Commission *for* Behavioral Health

Full Service Partnerships 2024 Legislative Report

by the Behavioral Health Services Oversight and Accountability Commission

Submitted to the Fiscal and Policy Committees of the Legislature

Commission for Behavioral Health

Executive Summary

"They always see the bad things, but we never really highlight some of the amazing success stories that we have and that we have done working with FSPs […] They have got amazing success stories with clients. That to me [means] we're on the right path, that we're doing the right thing. There's no such thing as a perfect system. There's always room for improvement. And we have to work collaboratively with other departments [to get there]."
– FSP Programs Director

The need for wide-scale, long-term solutions to California's mental health crisis has never been clearer. The number of homeless Californians and those engaged in the criminal justice system due to serious mental illness continues to grow. Despite expanding budgets, the state struggles to meet the needs of the estimated 2 million adults and children living with serious mental illness or serious emotional disturbance. Full Service Partnerships (FSPs) represent California's comprehensive and intensive efforts to serve individuals with serious mental illness in their communities and connect them to the resources they require to gain stability and maintain independence. On the continuum of care, FSPs are the last effort to divert individuals away from the most devastating impacts of serious mental illness, including homelessness, incarceration, and hospitalization.

FSPs provide services across the lifespan including to children, transition aged youth[1], adults, and older adults. A unique component to FSPs is that services are available 24/7 and can include therapy, assistance planning transportation to medical appointments, housing assistance, and more.

Report to the Legislature

Senate Bill 465 directs the Commission to provide biennial reports to the Legislature on the operations of FSPs and recommendations on improving outcomes for FSP clients. In these reports the Commission is charged with reporting on:

- Individuals eligible for FSPs, including information on incarceration or criminal justice involvement; housing status or homelessness; hospitalization, emergency room use, and crisis service use.
- Analyses of separation from an FSP and the housing, criminal justice, and hospitalization outcomes for the 12 months following separation.
- An assessment of whether those individuals most in need are accessing and maintaining participation in a FSP or similar programs.

[1] Youth ages 16-25

- Identification of barriers to receiving the data relevant to the report requirements.
- Recommendations to strengthen California's use of FSPs to reduce incarceration, hospitalization, and homelessness.

This is the second biennial report to the Senate and Assembly Committees on Health and Human Services, and Assembly Budget Subcommittee on Health and Human Services, in compliance with Senate Bill 465. Since its initial report, the Commission has carried out extensive work to better understand what needs to be done to improve FSPs and move the needle on hospitalization, homelessness, and incarceration for Californians with serious mental illness. This includes conducting targeted outreach, community forums, a statewide survey, and research efforts. In total these efforts reached participants from 45 counties (77 percent of counties).

This current report has two priorities. The most essential of these is to present the required information to the Legislature as directed by Senate Bill 465. The second priority is to examine FSPs as systems of care and illuminate how system-level issues, such as programmatic inconsistencies and State-mandated data collection and reporting policies and practices, impact quality of care and client outcomes. This is followed by a set of findings and recommendations, some of which are already underway, such as performance management and technical assistance to improve the quality of client care.

Figure 1: Learning Efforts, 2023-2024

Targeted Outreach	Community Forums	Statewide Survey	Research
• **87** participants • **40** organizations • **22** counties • **28%** identified as people of color • **24%** shared they had personal or family experience of behavioral health challenges	• **145** participants • **76** organizations • **29** counties • **43%** identified as people of color • **44%** shared they had personal or family experience of behavioral health challenges	• **228** participants • **35** counties • **57%** identified as people of color • **46%** shared they had personal or family experience of behavioral health challenges • Average of **10 years** of experience in FSPs	• **3** deep dives on county contract practices • **2** case studies on data collection and reporting • **2** pilot projects on performance management • **4** site visits (3 adult and 1 child/TAY)

Overview of FSP Partnerships

> *"Some of the best [parts] of FSP are related to our ability to join with the client wherever they may be. We make great connections with humans in need."* – County Behavioral Health Agency

To date, FSPs have served more than 222,145 clients, averaging tens of thousands of clients each year. About two-thirds of Full Service Partnerships are with clients over the age of 16 and one-third are with clients 15 and under, which is important as FSP service delivery largely differs by age group. Below is a brief description of each of the five categories of FSPs. Of these five, four are age specific and one is focused on justice-involved adults.

Child FSPs provide intensive, in-home mental health services for children ages 0-15 and their families. Using a wraparound approach, these FSPs work with children and families on goals that support safety, wellbeing, health, and stability of the family.

Transition Aged Youth (TAY) FSPs provide comprehensive, high-level outpatient mental health services that use a team approach to meeting the behavioral health needs of youth ages 16-25 experiencing social, behavioral, and emotional distress.

Adult FSPs are designed for adults ages 26-59 who have been diagnosed with a serious mental illness. Adult FSPs assist with housing, employment, and education, as well as mental health and substance use services when needed.

Older adult FSPs are for adults 60 and older with histories of homelessness and/or incarceration. These FSP programs often use the Assertive Community Treatment (ACT) model.

Forensic FSPs serve justice-involved adults with serious mental health needs and co- occurring substance abuse disorders.

Statewide, more than half of FSP clients are people of color, although the racial and ethnic makeup of FSP clients varies by region and age group. The data show that about 60 percent of adult client and about 30 percent of child/TAY clients are or were housing insecure. The Commission expects that these numbers underestimate the actual count as data on homelessness is often incomplete.

With regards to psychiatric diagnoses, the most common primary and secondary diagnoses that adult clients have received over time are: 1) schizophrenia/psychotic disorders; 2) depressive disorders; and 3) substance use/addictive disorders. This aligns with the aims of FSPs and suggests services are reaching the intended population. The data for children/TAYs presents a different pattern. The most reported diagnoses are: 1) depressive disorders; and 2) trauma/stressor-related disorders. While these diagnoses speak to the deep emotional and psychological needs of the young people being served by child/TAY FSPs, it is unclear why Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) funded services do not currently meet these needs.

Service Utilization and Outcomes

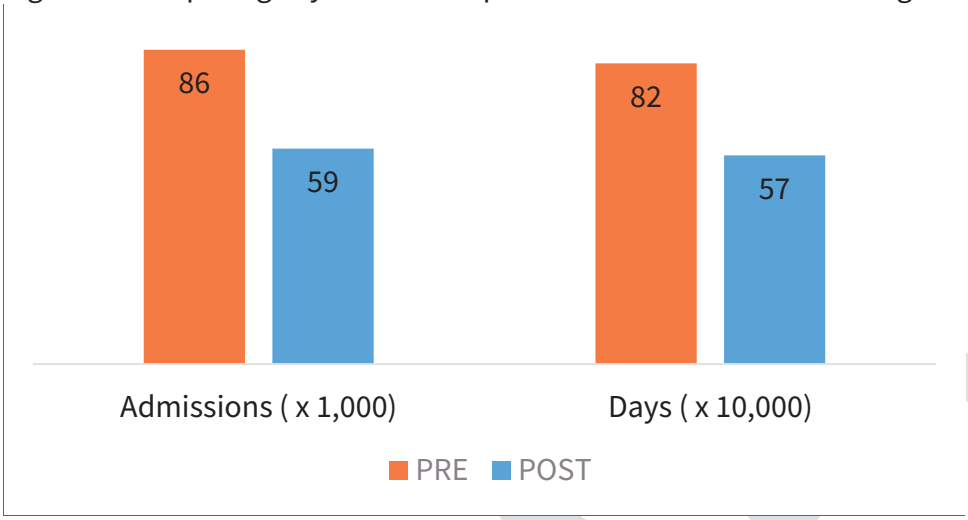
> *"[FSPs] create conditions to live with more dignity, be housed, … to transgress barriers, to have a soft landing and abundance of resources … [They give people their] own voice and connection back to families."* – Participant from Community Forum 1

