide a warm hand-off between

community partners and other Tri-City programs that could fulfill the request. To address the lack of TAY participation, program staff collaborated with educators and trusted adults that youth have close relationships with that help encourage them to attend stigma reduction events. Additionally, program staff hosted stigma reduction activities/presentations at the school sites to help eliminate transportation barriers. Program staff also plans on collaborating with the Workforce Education & Training Supervisor to recruit TAY service learners and have them participate in stigma reduction and suicide prevention programming.

Diversity, Equity and Inclusion

The Stigma Reduction program is designed to target underserved populations in the community, such as the stigma reduction/suicide prevention presentations, Creative Minds, Courageous Minds Speakers Bureau program, and the social media campaigns. Program staff also collaborates with Tri-City's Diversity, Equity, and Inclusion program via workshops, events, and social media campaigns. The program strives to help reduce stigma in the community across all cultures, backgrounds, and identities. By increasing mental health literacy among the Tri-City community members, they are more likely to reach out for help when needed. Lastly, staff utilize translation support for presentations and documents when requested and regularly participate in cultural competence trainings. Program staff currently collaborates directly with veterans through a relationship with Hope through Housing. To support the LGBTQ+ community, program staff works with the Pomona Valley Pride, presents stigma reduction workshops across the Tri-City area, and shares relevant LGBTQ+ mental health resources in stigma reduction/suicide prevention presentations.

Community Partners

The Stigma Reduction and Suicide Prevention program partners with several internal and external entities. Local school districts, colleges and universities are valuable partners in spreading the word regarding stigma awareness and reduction. Some universities the program partners with are Cal Poly Pomona, Claremont High School, Western University, University of La Verne, Pomona College, Claremont McKenna, Pitzer College, Scripps College and Harvey Mudd College. Several K-12 schools are also valuable partners, including those in Pomona Unified School District, Bonita Unified school District, and Claremont Unified School District. Other outside agencies include CalMHSA, Directing Change, Tracks Activity Center (TAC), Youth Activity Center (YAC), La Verne Community Center, Hope through Housing, Pomona Public Library, Claremont Public Library, La Verne Public Library and several small businesses in the service area.

Collaborations with internal programs include the Mental Health Student Services Act, Community Wellbeing Grantees, Peer Mentorship program, Adult Outpatient Services, Children Outpatient Services, Therapeutic Community Gardening, Wellness Center, Community Navigators, and Diversity, Equity, and Inclusion. Some events that manifested from these collaborations were Bee a Pollinator Hero with Therapeutic Community Gardening and Find Your Calm with the Mental Health Student Services Act.

Success Story

Program staff coordinated a Creative Minds – Paint & Sip event at a local boba tea shop in Claremont. The event was a notable success and had received positive feedback from the owner, specifying that they would like to continue this partnership to help combat the stigma, raise mental health awareness, and allow their patrons to feel more part of the community through these community mental health events. Attendees have also shared with program staff that they enjoy these events as they are able to build new connections, have healthy conversations around mental health, and have fun at the free art workshops. Since then, program staff has consistently hosted many Creative Minds art workshops at the local boba shop during FY 2023-2024.

Program Summary

Stigma Reduction, Courageous Minds & Creative Minds

How Much Did We Do?

12
Stigma Reduction Presentations

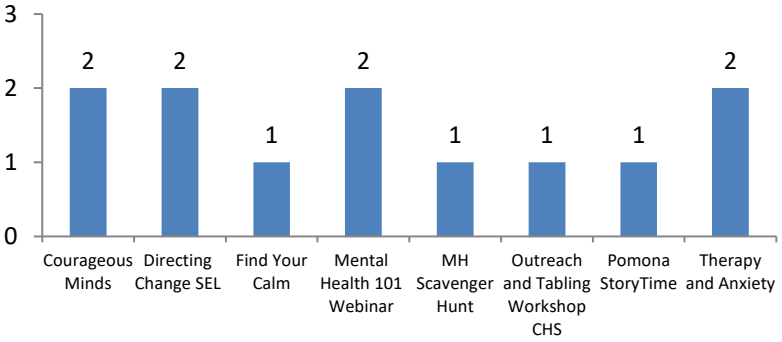
9
Active Courageous Minds Speakers

243
Attendees for Stigma Reduction Presentations

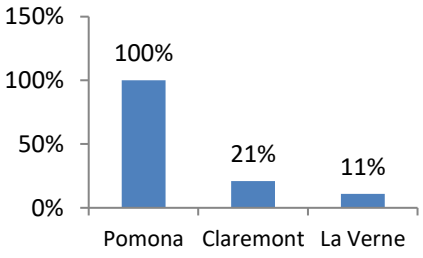
The number of Stigma Reductions presentations **decreased** from **41** in FY 2022-22 to **12** in FY 2023-24.

The number of active courageous minds speakers **increased** from **5** in FY 2022-22 to **8** in FY 2023-24.

Type of Stigma Reduction Presentations



Presentations by City

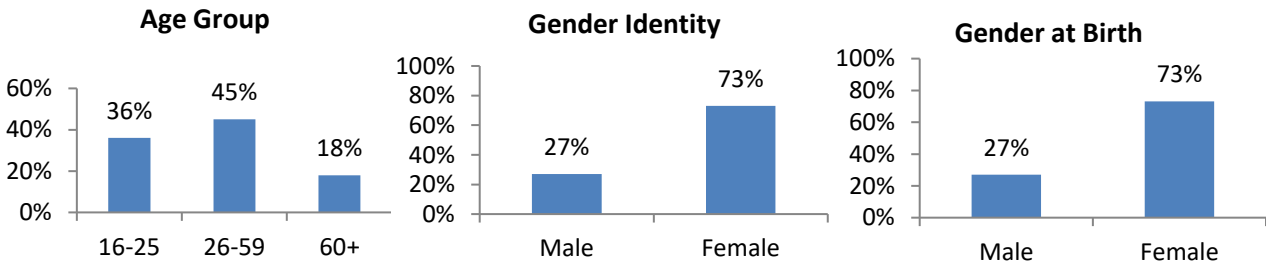


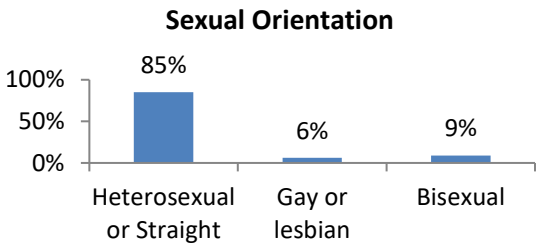
7
Art Events Held

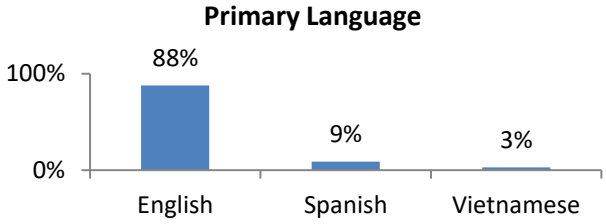
255
Artists Participated in Creative Minds Workshops

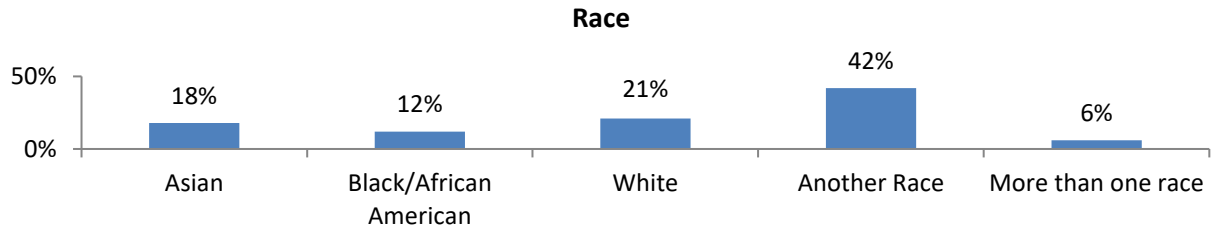
PEI Demographics from Post-Test Stigma Reduction Surveys (n=33)

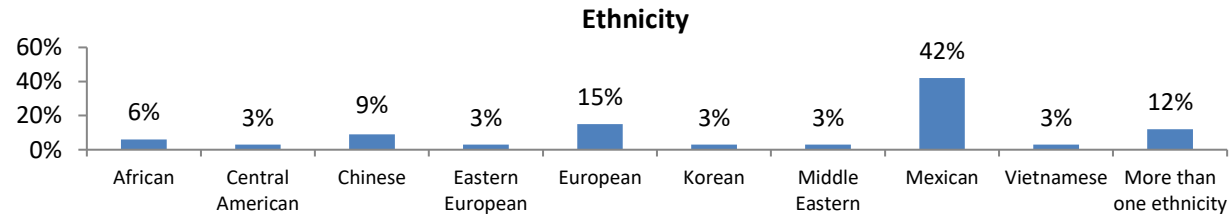
*PEI Demographics Completed Only by Adults 18+

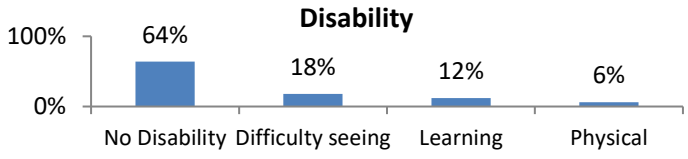


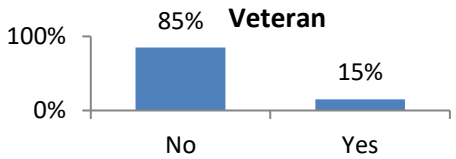


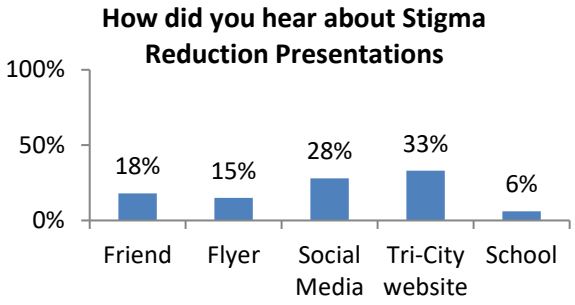


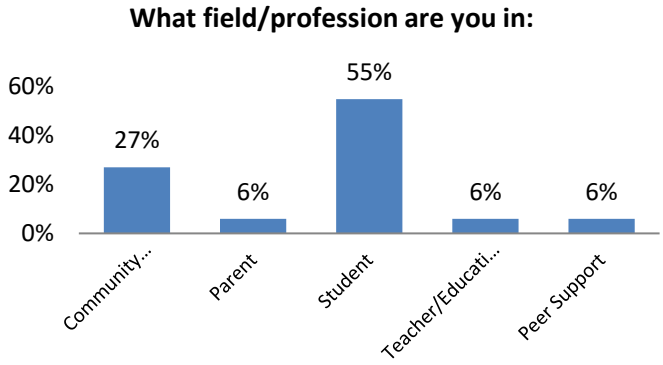












How Well Did We Do It?

243
Individuals Outreached for Stigma Reduction Presentations

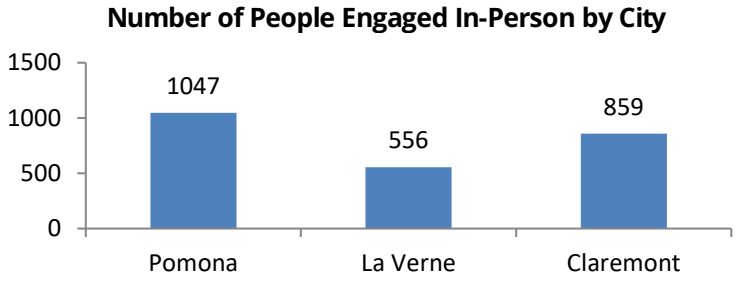
255
Individuals Outreached for Art Gallery/Creative Minds

Promotional Materials & Social Media Engagement for Stigma Reduction

12,093
Promotional Materials

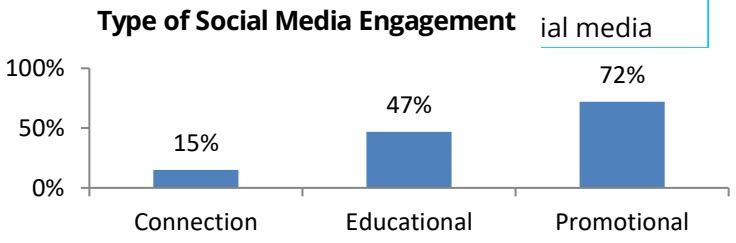
The number of promotional materials & people engaged from outreach **increased** from **8,342 and 1,404** in FY 2022-22 to **12,093 and 2,462** in FY 2023-24.

2,452
People Engaged from Outreach Efforts



6,665
Instagram accounts Reached for Social Media Engagement

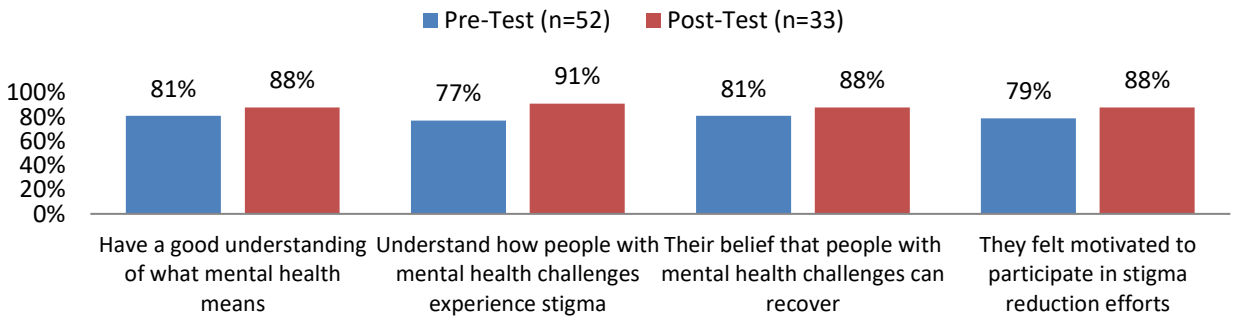
47 post/stories in ial media



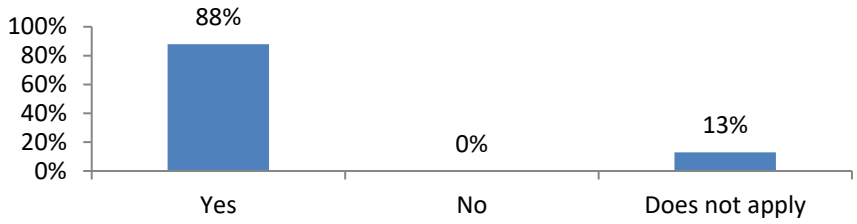
Is Anyone Better Off?

Stigma Reduction

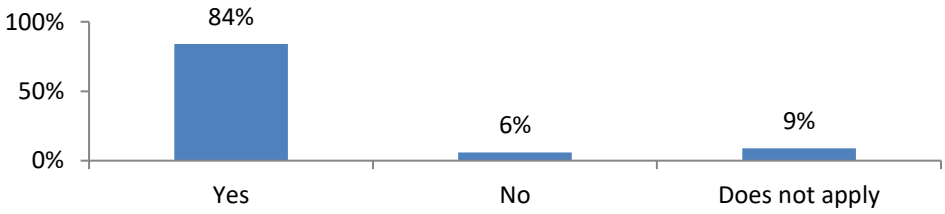
Q.1: Percentage of Stigma Reduction Survey Respondents who reported at Pre and Post Tests



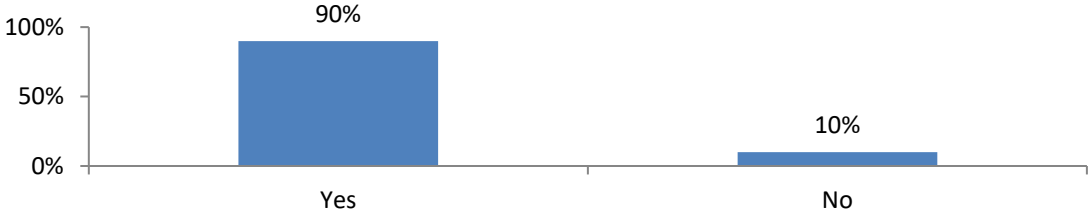
Does Art Help you Manage your Overall Wellbeing:



Q.2: Percentage of Stigma Reduction respondents who reported, "Have experienced any mental health challenges in the past:"



Q.3: Percentage of Stigma Reduction respondents who reported "Yes" to Q.2 and "Has this presentation helped you understand your overall wellbeing:"

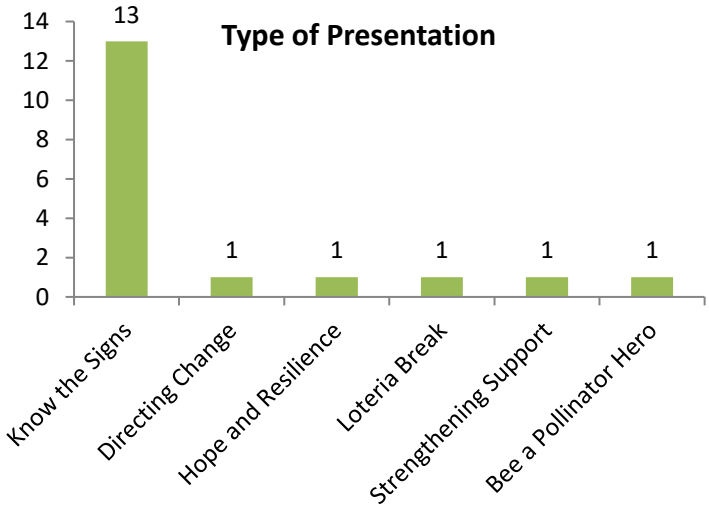


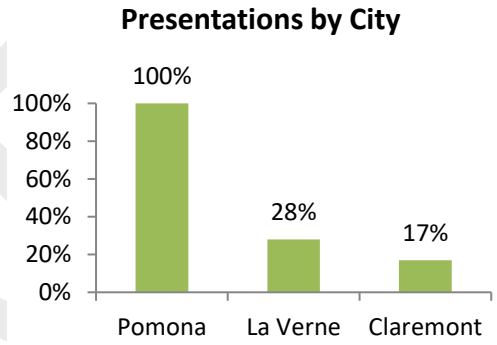
How Much Did We Do?

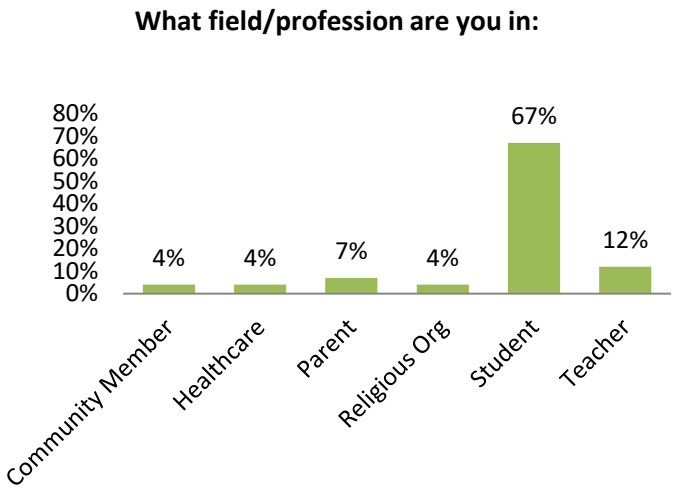
18
Suicide Prevention Presentations

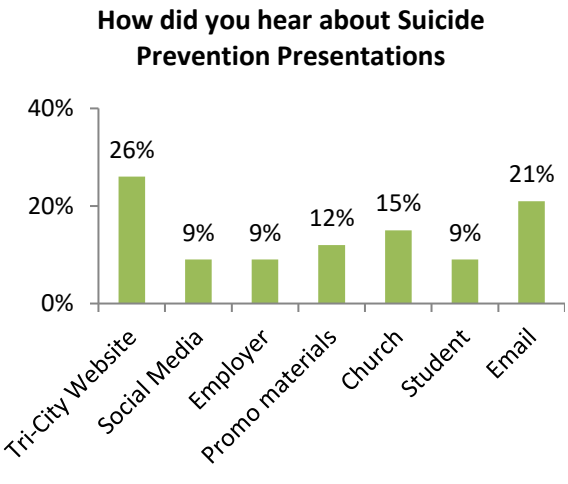
224
Attendees for Suicide Prevention Presentations

The number of Suicide Prevention presentations and attendees **increased** from **15 and 152** in FY 2022-22 to **18 and 224** in FY 2023-24.



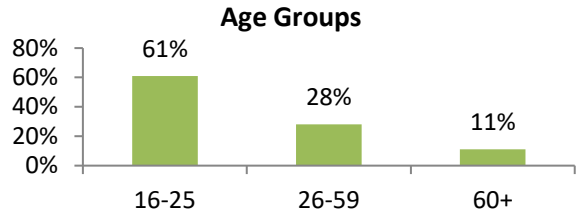


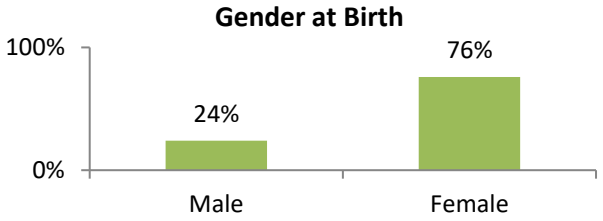


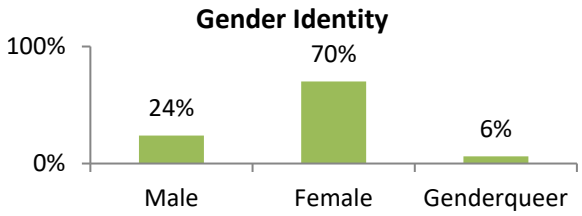


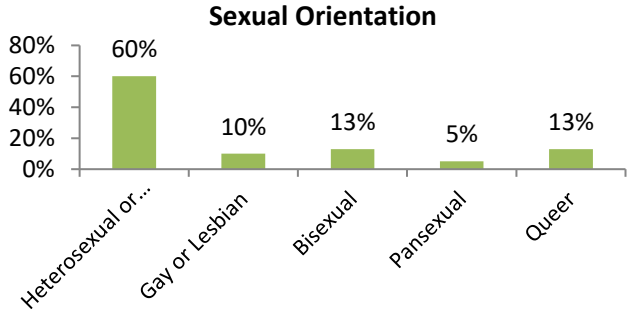
PEI Demographics from Post-Test Suicide Preventions Surveys (n=87)

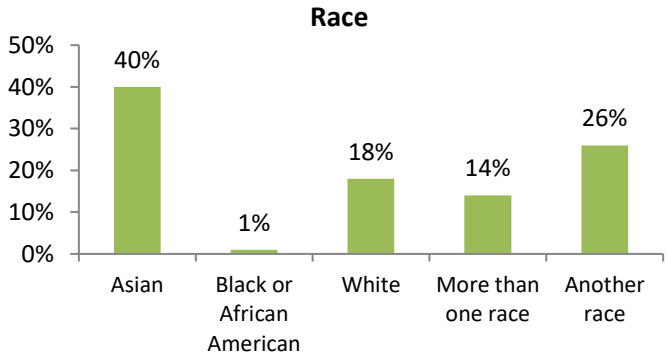
*PEI Demographics Completed Only by Adults 18+

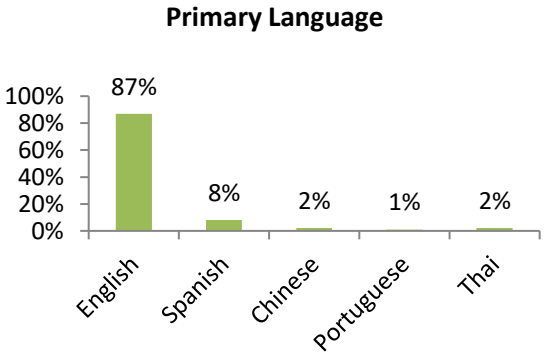


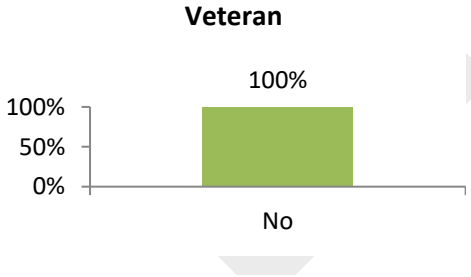


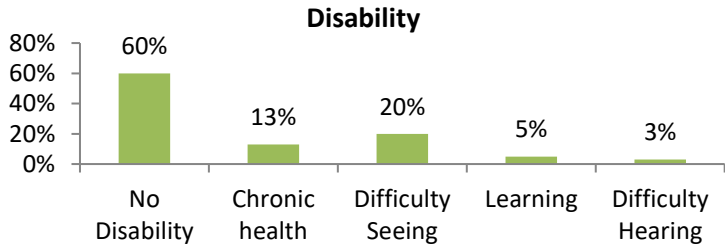


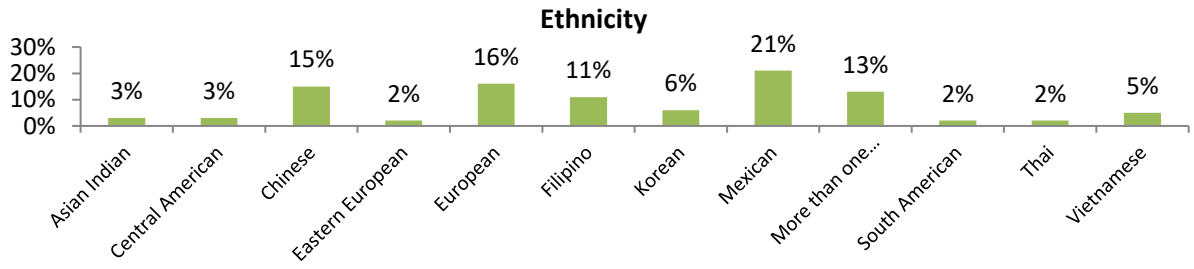












How Well Did We Do It?

224
Individuals Outreached for Suicide Prevention Presentations

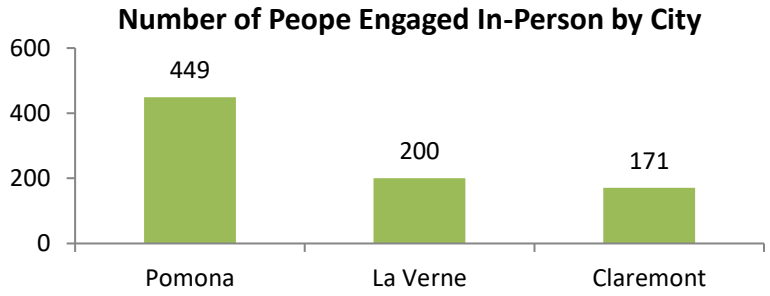
The number of individuals outreached from suicide prevention presentations **increased** from **152** in FY 2022-22 to **224** in FY 2023-24.

Promotional Materials & Social Media Engagement for Suicide Prevention

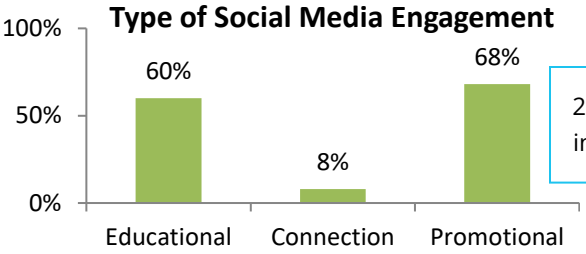
3,065
Promotional Materials

The number of people engaged from outreach **decreased** from **1,161** in FY 2022-22 to **820** in FY 2023-24.

820
People Engaged from Outreach Efforts

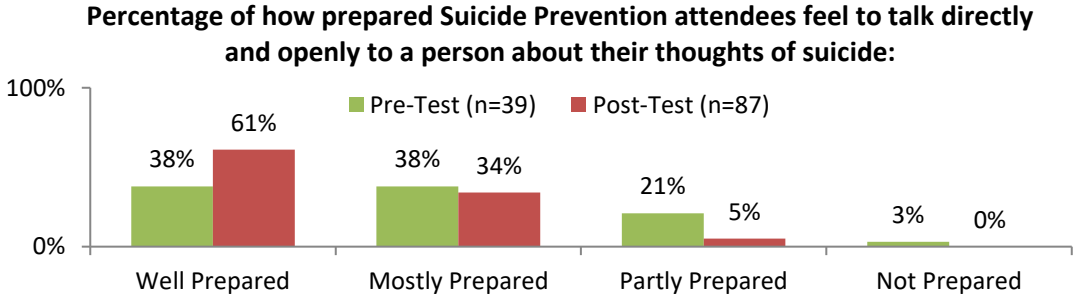


2,580
Instagram accounts Reached for Social Media Engagement

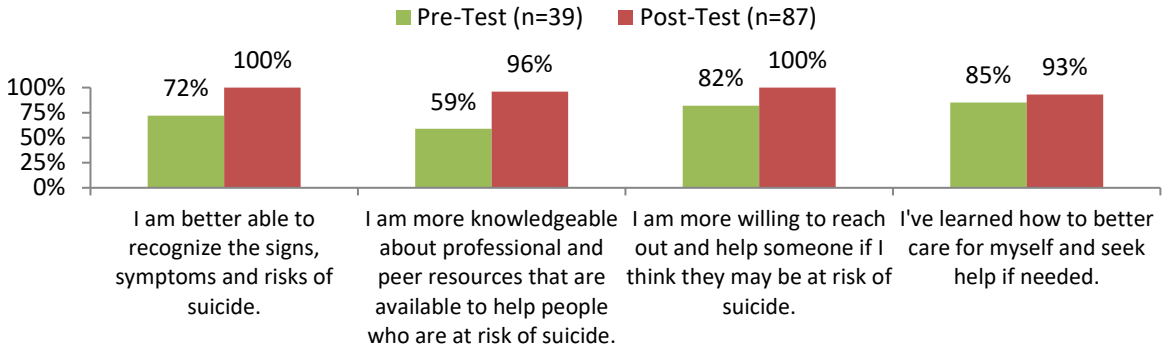


25 post/stories in social media

Is Anyone Better Off?



