California Behavioral Health Planning Council

Performance Outcomes Committee Agenda

Tuesday, January 14, 2025
2:00 pm to 5:00 pm

Hilton La Jolla Torrey Pines
10950 North Torrey Pines Road
La Jolla, California 92037
La Jolla Canyon Room

Zoom Meeting Link
Call-in #: 1 669 900 6833
Meeting ID: 817 6713 5337
Passcode: 752811

2:00 pm	**Welcome, Introductions, and Housekeeping** *Noel O'Neill, Chairperson*	
2:05 pm	**Review October 2024 Meeting Minutes** *Noel O'Neill, Chairperson*	**Tab 1**
2:10 pm	**Nominate Chair-Elect for 2025 (Action Item)** *Noel O'Neill, Chairperson and All*	**Tab 2**
2:20 pm	**Public Comment**	
2:25 pm	**Data Notebook "Part I" Analysis** *Samantha Spangler, Behavioral Health Data Project*	**Tab 3**
2:55 pm	**Public Comment**	
3:00 pm	**Break**	
3:10 pm	**Behavioral Health Transformation Quality and Equity Advisory Committee Updates** *Noel O'Neill, Chairperson and All*	**Tab 4**
3:25 pm	**Public Comment**	
3:30 pm	**Subcommittee Reports (Action Item)** *Noel O'Neill, Chairperson and Susan Wilson, Council Member*	**Tab 5**
3:50 pm	**Public Comment**	
3:55 pm	**Break**	
4:05 pm	**Data Notebook 2023 (Stakeholder Engagement) and 2024 (Homelessness) Updates**	**Tab 6**

If reasonable accommodations are required, please contact the Council at (916) 701-8211, not less than 5 working days prior to the meeting date.

Susan Wilson, Linda Dickerson, and Justin Boese

4:15 pm **Data Notebook 2025 Planning and Topic Selection** **Tab 7**
Noel O'Neill, Chairperson and All

4:45 pm **Public Comment**

4:50 pm **Next Steps and Planning for Future Activities**
Noel O'Neill, Chairperson and All

5:00 pm **Adjourn**

The scheduled times on the agenda are estimates and subject to change.

Public Comment: Limited to a **2-minute maximum** to ensure all are heard

Performance Outcome Committee Members
Chairperson: Noel O'Neill

Members:
Karen Baylor
Steve Leoni
Don Morrison
Uma Zykofsky
Erin Franco
Catherine Moore
Susan Wilson

Invited External Partners
Theresa Comstock, CA Association of Local Behavioral Health Boards/Commissions
Samantha Spangler, Behavioral Health Data Project

Council Staff
Justin Boese
Linda Dickerson

TAB 1

California Behavioral Health Planning Council
Performance Outcomes Committee
Tuesday, January 14, 2025

Agenda Item: Review October 2024 Meeting Minutes

Enclosures: Draft of October 2024 Meeting Minutes.

Background/Description:

Committee members will review the draft meeting minutes for October 2024 and have the opportunity to request edits to the documents.

California Behavioral Health Planning Council
Performance Outcomes Committee
October 15, 2024

Meeting Minutes

Committee Members Present:
Noel O'Neill, Chair-Elect
Erin Franco
Catherine Moore
Uma Zykofsky
Steve Leoni
Don Morrison
Karen Baylor

Invited External Partners Present:
Theresa Comstock, CA Association of Local Behavioral Health Boards/Commissions
Samantha Spangler, Behavioral Health Data Project

Staff Present:
Justin Boese
Jenny Bayardo
Naomi Ramirez

Item #1: Welcome and Introductions

The committee meeting began at 2:00pm.

Noel O'Neill, the Chair-Elect of the committee, facilitated in Susan Wilson's absence. Noel welcomed all committee members and guests. A quorum was established with 7 out of 8 members.

Item #2: Review Meeting Minutes

The Committee reviewed the meeting minutes for June 2024 and August 2024. One edit was requested to fix a typo on the August 2024 minutes. The minutes were accepted with that revision.

Item #3: Data Notebook Updates

Noel O'Neill and Justin Boese provided updates on the 2023 Data Notebook on Stakeholder Engagement and the 2024 Data Notebook on Homelessness. The overview report and executive summary for the 2023 data notebook is still in development and will be finalized soon. Justin said that the 2024 Data Notebook survey

was sent out to the counties at the beginning of September with a return date of November 30, 2024. So far there are several counties who have begun to fill out the online survey.

Item #4: Data Notebook "Part I" Analysis

Samantha Spangler gave a presentation on her work analyzing the "Part I" data from the 2019-2023 data notebooks. Samantha's presentation began with an overview of the missing county data, and a discussion about the options there are for addressing these gaps. The options include using data from submitted years to estimate missing years, using data from similar counties (matched by size and region) to estimate missing years, or not filling in the missing data at all and prioritizing accuracy even if it means not being able to analyze statewide trends.

Samantha then provided a quick explanation of "data cleaning" and data quality concerns that can cannot be addressed by data cleaning. Then she went over the four main topics of the Part I data (Adult Residential Facilities, Institutions of Mental Disease, Housing and Homelessness, and Children/Youth in Group Care) and provided commentary on the data quality concerns for each topic. This included missing data for each topic, inconsistencies in reporting, lack of baseline data, and other factors.

After the presentation, Samantha asked the committee for their opinions and feedback on what direction they would like her to take to address the missing data. Several members and partners, including Uma Zykofsky, Theresa Comstock, Steve Leoni, and Erin Franco voiced concerns with estimating missing data, and there was general consensus by the committee to prioritize accuracy. Karen Baylor suggested reaching out to the counties to give them a brief window of time to fill in missing data for analysis. Samantha said that was a potential option.

After hearing the feedback from the committee, Samantha said that she prioritize accuracy over completeness in her analysis. She will have another update on the analysis report for the January meeting.

California Behavioral Health Planning Council
Performance Outcomes Committee
October 15, 2024

Meeting Minutes

Item #5: Committee Workplan Implementation Planning

Noel O'Neill led the committee on a discussion of workplan implementation and presented a plan for two sub-committees to work on specific workplan goals. The two subcommittees are:

- Subcommittee 1, focused on Workplan Goal #4: Showcasing effective programs that feature the Council's guiding principles and that are successful in assisting consumers in their recovery. This subcommittee would initially be chaired by Noel O'Neil.
- Subcommittee 2, focused on Workplan Goal #3: Facilitating stakeholder engagement on behalf of the Council. This subcommittee would be chaired by Susan Wilson. The subcommittee will be guided by the Officer Team and the Executive Committee of the Council.

Noel said that participation in the subcommittees was voluntary, but they hoped that each member would choose at least one to participate in. These subcommittees will hold meeting between the quarterly meetings and would report to the full committee on their activities. The full committee will then give feedback and direction to each subcommittee.

Committee members voiced approval for the formation of the subcommittees. Several members volunteered to serve on the subcommittees. Justin Boese will confirm subcommittee membership and schedule meetings for them before the January quarterly meeting.

