MHSOAC
Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Research and Evaluation Committee Meeting

February 24, 2021
1:00 pm to 4:00 pm

Chair Itai Danovitch | Vice Chair Ken Berrick

Research and Evaluation Committee

Meeting Agenda

Wednesday, February 24, 2021
1:00 PM – 4:00 PM
MHSOAC: Zoom Teleconference
Note: The meeting audio will be recorded.
Link: https://zoom.us/j/93529583714?pwd=aG1lRkVYUkhLUlB3M3B4NUoyZmlwQT09
Call-in Number: 669-900-6833, 408-638-0968
Meeting ID: 935 2958 3714, **Password**: 714456

Meeting Purpose and Goals:

- Gather input to guide the work of the Commission's Research and Evaluation Division and provide feedback that will drive actions to improve performance in the public mental health system.

TIME	TOPIC	Agenda Item
1:00 PM	**Welcome** *Commissioners Dr. Itai Danovitch, Chair and Ken Berrick, Vice Chair* Welcome, opening remarks and review of the agenda.	
1:10 PM	**Action: Approval of Meeting Minutes** *Commissioner Dr. Itai Danovitch, Chair* The Research and Evaluation Committee will consider approval of the minutes from the November 18, 2020 meeting. • **Public comment** • **Vote**	**1**
1:20 PM	**Information: Summary of Committee Member Feedback and Next Steps for Committee Work** *Commissioners Dr. Itai Danovitch, Chair and Ken Berrick, Vice Chair* Commissioners Danovitch and Berrick will discuss feedback received from individual Committee members on priority areas for the Committee and tie that information to the Committee's work.	**2**
1:30 PM	**Information and Discussion to Guide the Commission's Evaluation and Research:** • **Brief Presentation on the Commission's Priority Areas to Facilitate Committee Discussion** *Dr. Dawnté Early, Chief of Research and Evaluation Division*	**3**

	Dr. Early will briefly lay out the work of the Research and Evaluation Division— school mental health, criminal justice, unemployment, suicide prevention, and disparities to facilitate initial Committee discussion, and further in-depth discussion in the breakout groups. • **10 Minute Break** • **Workgroup Breakout Discussion** The Committee and members of the public will break out into groups for in-depth discussion. Questions to guide the discussion will include: 1. What measures or outcomes are most important to monitor and drive improvement in performance? 2. What types of evaluation will expose disparities in outcomes, and drive reduction of disparities? 3. What evaluation frameworks should be used to standardize evaluations and improve their quality and utility? 4. How do we facilitate impactful research by others in each domain?	
3:20 PM	**Report Out and Further Committee Deliberation** The full Committee will reconvene and breakout groups will provide a brief summary of their discussion and feedback. • **Public comment**	**4**
3:50 PM	**Wrap-Up and Adjourn** *Commissioner Dr. Itai Danovitch, Chair*	

AGENDA ITEM 1

Action

February 24, 2021 Research and Evaluation Committee Meeting

Approval of Meeting Minutes

Summary: The Commission's Research and Evaluation Committee will review the minutes from the November 18, 2020 Committee teleconference meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting.

Presenter: None.

Enclosures (1): November 18, 2020 Meeting Minutes.

Proposed Motion: The Committee approves the November 18, 2020 meeting minutes.

Research and Evaluation Committee Teleconference Meeting Summary

Wednesday, November 18, 2020, 9:00 AM - NOON

Committee Members:	Staff:
Commissioner Itai Danovitch	Toby Ewing
Commissioner Ken Berrick	Filomena Yeroshek
Rikke Addis	Brian Sala
Robert Brook	Dawnté Early
Victor Carrión	Ashley Mills
Eleanor Castillo Sumi	Kai LeMasson
Jonathan Freedman	
Sharon Ishikawa	
Bridgette Lery	
Gustavo Loera	
April Ludwig	
Belinda Lyons-Newman	
Laysha Ostrow	
Mari Radzik	
Ruth Shim	
Katherine Watkins	

Committee members absent:
Sergio Aguilar-Gaxiola, Lonnie Snowden, Jr.

Welcome

Commissioner Danovitch, Chair of the Research and Evaluation Committee welcomed Committee members and the public to the second committee meeting. Rollcall was taken and a quorum was established.

Commissioner Danovitch reported the findings from the interviews conducted with Committee members after the August 24, 2020 Committee meeting. He presented three key themes derived from the interviews: (1) To understand more about MHSA and what it has accomplished; (2) Identify areas of focus such as COVID-19, racial equity, prevention and early intervention, and school mental health; and (3) Enhance Committee preparation and processes (e.g., action oriented meeting agendas and work groups).

Agenda Item 1: Approval of Meeting Minutes

There were no comments or feedback from Committee members or the public on the August 24, 2020 meeting minutes. Commissioner Danovitch called for a motion to approve the meeting minutes. Committee member Gustavo Loera motioned to approve, and Committee member Belinda Lyons-Newman seconded the motion. The Committee voted unanimously to approve the meeting minutes and the motion passed.

Agenda Item 2: The Research and Evaluation Committee Charter

Commission Danovitch stated that the charter would be used as a guiding document informed by consensus, and not as a policy that would require a formal vote. Committee member Robert Brook asked if there is any requirement for the Commission to respond to Committee comments. Commissioner Danovitch stated there is no required response because the Committee is an advisory body, but that it is in the Commission's best interest to leverage the Committee's guidance. Committee member Robert Brook made a recommendation to the Committee to begin every meeting with a summary of what was done with the Committee's guidance and work. Commissioner Berrick stated the Commission would create a communication process and feedback mechanism to accomplish this.

In reference to the charter, Committee members emphasized that the Committee's work must translate into improving practices that happen "on the ground." Committee member Sharon Ishikawa stated that the Committee should consider a wholistic approach, recognizing that MHSA data collection and reporting requirements are part of a broader set of data collection and reporting requirements for clients served through multiple funding streams (e.g., Medical, EPSDT). Committee member Mari Radzik suggested the Committee consider the impact of policy changes on frontline staff and the difficulty in delivering mental health services due to COVID-19.

Public Comment

- Steve Leone, a long-time mental health leader and consumer advocate, expressed disappointment in the charter and asked how "working closely and collaboratively with stakeholders" is done in a 2-minute public comment period. Mr. Leone also stated that the use of the term "professionals" misses the goal of the MHSA and emphasized that consumers and family members have their own form of expertise that can guide the Committee on transformational change.
- Theresa Comstock, the Executive Director for the California Association of Local Mental Health Boards asked the Committee to review the CALBHBC/s brief on performance outcomes data (see Appendix A). Ms. Comstock wanted the Committee to be aware that California law states the Department of Health Care Services is to work with the Commission to determine performance outcomes in collaboration with the County Behavioral Health Director's Association and with review and approval of the California Behavioral Health Planning Council.
- Poshi Walker of CalVoices affirmed Mr. Leone's comments. Ze advocated that data collection, reporting, and analysis should be prioritized and emphasized for people of color and LGBTQ people in the charter and in the Committee's work to measure the true impact of MHSA.
- Stacie Hiramoto, of REMHCO echoed the comments of Mr. Leone. She thanked Committee Member Robert Brook for his questions. Ms. Hiramoto stated that the Committee has produced reports in the past that have not been presented to the Commission even though Committee members requested it.

- Laurel Benhamida, of the Muslim American Society-Social Services Foundation which is contracted with the Office of Health Equity as one of the implementation projects, affirmed the comments from the public, and expressed appreciation for the comments at the beginning of the meeting.

Commissioner Danovitch thanked the public for their comments and stated that the Committee comprises people with lived experience; those who identify as consumers and those who are family members of consumers.

Agenda Item 3 - The Commission's Results Framework

Susan Brutschy and Lisa Colvig-Niclai from Applied Survey Research gave a presentation on the Results Framework from the Commission's Strategic Plan. Ms. Brutschy presented the strategic planning journey for clarifying the roles, scope and purpose of the Commission; aligning current efforts with desired results; and creating a framework for measuring results. Ms. Brutschy discussed the process for collecting data from stakeholders, Commissioners, and staff to inform the Strategic Plan. Ms. Colvig-Niclai presented the Commission's Theory of Change and explained relationships between the guiding principles, the Commission's functions to transform systems and produce results (e.g., reduce stigma, improve access to care). Ms. Colvig-Niclai also presented the Results framework, which was developed by staff and included process and outcomes measures. She emphasized that this was not a final list but a starting point for evaluation. Lastly, Ms. Colvig-Niclai reviewed recommendations for next steps with the Results Framework, including finalizing measures, collecting data, and developing a scorecard.

Committee members provided feedback on the framework, expressed concerns about the use of population-based outcomes given that the MHSA is only part of mental health spending in California, and suggested consideration of more "realistic" measures.

Public Comment

- Poshi Walker stated that it did not make sense to measure population-based outcomes for MHSA. Ze stated that the Committee should be aware that the MHSOAC is supposed to oversee the public mental health system as a whole. Ze also stated that the idea behind the MHSA is that it would influence the public mental health system and that eventually it would be one system as the aspirations of the MHSA (e.g., culturally competent care, recovery, and prevention) would make its way into the public mental health system.
- Dave Cortright said he appreciated the presentation and provided comment on the things he would want to see in a dashboard and scorecard such as showing trends over time, trends against plans and projections, and when it was last updated. Dave suggested the development of a brief, general survey of clients to improve the reporting of outcomes.
- Teresa Comstock stated that finalizing measures in the Commission's Results Framework should be done in partnership with the Department of Health Care Services and in collaboration with the Behavioral Health Director's Association with

the review and approval of the California Behavioral Health Planning council. She stated that it is important to put these measures in place through a public process that includes the entities that should be involved.

- Steve McNally stated he was speaking as a family member of a person with serious mental illness and appreciated Robert Brook's practical comments. He stated there needs to be more coordination among the 59 counties. Steve suggested referencing MHSA statute for guiding the work of the Committee.

At the end of this agenda item, Commissioner Danovitch reiterated the value of receiving public comment. Commissioner Danovitch provided context on the MHSA and said it was generated in response to gaps in the entire mental health system and that it accounts for approximately 25 percent of the public mental health system ($8 billion). He also stated that prior to MHSA, independent audits found that there were not widespread services tailored to the needs of individuals and an absence of prevention, innovation, and implementation of best practices, etc. MHSA was passed in 2004 to fill these gaps. Commissioner Danovitch briefly discussed some of the key things the MHSA has accomplished such as full-service partnerships in all 58 counties, processes for innovation, efforts to improve transparency and link data, and having statewide advocacy to focus on legislative mental health initiatives.

Agenda Item 4 - Breakout Sessions

Committee members, the public and MHSOAC staff participated in breakout sessions. Three sessions occurred concurrently and were facilitated by Commissioner Danovitch, Commissioner Berrick, and Dr. Dawnté Early. Key questions asked by facilitators during the breakout sessions included:

1) What do you think are some key priorities for evaluation?
2) What opportunities could be leveraged by this Committee?
3) What are your thoughts on forming workgroups to address evaluation priorities?

Agenda Item 5 - Report Back from Breakout Groups

Commissioner Danovitch welcomed Committee members and the public back from the breakout sessions and asked each group to report back and provide a summary of what was discussed. Steve Leone made a comment about getting buy-in from providers and counites so that they can see the value in collecting and reporting data to guide decision making.

The following provides a summary of what each breakout group reported they discussed during the breakout session.

Group 1 reported discussion:

- Quality data collection, reporting and analysis especially for marginalized populations, community-defined evidence from those communities, and prevention and early intervention as a key priority.

- Identifying appropriate solutions to root causes and identifying strategic priorities.
- Implementing uniform health care measures so that different agencies and counties are on the same page and making sure all players are at the table.
- Various ideas for forming workgroups such as by population, issue, or social identities.

Group 2 reported discussion:

- The framework and the need to specify the processes and mechanisms by which the Commission and Committee accomplishes what they are charged to do.
- Whether focus on MHSA-funded programs or the broader system, consider comparing both programs while also considering the availability of data.
- The dissemination of knowledge and where things stand in the State.
- How to use information that is gathered, and the importance of having clearly stated goals for measurement (e.g., early diagnosis, early access to effective treatment).
- Using the California Health Interview Survey (CHIS) for obtaining population outcomes.
- Concern about data quality coming out of mental health departments.
- Focus energy on school-based care and identifying and treating students showing symptoms.
- The need for an agreed upon set of metrics that drive decision making at the State and county level.
- Target data collection and research to help make systemic change across systems such as mental health, education, child welfare, and juvenile justice.