Joining an FSP can be an incredibly important step towards stability and health for many people living with serious mental illnesses and/or substance use disorders. But joining an FSP is just the first step. Clients must stay long enough to reap the full benefit of the services provided. Child and TAY clients tend to have shorter enrollment periods than adults. At the two-year mark, 50 percent of adult clients were no longer active members of their FSP partnership, compared to 77 percent for child/ TAY clients. A positive interpretation is that younger clients are reaching their goals faster than older clients, and there is evidence to suggest this is true. Overall, 48 percent of child/TAY clients and 28 percent of adult clients exit an FSP partnership due to meeting their goals. This was the most common reason for both groups.

With regards to hospitalization pre and post joining an FSP, if one looks at data between 2012 and 2022, it shows a decrease in both number of inpatient psychiatric admissions and in total days clients spent in the hospital for those stays. FSP clients experienced 85,590 psychiatric hospital admissions in the year prior to joining an FSP compared to 58,638 in the year after joining an FSP, a reduction of 41 percent.

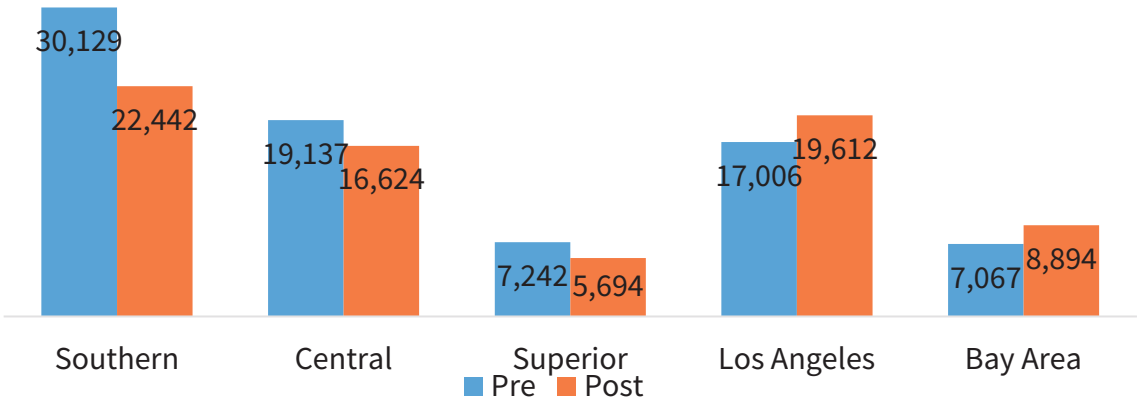
Similar trends exist for days spent in the hospital for those admissions, with hospital days in the year prior to joining an FSP coming in at 818,653 versus 568,348 afterwards, a reduction of 31 percent.

Figure 2: Comparing Psychiatric Hospitalization Pre and Post Joining an FSP



When examining crisis service utilization, we see a more complex pattern. The Figure below presents pre- and post-crisis service use for individuals enrolled in an FSP between 2019 and 2022. The blue bar represents the total crisis services FSP clients used one year prior to joining an FSP, and the orange bar represents the total services used in the year after joining an FSP. If service use was the same before and after, the orange and blue bars would be at the same height. Rather, in the Southern, Superior, and Central regions clients had higher service use prior to joining an FSP. This is a different pattern than in Los Angeles and the Bay Area, where clients' service use went up after getting connected to an FSP.

Figure 3. Crisis Service Usage Pre and Post FSP Enrollment Varies by Region



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Findings and Recommendations

Statewide Data Infrastructure

"[The] biggest barrier to data entry is the disconnect between what is valuable to the State and what is valuable to person in care ..." – FSP service provider

A substantial portion of this report is dedicated to the challenges that current data collection and reporting processes pose for FSP providers and counties. Providers are swimming in the administrative burden that results from redundant data entry with no practical purpose or benefit to clients. Providers are left to either keep secondary paper copies of forms and hand calculate client outcomes or pay for supplementary software to track their client's progress.

Proposition 1 makes clear that accountability and transparency are foundational to behavioral health transformation. It is the Commission's goal to highlight the implications of the current data system and elevate solutions for the Department of Health Care Services to consider as they shape the future of data collection and reporting for FSPs.

The Commission's findings suggest the existing Data Collection and Reporting (DCR) system is not sufficient for capturing the accurate, high-quality data necessary for accountability and transparency in FSPs. The Commission recommends the existing DCR system be replaced with a more flexible, adaptive, provider-centered system or be overhauled to have the following features at its core: functionality, customization, brevity, and interoperability.

While the Commission is aware that this suggestion is not one that can be implemented easily, or quickly, it also recognizes it is essential to reducing administrative burden on service providers and counties alike and improving the quality of data necessary for accurate accountability and transparency under Proposition 1.

Performance Management

Performance management focuses efforts on getting clients to their goals in a timely and efficient manner. It prioritizes client outcomes and creates an avenue of accountability for providers. Performance management is key to ensuring inputs produce results but does more than improve outcomes. When executed with care and fidelity, performance management can reduce provider

stress by offering clarity and direction in a seemingly endless cycle of work. Performance management should be viewed as a tool with equal benefit to clients, supervisors and staff.

This report's findings suggest most counties are not currently engaged in substantive performance management practices. Lack of funding and resources is partially responsible but equally so is the hesitation of many providers to engage in performance management. The Commission recommends California launch a statewide learning community where county behavioral health staff and providers can gain greater knowledge of the potential benefits of performance management for their teams and better understand the resources necessary to undertake performance management with fidelity. Furthermore, the Commission suggests an evaluation of the plausible impact and resources needed to create scalable performance management statewide.