Item #6: Data Notebook 2025 Planning and Topic Selection

Noel began the discussion of the 2025 Data Notebook planning with a few notes based on the 2024 Data Notebook development. He reminded the committee that one of the goals was to take the topic of the previous year (homelessness for 2024) and collect data on it again in 2025, along with adding a new topic. He also reminded the committee that the 2024 Data Notebook includes questions asking the local behavioral health boards and commissions about the kinds of performance outcomes they collect, and what topics they are interested in for future data notebooks. Noel asked the committee members if they wanted to select a topic for the 2025 Data Notebook now or

wait until January to pick a topic based on the results of the 2024 Data Notebook survey.

Erin Franco suggested moving forward with a topic for the 2025 Data Notebook now and utilizing the feedback from the 2024 Data Notebook survey for the development of the 2026 Data Notebook. Uma Zykofsky recommended that the committee put a pause on the data notebook for 2025 and spend more time thinking about the development of the project moving forward. Alternatively, if the committee does do one in 2025, she suggested that it should be very limited and discrete in scope. Steve Leoni raised concerns about the implementation of the Behavioral Health Services Act in 2026 and suggested that the committee use the Data Notebook to help establish a baseline in data before the system undergoes so much change. Don Morrison put forth the topic of peer services and peer certification.

Karen Baylor said that she had concerns about the value of the data notebook and believed that taking the time to gather feedback from the boards on what is of value to them would help improve the project moving forward. Samantha Spangler said that she was in favor of doing a 2025 Data Notebook but having it be a very streamlined and focused version. She also said that she felt it was very important to get the feedback from the 2024 Data Notebook first before deciding the topic, so that the boards know that the committee is listening to them.

Theresa Comstock shared a web page from the California Association of Local Behavioral Health Boards and Commissions (CALBHBC) website where they list performance outcomes data that is available from each county. She also shared a form that CALBHBC staff use to catalog the data from each county by source. Theresa suggested that the form could be adapted to survey counties directly on what performance outcomes data they collect.

Noel suggested that the committee wait until the January 2025 quarterly meeting to choose a topic for the 2025 Data Notebook, based on the results received for the 2024 Data Notebook at that time. He agreed with Karen’s comments that he wants the data notebook to be useful to the counties and the boards. Catherine Moore brought up that the work of the Department of Health Care Services (DHCS) Quality and Equity Advisory Committee (QEAC) may be relevant to the committee’s work regarding performance outcomes, given that they are currently working on identifying performance outcomes measures for standardization statewide.

California Behavioral Health Planning Council
Performance Outcomes Committee
October 15, 2024

Meeting Minutes

Item #7: Nominate Chair-Elect for 2025 (Action Item

Noel O'Neill, the current Chair-Elect of the Performance Outcomes Committee, will become the committee Chairperson in January 2025. The committee discussed nominations for a 2025 Chair-Elect. Noel recommended that Susan Wilson be nominated for the position.

Catherine Moore made a motion to nominate Erin Franco for performance outcomes committee Chair-Elect. The motion was seconded by Don Morrison.

During discussion of the motion, several members expressed that they would prefer if the committee voted on this item with Susan Wilson present.

Steve Leoni made a motion to table the original motion to the upcoming January Meeting, which was seconded by Uma Zykofsky. A vote was taken, and the motion passed.

Item #8: Next Steps and Planning for Future Activities

Noel O'Neill and the committee members identified next steps and agenda items for the January 2025 meeting. These next steps included:

- Nomination of a new Chair-Elect for the committee.
- The finalized 2023 Data Notebook Overview Report and Executive Summary on Stakeholder Engagement.
- Updates on the 2024 Data Notebook survey on Homelessness.
- Subcommittee report-outs.
- Updates on the Part I analysis by Samantha Spangler.
- Choose a topic for the 2025 Data Notebook, based on feedback received from the local boards and commissions in the 2024 Data Notebook survey.
- Updates from the DHCS Quality and Equity Advisory Committee.

The meeting adjourned at 5:00pm.

TAB 2

California Behavioral Health Planning Council
Performance Outcomes Committee
Tuesday, January 14, 2025

Agenda Item: Nominate Chair-Elect for 2025

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides the opportunity for committee members to nominate the next Performance Outcomes Committee Chair-Elect. The Chair-Elect is responsible for supporting the Chairperson with leading committee activities.

Background/Description:

Each standing committee shall have a Chairperson and Chair-Elect. The Chairperson serves a term of one year with the option for re-nomination for one additional year. The committee members shall nominate a Chairperson and Chair-Elect to be submitted to the Council's Officer Team for appointment in 2025.

Noel O'Neill will become the Chairperson for the Performance Outcomes Committee at the January 2025 meeting. The committee members shall nominate a Chair-Elect to be submitted to the Officer Team for appointment.

The role of the Chair-Elect is outlined below:

- Facilitate the committee meetings as needed, in the absence of the Chairperson.
- Assist the Chairperson and staff with setting the committee meeting agendas and other committee planning.
- Participate in the Executive Committee Meetings.
    - Wednesday of every quarterly meeting from 8:30 am – 10:00 am
- Participate in the Mentorship Forums.

Motion: Nomination of a committee member as the Chair-Elect.

TAB 3

California Behavioral Health Planning Council
Performance Outcomes Committee
Tuesday, January 14, 2025

Agenda Item: Data Notebook "Part I" Analysis

Enclosure:

- Data Notebook Part I: Initial Evaluation and Analysis Plan
- Preliminary Trend Analysis – Data Notebook Part I (For a copy of these PowerPoint slides, please contact Justin Boese at Justin.Boese@cbhpc.dhcs.ca.gov)

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item is related to the evaluation of the behavioral health system through the Data Notebook project.

Background/Description:

Each year the Council releases a Data Notebook to the local mental/behavioral health boards and commissions to complete with their perspectives on focused areas of the system. From 2019 to 2023, the committee designed a section of the survey (designated as "Part I") with standard questions to track potential trends in the behavioral health system affecting vulnerable populations. This included foster youth, homeless individuals, and those with serious mental illness (SMI) who need housing in adult residential facilities (ARFs) and some other settings.

The Council executed a contract with Samantha Spangler of the Behavioral Health Data Project in May 2024 to analyze the Part I data collected from 2019-2023. At the October 2024 committee meeting, Samantha presented a data quality summary and asked for committee input on how to proceed with data cleaning. Samantha will provide further updates on the analysis process.

Behavioral Health Data Project

California Behavioral Health Planning Council

Data Notebook Part I

Initial Evaluation and Analysis Plan

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Table of Contents

Background

The California Behavioral Health Planning Council ("Planning Council") develops an annual Data Notebook designed to capture information on the performance of the public behavioral health system. Data Notebooks are shared with local behavioral health boards and commissions, who are required to report local performance outcomes data to the Planning Council each year. The Data Notebooks include a series of questions for local boards and commissions to complete, typically centered around a theme selected by the Planning Council's Performance Outcomes Committee (POC). From 2019 through 2023, Data Notebooks also included a set of questions that were asked each year (called "Part 1" of the Data Notebook), covering four key subjects:

- Adult Residential Facilities (ARFs);
- Institutions of Mental Disease (IMDs);
- Homelessness and Housing Services; and
- Children and Youth in Group Care.

The Planning Council contracted Behavioral Health Data Project (BHDP) to review the data submitted in Part 1 of the Data Notebook to determine the quality of the data and create an approach to analyzing the data to identify statewide trends and key insights. This report describes the quality of the data collected and BHDP's proposed analysis approach.