Percentage of Suicide Prevention Survey Respondents who reported at Pre-Test and Post-Test:



Number of Potential Responders	722
Setting in Which Responders were Engaged	Community, colleges, schools, health Centers, workplace, shelters, online, and outdoors.
Type of Responders Engaged	TAYs, Adults, Seniors, teachers, LGTBQ, families, suicide attempters/survivors, religious leaders, and those with lived experience.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

Timely Access to Services for Underserved Populations Strategy

0
MHSA Referrals to Stigma Reduction/ Suicide Prevention Programs

Peer Mentor and Wellness Center PEI Programs

Older Adult and Transition Age Youth Wellbeing

Both the Older Adult Wellbeing and the Transition Age Youth Wellbeing programs are comprised of two projects: The Peer Mentor program and specialty groups/programing offered at the Wellness Center specific to TAY and older adults needs.

Peer Mentor Program (Prevention & Early Intervention)

Program Description

Trained volunteers (peer mentors) from the Tri-City area provide support to peers (mentees) who are looking for emotional support. Peer mentors offer both individual and group support, and additional assistance through linkage to community resources that are both age and culturally matched to each individual mentee. For every individual they meet with, the role of peer mentors is to listen, help identify strengths and areas of need, identify supports and suggests resources to help address mentee concerns.

Target Population

All community members with a focus on transition age youth (TAY ages 18-25) and older adults (ages 60 and over).

Mentors						
Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	0	12	10	5	0	**27**
Projected Number to be Served FY 2024-25	0	11	10	5	0	**26**
Cost Per Person	N/A	$2,853	$2,853	$2,853	N/A	**$2,853**

Mentees						
Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	**Total Served**
Number Served FY 2021-22	0	12	9	5	0	**26**
Projected Number to be Served FY 2024-25	0	29	21	12	0	**62**

Program Update

During FY 2023-24, the Peer Mentor program hosted its first Open House Event. The purpose of the event was to promote the program, highlight mentors, and emphasize the work they do for National Mentoring Month. Mentors were able to share how the program has been beneficial to them and highlight benefits of joining the program. Community Mental Health Training staff, also talked about the mental health benefits of volunteering. The program was well attended and received 2 new applications from prospective peer mentors. In total, the Peer Mentor program received 24 applicants in FY 2023-24, a 50% increase from FY 2022-23. Furthermore, 6 peer mentors from the program applied for paid positions at Tri-City Mental Health. Of the 6 who applied, 3 gained employment at the agency. The knowledge and experience they gained from working with mentees in the program was referenced in their applications and interviews.

Challenges and Solutions

With the expansion of our mentor team, the program placed great emphasis on providing comprehensive training and support to the new mentors to ensure their success. While this was an effective approach, it did take up a considerable amount of time due to significant growth of the program. During the FY 2023- 24 the program focused on re-engaging previous mentors in order to have seasoned and experienced mentors to support existing mentee requests. Through in-person lunch opportunities, group wellness retreats and special events, the program emphasized empowering both new and seasoned mentors through tailored training, addressing their concerns, and answering their questions to foster a vibrant and supportive mentor community.

Diversity, Equity and Inclusion

The Peer Mentor program is dedicated to actively seeking new mentor recruits from underserved populations to ensure greater accessibility for mentees from similar communities. The program staff are bilingual in English and Spanish and 23% of the mentors are proficient in a language other than English. Additionally, program staff proactively reach out to underserved communities through events and collaborations with relevant agencies. One of the 15 trainings offered to peer mentors focuses on working with diverse populations. During this training, mentors are informed about some of the

barriers underserved populations can encounter. From a lived experience perspective, a vast number of mentors themselves identify as being part of underserved communities and having diversities within the mentors helps to reduce stigma and support participants in feeling more comfortable when receiving services.

During FY 2023-24, the program connected with the Veteran's Affairs Department at the University of La Verne to provide them with information about the Peer Mentor program. Currently, the Peer Mentor program works with a mentor who identifies as a veteran and has previously mentored veterans.

Community Partners

The Peer Mentor program has several interdepartmental collaborations to support the community, recruit mentors, and enroll mentees. Some of the collaborations include Stigma Reduction, Workforce Education and Training, various clinical departments, Community Mental Health Training, Therapeutic Community Gardening, Community Navigators, and the Wellness Center.

Through events and activities, these collaborations provide opportunities for mentor recruitment, mentee referrals, trainings, and community resources. Mentors also gain knowledge about Tri-City services to refer or provide resources to their mentees when necessary. Additionally, a large portion of mentors are college students, so connections with the universities in the service area are beneficial to the program and to mentees seeking support.

Success Story

An older adult called Tri-City and inquired about receiving services at the Adult Outpatient Clinic. It was clinically determined that they did not meet medical necessity for specialty mental health services, and they were referred to the Wellness Center. Once they began attending the Wellness Center, it was determined that the individual could benefit from 1:1 support, and they were subsequently referred to the Peer Mentor program. The participant reported that they were involved with Tri-City decades ago that they were interested in receiving services based on their history with Tri-City and being aware of the range of services available.

Program Summary

How Much Did We Do?

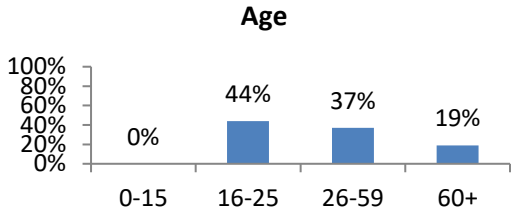
Peer Mentors

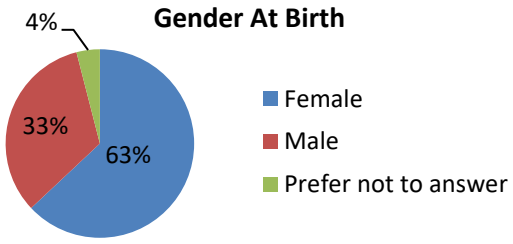
24
Individuals Applied to Peer Mentor Program

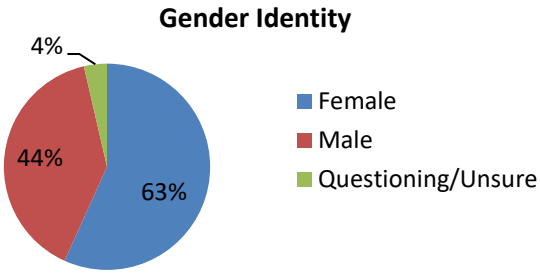
19
Peer Mentor Meetings/Trainings

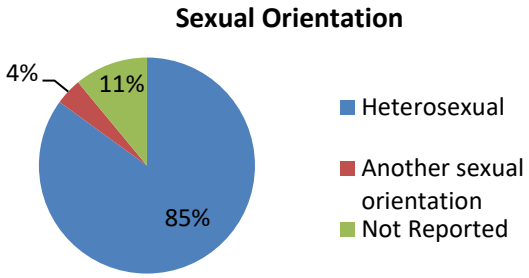
27 Active Peer Mentors
12 New Mentors
15 Returning Mentors

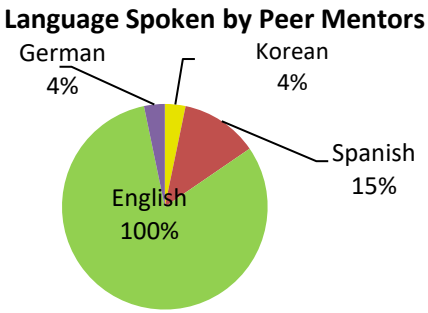
The number of active mentors **increased** from **14 active mentors** in FY 2022-23 to **27 active mentor** in FY 2023-24.

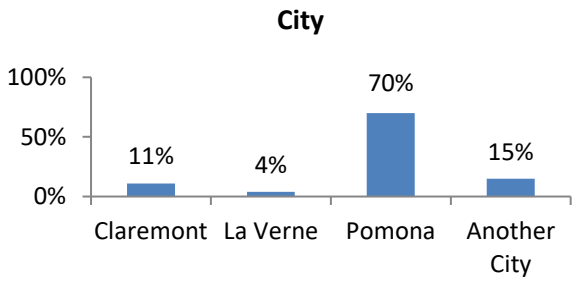




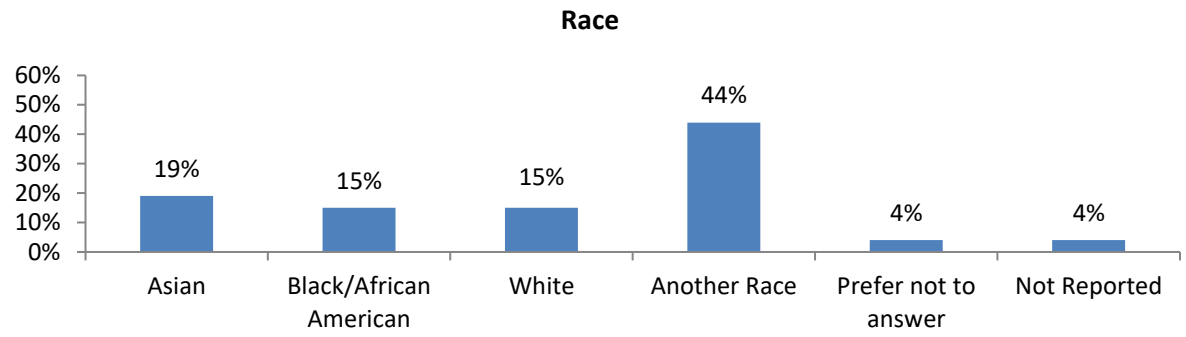


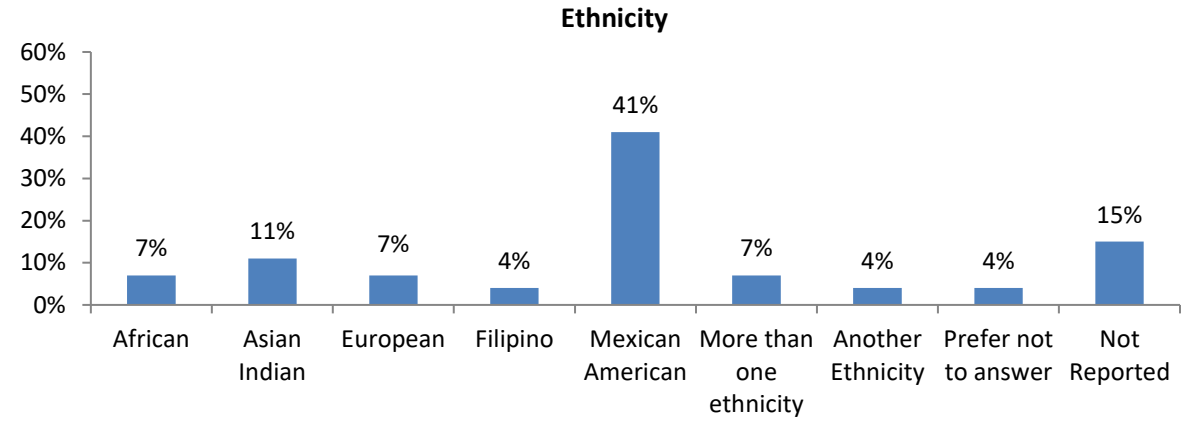


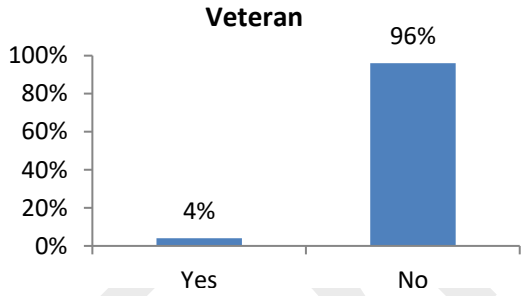


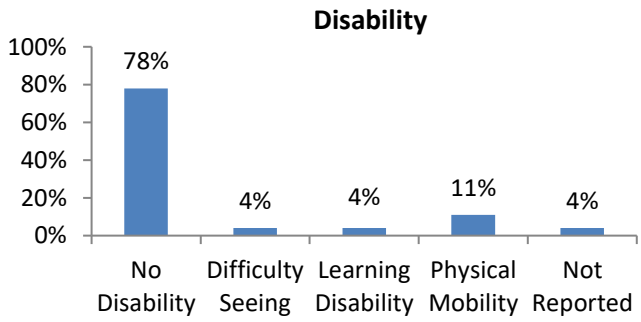


The number of available languages by mentors **increased** from **3 languages** in FY 2022-23 to **4 languages** in FY 2023-24.







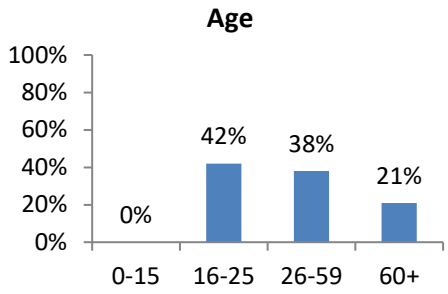


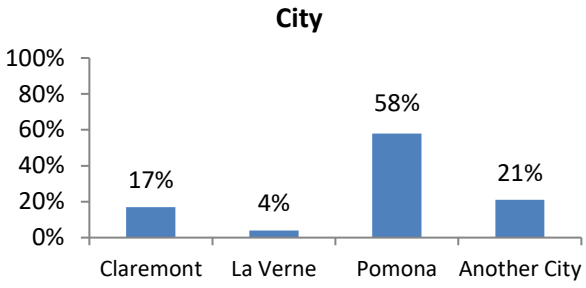
Peer Mentees

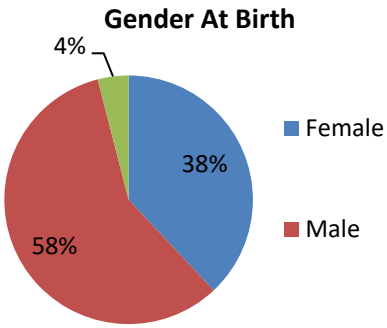
26 Mentees Served

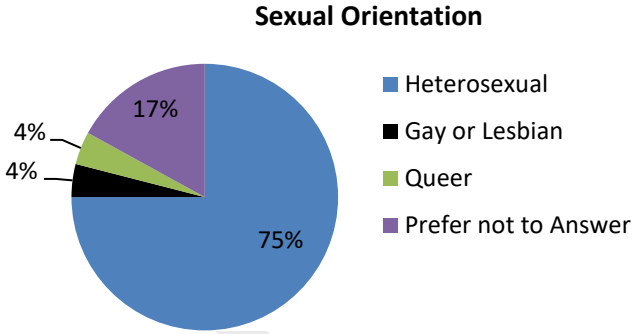
22 Mentee Referrals to the Peer Mentor Program

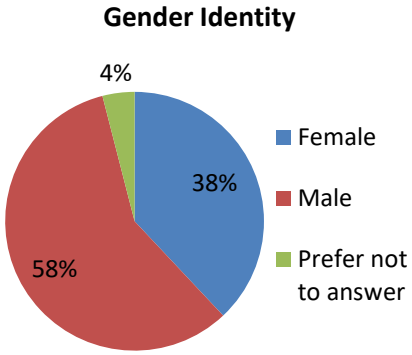
Peer mentees served **decreased** from **40 mentees** in FY 2022-23 to **26 mentees** in FY 2023-24.

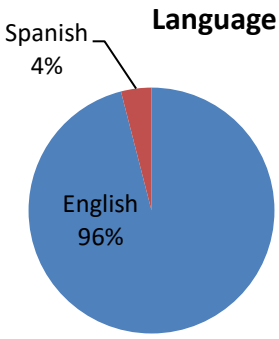

Age
100%
80%
60%
40%
20%
0%
0%
42%
38%
21%
0-15
16-25
26-59
60+

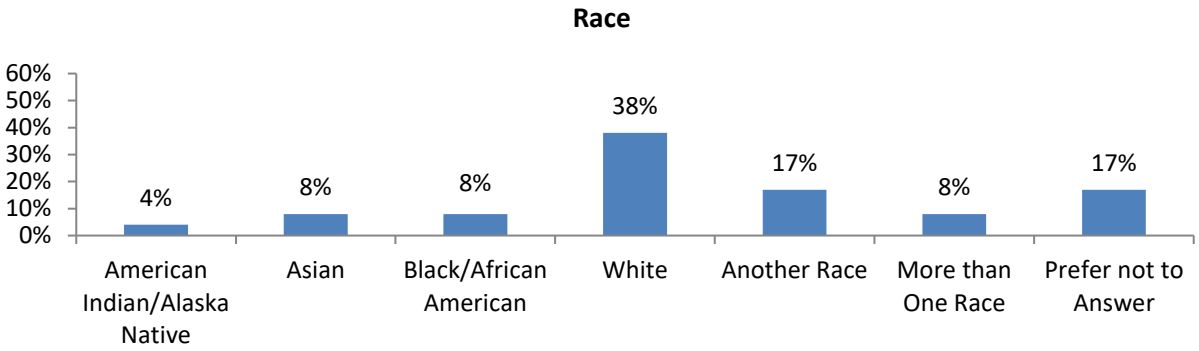

City
100%
80%
60%
40%
20%
0%
17%
4%
58%
21%
Claremont
La Verne
Pomona
Another City

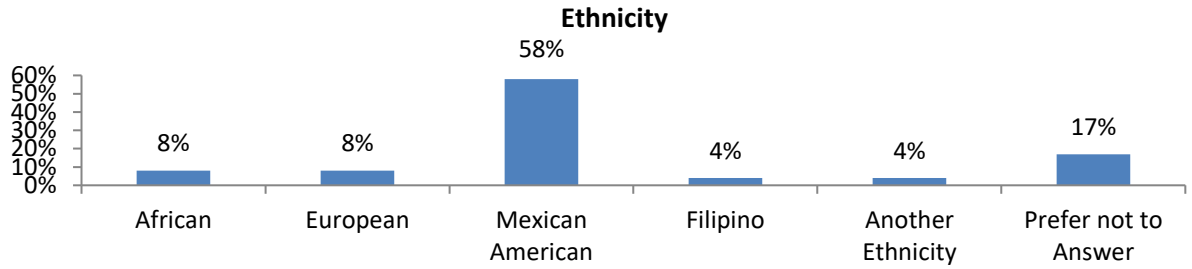

Gender At Birth
4%
38%
58%
Female
Male

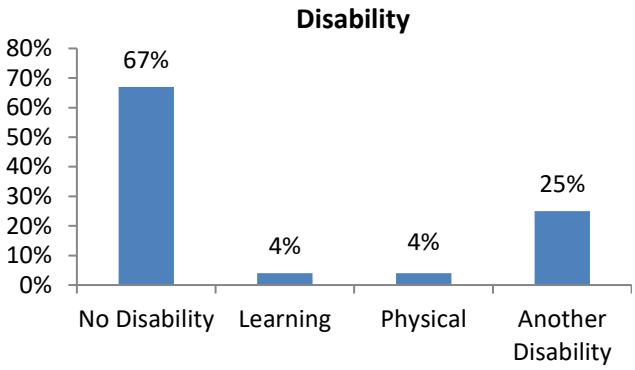

Sexual Orientation
17%
4%
4%
75%
Heterosexual
Gay or Lesbian
Queer
Prefer not to Answer

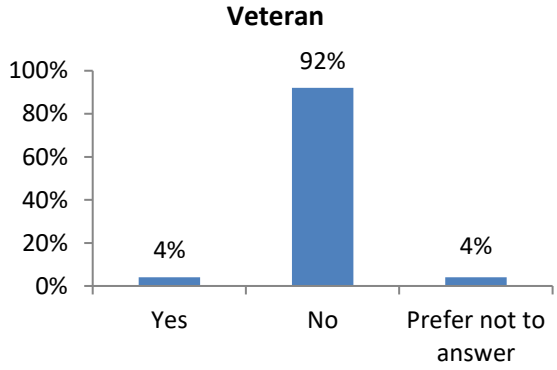

Gender Identity
4%
38%
58%
Female
Male
Prefer not to answer


Language
Spanish
4%
English
96%


Race
60%
50%
40%
30%
20%
10%
0%
4%
8%
8%
38%
17%
8%
17%
American Indian/Alaska Native
Asian
Black/African American
White
Another Race
More than One Race
Prefer not to Answer







How Well Did We Do It?

Peer Mentor

12 out of 24 (50%) Mentor Applicants Became Mentors

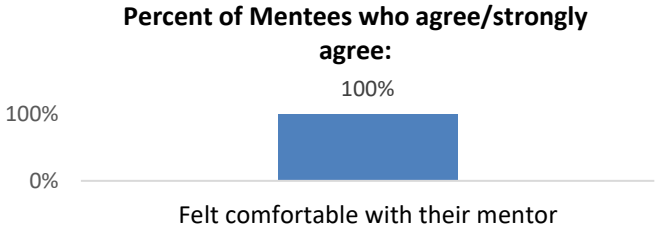
613
Hours Completed by Peer Mentors
Direct Time with Mentees: 245
Trainings and Supervision: 351
Community Engagement: 17

16
Peer Mentors Self-Identify with Lived Experience

Peer mentors self-identifying with lived experience **increased** from **8 mentors** in FY 2022-23 to **16 mentors** in FY 2023-24.

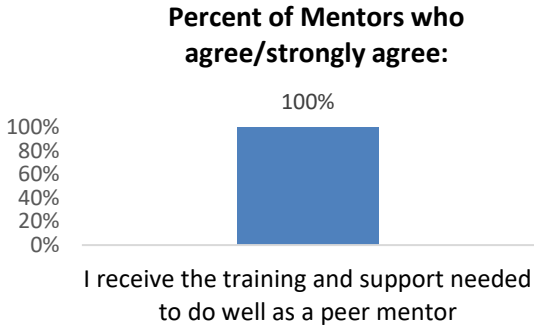
Peer Mentees

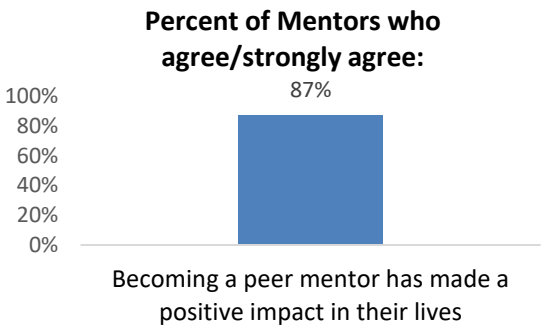
15 out of 22 (68%) Mentee Referrals Became Mentees



Is Anyone Better Off?

Peer Mentors

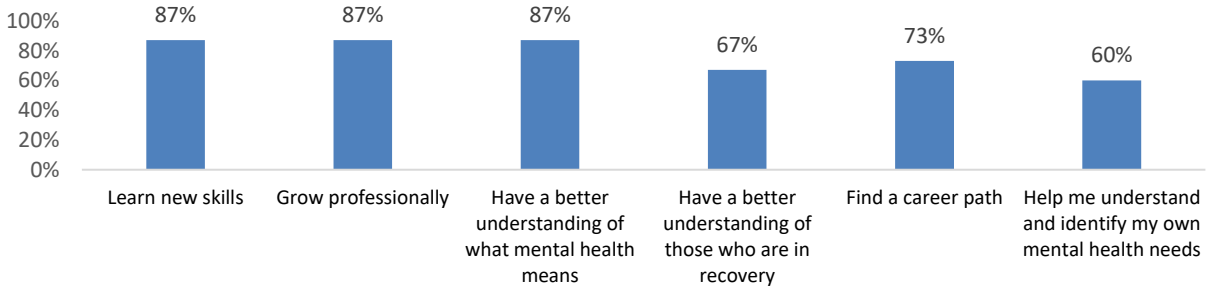




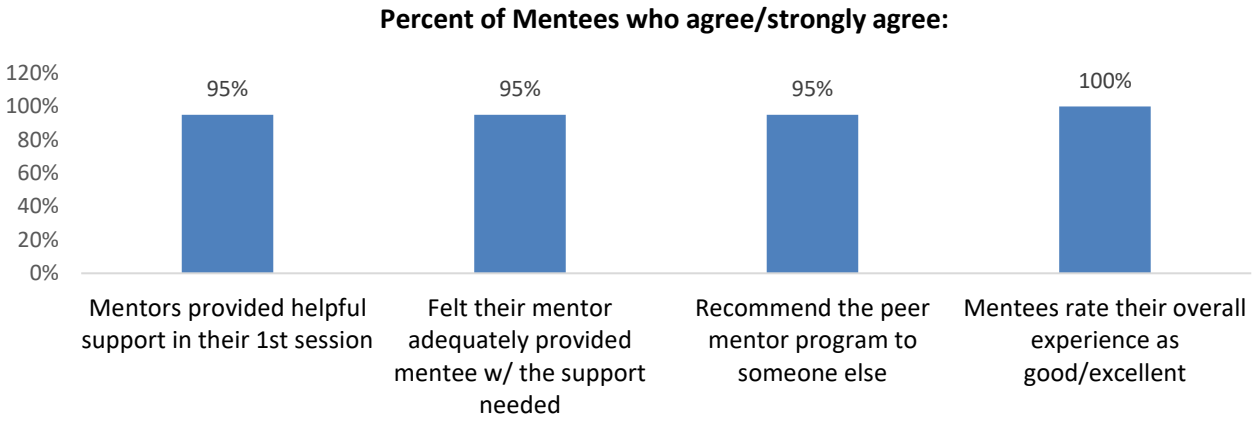
What was your favorite part of being a mentor? (n=13)

List one thing from the peer mentor program you feel was most beneficial (n=13)

How has the program helped you personally as Mentor: (Check all that apply)



Peer Mentees



List one thing from the mentee program you feel was most beneficial: (n=9)

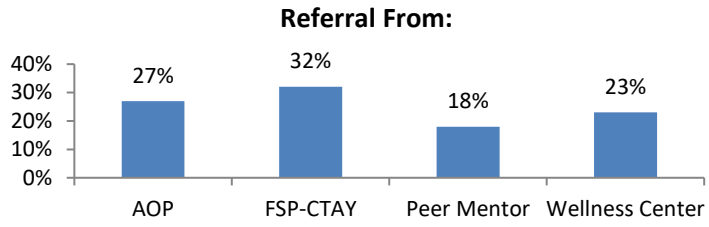
Number of Potential Responders	51
Setting in Which Responders were Engaged	Virtual platforms, Phone, Community
Type of Responders Engaged	TAYs, Adults, Seniors, and those with lived experience
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

Timely Access to Services for Underserved Populations Strategy

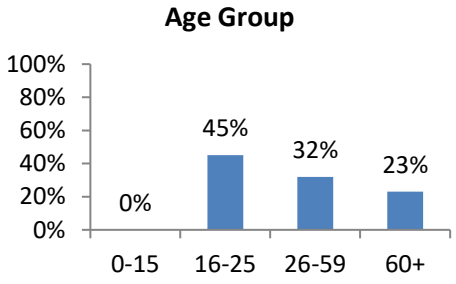
22
MHSA Referrals received by Peer Mentor program

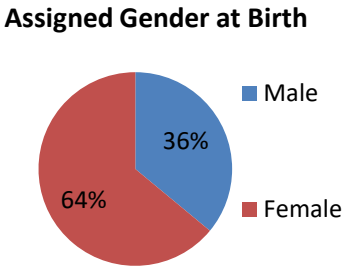
15 out of the 22
Referrals became mentees

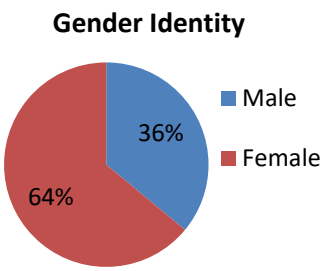
2 Days
Average Time between Referral and becoming a mentee

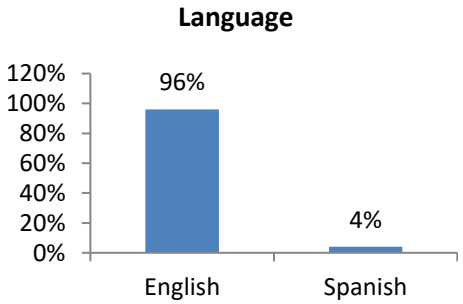


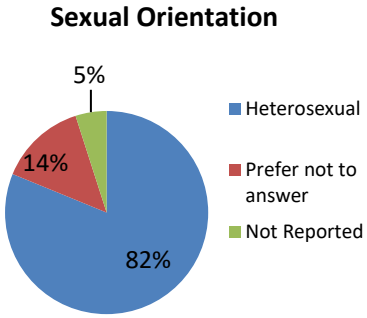
PEI Demographics Based on Referrals

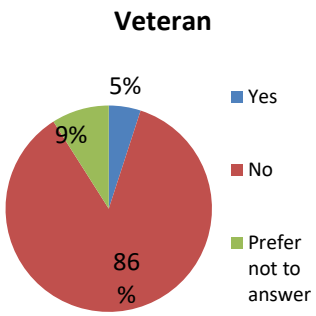


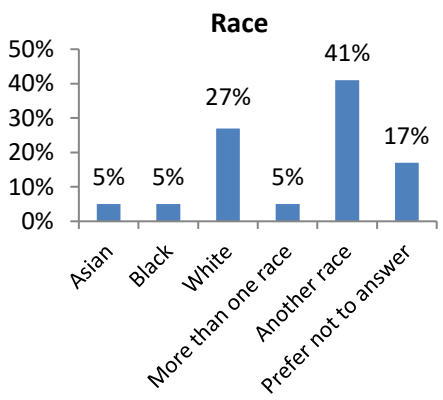


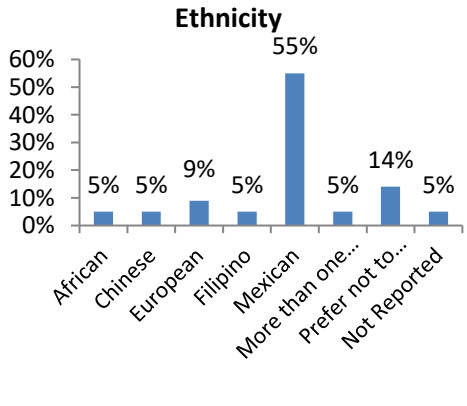


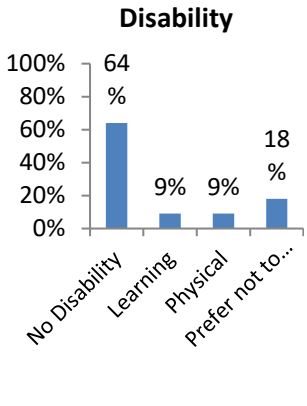












Wellness Center PEI Programs

(Prevention & Early Intervention)

Transition Age Youth and Older Adults

Program Description

Individuals attending the transition age youth (TAY) and older adult programming located at the Wellness Center benefit from specialized support groups and activities targeting their specific needs.