Outcomes Contracts

> *"What is the goal of the person in care? It doesn't have to be the goal of the State. What do they want out of [FSP] and are we meeting their goals? If you don't start with that, I don't know how you are going to get anyone to engage. One of the person's goals was to have teeth so they could smile. That was their whole goal from the FSP. Then they could go for a job and show up and be present. If you don't focus on that, celebrate it, and work on it, you'll never get to the downstream goals [like housing stability]."*

The current contracting practices between counties and providers do not place enough focus on reaching outcomes, including client-specified outcomes. The Commission recommends counties include performance metrics, including client-specified goals, into future contracts with service providers. The Commission also suggests outcome based contracting be thoroughly vetted and an evaluation should be conducted to identify:

- Impacts on providers, both immediate and long term
- Disproportionate impacts on certain demographic groups and regions
- Impacts on both state-specified and client-specified outcomes
- Impacts on retention, step down, and service utilization
- Sustainability and scalability of such models statewide

Funding

Contracted providers shared their confusion around how to maximize FSP dollars, including what services were billable and to whom. The Commission was surprised to learn that about one in 10 providers were funding FSP services strictly through CSS funds and not billing Medi-Cal. Even providers who were successfully braiding funding were overwhelmed with changes to billing through CalAIM and the potential funding changes through Proposition 1.

The Commission suggests technical assistance and training for counties and service providers on:

- Braiding funding and sustainability
- Clarity around Medi-Cal billable services
- Impacts of CalAIM: Developing new county-to-provider payment models that support FSP service delivery and account for technical changes that occurred as part of CalAIM payment reform
- Impacts of Proposition 1

FSP Service Delivery Models

The Commission's extensive conversations and information gathering suggests most service providers would benefit from increased structure in both process and approach to service provision. Guidance on what service delivery models are best suited to particular populations, and best practices within these models, could go far in providing the kinds of supports service providers have requested. Under the new BHSA, each county will be required to implement the following models through their FSPs: Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Individual Placement and Support model of Supported Employment, and High Fidelity Wraparound. Counties with under 200,000 residents may be granted an exemption from this requirement by the California Department of Health Care Services.

The Commission recommends California develop and disseminate clear service model guidelines for FSP programs statewide, including:

- A clear definition of what an FSP is, and what the shared goals of FSPs are.
- Clear and specific eligibility requirements for FSP clients to reduce wait times and ensure individuals are connected to the correct resources from day one.
- Recommended evidence-based practices for treatment models specified in BHSA.
- Guidance on selecting an appropriate treatment model.

Staffing and Resources

The ongoing workforce crisis significantly affects all aspects of FSP programs. FSP providers repeatedly called for solutions to address persistent staff shortages and guidance on how to better leverage current staff resources. Training and capacity building alone will not be sufficient to alleviate the current strain on FSP providers or alleviate the resulting turnover.

The Commission suggests the State invest significant resources in identifying scalable solutions that can:

- Widen the Pipeline
    - Create a stronger behavioral health workforce pipeline by building relationships with local universities and developing internship programs specifically tailored to prepare future clinicians to succeed in FSP settings.

- Increase Incentives/Benefits
    - Provide financial resources for counties to raise wages in areas most struggling to fill positions or offer workforce incentives like subsidized housing, loan repayments or paid internships.
- Reduce Provider Stress
    - Support counties in developing trainings on specific high-stress and high-priority topics, including billing, documentation and data entry, housing, and serving individuals with SUDs.
- Utilize Peers
    - Invest in expanding peer certification and placement programs, including licensing, training, and post placement supports. Peers are more than a workforce shortage solution; they are key to increasing client retention and ultimately improving client outcomes.

Next Steps

This report lays out, as clearly and practically as possible, the Commission's recommendations for bringing transformational change to FSPs. Below are the Commission's current and forthcoming efforts to make these recommendations a reality.

In February of 2024, the Commission allocated $20 million in Mental Health Wellness Act funds towards a technical assistance and capacity building strategy to:

- Advance sustainable funding solutions through the restructuring of current funding models to increase efficiency and impact.
- Strengthen the workforce by identifying innovative, scalable workforce development solutions to increase capacity and reduce turnover.
- Improve accountability by developing metrics of success, identifying key client outcomes, and improving data collection and reporting practices.
- Fortify current infrastructure by strengthening service delivery models connected to the broader continuum of care.

The Commission is currently developing a request for proposals, not to exceed $10 million, for technical assistance and capacity building to meet these needs.

Complementing the MHWA dollars for technical assistance, the Commission has several additional projects underway aimed at improving FSPs. The first is the creation of a best practices toolkit for service providers, currently in development in collaboration with Third Sector Capital Partners. This toolkit will bring together recommendations and best practices identified by FSP service providers and county behavioral health staff into a single resource that will be widely available for the behavioral health system statewide.

The toolkit will focus on the following five topics and is expected to be available in summer of 2025:

- Peer and paraprofessional supports in the workforce
- Services and treatment for individuals with substance use disorders
- Collaboration with community and cultural partners
- Step-down levels of support
- Outreach and engagement

Simultaneously, the Commission launched two pilot projects with Healthy Brains Global Initiative (HGBI) to provide performance management capacity building and technical assistance to FSP service providers in Sacramento and Nevada counties. In these pilots, counties and service providers work together to identify performance goals and develop performance monitoring tools to track progress towards these goals. Results from these pilots will also be available in the summer of 2025.

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PART 1

"They always see the bad things, but we never really highlight some of the amazing success stories that we have and that we have done working with FSPs […] They have got amazing success stories with clients. That to me [means] we're on the right path, that we're doing the right thing. There's no such thing as a perfect system. There's always room for improvement. And we have to work collaboratively with other departments [to get there]."

– FSP PROGRAMS DIRECTOR

Acknowledgements

The Commission would like to acknowledge the hundreds of service providers, supervisors, county behavioral health staff, content experts, clients, peers and family members who shared their thoughts, experiences, and value time with us over the last two years. Without their contributions this report would not be possible. We would also like to thank our partners at Third Sector Capital Partners and Healthy Brains Global Initiative whose collaboration was essential to our engagement and learning efforts.

Lastly, we'd like to thank our colleagues at the California Department of Health Care Services and the California Health and Human Services Agency who have consistently offered their collaboration to better the behavioral health and wellbeing of Californians.

Commission for Behavioral Health

Chapter 1: Whatever It Takes

"Some of the best [parts] of FSP are related to our ability to join with the client wherever they may be. We make great connections with humans in need." – County Behavioral Health Agency

About This Report

Full Service Partnerships (FSPs) represent California's comprehensive and intensive efforts to serve individuals with serious mental illness in their communities and connect them to the resources they need to gain stability and maintain independence. On the continuum of care, FSPs are the last effort to divert individuals away from the most devastating impacts of serious mental illness, including homelessness, incarceration, and hospitalization.

This is the second biennial report to the Senate and Assembly Committees on Health and Human Services, and Assembly Budget Subcommittee on Health and Human Services, in compliance with Senate Bill 465.

Part 1 provides an overview of FSPs and examines the data collection, reporting, and monitoring done by FSP and county staff to meet the needs of clients and comply with existing mandates. A key component to this evaluation is examining the role of the Data Collection Reporting system managed by the Department of Health Care Services and providing possible solutions to improve data accuracy and transparency, while reducing administrative burden.

Part 2 provides a comprehensive overview of clients served by FSPs since their inception more than two decades ago. This includes age, race/ethnicity, gender, place of birth, and experiences of homelessness. It also examines service usage and outcomes, such as crisis service utilization, inpatient psychiatric hospitalization, and emergency department visits.