BHDP met with the Planning Council POC to discuss their preferred approach to analyzing Part 1 data. The POC hopes to maximize the use of the data submitted, while minimizing estimation of missing data. They hope to be able to identify statewide trends where possible. Additionally, there have been significant improvements to public data reporting since collection of Part 1 data began. Where possible, BHDP will incorporate publicly available data to provide context to the data and address gaps in data submitted via the Data Notebook.

BHDP will also use publicly available data to normalize data to county[1] population and control for differences in county size. BHDP will use two data sources for normalization:

- Total population data; and
- Medi-Cal eligibility data.

BHDP will consider three different approaches to identifying trends in data. First, five year trend analysis, which looks at data across all five years from 2019 to 2023. This analysis requires the highest standard of data quality and necessitates having data for each year in the data collection period. Second, five year change analysis, which compares data for 2019 with data from 2023. This analysis only requires data for the 2019 and 2023 Data Notebooks, but may miss interesting trends that occur in the interim years. Third, first to last change analysis compares data for the first and last years of data submitted for each county. This analysis can be completed with any two years of data and allows the greatest representation of data submitted, but presents significant challenges with interpreting analysis results due to the variability in the years when data was collected. BHDP recommends focusing on results from the five year trend and five year change analysis but has included information on the feasibility of first to last change analysis as well for discussion purposes.

[1] Most specialty mental health services in California are administered by county mental health plans. However, there are a few exceptions to this structure: City of Berkeley and Tri-City mental health plans function independently of their respective counties, and Sutter and Yuba Counties have one, merged mental health plan. For simplicity, this report uses the term "counties" throughout to describe local mental health plans.

Data Notebook Submission

Each year, local behavioral health boards and commissions receive and complete the Data Notebook. On average, approximately 45 counties (77%) completed the Data Notebook each year between 2019 and 2023. 30 counties (51%) completed all five Data Notebooks between 2019 and 2023. 54 counties (92%) completed two or more Data Notebooks.

In addition to statewide trends, BHDP will consider trends based on county size and region. The tables below show Data Notebook submission across county regions and sizes.

Region	Less than 2	2-4	5	Total
Central	0 (0.0%)	9 (47.4%)	10 (52.6%)	19
Greater Bay Area	2 (15.3%)	5 (38.5%)	6 (46.2%)	13
Los Angeles	0 (0.0%)	0 (0.0%)	1 (100.0%)	1
Southern	1 (10.0%)	2 (20.0%)	7 (70.0%)	10
Superior	2 (12.5%)	8 (50.0%)	6 (37.5%)	16

Size	Less than 2	2-4	5	Total
Extra Small	1 (6.7%)	7 (46.7%)	7 (46.7%)	15
Small	1 (7.1%)	6 (42.9%)	7 (50.0%)	14
Medium	1 (6.7%)	7 (46.7%)	7 (46.7%)	15
Large	2 (14.3%)	4 (28.6%)	8 (57.1%)	14
Extra Large	0 (0.0%)	0 (0.0%)	1 (100.0%)	1

BHDP will reach out to representatives from counties whose data did not meet the standards for inclusion in Part 1 analysis. Five counties did not submit sufficient data to be included in analysis of Data Notebook data:

- City of Berkeley;
- Modoc;
- Riverside;
- Solano; and
- Tehama.

These five counties will be included in the analysis of publicly available data and qualitative analysis where possible.

Adult Residential Facility (ARF) Data

Part 1 of the Data Notebook asked three questions about services provided in ARFs:

- For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Facility (ARF) during the last fiscal year?
- What is the total number of ARF bed-days paid for these individuals, during the last fiscal year?
- How many individuals served by your county behavioral health department need this type of housing but currently are not living in an ARF?

Data on the number of ARFs and the number of beds in those facilities is published by the California Department of Social Services (CDSS). The data collected in Data Notebook Part 1, combined with publicly available data, can be used to calculate the following measures related to ARFs[2]:

- *Number of ARFs;*
- *Number of ARF beds;*
- Number of people served in ARFs;
- Number of bed-days paid for ARF services;
- ARF length of stay (bed-days/people served); and
- Number of people with unmet needs for ARF services.

Data Quality

The primary concern with ARF data quality is missing data, particularly for the number of people with unmet needs for ARF services. Additionally, there is some degree of inconsistent reporting of individuals and bed-days (i.e., the number of bed-days reported exceeds the maximum for the number of individuals served) and use of inconsistent methodology for calculating unmet needs. The table below depicts the number of counties and the percent of the total statewide population with sufficient data to include in each type of analysis.

[2] Italicized measures are calculated using publicly available data

Measure	5 Year Trend		5 Year Change		First to Last	
	No Estimation	Estimation	No Estimation	Estimation	No Estimation	Estimation
Number of ARFs	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)
Number of ARF beds	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)
Number of people served in ARFs	24 (30.0%)	32 (74.0%)	36 (78.6%)	37 (79.7%)	52 (91.0%)	54 (91.8%)
Number of ARF bed-days paid	23 (29.9%)	32 (74.0%)	35 (78.4%)	37 (79.7%)	52 (91.0%)	53 (91.4%)
ARF length of stay (bed-days/people served)	23 (29.9%)	32 (74.0%)	35 (78.4%)	37 (79.7%)	52 (91.0%)	53 (91.4%)
Number of people with unmet ARF needs	6 (1.4%)	18 (17.8%)	14 (8.2%)	21 (20.8%)	43 (52.0%)	43 (52.0%)

Analysis Approach

BHDP will calculate all measures including and excluding estimated data to understand the impact of including estimated data on overall conclusions and the ability to identify statewide trends. Due to the small number of counties with sufficient data quality on unmet ARF needs, BHDP anticipates that analysis of this measure will be limited to local, rather than state-wide, insights.

Institutions of Mental Disease (IMD) Data

Part 1 of the Data Notebook asked three questions about services provided in IMDs:

- Does your county have any "Institutions for Mental Disease" (IMDs)? If Yes, how many IMDs?
- For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year?
    - In-County
    - Out-of-County
- What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period?

Data on the number of IMDs and the number of beds in those facilities is published by the California Department of Health Care Services (DHCS). The data collected in Data Notebook Part 1, combined with publicly available data, can be used to calculate the following measures related to IMDs[3]:

- *Number of IMDs;*
- *Number of IMD beds;*
- *Number of counties with IMDs;*
- *Distance to closest IMD;*
- Number of people served in IMDs in-county;
- Number of people served in IMDs out-of-county;
- Number of IMD bed-days paid; and
- IMD length of stay (bed-days/people served).

Data Quality

Since data on the number of IMDs was available both publicly and in the Data Notebook submissions, BHDP compared the responses. Differences between the two data sources appear for two main reasons: some counties included out-of-state IMDs in their count, while others did not include all IMDs found on the state list.

[3] Italicized measures are calculated using publicly available data

The primary concern with the quality of data on individuals served in IMDs and the number of bed-days paid is inconsistent reporting of individuals and bed-days (i.e., the number of bed-days reported exceeds the maximum for the number of individuals served). There is also some degree of missing data. The table below depicts the number of counties and the percent of the total statewide population with sufficient data to include in each type of analysis.