Group 3 reported discussion:

- Having a community planning reporting system in place to know which stakeholders were involved in developing County Innovation Plans that are presented to the Commission.
- How to mitigate the burden put on providers when asking them to collect and report data (e.g., using data already collected by MHSA programs).
- Bringing together the disparate demographic data collected across different agencies and programs.
- Having a feedback mechanism in place so that counties understand the value of the data they collect and report to use for decision making.
- Providing the MHSA regulations to the Committee and identifying data available at the State.

<u>Public Comment</u>

- Poshi Walker stated ze agrees that the burden of data collection on providers is a concern. Ze also stated that agencies collect data differently which makes it difficult to compare and gave the example of sexual orientation and gender identity (SOGI) data. Poshi cautioned the Committee in using existing data because of gaps in the

data that is collected for certain groups. Ze suggested when putting together workgroups that members of the public with subject matter expertise be included.

- Laurel Benhamida said she was pleased to learn that the MHSOAC staff were working with the Office of Health Equity and the Office of the Surgeon General. She also expressed concern about the threshold language process for mental health and stated it left out certain communities (e.g., Afghan) who do not have the numbers to meet the threshold.

Wrap-Up and Adjourn

Commissioner Danovitch stated that he and Vice Chair Berrick would take some time to process the feedback and comments received from Committee members and the public and discuss with Commission staff.

Commissioner Danovitch also laid out potential options for the Committee to begin their work and potentially divide into workgroups. He stated: (1) The Committee could give the Commission advice on a standardized evaluation framework with different components (e.g., access) that could apply to different Commission initiatives (focus on process); or (2) The Committee could elect a specific population to focus on such as students or subgroups of students not receiving services (focus on priority area). Committee member Gustavo Loera stated that a standard evaluation framework would be useful for various evaluations across the State but should also be flexible to capture the uniqueness of different communities and what matters most to them.

Commissioner Danovitch stated that the next steps would be to: (1) synthesize and process the meeting minutes; (2) Survey Committee members within a narrower set of options to identify evaluation priorities; and (3) Loop back with members and stakeholders to demonstrate how comments and suggestions are being incorporated into the work of the Committee. Lastly, Commissioner Danovitch welcomed Committee members and stakeholders to send their comments and constructive feedback to the Committee leadership and staff.

AGENDA ITEM 2

Information

February 24, 2021 Research and Evaluation Committee Meeting

Summary of Committee Member Feedback and Next Steps for Committee Work

Summary: Commissioners Danovitch and Berrick will discuss feedback received from individual Committee members on priority areas to connect to the work of the Committee.

Presenters: Commissioner Dr. Itai Danovitch, Chair and Commissioner Ken Berrick, Vice Chair

Enclosures: None.

AGENDA ITEM 3

Information and Discussion

February 24, 2021 Research and Evaluation Committee Meeting

Presentation on the Commission's Priority Areas to Facilitate Committee Discussion

Summary: A brief overview of the Research and Evaluation Division's work will be provided in the areas of school mental health, crisis services, suicide prevention, criminal justice involvement, unemployment, and disparities, followed by Committee members and stakeholders taking part in facilitated breakout group discussions.

Outcomes	**The Commission's Projects**
Crisis Services	1. Triage School-County Collaboration grants 2. S.B. 82 Triage Grant Programs and Summative Evaluation
Suicide	1. Suicide Prevention Project, *Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025* 2. Request for data from Vital Statistics and the Office of Statewide Health Planning and Development 3. Suicide dashboard (in progress)
Criminal Justice Involvement	1. Criminal Justice and Mental Health Project Report *Together We Can: Reducing Criminal Justice Involvement for People with Mental Illness* 2. Request for data from Department of Justice to link to clients served in the public mental health system 3. Data from Criminal Justice Mental Health Project: Demographics and Outcomes
Unemployment	1. Request for data from the Employment Development Department to link to clients served in the public mental system
School Failure	1. Schools and Mental Health Project Report, *Every Young Heart and Mind: Schools as Centers of Wellness* (2020) 2. Mental Health Student Services Act (MHSSA) grants 3. Request for data from the CA Department of Education to link to children and youth served in the public mental health system (See Appendix C for CDE variable list)
Disparities	1. Dashboard - Highlighting Differences to Understand Disparities

Background: The Research and Evaluation Division guides the Commission's assessment activities to realize transformational changes across service systems to advance the overarching goal of ensuring that everyone receives timely and effective mental health services when needed. The Division's contribution is to produce data products and studies that generate new insights, promote continuous learning, and drive improvements in public health and policy.

The Division's primary goal is described in the Commission's strategic plan:

> **Strategic Goal 2:** *The Commission will advance data and analytics that will better describe desired outcomes; how resources and programs are attempting to improve those outcomes; and, elevate opportunities to transform and connect programs to improve results*.

The Research and Evaluation Committee provides guidance and expertise for driving transformational change using research to improve prevention and innovation, as well as mental health services and supports.

Presenter: Dr. Dawnté Early, Chief of Research and Evaluation

Enclosures (8): (1) Crisis Services; (2) Suicide Prevention; (3) Criminal Justice; (4) Employment; (5) School Mental Health; (6) Disparities; (7) CALBHB/C letter; (8) Appendices

Handout (1): PowerPoint presentation

1. SB 82 TRIAGE CRISIS SERVICES

Description of S.B. 82 Triage Grant Programs

The Investment in Mental Health Wellness Act of 2013 (SB 82)

Created by Senate Bill (SB) 82, this was signed into law by Governor Jerry Brown in June 2013 and provides grant funds to improve access to and capacity for mental health crisis services. This grant program provides funds to California counties to increase capacity for client assistance and services in crisis intervention, stabilization, treatment, rehabilitative mental health services and mobile crisis support teams. Services are designed to increase access to effective outpatient and crisis services, provide an opportunity to reduce costs associated with expensive inpatient and emergency room care, reduce incarceration, and better meet the needs of individuals experiencing a mental health crisis in the least restrictive manner possible.

Mental Health Triage Personnel Program objectives include:

- Expand crisis treatment services by adding Crisis Residential Treatment beds, Crisis Stabilization services, Mobile Crisis Support Teams, Triage personnel.
- Improving the client experience, achieving recovery and wellness, and reducing costs.
- Reducing unnecessary hospitalizations and inpatient days.
- Reducing recidivism and mitigating unnecessary expenditures of law enforcement.
- Expand the continuum of services with early intervention and treatment options that are wellness, resiliency, recovery oriented in the least restrictive environment.

Triage services allow crisis personnel to reach out to people during crisis before their situations become more desperate, linking them to appropriate services. See Appendix A for more information about the evaluation of Triage grant programs.

2. SUICIDE PREVENTION

Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025

The Commission produced a strategic plan for suicide prevention that includes objectives for establishing centralized data reporting systems, and an agenda for data reporting and evaluation of suicide deaths and suicidal behavior.

State Objective

OBJECTIVE 3A Establish centralized electronic reporting systems to capture data related to suicide deaths and suicidal behavior. The systems should include data by demographics – such as race/ethnicity, age, sex, gender identity, and sexual orientation – as well as vulnerable group membership, such as military service and women in the perinatal and postpartum period. Uniform coding procedures should be used.

OBJECTIVE 3B Develop a data monitoring and evaluation agenda on suicide deaths and suicidal behavior, including data elements documenting interrupted or aborted suicide attempts and crisis service interventions ("save data") that resulted in the de-escalation of desire and intent to die by suicide. The agenda should include guidance to support state and local data and information sharing, including methods for sharing confidential information among diverse partners while adhering to state and federal privacy and security laws (See Appendix B for the plan's implementation schedule).

The Commission's Request for Vital Statistics and OSHPD Data

The Commissions leads several projects to examine outcomes for public mental health consumers. These projects involve linking mental health client data to birth and death records, and hospital discharge records to examine the impact of services on reducing suicide, emergency department use, and inpatient hospitalization.

A main objective of the SB 82 Triage program is to lessen the use of hospital emergency rooms and psychiatric beds.

Primary Research Questions:

- What are the death outcomes include suicide rates for clients receiving services in the public mental health system?
- Does SB 82 Triage Crisis services reduce emergency department visits and psychiatric inpatient stays? (See Section on Triage Crisis Services)?

3. CRIMINAL JUSTICE INVOLVEMENT

As part of the Commission's policy project on Criminal Justice and Mental Health that culminated in a final report adopted by the Commission in 2017, the Commission acquired and linked data from the Department of Justice (DOJ) to examine criminal justice history and arrest rates for clients in the public mental health system.

In addition, the SB 82 Triage grant program funds 30 programs in 20 counties to provide crisis services. A main objective of the Triage program is to divert people from jails, reduce law enforcement involvement with mental health crisis, and provide crisis treatment in the least restrictive setting.

Excerpt from the Commission's Criminal Justice Report, *Together We Can: Reducing Criminal Justice Involvement for People with Mental Illness*

Report Finding #5:

Data is a critical tool in decision-making and service delivery, but state and local agencies are not effectively harnessing its power to improve outcomes for those in need.

Report Recommendation #5:

The California Health and Human Services Agency should reduce or eliminate barriers so that data and information technology are used to drive decision-making, identify service gaps, and guide investments in programs to reduce the number of people with mental health needs in the criminal justice system (See Appendix C for further details).

Criminal Justice Mental Health Data Project

California mental health service and program data were linked with criminal justice arrest data, and results from analyses of these linked data showed a dramatic reduction in arrest rates for clients after participating in intensive mental health services in Full Service Partnership (FSP) programs (See Appendix D and E for CSI and FSP data dictionaries and Appendix F for methodology)

4. UNEMPLOYMENT

Data Use Agreement with the Employment Development Department (EDD)

The Commission is entering into a data use agreement with the Employment Development Department (EDD) to receive quarterly wage data and employer data for mental health consumers served by the California public mental health system for the purpose of monitoring and evaluating employment outcomes to determine the effectiveness of mental health services (See Appendices A and B for CSI and FSP data dictionaries).

Data elements received from the EDD will include: Name, SSN, Filing Name, Wages, NAIC (Industry), and Employer Zip Codes.

Research Questions include:

Among public mental health and Full Service Partnership clients,

- What is the proportion who are employed?
- What is the proportion of who are employed before and after first mental health service? By service type? By diagnoses? By racial-ethnic groups?
- What are the median and mean wages of mental health consumers before and after first mental service? By diagnoses? By racial-ethnic groups?

5. SCHOOL MENTAL HEALTH

For the past 4 years, the Commission has led a school mental health policy project to address school failure due to untreated trauma and mental health needs through a prevention, early intervention strategy. The project culminated in a final report, *Every Young Heart and Mind: Schools as Centers of Wellness*, adopted by the Commission in October 2020 (See Appendix G for more information).

As part of those efforts, the Commission:

- Funded 22 County-School partnerships through Triage and MHSSA grant funding to strengthen local collaborations and bring more MH resources including school MH personnel to schools.
- Established a data sharing agreement with the California Department of Education (CDE) to enable the MHSOAC to provide data-based evidence to monitor and evaluate MHSA-funded programmatic efforts to reduce school failure and/or dropout.

The goal is for research and analyses to provide evidence that will enhance state and local partners' collaborative efforts to improve mental health aid for students and to improve general instruction to students with mental health needs. Several key questions will guide our research and analyses, as follows:

- What is the descriptive demographic, programmatic, and educational profile of students who are receiving MHSA or other community mental health services?
- How does mental health treatment or service need affect student outcomes (e.g., mental health program completion, graduation rates, attendance, assessment scores, suspension/expulsion, grade retention)?

6. DISPARITIES

The Commission seeks to understand disparities in access to program services and client outcomes across of all of its projects.

A current dashboard in the MHSOAC transparency suite shows the racial-ethnic makeup of persons receiving publicly funded mental health services to the corresponding Medi-Cal population and the population of California to provide a broad overview of access to program services.

Research Questions

- Compared to the total population, are there racial-ethnic disparities in enrollment in specialty mental health services and FSPs?
- Are there racial-ethnic disparities in who exits early from FSPs?
- Are there racial-ethnic disparities among FSP clients in transitioning to independent living? Arrest rates? Suicide rates?
- Are there racial-ethnic disparities in who benefits from S.B. 82 Triage Crisis Services related to law enforcement involvement and inpatient hospitalization?