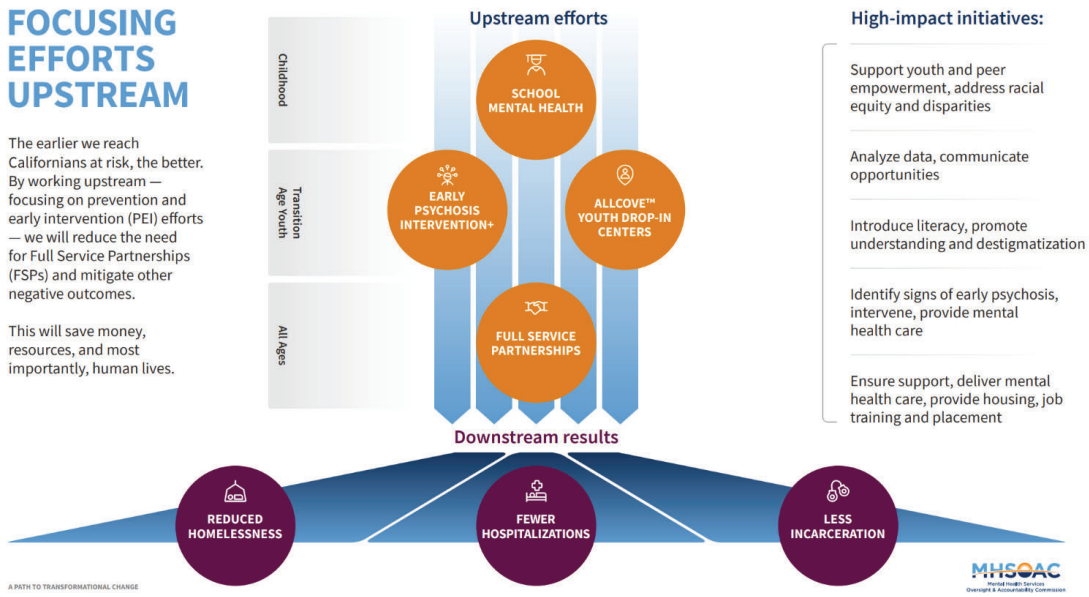
There are limitations to the information included in this report. Due to a lack of data, the Commission is not able to provide information on clients' incarceration, probation, or recidivism prior to, during, or after FSP participation. Some of the estimates may be inaccurate at the county level due to missing data or errors in reporting. Despite these limitations, this report outlines the potential for FSPs to deliver invaluable resources to individuals with severe mental illness and/or substance use disorders and identifies several roadblocks currently limiting their impact. The report includes specific recommendations for California to ensure FSPs meet their full potential and the expectations of Proposition 1 and the Behavioral Health Services Act.

"[FSPs] create conditions to live with more dignity, be housed, … to transgress barriers, to have a soft landing and abundance of resources … [They give people their] own voice and connection back to families." – Participant from Community Forum 1

History and Role of Full Service Partnerships

California's Full Service Partnership (FSP) programs are recovery-oriented, comprehensive services targeted to individuals who are unhoused or are at risk of becoming unhoused, and who have a severe mental illness, often with a history of criminal justice involvement and repeat hospitalizations. FSP programs were designed to serve people in the community rather than in locked state hospitals. FSPs provide services across the lifespan including children, transition aged youth[2], adults, and older adults. A unique component to FSPs is that services are available 24/7 and can include therapy, assistance planning transportation to medical appointments, housing assistance, and more.

Figure 1: FSPs are the Last Stop in the Upstream Efforts to Reduce Homelessness, Incarceration and Hospitalization



By engaging mental health consumers in their care and providing services tailored to individual needs, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and, most importantly, save lives. The name – Full Service Partnership – reflects the goal of developing a partnership between the person being served and the service provider, and offering a full array of services through a "whatever it takes" approach to meeting the consumer's needs. FSPs are core investments of the Behavioral Health Services Act (BHSA) and a key element of California's

[2] Youth ages 16-25

continuum of care, intended to be the bulwark against the most devastating impacts of untreated mental illness.

California's investment in FSPs evolved from advocacy efforts in the 1990s to reduce the number of people sent to locked state mental hospitals who could be better served in the community. In 1999, the state passed legislation to establish pilot projects across California, funding comprehensive, integrated care for people with high risk for homelessness, justice involvement, and hospitalization. After signs of success, the program was expanded to more sites across the state. Follow-up evaluations confirmed early findings: housing is a critical component of recovery, and people with serious mental illness *can* achieve housing stability with adequate support.

In the more than two decades since the birth of FSPs, numerous factors have led to advances and changes in how FSPs serve the community and who they serve.

In September 2022, Governor Newsom signed the Community Assistance, Recovery and Empowerment (CARE) Act. The goal of the CARE Act is to improve access to mental health services for people experiencing schizophrenia or other psychotic disorders and who are either not receiving adequate treatment or who do not have stable housing. Under the CARE Act, mental health consumers and counties negotiate individualized service plans called CARE Plans. CARE Courts oversee these plans and have the authority to compel counties to participate in those plans when necessary. Most CARE Courts were set to roll out in 2024. As more and more counties enact CARE Courts, it is expected that demand on FSPs will increase.

The most recent, and probably most prominent, changes to FSPs come from mandates enacted by Proposition 1. In March 2024, California voters approved Proposition 1, transforming the Mental Health Services Act into the Behavioral Health Services Act (BHSA). With this shift, several fundamental changes through the Welfare and Institutions Code Section 5887 were set in motion that will have substantial impacts on FSPs, including:

- The expansion of services to individuals with substance use disorders (SUD), including assertive, field-based treatment
- The development of standardized, evidence-based practices for models of treatment including Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Individual Placement and Support model of Supported Employment, high fidelity wraparound, or other evidence-based services and treatment models, as specified by the State Department of Health Care Services (DHCS).
- The establishment of levels of care and criteria for stepping down to the least intensive level of care per the guidance of DHCS in consultation with the Commission.

These changes are set to go into effect in July of 2026. The State Department of Health Care Services (DHCS) has provided an overview of the new Behavioral Health Services Act and how it impacts FSPs here.

Lastly, Proposition 1 mandates the allocation of 30 percent of BHSA funds towards housing for eligible individuals, shifts FSP funding to 35 percent of BHSA revenue, and places a heightened focus on transparency and accountability for financial, performance, and outcomes data.

Report to the Legislature

Senate Bill 465 directs the Commission to provide biennial reports to the Legislature on the operations of FSPs and recommendations on improving outcomes for FSP clients. In these reports the Commission is charged with reporting on:

- Individuals eligible for FSPs, including information on incarceration or criminal justice involvement; housing status or homelessness; hospitalization, emergency room use, and crisis service use.
- Analyses of separation from an FSP and the housing, criminal justice, and hospitalization outcomes for the 12 months following separation.
- An assessment of whether those individuals most in need are accessing and maintaining participation in a FSP or similar programs.
- Identification of barriers to receiving the data relevant to the report requirements and recommendations to strengthen California's use of FSPs to reduce incarceration, hospitalization, and homelessness.