Target Population

Transition age youth (TAY) and older adults are considered specialized populations in need of support, however these populations also tend to be some of the most difficult to engage in and maintain in services. Reasons include issues related to stigma and difficulty with transportation. To meet the needs of these individuals, the Wellness Center utilizes Prevention and Early Intervention (PEI) funding to create programing specific to the needs and interests of these populations.

Age Group	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	1,152	122	43	0	**1,317**
Projected Number to be Served FY 2024-25	900	95	34	N/A	**1,029**
Cost Per Person	$1,645**	$1,645**	$$1,645***	N/A	**$1,645****

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

Program Update

The Wellness Center Senior Retreat was held in September 2023 in collaboration with Therapeutic Community Gardening. Participants were able to learn about taking care of succulents, how to plant them, and created terrariums. The participants expressed how grateful they were for the information that they learned during the retreat; emphasizing positive memories were made and connections with others enhanced their social wellness. In August of 2023, the Wellness Center collaborated with the Joselyn Senior Center in Claremont to incorporate in-person support groups at their Center. The program facilitated Senior Calm groups in which participants practiced coping skills and engage in mindfulness activities. The Wellness Center program also hosted a fieldtrip to Pomona College's

Organic Farm. The participants were able to enjoy a day of nature and light lunch under the trees. The seniors expressed high levels of satisfaction during and after the fieldtrip, reporting an appreciation to reconnect with nature.

In November of 2023, the program hosted a TAY harvest event, Fall Y'all. Attendees enjoyed an evening of autumn festivities, socialization with peers, games, and crafts. During the fiscal year, a friendship event also took place where TAY participants celebrated friendships, enjoyed food, engaged in crafts, and won raffle prizes. Towards the end of the fiscal year, the Annual Talent Show was held, giving the TAY participants an opportunity to showcase their talents, and enjoy a free event filled with music, art, poetry, and much more.

Challenges and Solutions

The older adults in the program share that they enjoy groups however have issues with transportation. To alleviate this challenge, we plan to have a designated driver at the Wellness Center to provide transportation. Our participants also express a struggle with symptoms and/or illnesses that prevent them from attending. Some of the older adult participants also report memory issues that impact their ability to recall dates and times of events. To address this challenge, reminder calls are provided, frequent announcements are made, and appointment cards are distributed.

Retaining TAY individuals in groups is a challenge as well. Youth will attend an event on a one-time basis, and not return for groups consistently. It has been reported that some TAY struggle with balancing time for work, school, and support groups. While others state that they have reduced their attendance, or removed themselves from groups completely, due to feeling that the groups were too small. The Wellness Center will continue to conduct outreach in the community, distribute group calendars and event flyers to local school districts, colleges, and other local organizations to address this challenge and connect with the TAY population.

Diversity, Equity and Inclusion

The Wellness Center includes Spanish speaking staff and materials, and resources are available for non-English speaking participants. Furthermore, the Center hosts several support groups for non-English-speaking individuals.

The TAY Resource Center is a designated safe place to provide support and serve the specific needs of the TAY community. Activities and groups are created based on the needs and requests of the participants. Workshops and events are designed and tailored to meet the interests of the attendees. Staff are also regularly trained on specialized populations, diversity/inclusion, cultural competence, and culture- centered approaches to recovery. Programming always includes a welcoming, inclusive, and nonjudgmental environment. Staff are encouraged to take training courses on the importance of diversity and inclusion of all individuals regardless of their sexual orientation. The TAY program also connects participants who identify LGBTQIA+ with Pomona Valley Pride.

Community Partners

For the purposes of collaborative events, workshops, group enrollment, and resource sharing, the Wellness Center program has collaborated with agencies such as Aging Next in La Verne and the Palomares Senior Center in Pomona to support our older adults. Aging Next (older adult volunteers) also visit the Wellness Center to hold meetings. Additionally, local artists from Saint Remy Arts and Culture provide participants with workshops on creating clay artwork.

TAY programming partners with agencies such as the Youth Activity Center in Claremont to develop and present content to their TAY attendees. Some of the topics have included the importance of boundaries and forming and maintaining friendships. The Wellness Center TAY programming also frequently collaborates with the Cal Poly University Village to develop workshops addressing topics such as college struggles and healthy coping strategies that can help college students enhance their mental health.

Success Story

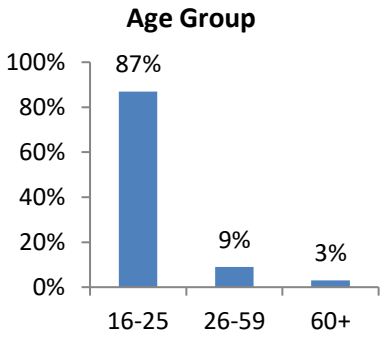
A consistent participant in our older adult support groups expressed struggles with mental health concerns. They highlighted the meaningful impact that the Wellness Center and the senior groups have made in helping manage their symptoms, learn how to cope, and not feel as isolated. They also expressed a benefit in feeling comfortable enough to express themselves in groups and feel supported in a safe environment.

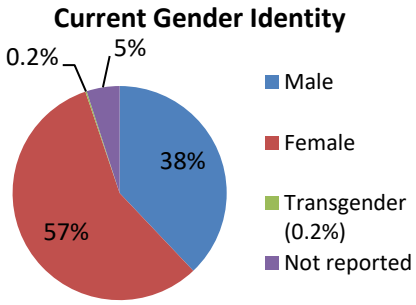
A TAY participant struggled with identifying healthy ways to cope with their mental health challenges. They expressed feelings of boredom and a lack of direction, contributing to coping in unhealthy ways. Currently, the TAY individual participates consistently in the support groups. They report enjoying spending time at the Wellness Center, increasing socialization with others and gaining confidence in vocalizing their needs to others.

Program Summary

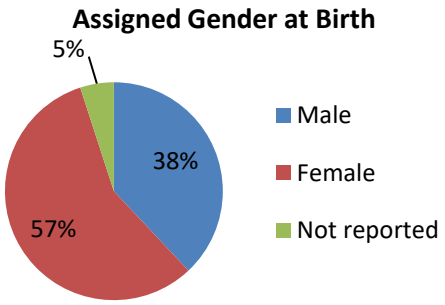
How Much Did We Do?

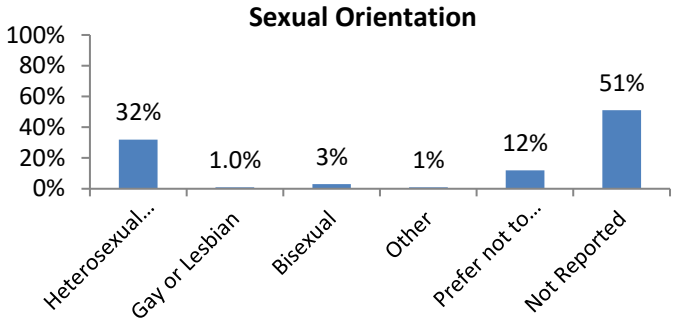
1,317
Unique Individuals attending Wellness Center TAY/Senior

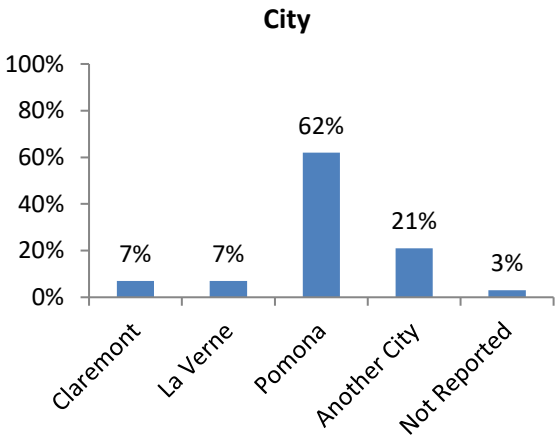


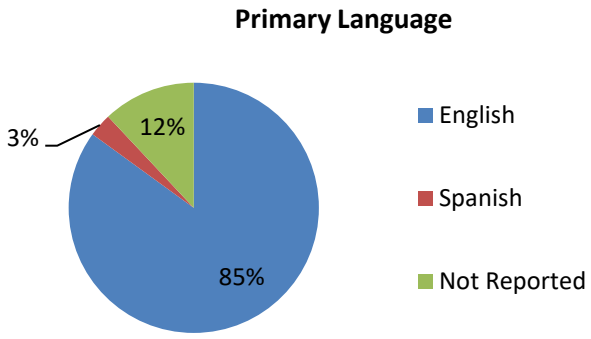


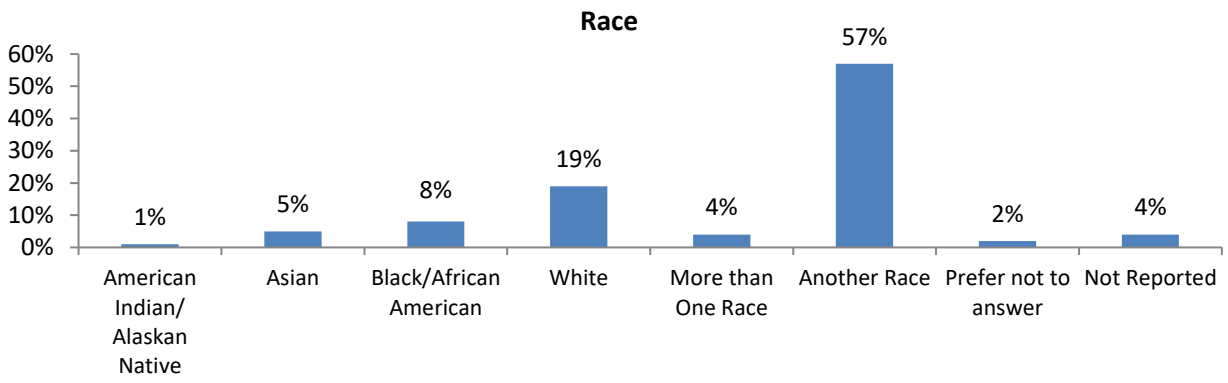
The number of individuals attending Wellness Center TAY/Senior groups **remained constant** from FY 2022-23 to FY 2023-24.



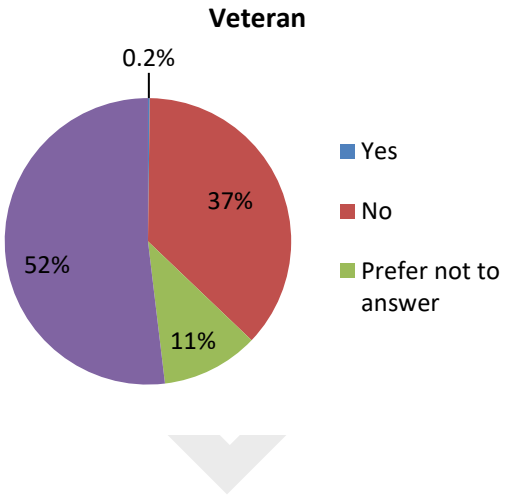


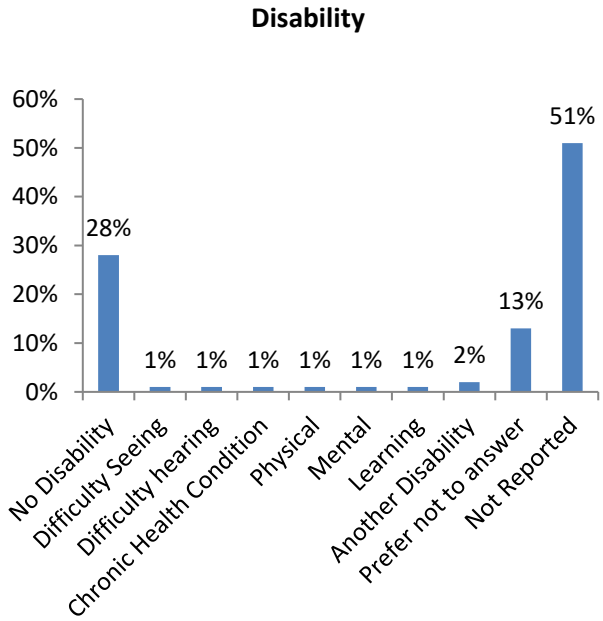





Race
60%
50%
40%
30%
20%
10%
0%
1%
5%
8%
19%
4%
57%
2%
4%
American Indian/ Alaskan Native
Asian
Black/African American
White
More than One Race
Another Race
Prefer not to answer
Not Reported


Ethnicity
60%
50%
40%
30%
20%
10%
0%
8%
1%
0.1%
0.2%
1%
2%
15%
1%
1%
57%
0.2%
1%
0.2%
4%
4%
2%
4%
African
Asian Indian
Camboadian
Caribbean
Central American
Chinese
European
Filipino
Korean
Mexican/Mexican...
Middle Eastern
Vietnamese
South American
More than one...
Another Ethnicity
Prefer not to answer
Not Reported

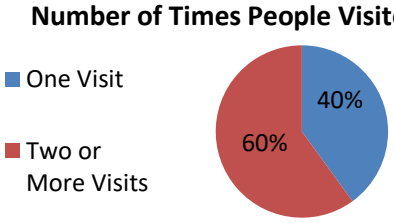

Veteran
0.2%
37%
52%
11%
Yes
No
Prefer not to answer


Disability
60%
50%
40%
30%
20%
10%
0%
28%
1%
1%
1%
1%
1%
1%
2%
13%
51%
No Disability
Difficulty Seeing
Difficulty hearing
Chronic Health Condition
Physical
Mental
Learning
Another Disability
Prefer not to answer
Not Reported

How Well Did We Do It?

4,482
Number of Wellness Center PEI: TAY/Senior Events
(Duplicated Individuals)

Number of Times People Visited

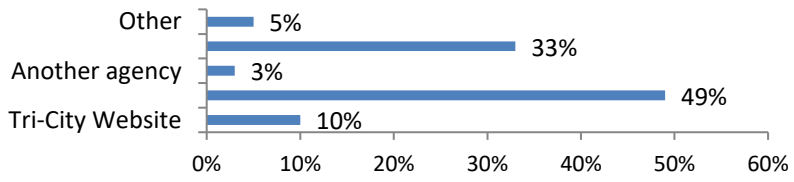


The total number of (duplicated) individuals attending Wellness Center TAY/Senior groups **increased** from **4,435** FY 2022-23 to **4,482** FY 2023-24.

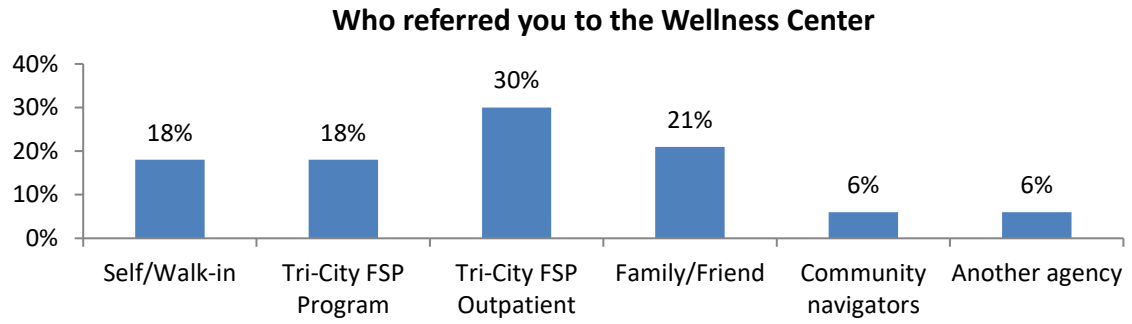
Support Activities Name	Number of Times Activity Was Held	Average Number of Attendees at an Activity
Platica Entre Amigos	29	1
Senior Calm	70	5
Senior Socialization	39	2
Senior Bingo	7	2
Senior Virtual Vacation	1	1
TAY – Brunch Club	32	2
TAY – Friendly Feud	38	1
TAY – Fun with Friends	45	2
TAY – Peace of Mind	41	2
TAY – Popcorn, Peers & Leadership (PPL)	35	2

Contacts by Type	Number of Individuals
TAY – Phone Call - Wellness Calls	1,240

How Did You Learn About the Wellness Center Programs?
(Choose All that Apply)z

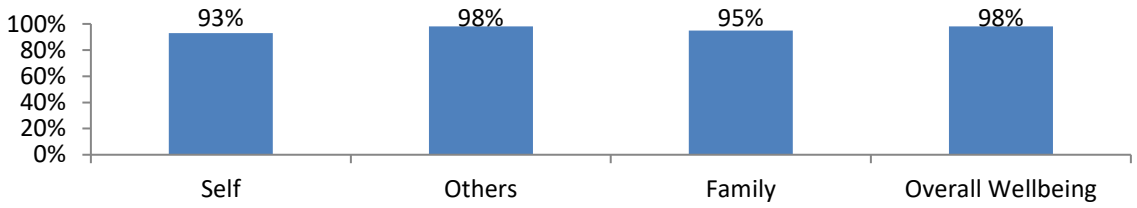


100%
Satisfied with the "help I get at Wellness Center"



Is Anyone Better Off?

Percent of people who report improved relationships with the following because of the help they get from the Wellness Center Programs:



Number of Potential Responders	1,317
Setting in Which Responders were Engaged	Virtual platforms, Phone, Community, Wellness Center
Type of Responders Engaged	TAY, Adults, Seniors
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

Timely Access to Services for Underserved Populations Strategy

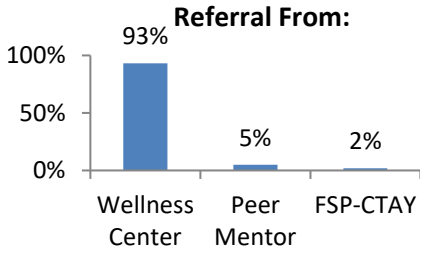
42
Referral coming into Wellness Center TAY

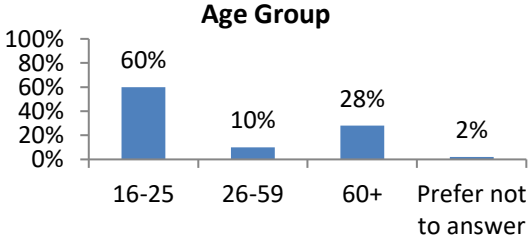
35 out of the 42
Referrals attended a Wellness Center group

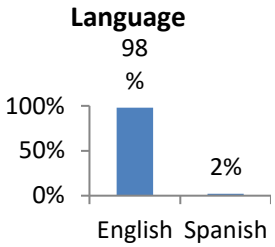
3 Days
Average Time between referral and participation

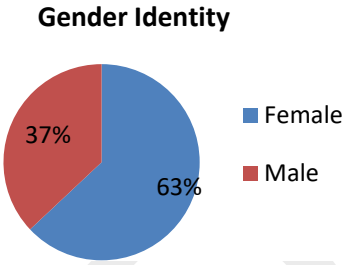
The number Wellness Center referrals **increased** from **6** FY 2022-23 to **42** FY 2023-24.

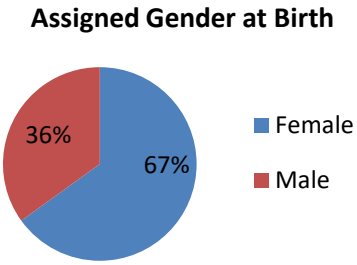
PEI Demographics Based on Referrals

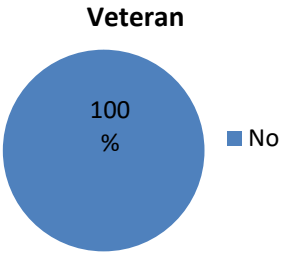


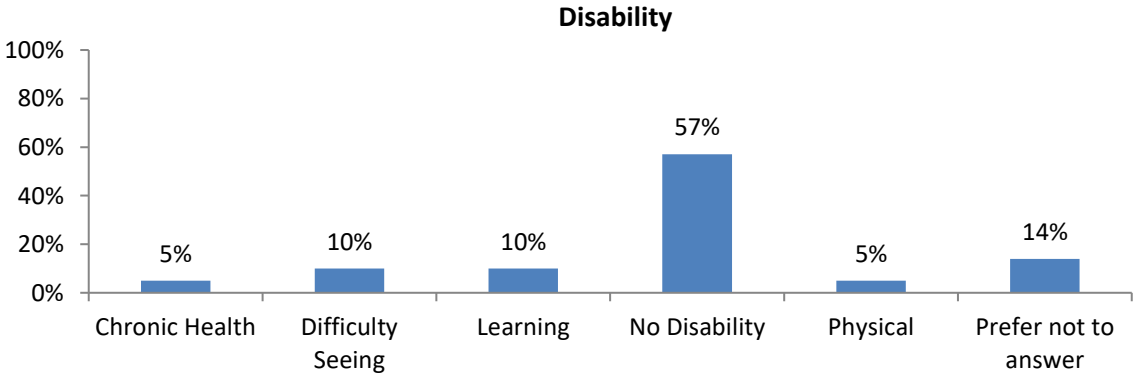


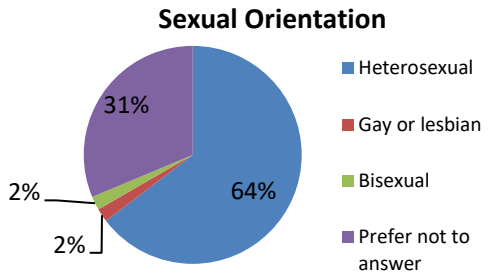


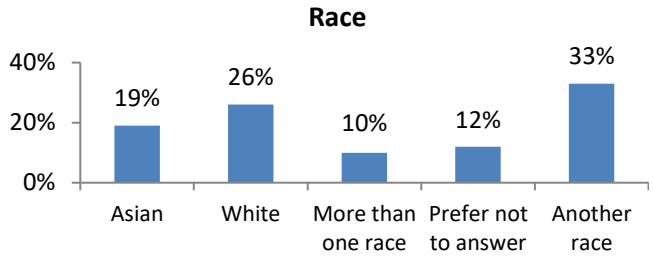


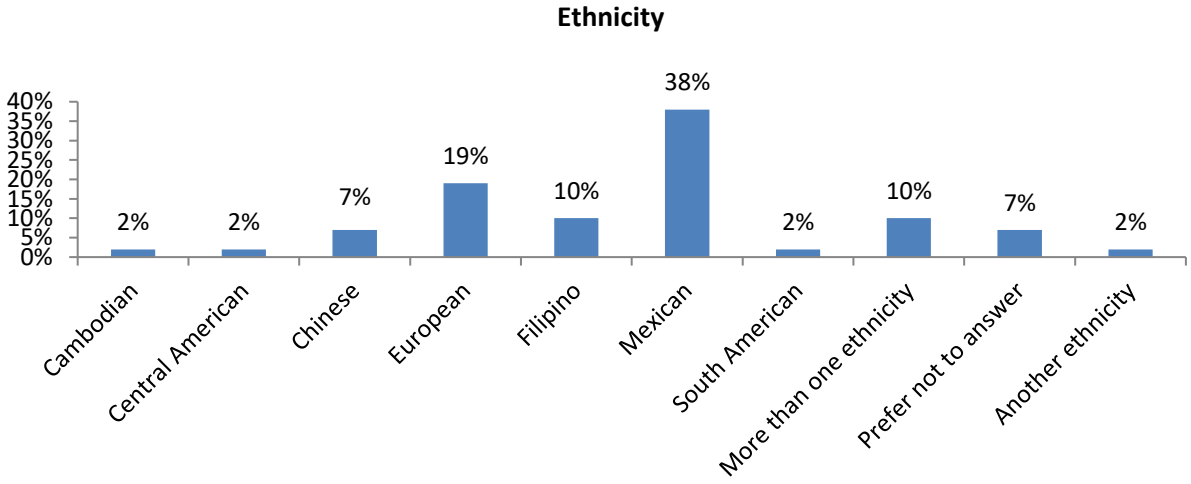







Sexual Orientation
31%
64%
2%
2%
Heterosexual
Gay or lesbian
Bisexual
Prefer not to answer


Race
40%
20%
0%
19%
26%
10%
12%
33%
Asian
White
More than one race
Prefer not to answer
Another race


Ethnicity
40%
35%
30%
25%
20%
15%
10%
5%
0%
2%
2%
7%
19%
10%
38%
2%
10%
7%
2%
Cambodian
Central American
Chinese
European
Filipino
Mexican
South American
More than one ethnicity
Prefer not to answer
Another ethnicity

Family Wellbeing Program

(Prevention & Early Intervention)

Program Description

The Family Wellbeing (FWB) program consists of a dynamic set of programing focused on addressing the needs of families and caregivers of people experiencing mental health challenges. Programing includes support groups, 1-1 support, and an array of culturally appropriate activities focused on wellness (e.g., exercise, cooking) and other interests that can attract family members and caregivers into peer-supported experiences. By creating a positive and nurturing support system, family members are provided the knowledge and skills necessary to increase the wellbeing of all members.

Target Population

Family members and caregivers of people who struggle with mental illness, especially those from unserved and under-served communities.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	184	70	483	88	53	**878**
Projected Number to be Served FY 2024-25	109	41	286	52	31	**519**
Cost Per Person	$263**	$263**	$263**	$263**	$263**	$263**

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

Program Update

The Family Wellbeing program hosted a Thanksgiving basket giveaway in November, FY 2023-24. The baskets consist of a turkey and all the sides to provide a free meal to families in need. The program also hosted the annual tree lighting for all families in the community. The event was accompanied by hot chocolate, music, singing, and a gift for all the children in attendance. The evening ended with the tree lighting and a holiday movie.

The Wellness Center Summer Camp, for children 7–12 years of age, is a highly anticipated event annually and once again received positive feedback from the community. The Summer Camp provides a positive and safe learning environment where campers can explore, experience educational outings, and participate in an array of activities.

Another update to the Family Wellbeing program was that some of the groups start time was changed to adjust with families' schedules. Additionally, the program hosted groups at the Children's Outpatient clinic to accommodate parents by reducing barriers related to transportation. Lastly, some groups have remained hybrid to accommodate those who experience barriers related to attending groups in-person.

Challenges and Solutions

Challenges experienced during FY 2023-24 included transportation as well as some families not being able to attend groups due to financial hardship. Another challenge for some attendees is the time of the group, one conflict specifically being with after school programs or sports that end late. Lastly, children and teens are typically not able to attend groups if there is no ride available from parents or caregivers. Addressing this challenge is multifaceted, however the program can consider changing the time of additional groups to address attendance. Furthermore, having the groups in a hybrid format could increase attendance as this would expand accessibility.

Diversity, Equity and Inclusion

Family Wellbeing staff are bilingual and diverse in race, ethnic background, cultures, age, and sexual orientation which helps to reduce stigma and barriers to seeking services. Program and information brochures are available in both English and Spanish.

Staff attend various community events to meet with children and families to reduce barriers when accessing mental health services. By engaging families using personal stories of success and inviting participants to share their experience in groups, staff attempt to reduce the stigma surrounding mental health services. Staff are also well versed in internal and external community resources, to refer appropriately when individuals are seeking support directly related to culture, gender identity, military status or otherwise. Groups have also been reimagined to be more inclusive, for example, *Mommy and Me* being redesigned to *Baby and Me*.

Community Partners

Family Wellbeing program collaborates with several internal and external partners within the service area. Some internal partnerships include the Adult Outpatient program, Therapeutic Community Gardening and Children's Outpatient program who assist with promoting Summer Camp to their clients, providing general referrals and collaborating on events.

Examples of external partnerships include Gen Her (a non-profit organization who supports single mothers), Parents in Partnership (DCFS program that hosts support groups for families with open court cases), Parents Anonymous (hold certified classes for parents at the Wellness Center), and collaborations with Foothill Family Services (providing groups to individuals seeking parenting, couple and individual support). These collaborations, among others, lead to enhancing existing groups, developing supportive programs, and planning specialty events for the community.

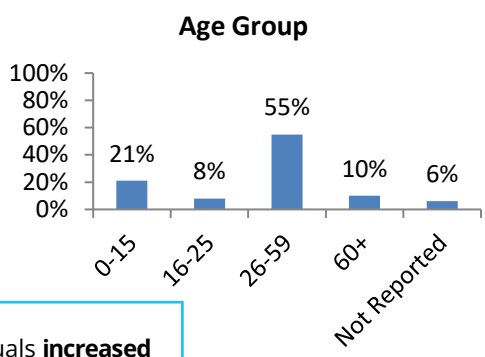
Success Story

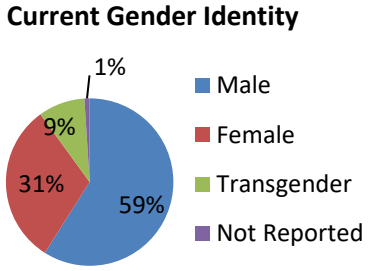
A single parent attending the *Baby and Me* group reported that their child was diagnosed with a learning disability. The parent's goal was to find as many groups as possible and activities in the community in order to support the child and their needs. After attending the *Baby and Me* group regularly, the parent disclosed that the child had displayed noticeable improvements with their speech.