Measure	5 Year Trend		5 Year Change		First to Last	
	No Estimation	Estimation	No Estimation	Estimation	No Estimation	Estimation
Number of IMDs	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)
Number of IMD beds	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)
Number of counties with IMDs	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)
Distance to closest IMD	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)	59 (100.0%)
Number of people served in IMDs in county	23 (36.9%)	30 (51.4%)	34 (77.9%)	37 (79.3%)	53 (91.6%)	53 (91.6%)
Number of people served in IMDs out of county	23 (36.9%)	30 (51.4%)	34 (77.9%)	37 (79.3%)	53 (91.6%)	53 (91.6%)
Number of IMD bed-days paid	19 (34.3%)	31 (51.4%)	33 (78.4%)	36 (78.8%)	54 (91.6%)	54 (91.6%)
IMD length of stay (bed-days/people served)	19 (34.3%)	30 (51.4%)	33 (77.2%)	35 (78.7%)	53 (91.6%)	53 (91.6%)

Analysis Approach

To facilitate broader statewide analysis and minimize differences in approaches to counting IMDs, BHDP plans to use publicly available data on the number of IMDs rather

than the data reported in the Data Notebook. However, BHDP will analyze differences in what was reported in the Data Notebook and what is publicly available to understand ways in which data may be interpreted inconsistently.

For other measures, BHDP will calculate measures including and excluding estimated data to understand the impact of including estimated data on overall conclusions and the ability to identify statewide trends.

Housing and Homelessness

Part 1 of the Data Notebook asked one question about programs serving individuals who are both homeless and have severe mental illnesses:

- During the most recent fiscal year (2020-2021), what new programs were implemented, or existing programs were expanded, in your county behavioral health department to serve persons who are both homeless and have severe mental illness? (Mark all that apply)
    - Emergency Shelter
    - Temporary Housing
    - Transitional Housing
    - Housing/Motel Vouchers
    - Supportive Housing
    - Safe Parking Lots
    - Rapid re-housing
    - Adult Residential Care Patch/Subsidy
    - Other (please specify)

Data on people experiencing homelessness and programs intended to serve them is published by the United States Department of Housing and Urban Development (HUD). The data collected in Data Notebook Part 1, combined with publicly available data, can be used to calculate the following measures related to housing and homelessness[4]:

- *Number of individuals and households experiencing homelessness;*
- *Number of programs for individuals and households experiencing homelessness;*
- *Number of beds for individuals and households experiencing homelessness; and*
- Counties reporting expansion of programs serving people who are both homeless and have severe mental illness.

HUD data is aggregated by Continuum of Care (CoC), rather than county. A crosswalk of CoCs in California to the counties they comprise is available in Appendix A.

[4] Italicized measures are calculated using publicly available data

Data Quality

HUD tracks housing and homelessness data via two primary data sources:

- Housing Inventory Count (HIC)[5], which describes the programs and beds that are active in a given year; and
- Point-in-Time (PIT) count[6], which describes the number of individuals experiencing sheltered or unsheltered homelessness on a specific day in January of each year.

HIC and PIT data is available for all years in this time frame but is aggregated by Continuum of Care, not county[7]. There are 47 CoCs in California. One county (Los Angeles) has more than one CoC, while 23 counties are in CoCs that contain more than one county. City of Berkeley and Tri-City data is merged into Alameda County and Los Angeles County CoC data, respectively.

HIC and PIT data allows calculation of a variety of measures related to housing and homelessness. HIC data reports the following data for Emergency Shelter, Safe Haven, Transitional Housing, Permanent Supportive Housing, Rapid Rehousing, and Other Permanent Housing programs:

- Number of programs
- Number of family units
- Number of beds (broken down by family, adult only, child only)
- Seasonal beds
- Overflow/voucher beds
- Chronic beds
- Veteran beds
- Youth beds

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[5] CoC Housing Inventory Count Reports - HUD Exchange

[6] CoC Homeless Populations and Subpopulations Reports - HUD Exchange

[7] Due to the large volume of data available in the HIC and PIT data sources, that data is not transcribed in this report.

PIT data reports the number of people experiencing homelessness in Emergency Shelter, Transitional Housing, or Unsheltered settings. The data is segregated into the following categories:

- Number of homeless individuals and families
- Age/Ethnicity/Gender/Race breakdown of homeless individuals
- Chronically homeless households
- Individuals who self-report the following characteristics:
    - Severely mentally ill
    - Chronic substance abuse
    - Veterans
    - HIV/AIDS
    - Victims of Domestic Violence
    - Unaccompanied Youth
    - Parenting Youth
    - Children of Parenting Youth

Importantly, HIC and PIT data are not exclusive to programs serving individuals with serious mental illnesses. Information reported in Data Notebook Part 1 provides additional context on programs that may not be included in HIC data, as well as qualitative information about counties' initiatives to serve this population.

Analysis Approach

BHDP plans to use publicly available data to provide context on housing and homelessness services, alongside a summary of the data provided in Data Notebook Part 1. Additionally, BHDP will conduct a qualitative analysis of data provided in Data Notebook Part 1 to fully characterize the behavioral health system's efforts to support people experiencing both homelessness and serious mental illness.

Children/Youth in Group Care Data

Part 1 of the Data Notebook asked three questions about children and youth served in group care settings:

- Do you think your county is doing enough to serve the children/youth in group care? If No, what is your recommendation? Please list or describe briefly
- Has your county received any children needing "group home" level of care from another county? If Yes, how many?
- Has your county placed any children needing "group home" level of care into another county? If Yes, how many?

Data on the number of out-of-county placements for children and youth in group care is published via CDSS's Continuum of Care Reform (CCR) dashboards[8]. The data collected in Data Notebook Part 1, combined with publicly available data, can be used to calculate the following measures related to children and youth in group care[9]:

- Counties who feel they're doing enough to serve children/youth in group care;
- *Children/youth placed out of county; and*
- *Children/youth placed from out of county.*

CCR dashboard data is reported on a quarterly, rather than annual basis.

Data Quality

CCR dashboards were launched since the Planning Council began collecting the information in Part 1 of the Data Notebook, but data is available for all years in this time frame. Unfortunately, the data is not directly comparable because CCR dashboard data is reported quarterly and Data Notebook data is reported annually, and there may be duplication across quarters in CCR dashboard data if aggregated on an annual basis.

The primary concern with the quality of data on children and youth served in group care settings is missing data, along with inconsistent definitions of sufficient care and approaches to quantifying individuals transferred into and out of county for group care services. The table below depicts the number of counties and the percent of the total

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[8] CCR Dashboard | Tableau Public

[9] Italicized measures are calculated using publicly available data

statewide population with sufficient data to include in each type of analysis using data from the Data Notebook.