The Commission's previous report to the Legislature in January 2023 identified three primary concerns. First, the report noted that missing and inaccurate data limit the Commission's ability to fully understand how effective FSPs are in preventing homelessness, justice involvement, and hospitalization. Second, despite regulatory requirements, county behavioral health departments did not appear to be allocating the mandatory minimum funding levels for FSP as specified by the law. Third, as of the time of the report, California had not established sufficient technical assistance and support for counties and providers to ensure that FSP programs are meeting the goals of reducing homelessness, hospitalizations, and justice involvement.

Since the Commission's initial report, the need for high quality FSPs has only grown. An increasing number of unhoused residents, long waiting lists to enter state hospitals, and ongoing reliance on local law enforcement and community hospital care suggest the need for high-quality FSP programs is greater than ever.

- In 2020, approximately 37,000 unhoused Californians were living with mental illness and a similar number were living with chronic substance use disorder.
- Nearly 80 percent of unhoused individuals in California have a previous incarceration, and approximately 30 percent had been detained during their most recent experience of homelessness. This suggests a strong relationship between living unhoused and being involved in the criminal justice system.

- Approximately 30 percent of individuals incarcerated at the state and county level were either in need of mental health services or actively receiving psychotropic medication.
- In 2022, more than 1,700 individuals who were found incompetent to stand trial were being held in jail while on the waitlist for treatment at a state hospital. The cost of treating individuals in jails to restore them to competency was about $172 million.
- Those who are moved off the waitlist, are sent to one of five state hospitals that serve more than 6,200 individuals. The cost to run these five hospitals exceeds $2 billion annually.

Since our initial report, The Commission has done extensive work to better understand what needs to be done to improve FSPs and move the needle on hospitalization, homelessness, and incarceration for Californians with severe mental illness. This includes conducting targeted outreach, community forums, and a statewide survey. In total, our efforts reached participants from 45 counties (77 percent of counties).

In addition to the efforts above, the Commission:

- Conducted deep dives with Nevada, San Francisco and Orange counties to review current FSP contract practices.
- Conducted case studies in two counties to better understand data collection and reporting practices, and the use of outcome and performance metrics by counties and providers.
- Are conducting performance management technical assistance and capacity building pilots in Sacramento and Nevada counties.

Lastly, the Commission hosted two public panels on FSPs including representatives from the Department of Health Care Services, a county behavioral health director, and leading researchers in the field of behavioral health.

Figure 2: Learning Efforts, 2023-2024

Targeted Outreach	Community Forums	Statewide Survey	Research
• **87** participants • **40** organizations • **22** counties • **28%** identified as people of color • **24%** shared they had personal or family experience of behavioral health challenges	• **145** participants • **76** organizations • **29** counties • **43%** identified as people of color • **44%** shared they had personal or family experience of behavioral health challenges	• **228** participants • **35** counties • **57%** identified as people of color • **46%** shared they had personal or family experience of behavioral health challenges • Average of **10 years** of experience in FSPs	• **3** deep dives on county contract practices • **2** case studies on data collection and reporting • **2** pilot projects on performance management • **4** site visits (3 adult and 1 child/TAY)

Notes: Learning efforts were carried out by Commission staff in collaboration with Third Sector Capital Partners and Healthy Brains Global Initiative

This current report has two priorities. The most essential of these is to present the required information to the Legislature as directed by Senate Bill 465, and as outlined at the beginning of this section. The Commission is prepared to meet this directive in all areas except reporting on client' criminal justice involvement, both before and after FSP participation. Despite existing memoranda of understanding between the Department of Justice (DOJ) and the Commission, the Commission has not received updated criminal justice involvement data since 2016. Despite the lack of current DOJ data, this report will cover trends in the characteristics of clients including race and ethnic composition, diagnoses, service utilization, and housing status. The report will look at these issues, both as they are now and as trends over time. The report will also examine how clients have fared prior to and immediately after joining an FSP. Even with the lack of current criminal justice data the Commission believes this report presents a compelling narrative on the effectiveness, strengths, and areas of opportunity for California's FSPs.

The report's second priority is to examine FSPs as systems of care and illuminate how system-level issues, such as State-mandated data collection and reporting policies and practices, impact quality of care and client outcomes.

The information in this report is presented in the context of the rapidly approaching implementation of Proposition 1's mandates, including changes to eligibility criteria, target populations, and funding structure. At its core, Proposition 1 promises to improve accountability and quality of service by:

- Creating standards and guidelines for service delivery models, including ACT and FACT
- Developing recommendations around levels of care, including step-up and step-down criteria and services
- Improving fiscal and service quality accountability through developing performance metrics and increasing data transparency
- Expanding eligibility criteria to include individuals with SUD
- Requiring mobile, street-based treatment for SUD
- Maintaining the expectation of both clinical and non-clinical services for eligible clients
- Coordinating housing and providing supports for clients to maintain stable housing

The goals of Proposition 1 are ambitious and could have a transformational impact on FSP service delivery and outcomes, but its success will be determined by the intentionality and thoughtfulness of its implementation. In the next few chapters, the report examines some of the challenges faced by FSP service providers and county behavioral health staff and lays out potential solutions to overcome these challenges.

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Chapter 2: Data Collection and Reporting

"We have to double enter or triple enter our data." – FSP program lead

Terms Used in this Chapter

The DCR

Currently, California data on FSP program services and outcomes are housed in the Data Collection and Reporting system that is maintained by the Department of Health Care Services (DHCS). The system was developed in 2005, and all counties that have an FSP program submit information to DHCS through the Data Collection and Reporting system.

Three forms are used to collect all the necessary information, which include: the Partnership Assessment Form that gathers baseline information about the partner, such as demographics; the Key Event Tracking that gathers and updates information on events related to health and other milestones, such as graduating high school or obtaining employment; and the Quarterly Assessment form that gathers follow up information to the PAF.

There are four age groups that receive services through FSP: child/youth (ages 0-15), transition age youth (ages 16-25), adult (ages 26-60), and older adult (60+). Each age group has its own unique form that varies slightly from others, resulting in a total of 12 different forms.

Term	Meaning
3M	Quarterly Assessment
County M	Participating county in a large/metropolitan region of California
County S	Participating county in a small/rural region of California
DCR	Data Collection and Reporting
DHCS	Department of Health Care Services
FSP	Full Service Partnership
KET	Key Event Tracking
PAF	Partnership Assessment Form
Partner	A client of the Full Service Partnership
Provider A	Adult FSP program in County S
Provider C	Provider of child/TAY FSP program in County S

How Does Client Data Get to the Commission?

INDIVIDUAL

Individuals get referred to FSPs through various sources. Regardless of where the referral originates, the referral must go through the county where the individual is screened for eligibility.