See MHSOAC dashboard Highlighting Differences to Understand Disparities

See California Reducing Disparities Project

7. LETTER FROM THE CALIFORNIA ASSOCIATION OF LOCAL BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

California Association of Local Behavioral Health Boards and Commissions

February 15, 2021

Itai Danovitch, M.D., Committee Chair
Ken Berrick, Committee Vice Chair
MHSOAC Research and Evaluation Committee
& Research and Evaluation Committee Members

Dear Chair Danovitch, Vice Chair Berrick and Committee Members,

On behalf of CALBHB/C, we appreciate your focus on outcome measures (2/24/2021 Research and Evaluation Committee Agenda Item #3). Please consider the following items as you move forward.

1) **Currently Reported Data:** Performance Outcome Data culled from MHSA 3-Year Plans and Updates, sorted by:
   a. Topic: Children & Youth, Criminal Justice, Employment, Hospitalization & Housing
   b. County/Jurisdiction (All 59. Note that each of CA's 59 mental/behavioral health agencies collect and report on different MHSA performance outcome measures, with some providing meaningful data, and some providing very little performance outcome data.)

2) **Data Points** (suggested): CALBHB/C Issue Brief (attached) ADA Version

3) **Establishment of Performance Measures:** CA WIC 5848(c) specifies that MHSA plans shall include reports on the achievement of performance outcomes to be established jointly by DHCS, MHSOAC, in collaboration with CBHDA and with the review and approval of the CA Behavioral Health Planning Council. (On the local level, it is the duty of CA's 59 local mental/behavioral health boards and commissions to review and comment on performance outcome data to the CA Behavioral Health Planning Council (WIC 5604.2(7)) (Outlined in: CALBHB/C Issue Brief ADA Version)

We are glad to stay in communication regarding this important topic. Thank you for your work in this area.

Sincerely,

Harriette S. Stevens

Harriette S. Stevens, Ed.D., President

Theresa Comstock, Executive Director

cc: See next page.

California Association of Local Behavioral Health Boards and Commissions

cc: Toby Ewing, Ph.D., Executive Director, MHSOAC
Dawnté Early, Ph.D., Chief of Research and Evaluation, MHSOAC

Kelly Pfeifer, MD, Deputy Director, Behavioral Health, DHCS
Jim Kooler, Dr.P.H., Assistant Deputy Director, Behavioral Health, DHCS
Marlies Perez, Chief, Behavioral Health Community Services, DHCS

Michelle Cabrera, County Behavioral Health Directors Association of CA

Jane Adcock, Executive Officer CA Behavioral Health Planning Council
CA Behavioral Health Planning Council Performance Outcomes Committee

Kathi Mowers-Moore, Deputy Director, CA Department of Rehabilitation
Cindy Chiu, Assistant Deputy Director, CA Department of Rehabilitation

California Association of Local Behavioral Health Boards and Commissions

August 2020 www.calbhbc.org/performance

ISSUE BRIEF: Performance Outcome Data

PERFORMANCE OUTCOME DATA

It is in the best interest of the state and local communities to know the impact of Mental Health Services Act ("MHSA", Proposition 63) offerings.

Need to Standardize

Each of CA's 59 mental/behavioral health agencies collect and report on different MHSA performance outcome data, with some providing meaningful data, and some providing very little performance outcome data.

Suggested Data Points[1 2]

Children & Youth
- School-based Wellness (Attendance, Grades, Classroom Behavior)
- Standardized Screening /Assessment
- Reporting by Self/Family

Criminal Justice Involvement
- Incarceration/Diversion (# of Days, # of Arrests, Referral/Placement)

Employment
- Competitive
- Sustained

Hospitalizations
- # of Hospitalizations
- Days Hospitalized
- Emergency-Room Visits
- Crisis Psychiatric Visits

Housing/Homelessness
- Permanent Housing
- Days of Homelessness

1. Data should include outcomes specific to culture/race/ethnicity and age.
2. Very small counties may need to report trends instead of numbers.

California Law WIC 5848(c)) specifies that MHSA plans shall include reports on the achievement of performance outcomes, to be established jointly by:

Department of Health Care Services
and
Mental Health Services Oversight & Accountability Commission

in collaboration with

County Behavioral Health Directors Association of CA

and with the review and approval of the

CA Behavioral Health Planning Council

CBHPC is tasked with reviewing and approving the performance outcome measures, and reviewing the performance of mental health and substance use disorder programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources (WIC 5772)

On the local level, it is the duty of:

California's 59
Local Mental/Behavioral Health
Boards & Commissions

to review and comment on performance outcome data to the CA Behavioral Health Planning Council. (WIC 5604.2(7))

CALBHB/C supports the work of California's 59 local mental/behavioral health boards and commissions. www.calbhbc.org

PROMISING DATA

The following counties report the most MHSA-related performance outcome data by topic.

Children & Youth
Nevada County

Criminal Justice
Los Angeles County
Merced County
Sacramento County
San Diego County
San Mateo County
Sonoma County

Employment
Alameda County
Los Angeles County
Solano County

Hospitalization
Los Angeles County
Merced County
Riverside County
Sacramento County
Sonoma County

Housing/Homelessness
Los Angeles County
Merced County
Placer County
Sonoma County

ALL COUNTIES

Links to performance outcome data for all counties/juridictions (Medi-Cal, SAMHSA and MHSA).

Alameda
Alpine
Amador
City of Berkeley
Butte
Calaveras
Colusa
Contra Costa
Del Norte
El Dorado
Fresno
Glenn
Humboldt
Imperial
Inyo
Kern
Kings
Lake
Lassen
Los Angeles
Madera
Marin
Mariposa
Mendocino
Merced
Modoc
Mono
Monterey
Napa
Nevada
Orange
Placer
Plumas
Riverside
Sacramento
San Benito
San Bernardino
San Diego
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Santa Cruz
Shasta
Sierra
Siskiyou
Solano
Sonoma
Stanislaus
Sutter-Yuba
Tehama
Tri-City
Trinity
Tulare
Tuolumne
Ventura
Yolo

8. Appendices List

Appendix A: S.B. 82 Triage Grant Program

Background: Evaluation of Round 1 Triage Grant Programs

a. **Excerpt from California State Auditor Report 2017-117, pages 33-35**
https://www.auditor.ca.gov/pdfs/reports/2017-117.pdf

The Oversight Commission Is Developing Statewide Metrics to Evaluate the Effectiveness of MHSA-Funded Triage Grants

The Legislature created the MHSA triage grants in 2013 with the intent of establishing a competitive grant process, administered by the Oversight Commission, that would enable local mental health agencies to add at least 600 mental health triage personnel statewide, among other objectives. The intent of these triage grants is to expand the number of mental health personnel available at various points of access throughout the community, such as emergency rooms, jails, homeless shelters, and clinics. The funding for triage grants comes from the MHSA's 5 percent state administrative funds.

In its 2014 status report to the Legislature, the Oversight Commission indicated that in its first funding cycle it had awarded three-year grants to 22 local mental health agencies in fiscal year 2013–14, with an annual total allocation of $32 million in MHSA funds. Additionally, the Oversight Commission awarded three-year grants to two more local mental health agencies because it had unexpended funds from fiscal year 2013–14. In 2016 the Legislature approved the funding of the triage grant program through June 2018. According to the Oversight Commission, it granted amendments to 18 of the 24 local mental health agencies that had received grants in fiscal year 2013–14 to extend these grants for one more year, through fiscal year 2017–18. The Oversight Commission announced availability of the grants for the next three-year funding cycle in December 2017 and plans to award the grants in summer 2018.

Although state law anticipates that the Oversight Commission will evaluate the effectiveness of the services provided through the grants, the Oversight Commission has indicated that it has faced challenges in creating a consistent statewide picture based on the local mental health agencies' individual evaluations. The Oversight Commission requires the local mental health agencies that receive the grants to submit progress reports on the number of triage personnel they have hired, the individuals they have served, and the encounters with individuals that have led to referrals to mental health services. The Oversight Commission reviews these reports and conducts site visits to ensure that the grantees have attained the goals they identified in their grant applications. Nonetheless, the Oversight Commission stated that during the initial round of triage grant awards, it prioritized implementing services, and consequently it did not develop a unified evaluation approach but rather chose to let the grant applicants specify how their projects would be evaluated.

In October 2016, the Oversight Commission conducted a survey to which 20 local mental health agencies responded to assess which local mental health agencies were collecting data that could be used to evaluate the success of the triage grants (See b. Summary of Findings). The Oversight Commission expressed that these survey data provided some basis for a statewide assessment of the effectiveness of the triage grant program. However, it also stated that the evaluations it received from the local mental health agencies represented different approaches and proved too diverse for the Oversight Commission to aggregate and translate into a statewide picture. The Oversight Commission indicated that it will allocate a portion of the newest round of triage grant funds for a statewide evaluation that may include the use of a third-party contractor to conduct a statewide analysis.

Although these steps are reasonable, we question why the Oversight Commission did not establish a process for evaluating the effectiveness of the MHSA triage grants sooner, given that the law has been in place since 2013. The Oversight Commission stated that the focus for the first round of triage grants was to implement services as quickly as possible, rather than to establish statewide evaluation criteria. Without the statewide metrics, local MHSA stakeholders are unable to fully evaluate the effectiveness of the triage grants and the Oversight Commission is not fulfilling its statutory responsibility to conduct such evaluations.

California State Auditor's Recommendation: To ensure that the MHSA-funded triage grants are effective, the Oversight Commission should require that local mental health agencies uniformly report data on their uses of triage grants. It should also establish statewide metrics to evaluate the impact of triage grants by July 2018.

b. Summary of Findings: October 2016 Triage Questionnaire

Twenty counties participated in the Triage Questionnaire providing insight on the data collected (or not collected} on the different outcomes. The participating counties include: Alameda, Butte, Fresno, Lake, Los Angeles, Madera, Marin, Merced, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Francisco, Santa Barbara, Tuolumne, Ventura, and Yolo.

The frequency of responses to whether or not counties currently collect data or have the data available to assess change for each of the outcomes was calculated. This number was used to determine which of the outcomes were most collected and accessible. Counties also had an opportunity to describe how they defined and/or measured each of the outcomes. These open- ended responses were evaluated and categorized by common answers and ideas. The frequency of each answer was calculated to determine similarities in how data was collected.

There are seven possible outcomes in which 10 or more of the counties have responded to currently collecting data. The possible seven outcomes can be included in RFP: psychiatric hospitalizations, consumer well-being, linkage to services and resources, timeliness of services, access to services, consumer experience, and in-patient psychiatric

hospitalization costs.

For each of the individual-level and system-level outcomes, the data collected varies across the counties and counties may have more than one way of tracking each of the outcomes. Some counties also expressed experiencing some limitations on data collection (Medi-Cal only, TAY only, repeat consumers only, etc.).

Individual-Level Outcomes

- Psychiatric Hospitalizations: 18 out of 20 counties (90%) currently collect data on psychiatric hospitalizations.
- Criminal Justice Involvement: 6 out of 20 counties (30%) currently collect data on criminal justice involvement.
- Consumer Well-Being: 11 out of 20 counties (55%) currently collect data on consumer well- being.
- Linkage to Services and Resources: All 20 counties (100%) are currently collecting data on linkage to services and resources.

System-Level Outcomes

- Timeliness of Services: 17 out of 20 counties (85%) are currently collecting data on timeliness of services.
- Access to Services: 16 out of 20 counties (80%) currently collect data on access to services.
- System Capacity: 8 out of 20 counties (40%) currently collect data to measure system capacity outcomes.
- Consumer Experience: 14 out of 20 counties (70%) currently collect data on consumer experience.
- Costs - Law Enforcement: 1 out of 20 (5%) counties collect data on law enforcement costs.
- Costs - Emergency Departments: 2 out of 20 counties (10%) collect data on emergency department costs.
- Costs - Inpatient Psychiatric Hospitalizations: 13 out of 20 counties (65%) collect data on inpatient psychiatric hospitalization costs.
- Stigma: Of the 20 counties, only two counties (10%) have stated that they collect and have the data available to assess change on stigma.
- Coordination Across Service Providers: 6 out of 20 counties (30%) collect data on coordination across service providers.

1. Evaluation of Round 1 Triage Grant Programs

There are currently 30 Triage programs operating in 20 counties (Round 2). The Commission leads the summative evaluation, and UC Davis and UCLA lead the formative/process evaluation.