Measure	5 Year Trend		5 Year Change		First to Last	
	No Estimation	Estimation	No Estimation	Estimation	No Estimation	Estimation
Counties "doing enough" to serve this population	29 (66.3%)	30 (66.8%)	36 (79.7%)	36 (79.7%)	55 (92.0%)	55 (92.0%)
Number of children and youth received from other counties	17 (30.5%)	26 (40.2%)	25 (37.5%)	34 (79.4%)	52 (88.6%)	52 (88.6%)
Number of children and youth placed into other counties	22 (30.9%)	29 (48.5%)	32 (71.1%)	35 (78.4%)	52 (88.5%)	52 (88.5%)

Analysis Approach

BHDP plans to analyze and compare both publicly available data and data submitted via Part 1 of the Data Notebook for children and youth in group care. BHDP will also conduct a qualitative analysis of counties' recommendations for improving the ways California serves this population.

Conclusions and Next Steps

After analyzing the quality of the data submitted via the Data Notebook Part 1 and available public data related to the same topics, BHDP is confident that it is possible to analyze the data and identify key state, regional, and local trends and insights. However, full five year trend analysis of Data Notebook data will represent only a fraction and may therefore not meaningfully represent statewide trends. Data on changes over the full five years (comparing 2019 data to 2023) is expected to represent a larger proportion of the state. Moreover, BHDP will be able to compare the data reported via the Data Notebook with that reported via publicly available data sources to identify commonalities and discrepancies in findings based on the data source. BHDP will share preliminary analysis findings with the Planning Council POC to discuss conclusions and interpretations of the data and how to summarize the data for publication.

Appendix A. California Continuums of Care (CoC)

County	CoC Number	CoC Name
Alameda	CA-502	Oakland, Berkeley/Alameda County
Alpine	CA-530	Alpine, Inyo, Mono Counties
Amador	CA-526	Amador, Calaveras, Mariposa, Tuolumne Counties
City of Berkeley	CA-502	Oakland, Berkeley/Alameda County
Butte	CA-519	Chico, Paradise/Butte County
Calaveras	CA-526	Amador, Calaveras, Mariposa, Tuolumne Counties
Colusa	CA-523	Colusa, Glenn, Trinity Counties
Contra Costa	CA-505	Contra Costa County
Del Norte	CA-516	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties
El Dorado	CA-525	El Dorado County
Fresno	CA-514	Fresno City and County/Madera County
Glenn	CA-523	Colusa, Glenn, Trinity Counties
Humboldt	CA-522	Humboldt County
Imperial	CA-613	Imperial County
Inyo	CA-530	Alpine, Inyo, Mono Counties
Kern	CA-604	Bakersfield/Kern County
Kings	CA-513	Visalia/Kings, Tulare Counties
Lake	CA-529	Lake County
Lassen	CA-516	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties
Los Angeles[10]	CA-600 CA-606 CA-607 CA-612	Los Angeles City and County Long Beach Pasadena Glendale
Madera	CA-514	Fresno City and County/Madera County
Marin	CA-507	Marin County
Mariposa	CA-526	Amador, Calaveras, Mariposa, Tuolumne Counties
Mendocino	CA-509	Mendocino County
Merced	CA-520	Merced City and County

[10] Los Angeles County's population has been adjusted to remove the population residing in the Tri-City region (Claremont, La Verne, and Pomona).

Modoc	CA-516	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties
Mono	CA-530	Alpine, Inyo, Mono Counties
Monterey	CA-506	Salinas/Monterey, San Benito Counties
Napa	CA-517	Napa City and County
Nevada	CA-531	Nevada County
Orange	CA-602	Santa Ana, Anaheim/Orange County
Placer	CA-515	Roseville, Rocklin/Placer County
Plumas	CA-516	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties
Riverside	CA-608	Riverside City and County
Sacramento	CA-503	Sacramento City and County
San Benito	CA-506	Salinas/Monterey, San Benito Counties
San Bernardino	CA-609	San Bernardino City and County
San Diego	CA-601	San Diego City and County
San Francisco	CA-501	San Francisco
San Joaquin	CA-511	Stockton/San Joaquin County
San Luis Obispo	CA-614	San Luis Obispo County
San Mateo	CA-512	Daly City/San Mateo County
Santa Barbara	CA-603	Santa Maria/Santa Barbara County
Santa Clara	CA-500	San Jose/Santa Clara City and County
Santa Cruz	CA-508	Watsonville/Santa Cruz City and County
Shasta	CA-516	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties
Sierra	CA-516	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties
Siskiyou	CA-516	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties
Solano	CA-518	Vallejo/Solano County
Sonoma	CA-504	Santa Rosa, Petaluma/Sonoma County
Stanislaus	CA-510	Turlock, Modesto/Stanislaus County
Sutter-Yuba	CA-524	Yuba City and County/Sutter County
Tehama	CA-527	Tehama County
Tri-City	CA-600	Los Angeles City and County
Trinity	CA-523	Colusa, Glenn, Trinity Counties
Tulare	CA-513	Visalia/Kings, Tulare Counties
Tuolumne	CA-526	Amador, Calaveras, Mariposa, Tuolumne Counties
Ventura	CA-611	Oxnard, San Buenaventura/Ventura County
Yolo	CA-521	Davis, Woodland/Yolo County

TAB 4

California Behavioral Health Planning Council
Performance Outcomes Committee
Tuesday, January 14, 2025

Agenda Item: Behavioral Health Transformation Quality and Equity Advisory Committee Updates

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item is related to the evaluation of the behavioral health system through the development of statewide performance outcomes measures.

Background/Description:

The Department of Healthcare Services has convened the Behavioral Health Transformation Quality and Equity Advisory Committee to support the development of a quality and equity strategy and advise the Department in improving behavioral health statewide. This committee will meet quarterly to provide the Department with guidance and recommendations on proposed statewide population behavioral health goals and associated measures. A subset of members of the Quality and Equity Advisory Committee are involved on the Technical Sub-Committee, which will meet bi-monthly to provide DHCS with recommendations based on their expertise in behavioral health data and measurement, population health, quality improvement, and equity.

The Performance Outcomes Committee has identified that the activities of the Quality and Equity Advisory Committee regarding performance outcomes measures align with the committee's duties and interests. Several members and partners of the Performance Outcomes Committee are on the Quality and Equity Advisory Committee including Noel O'Neill, Theresa Comstock, and Samantha Spangler. Samantha is also on the Quality and Equity Advisory Committee Technical Sub-Committee. They will provide relevant updates to the Performance Outcomes Committee.

TAB 5

California Behavioral Health Planning Council
Performance Outcomes Committee
Tuesday, January 14, 2025

Agenda Item: Subcommittee Reports

Enclosures: Performance Outcomes Committee – Subcommittee 1 Meeting Notes

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item is related to the evaluation and advocacy of the behavioral health system by identifying promising behavioral health programs and facilitating stakeholder engagement on behalf of the Planning Council.

Background/Description:

At the October 2024 quarterly meeting, the Performance Outcomes Committee decided to form two subcommittees to facilitate work on specific workplan goals. The two subcommittees formed are:

- Subcommittee 1, focused on Workplan Goal #4: Showcasing effective programs that feature the guiding principles of the committee and the Council that are successful in assisting consumers in their recovery. This subcommittee would initially be chaired by Noel O'Neil.
- Subcommittee 2, focused on Workplan Goal #3: Facilitating stakeholder engagement on behalf of the Council. This subcommittee will be chaired by Susan Wilson. The subcommittee will be guided by the Officer Team and the Executive Committee of the Council.