PROVIDER

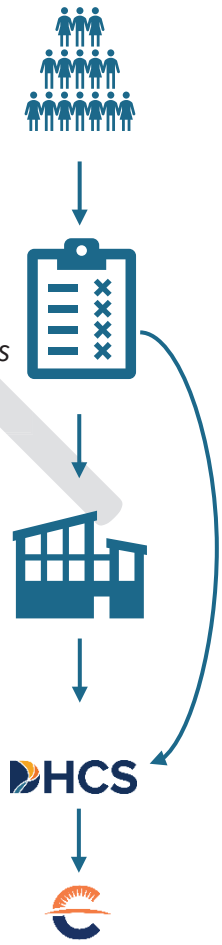
Once an individual meets eligibility the provider can complete the Partnership Assessment Form. The client's information is collected by the service provider and entered into a data collection system. Some providers enter data directly into the DCR, and some send the data to the county.

COUNTY

Counties which receive data from providers review the data, look for missing or incorrect data, and then submit the reviewed data to DHCS through the DCR.

STATE

DHCS receives data from the counties and then shares these data with the Commission twice a year. These data include new client intake forms called Partnership Assessment Forms, Key Event Trackers, and quarterly updates.



What Data Does the State Collect for FSPs?

PAF The Partner Assessment Form (PAF) collects client data at intake, including housing status, education, employment, financial support and other relevant information.

KET The Key Event Tracking (KET) captures when a client has a change in their residence, employment, health, justice involvement etc. or exits the program.

3M A 3M is a quarterly report (filled out every three months) that tracks a client's progress over time and updates information provided on the PAF.

Accountability Under BHSA

The BHSA promises to put into place greater accountability for FSP spending and outcomes, but the current data collection and reporting procedures make this task difficult. Data quality challenges not only threaten the State's ability to make the case for continued investment in FSPs – they undermine the efforts of service providers on the ground and invalidate the experiences of clients and their families. The Commission recognizes that DHCS has made important strides in developing and soliciting feedback on core performance measures for Behavioral Health Transformation through its Quality and Equity Advisory Committee. These and other data improvement efforts across the state will provide foundational support to any FSP-specific data reporting improvement projects.

This chapter details the findings from the Commission's research on the current processes and procedures for data collection and reporting in FSPs and identifies how and where the current system fails to meet the standards necessary to protect California's investment in FSPs.

Getting Data into the System

Once an individual has been screened and deemed eligible for FSP services, the individual can seek a partnership with an FSP. An individual becomes a client when they complete the intake process, which includes filling out the Partnership Assessment Form (PAF). Many providers have their clinical staff complete the PAF, others have dedicated intake staff complete it. In each setting, the PAF is primarily completed on paper and then information is entered into whatever electronic system(s) providers use. Counties use a range of different electronic health records systems (EHRs). In some cases, there may even be multiple EHRs used in the same county, since contracted providers may use different EHRs than the county does. These EHRs are generally stand alone, and do not handshake well with other EHRs or with the state Data Collection and Reporting (DCR) system. This means that **FSP staff often have to enter duplicate data across two or three systems, a process that is cumbersome, time-consuming, and demoralizing**.

Regardless of how many data systems a county uses, all counties must eventually submit their data through the DCR. In some counties this is done directly by the provider. In other counties providers enter their data into a separate EHR and then the county compiles and submits those data to the DCR. Either way, at some point data must go through the DCR to get to DHCS and any other state agency who seeks to use them.

The usability of the DCR is key to understanding a major sticking point in the data collection and entry process. Many FSP staff and experts recognize the DCR as a potentially strong tool for demonstrating the effectiveness of FSP programs since it can help show reductions in incarcerations, psychiatric hospitalizations, and interactions with law enforcement. Nonetheless,

the Commission's research shows that FSP staff and experts universally dislike the DCR system, and find it difficult to enter, access, or use the data. Stakeholders reported that the format and language of the system are challenging, and that there are some glaring issues in the logic used to create data fields. For example, one staff person noted that employment data was required for children and that users were prompted to indicate whether adults without children had any adopted children.

Many counties still use paper forms or use digital forms that must be sent back and forth over email for completion and approval (e.g., fillable PDFs). These forms must then be individually uploaded or manually entered into the EHR. In counties with digital forms, many staff are still unable to enter data in real time when they are with a client, either because the client's needs do not allow for concurrent documentation or because limited Wi-Fi or cell service – or restrictions about how the EHR can be used – prevent them from accessing the digital forms while meeting with clients in the field. Staff must then do data entry after the fact. All of these formats also add time to the data collection and entry process; time that is typically not billable if it is not done while the staff member is with the client.

Staff turnover also affects service providers' ability to enter data factually. Multiple programs' staff mentioned having **multi-year gaps in data entry while they waited to fill a data-related position**. Another noted that in an effort to address this problem, newly hired staff were sometimes asked to enter data for which they did not have sufficient knowledge or context to do so accurately. The multiple systems and staff turnover can also lead to accidental duplicate entries, further muddying data.

> *"When staff leave or quit and they leave 10 FSP clients and there's not a single KET or 3M [quarterly update] entered, the new person looks at it and they can't fill that out. – FSP service provider*

Data quality is a major barrier to understanding FSP effectiveness. To a large degree, unreliable data quality is a product of the systems challenges combined with the limited staff capacity. The Commission surveyed providers about their staff roles, and of the 79 providers who responded, under half (48 percent) reported having a Data or Evaluation Specialist on staff. Staff who are already stretched thin often struggle to see the value in entering similar data into multiple systems and so enter data belatedly (especially into DCR) and sometimes simply do not enter all data into all systems. Additionally, there can be a disincentive to enter some data, particularly Key Event Tracking forms (KETs). KETs are supposed to track both positive and negative changes in a client's life. But service providers are often focused on preventing or triaging negative events as they happen, and positive events can fall to the wayside. As a result, KETs more often track negative life events, and so the fewer KETs a client has, the better they appear to be doing.

> *"[The] biggest barrier to data entry is the **disconnect between what is valuable to the State and what is valuable to person in care and what is valuable to the staff.** … If you do it in way that is relevant to people in care, it should be relevant to [the] State as*

well. If you create system solely focused on needs of State and not the people in care and staff providing [care], it will only result in very low quality of care." – FSP service provider

Given all these factors and the key role individual providers play in gathering and entering data, data quality varies not just from county to county, but from program to program. A lot of data cleanup is needed for meaningful analysis, and it remains difficult to identify strong practices by comparing across programs, or even to track outcomes longitudinally within a single program.

Getting Data Out of the System

"[It] feels like an act of God to get someone access to DCR"
– County behavioral health data lead

More than half (53 percent) of the 95 providers we surveyed said they would like additional technical assistance and support around using the DCR and more than 70 percent wanted support in determining and tracking client outcomes.

Service providers and county staff spend countless hours collecting and entering data into the DCR. It would only make sense that the data they put in would be available to take out and use to track client progress and service utilization. But this is not the case. The DCR was created as a mechanism to help the State hold counties accountable; it was not set up to make it easy for counties to access and use the data they input. However, among the county staff the Commission spoke with, **there was a clear sense that counties should be receiving DCR data reports, and a mixture of frustration and resignation that they were not receiving the reports with the desired frequency**, or at all. Although some counties receive quarterly reports with DCR data, the supplied data is individual-level and needs further synthesis (including grouping individuals by FSP program) before most counties find it useful for program planning.