Program Summary

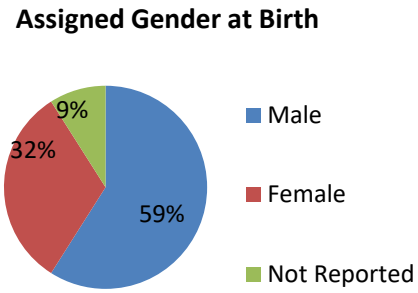
How Much Did We Do?

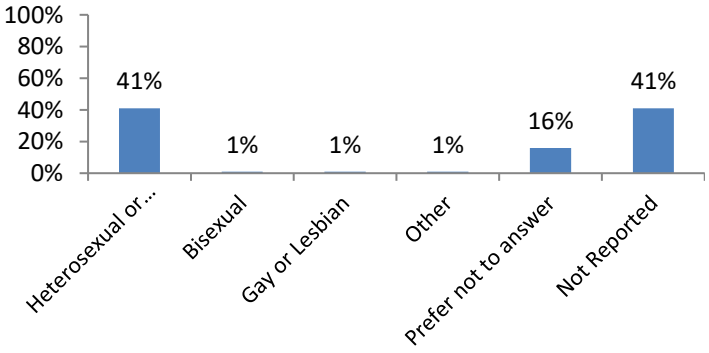
878
Unique Individuals attending Family Wellbeing

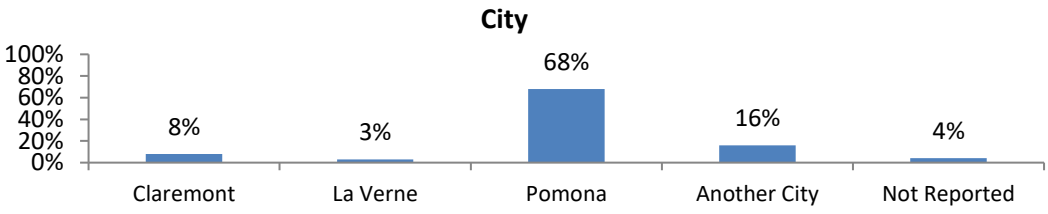


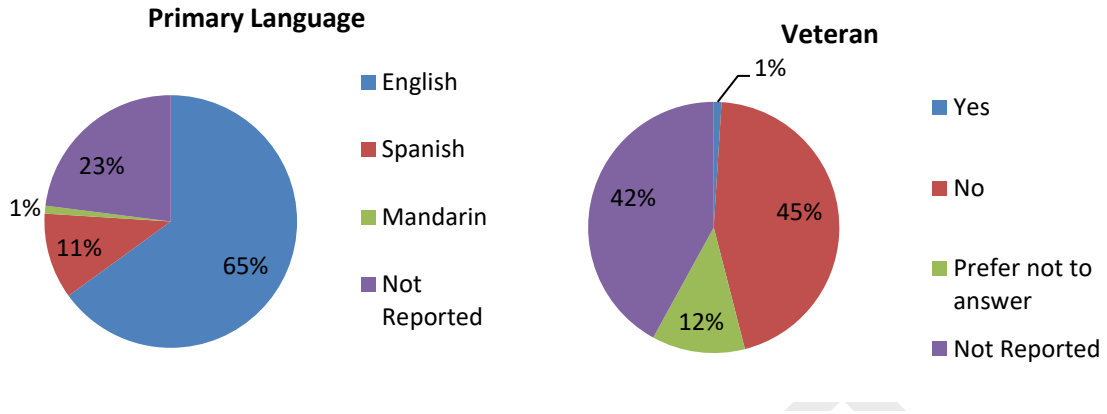


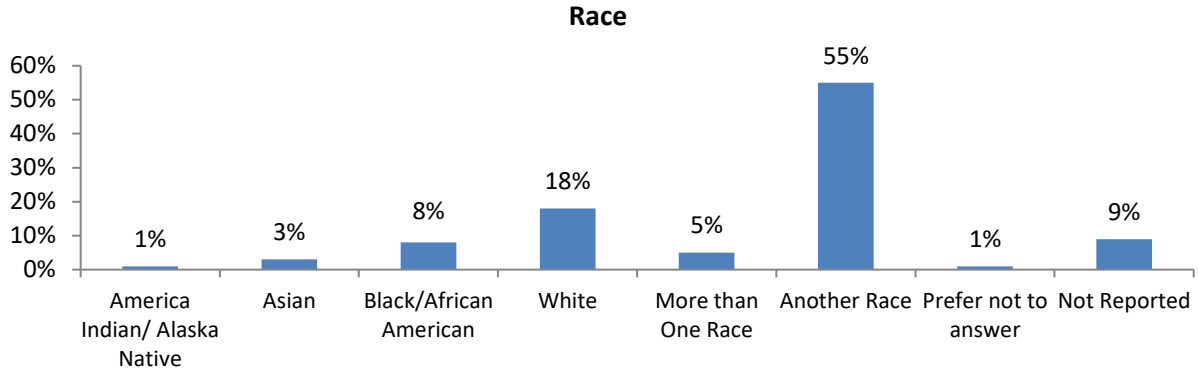
The number of unique individuals **increased** from **522** in FY 2022-23 to **878** in FY 2023-24.

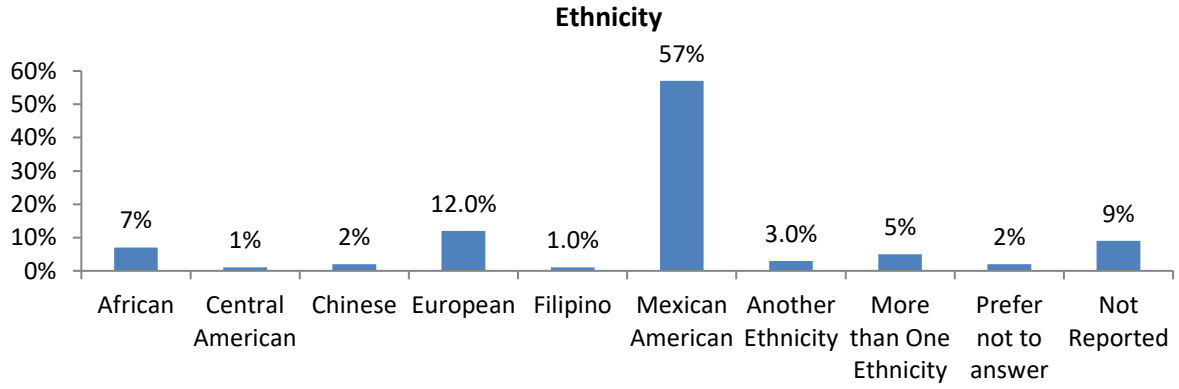


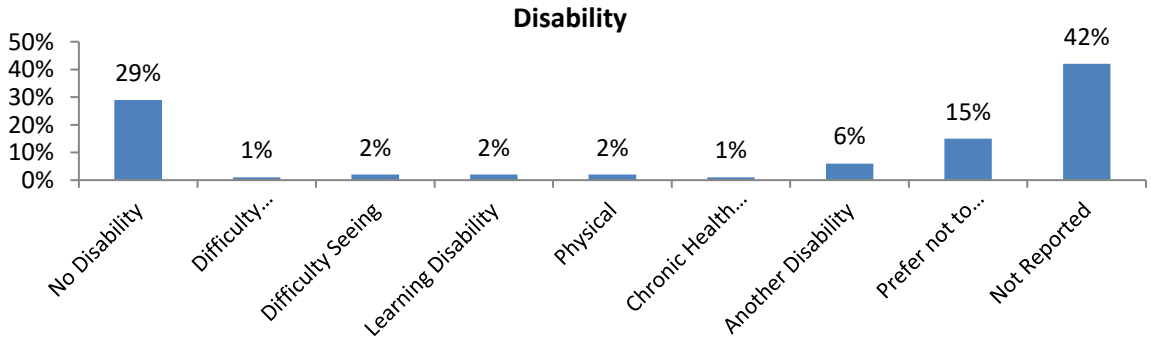





Primary Language
English
Spanish
Mandarin
Not Reported
65%
11%
1%
23%
Veteran
Yes
No
Prefer not to answer
Not Reported
45%
12%
42%
1%

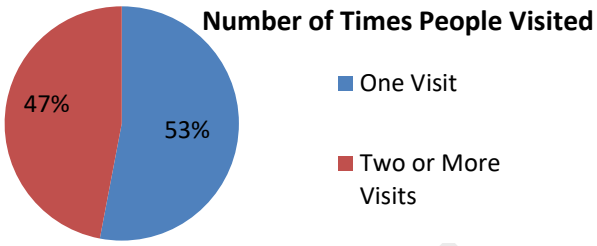

Race
60%
50%
40%
30%
20%
10%
0%
1%
3%
8%
18%
5%
55%
1%
9%
America Indian/ Alaska Native
Asian
Black/African American
White
More than One Race
Another Race
Prefer not to answer
Not Reported


Ethnicity
60%
50%
40%
30%
20%
10%
0%
7%
1%
2%
12.0%
1.0%
57%
3.0%
5%
2%
9%
African
Central American
Chinese
European
Filipino
Mexican American
Another Ethnicity
More than One Ethnicity
Prefer not to answer
Not Reported


Disability
50%
40%
30%
20%
10%
0%
29%
1%
2%
2%
2%
1%
6%
15%
42%
No Disability
Difficulty...
Difficulty Seeing
Learning Disability
Physical
Chronic Health...
Another Disability
Prefer not to...
Not Reported

How Well Did We Do It?

5,129
Number of Family Wellbeing Events
(Duplicated Individuals)

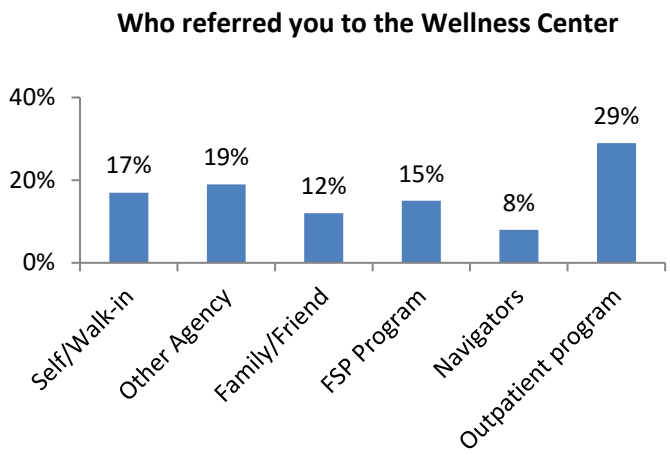


The number of family wellbeing activities **increased** from **9** in FY 2022-23 to **14** in FY 2023-24.

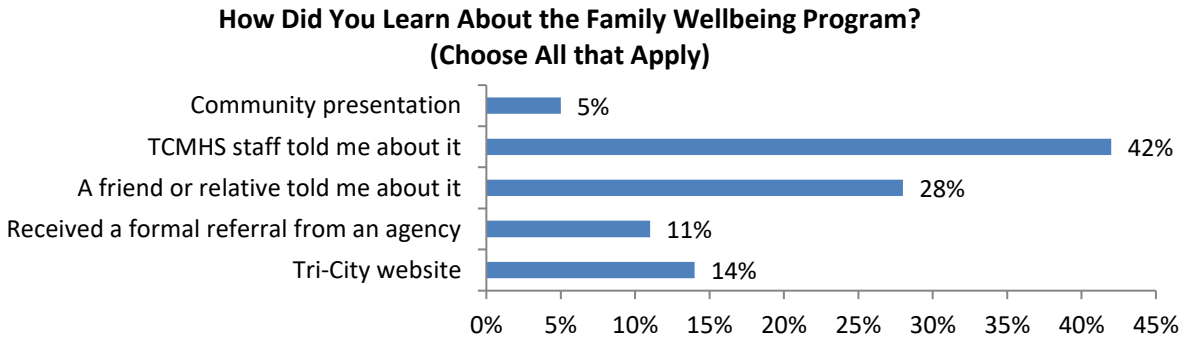
Family Wellbeing Activities	Number of Times Activity Was Held	Average Number of Attendees at an Activity
Arts & Crafts	39	4
Cooking Class	22	4
Grief and Loss	46	4
Kid's Hour	46	3
Limited to Limitless	46	3
Baby & Me	8	3
Movie Night	19	8
Music	36	4
Spirituality	51	5
Summer Camp	26	8
Teen Hour	48	4
United Family	79	7
Walking Adventures	40	2
Writing to Heal	17	3

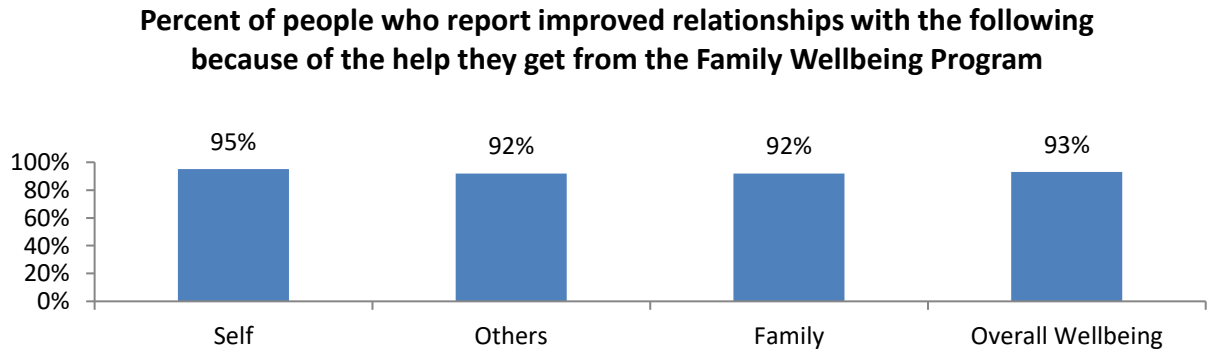
Contacts/Events by Type	Number of Individuals Attending Contacts/Events
Attendance Letter	153
One-on-One	55
MHSA PEI Referrals	163
Other	289
Phone Call/Email	2,051
FWB Meeting/Event	32

97%
Satisfied with the "help I get at Family Wellbeing Program"



Is Anyone Better Off?

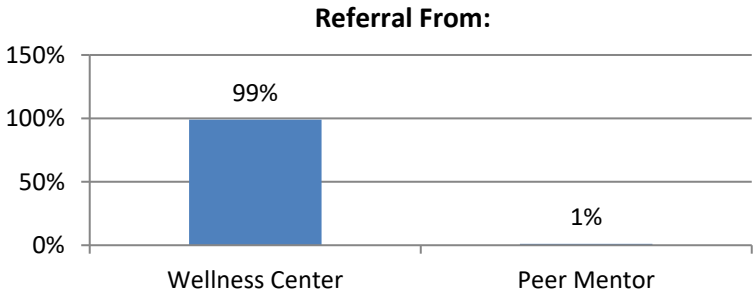




Number of Potential Responders	878
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Parents and children
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

Timely Access to Services for Underserved Populations Strategy

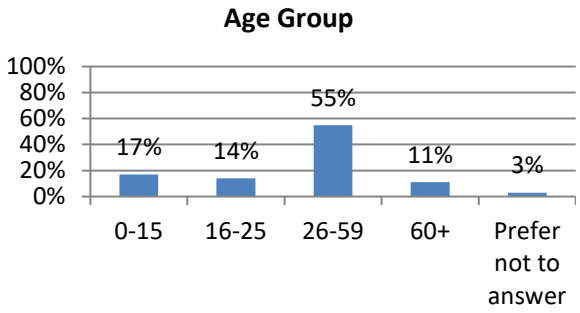
71
MHSA Referrals coming into Family Wellbeing

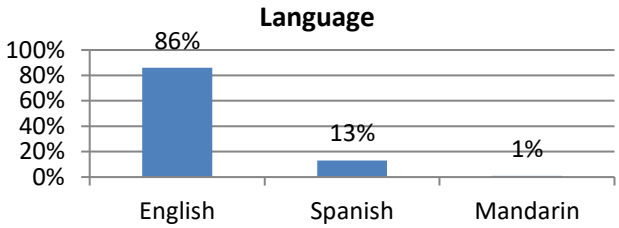


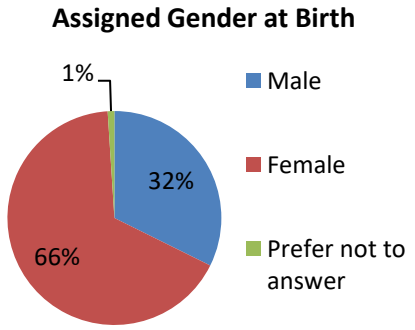
71 out of 71 Referrals Participated in Family Wellbeing Program

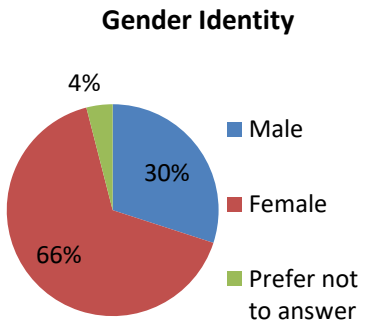
2 Days
Average Time between Referral and Participation in Family Wellbeing Program

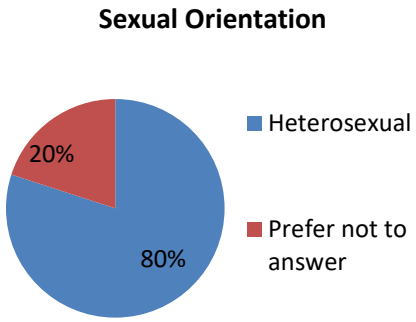
PEI Demographics Based on Referrals

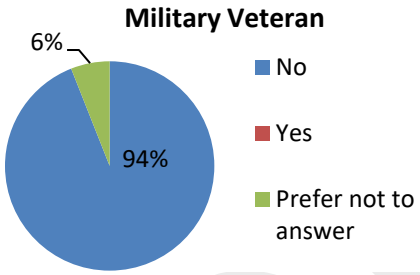


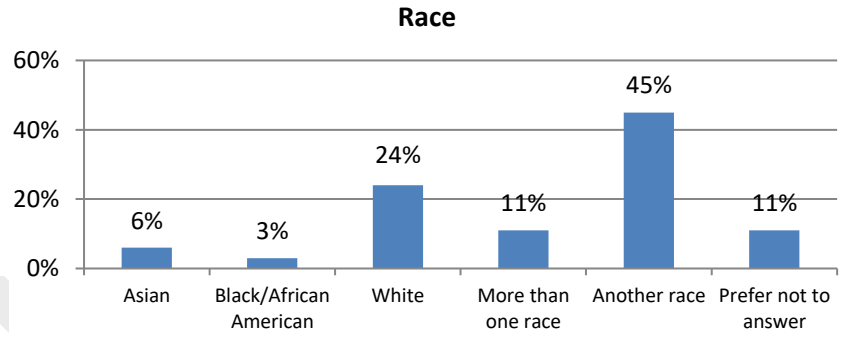


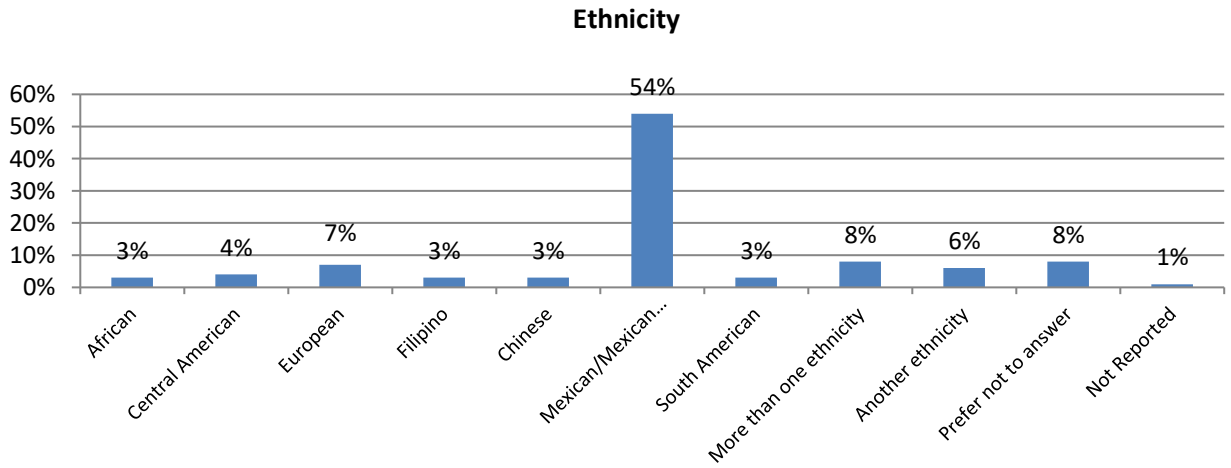


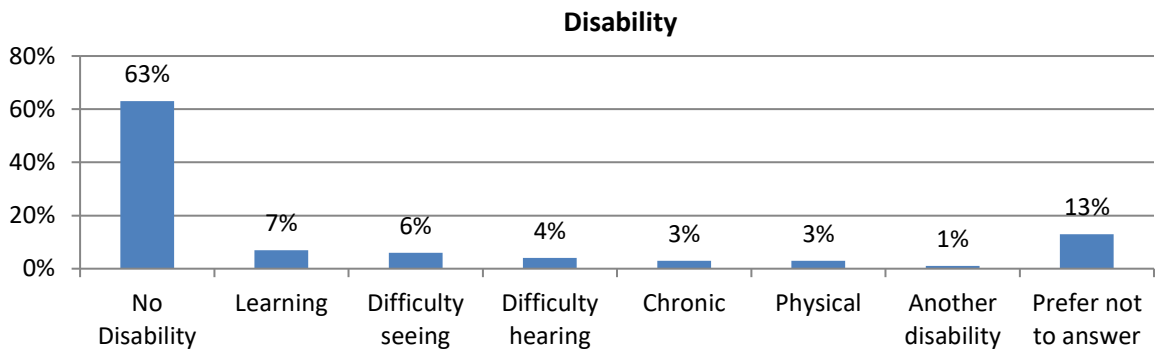











Disability
80%
60%
40%
20%
0%
63%
7%
6%
4%
3%
3%
1%
13%
No Disability
Learning
Difficulty seeing
Difficulty hearing
Chronic
Physical
Another disability
Prefer not to answer

NAMI Community Capacity Building Program

Ending the Silence and NAMI 101 (Prevention)

Program Description

Ending the Silence and NAMI 101 are community presentations offered through the National Alliance on Mental Illness (NAMI) and provide an overview of emotional disorders and mental health conditions commonly experienced among children, adolescents and youth.

Ending the Silence is a 50-minute presentation designed to teach students, school staff and families to recognize the warning signs of mental health issues and what steps to take when they observe these symptoms in their students, friends or loved ones.

The second presentation, NAMI 101, is designed to strengthen program participants' knowledge while providing a more solid development of skills through structured content. The topics to be covered in NAMI 101 include: an overview of what mental illness is, how to maintain wellness, how to identify symptom triggers, how to identify a support system, mental health warning signs, empathy, boundary setting, and self-care.

Target Population

Both programs target middle and high school students; teachers and school staff; and adults with middle or high school youth.

Number of Presentations	4	**Total Number Served FY 2021-22**	176

Program Update

Throughout FY 2023-24, NAMI continued to solidify existing school partnerships as well as build new ones. This work has allowed the program to execute more presentations within the public school system, which is aiding in the goal of reestablishing the frequency of programming that was experienced pre-Covid. Regarding classes and support groups, the program trained several additional facilitators (in English and Spanish), which expands capacity to add more support groups and classes to the calendar and accommodate more community members.

Challenges and Solutions

Toward the beginning of the 2023-24 fiscal year, capacity was a concern. The program lacked enough staff to return to the engagement levels of previous years. Overall, visibility has been a challenge as many community members or organizations report not knowing who NAMI is or what the program does.

Part of the solution is to continue building relationships. The program is very community facing, the board is active and engaged in outreach, and staff are dedicated to building strong partnerships with community organizations and entities to enhance the range of collaboration opportunities. NAMI participates in events, attends campus drop-ins, and works on identifying additional ways to be more visible to the youth.

Diversity, Equity and Inclusion

NAMI 101 and the Ending the Silence are available in both English and Spanish and are facilitated by a diverse set of trainers who incorporate concepts such as how cultural difference can contribute to mental health conditions and/or how signs and symptoms may not be addressed or acknowledged. Additionally, some trainers identify as having lived experience. NAMI partners with several external entities that support older adults and veterans and is equipped to provide referrals and resources to these entities when needed. Presentations allow space to converse about the specific challenges/stigma/barriers that the LGBTQ+ communities encounter. NAMI also had presenters who identify with this community in the queue to be trained for presentations and this will allow ways to expand on these conversations.

Success Story

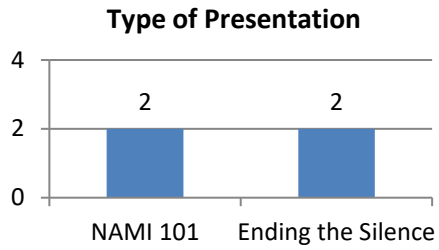
The program received feedback from a community member reporting the benefits they experienced related to being involved in NAMI classes. The individual reported feeling grateful for the program, stating that the classes had been extremely helpful in their journey. They also reported that the topics discussed had never been presented to them in the way they were in the 8-week course, allowing them to form new perspectives and ideas regarding mental health. They also expressed appreciation for the transparency of the group leadership and the opportunity to hear stories from individuals with lived experience.

Program Summary

How Much Did We Do?

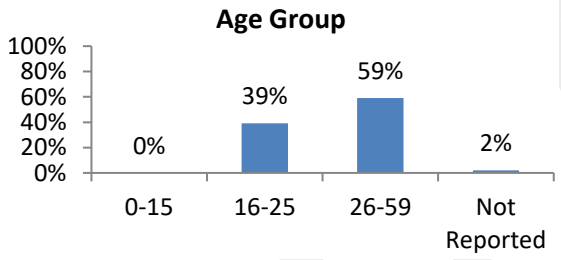
4
Presentations

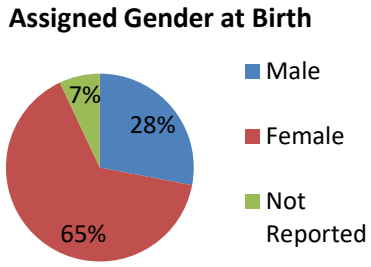
176
Attendees

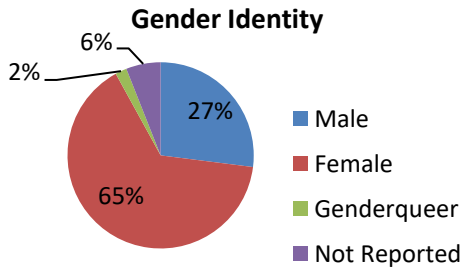


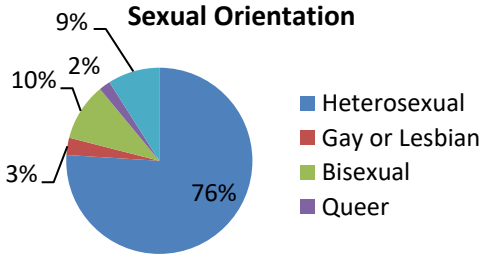
The number of presentations **increased,** and attendees **decreased** from **3 and 359** in FY 2022-23 to **4 and 176** in FY 2023-24.