Grantee	Program Focus
Alameda County	Adult/Transition Age Youth
Berkeley City	Adult/Transition Age Youth Child and Youth
Butte County	Adult/Transition Age Youth
The California Association of Health and Education Linked Professions JPA	School/County Collaborative
Calaveras County	Adult/Transition Age Youth
	Children and Youth
Humboldt County	Adult/Transition Age Youth
	Children and Youth
	School/County Collaborative
Los Angeles County	Adult/Transition Age Youth
	Children and Youth
Merced County	Adult/Transition Age Youth
Placer County	Adult/Transition Age Youth
	Children and Youth
	School/County Collaborative
Riverside County	Children and Youth
Sacramento County	Adult/Transition Age Youth
	Children and Youth
San Francisco County	Adult/Transition Age Youth
San Luis Obispo County	Children and Youth
Santa Barbara County	Children and Youth
Sonoma County	Adult/Transition Age Youth
Stanislaus County	Adult/Transition Age Youth
	Children and Youth
Tulare Office of Education	School/County Collaborative

Appendix B: *Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025*

OBJECTIVE 3A: Establish centralized electronic reporting systems to capture data related to suicide deaths and suicidal behavior. The systems should include data by demographics – such as race/ethnicity, age, sex, gender identity, and sexual orientation – as well as vulnerable group membership, such as military service and women in the perinatal and postpartum period. Uniform coding procedures should be used.

Implementation Schedule

By July 1, 2021, the State should authorize counties to utilize interagency death review team models to identify, review, and evaluate suicide death trends, circumstances, and outcomes to inform and strengthen local prevention strategies, including the sharing of confidential information while protecting privacy.

By July 1, 2021, the State should create incentives for schools to regularly participate in the California Healthy Kids Survey to monitor trends in suicidal behavior among students. These should include allocating additional resources to create reports on student suicidal behavior that are specific to each school and additional incentives for collecting key demographic data, such as sexual orientation and gender identity.

By December 31, 2021, the State, with leadership from the Department of Public Health, should expand the existing California Violent Death Reporting System (CalVDRS) to more counties to collect and analyze local and state suicide data by delivering technical assistance to local coroners and medical examiners. The assistance should enhance the timely and electronic reporting of suicide deaths and their circumstances – including contributing factors and the specific location of death if outside the home – to help identify and fortify the safety of sites used by people to die by suicide. The State should invest additional resources in technical assistance to increase participation by coroners, medical examiners and law enforcement agencies in the CalVDRS to provide more detailed information on circumstances surrounding violent deaths, including suicide. This detail should include standardized data on demographic characteristics, membership in a vulnerable group, utilization of mental health services prior to death, and social determinants, such as housing and employment status.

By January 1, 2022, the State, with leadership from the Department of Public Health and the Department of Health Care Services, should identify additional data elements to be collected via the California Health Interview Survey. The additional data should focus on suicide risk and protective factors to improve monitoring of suicidal behavior across the state.

By July 1, 2023, the State, including private and public partners, should develop and implement a strategy to improve the standardization of coding and reporting of suicidal behavior, including the development of guidelines for determining intent to die by suicide.

The state also should develop a plan to deliver training and technical assistance to hospital representatives to improve the identification, coding, and reporting of suicidal behavior for people seen in emergency departments and admitted to hospitals.

By December 31, 2023, the State, including private and public partners, should create a mechanism for centralized and electronic reporting of the number of people screened for suicide risk in hospitals and emergency departments, and data documenting how those who were positively identified at various levels of risk were triaged into services. For example, data in electronic health records could be extracted and aggregated prior to submission to a centralized database. This effort also should explore opportunities to expand the State's participation in the Centers for Disease Control and Prevention's National Syndromic Surveillance Program BioSense Platform, a database that collects and analyzes near real-time data and trends on people receiving services in emergency departments.

OBJECTIVE 3B: Develop a data monitoring and evaluation agenda on suicide deaths and suicidal behavior, including data elements documenting interrupted or aborted suicide attempts and crisis service interventions ("save data") that resulted in the de-escalation of desire and intent to die by suicide. The agenda should include guidance to support state and local data and information sharing, including methods for sharing confidential information among diverse partners while adhering to state and federal privacy and security laws.

Implementation Schedule

By December 31, 2021, the Office of Suicide Prevention should create a task force, including people with lived experience and other subject matter experts, to develop a data monitoring and evaluation agenda on suicidal behavior, including data elements documenting interrupted or aborted suicide attempts and crisis service interventions that resulted in the de-escalation of desire and intent to die by suicide. The agenda should include guidance on local program evaluation and should identify measures to monitor state-level outcomes. The agenda should create and implement methodology for using suicide death and suicidal behavior data to evaluate the proportion of suicidal behavior that results in death, and should describe how trends in high-risk groups and lethal means used will be monitored. The task force should identify opportunities for expanding research exploring community-defined practices that reduce suicide risk in diverse cultural groups and should disseminate findings directly to affected communities and the public.

By July 1, 2023, the task force should develop for the Governor and Legislature a proposal to create a centralized, electronic database and reporting standards to capture data on interrupted or aborted suicide attempts and crisis service interventions that resulted in the de-escalation of desire and intent to die by suicide. The data must include the type of intervention used and should include the type of services referred and the duration between incident and entry into services. Data sources include, but are not limited to, first responders, emergency and health care providers, crisis service providers, and bridge and

transportation representatives. The proposal must include an estimate for costs associated with the centralized database, as well as reporting standards.

Appendix C: Excerpt from the Commission's Criminal Justice Report,
Together We Can: Reducing Criminal Justice Involvement for People with Mental Illness

FINDING FIVE: *Data is a critical tool in decision-making and service delivery, but state and local agencies are not effectively harnessing its power to improve outcomes for those in need.*

In California today, it is impossible to accurately describe the number of people with mental health needs housed in county jails. A lack of accurate, up-to-date information on consumers, coupled with inconsistent data collection practices and definitions, is a significant barrier to efforts to keep people with mental health needs out of the criminal justice system. Without data, it is difficult to understand not only the scope of the problem, but its multiple dimensions and potential solutions.

Community-based treatment providers do not consistently share information with correctional health care providers, and vice versa. Program costs and outcomes often are not tracked. Community consultation processes often do not include data to monitor outcomes and the quality of services. Data regarding race, ethnicity, sexual orientation, and gender identity is lacking, making the task of identifying, tracking, and monitoring disparities within the system challenging.

Data can be a powerful tool to identify gaps and disconnects, guide management decisions, and drive continuous improvement efforts. Information technology also is providing better methods for integrating services, coordinating the efforts of public agencies, and informing real-time decisions by professionals.

At the local level, data can support the coordination of services in the community and in custody. Data can help administrators allocate resources across systems. Even small scale efforts can benefit by using data to measure shared outcomes. By understanding needs and whether programs are meeting those needs, data could support funding decisions and program improvements. Improving data collection and utilization also could help shape a strategic plan for future investments. When data is not collected or available, people within a system become invisible and problems are minimized. Data can help an individual be "seen" and consequently reached and served.

Some collaborative efforts have relied on team approaches, with behavioral health and criminal justice staff meeting frequently to discuss shared clients. This approach can work well for individual clients. But a system approach must be predicated on using data to develop a better understanding of challenges and opportunities.

Local governments nationally spend at least $22 billion to incarcerate approximately 11 million people each year. By using data, communities can fully understand the cost of a relatively small number of people cycling in and out of their publicly funded systems. San

Diego County's Project 25, for example, identified 28 people who alone consumed $3.5 million in public resources in 2010. In Miami-Dade County, Florida, 97 people with serious mental health needs accounted for $13.7 million in services over four years, spending more than 39,000 days in county jails, emergency rooms, state hospitals, or psychiatric facilities.

Over the last year or so, state and national efforts have pushed local communities to use data to better understand "high utilizers" of public systems. Such efforts seek to demonstrate that if agencies can identify a small number of people using the majority of public resources, potential cost savings can be realized through targeted outreach, engagement, and service delivery.

The small Fresno County city of Selma is a case in point. Police Chief Greg Garner said that for years, police officers and other emergency service workers were frustrated by repeatedly encountering the same community members struggling with the same problems. "The genesis of their problems is mental illness, but traditionally, they've just been hidden away in an ER or jail cell," Garner said. "That not only costs a lot of money, their problems never get addressed."

Now, under a Fresno County triage program that dispatches mental health workers to help police in the field, disruptive individuals with mental health needs are receiving referrals and treatment, Garner said. "Having trained mental health clinicians respond in the field with our officers has been a godsend. And for the people we encounter, the program means they get plugged into support services rather than deposited in the criminal justice system."

At the national level in 2016, the White House launched the Data-Driven Justice Initiative to promote state and local practices to identify people with physical and behavioral health needs served through the criminal justice and health care systems. With such data, agencies can target scarce resources toward the greatest needs and identify those falling through the cracks. Los Angeles, San Diego, San Francisco, and Santa Clara counties joined the Initiative. Participating counties agreed to facilitate data sharing, implement pre-arrest diversion, and use data-driven risk assessment tools.

Along with the potential to use data comes the barriers to sharing data. There are technological barriers, such as antiquated systems in incompatible formats or data kept in paper files. There are cultural barriers, such as mistrust of how data will be used, interpreted, or modified by others outside programs or agencies. Then there are legal barriers, which can be real – such as restrictions defined by law – and perceived, perhaps a misunderstanding of complicated privacy rules and restrictions. The number one barrier identified by stakeholders to sharing data was confusion or fear around violating client confidentiality, or, more directly, violating the Health Insurance Portability and Accountability Act (HIPAA), which protects confidential medical information.

While the need for privacy is generally understood and accepted in the field, professionals also express frustration over the lack of clarity around what type of information can be shared, who may receive the information, and how it may be distributed. The California Office of Health Information Integrity, within the California Health and Human Services Agency, is responsible for ensuring compliance with HIPAA and other privacy laws. In July 2017, the agency, in collaboration with an advisory group, released a document to clarify laws and regulations using common scenarios, including three specific to the justice-involved population with behavioral health needs.

RECOMMENDATION FIVE: *The California Health and Human Services Agency should reduce or eliminate barriers so that data and information technology are used to drive decision-making, identify service gaps, and guide investments in programs to reduce the number of people with mental health needs in the criminal justice system.*

The California Health and Human Services Agency is engaged in several efforts related to promoting data integration and improving care coordination. In addition to housing the Office of Health Information Integrity, the agency oversees departments and offices that provide a wide range of services in the areas of health care, mental health, public health, alcohol and drug treatment, income assistance, social services and assistance to people with disabilities, and the state-level data that is collected on each. Additionally, the Department of Health Care Services is charged with administering the Whole Person Care Pilot, which has the overarching goal of service coordination, and data sharing and integration to support that coordination. The department is also collaborating with the Council on Criminal Justice and Behavioral Health to study patterns of health care service utilization among former offenders released from state prison. To achieve the study's goals, the department's health care information will be linked with the California Department of Corrections and Rehabilitation's prison data.

Data is a valuable tool for providing person-centered, culturally competent, and community-based care, especially through the integration of services provided by multiple local agencies and providers. Further, collecting data on race, ethnicity, sexual orientation, and gender identity will enable researchers and policy makers to better understand and address the nature and extent of disparities within the mental health and criminal justice systems. The agency could lead in advancing the statewide use of emerging technology to integrate data while ensuring protection of confidential health information. The agency should support efforts to ensure that screening and assessment and care coordination become standard operating procedure in California.

Key outcome measures previously mentioned in this report – reduction in the number of people with mental illness booked into jail, shorter jail stays for people with mental illnesses, increase in the percentage of people with mental illnesses in jail connected to the right services and supports once released, and lower rates of recidivism – also seek to

track and improve progress on diversion efforts, but more must be done to understand missed prevention opportunities. Related to these key outcomes are two questions counties must ask to identify ways to improve prevention opportunities: (1) How many people in jail have a mental health need?, and (2) How many of those people were actively receiving mental health services at the time of booking?

Asking these questions can help community-based service providers and administrators identify gaps in efforts to reach and engage unserved and underserved consumers and enhance efforts to prevent incarceration. Answering these questions may require integrating community-based mental health data and jail data. The agency should support data integration efforts. The Commission could support the agency's efforts by demonstrating the value of integrated data through the linking and analyzing of mental health and criminal justice data.