Even when counties use duplicate systems for data collection and analysis, different EHRs require different processes for inputting data and pulling it into reports, meaning that it can be difficult (sometimes impossible) and labor-intensive to create reports across multiple systems. Even systems that use the exact same progress or outcomes metrics. The **difficulty of making "apples to apples" comparisons across programs and counties makes it hard, in turn, to identify discrepancies** (positive or negative) and understand when a county is doing a particularly good or bad job at serving a particular population. Without that information, it is challenging to identify best practices among peer counties or to use data to make clinical decisions or program changes with any certainty.

Counties and providers are capturing an array of information through a litany of tools, none of which align with the DCR. Even still this information is critical to providers ensuring clients are getting the highest quality of care possible and tracking client experiences and outcomes. Table 1

below outlines some of the most common tools used by survey respondents (N=104) to measure client outcomes. The Child and Adolescent Needs and Strengths assessment was easily the most common at 64 percent.

Table 1: Most Commonly Used Tools for Measuring Outcomes

Tool	%	n	This tool assesses:
CANS	64	67	Strengths and needs in children and youth
PSC-35	48	50	Emotional and physical health
PHQ-9	38	39	Depression in adults
Service utilization data	28	29	Frequency and type of services used
Other	27	28	
Inpatient hospitalization	25	26	Number and days of hospitalization
Gad-7	22	23	Anxiety in adults and youth
Mors	16	17	Recovery in adults
Ansa	14	15	Strengths and needs in adults

Notes: A total of 104 respondents answered the question. Respondents could select more than one tool.

Many counties expressed a strong desire for a **data system that could serve the dual function of reporting county data to the state *and* allowing counties to pull data to examine trends within their county and across the state**. However, many noted how challenging it is to switch data systems and expressed hesitancy to institute sweeping changes in how they gathered data or tracked outcomes until they had some confidence that the changes would be valuable. As one participant in a community forum on data and outcomes said, **"Instead of investing resources in improving the DCR and DCR response rates, I think it might be better to invest in figuring out what you actually want to be measuring in FSPs.**" In fact, given the DCR's limitations, multiple leaders and experts in the field suggested that it would be best to get rid of it. One county behavioral health lead shared: "We certainly utilize the DCR, but if you have any leverage I would do away with that time consuming exercise. … I haven't seen a report from DCR in over five years."

Sharing data across agencies and systems remains a challenge in most counties, and as a result, **FSP programs often do not know about significant events** – such as hospitalization or release from jail – that might be included in outcomes measures or inform future client care. Information of this type is gathered piecemeal, if at all, and is usually labor-intensive. One county reported searching the county criminal justice system's website for information about people who had been arrested. Another assigned a specialist to track in-patient hospital admissions and flag for their team when KETs needed to be added.

Chapter 3: A Case Study of Data Reporting and Monitoring

County S may be considered small by a population standards, but they are big in their regard for providing the most effective services possible to their partners in the community. County S consists of two providers, one for adult clients and one for child/TAY clients. Staff for both providers were welcoming, smart, highly capable, and committed to developing better solutions to meet the needs of their clients.

County S works hard to cultivate collaborative and supportive relationships with their providers. In turn, providers voiced a deep respect for their county leadership and felt the county worked hard to ensure they had the necessary tools and training to provide the highest quality service possible. In the Commission's time with County S, Commission staff were impressed by their desire to continuously learn and grow.

County M may be a large county by population, but staff in County M approach their work with a level of collaboration and camaraderie one might expect from a small county.

County M has numerous contracted providers, and must balance meeting the needs of the state and the very real challenges faced by their many providers. One of County M's primary responsibilities is providing technical assistance to FSP providers and supporting them in navigating a daunting data collection and reporting process. County M has one of the most knowledgeable and highly experienced staff in the state. They bring to this study an invaluable insight into the opportunities and challenges large counties face regarding data collection and reporting for FSPs.

Current Study

The Commission presents the collective findings from two case studies consisting of qualitative information gathered from service providers, program staff, and county staff working directly with Full Service Partnerships (FSPs) and the Data Collecting and Reporting (DCR) system. The case studies are based on interviews conducted with 16 program staff and eight county staff in two counties. The findings represent common themes that emerged during interviews and illustrate the challenges faced by program and county staff with data collection, reporting, and monitoring.

In order to establish open and honest communication with selected counties, the names of those interviewed, as well as the service providers, and county names are kept confidential and where needed, pseudonyms of individuals, providers, and counties are used.

Selection of Counties

To gather information that would help illustrate the complexities experienced by both providers and counties in collecting data and reporting on programs, Commission staff sought to engage with counties with unique experiences. The selection for county participation in the case studies were based on diversity of geographic location and population size. It was the goal of the Commission to include a county that represented a small/rural region of California and a county that represented a large/metropolitan region of California.

Staff reached out to potential counties and spoke with them about their general experiences with data collection and reporting. Based on their responsiveness and openness to share their practices, two counties were selected to participate. County S is representative of a small county in a rural region of California, and County M is representative of a large county in a metropolitan region of California.

Methodology

During the studies, Commission staff visited service providers and county staff in each selected county. Staff were selected on their ability to speak directly to the data collection, reporting and monitoring processes within their organization, as well as their experiences with the DCR. Each of these topics are quite different, and individuals may have spoken to one or all topics depending on their role and responsibilities. Participants consisted of administrative and managerial staff, those involved in the collection of FSP data, and those who use the data submitted to the DCR for various program, county, or State reporting requirements.

To guide the conversation, staff utilized a case study protocol consisting of learning goals for the project, as well as questions on experiences with data collection, data reporting, and data monitoring (see interview protocol here).

Learning Goals

1) What are the current processes for collecting, inputting, and extracting client data?
2) What challenges exist in this process?
3) What solutions have counties developed to address these challenges?
4) How is data currently being used by providers to measure client progress?
    a. What data would be helpful to providers to better serve clients?
5) How is data currently being used by counties to measure provider success?
    a. What data would be helpful to counties to better measure provider progress?

The interviews were transcribed, and Commission staff conducted a content analysis, coding key words, phrases, and quotes from the interview. Challenges and experiences were organized according to the data collection, data reporting, and data monitoring process within each county. What emerged were themes that represent the most frequently occurring comments and feedback. These domains and categories are presented in Table 2.