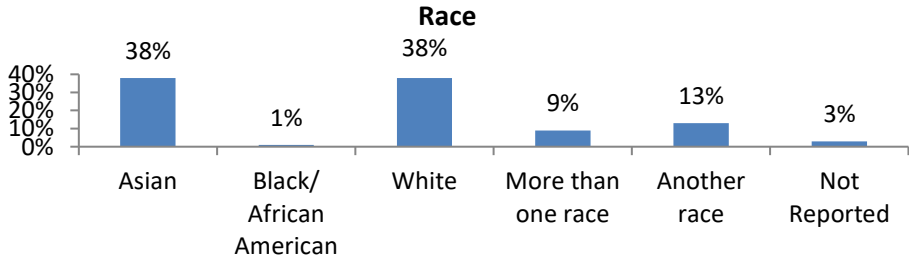
Demographics from Surveys Completed by Participants (n=176)

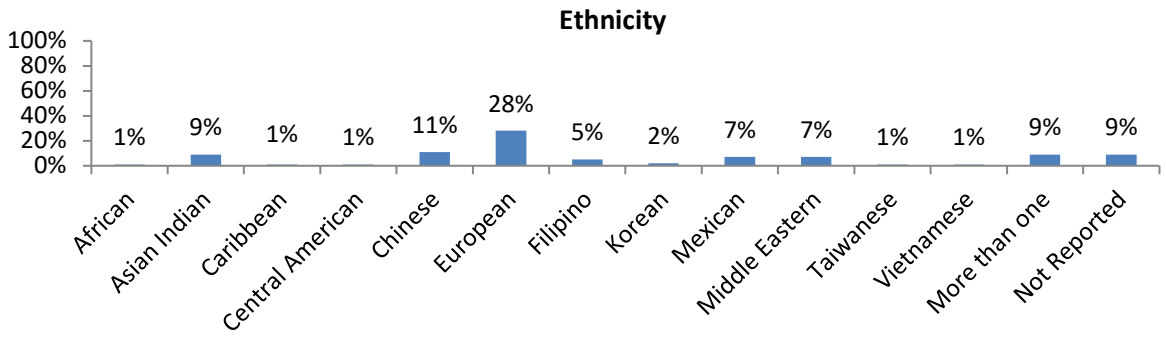


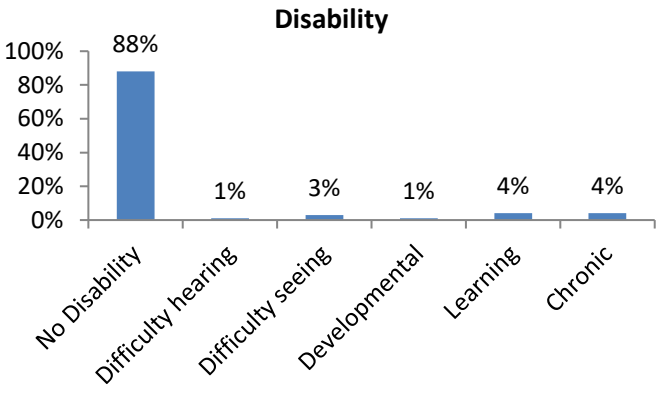


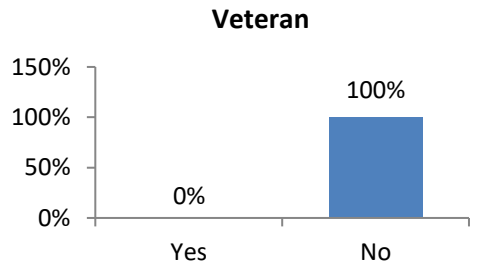


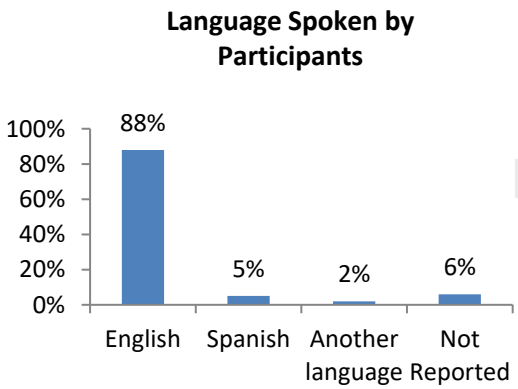


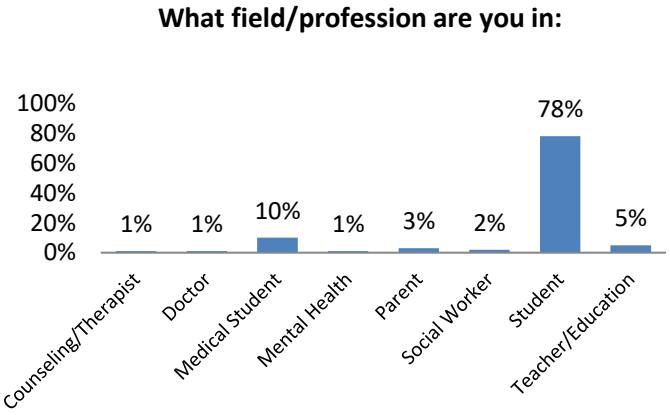


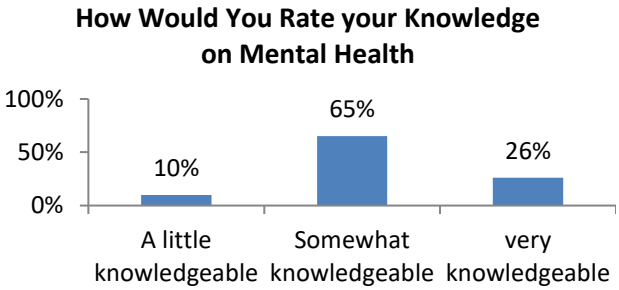

Ethnicity
100%
80%
60%
40%
20%
0%
1%
9%
1%
1%
11%
28%
5%
2%
7%
7%
1%
1%
9%
9%
African
Asian Indian
Caribbean
Central American
Chinese
European
Filipino
Korean
Mexican
Middle Eastern
Taiwanese
Vietnamese
More than one
Not Reported

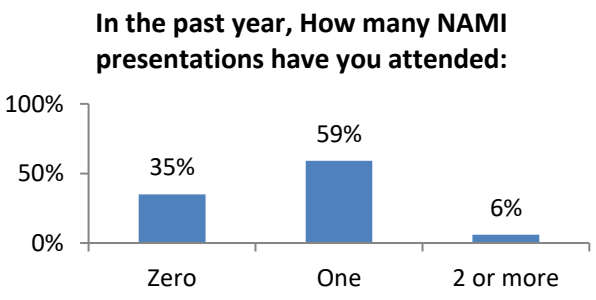

Disability
100%
80%
60%
40%
20%
0%
88%
1%
3%
1%
4%
4%
No Disability
Difficulty hearing
Difficulty seeing
Developmental
Learning
Chronic


Veteran
150%
100%
50%
0%
0%
100%
Yes
No


Language Spoken by Participants
100%
80%
60%
40%
20%
0%
88%
5%
2%
6%
English
Spanish
Another language
Not Reported


What field/profession are you in:
100%
80%
60%
40%
20%
0%
1%
1%
10%
1%
3%
2%
78%
5%
Counseling/Therapist
Doctor
Medical Student
Mental Health
Parent
Social Worker
Student
Teacher/Education


How Would You Rate your Knowledge on Mental Health
100%
50%
0%
10%
65%
26%
A little knowledgeable
Somewhat knowledgeable
very knowledgeable


In the past year, How many NAMI presentations have you attended:
100%
50%
0%
35%
59%
6%
Zero
One
2 or more

How Well Did We Do It?

NAMI 101

97%
Agreed or strongly agreed that the presentation increased their understanding of symptoms associated with mental health challenges.

92%
Agreed or strongly agreed that the presentation will help me recognize early warning signs of mental health challenges.

Ending the Silence

86%
Agreed or strongly agreed that the presentation increased their understanding of symptoms associated with student mental health.

93%
Agreed or strongly agreed that the presentation will help me recognize early warning signs of student mental health.

Is Anyone Better Off?

NAMI 101

94%
Agreed or strongly agreed that the presentation provided me with new and useful resources.

98%
Agreed or strongly agreed that the presentation helped me understand the impact of untreated mental health challenges.

Ending the Silence

94%
Agreed or strongly agreed that the presentation provided me with new and useful resources I can use on a regular basis.

96%
Agreed or strongly agreed that the presentation helped me understand the impact of unaddressed mental health issues.

Number of Potential Responders	165
Setting in Which Responders were Engaged	Schools
Type of Responders Engaged	Parents and teachers
Underserved Populations	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

Timely Access to Services for Underserved Populations Strategy

There were 0 MHSA referrals to NAMI PEI.

Housing Stability Program (Prevention)

Program Description

Stable housing is a necessary foundation to be able to create wellbeing and support a person's mental health and overall wellness. Tri-City Housing Division (HD) work diligently with clients, mental health service providers, landlords, and property managers to secure housing placements, mediate conflicts, and strengthen relationships. The Housing Stability Program (HSP) is a prevention program designed to help people with mental illness maintain their current housing or find more appropriate housing.

Target Population

Landlords, property owners and property managers in the Tri-City area who could have tenants experiencing mental illness who need support to maintain their current housing or to find a more appropriate place of residence. Program staff members work with clients, mental health service providers, landlords, and property managers to secure housing placements, mediate conflicts, and strengthen relationships.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	0	0	9	3	49	**61**
Projected Number to be Served FY 2024-25	0	0	12	4	63	**78**
Cost Per Person	$2,710**	$2,710**	$2,710**	$2,710**	$2,710**	**$2,710****

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

Program Update

The HSP had a vacancy in the Housing Outreach Specialist position that runs the Housing Stability programming. However, towards the beginning of the fiscal year, the program was able to fill the position. Over the course of the year, the Housing Outreach Specialist reestablished groups and workshops to help support the community. In January, the Landlord Hour returned, and the Good Tenant Curriculum resumed. The program continues to look for more spaces to host these group in the community to expand the reach.

The Landlord Hour had a name change in April and is now called the Housing Provider Hour. The term "housing provider" is seen as more inclusive and comprehensive of what the role is. The Housing Provider Hour had more consistent attendance, and the Specialist has built rapport with the providers that attend. In the fiscal year to come, the program intends to create a yearly calendar for Housing Provider Hour in order to identify the topics and presenters in advance, as opposed to waiting month by month. This will help our targeted audience plan better for the meeting and increase attendance.

HSP also would like to develop a spreadsheet as a database of housing providers, along with requirements that each property looks for (income req., pet policy). This will assist the program with a better understanding of the housing climate and support housing staff with providing resources.

Challenges and Solutions

The primary challenge for HSP was lack of engagement in Good Tenant Curriculum from community members. To increase attendance, the groups were moved to properties and hosted in community rooms as opposed to being held only at the Wellness Center. The program also increased outreach by going into the field to meet with new housing providers and attended community events such as Pomona Wellness Center's Housing event and Claremont Housing meetings. There was also an effort made to visit local colleges (Claremont Colleges and Western) and their student housing departments.

Diversity, Equity and Inclusion

The Housing Stability Program offers fair housing to all clients and their families regardless of status. In addition, the Housing Division staff are trained in cultural competency, stigma reduction, and aware of fair housing law. Staff are bilingual in English and Spanish and groups provide education on protected rights. The language line is available as well if assistance is needed in a different language. Communication is maintained by distributing flyers in multiple languages throughout the sites.

Staff are aware of resources pertaining to specialized populations, referral processes and accommodations. Older adults who may not feel comfortable with technology are able to have their services in-home. The program also conducts in-person outreach to senior living and veteran apartments.

Monthly meetings, Mental Health First Aid training and stigma reduction training are offered to landlords, owners, and property managers to help them better understand and support individuals with mental illness.

Community Partners

In addition to referrals made within Tri-City's own departments, the Housing Division staff work collaboratively with outside community partners including landlords in the community, Volunteers of America, Catholic Charities, Family Solutions, Union Station, Pomona Housing Authority, sober living facilities, Los Angeles County Development Authority, Housing Rights Center, Neighborhood Legal Services, House of Ruth, Pomona Youth Prevention Council and Just Us 4 Youth. These entities, among others, work in collaboration with HSP to provide/receive referrals, educate/empower tenants,

support landlords and property managers in appropriately recognizing and responding to individuals with symptoms of mental illness, and provide additional resources inside and outside of Tri-City.

Success Story

A notable success for the program this fiscal year was the increased attendance for Housing Provider Hour. Having the opportunity to engage local housing providers creates community, cohesion, provides education, and stigma reduction. These efforts can contribute to tenants maintaining the housing they have established.

Program Summary

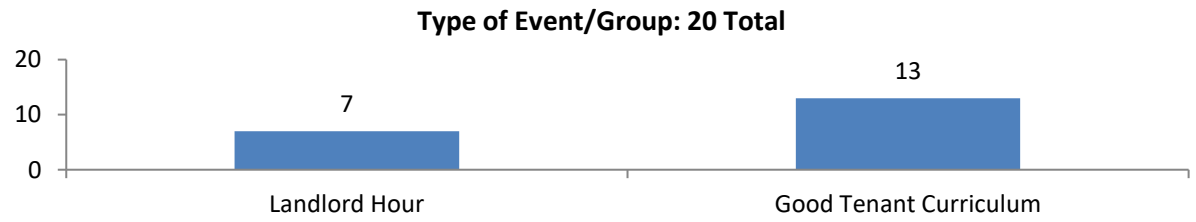
How Much Did We Do?

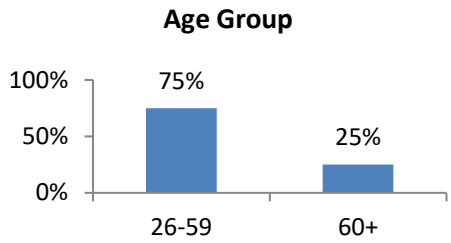
20	11	7	65	22
New Landlord Contacts	Landlord Follow Ups	Landlord Hour Events Held	Total Attendees	Unique Attendees

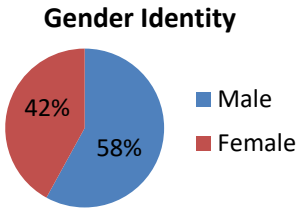
The number of new landlord contacts and follow-ups **increased** from **13 and 2** in FY 2022-23 to **20 and 11** in FY 23-24.

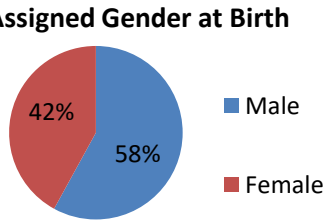
The number of landlord hour events **increased** from **3** in FY 2022-23 to **7** in FY 2023-24.

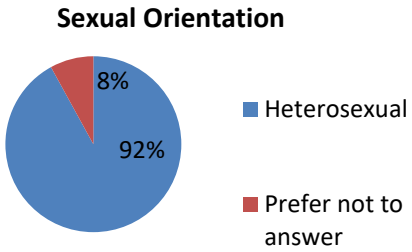
13	19
Housing Groups Held	Total Attendees

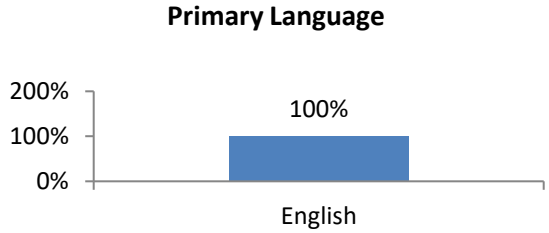


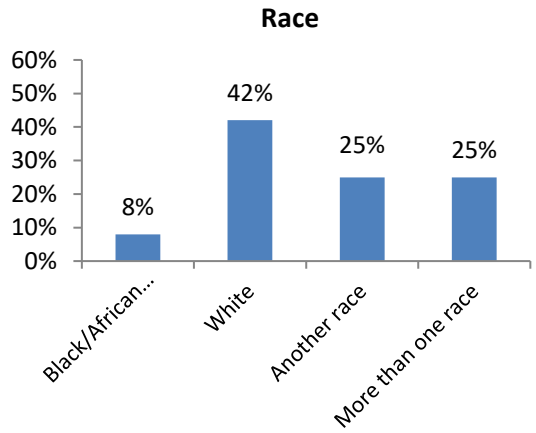

Age Group
100%
50%
0%
75%
25%
26-59
60+

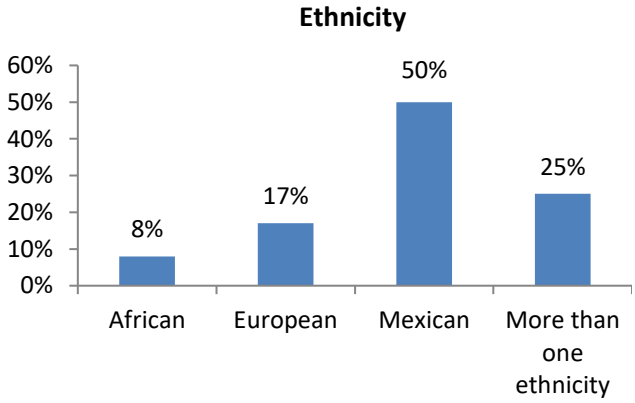

Gender Identity
42%
58%
Male
Female

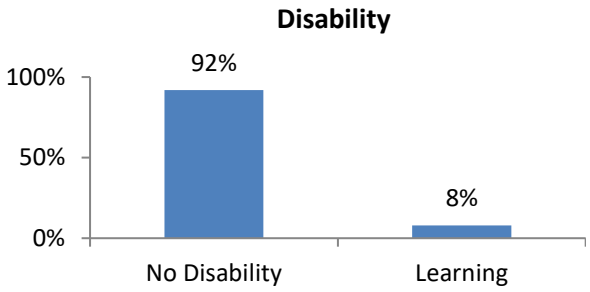

Assigned Gender at Birth
42%
58%
Male
Female

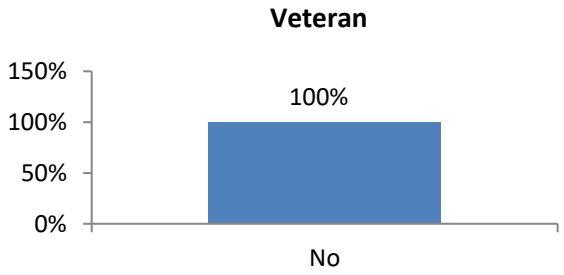

Sexual Orientation
8%
92%
Heterosexual
Prefer not to answer


Primary Language
200%
100%
0%
100%
English


Race
60%
50%
40%
30%
20%
10%
0%
8%
42%
25%
25%
Black/African...
White
Another race
More than one race

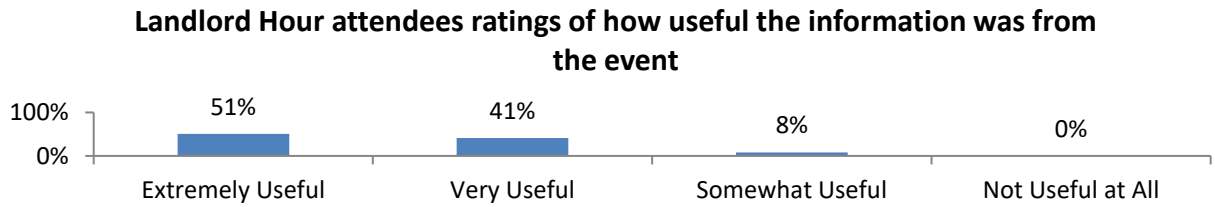

Ethnicity
60%
50%
40%
30%
20%
10%
0%
8%
17%
50%
25%
African
European
Mexican
More than one ethnicity

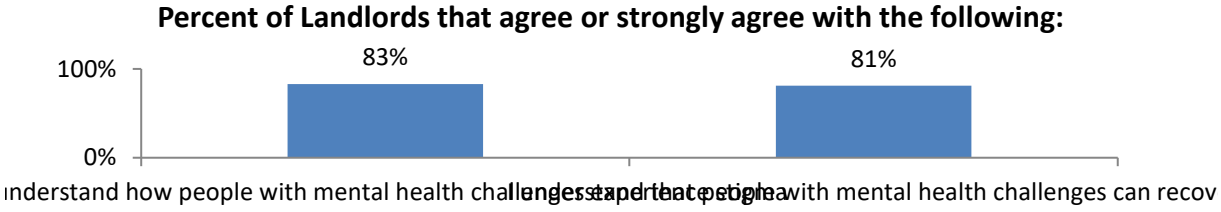

Disability
100%
50%
0%
92%
8%
No Disability
Learning

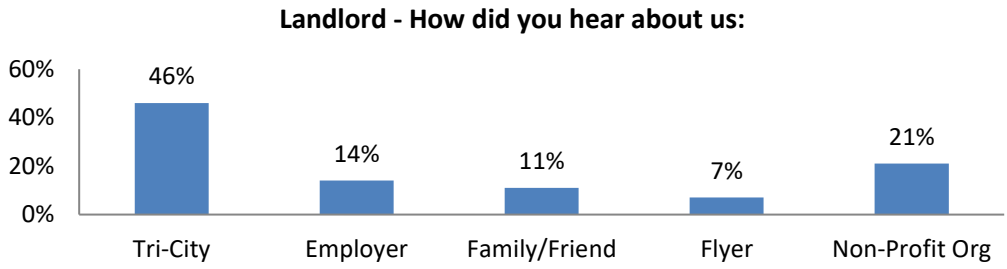

Veteran
150%
100%
50%
0%
100%
No

How Well Did We Do It?

Landlord Hour

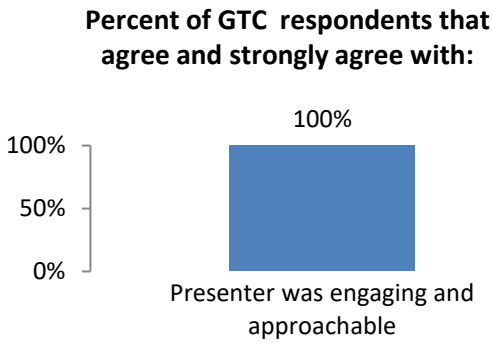


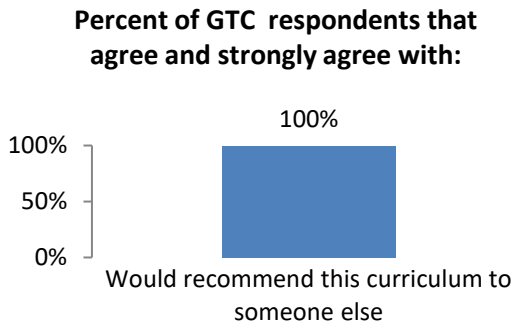




The percent of landlords hearing about the program via Tri-City **increased** from **0%** in FY 2022-23 to **46%** in FY 2023-24.

Good Tenant Curriculum (GTC)

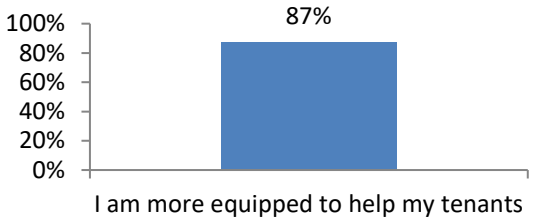




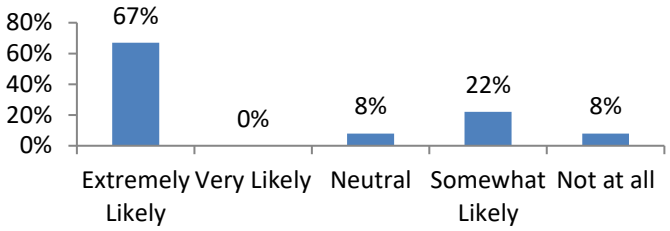
Is Anyone Better Off?

Landlord Hour

Percent of participants, as a result of this training:

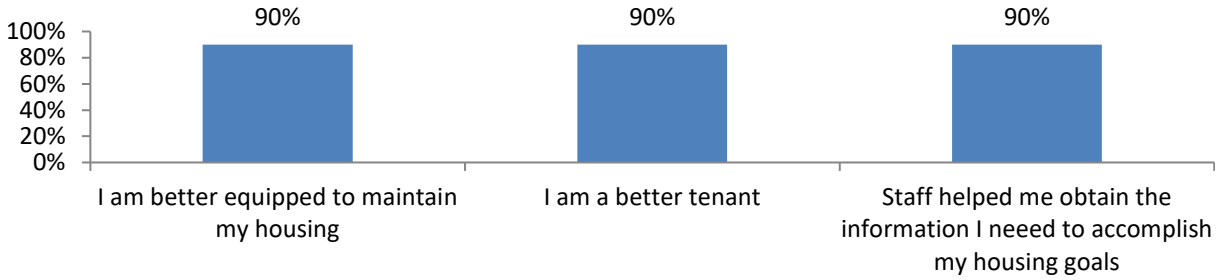


If you suspect someone has a mental health challenge, how likely are you to reach out



Good Tenant Curriculum (GTC)

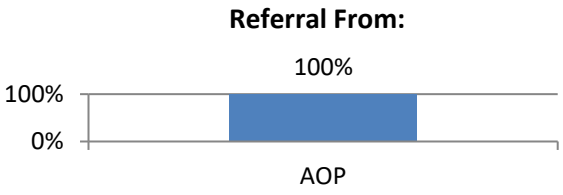
Percent of Good Tenant Curriculum respondents that agree or strongly agree with the following:



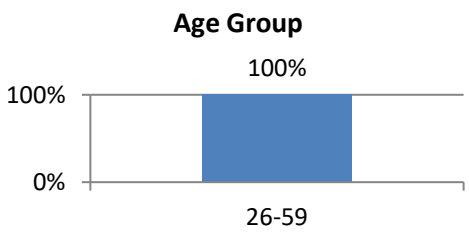
Number of Potential Responders	61
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Landlords and community members
Underserved Populations	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

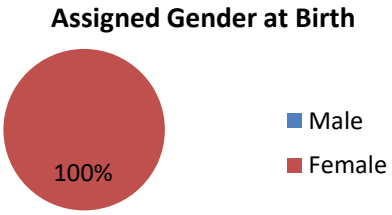
Timely Access to Services for Underserved Populations Strategy

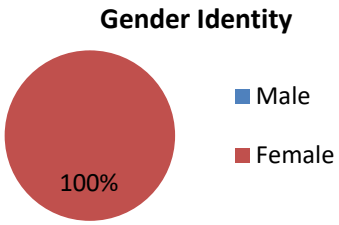
1
MHSA referral into Housing Stability

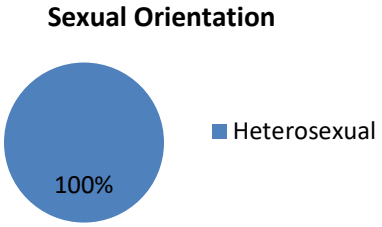


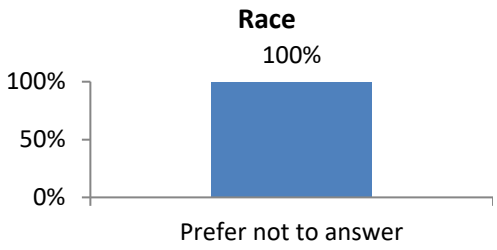
PEI Demographics Based on MHSA Referral

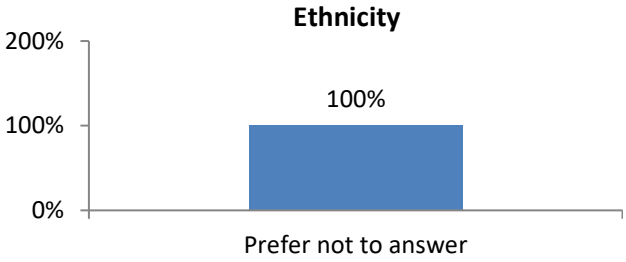


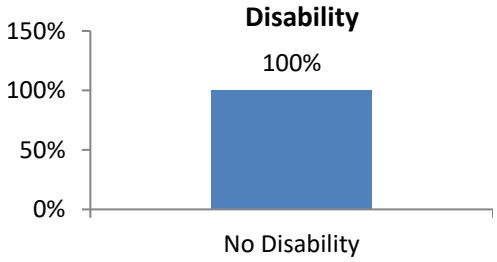


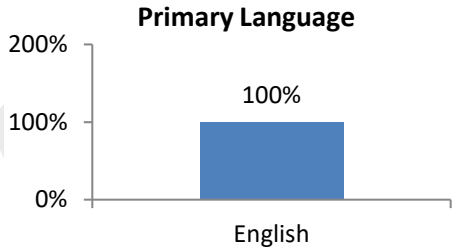

Gender Identity
Male
Female
100%

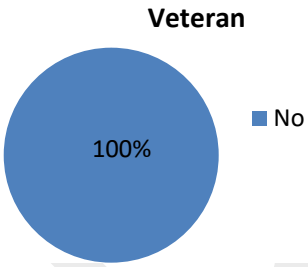

Sexual Orientation
Heterosexual
100%


Race
100%
100%
50%
0%
Prefer not to answer


Ethnicity
200%
100%
0%
100%
Prefer not to answer


Disability
150%
100%
50%
0%
100%
No Disability


Primary Language
200%
100%
0%
100%
English


Veteran
No
100%

Therapeutic Community Gardening

(Early Intervention)

Program Description

Therapeutic Community Gardening (TCG) utilizes therapeutic horticulture, a process of incorporating the relationship between individuals and nature as a form of therapy and rehabilitation with the goal of decreasing isolation and increasing mental health benefits through gardening activities and group therapy exercises. The Garden offers the perfect setting for promoting mindfulness, healing, resiliency, support, and growth for participants. Attendees learn to plant, maintain, and harvest organic fruits, vegetables, flowers, and other crops for therapeutic purposes and symptom management. TCG staff includes a clinical program manager, clinical supervisor, two clinical therapists, a behavioral health specialist and community garden farmer. Groups are available in both English and Spanish.

Target Population

Community members including unserved and underserved populations, adults, transition age youth, families with children, older adults, and veterans.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2021-22	0	19	58	39	214	**330**
Projected Number to be Served FY 2024-25	0	4	52	22	N/A	**78**
Cost Per Person	N/A	$6,023**	$6,023**	$6,023**	N/A	$6,023**

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

Program Update

The construction of the rejuvenation project in the garden, which began the previous fiscal year, continued throughout FY 2023-24. TCG also filled a position for a second clinical therapist. With the addition of another team member, the program was able to increase output with regards to curriculum, workshops, and with community partner collaborations. The TCG team doubled the

number of workshops and events in this fiscal year compared to the last fiscal year (FY 2022-23: n = 16, FY 2023-24: n = 32). This increase was also reflected in the number of workshop participants more than doubling from year to year (FY 2022-23 n = 132, FY2023-24 n = 288).

There was also a marked increase in TCG group participant satisfaction and longevity in the program this fiscal year. This is reflected in the data that states the average length of time a participant remained in the program increased to 12 months. Likewise, survey results indicate that 100% of participants enjoyed TCG groups as well as felt more confident in the skills they learned in TCG Groups.

Challenges and Solutions

Construction in the Garden impacted the programs' ability to function at full capacity. For example, TCG was unable to have consistent in-person group and was unable to harvest from the fruit trees or vegetable beds. Furthermore, groups remaining virtual has made it difficult to retain TCG participant attention and interest in the program. Many potential new referrals reported wanting to be involved in the TCG program after attending an in-person event. However, upon learning of the virtual nature of the groups, these new referrals reported wanting to wait until the Garden opens to join. Reaching the child and TAY audience in TCG groups continues to be a challenge. The Youth and Family Groups struggle with retaining participants.

When the Garden opens, many of these challenges will be solved or provide an opportunity for TCG to see if there are other barriers beyond garden access. Currently, the program offers occasional in-person groups with activities for participants to enjoy hands on activities preparation for in-person groups. Another potential solution that has been developed by the team is to collaborate with more internal programs to provide TCG programming that will allow clients and community members to engage with the gardening program (examples of this are collaborations with Wellness Center and Co-Occurring Support Team for workshops). Additionally, creating workshops specifically for the younger demographic has assisted the program in addressing low attendance in youth and family groups.