The two subcommittees had their initial meetings in December 2024. Noel O'Neill and Susan Wilson will report to the Performance Outcomes Committee on subcommittee activities.

California Behavioral Health Planning Council
Performance Outcomes Committee

Subcommittee for Identifying Innovative Programs
December 10, 2024
Meeting Notes

Members Present: Noel O'Neill, Karen Baylor, Don Morrison
CBHPC Staff Present: Jenny Bayardo, Naomi Ramirez, Justin Boese

To accomplish the Performance Outcomes Committee's 2024-25 Work Plan Goal 4, this new subcommittee had an initial meeting on 12/10/24. The following points were discussed:

- Identified that WIC 5772-C-4 requires the Council to identify and highlight innovative and exciting programs.
    - Programs identified need to reflect the stated values of the Council.
- Reviewed the Council's guiding principles.
- Once programs are identified and researched, the subcommittee will produce a white paper that includes the committee's discoveries and findings.
- Subcommittee members agreed that there would be no timeline for this project. The Subcommittee is far more interested in quality of the white paper rather than the timeline. This project is not meant to be an annual accomplishment.
- We discussed a range of audiences for the white paper which will include the legislature, The Department of Health Care Services, Behavioral Health Directors, County Boards, Boards of Supervisors across the State, and all stakeholders, especially consumers of services.
- Identified a range of potential innovative programs to focus on. The subcommittee members agreed to include both Mental Health and Substance Use Disorder consumers in our focus. Some initiatives considered are:
    - Peer Respite Centers
    - Wellness Centers
    - Transition Age Youth Full-Service Partnership Programs
    - Mobile Crisis Teams
    - Sobering Centers
    - Adolescent Substance Use Disorder Residential Treatment Programs
- The subcommittee is leaning toward researching and recommending a type of program rather than individual programs. The subcommittee will not endorse any specific program but may list examples of existing programs in reports.
- After much discussion members decided a good first project will be Wellness Centers. The subcommittee will describe different models and variations of Wellness Centers and will interview a variety of persons involved including consumers who participate; direct line staff; direct supervision staff; and County administrators who may fund the program.

- Since most counties have Wellness Centers, the subcommittee plans to visit local centers. They will aim to visit programs that are close to the locations of the Council's quarterly meetings to reduce travel expenses.
- The overall intention is to bring attention to programs that are working well, identify real challenges, discuss funding, and mention benefits to consumers. As we do this work, we will be keeping the six primary Guiding Principles the Council abides by in mind.
- The subcommittee may make some recommendations in the white paper based on the findings.
- The subcommittee will not move forward with this plan until approval is given by the full committee.

TAB 6

California Behavioral Health Planning Council
Performance Outcomes Committee
Tuesday, January 14, 2025

Agenda Item: Data Notebook 2023 (Stakeholder Engagement) and 2024 (Homelessness) Updates

Enclosures: 2023 Data Notebook Executive Summary

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides an update for committee members on the 2023 Data Notebook on Stakeholder Engagement and the 2024 Data Notebook on Homelessness as part of the committee's work evaluating the behavioral health system.

Background/Description:

Each year the Council releases a Data Notebook to the local mental/behavioral health boards and commissions to complete with their perspectives on focused areas of the system.

The final draft of the 2023 Data Notebook Overview Report was submitted to the Performance Outcomes Committee members for review in December 2024 with a finalization date of December 31, 2024.The final copy of this report will be provided at the meeting.

During this agenda item members will have an opportunity to review the enclosed 2023 Data Notebook Executive Summary and provide feedback. Additionally, Justin Boese, committee staff, will provide an update on the status of the 2024 Data Notebook online survey.

EXECUTIVE SUMMARY:

OVERVIEW REPORT OF THE 2023 DATA NOTEBOOK PROJECT ON CALIFORNIA BEHAVIORAL HEALTH

California Behavioral Health Planning Council

ADVOCACY • EVALUATION • INCLUSION

PREPARED FOR:

THE PERFORMANCE OUTCOMES COMMITTEE OF THE CALIFORNIA BEHAVIORAL HEALTH PLANNING COUNCIL

DECEMBER 2024

The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies, and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally, and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness.

What is the Data Notebook? Purpose and Goals

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council).[1]

Part I of the data notebook has standard questions on foster youth, homeless individuals, and those with serious mental illness (SMI) who need housing in adult residential facilities (ARFs) and some other settings. These Part I questions have been used from 2019-2023. *The 2023 Data Notebook is the last year to include the Part I data and questions.* An analysis of the results for that 5-year time span is underway.

Part II is focused on "Stakeholder Engagement in the Public Mental Health System."

Methods

- A comprehensive review of this topic is addressed within the Part II 'Background' and 'Context' sections of the "Overview Report 2023 Data Notebook Project on California Behavioral Health: Stakeholder Engagement in the Public Mental health System."[2]
- Questions were developed about local stakeholder engagement and distributed to the local boards via 'SurveyMonkey'.
- These responses were compiled and analyzed by Planning Council staff in consultation with the Performance Outcomes Committee.
- After review and screening by the HIPAA and Data De-identification Offices at the Department of Health Care Services (DHCS), the report is posted on our website.

In addition, Council staff researched information from DHCS Medi-Cal data to gain perspective on the magnitude and composition of the demographic groups who were able to access Specialty Mental Health Services, designed for children and youth with

[1] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California
[2] N:\NDMC\Grants\CMHPC\Data Notebook Project\2023 Data Notebook\Overview Report & Exec SummDN2023

serious emotional disorders, and for adults with severe mental illness. Each year, our public mental health system serves a considerable number of people.

DHCS data available in 2023 were collected during fiscal year (FY) 2021-22,[3] for our California population[4] of 39,145,060 (2021):

- There were more than 15.3 million Medi-Cal beneficiaries in total (39.2% of the population).
- Specialty Mental Health Services (SMHS) were received by approximately 586,000 persons, slightly more than the same number as the prior year. These SMHS clients represented 3.8% of those eligible for Medi-Cal. Of these clients who received SMHS, 244.5K individuals were children and youth up to the age of 20. Those SMHS clients who were adults aged 21 and above (including adults 65+), comprised a total of 341.5K clients.

- In addition, approximately 1.6 million persons with mild to moderate mental health needs typically access non-specialty mental health services each year (11% of those covered by Medi-Cal).

  Compared to adults and older adults (combined, access rate of 3.6%), children and youth had higher access rates (4.3%) to both specialty (SMHS) and non-specialty mental health services[5] in the population served by Medi-Cal Service access rates varied cross demographic groups by age, race/ethnicity, and geographic region**.**

Part I: Data for Services to Vulnerable Groups with Serious Mental Illness (SMI)

The four areas addressed in Part 1 were Adult Residential Facilities (ARFs), Institutions for Mental Disease (IMDs), Foster Youth, and Homelessness.

Adult residential facilities (ARFs) serving persons with chronic or serious mental illness. ARFs are residential facilities that may provide social support services such as case management but not psychiatric treatment. Similarly, RFEs are a type of ARF that serves the elderly.

For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Care Facility (ARF), during the last fiscal year?

The total reported by 44 of the 50 reporting counties was 8,048 individuals served in an ARF. The remaining 6 small population counties plus the Tri-City agency reported zero persons were served in an ARF.