Appendix D: Client Service Information (CSI) System Data Dictionary

List of data fields

Header Fields:

H-01.0 COUNTY/CITY/MENTAL HEALTH PLAN SUBMITTING RECORD (SUBMITTING COUNTY CODE)

H-02.0 COUNTY CLIENT NUMBER (CCN)

H-03.0 RECORD TYPE

H-04.0 TRANSACTION CODE

Control Fields:

X-01.0 PRODUCTION OR TEST INDICATOR

X-02.0 FROM REPORT PERIOD

X-03.0 THROUGH REPORT PERIOD

X-04.0 CREATION DATE

X-05.0 KEY CHANGE RECORD COUNT

X-06.0 CLIENT RECORD COUNT

X-07.0 SERVICE RECORD COUNT

X-08.0 PERIODIC RECORD COUNT

Client Fields:

C-01.0 BIRTH NAME

C-02.0 MOTHER'S FIRST NAME

C-03.0 DATE OF BIRTH

C-04.0 PLACE OF BIRTH

C-05.0 GENDER

C-06.0 ETHNICITY/RACE

C-07.0 PRIMARY LANGUAGE

Service Fields:

S-25.0 EVIDENCE-BASED PRACTICES / SERVICE STRATEGIES

S-26.0 TRAUMA S-01.0 RECORD REFERENCE NUMBER (RRN)

S-02.0 CURRENT LEGAL NAME / BENEFICIARY NAME

S-03.0 SOCIAL SECURITY NUMBER

S-04.0 MEDI-CAL NUMBER (OPTIONAL)

S-05.0 MODE OF SERVICE

S-06.0 SERVICE FUNCTION

S-07.0 UNITS OF SERVICE

S-08.0 UNITS OF TIME

S-09.0 PRINCIPAL MENTAL HEALTH DIAGNOSIS

S-10.0 SECONDARY MENTAL HEALTH DIAGNOSIS

S-11.0 ADDITIONAL MENTAL OR PHYSICAL HEALTH DIAGNOSIS

S-12.0 SPECIAL POPULATION

S-13.0 PROVIDER NUMBER

S-14.0 COUNTY/CITY/MENTAL HEALTH PLAN WITH FISCAL RESPONSIBILITY FOR CLIENT Service Fields - 24 Hour Mode of Service:

S-15.0 ADMISSION DATE

S-16.0 FROM/ENTRY DATE

S-17.0 THROUGH/EXIT DATE

S-18.0 DISCHARGE DATE

S-19.0 PATIENT STATUS CODE Service Fields - Hospital, PHF, and SNF:

S-20.0 LEGAL CLASS - ADMISSION

S-21.0 LEGAL CLASS - DISCHARGE

S-22.0 ADMISSION NECESSITY CODE Service Fields - Non-24 Hour Mode of Service:

S-23.0 DATE OF SERVICE

S-24.0 PLACE OF SERVICE

Periodic Fields:

P-01.0 DATE COMPLETED

P-02.0 EDUCATION

P-03.0 EMPLOYMENT STATUS

P-04.0 AXIS-V / GAF

P-05.0 OTHER FACTORS AFFECTING MENTAL HEALTH -SUBSTANCE ABUSE

P-06.0 OTHER FACTORS AFFECTING MENTAL HEALTH - DEVELOPMENTAL DISABILITIES

P-07.0 OTHER FACTORS AFFECTING MENTAL HEALTH - PHYSICAL HEALTH DISORDERS

P-08.0 CONSERVATORSHIP / COURT STATUS

P-09.0 LIVING ARRANGEMENT Key Change Fields:

K-01.0 FIRST SOURCE COUNTY CLIENT NUMBER

K-02.0 ADDITIONAL SOURCE COUNTY CLIENT NUMBER

Appendix E: Full Service Partnership (FSP) Data Collection & Reporting (DCR) Data Dictionary

Background County Mental Health Plans (MHPs) receive state-based funding for mental health services as a result of California Proposition 63 (now known as the Mental Health Services Act or MHSA), passed in November of 2004. MHSA provides increased funding to support California's county mental health programs. The MHSA imposes a one percent income tax on personal income in excess of $1 million to address a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system, with the purpose of promoting recovery for individuals with serious mental illness. MHPs develop customized plans for mental health partner service in accordance with numerous requirements, including that it must provide for significant local stakeholder input and involvement.

MHSA also funds a special program called the Full Service Partnership (FSP). FSP programs provide a full spectrum of mental health services to children/youth (ages 0 – 15) and transition age youth (TAY) (ages 16 – 25) who are seriously emotionally disturbed and adults (ages 26 – 59) and older adults (ages 60+) who have a serious mental disorder; all of which are referred to as partners in the program. Additional criteria, described in WIC §5600.3, must also be met. A basic principle of the program is its flexible funding, which assures that MHPs may provide whatever services are necessary to help the individual access needed resources. Services offered by local programs include assessing the individual's needs; providing shelter/housing; establishing identification and legal assistance needs; and providing food, clothing, showers, medical, psychiatric dental care, alcohol/drug treatment, and social rehabilitation.

MHPs report partner information and outcomes of the FSP program directly to the Data Collection and Reporting (DCR) system. Current regulations require MHPs to collect partner outcome FSP data (CCR Title 9 § 3620.10.) and submit it to DMH within 90 days (CCR Title 9 § 3530.30). MHPs submit data for three different types of partner assessments into the DCR through an online interface. The Partnership Assessment Form (PAF) gathers baseline information about the partner, while Key Event Tracking (KET) and Quarterly Assessment (3M) gather follow up information. The questions on the each of the PAF, KET and 3M forms may differ slightly depending on the four age groups (Child/Youth, TAY, Adult and Older Adult). Therefore, there are individual forms for each partner assessment and each age group, resulting in 12 different forms for data collection.

Information is collected at intake (PAF) about the current status, the status in the 12 months before enrollment, and the status prior to the last 12 months for the partner. Then some information is updated only quarterly via the 3M form, while other changes in status are collected on an ongoing basis via the KET form as certain key events occur. Information is collected in the following domains: Residential Housing, Employment, Education, Financial Support, Health Status, Emergency Intervention, Substance Abuse,

Activities of Daily living (older adults only), and Legal Issues, such as criminal justice and other legal designations such as foster care

Questions for each domain are collected at various intervals depending on the nature of the information being collected. Baseline information in relation to all questions are collected at partner intake via the PAF. Questions in which it is important to know the date of the event occurred are collected via the KET forms. All other questions are collected only at intake via the PAF or on intake via the PAF and then quarterly via the 3M. Other than partnership information variables, no information for a particular question is collected via both the KET and 3M. This is important to understand as one method will be used for analyzing data for questions collected via PAF and KET, and a different method will be applied for analyzing data for questions collected via PAF and 3M.

For example, all residential questions are collected at intake on the PAF and then as the residential status changes via the KET. Since it is assumed all of the residential changes will be captured in near-real time on the KET, the quarterly assessments are not used for tracking residential status. The same collection method is applied for all questions in the employment and the emergency intervention domains.

All question for the following domains are only collected at intake on the PAF and updated quarterly via the 3M: Sources of Financial Support, Health Status, Substance Abuse, Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) domains.

For the remaining domains, some domain questions are collected on the PAF and KET and other questions are collected on the PAF and 3M: Education, and Legal Issues / Designations.

<u>Quick Overview of Data Collection Intervals by Domain</u>

Domain contains questions collected at PAF and KET only:

- Residential
- Employment
- Emergency Intervention

Domain contains questions collected at PAF and 3M only:

- Sources of Financial Support
- Health Status
- Substance Abuse
- ADL o IADL

Domain contains some questions collected on PAF and KET only and other questions collected on PAF and 3M only:

- Education
- Legal Issues/Designation

The data collection forms ask specific questions about the partner in relation to a domain. Answers to all of the specific questions within each domain are stored in fields, referred to as variables, in a dataset. Every question on the PAF form stores the answer in a related PAF variable; every question on the KET form stores the answer in a related KET variable, and every question on the 3M form stores the answer in a related 3M variable. A complete crosswalk from form questions to variables numbers and names exists in the CROSSWALK sections of this document. A hyperlink connects each question to its related variable definition where the answers are stored.

When questions are the same between form types (i.e., PAF, KET, and 3M), then the answers may be stored in variables of the same name. However, when data is extracted from the system via the online DCR system, three data files are generated for each form type (PAF, KET, and 3M), and only the variables related to that form type exist in each file. A complete list of variables by form type can be found in the Complete Variable Index (CVI) section of this document. A hyperlink connects each variable to its variable definition for all related forms (PAF, KET, and 3M) where applicable.

Some questions are asked for all age groups, while other questions are specific to a subset of age groups. Therefore, the CVI also lists which variables exist for each age group. A hyperlink also connects each variable to the form where the question first appears for all related age groups (Child/Youth, TAY, Adult or Older Adult).

Complete Variable Index (CVT)

VARIABLES		Used for:			On form for:			
No.	Variable Name	PAF	KET	3M	CHILD	TAY	ADULT	OLDER ADULT
		Click to hyperlink to page with variable definition			Click to hyperlink to place on forms where variable first appears			
INTERNAL VARIABLES								
1.01	GlobalID	53	164	210	*(Internally generated variables)*			
1.02	AssessmentID	53	164	210				
1.03	PAFStatus	53						
1.04	DatePartnershipStatusChange	53	164	210				
1.05	PartnerShipStatus	54	164	210				
1.06	CreatedDate	54	165	211				
1.07	Age_Group	54	165	211				
1.08	AssessmentType	55	165	211				
1.09	AssessmentSource	55	166	212				
FROM CSI VARIABLES								
2.01	CSIDateOfBirth	56	167	213	*(These variables are populated from Client Services Information (CSI) system linkage via CSINumber variable. These variables are blank when CSINumber is omitted or invalid.)*			
2.02	Gender	56	167	213				
2.03	CSIRace1	57	168	214				
2.04	CSIRace2	57	168	214				
2.05	CSIRace3	58	169	215				
2.06	CSIRace4	58	169	215				
2.07	CSIRace5	59	170	216				
2.08	Ethnicty_A	59	170	216				
2.09	Ethnicty_B	60	171	217				
2.10	CSIHispanic	60	171	217				
PARTNERSHIP INFORMATION VARIABLES								
3.01	CountyID	61	172	218	16	24	34	42
3.02	CSINumber	61	172	218	16	24	34	42
3.03	CountyFSPID	61	172	218	16	24	34	42
3.04	Name	62	173	219	16	24	34	42
3.05	PartnershipDate	62	173	219	16	24	34	42
3.06	AssessmentDate	62	173	219	16	24	34	42
3.07	DateOfBirth	63	173	219	16	24	34	42
3.08	ReferredBy	63			16	24	34	42
ADMINISTRATIVE INFORMATION VARIABLES								
4.01	DateProviChange		175		139	145	151	158
4.02	ProviderSiteID	64	175		16	24	34	42
4.03	DateProgmChange		175		139	145	151	158
4.04	ProgramDesc	64	175		16	24	34	42
4.05	DatePSCIDChange		176		139	145	151	158
4.06	CoordinatorID	64	176		16	24	34	42
4.07	AB2034ChangeDate		176			146	152	158

Complete Variable Index

VARIABLES		Used for:			On form for:			
No.	Variable Name	PAF	KET	3M	CHILD	TAY	ADULT	OLDER ADULT
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ADMINISTRATIVE INFORMATION VARIABLES (Cont.)								
4.08	AB2034	64				24	34	42
4.09	GHIChangeDate		176			146	152	158
4.10	GHI	65				24	34	42
4.11	MHSAChangeDate		177			146	152	158
4.12	MHSA	65				24	34	42
4.13	DateKETStatusChange		177		139	145	152	158
4.14	KETStatus		177		139	145	152	158
4.15	DiscontReason		178		139	145	152	158
4.16	AB2034		178			146	152	158
4.17	GHI		179			146	152	158
4.18	MHSA		179			146	152	158
RESIDENTIAL VARIABLES								
5.01	DateResidentialChange		180		140	147	153	159
5.02	Current	66	180		17	25	35	43
5.03	Yesterday	67			17	25	35	43
5.04	ApartmentAlone_PastTwelveOccurences	68			17	25	35	43
5.05	ApartmentAlone_PastTwelveDays	68			17	25	35	43
5.06	ApartmentAlone_PriorTwelve	68			17	25	35	43
5.07	WithParents_PastTwelveOccurences	69			17	25	35	43
5.08	WithParents_PastTwelveDays	69			17	25	35	43
5.09	WithParents_PriorTwelve	69			17	25	35	43
5.10	WithOtherFamily_PastTwelveOccurences	70			17	25	35	43
5.11	WithOtherFamily_PastTwelveDays	70			17	25	35	43
5.12	WithOtherFamily_PriorTwelve	70			17	25	35	43
5.13	SingleRoomOccupancy_PastTwelveOccurences	71				25	35	43
5.14	SingleRoomOccupancy_PastTwelveDays	71				25	35	43
5.15	SingleRoomOccupancy_PriorTwelve	71				25	35	43
5.16	FosterHomeRelative_PastTwelveOccurences	71			17	25		
5.17	FosterHomeRelative_PastTwelveDays	72			17	25		
5.18	FosterHomeRelative_PriorTwelve	72			17	25		
5.19	FosterHomeNon-relative_PastTwelveOccurences	72			17	25		
5.20	FosterHomeNon-relative_PastTwelveDays	72			17	25		
5.21	FosterHomeNon-relative_PriorTwelve	73			17	25		
5.22	EmergencyShelter_PastTwelveOccurences	73			17	25	35	43
5.23	EmergencyShelter_PastTwelveDays	73			17	25	35	43
5.24	EmergencyShelter_PriorTwelve	74			17	25	35	43
5.25	Homeless_PastTwelveOccurences	74			17	25	35	43
5.26	Homeless_PastTwelveDays	74			17	25	35	43
5.27	Homeless_PriorTwelve	75			17	25	35	43
5.28	IndividualPlacement_PastTwelveOccurences	75				25	35	43