Diversity, Equity and Inclusion

TCG specifically collaborates with agencies that target groups such as TAY, children, families, Veterans, older adults and the LGBTQ+ community. When harvest is available, a food security program exists that provides excess produce to community members and agencies in need. Staff regularly attend cultural competence trainings, and its staff are bilingual in both English and Spanish. A staff member is also the chair of the RAINBOW Wellness Collaborative, allowing for concepts such as diversity and inclusion to be embedded into TCG curriculum for the community. TCG frequently partners with agencies in Pomona, Claremont and La Verne that target underserved and unserved individuals and families. There are also groups developed specifically for the Spanish speaking community, and flyers are translated into Spanish. Lastly, the cultural significance of food is used in curriculum and this concept has always been well received by community members.

Community Partners

The Therapeutic Community Gardening staff network and collaborate with a multitude of community partners and organizations. Examples include annual events with Cal Poly Pomona Veterans Resource Center, outreach with Pomona Unified School District targeting children and TAY, collaborations with Casa Colina Hospital and Centers for Healthcare, schools in the service area, community centers, and several small businesses.

Other examples of organizations in which TCG engages in strong community partnerships are: Sustainable Claremont, Lopez Urban Farm, Bridge the Gap, Traumatic Brain injury- Outreach, DA Center for The Arts, California Horticultural Therapy Network, Pomona Valley Pride and animal therapy agencies. Outcomes of these connections include development of workshops, general outreach, group referrals, seedling donations, and produce donations to community agencies when available.

Success Story

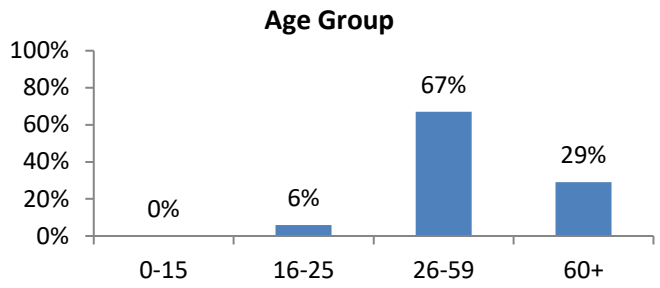
This fiscal year the TCG team provided an in-person group that encouraged participants to socialize face-to-face, as well as prepare them for the eventual transition to in-person groups in the Garden. Participants learned about mindfulness and addressed stress management. Attendees created pressed herb canvas paintings as the hands-on activity. Staff informed participants on the benefits of being in the present moment, while connecting with their senses and learned about how colors can impact our mood. Participants shared their appreciation for the opportunity to interact with each other in-person, create a natural art piece, and gain knowledge about color psychology.

Program Summary

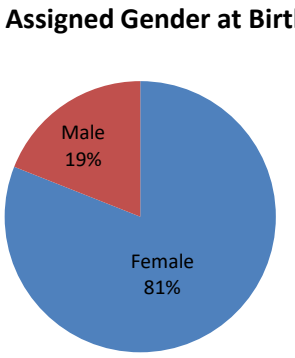
How Much Did We Do?

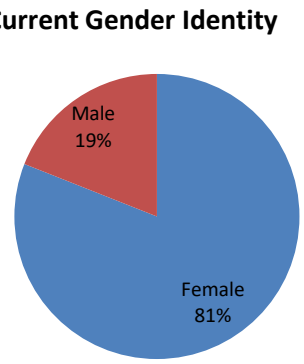
42
Participants Enrolled in TCG Program Groups

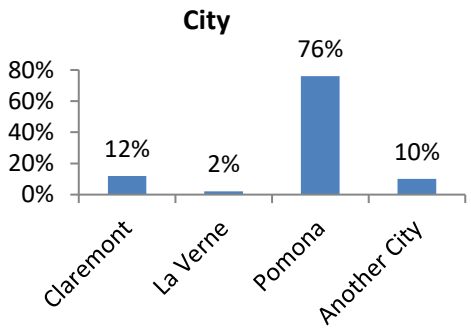
12 Months
Average Length of Time Participants Enrolled in TCG

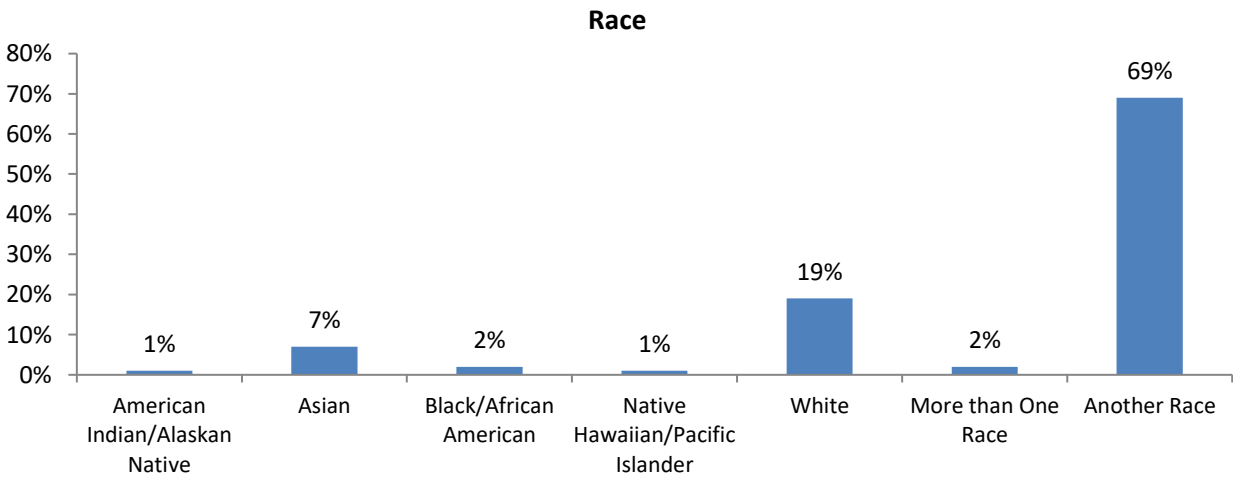


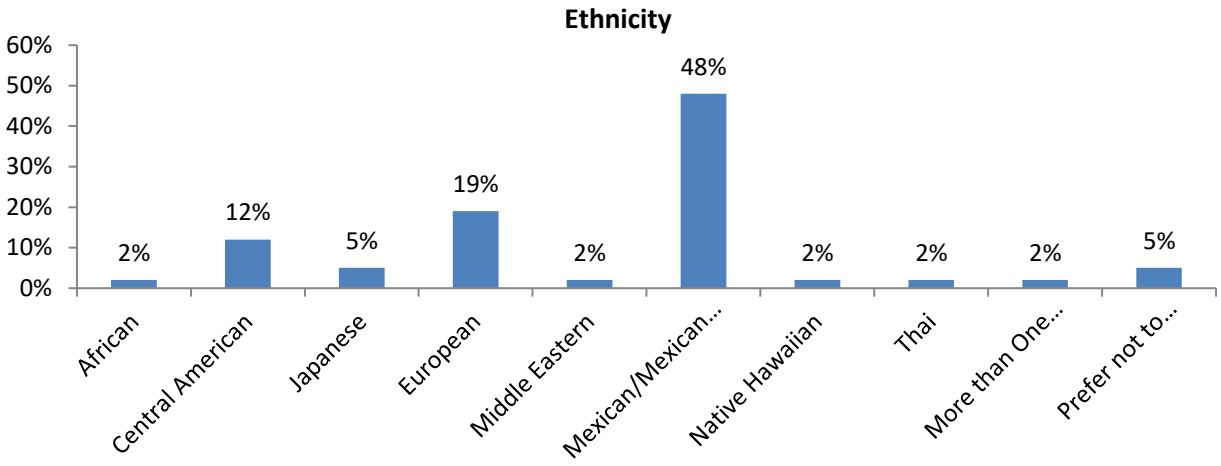
The number of participants enrolled in TCG groups **decreased** from **85** in FY 2022-23 to **42** in FY 2023-24.

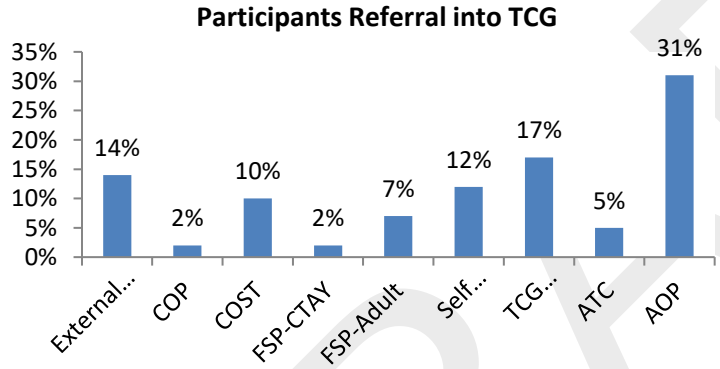


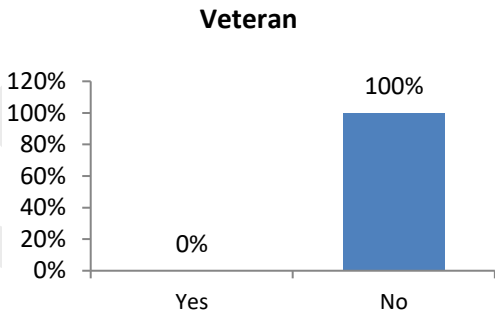


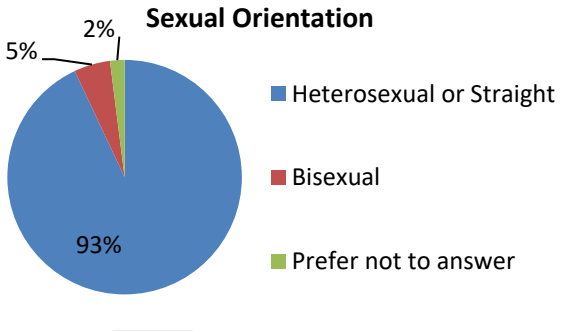


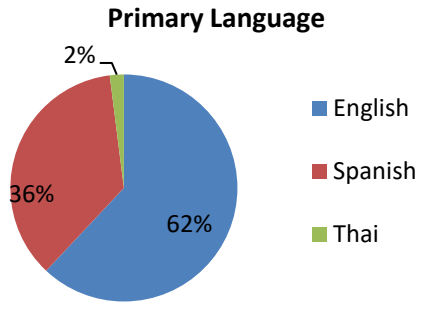


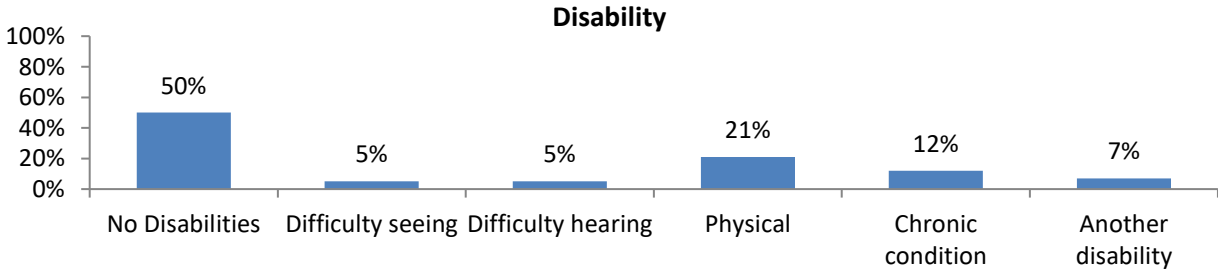

Ethnicity
60%
50%
40%
30%
20%
10%
0%
2%
12%
5%
19%
2%
48%
2%
2%
2%
5%
African
Central American
Japanese
European
Middle Eastern
Mexican/Mexican...
Native Hawaiian
Thai
More than One...
Prefer not to...


Participants Referral into TCG
35%
30%
25%
20%
15%
10%
5%
0%
14%
2%
10%
2%
7%
12%
17%
5%
31%
External...
COP
COST
FSP-CTAY
FSP-Adult
Self...
TCG...
ATC
AOP


Veteran
120%
100%
80%
60%
40%
20%
0%
0%
100%
Yes
No


Sexual Orientation
5%
2%
93%
Heterosexual or Straight
Bisexual
Prefer not to answer


Primary Language
2%
36%
62%
English
Spanish
Thai


Disability
100%
80%
60%
40%
20%
0%
50%
5%
5%
21%
12%
7%
No Disabilities
Difficulty seeing
Difficulty hearing
Physical
Chronic condition
Another disability

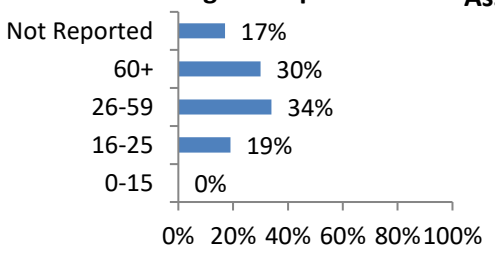
TCG Workshop/Events Survey Demographics (n=89)

32 Workshop/Events

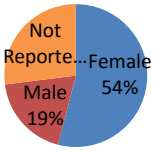
288 Attendees

The number of workshops/events and attendees **increased** from **16 and 132** in FY 2022-23 to **32 and 288** in FY 2023-24.

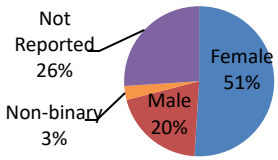
Age Group



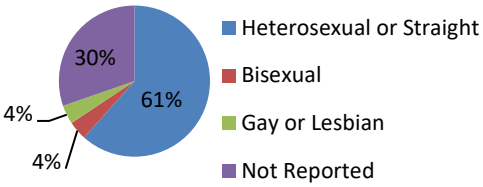
Assigned Gender at Birth



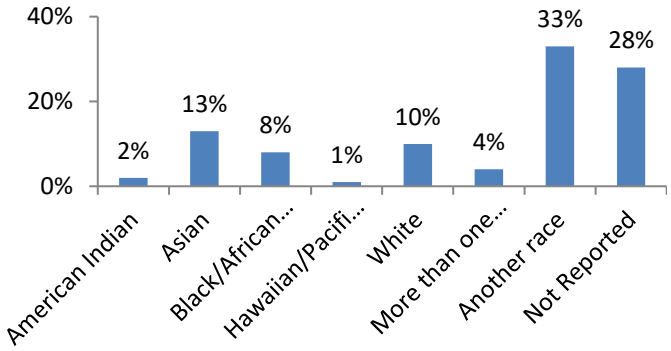
Current Gender Identity



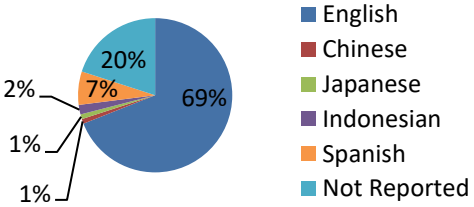
Sexual Orientation



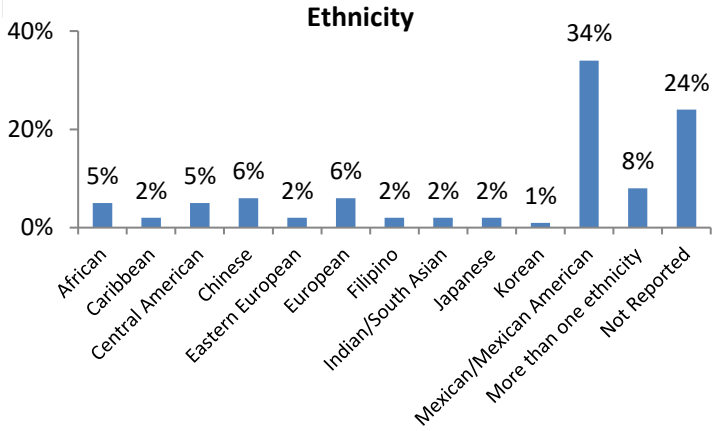
Race



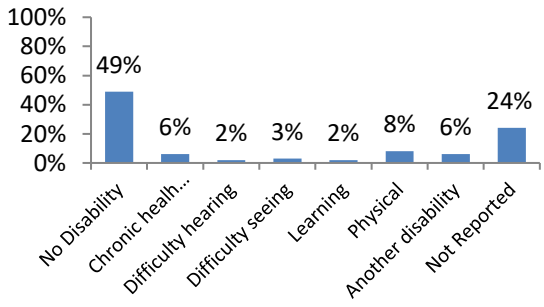
Primary Language



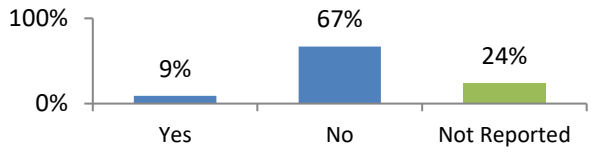
Ethnicity



Disability

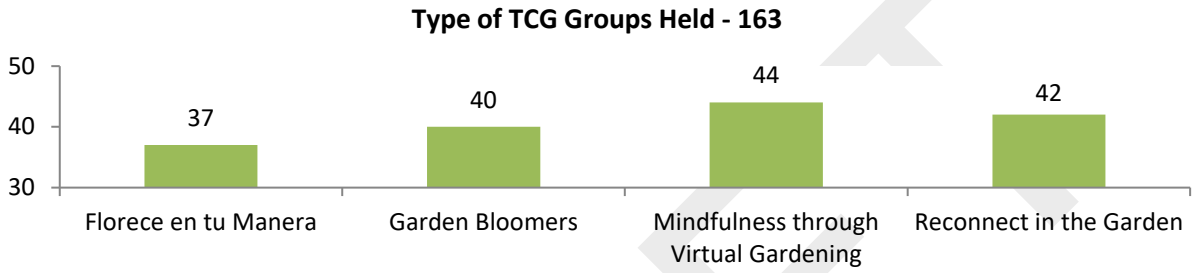


Veteran



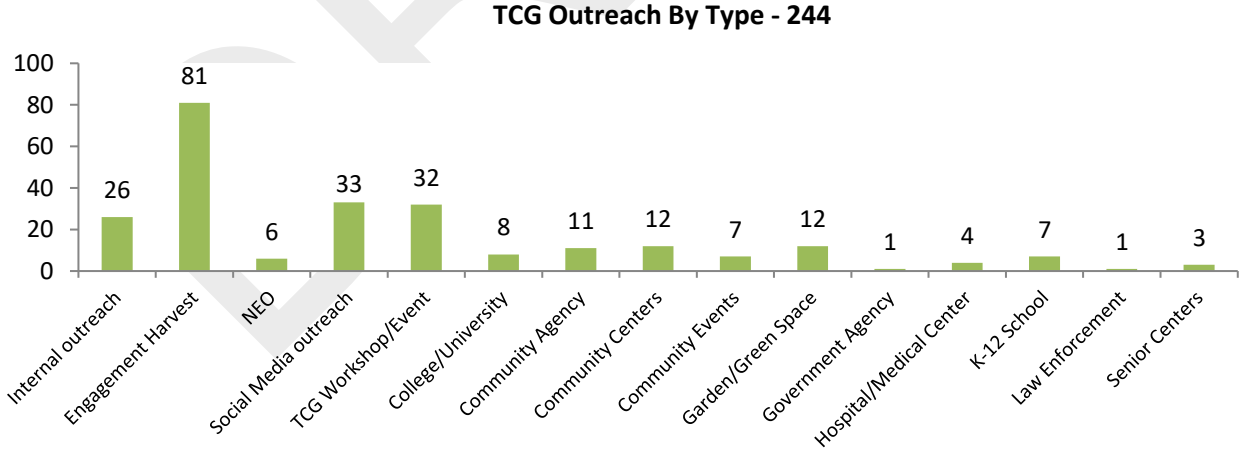
How Well Did We Do It?

163	465
TCG Groups Held	Participants Attending TCG Groups



The number of TCG Groups held **decreased** from **180** in FY 2022-23 to **163** in FY 2023-24.

244	1,867	5,304
Number of TCG Outreach	Number of Individuals Outreached	Number of Individuals Outreached via Social Media



The number of individuals outreached **increased** from **2,557** in FY 2022-23 to **7,171** in FY 2023-24.

Is Anyone Better Off?

TCG Group Survey Responses Based on Completed Surveys (n=17)

100%	94%	88%	100%
TCG participants enjoy participating TCG groups	TCG participants feel more connected to others (peers, family, etc.) because of TCG groups	TCG participants have better communication with others because of TCG	TCG participants feel more confident from the skills learned in TCG

TCG Workshop Survey Responses Based on Completed Surveys (n=89)

93%	85%	91%
TCG participants enjoy participating in TCG workshop or events	TCG participants feel less isolated by attending TCG workshops or events	TCG participants would return to a TCG workshop or event

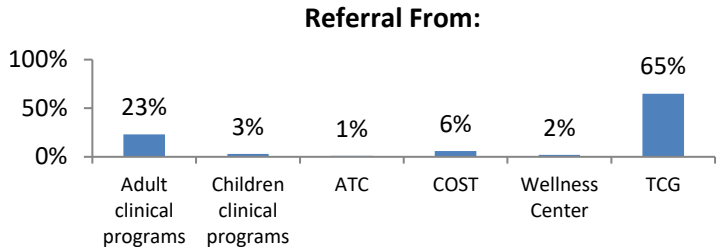
TCG Participant Feedback – How have you benefited from participating in TCG groups?	
It has made me more social through quarantine and everything. I have benefited through it in all aspects of my life.	I have benefited because it has helped me to understand how plant and what soil to use and I now feel more confident in how I am planting.
More knowledgeable about plants and also when provided resources during group has been helpful, keeps me informed.	Getting to know more people. Also having the opportunity to work on more self-awareness and learn mindfulness.
I am a little bit more social in public because of the TCG groups.	I have benefited from TCG when feedback is expressed and there is connection between group participants, and everyone can be themselves.
It has helped me to be more connected with nature evoking calm and relaxation.	I learned a lot about myself.
Building a connection with others. Connection of earth to myself.	I'm inspired to do painting at home. It's therapeutic.
Fun community.	Learning how to propagate properly has been helpful.
My garden is looking good and providing food.	TCG has helped me be myself and open myself up more to who I am. My life is more positive!

TCG Participant – Please share any thoughts, comments you may have about the TCG program, groups, and/or activities:	
I like how the program is led.	Everything is good.
Everything is on point. I always love to learn, and I can share with others.	Everything is nice the way it is, all is good. I really enjoy group.
I enjoy each group meeting.	I am just waiting for the garden to open, although, I do enjoy the virtual groups.
I hope that I am able to participate in person when the garden is open.	I feel that the virtual garden is a great program that opens doors for connection.
I would like the group to be big!	I look forward to going into the real garden soon.
The program is good	TCG program has been above my expectations and group has brought me much joy.
These types of social activities are essential to help PTSD survivors.	I am so impressed in every group and the learning aspect of it.

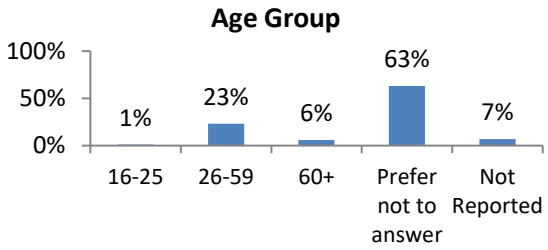
Number of Potential Responders	7,836
Setting in Which Responders were Engaged	Community, schools, health Centers, workplace, and outdoors.
Type of Responders Engaged	TAYs, teachers, LGTBQ, families, religious leaders, and those with lived experience.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

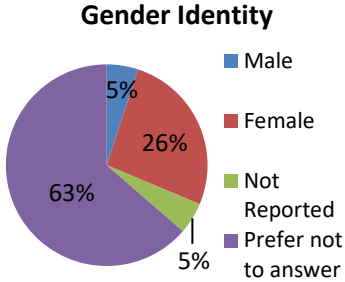
Timely Access to Services for Underserved Populations Strategy

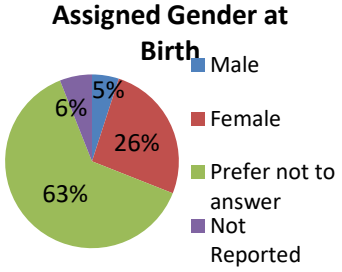
93
MHSA Referrals coming into TCG Program

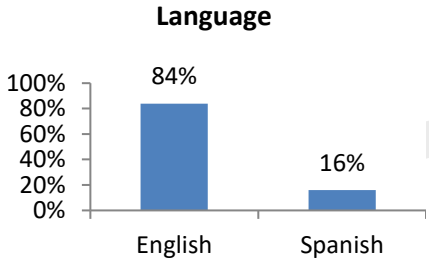


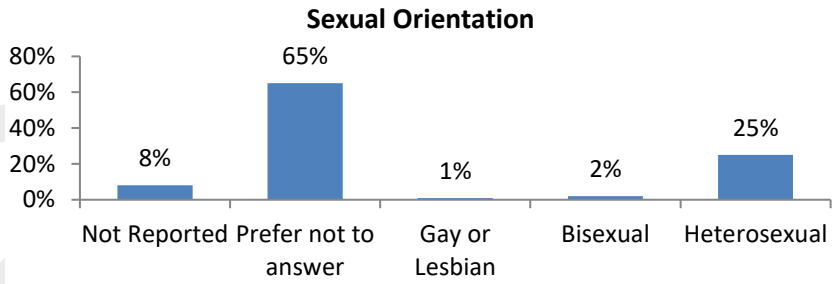
PEI Demographics Based on MHSA Referrals

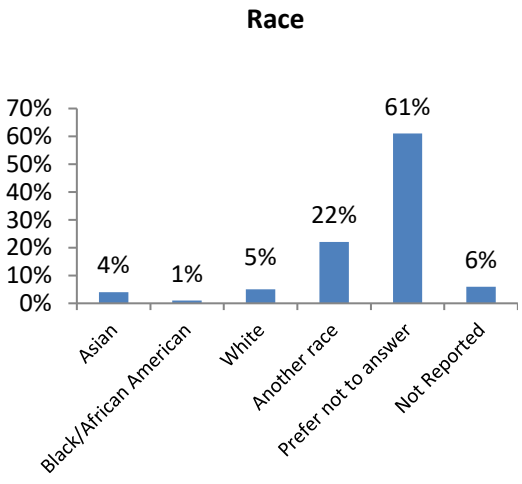


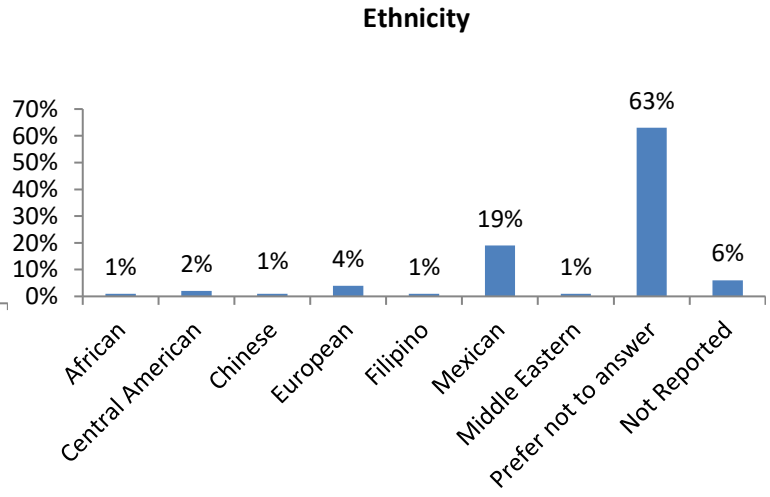


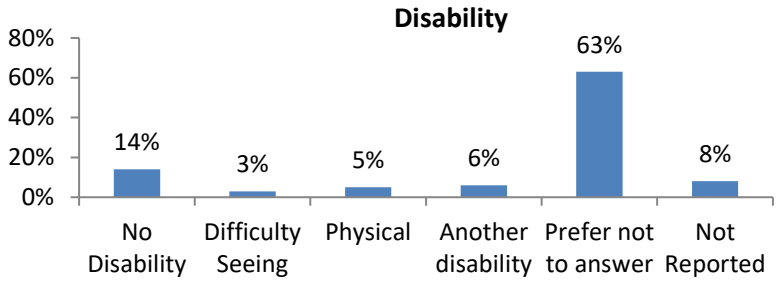


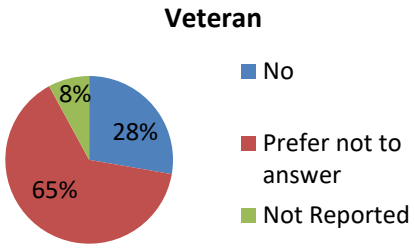









Disability
80%
60%
40%
20%
0%
14%
3%
5%
6%
63%
8%
No Disability
Difficulty Seeing
Physical
Another disability
Prefer not to answer
Not Reported


Veteran
8%
28%
65%
No
Prefer not to answer
Not Reported

Early Psychosis Program

(Prevention & Early Intervention)

Program Description

The Early Psychosis (EP) program is designed for young people who are at risk of developing psychosis or experiencing a first episode psychosis and their families. This coordinated specialty care program is focused on assisting a young person manage their symptoms, prevent deterioration, and equip their family to be the best support for them. Awareness, early detection, and access to services is needed to help young people with psychosis recover. Utilizing the PIER (Prevention, Intervention, Enforcement and Reentry) model, Tri-City staff host workshops and trainings for community members and school personnel focused on recognizing and addressing the earliest symptoms of mental illness. This evidence-based treatment option uses three key components: community outreach, assessment, and treatment to reduce symptoms, improved function and decrease relapse.

Target Population

Transition age youth (TAY) ages 12 to 25 who are experiencing psychosis and are not currently enrolled in mental health services.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	6	18	0	0	0	**24**
Projected Number to be Served FY 2024-25	14	41	N/A	N/A	N/A	**54**
Cost Per Person	$5,126**	$5,126**	N/A	N/A	N/A	**$5,126****

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

Program Update

In FY 2023-24, there was an increase in participants whose family were monolingual Spanish speaking. As a result, the caseload for the Spanish speaking clinician and Spanish speaking group grew this year. The EP team established weekly team meetings where staff (including psychiatrist) took the opportunity to discuss important updates and directions in the cases. Due to this care team approach, staff are feeling supported and informed. Notably, clients a have experienced minimal need for crises intervention requiring hospitalization and several client graduations are pending due to

improvements in symptoms and treatment goals being met. A program change was the expanded criteria to allow for onset of symptoms to be within the past 18 months, rather than 12 months to match best practices.