[3] Data for FY 21-22 were the most recent available from DHCS at the time of the 2023 Data Notebook.
[4]State of California population data are from https://www.census.gov/quickfacts/CA.
[5] Data not shown for non-SMHS; this point refers to recent historical data (2020-2022).

What is the total number of ARF bed-days paid for these individuals, during the last fiscal year?

A total of 1,721,120 ARF bed-days were paid for by 45 of the 50 responding counties. Zero bed-days were reported by 5 responding counties. One small county had reported zero persons, but stated they paid for 2,105 ARF bed-days.

Unmet needs: How many persons served by your county behavioral health department need this type of housing but currently do not live in an ARF?
The summed total from the 37 responding counties was 1,429 persons were known to need an ARF. And 14 counties said that they had no data available.

Numbers and utilization of IMD beds by counties (and beds in specially qualified SNFs) for persons with serious mental illness (SMI): 'IMDs' refer to Institutions for Mental Diseases, generally defined as locked psychiatric facilities for individuals on involuntary '5150' holds or who have been placed under a conservatorship.

Does your county have any 'Institutions for Mental Disease' (IMD)?

- No: 30 counties (59% of the responding boards/counties, including the Tri-City board in L.A. County).
- Yes: 21 counties (41% of the reporting counties).
- If 'Yes', how many IMDs? These 21 counties reported 59 IMDs

For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year?

- In-county: 13,528 in-county IMD clients were served in those 21 counties reporting that they have at least one IMD within their county.
- Out-of-county: 7,222 patients were served by IMDs outside of their county.
- Total IMD clients reported by the 51 counties/boards: 20,750 clients.

What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period?

A total of 1,531,500 IMD bed-days were paid for during the last fiscal year by the 49 responding counties and 1 agency (Tri-Cities Behavioral Health). This resulted in an average length of stay of 73.8 bed-days per client.

Foster youth with significant mental health needs or who are in crisis and cannot be placed safely within a foster family (or "resource family"). Programs were developed for these foster youth that included Short-Term Residential Treatment Program (STRTP) facilities to replace traditional group homes and meet higher standards with more comprehensive mental health services. The Department of Social Services reported:

- There was a continued decrease in foster youth served in 'group homes',
- There was an increase in numbers of youth served in STRTPs, and

- These trends were sustained during the first six months of 2020 (beginning of pandemic) and continued through 2023.

Homeless persons with serious mental illness and/or substance use disorders. The most striking piece of data in this section came from the January 2022 point-in-time count of homeless persons (www.HUD.gov).

- The total numbers for California continued to increase over the pre-pandemic baseline of 2019[6], such that in 2022, California numbers comprised 29.4% of all homeless persons in the USA, and nearly half, 49.4%, of all 'unsheltered' homeless persons in the country.
- Contrast that with California's population being only 11.8%, or slightly less than one-eighth, of the nation's overall population.
- Those with severe mental illness comprised 23.2% of California's homeless. Those with chronic substance use disorders were 21.0% of California's homeless. Those who were chronically homeless were 35.5% of the total.

Part II: Data Collection for Understanding Engagement in the Public Mental Health System

We asked: How often your county organizes stakeholder engagement meetings or events, for various types of community planning and outreach activities.

The summary of these data indicated that**:**

- Meetings that were held once each year or somewhat more frequently included community planning processes for MHSA programs, the annual update of the MHSA 3-year plans, EQRO focus groups, and the reviews of SAMHSA-funded grant programs.
- Local Behavioral Health advisory boards typically meet once/month, as do some meetings with other departments or agencies co-sponsored by county Behavioral Health. We note the caveat that some county Behavioral Health Boards may not have meetings all twelve months, but may be on hiatus in August or December.
.

We asked the counties and their boards to estimate the number of people who participated in your stakeholder processes in fiscal year 2022-2023:

- The total estimate was 54,595 individuals, according to data submitted by 50 counties/boards.
- However, there were many comments about meetings for which no 'count' was obtained, and some numbers were estimated.
- From the overall comments, the total given above is likely an undercount of the true numbers, but nonetheless suggest the presence of significant stakeholder participation across the state.

[6] Numbers for the 2021 Point-in-Time count did not include numbers for unsheltered individuals, due to protocols intended to reduce risk of contracting COVID-19. Normal data collection largely resumed in early 2022.

We asked: Approximately what percentage of stakeholder engagement events or efforts in your county were in-person only, virtual only, a combination of both in-person and virtual, or written communications?

- **In-person only:** 41 counties, 1404 events, 82% of total counties responding.
- **Virtual only:** 41 counties, 1407 events, from 82% of total counties responding.
- **Combination of both in-person and virtual:** 45 counties, 1499 events, 90% of total counties responding.
- **Written communications (such as online surveys or email questionnaires):** 42 counties, 699 outreach projects, 84% of counties responded.

From these data, we concluded that there were 4,310 outreach events of all types (in-person + virtual + hybrid), plus the 699 written and survey outreach projects conducted by the 51 counties/boards that responded to this question. These data provide evidence for a robust and widespread stakeholder process across the state.

We asked: Which of the most common 18 threshold languages (including American Sign Language) for California were used to conduct stakeholder meetings or outreach during fiscal year 2022-2023, with or without the use of interpreters?

- Responses indicated that the most frequent languages used in outreach events besides English were Spanish (76% of counties), American Sign Language (22% of Counties), Chinese and Tagalog (each cited by 10% of counties.
- Several languages were listed by 12% of counties under “other”:
    - Vietnamese, 7 counties
    - Mixteco, 1 or more counties
    - Dari, 2 counties
    - Pashto, Tajik, Assyrian, Persian: 1 county each.

We asked: Which of the following stakeholder groups have you collected and implemented input from within the last year? (An extensive list was provided).

The responses indicated that stakeholder groups could be separated into two broad groups, for purposes of data analysis: (1) groups of stakeholders that are clients or family members of clients who receive or need to receive services, and (2) groups of stakeholders that include those with a community role that involves these services, such as providers of mental health and/or substance use treatment services, law enforcement, representatives of managed care plans, or health care organizations.

- At least 74% of the responding counties listed all the groups of community-involved entities as being sources of input that was implemented in county programs or services.
- And 64% of counties received input from representatives of veterans’ services.
- With respect to clients of services and their family members, at least 74% of counties indicated that they obtained feedback that was implemented in their programs from individuals with SMI, including youth, adults and older adults, LGBTQ+ individuals, members of historically underserved minority groups and their family members.

- Only 64% of counties received input regarding services for developmentally disabled individuals.
- Only 36% of counties received input regarding services for hearing-impaired individuals.

We asked: Please describe how stakeholder input is communicated to the behavioral health director, the mental/behavioral health board/commission, and any other agencies or groups for informing policy.

- From the aggregated responses, it appears that counties have multiple pathways by which information gets to the various levels of the behavioral health departments, their directors, and eventually to the county boards of supervisors.
- Some of the information may come from meetings of the behavioral health boards and any of their issue-related work groups, and from public stakeholder engagement meetings held in the county, or in writing as part of meeting minutes, short reports, or issue briefings.
- Planning Council members commented that sometimes an important program or area of BH need has to be introduced multiple times, by different people, in different settings, to different audiences, before the ideas coalesce organically into tangible proposals and programs.
- Participant comments emphasized the importance of active listening skills at multiple levels of leadership and advocacy.