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RESIDENTIAL VARIABLES (Cont.)								
5.29	IndividualPlacement_PastTwelveDays	75				25	35	43
5.30	IndividualPlacement_PriorTwelve	76				25	35	43
5.31	AssistedLiving_PastTwelveOccurences	76					35	43
5.32	AssistedLiving_PastTwelveDays	76					35	43
5.33	AssistedLiving_PriorTwelve	76					35	43
5.34	CongregatePlacement_PastTwelveOccurences	77				25	35	43
5.35	CongregatePlacement_PastTwelveDays	77				25	35	43
5.36	CongregatePlacement_PriorTwelve	77				25	35	43
5.37	CommunityCare_PastTwelveOccurences	78				25	35	43
5.38	CommunityCare_PastTwelveDays	78				25	35	43
5.39	CommunityCare_PriorTwelve	78				25	35	43
5.40	MedicalHospital_PastTwelveOccurences	78			17	25	35	43
5.41	MedicalHospital_PastTwelveDays	79			17	25	35	43
5.42	MedicalHospital_PriorTwelve	79			17	25	35	43
5.43	PsychiatricHospital_PastTwelveOccurences	79			17	25	35	43
5.44	PsychiatricHospital_PastTwelveDays	80			17	25	35	43
5.45	PsychiatricHospital_PriorTwelve	80			17	25	35	43
5.46	StatePsychiatric_PastTwelveOccurences	80			17	25	35	43
5.47	StatePsychiatric_PastTwelveDays	80			17	25	35	43
5.48	StatePsychiatric_PriorTwelve	81			17	25	35	43
5.49	GroupHome0-11_PastTwelveOccurences	81			17	26		
5.50	GroupHome0-11_PastTwelveDays	81			17	26		
5.51	GroupHome0-11_PriorTwelve	81			17	26		
5.52	GroupHome12-14_PastTwelveOccurences	82			17	26		
5.53	GroupHome12-14_PastTwelveDays	82			17	26		
5.54	GroupHome12-14_PriorTwelve	82			17	26		
5.55	CommunityTreatment_PastTwelveOccurences	82			17	26		
5.56	CommunityTreatment_PastTwelveDays	83			17	26		
5.57	CommunityTreatment_PriorTwelve	83			17	26		
5.58	ResidentialTreatment_PastTwelveOccurences	83			17	26	35	43
5.59	ResidentialTreatment_PastTwelveDays	83			17	26	35	43
5.60	ResidentialTreatment_PriorTwelve	84			17	26	35	43
5.61	NursingPsychiatric_PastTwelveOccurences	84				26	35	43
5.62	NursingPsychiatric_PastTwelveDays	84				26	35	43
5.63	NursingPsychiatric_PriorTwelve	85				26	35	43
5.64	NursingPhysical_PastTwelveOccurences	85				26	35	43
5.65	NursingPhysical_PastTwelveDays	85				26	35	43
5.66	NursingPhysical_PriorTwelve	85				26	35	43
5.67	Long-TermCare_PastTwelveOccurences	86				26	35	43
5.68	Long-TermCare_PastTwelveDays	86				26	35	43

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RESIDENTIAL VARIABLES (Cont.)								
5.69	Long-TermCare_PriorTwelve	86				26	35	43
5.70	JuvenileHall/Camp_PastTwelveOccurences	87			17	26		
5.71	JuvenileHall/Camp_PastTwelveDays	87			17	26		
5.72	JuvenileHall/Camp_PriorTwelve	87			17	26		
5.73	DJJ_PastTwelveOccurences	87			17	26		
5.74	DJJ_PastTwelveDays	88			17	26		
5.75	DJJ_PriorTwelve	88			17	26		
5.76	Jail_PastTwelveOccurences	88				26	36	43
5.77	Jail_PastTwelveDays	88				26	36	43
5.78	Jail_PriorTwelve	89				26	36	43
5.79	Prison_PastTwelveOccurences	89				26	36	43
5.80	Prison_PastTwelveDays	89				26	36	43
5.81	Prison_PriorTwelve	89				26	36	43
5.82	OtherSetting_PastTwelveOccurences	90			17	26	36	44
5.83	OtherSetting_PastTwelveDays	90			17	26	36	44
5.84	OtherSetting_PriorTwelve	90			17	26	36	44
5.85	UnknownSetting_PastTwelveOccurences	91			17	26	36	44
5.86	UnknownSetting_PastTwelveDays	91			17	26	36	44
5.87	UnknownSetting_PriorTwelve	91			17	26	36	44
EDUCATION VARIABLES								
6.01	DateGradeComplete		181		141	148	154	160
6.02	HighestGrade	92	181		18	27	36	44
6.03	EmotionalDisturbance	92		221	18	27		
6.04	AnotherReason	92		221	18	27		
6.05	AttendancePast12	93			18	28		
6.06	AttendanceCurr	93		221	18	28		
6.07	GradesCurr	93		221	18	28		
6.08	GradesPast12	94			18	28		
6.09	SuspensionPast12	94			18	28		
6.10	DateSuspension		181		141	148		
6.11	ExpulsionPast12	94			18	28		
6.12	DateExpulsion		182		141	148		
6.13	DateSettingChange		182			148	154	160
6.14	NotinschoolPast12	94				28	36	44
6.15	NotinschoolCurr	95	182			28	36	44
6.16	HighSchoolPast12	95				28	36	44
6.17	HighSchoolCurr	95	182			28	36	44
6.18	TechnicalPast12	95				28	36	44
6.19	TechnicalCurr	96	183			28	36	44
6.20	CommunityCollegePast12	96				28	36	44

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EDUCATION VARIABLES (Cont.)								
6.21	CommunityCollegeCurr	96	183			28	36	44
6.22	GraduatePast12	97				28	36	44
6.23	GraduateCurr	97	183			28	36	44
6.24	OtherEducationPast12	97				28	36	44
6.25	OtherEducationCurr	97	183			28	36	44
6.26	CompletePgm		184			148	154	160
6.27	EdRecoveryGoals	98	184			28	36	44
EMPLOYMENT VARIABLES								
7.01	Past12_Competitive	99			19	29	37	45
7.02	Past12_CompetitiveAvgHrWeek	99			19	29	37	45
7.03	Past12_CompetitiveAvgHrWage	99			19	29	37	45
7.04	Past12_Supported	100			19	29	37	45
7.05	Past12_SupportedAvgHrWeek	100			19	29	37	45
7.06	Past12_SupportedAvgHrWage	100			19	29	37	45
7.07	Past12_Transitional	101			19	29	37	45
7.08	Past12_TransitionalAvgHrWeek	101			19	29	37	45
7.09	Past12_TransitionalAvgHrWage	101			19	29	37	45
7.10	Past12_In-House	102			19	29	37	45
7.11	Past12_In-HouseAvgHrWeek	102			19	29	37	45
7.12	Past12_In-HouseAvgHrWage	102			19	29	37	45
7.13	Past12_Non-paid	103			19	29	37	45
7.14	Past12_Non-paidAvgHrWeek	103			19	29	37	45
7.15	Past12_OtherEmployment	103			19	29	37	45
7.16	Past12_OtherEmploymentAvgHrWeek	104			19	29	37	45
7.17	Past12_OtherEmploymentAvgHrWage	104			19	29	37	45
7.18	Past12_Unemployed	104			19	29	37	45
7.19	DateEmpChange		185		142	149	155	161
7.20	Current_CompetitiveAvgHrWeek	105	185		20	30	38	46
7.21	Current_CompetitiveAvgHrWage	105	185		20	30	38	46
7.22	Current_SupportedAvgHrWeek	105	186		20	30	38	46
7.23	Current_SupportedAvgHrWage	106	186		20	30	38	46
7.24	Current_TransitionalAvgHrWeek	106	186		20	30	38	46
7.25	Current_TransitionalAvgHrWage	106	187		20	30	38	46
7.26	Current_In-HouseAvgHrWeek	107	187		20	30	38	46
7.27	Current_In-HouseAvgHrWage	107	187		20	30	38	46
7.28	Current_Non-paidAvgHrWeek	107	188		20	30	38	46
7.29	Current_OtherEmploymentAvgHrWeek	108	188		20	30	38	46
7.30	Current_OtherEmploymentAvgHrWage	108	188		20	30	38	46
7.31	Current_Unemployed	108	189		20	30	38	46
7.32	EmpRecoveryGoals	108	189		20	30	38	46

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FINANCIAL VARIABLES								
8.01	Caregivers_Past12	109			21	31		
8.02	Caregivers_Curr	109		222	21	31		
8.03	Wages_Past12	109			21	31	39	47
8.04	Wages_Curr	109		222	21	31	39	47
8.05	Spouse_Past12	110			21	31	39	47
8.06	Spouse_Curr	110		222	21	31	39	47
8.07	Savings_Past12	110			21	31	39	47
8.08	Savings_Curr	110		222	21	31	39	47
8.09	ChildSupport_Past12	111			21	31		
8.10	ChildSupport_Curr	111		223	21	31		
8.11	OtherFamily_Past12	111			21	31	39	47
8.12	OtherFamily_Curr	111		223	21	31	39	47
8.13	Retirement_Past12	112			21	31	39	47
8.14	Retirement_Curr	112		223	21	31	39	47
8.15	Veterans_Past12	112			21	31	39	47
8.16	Veterans_Curr	112		223	21	31	39	47
8.17	Loan_Past12	113			21	31	39	47
8.18	Loan_Curr	113		224	21	31	39	47
8.19	Housing_Past12	113			21	31	39	47
8.20	Housing_Curr	114		224	21	31	39	47
8.21	General_Past12	114			21	31	39	47
8.22	General_Curr	114		224	21	31	39	47
8.23	FoodStamps_Past12	114			21	31	39	47
8.24	FoodStamps_Curr	115		224	21	31	39	47
8.25	TANF_Past12	115			21	31	39	47
8.26	TANF_Curr	115		225	21	31	39	47
8.27	SSI_Past12	116			21	31	39	47
8.28	SSI_Curr	116		225	21	31	39	47
8.29	SSDI_Past12	116			21	31	39	47
8.30	SSDI_Curr	116		225	21	31	39	47
8.31	SDI_Past12	117			21	31	39	47
8.32	SDI_Curr	117		226	21	31	39	47
8.33	TribalBenefits_Past12	117			21	31	39	47
8.34	TribalBenefits_Curr	118		226	21	31	39	47
8.35	OtherSupport_Past12	118			21	31	39	47
8.36	OtherSupport_Curr	118		226	21	31	39	47
8.37	NoSupport_Past12	118			21	31	39	47
8.38	NoSupport_Curr	119		226	21	31	39	47