Lastly, EP joined an early psychosis collaborative with other local counties who have established early psychosis programs. The goal of this collaborative is to share knowledge, resources and problem solve to ensure that program is operating within best practices and standards of care. The focus of the next fiscal year will be to improve outcome measures and data tracking. This includes collecting surveys more regularly to ensure that work done is participant informed. Along with this, there will be an increase in community outreach.

Challenges and Solutions

There has been a challenge growing the adult TAY cohort, as most often the TAY are attempting to work or go back to school. As a result, there have been challenges with accepting or consistently participating the multiple services included in the program. Along with this, there has been a slowdown in incoming referrals in the past fiscal year.

To address this challenge, the team has changed time of services and offered it in different modalities. It appears that virtual has been easier to maintain consistent participation for the adult TAY population, whereas the Spanish speaking child cohort tends to be more responsive to in person groups and workshops.

Diversity, Equity and Inclusion

The Early Psychosis program consists of multicultural staff who provide services in both English and Spanish. Workshops and webinars, including outreach and engagement, are also available in both languages. Additional languages are available via a language line. Materials for trainings are available to be translated upon request. The EP team is representative of staff of various cultural backgrounds, ages and languages which allows for representative for the participants. The program includes a peer support specialist who can share their lived experience with participants, in regards to experiences with disparities in the mental health system.

In addition, barriers to seeking services due to stigma, lack of knowledge, or other barriers experienced by individuals who identify as LGBTQIA+ are addressed. Furthermore, client's electronic health record indicates preferred pronouns and/or name to reduce mis-gendering. Workshops and groups also promote inclusivity by allowing time to identify pronouns and preferred names.

Barriers related to socioeconomic status, transportation or otherwise are also reduced by offering sessions in a variety of ways (virtual, in person, home, school, in office).

Community Partners

Local schools within the service area are the primary community partners for this program (Schools and colleges in Pomona, Claremont, and La Verne). The EP team has a designated peer support

specialist, psychiatrist, and occupational therapist, which makes for effective collaboration inside and outside of treatment. Along with this, in the past fiscal year there has been improved collaboration with the Co-Occurring Support Team (COST). Cost provider has intermittently participated in weekly EP team meetings and regularly participates in care and communication. This has helped to improve treatment outcomes and knowledge for staff.

Success Story

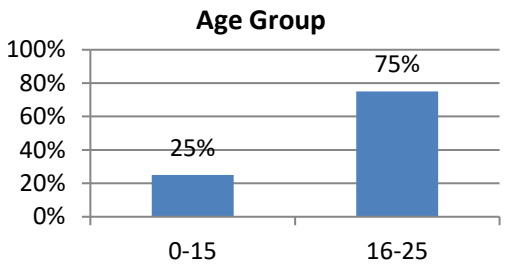
A TAY individual had been involved in the EP program for about a year. The individual had a history of hospitalizations and severe symptoms of psychosis impairing their functioning and leading to risk factors. Due to client's level of psychosis, they were hesitant about treatment recommendations being made, particularly around medication. Their family also struggled with coping with their loved one's symptoms, and not knowing how to best support them. The individual began to severely decompensate, almost requiring hospitalization. The client had access to a clinical therapist, behavioral health specialist, occupational therapist, peer support and psychiatrist. Team members regularly had internal meetings, as well as meetings involving the family. Trust was built and treatment recommendations began to be implemented by the client and family members. The client was able to avoid hospitalization, stabilized, and work has shifted to focusing on independent living skills.

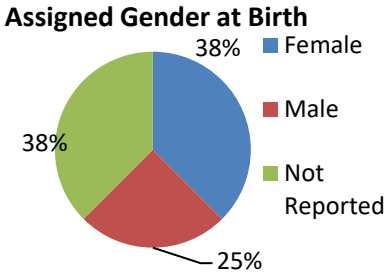
Program Summary

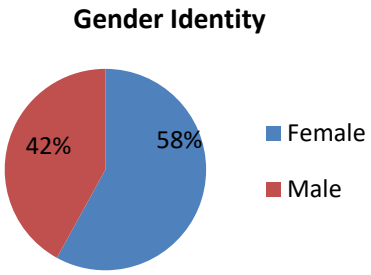
How Much Did We Do?

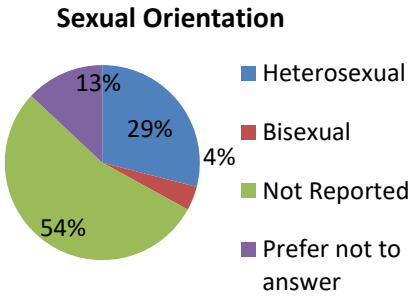
24
Individuals Enrolled In Early Psychosis

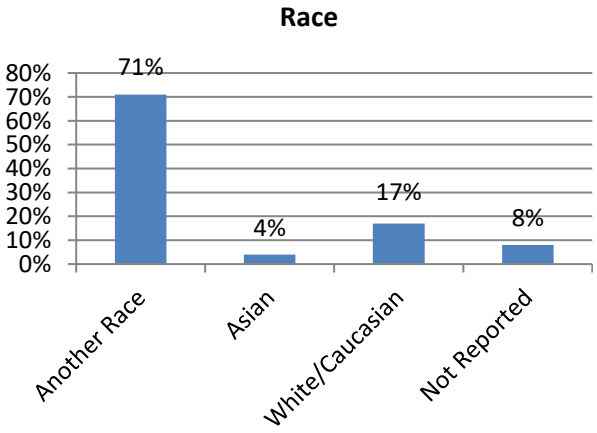
The number of individuals enrolled **increased** from **19** in FY 2022-23 to **24** in FY 2023-24.

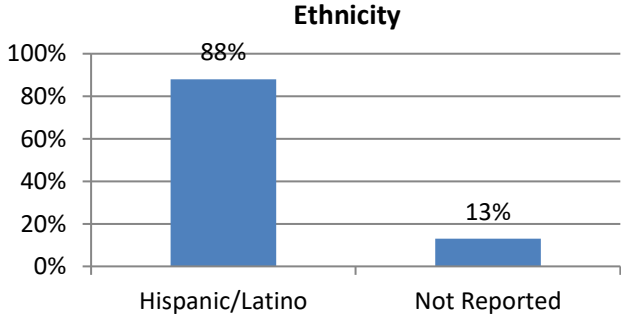


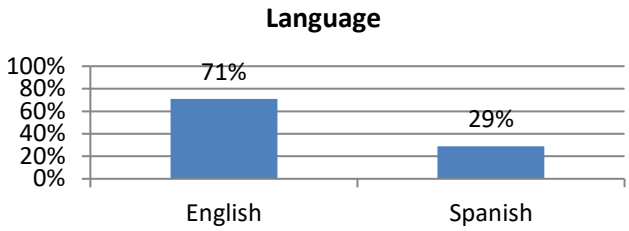


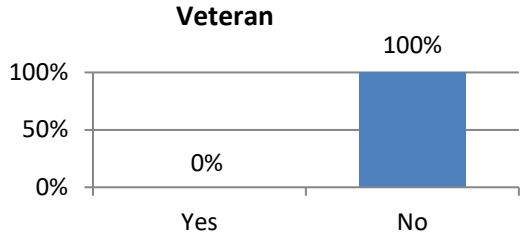


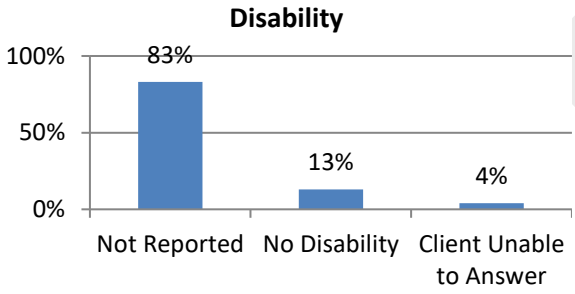


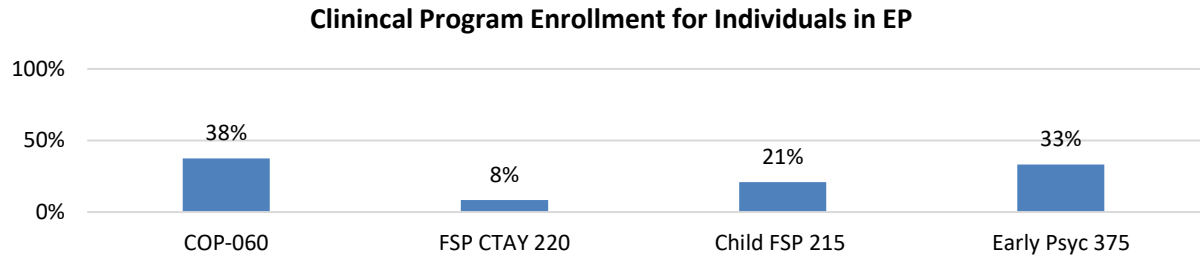








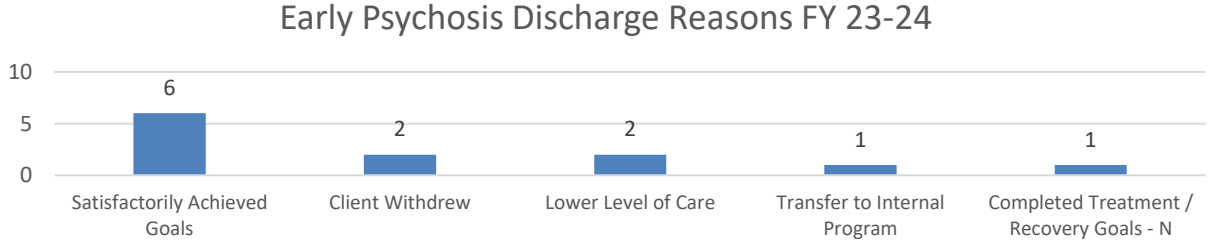




How Well Did We Do It?

Early Psychosis hosted 3 psychoeducation workshops for client and families & 1 community outreach event

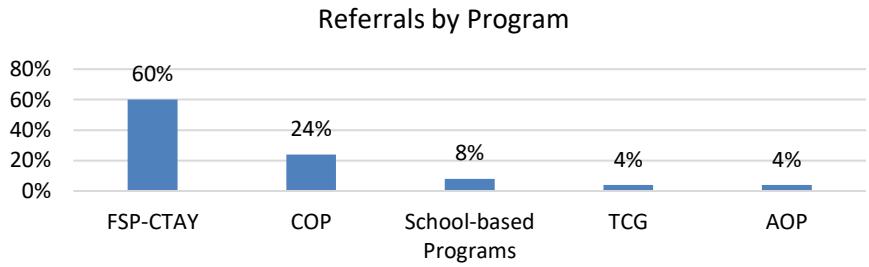
Is Anyone Better Off?



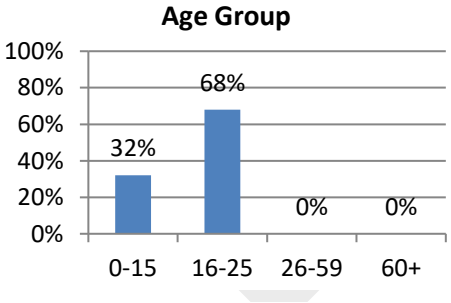
Underserved Populations	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability.
Access and Linkage to Treatment Strategy	Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

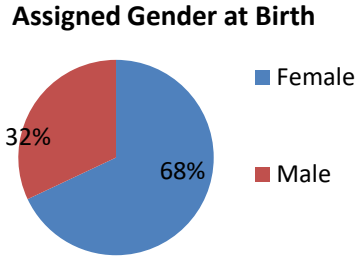
Timely Access to Services for Underserved Populations Strategy

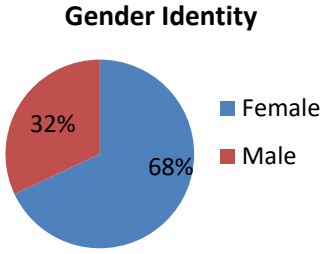
25
MHSA Referrals to Early Psychosis

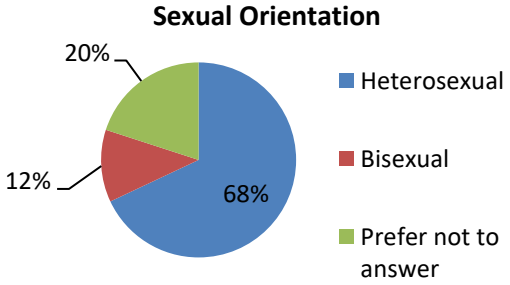


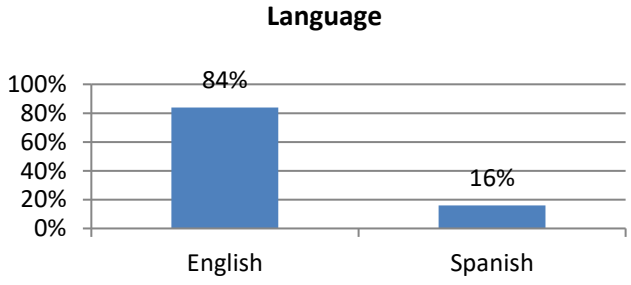
PEI Demographics Based on MHSA Referrals

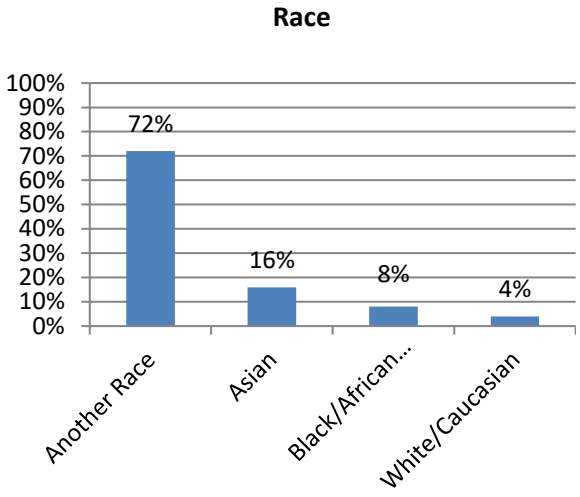


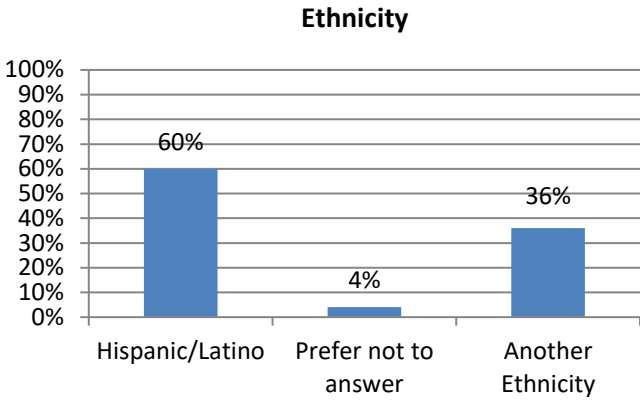


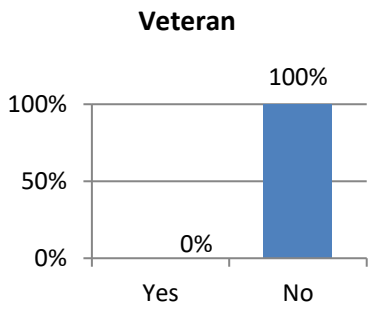


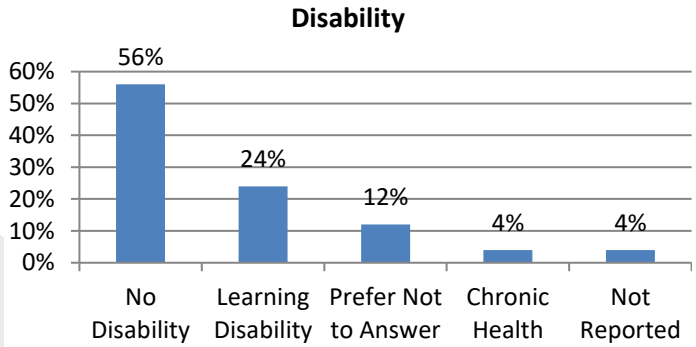





Race
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
72%
16%
8%
4%
Another Race
Asian
Black/African...
White/Caucasian


Ethnicity
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
60%
4%
36%
Hispanic/Latino
Prefer not to answer
Another Ethnicity


Veteran
100%
50%
0%
0%
100%
Yes
No


Disability
60%
50%
40%
30%
20%
10%
0%
56%
24%
12%
4%
4%
No Disability
Learning Disability
Prefer Not to Answer
Chronic Health
Not Reported

School-Based Services

(Early Intervention)

Program Description

School-Based Services (SBS) provide services to students directly on local school campuses during school hours. SBS bridge the gap between community mental health services and local schools, reducing barriers to accessibility by meeting the youth where they are at.

Target Population

Students attending school in the school districts and colleges located within the Tri-City service area (Pomona, Claremont and La Verne).

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	123	76	2	N/A	N/A	**201**
Projected Number to be Served FY 2024-25	177	109	3	N/A	N/A	**289**
Cost Per Person	$2,716**	$2,716**	$2,716**	N/A	N/A	**$2,716****

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

Program Update

School-Based Services (SBS) experienced an increase in referrals from students at universities. There was also notable increase in new schools reaching out for support and services. The program made an effort to increase outreach and engagement with elementary schools in the city of Claremont and also increased services with the School of Arts and Enterprises. This included crisis support following the death of a student due to an overdose. The SBS program also added a virtual office hour which is open to all school partners to consult on referrals or ask questions.

In the upcoming fiscal year, the program intends to add more collaboration with schools underutilizing SBS services as well as participate in more school events to promote awareness of services (i.e. Back to School Night).

Challenges and Solutions

School partners often are busy and struggle to attend monthly meetings leading to some possible gaps in communication regarding referrals or needs. Additionally, school schedules are different than the typical Tri-City work schedule, leading to difficulty connecting with schools. There was also a decrease in referrals this fiscal year as well as a struggle for families to complete the enrollment process or attend appointments at the clinic.

To address this challenge, SBS offered school partners to meet virtually vs in person. There is also a ongoing effort to make enrollment easier, such as revising interview questions to screen for appropriate candidates and rule in or out services at this level. The program also aims to make services more accessible, collaborate with school partners on different needs and continue to work on becoming the preferred referral for local schools.

Diversity, Equity and Inclusion

SBS staff prioritizes on-site school visits to assist with removing barriers to attending services such as transportation. Although a big focus of services is to provide treatment at school, both treatment and intake services are being offered in the office and via telehealth to increase families' access to mental health services. Additionally, parents/caregivers are included in the client's services to better assess the needs, create realistic goals and interventions for clients, and provide access to resources.

Spanish speaking clients have access to bilingual staff, and other languages are offered through a language line. A diverse group of providers supports the SBS team in increasing representation for the community leading to improved engagement in services. Additionally, all documents are translated in the threshold languages.

The SBS team educates themselves on barriers and stigma the LGBTQ+ community may experience by reviewing available community resources, completing trainings, and attending department meetings focusing on this population. Inclusivity is also ensured through electronic health records reflecting the client's desires and culture needs such as appropriate pronouns and names. There is also support provided to parents, which teaches them gender affirming parenting skills and behaviors.

Community Partners

Community Partners largely consist of local schools and colleges within the Tri-City service area. Some examples include: California Polytechnic University, University of La Verne, Pomona Unified School District (PUSD), Bonita Unified School District (BUSD), Claremont Unified School District (CUSD), and The School of Arts and Enterprise (SOAE). These partnerships foster resource sharing, increase access for students in need of mental health services and generate referrals to the SBS team.

Success Story

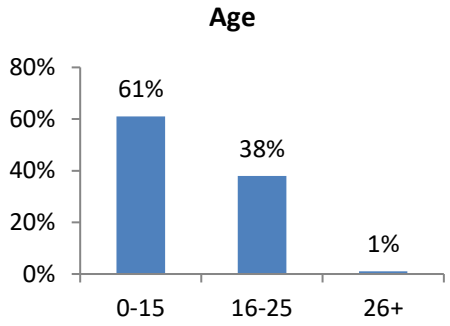
During FY 2023-24, SBS held meetings with district leadership, resulting in dialogue and overviews of program performance at CUSD schools. This resulted in a shift in focus based on client needs identified and research of student demographics. The program was also able to identify new schools as a primary target for service delivery, resulting in an initial connection and service delivery to students at the school. Lastly, the elementary counselor observed a need and services were provided at the identified schools, resulting in increased referrals from all elementary schools at Claremont Unified School District.

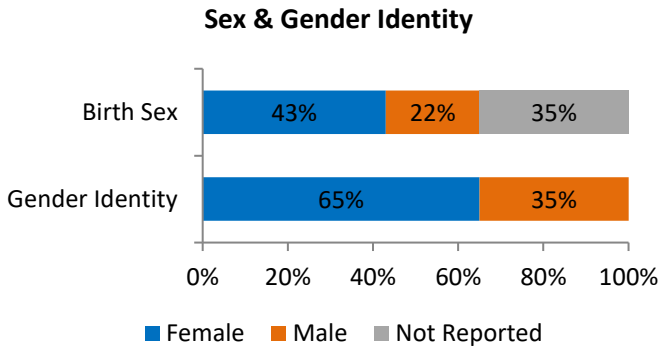
Program Summary

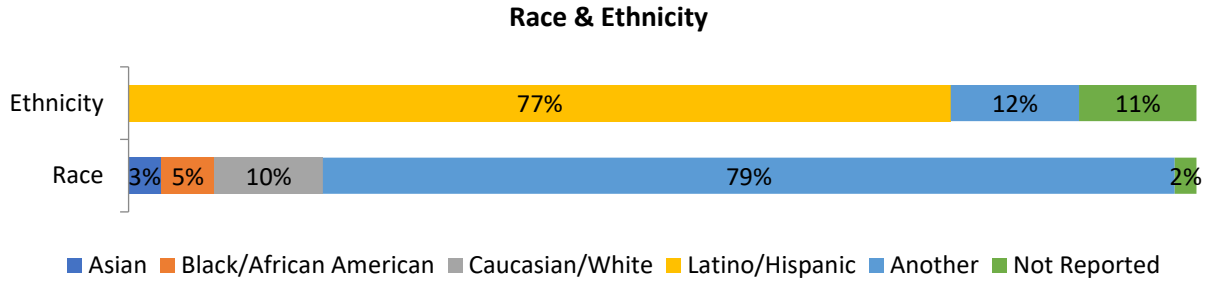
How Much Did We Do?

201
Individuals received a school partnership intervention

91%
of enrolled SPT clients lived in Pomona in 2023-2024
while 4% of clients lived in Claremont and 5% of clients lived in La Verne.







Data not available for Disability and Sexual Orientation

How Well Did We Do It?

SBS Services Provided by Type	Number of Services Provided
Crisis - CA	3
Family Therapy - CA	102
Individual Therapy - CA	2,369
Intensive Care Coordination - CA	8
Plan Development/Tx Planning - CA	282
Psychiatric Evaluation / Assessment - CA	9
Psychosocial Rehabilitation - CA	464
Targeted Case Management - CA	6
Grand Total	**3,243**

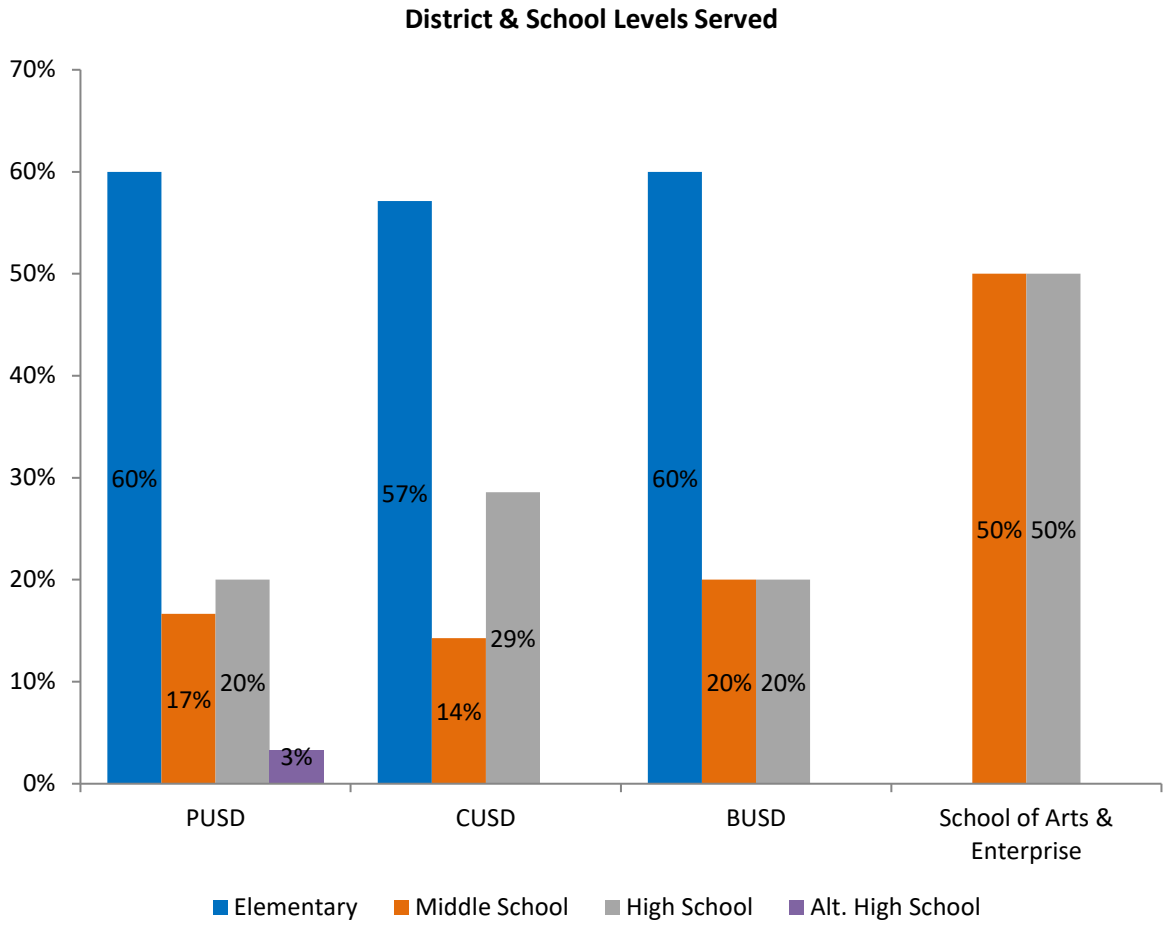
SBS Services Provided by Location	Number of Services Provided
Clinic/Office	1017
Home	42
Other	1
Other Community Location	13
Phone	993
School	610
Telehealth	372
Telehealth - Patient's Home	195
Grand Total	**3,243**

68
Individuals received services at school sites

Individual Therapy account for 73% of School-Based Services
with psychoeducation at 14%, plan development at 9% and family therapy at 3%.

Is Anyone Better Off?

43
Schools served by SBS Staff



Innovation (INN)

The Innovation (INN) Plan consists of short-term projects, one to five years, that explore novel efforts to strengthen aspects of the mental health system.

Innovation (INN)

Innovation projects are designed to evaluate the effectiveness of new or changed practices in the field of mental health, with a primary focus on learning. Innovation provides county-administered mental health systems in California the opportunity to "try out" new or changed approaches that can inform current and future mental health practices. These projects are intended and implemented as time-limited (maximum of five years), after which an alternative source of funding must be identified if the project is deemed successful.

Innovation expanded in August 2023 with the addition of an MHSA Program Coordinator for Innovation and a Peer Support Specialist. Tri-City currently has two active projects and one project recently ending.

Help@Hand/Tech Suite

Project Update

Tri-City partnered with CalMHSA in a multi-year Innovation project in which 11 California cities and counties worked together to explore mental health solutions through the use of technology. This project began on January 1, 2019, and ended on December 31, 2023. For more information and details regarding the outcomes of this project, please see the Help@Hand Innovation Project Final Report located in the appendix of this Annual Update.

Project Dates	January 1, 2019 to December 31, 2023
Project Funding Amount	$1,674,700
Target Populations	• Transition age youth and college students (up to age 25) • Older adults (ages 60+) • Non-English-speaking clients and community members who may be experiencing stigma and language barriers

Challenges and Solutions

The Innovation staff discovered that older adults required more personalized assistance to sign up for the myStrength app. It became clear that simple outreach efforts, such as distributing flyers, were insufficient. During a tabling event at a local community center, the team observed that effective outreach involved more than promotion; it required hands-on help with every step of the sign-up process, including email setup and navigation. The myStrength app's multi-step sign-up process highlighted the need for in-person support to ensure a smoother user experience.

Additionally, there was a challenge related to the technology itself, particularly in educating older adults about digital tools. Virtual Digital Health Literacy (DHL) training sessions had low attendance, which underscored the need for more accessible, in-person training opportunities. To address the challenge of signing up older adults for the myStrength app, the team shifted to providing direct, in-person assistance.

Another challenge was enrollment, retention and repeated use of the app when determining total number served. While 54 individuals were documented as users of the app, 46 followed through to activate an account/profile, while 8 did not. Those who did not activate an account were not able to utilize the application to its full extent and as intended. Additionally, of those who activated an account (46 users), 24 individuals returned to utilize the application one or more times after initial enrollment. As with other programs and projects, increased engagement and retention is always a goal for future endeavors.