We asked: Please describe how your county implements collected stakeholder input to actively inform policy and programs. Include how the county decides what ideas to implement or actions to take implement or actions to take. (Descriptive data responses were received from 50 of 51 counties/boards). Examples of dividual county responses were presented in the full-length Overview Report.

We asked: Does your county have a Community Program Planning Process (CPP) in place? The responses are summarized as follows:

- No: 7 counties/boards (14% of responses)
- Yes: 44 counties (86% of responses)
- If yes, describe how you directly involve stakeholders in the development and implementation of this plan. Descriptive responses were received from 45 counties/boards.

We asked about strategies used by county departments of Behavioral Health to support the Community Planning Process. Responses were received from 51 counties/boards.

- The data indicated that 90% of the responding counties/boards use strategies that include scheduling meetings at times convenient to the community, hold meetings in geographical accessible locations around the county, designate staff assistance to facilitate meetings, provide information and training for stakeholders on MHSA programs, regulations, and procedures, and provide refreshments and/or food for participants.
- About 70% of responding counties use language translation services.

- About 55% of counties provided technical assistance to stakeholders participating in webinars, etc.
- Only 24% of counties were able to provide reimbursement for travel costs for participants, due to strict policies limiting this activity.

We asked: Does your county provide training for staff on cultural awareness, community outreach, and stakeholder engagement?

- No: 2 percent (N=1 board) (no explanatory comment was supplied).
- Yes: 98 % (N=50 counties/boards)
- If yes, describe how? Fifty counties supplied descriptive comments. These comments are summarized in the full-length Overview Report (online.)

We asked: Which barriers does your county face regarding achieving meaningful and impactful engagement of stakeholders (specifically, mental health consumers and family members)? Respondents were asked to check all that apply Number in parenthesis is percent of responding counties that selected that item (N=51).

- General difficulty with reaching stakeholders. (59%)
- Difficulty conducting community outreach to racial/ethnic communities or other specific communities of interest. (45%)
- Difficulty reaching stakeholders with disabilities. (45%)
- Shortage of properly trained staff to support/facilitate stakeholder engagement. (27%)
- Lack of funding or resources for stakeholder engagement efforts. (25%)
- Difficulty incorporating stakeholder input in the early stages of programming (18%)
- Difficulty adapting to virtual meetings/communications. (14%)
- Difficulty providing accommodations to stakeholders. (2%)

Several counties commented that transportation issues and limited bus schedules presented an important barrier to stakeholder engagement in their community.

We asked: Are your behavioral health board/commission members involved in your county's stakeholder engagement and/or CPP processes? If yes, describe how.

- Yes: 49 Counties/boards (96%) (with text comment)
- No: 2 counties/boards (4%)
- If 'Yes", describe how. Detailed descriptions were provided by 49 counties.

We asked: Has the COVID-19 pandemic increased or decreased the level of stakeholder engagement and input in your county?
Increased: 34%
Decreased: 39%
No change: 17%
Other: 10%; commonly expressed that engagement decreased during some phases of the pandemic, and increased at other times (example: after vaccines became available).

We asked: Is there a fear or perception in your county that spending time, money, or other resources on stakeholder engagement conflicts with the need to provide direct services? *(Yes/No)*

- Interestingly, 40 counties (78%) answered 'No.' Respondents were also offered the option to add a comment.
- These data can be taken as a positive or optimistic finding, as evidenced by the responses from nearly four-fifths of the responding counties/boards.

Conclusion, Summary of Findings, and Recommendations

There are two or three main conclusions to be drawn from the aggregated data submitted by fifty counties (out of 58) plus one non-county mental health board.

First, each county is an individual entity and has its own culture and practices that affect how they deliver services and how the counties engage with the public. That engagement can be directed in part to activities that provide public information and outreach to prospective clients and families that may need Behavioral Health services. In addition, there are other activities for outreach and engagement with stakeholders to obtain feedback on quality and type of services needed, and whether there are service gaps in terms of communities that are not being adequately or appropriately served. Some of the outreach to stakeholders involves members of the public who are involved in some aspect of providing services and assist in safety matters when individuals and/or their families experience a crisis indicating an urgent need for behavioral health services. These other stakeholders include providers of therapeutic services, emergency department physicians, educators and counselors in schools who may assist students who need help, and social services agencies who manage foster care placements, and they also help in connecting homeless individuals to safe shelters and other services. Law enforcement officers also play a role when public safety issues arise during a crisis, and they are also stakeholders in county Behavioral Health policies and services. Many of the changes in crisis services during the last five years, such as mobile crisis units with clinical staff, or crisis respite centers, and other care options, were the result of persistent and long-term advocacy across the state.

Second, based on responses to question we asked about policies and practices designed to acquire information and feedback from stakeholders. Then we asked further, 'how is that information transmitted through the different offices and layers of organization within County Departments of Behavioral Health, the local advisory boards, the office of the Director and their staff. And finally, how does all this feedback get formulated in specific recommendations from the Department to the County Board of Supervisors? That is the penultimate step before specific plans can be drawn up and requests for funds made so that new programs and service improvements actually can be implemented. And again, from the responses received, we see the effects of individual culture and practices in different counties across the state, due to different populations and local circumstances. (e.g. Rural and agrarian based counties versus

those that are predominantly urban or suburban; each of these have different needs and availability of resources trained to meet their cultural needs).

Third, we received evidence in our data of a widespread and vibrant culture of stakeholder engagement across the state. These outreach and engagement efforts utilized both in-person and virtual (e.g. ‘Zoom’) meetings and those conducted using both methods in a hybrid approach. Further, there are many online surveys and questionnaires presented by counties, as well as printed/written material and brochures, many of which are translated into the most common threshold languages in that county or region. Many of the counties also conduct meetings at which there are translation services available, especially Spanish and American Sign Language, and translators of other threshold languages, depending on local need and interest.

However, the statement regarding the existence of a widespread culture of stakeholder engagement does not account for those counties with limited resources or small populations spread out of a large geographic area. For example, at least 7 counties stated that they do not have a CPP planning process that takes place on a regular basis. And there were 8 other counties that did not submit a Data Notebook this year, so we are missing their potential data on this topic. We encourage and recommend that further research should examine trends and practices at the county level in more detail.

TAB 7

California Behavioral Health Planning Council
Performance Outcomes Committee
Tuesday, January 14, 2025

Agenda Item: 2025 Data Notebook Planning and Topic Selection

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item is focused on the development of the 2025 Data Notebook.

Background/Description:

Each year the Council releases a Data Notebook to the local mental/behavioral health boards and commissions to complete with their perspectives on focused areas of the system.

At the October 2024 meeting the Performance Outcomes Committee decided to choose a topic for the 2025 Data Notebook based on input from the local boards/commissions. A question was included in the 2024 Data Notebook survey that asked the boards/commissions to identify up to 5 performance outcomes that they would like the committee to focus on in future data notebooks. The committee will review the responses to this survey item and select a topic for the 2025 Data Notebook.