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LEGAL ISSUES / DESIGNATIONS VARIABLES								
9.01	DateArrested		190		143	150	156	162
9.02	ArrestPast12	120			22	32	40	48
9.03	ArrestPrior12	120			22	32	40	48
9.04	DateProbation		190		143	150	156	162
9.05	ProbationStatus	120			22	32	40	48
9.06	ProbationStatus		190		143	150	156	162
9.07	ProbPast12	120			22	32	40	48
9.08	ProbPrior12	121			22	32	40	48
9.09	ParoleStatus	121			22	32		
9.10	DateParole		190		143	150		
9.11	ParoleStatus		191		143	150		
9.12	ParolePast12	121			22	32	40	48
9.13	ParolePrior12	121			22	32	40	48
9.14	ConservaStatus	122			22	32	40	48
9.15	DateConserva		191		143	150	156	162
9.16	ConservaStatus		191		143	150	156	162
9.17	ConservPast12	122			22	32	40	48
9.18	ConservPrior12	122			22	32	40	48
9.19	PayeeStatus	122			22	32	40	48
9.20	DatePayee		191		143	150	156	162
9.21	PayeeStatus		192		143	150	156	162
9.22	PayeePast12	123			22	32	40	48
9.23	PayeePrior12	123			22	32	40	48
9.24	DateDepen		192		143	150		
9.25	WICodeStatus	123			22	32		
9.26	WICodeStatus		192		143	150		
9.27	DepenPast12	123			22	32		
9.28	DepenPrior12	124			22	32		
9.29	DepenYear	124			22	32		
9.30	Dependent	124		227	22	32	40	48
9.31	Foster	124		227	22	32	40	48
9.32	Reunified	125		227	22	32	40	48
9.33	Adopted	125		227	22	32	40	48
EMERGENCY INTERVENTION VARIABLES								
10.01	PhyRelated	126			23	33	41	49
10.02	MenRelated	126			23	33	41	49
10.03	DateEmergencyChange		193		143	150	156	162
10.04	EmergencyType		193		143	150	156	162

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HEALTH STATUS VARIABLES								
11.01	PhysicianCurr	127		228	23	33	41	49
11.02	PhysicianPast12	127			23	33	41	49
SUBSTANCE ABUSE VARIABLES								
12.01	MentalIllness	128			23	33	41	49
12.02	ActiveProblem	128		229	23	33	41	49
12.03	AbuseServices	128		229	23	33	41	49
ADL VARIABLES								
13.01	Bathing	129		230				50
13.02	Dressing	129		230				50
13.03	Toileting	129		230				50
13.04	Transfer	130		231				50
13.05	Continence	130		231				50
13.06	Feeding	130		231				50
13.07	Walking	130		231				50
13.08	HouseConfinement	131		232				51
IADL VARIABLES								
14.01	Telephone	132		233				51
14.02	WalkingDistance	132		233				51
14.03	Groceries	132		233				51
14.04	Meals	132		233				51
14.05	Housework	133		234				51
14.06	Handyman	133		234				51
14.07	Laundry	133		234				51
14.08	Medication	134		235				51
14.09	Money	134		235				51
COUNTY USE VARIABLES								
15.01	DateKETCntyUse1		194		143	150	156	162
15.02	KETCntyUse1	135	194		23	33	41	51
15.03	DateKETCntyUse2		194		143	150	156	162
15.04	KETCntyUse2	135	194		23	33	41	51
15.05	DateKETCntyUse3		195		143	150	156	162
15.06	KETCntyUse3	135	195		23	33	41	51
15.07	QtrlyCntyUse1	135		236	23	33	41	51
15.08	QtrlyCntyUse2	136		236	23	33	41	51
15.09	QtrlyCntyUse3	136		236	23	33	41	51

Appendix F: Criminal Justice Mental Health Data Project

Summary
California mental health service and program data were linked with criminal justice arrest data, and results from analyses of these linked data showed a dramatic reduction in arrest rates for clients after participating in intensive mental health services in Full Service Partnership (FSP) programs.

Methodology

Mental Health Data from DHCS

Mental health data were obtained from the Department of Health Care Services (DHCS) whom collects mental health data from county MHSA-funded programs including clients' demographic information (age, race/ethnicity, gender, social security number), diagnoses codes, treatment type and frequency, program information (enrollment and exit dates), and self-reported information about clients' educational experience, residential status (e.g., homeless), juvenile justice and criminal justice involvement, social services experience, and more.

DOJ Data from DOJ

Mental Health Data linkage

DOJ and mental health data were linked using a probabilistic matching method using individuals' names, dates of birth, ages, and their race/ethnicity. More detail about the linking process can be found here: Link to methodology report.

Study Period

The study period was from July 1, 2007 – June 30, 2016.

Sample

The final data set included 64,294 partners (age 18 or older), and 59,013 unique clients. Clients could potentially have had more than one full-service partnership because they enrolled in a partnership in a new county or exited a partnership in one county, and then re-enrolled in a partnership more than 12 months later in the same county. Therefore, the number of partnerships is not equivalent to numbers of unique clients. In this sample, the number of partnerships per clients ranged from 1 to 10. Partners under 18 were excluded from this analysis, as they were not present in the Department of Justice Data.

Time Periods

Three time periods were identified for each partnership including: Before FSP - the 12-month period before participating in the FSP program; During FSP - the entire time during FSP participation, and After FSP - the 12-month period after FSP participation.

Arrests Rates

Arrest rates were calculated across the 3 time periods. To ensure arrest rates for each time period were comparable, rates for each time period were annualized – that is, calculated by dividing each partner's total number of arrests by the length of full partnership service for that period in numbers of days, and multiplying the result by 365. Arrest rates were then calculated per 100 partners overall, at the county level, and for subgroups. Finally, arrest rate percent reductions were calculated overall, at the county level, and for subgroups by calculating the difference in the Before and After FSP rates (numerator) and dividing the difference by the original rate (denominator).

Appendix G: School Mental Health

I. The Commission's School Mental Health Report

The Commission's report, *Every Young Heart and Mind: Schools as Centers of Wellness,* highlighted three broad recommendations for promoting school mental health, and the wellbeing and success of children throughout California, under the headings of State Leadership, State Investment, and State-supported Capacity Building.

At its November 2020 meeting, the Commission directed staff to develop an implementation plan aligned with that report. The Commission approved the implementation plan in January 2020.

The implementation plan includes the following actions related to data and management:

- Establish data sharing agreements with the California Department of Education, the Department of Health Care Services and other relevant entities to create appropriate, secure access to education and mental health data. (This work is underway.)
- In partnership with the California Department of Education, the Department of Health Care Services, and others, convene a working group to develop agreed-upon measures of student wellness, including measures relating to suicide and suicide prevention, that can be assessed with existing data and that are useful to inform school mental health decisions.
- Explore how the Commission's school mental health metrics can be coordinated and/or incorporated into the Governor's Cradle-to-Career Data System.
- Based on the work mentioned above, develop a dashboard to communicate information on school mental health metrics in support of mental health planning and decision-making.

II. Data Use Agreement with the California Department of Education

Working Title: *Reducing School Failure through Mental Health Service and Partnerships*

The goal is for research and analyses to provide evidence that will enhance state and local partners' collaborative efforts to improve mental health aid for students and to improve general instruction to students with mental health needs. Several key questions will guide our research and analyses, as follows:

1. **What is the descriptive demographic, programmatic, and educational profile of students who are receiving MHSA or other community mental health services?**
    - What are the general demographics of students who have received MHSA services (e.g., language, race/ethnicity category, special education status, migrant ed status, socioeconomically disadvantaged (SED) status, homeless status, foster status, gender, disability status, migrant status, English learner status)? Can comparisons

among students within and across demographic categories provide insight into differences in mental health needs and supports?

- What are educational outcomes of students who have received MHSA services (e.g., four-year graduation status, UC/CSU requirements met, assessment performance levels for grades 3–8 and 11, and four-year graduation cohort outcome)?
- What is the enrollment, attendance, and discipline status of students who have received MHSA services (e.g., school, district, and county where enrolled, days absent, chronically absent, incident and offense type, disciplinary action, incident year)?
- Does the profile of students who received MHSA services differ from comparable students (e.g., students with IEPs students who are not receiving MHSA services?)
- The Commission obtains self- or caregiver-report data for children and youth who receive MHSA-funded services, including information such as residential status (group home, foster home placement, kin-caregiver), juvenile or Department of Justice system involvement, school achievement, disciplinary information (special education, suspension/expulsion, education success), and career pathways. By linking CDE data with mental health data available from the Department of Health Care Services, including Client Service and Information System (CSI) and Data Collection & Reporting (DCR) datasets, the Commission would be able to establish the accuracy of self-reported information.

2. **How does mental health treatment or service need affect student outcomes (e.g., mental health program completion, graduation rates, attendance, assessment scores, suspension/expulsion, grade retention)?**

- Does receiving MHSA-funded services improve student outcomes in critical areas such as student conduct and school discipline, student attendance, state test scores, graduation rates?
- What is the impact of MHSA services on outcomes over time?
- What is the dose response outcome for student receiving mental health services, that is, does frequency or intensity of services relate to better mental health outcomes?

<u>Research Methodology</u>

Mental health data from MHSA clients and program participants in our CSI and DCR data sets (See Appendices A and B for data dictionaries), will be linked to CDE data using probabilistic matching based on demographic variables (name, age, race, birthday, gender, place of birth, county of residence) to create working data sets from which the following analyses will be conducted. Relevant data from the DOJ and EDD may be linked

to CDE data in a similar manner to provide a comprehensive portrayal of the impact of MHSA services on key outcomes.

III. Description of Mental Health Student Services Act

The Mental Health Student Services Act (MHSSA) is a competitive grant program established to fund partnerships between county behavioral health departments and local education entities for the purpose of increasing access to mental health services in locations that are easily accessible to students and their families. The MHSOAC awarded grants totaling $75 million dollars over a four-year grant cycle, to county behavioral health departments to fund the partnership between educational and county mental health agencies. The grants awarded shall be used to provide support services that include, at a minimum, services provided on school campuses, suicide prevention services, drop-out prevention services, placement assistance and service plans for students in need of ongoing services, and outreach to high-risk youth, including foster youth, youth who identify as LGBTQ, and youth who have been expelled or suspended from school.

County, city, or multi-county mental health or behavioral health departments, or a consortium of those entities, including multi-county partnerships, may, in partnership with one or more school districts and a County Office of Education or charter school within the county, apply for a grant. An educational entity may be designated as the lead agency to submit the application, while the county, city or multicounty mental health department, or consortium, shall receive the grant funds. Allocation of grant funds require that all school districts, charter schools and the County Office of Education be invited to participate in the partnership, to the extent possible, and that applicants include with their application a plan developed and approved with the participating educational partners.

In 2020, the Commission awarded MHSSA grants to 18 school-county mental health partnerships across California. The Commission also funds an additional four school-county mental health partnerships through the Triage Grant program.

County	Size
Calaveras County	Small
Humboldt County	Small
Madera County	Small
Mendocino County	Small
Tehama County	Small
Trinity/Modoc County	Small
Placer County	Medium
San Luis Obispo County	Medium
Santa Barbara County	Medium
Solano County	Medium
Tulare County	Medium

County	Size
Yolo County	Medium
Fresno County	Large
Kern County	Large
Orange County	Large
San Mateo County	Large
Santa Clara County	Large
Ventura County	Large

IV. Evaluation of MHSSA-Funded Programs (See Section 5886, Part 4 of Division 5 of the Welfare and Institutions Code)

(j)(1) The commission shall develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants.

(2)(A) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation of this section no later than March 1, 2022. The report shall address, at a minimum, all of the following:

(i) Successful strategies.
(ii) Identified needs for additional services.
(iii) Lessons learned.
(iv) Numbers of, and demographic information for, the school-age children and youth served.
(v) Available data on outcomes, including, but not limited to, linkages to ongoing services and success in meeting the goals identified in paragraph (3) of subdivision (c).

(B) A report to be submitted pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.