Enrolled	Activated	Returning
54	46	24

Diversity, Equity and Inclusion

The myStrength app was made available in both English and Spanish and was accessible via smart phone, tablet or computer. Tablets were provided to individuals who did not have computers or phones to utilize the app. myStrength offered evidenced-based LGBTQ+ behavioral health resources such as informative content, interactive quizzes, and worksheets that discuss LGBTQ+ pride, allyship, depression and shame in LGBTQ+ communities. Partnering with local senior centers within our three cities supported outreach and engagement to older adults and veterans. Resource tables were made available during the center's lunch hours to promote Help@Hand when foot traffic is high. Staff also held a DHL training at the senior center in Claremont to eliminate barriers for our older adults and ensure they could participate.

Community Partners

Innovations relied on community partners and social media posts to help encourage individuals to sign up for myStrength. Community Navigators and other staff supported promoting the myStrength app to the community. Innovation staff worked with market partners, Uptown Studios, who helped create flyers for the three target populations: TAY, older adults and monolingual Spanish speakers.

Other community partners included Cal Poly Pomona and Western University of Health Sciences through the Youth Wellness Symposium collaboration. Through these efforts, DHL workshops were held in Spanish and for older adults. The TAY population was outreached through various connections to schools and colleges.

Psychiatric Advance Directives (PADs) Multi-County Collaborative

Tri-City joined the Psychiatric Advance Directives (PADs) Multi-County Collaborative on July 1, 2022. This Innovations project aims to develop and test the feasibility of Psychiatric Advance Directives (PADs) in California.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Projected Number to be Served FY 2024-25	N/A	41	11	3	N/A	**55**
Cost Per Person	N/A	$6,818**	$6,818**	$6,818**	N/A	**$6,818****

**The estimated projections were determined by prior participation rates for INN projects and total budget allocated to the INN plan.

Project Update

Project Dates	PADs Phase I: July 1, 2023 to June 30, 2025 PADs Phase II: July 1, 2025 to June 30, 2029
Project Funding Amount	PADs Phase I: $761,672 PADs Phase II: $1,500,000
Target Populations	• Transition age youth and young adults (ages 18 to 25) • Older adults (ages 60+) • Individuals who are homeless or at risk of homelessness

In the peer-led Psychiatric Advance Directives (PADs) project, peers from the communities provided feedback to the technology subcontractor, Chorus, to finalize the PADs platform. By March 2024, two new team members were trained on the PADs platform for participant sign-ups. A specialized version of the PADs platform was developed for law enforcement and hospital staff. Additionally, the marketing subcontractor, Idea Engineering, completed the project's logo and produced new branding materials to boost outreach efforts. Phase II of the project is scheduled to begin on July 1, 2025, following requested endorsement from the Tri-City Mental Health Commission, pending approval by the Tri-City Governing Board and resulting submission to the Mental Health Services Oversight and Accountability Commission. Phase II will involve the enrollment of participants onto the PADs system, and the resulting opportunity to track number served once that data is available.

Challenges and Solutions

Community member perception of PADs was a challenge. Individuals reported discomfort with having their information made available to law enforcement or hospitals. Educating the community about the various concepts involved in PADs was crucial to reducing misconceptions about the platform. For example, it was helpful to alert community members that a PAD is to be filled out with full consent of the individual, it was also beneficial to inform community members that a PAD is not required, in addition to informing individuals about the various ways a PAD can be customized and personalized.

Diversity Equity and Inclusion

Innovation projects focus on increasing access and engagement for underserved populations by introducing and refining mental health approaches that facilitate learning. The PADs project specifically targets transition age youth (TAY). Innovation projects aim to reduce stigma, enhance accessibility, and improve the quality of mental health services, ensuring broader participation across various demographics.

Community Partners

Concepts Forward Consulting (CFC) is the lead project director, overseeing county and subcontractor activities and closely with county and oversight staff to ensure all requirements are met. Idea Engineering (IE), is a full-service marketing agency specializing in community communications and is responsible for developing branding and outreach materials, including flyers, the main PADs website, informational videos, and promotional items. Chorus serves as the technology subcontractor, developing and improving the PADs platform that allows participants to create and access their completed PADs, which will be available to law enforcement, first responders, and hospitals. Painted Brain is also involved in this project due to its alignment with peer-led initiatives. Leveraging their experience in peer advocacy, Painted Brain assists with component identification, peer facilitator curriculum development, and provides Training for the Trainer, ensuring the project's peer-led approach is effectively implemented.

Community Planning Process Project

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Projected Number to be Served FY 2024-25	N/A	18	252	90	N/A	**360**
Cost Per Person	N/A	$1,403**	$1,403**	$1,403**	N/A	**$1,403****

**The estimated projections were determined by prior participation rates for INN projects and total budget allocated to the INN plan.

Project Update

Project Dates	July 1, 2023 to June 30, 2026
Project Funding Amount	$675,000
Primary Purpose	Promote interagency and community collaboration related to mental health services, supports or outcomes

The Community Planning Process (CPP) project aims to reimagine our current community program planning process by making it more accessible, inclusive, and taking into consideration suggestions made by community members and partners regarding how to make improvements. Innovation funds in the amount of $675,000 are to be used over three years to develop a robust and effective strategic CPP and related activities, resulting in future Innovation plans that are calculated, meaningful, and effective. This includes changes to the CPP survey, peer-support contracts, marketing strategies, focus groups and more. The CPP Innovation plan was posted on August 11, 2023, for a 30-Day review period. Following the 30-day comment period, a Public Hearing was held during the Mental Health Commission meeting on September 12, 2023, and to the Governing Board on September 20, 2023, gaining approval. With Governing Board approval, the plan was submitted to the Mental Health Oversight and Accountability Commission, who approved the project to move forward.

This project partnered with Pomona Consulting Group (PCG), a student-led group from Pomona College, marking Tri-City's first collaboration with PCG. The students provided valuable insights into survey design, marketing, and strategies to engage transition age youth (TAY), aiming to improve survey effectiveness and participation. In the subsequent months, the team refined and finalized an updated version of the CPP survey. Requests for Quotes (RFQs) for marketing and peer consultant

roles were issued, and the team is currently evaluating a Peer Consultant agency for approval and posting an RFQ for marketing services on the Tri-City website. Revised CPP surveys are expected to be distributed during the fall 2024 CPP and subsequent numbers served and resulting data will be captured.

Workforce Education and Training (WET)

The Workforce Education and Training (WET) Plan focuses its efforts on strengthening and supporting existing staff and caregivers through trainings while focusing on attracting new staff and volunteers to ensure future mental health personnel.

Workforce Education and Training (WET)

The Workforce Education and Training plan is dedicated to training and supporting the people who are charged with the delivery of the services and supports. This includes clinical staff providing treatment services, staff who provide prevention and wellbeing supports, family and community caregivers and volunteers who offer informal support to loved ones and others.

A second component of this plan is the recruiting of students, community members, and volunteers to expand the recovery and wellbeing support provided by staff. It is clear the demand for mental health services in the Tri-City area far exceeds the current and projected availability of staff. By increasing the pool of interest in the mental health system, these efforts can work to generate new staff members over time by encouraging high school and college students to realistically consider a career in the community mental health field.

Program Update

During the FY 2023-2024 twelve of our Peer Support Specialist were awarded with $500 stipends through our partnership with SCRP and our WET program funding. Fifty-six staff members were also awarded $7,500 towards their student loans. Twelve staff members also received loan repayment funding through the loan repayment program sponsored by the Southern Counties Regional Partnership (SCRP). There are also efforts being made to allow high school students (16-17) to be able to volunteer year-round, as opposed only having this opportunity available for the Wellness Center Summer Camp. There is also a plan to launch a pilot program at Pomona Unified School District which will allow their students to volunteer during the year. WET also plans on bringing back the Working Independence Skills Helping (WISH) program for clients. WISH helps individuals build their self-confidence and self-esteem while gaining viable skills to further their professional and employment growth. The eight-week program emphasizes team building, conflict resolution, communication and employment skills building.

Pathway to Career Opportunities:

Service-Learner

Service-Learners (formerly called volunteers) provide support in many of the MHSA programs offered by Tri-City. Service-Learners participate in various community events throughout the year such as community meetings, and stigma reduction events such as Tri-City's Green Ribbon Week.

Wellness Center Summer Camp

The annual Wellness Center Summer Camp provides a unique opportunity for individuals ages 16 and over who are interested in working with children to volunteer and provide support to a four-week day camp facilitated by Tri-City Wellness Center staff.

Peer Mentor Program

This program is comprised of a committed diverse group of individuals with various backgrounds, culture, identities and lived experiences age 18 and over. Participants gain hands-on experience working with individuals in community mental health. The program provides extensive training and supervision on numerous topics focusing on mental health, mental wellbeing and personal growth.

Relias Training

Relias is an online e-learning system that is a recognized leader in online training services for the healthcare industry. Relias is self-paced and serves staff who are required to complete a set of courses, provides an opportunity to pursue courses that are of interest, and is a viable resource for obtaining continuing education units (CEUs).

Challenges and Solutions

During FT 2023-24, WET received feedback regarding the 'value of the experience' for service learners. Through a post survey, service learners provided feedback that provided insight into the way the program is structured, as well as how to address improvements. One solution is to provide a more structured program. This would include required Wellness Center Groups, spending time at the Therapeutic Community Garden, joining stakeholder meetings, attending Mental Health Commission meetings, and Governing Board meetings to help broaden their understanding of Tri-City and how the agency operates. Also revamping the orientation to include a slideshow presentation to cover key points about Tri-City, as well as how to conduct themselves professionally (which was feedback from the Stigma Reduction and Suicide Prevention program on interactions they had with service learners).

Diversity, Equity and Inclusion

INN strives to engage underserved populations by communicating in ways that are accessible to all members of the community. This includes communicating via a variety of social media platforms and incorporating messaging that is reflective of the diverse populations that we serve and containing messaging that is often directly relevant to the experiences of these populations within our service area. The perspectives of members of these underserved communities are considered in the selection of content that is represented on social media, and in the selection of trainings that are offered to staff (i.e. cultural competency and implicit bias).

Tri-City supports staff in building their capacity to address barriers related to disparities. The service learner program is designed to welcome individuals from any background to volunteer their time to participate in various community events throughout the year. Events include community meetings, and stigma reduction events such as Tri-City's Green Ribbon Week. Additionally, depending on the assignment, they can volunteer and suggest different ways to engage individuals experiencing different disparities.

Program Summary

How Much Did We Do?

510	23	40
Service Learner Hours	Service Learner Applications	Trainings, Conferences and Educational Opportunities for Staff

The number of service learner hours, applications and trainings **increased** from **27, 11, and 7** in FY 2022-23 to **510, 23, and 40** in FY 2023-24.

56	12
Tri-City Loan Repayment Program Recipients	SCRP Loan Repayment Program Recipients

How Well Did We Do It?

12	1	1,189
Applicants Became Service Learners	Service Learners were Hired at Tri-City	Courses Completed through Relias Program

The number of applicants who became service learners **increased** from **1** in FY 2022-23 to **12** in FY 2023-24.

Is Anyone Better Off?

100%
Services learners (strongly agree/agree)
"This experience gave them a better understanding of working in Public Behavioral Health."

Capital Facilities and Technological Needs (CFTN)

The Capital Facilities and Technological Needs (CFTN) Plan focuses on improvements to facilities, infrastructure, and technology of the local mental health system.

Capital Facilities and Technological Needs (CFTN)

The Capital Facilities and Technological Needs (CFTN) component of the Mental Health Services Act allocates funds for projects designed to improve the infrastructure of community mental health including the purchase, development or renovation of buildings used to house and support MHSA programs and staff. The technological portion of this plan supports counties in transforming existing clinical and administrative technology systems while increasing access to mental health records and information electronically for consumers and family members.

Program Update

There were several notable events in FY 2023-24 impacting the CFTN plan. One major project was the remodeling of the 2001 MHSA Administrative Office building. The majority of the work on this project was completed during the 2023-24 fiscal year. Additionally, the Therapeutic Garden and 2008 Parking Lot construction was largely completed in the same fiscal year as well. Lastly, upgraded network infrastructure (switches and wireless access points) were completed at the 2001 MHSA Administrative Office building, the Wellness Center, and the Claremont Administrative Office building. This upgrade provided staff at these locations with faster speeds and more resilient networks.

MHSA Expenditure Plan

The following section includes information regarding Cost Per Participant for MHSA Programs and TCMHA Staff Demographics

Cost Per Participant

The services provided in Fiscal Year 2023-24 are summarized in the table below per the guidelines for this Annual Update by age group, number of clients served, and average cost per person:

Summary of MHSA Programs Serving Children, Including TAY			
Program Name	Type of Program	Unique Clients Served	Cost Per Person
Full-Service Partnership (Child)	CSS	98	$17,040
Full-Service Partnership (TAY)	CSS	162	$14,854
Community Navigators	CSS	127	$706**
Wellness Center	CSS	284	$1,645**
Supplemental Crisis Services	CSS	6	$1,056**
Access to Care	CSS	958	$544**
Family Wellbeing Program	Prevention and Early Intervention	254	$263**
Peer Mentor Program (TAY Wellbeing)	Prevention and Early Intervention	12	$278**
Therapeutic Community Gardening	Early Intervention	2	$6,023**
Early Psychosis	Prevention and Early Intervention	24	$5,126**
School-Based Services	Early Intervention	199	$2,716**

Summary of MHSA Programs Serving Adults and Older Adults, Including TAY			
Program Name	Type of Program	Unique Clients Served	Cost Per Person
Full-Service Partnership (TAY)	CSS	162	$14,854
Full-Service Partnership (Adult)	CSS	454	$11,670
Full-Service Partnership (Older Adult)	CSS	73	$10,927
Community Navigators	CSS	641	$706**
Wellness Center	CSS	1,466	$1,645**
Supplemental Crisis Services	CSS	64	$1,056**
Access to Care	CSS	2,364	$544**
Field Capable Clinical Services for Older Adults	CSS	52	$5,005
Family Wellbeing Program	Prevention and Early Intervention	641	$263**
Peer Mentor Program (Older Adult Wellbeing)	Prevention and Early Intervention	5	$278**
Therapeutic Community Gardening	Early Intervention	42	$6,023**

** These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

In FY 2023-24, Tri-City served approximately 2,960 unduplicated clients who were enrolled in formal services. Tri-City's Fiscal Year 2024-25 budget included a total of 251 Full-time/Equivalent employees and an annual operating budget of approximately $37.5 million dollars.

Capacity Assessment

Tri-City strives to reflect the diversity of its communities through it hiring, languages spoken, and cultural competencies. The following sections reflect TCMHA's efforts to meet the diverse needs of populations served within Pomona, Claremont and La Verne.

Mental health needs of unserved, underserved/inappropriately served, and fully served city residents who qualify for MHSA services:

Recent data were gathered to determine whether those served at Tri-City were representative of the Tri-City area. Participant/client data were compared to U.S. Census data (2021 ACS 5-Year Estimates). Demographic information includes what participants feel comfortable sharing; therefore, there are demographics that are not reported.

Overall, Tri-City is fully serving all age groups with the exception of those in the 60+ age range. With regard to race/ethnicity, services are provided to African Americans and Hispanic/Latino/a/x populations, however, Asian Pacific Islanders, Native Americans and those who identify as having more than one race appear to be underserved. More data will need to be collected to address the high percentage (63%) of those who did not report their race.

Age of Those Served by Tri-City	Percentage		Population of Tri-City Area	Percentage
0-15	16%		0-14	19%
16-25	20%		15-24	17%
26-59	48%		25-59	44%
60+	8%		60+	21%
Not Reported	9%		Not Reported	0%

Race of Those Served at Tri-City	Percentage		Population of Tri-City Area	Percentage
African American	6%		African American	6%
Asian Pacific Islander	2%		Asian Pacific Islander	12%
Native American	0%		Native American	2%
White	9%		White	42%
Another Race	18%		Another Race	26%
Two or More Races	2%		Two or More Races	13%
Not Reported	63%		Not Reported	0%

Ethnicity of Those Served by Tri-City	Percentage		Population of Tri-City Area	Percentage
Hispanic/Latino/a/x	56%		Hispanic/Latino/a/x	59%
Another Ethnicity	30%		Another Ethnicity	41%
Not Reported	14%		Not Reported	0%

Percentages of diverse cultural, racial/ethnic, and linguistic groups represented among direct service providers, as compared to percentage of the total population needing services and the total population being served:

HR Staff Data compared to Tri-City Race Demographics			
Demographic for Cities of Claremont, La Verne and Pomona	**Percent of Population**	**Demographics for Tri-City Mental Health Staff**	**Percent of Staff**
White	20%	White	15.6%
Hispanic/Latinx	54%	Hispanic/Latinx	61.4%
Asian/Pacific Islander	3%	Asian	10.7%
Black/African American	13%	Black/African American	7.3%
Native American/Alaska Native	0.5%	Native American/Alaska Native	0.5%
Other	3%	Other	2.4%
Two Or More Races	4%	Two Or More Races	1.9%

(Total may not add up to 100 percent, as individuals may select multiple races/ethnicities). Source: U.S. Census data from 2023 DEC Redistricting Data

Assessment of bilingual proficiency in threshold languages:

Bilingual proficiency was assessed by gathering data on the languages spoken by staff. Additionally, Tri-City also provides access to language interpretation services

Approximately 52% of the Tri-City workforce is bilingual. Approximately 46% of the Tri-City workforce is qualified to provide bilingual interpretation services in the threshold language, Spanish. These percentages reflect a significant increase from the previous fiscal year 2022-23.

Number of Staff Certified/Qualified for Bilingual Interpretation		
Language	**# Bilingual**	**% Bilingual**
Spanish (Threshold Language)	96	46.82%
Vietnamese	3	1.46%
French	2	0.97%
Khmer	0	0%
Persian	1	0.48%
Punjabi	1	0.48%
Russian	0	0%
Mandarin & Chinese	0	0%
Hindi	1	0.48%
Japanese	1	0.48%
Tagalog	2	0.97%
Total Bilingual	**107**	**52.14%**

Source: HR Bilingual Staff Report and CC Plan Population Demographic Language Data.

As with many agencies and organizations, Tri-City has struggled with both staff recruitment and retention. In an effort to recruit, train and attract a workforce that mirrors our client population, Tri-City's Human Resources Department actively seeks out recruitment advertisement opportunities with a variety of culturally specific organizations and associations. We advertise with and participate in employment fairs with the Network of Social Workers, the County Behavioral Health Directors Association of California (CBHDA), the Collaborative to Improve Behavioral Health Access (CIBHA), the African American Mental Health Conference, the Latino Behavioral Health Conference and Mental Health America. Additionally, WET program staff actively outreaches to students from high schools and universities within our service area. The goal of this outreach is to educate and encourage students about the potential of working within the community mental health system. Through student career fairs and class specific presentations, Tri-City staff engage residents and students of the three cities to participate as Service-Learners, a volunteer program to support Tri-City staff and departments to meet the needs of consumers and community members.

Tri-City has emphasized the value of those with lived experience within our workforce and has made a concerted effort to include peers throughout our system of care. Peers, representatives of the population we serve, and our clients are also included in our Service-Learning program.

In addition, Tri-City's implementation of hiring incentives such as a sign-on bonus, hybrid work schedules, hazard and longevity pay have helped to create a more attractive compensation and benefit package to attract staff and we often survey our current workforce for ideas on attractive benefits and incentives.

Lastly, each month Tri-City staff review and prepare reports for the Governing Board which reflect our current staffing including diversity and comparison to the community we serve. Through this practice, staff are able to determine the limitations of our agency and able to address these concerns on a monthly basis.

The strengths and limitations of the city and service providers that impact their ability to meet the needs of racially and ethnically diverse populations:

Service providers are representative of the Tri-City cities for Hispanic/Latino/a/x, Asian Americans, and Black/African Americans. Staff are less represented for Native American/Alaska Natives, Whites, and those who are two or more races.

Possible barriers to implementing the proposed programs/services and methods of addressing these barriers:

Lack of awareness can be a barrier to individuals accessing our programs and utilizing the services. Despite increased outreach and engagement in the community, there is feedback provided indicating individuals in the community do not know what Tri-City is or what the organization does. In an effort to increase awareness Tri-City continues to implement smaller community forums for schools, school district meetings, organizations, faith-based establishments, government agencies, community groups and more. This is increasing the awareness in the community as well as growing our stakeholder list, which is used to inform community members of Tri-City events, stakeholder meetings and public hearings for example.

An additional barrier is stigma. Even in a situation where an individual is aware of Tri-City and its services, there may be resistance, shame or hesitation to reach out for support due to the negative beliefs associated with mental health treatment, support, or illness. Tri-City addresses this directly through many community efforts and engagements. One in particular is the Stigma Reduction and Suicide Prevention program. The program offers free presentations, for the community to raise mental health awareness and inspire conversation. By sharing information and increasing understanding of mental illness and recovery, community members begin to see how stigma is a barrier and can be addressed appropriately so individuals can get their needs met. These conversations have been provided formally, in school settings and for community partner organizations; while also being offered in more casual settings, such as at local tea, boba, and coffee shops.

Continuing efforts to increase awareness and decrease stigma will be a large component that contributes to community members knowing where they can turn when they need additional support and the ability to follow through with reaching out to that support when they need to.

FY 2025/26 Mental Health Services Act Annual Update
Funding Summary

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/7/2025

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	24,523,448	4,078,128	3,670,798	548,773	5,881,190	
2. Estimated New FY 2025/26 Funding	11,518,521	2,879,630	757,797			
3. Transfer in FY 2025/26 [a/]	(3,000,000)	0	0	1,500,000	1,500,000	0
4. Access Local Prudent Reserve in FY 2025/26	0	0				0
5. Estimated Available Funding for FY 2025/26	33,041,969	6,957,758	4,428,595	2,048,773	7,381,190	
B. Estimated FY 2025/26 MHSA Expenditures	15,624,618	3,636,618	1,021,033	456,602	700,000	
G. Estimated FY 2025/26 Unspent Fund Balance	17,417,351	3,321,140	3,407,562	1,592,171	6,681,190	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2025	2,199,999
2. Contributions to the Local Prudent Reserve in FY 2025/26	0
3. Distributions from the Local Prudent Reserve in FY 2025/26	0
4. Estimated Local Prudent Reserve Balance on June 30, 2026	2,199,999

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2025/26 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/7/2025

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. 1a-Child FSP	1,874,346	529,145	891,433		453,768	
2. 1b-TAY FSP	1,990,501	336,940	1,257,838		395,723	
3. 1c-Adult FSP	3,594,449	1,200,424	2,295,700		98,325	
4. 1d-Older Adult FSP	611,898	273,143	328,952		9,803	
5.						
Non-FSP Programs						
1. Community Navigators	757,451	757,451				
2. Wellness Center	1,476,861	1,476,861				
3. Field Capable Clinical Services for Older Adults	175,167	11,176	159,129		4,862.00	
4. Permanent Supportive Housing	608,971	603,971				5,000
5. Access To Care	1,520,051	251,088	1,100,514		168,449	
6. Mobile Crisis Care (MCC) Pilot Program Expanding Temporary Supportive Housing	950,757	950,757				
7. Options for Tri-City Clients	5,200,000	5,200,000				
CSS Administration	4,033,662	4,033,662				
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Program Estimated Expenditures	22,794,114	15,624,618	6,033,566	0	1,130,930	5,000
FSP Programs as Percent of Total	51.7%					

FY 2025/26 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/7/2025

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Family Wellbeing	136,400	136,400				
2. Older Adult Wellbeing (Peer Mentor)	91,557	91,557				
3. Transition-Age Youth Wellbeing (Peer Mentor)	104,141	104,141				
4. Community Capacity Building (Community Wellbeing, Stigma Reduction and Suicide Prevention, and Community Mental Health Training)	549,071	549,071				
5. NAMI Community Capacity Building Program (Ending the Silence)	16,500	16,500				
6. Housing Stability Program	211,370	211,370				
PEI Programs - Early Intervention						
7. Older Adult Wellbeing (Peer Mentor)	91,557	91,557				
8. Transition-Age Youth Wellbeing (Peer Mentor)	104,141	104,141				
9. Therapeutic Community Gardening	469,827	469,827				
10. Early Psychosis	276,780	276,780				
11. School Based	784,940	784,940				
PEI Programs - Other						
12.	0	0				
13.	0	0				
14.	0	0				
PEI Administration	768,335	768,335				
PEI Assigned Funds	32,000	32,000				
Total PEI Program Estimated Expenditures	3,604,618	3,636,618	0	0	0	0

FY 2025/26 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/7/2025

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Psychiatric Advance Directive (PADs) Multi-County Collaborative	375,000	375,000				
2. Community Planning Process for Innovation Project (s)	505,000	505,000				
INN Administration	141,033	141,033				
Total INN Program Estimated Expenditures	1,021,033	1,021,033	0	0	0	0

FY 2025/26 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/7/2025

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. A Systematic Approach to Learning and Improvement	296,139	296,139				
2. Engaging Volunteers and Future Employees	34,412	34,412				
WET Administration	126,051	126,051				
Total WET Program Estimated Expenditures	456,602	456,602	-	-	-	-

FY 2025/26 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/7/2025

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Technological Needs Projects						
4. Technology Upgrades	700,000	700,000				
5.	0	0				
6.	0	0				
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	700,000	700,000	0	0	0	0

Appendix

Tri-City Mental Health Authority
AGENDA REPORT

DATE: **April 16, 2025**

TO: **Governing Board of Tri-City Mental Health Authority**

FROM: **Ontson Placide, LMFT, Executive Director**

BY: **Diana Acosta, CPA, Chief Financial Officer**

SUBJECT: **Consideration of Resolution No. 780 Declaring an Emergency Due to Damage to TCMHA Property Located in the City of Pomona, and Authorizing the Executive Director to Award a Contract to Rehabilitate the Property on an Emergency Basis and without Giving Notice for Bids to Let Contracts**

Summary:

Property owned by Tri-City and currently occupied by tenants, is currently in need of repair. The Executive Director is requesting the Governing Board to Declare an Emergency and authorize the award of a contract for repairs on an emergency basis to prevent endangering the health and safety of the current occupant.

Background:

The Tri-City Mental Health Authority ("TCMHA") owns certain real property located in the City of Pomona (at an undisclosed location due to confidentiality), where it operates as multi-family residential use housing as part of its Permanent Supportive Housing program offering living spaces for clients who are currently receiving mental health services. Permanent supportive housing has proven to be a significant part of successful recovery plans for many people with serious mental illness. Such housing enables successful pathways to recovery and, ultimately, can reduce the cost of other services such as emergency room visits and incarceration.

Through periodic inspections performed by Tri-City Staff and the Housing Authority, damages to the property were identified in need of repair. The most recent inspection identified damages that are considered significant and must be repaired but the unit is also currently occupied and therefore must be repaired as soon as possible to minimize or prevent endangering the health and safety of the current occupant. We are continuing to monitor the situation and plans and/or arrangements are currently being made for the occupant while repairs are being completed.

The Public Contract Code and Tri-City's Purchasing Policy permit contracts for public works to be awarded without formal bidding in response to an emergency declared by a 4/5 vote of the Governing Board.

Fiscal Impact:

The cost of rehabilitation has been estimated to be approximately $16 thousand and a contractor has been identified after having received proposals. At this time Bridgerock Construction, Inc. has been identified as a qualified contractor to perform the repairs.

Recommendation:

Staff recommends that the Governing Board Adopt Resolution No. 780 approving the Emergency Declaration and Authorize the Executive Director to award a contract to rehabilitate the Authority's Property due to damage, without giving notice to bids.

Attachments:

Attachment 14-A: Resolution No. 780 - Draft

RESOLUTION NO. 780

A RESOLUTION OF THE GOVERNING BOARD OF THE TRI-CITY MENTAL HEALTH AUTHORITY DECLARING AN EMERGENCY DUE TO DAMAGE TO AUTHORITY'S PROPERTY LOCATED IN THE CITY OF POMONA, CALIFORNIA AND AUTHORIZING THE EXECUTIVE DIRECTOR TO AWARD A CONTRACT TO REHABILITATE THE PROPERTY ON AN EMERGENCY BASIS AND WITHOUT GIVING NOTICE FOR BIDS TO LET CONTRACTS

The Governing Board of the Tri-City Mental Health Authority does resolve as follows:

1. Findings. The Governing Board hereby finds and declares the following:

A. The Tri-City Mental Health Authority ("TCMHA" or "Authority") owns that certain real property in the City of Pomona (at an undisclosed address due to confidentiality) ("Subject Property"), where it operates a multi-family residential use as part of its Permanent Supportive Housing program, offering living spaces for clients who are currently receiving mental health services.

B. The Subject Property has sustained significant damage that must be repaired but is also currently occupied and therefore must be repaired as soon as possible to minimize or prevent endangering the health and safety of the current occupant.

C. Pursuant to the California Public Contract Code and TCMHA Policy and Procedure IX.1, the TCMHA Governing Board ("Board") has delegated to the Executive Director its authority to repair or replace a public facility, take any directly related and immediate action required by that emergency, and procure the necessary equipment, services, and supplies for those purposes, without giving notice for bids to let contracts.

2. Action

A. Pursuant to the California Public Contract Code and TCMHA Policy and Procedure IX.1, the TCMHA Governing Board ("Board") The Governing Board hereby declares that the damage to the Subject Property constitutes an emergency and authorizes the Executive Director to award a contract to rehabilitate the Subject Property without giving notice for bids to let contracts.

B. The Governing Board further directs the Executive Director to report to the Governing Board the status of the rehabilitation and the emergency declared by this resolution at each regularly scheduled Governing Board meeting hereafter until the emergency has ended.

3. Adoption

Pursuant to the requirements of the California Public Contract Code, this Resolution must be adopted by a 4/5 vote of the Governing Board.

PASSED AND ADOPTED at a Regular Meeting of the Governing Board held on April 16, 2025, by the following vote:

AYES:
NOES:
ABSTAIN:
ABSENT:

JED LEANO, CHAIR

APPROVED AS TO FORM:

STEVEN L. FLOWER, GENERAL COUNSEL

ATTEST:

MICAELA P. OLMOS, RECORDING SECRETARY