V. CDE Data Requested

Cumulative Enrollment

Field #	Column Name	FieldType	MaxLen	Definition
1	ClientID	Character	TBD	MHSOAC unique ID
2	Cds	Character	14	County(2)-District(5)-School(7) code
3	County	Character	50	County name
4	District	Character	80	District Name
5	School	Character	90	School name

Field #	Column Name	FieldType	MaxLen	Definition
6	Stukey	Integer		A unique identifier assigned to the student
7	FirstName	Character	50	Student legal first name
8	MiddleName	Character	50	Student legal middle name
9	LastName	Character	50	Student legal last name
10	GenderCodeForReportin g	Varchar	1	A coded value representing a student gender
11	birthdate	Date		The student day of birth
12	FinalCountyCode	Varchar	2	County code
13	modLeaRptngCDSCode	Varchar	7	County(2) - District(5) code
14	modschlatndnccdscode	Varchar	7	School code
15	GrdLvlCode	Character	2	Student Grade Level
16	StuEsiRltnspExpctdSchlSt artDate	Date		The date the student first attended the school.
17	Withdrldate	Date		The date of the last day of attendance at the school.
18	StukExitCatgCode	Character	4	A coded value category when the student left a school.
19	SchlCmpltnStatCode	Character	3	A coded value representing a school completion status.
20	GraduateMetUSCSU	Character	1	A flag of whether or not the student met all of the admission requirements for admission to a University of California or California State University college. "Y" indicates that the student has met all the requirements; "N" indicates that the student has not.
21	SchSPEDForReporting	Character	1	A Flag of whether or not a student is participating in Special Education program. "Y" indicates that the student is participating; "N" indicates that the student is not.
22	SchMigForReporting	Character	1	A Flag of whether or not a student is participating in migrant program. "Y" indicates that the student is

Field #	Column Name	FieldType	MaxLen	Definition
				participating; "N" indicates that the student is not.
23	SchHomForReporting	Character	1	A Flag of whether or not a student is participating in homeless program. "Y" indicates that the student is participating; "N" indicates that the student is not.
24	SchlELForReporting	Character	1	A Flag of whether or not a student is participating in English Learner program. "Y" indicates that the student is participating; "N" indicates that the student is not.
25	SchSEDForReporting	Character	1	A Flag of whether or not a student is participating in Socio-Economically Disadvantaged program. "Y" indicates that the student is participating; "N" indicates that the student is not.
26	PregnantOrParentingIndicator	Character	1	A Flag of whether or not a student is participating in Pregnant or Parenting program. "Y" indicates that the student is participating; "N" indicates that the student is not.
27	AcdmcYear	Character	9	Indicates the academic year the student is enrolled.
29	Schooltype	Character	45	A general description of the type of educational services provided by the school.
30	EdOpsCode	Character	7	The educational options code field representing information similar to the schooltype field. This data element will eventually replace the schooltype element.
31	EdOpsName	Character	45	School and program alternatives that provide students with the environment, curriculum, and support systems needed to ensure that they achieve their full academic potential.

Field #	Column Name	FieldType	MaxLen	Definition
32	LangName	Character	30	The native language of the student.
33	HomelessDwellingTypeName	Character	25	A description of the temporary residence for homeless students.

4 Year Adjusted Cohort

Field #	CDE Column Name	Field Type	Field Length	Description
1	Stukey	Integer		A unique identifier assigned to the student
2	CohortYear	Character	4	Cohort Year - Last year of 4-year cohort
3	FileDate	Date		Date file produced
4	Cds	Character	14	County(2)-District(5)-School(7) code
5	County	Character	50	County name
6	District	Character	80	District Name
7	School	Character	90	School name
8	SSID	Character	10	Statewide Student Identifier (SSID)
9	Student Enrollment Date	Date		Date student enrolled in school
10	Student School Exit Effective Date	Date		Date student exited the school
11	enrollment status code	Character	2	Enrollment Status
12	Student Exit Category Code	Character	4	The students' status on exit from a school
13	Student School Completion Status Code	Character	3	The students School completion status on exit from a school
14	Graduate Meets UCCSU	Character	1	Flag indicating if the graduating student met all UC/CSU entrance requirement

Field #	CDE Column Name	Field Type	Field Length	Description
15	StuFstNameLgl	Character	30	Student's legal first name
16	StuLastOrSrnmLgl	Character	50	Student legal last name
17	StuMdlNameLgl	Character	30	Student's legal Middle name
18	NameSfxCode - REMOVED	Character	3	Student's suffix code
19	StuBirDate	Date		Student's birthdate
20	gender code	Character	1	Student's gender code
21	StuBirCityName	Character	30	Student's birth city name
22	StuBirStOrProvncName	Character	60	Student’s Birth State or Province name
23	StuBirCntryName	Character	60	Student’s birth county name
24	LangName	Character	60	Student’s primary language name
25	EngLangAcqstnStatStCode	Character	4	English Language Acquisition status
26	Race Ethnicity Category Code	Character	3	Student’s Race/Ethnicity category code
27	SpecialEd	Character	1	Special education program participant
28	MigrantEd	Character	1	Migrant education program participant
29	FRPL	Character	1	FRPL program participant
30	Gate - REMOVED	Character	1	GATE program participant

Field #	CDE Column Name	Field Type	Field Length	Description
31	SocDisad	Character	1	Socio-economically Disadvantaged
32	English Learner	Character	1	Identified as a English Learner
33	Homeless	Character	1	Identified as Homeless
34	DirectCert	Character	1	Direct certification status
35	Foster	Character	1	Foster Student
36	CohortOutcome	Character	7	Final cohort-outcome status
37	StillEnrolled	Character	1	Final status is still enrolled on the following Census Day

Discipline Incidence-Outcome

Field #	CDE Column Name	Field Type	Field Length	Description
1	StuKey	Integer		The unique identifier assigned to the student by CALPADS.
2	Cds	Character	14	County(2)-District(5)-School(7) code
3	County	Character	50	County name
4	District	Character	80	District Name
5	School	Character	90	School name
6	StuFstNameLgl	Character	30	The student's first name.
7	StuLastOrSrnmLgl	Character	50	The student's last name.
8	GenderCodeForReporting	Character	7	The student's gender.
9	StuBirDate	Date	10	The student's birth date.

Field #	CDE Column Name	Field Type	Field Length	Description
10	RaceEthnicityForReporting	Character	1	The student's ethnicity.
11	SchSpedForReporting	Character	1	'Y' indicates the student has a disability.
12	SchMigForReporting	Character	1	'Y' indicates the student is a migrant student.
13	ModLEARptngCDSCode	Character	7	The first seven digits of the CDS code where the incident was reported. (County-District code.)
14	ModSchlAtndncCDSCode	Character	7	The last seven digits of the CDS code where the incident was reported. (School Code)
15	IncdtKey	Integer		The unique identifier assigned to the incident. An incident may include one or more offenses committed by one or more students.
16	DscplnryActnTknKey	Integer		The final disciplinary action taken against the student for a specific incident. Example: If a student is initially suspended, then later expelled for an incident, this record would capture the expulsion.
17	AcademicYear	Character	9	Indicates the academic year in which the incident occurred. (July 1 - June 30.)

Discipline Offense

Field #	CDE Column Name	Field Type	Field Length	Description	Code Set
1	Cds	Character	14	County(2)-District(5)-School(7) code	
2	County	Character	50	County name	
3	District	Character	80	District Name	
4	School	Character	90	School name	
5	StuKey	Integer		The unique identifier assigned to the student by CALPADS.	
6	ModLEARptngCDSCode	Character	7	The first seven digits of the CDS code where the incident was reported. (County-District code.)	
7	ModSchlAtndncCDSCode	Character	7	The last seven digits of the CDS code where the incident was reported. (School code.)	
8	IncdtKey	Integer		The unique identifier assigned to the incident. An incident may include one or more offenses committed by one or more students.	
9	OfnsKey	Integer		A value indicating which of the 33 California Education Code sections pertaining to discipline was violated by the student during the incident.	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33

Attendance

Field #	CDE Column Name	Field Type	Field Length	Description
1	Cds	Character	14	County(2)-District(5)-School(7) code
2	County	Character	50	County name
3	District	Character	80	District Name
4	School	Character	90	School name
5	StuKey	Integer		The unique identifier assigned to the student by CALPADS.
6	Academic Year	Character	9	The academic year
7	STAS Exempt Indicator	Character	1	An indicator of whether or not the student is exempt from the CALPADS absence summary data collection because the student: • Is enrolled in a Non-Public School (NPS); or • The student receives instruction through a home or hospital instructional setting as authorized by Education Code section 48206.3-48208.
8	Hourly Indicator	Character	1	An indicator of whether the student is attending a school for which the calculation for all students is based on hourly attendance (e.g. continuation schools).
9	Expected Days Attended	Decimal (5,2)	6	Total number of days the individual student was scheduled to attend during the Academic Year from the

Field #	CDE Column Name	Field Type	Field Length	Description
				student's Enrollment Start Date to the Enrollment Exit Date. Expected attendance days are the number of days a student was scheduled to attend, whether or not he or she was actually in attendance based on the Enrollment Start and End date. For hourly programs, (e.g. continuation) expected attendance days must include all of the schooldays a student was scheduled to attend in the hourly program. This may be less than five days in a typical five-day week.
10	Days Attended	Decimal (5,2)	6	Total number of days the student attended the school. A day attended is defined as any day a student attended for all or part of a school day.
11	Days Absent Out of School Suspension	Decimal (5,2)	6	Total number of days the student was absent from the regular classroom for the entire school day due to an out-of-school suspension pursuant to EC 48911.
12	Days Attendance In School Suspension	Decimal (5,2)	6	Total number of days the student was in attendance but absent from the regular classroom **for the entire school day** due to either an in-school suspension pursuant to EC 48911.1, or a teacher suspension from a classroom pursuant to EC 48910(c) or a combination of both.
13	Days Absent Excused	Decimal (5,2)	6	Total number of days the student was absent for the entire school day with a valid excuse, per Education Code sections 48260(c). (This does not include an absence due to an out-of-school or in-school suspension.)

Field #	CDE Column Name	Field Type	Field Length	Description
14	Days Absent Unexcused	Decimal (5,2)	6	Total number of days the student was absent for the entire school day without a valid excuse. (This does not include students who are absent due to an out-of-school suspension or who attended in-school suspension.)
15	Incomplete Independent Study Days	Decimal (5,2)	6	Total number of days the student did not satisfy statutory and regulatory requirements necessary to earn attendance credit
16	Grade Level	Character	2	Student grade level
17	Gender	Character	1	Gender of the student
18	Ethnicity	Character	1	Student race/ethnicity
19	English Learner Indicator	Character	1	Identified as an English learner
20	Student with Disability Indicator	Character	1	Identified as a student with disability
21	Disability Category	Character	3	For students Identified with a disability, A coded value representing a Disability Category.
22	Migrant Indicator	Character	1	Identified as a migrant student
23	Free or Reduced-Price Meal Indicator	Character	1	Participates in the free or reduced-price meal program
24	Homeless Indicator	Character	1	Identified as a homeless student
25	Direct Certification Indicator	Character	1	Participates in the direct certification program
26	Foster Indicator	Character	1	Identified as a foster student
27	Socioeconomically Disadvantaged Indicator	Character	1	Identified as a socioeconomically disadvantaged student
28	Educational Options Description	Character	75	School and program alternatives that provide students with the environment, curriculum, and support systems needed to ensure that they achieve their full academic potential
29	Date Created	Date	10	Date of file created
39	Days Absent	Decimal(5,2)	6	Expected Days Attended – Days Attended

Field #	CDE Column Name	Field Type	Field Length	Description
31	Percent Absent	Decimal(5,2)	6	Days Absent / Expected Days Attended * 100
32	School Level Chronically Absent Indicator	Character	1	An indication of whether or not the student met the **schoolwide** chronic absenteeism criteria: 1) Not exempt from STAS reporting. 2) Met the minimum 30 days expected attendance. 3) Met the minimum 1 day attended 4) Was absent at least 10% of their expected attendance.
33	Statewide Chronically Absent Indicator	Character	1	An indication of whether or not the student met the **statewide** chronic absenteeism criteria: 1) Not exempt from STAS reporting. 2) Met the minimum 30 days total expected attendance statewide. 3) Met the minimum 1 day attended 4) Was absent at least 10% of their expected attendance.

CAASPP ELA-Math

Field #	CDE Column Name	Field Type	Field Length	Description
4	Cds	Character	14	County(2)-District(5)-School(7) code
5	County	Character	50	County name
6	District	Character	80	District Name
7	School	Character	90	School name
1	StuKey	Integer		The unique identifier assigned to the student by CALPADS.
2	Academic Year	Character	9	The academic year
3	Grade Level	Integer	2	3-8,10, 11, 12
4	Test Type	Character	1	SBAC ELA = A SBAC Math = B CAA ELA = C CAA Math = D

5	Mean Scale Score	number	6	Score depends on grade level and test type. See CAASPP.org for additional information
6	Performance Level	Integer	1	SBAC ELA and Math = 1, 2, 3, 4 CAA ELA and Math = 1, 2, 3

Appendix H: The Community Wellness Outcomes Project: Reporting on Outcomes that Matter for Communities, UCLA

UCLA has proposed population level measures. See Community Wellness Outcomes Project Report.