Table 2: Case Study Themes

Domain	Category	Subcategory
Data Collection and Entry	Lack of Clarity	• Not all staff versed in data systems • Lack of guidance on forms
	Inefficiency	• Paper forms, paper trail • Inflexibility of the DCR system
	Redundancy Administrative Burden	• Same information entered into multiple systems • Validation impedes submissions
Data Reporting and Monitoring	Inability to Pull Data	• Providers cannot pull their own data for reporting
	Lack of Good Data	• No reciprocation • No collective understanding
Aspirations	Make it Useable	• Make the system user friendly • Involve providers in creation
	IT Solutions to Data System	• Connect to EHRs • Automation

Themes

Data Collection and Entry

The journey that individual client data take to get to the DCR begins at the program level. Access to the DCR is strictly controlled, therefore, most clinical and managerial staff are not able to enter data directly into the DCR. Instead, clinical staff or case managers collect data directly from clients and either keep paper records or enter them into a secondary software program. The reliability of the data collected depends on staff having a high level of training and skill. However, as William, Programs Director in County M explained, "there's staff attrition and turnover, and that's a problem." Frequent turnover means more program staff lack the experience or training necessary for proper data collection and entry procedures. Many counties provide training and education to their own staff, who in turn provide technical assistance to providers. Even still, it is difficult to ensure that all provider staff have the same training and skills. This means errors in the data may be introduced before the data ever make it into the DCR.

How client information gets from clinician to the DCR differs substantially across providers and counties. In County M, providers enter data into a county specific program. These data are reviewed and validated by County M's data personnel and then submitted in batch to the DCR. It is a process that has its benefits and its challenges, born out of early issues with submitting data directly into the DCR. Overhauling or replacing such large, legacy systems is not an easy process.

Contrast this with the data collection and reporting processes of County S. Although small, County S has multiple providers, with a single provider for adult clients (Provider A) and another for child/TAY (Provider C) clients. Even though these providers are within the same county, they have vastly different data collection and reporting processes. Provider access to the DCR is typically limited to one or a few individuals within an organization. This is the case with Provider C, who has an in-house data team that check and validate data in real-time with staff located in the same office.

With the exception of the Partner Agreement Form (PAF), Provider C's data collection is primarily done by case managers who gather information on clients during weekly check-ins where clinical staff provide updates to case managers on their clients and any changes or events worth noting. Case managers then fill out paper versions of the quarterly assessment (3M) or Key Event Tracking (KET) and submit these to their in-house data team. Provider C was candid with the Commission that although they try to complete 3Ms and KETs in a timely manner, 3Ms in particular, can fall to the wayside. If there is no issue or event that prompts a KET, it can be difficult to prioritize the time to complete mandatory 3Ms on seemingly unchanged information. Additionally, because these documents are completed on paper and not in a system that allows for iteration, all 3Ms completed must be done from scratch, regardless of whether any information on a client has changed in the last 90 days. This adds immense administrative burden to an already burdensome process.

"I pull data from our EHR [electronic health record system], another unit pulls data mainly from our [other internal system] only because as it stands currently [our EHR] doesn't have as much data that we would need for the reporting purposes. And so that is why although it is cumbersome, and I do understand that, multiple entries have to occur for our sake." – Phillip, Analyst for Provider C

Lack of Clarity

Entering data into the DCR is a finicky and convoluted process. The nuances of the system take time to learn and become a critical skill for providers. Some staff become so well versed that they hold what Tanya from County S referred to as their entire *"institutional knowledge about the DCR and how it works."* Tanya recounted how a former employee Sabrina held *"all of the knowledge around the DCR."* This posed substantial challenges for County S when Sabrina retired.

With that institutional knowledge gone, the opportunity for cross-training and providing current employees with that knowledge, is also lost. Understanding how and why data is submitted and stored in the DCR also plays a key role into the clarity of how information should be collected.

"It is challenging on the side of collecting the data, obviously, because [it's] confusing for staff to fill out the forms." – Tiffany, County S

Depending on the length that a client remains in services, there are a lot of forms and thus a lot of information that providers must collect over time. Staff expressed frustration in the current state of some forms. For example, providers are required to collect school attendance and grades data for children ages 0-5, and ask clients questions that relate to obsolete programs.

"*I can understand why it is challenging to make changes to the forms and DCR, but without changes, it makes providers collect unnecessary and irrelevant information*." – Tabatha, Manager in County M.

Staff identified the KET as being the most challenging to complete due to the different forms by age group. As Tiffany in County S proposed, *"I think [the KET] is the one that gets the most questions because there are so many [age] variations."* For example, the form doesn't differentiate between *who* a child lives with and *where* a child lives. A child may live with their parents who are homeless, but because residential status is mutually exclusive for children, that child would either be counted as "living with one or more biological parents" or as "homeless", but not both. This dilutes California's ability to capture the full dimensions of the child's living situation and threatens to artificially reduce counts of homelessness for these children. Because the forms may be unclear, the KET is handed over to other staff more familiar with the DCR validation rules who will look it over, make judgements, and then hand the form over to their data team who enter the data into the system. The multiple exchanges and differing interpretations of the information can change from staff member to staff member, calling into question the validity of the data and how it was originally expressed by the client to staff.

This sentiment was expressed by both providers in County S, particularly when needing to update a record or fill in missing gaps in a client's partnership timeline. Issues with inflexibility arise often when filling out a PAF form, which requires accounting for where a client has lived for the last 365 days. If a client states they lived in a shelter and in their car on and off, the provider must enter the exact number of days spent in each housing category and those categories must add up to 365 days. This process is daunting for all involved, and if a client is having or had issues with clarity of thought, the process can be impossible. Further, there are no reference materials or standardized definitions to help guide providers and counties when collecting these data. Even still, the provider must enter data that equates to 365 days. Requiring data that may not be accurate simply to comply with mandates undermines the validity of the data submitted through the DCR, the same data the State uses to assess the impact and functionality of FSPs.

"There is no database that we can access to [say], okay, where were you? We have to piece it together. And that is probably one of the more frustrating parts that we have to say, okay, we know today, because we're sitting with you, but even yesterday may not be clear." – Thalia, Analyst in County S

Data is gathered for each partner and updated as their placement changes or when a milestone or key event occurs. The chronological way in which the DCR system was developed does not always align with the placement of a partner and their movements within the system. For instance, Mark in County M shared that *"one of the major hiccups for our providers is when another [provider] doesn't enter their data in a timely manner. So, that is a roadblock for [the other provider] to enter their data."*

This can happen when, for example, Provider A fails to submit a completed PAF because they were waiting on the status of a client, and Provider B is unable to submit any additional forms until the previous form has been submitted. This can cause issues if a long period of time has lapsed since the client was seen by Partner A or if Partner A lost documentation for that client.

"I think the issue with FSP is just the data builds on each other as the client transfers from provider to provider." – Tabatha, Manager in County M

County M experienced challenges with the DCR system from its inception due to the amount of data that was being submitted into the system. Staff shared that when the DCR was launched, large counties, including County M, were unable to submit data directly through the DCR. County M was forced to create their own system to maintain the data until the state's DCR could accept such a large transfer of data, Tabatha recounts: *"The State wants the data in order, right? […] sometimes, things don't happen like [that]. And we struggle with this too, right? Do we build for the exceptions, or do we build for how things are supposed to go?"*

The process of validating these data before they are submitted to the DCR is extensive. County M's staff must examine the data submitted by providers for completeness and accuracy. Because County M's staff are not *"on the ground"* with individual providers, it can be a difficult and labor-

intensive process to validate these data, including reaching out to providers, requesting they submit missing data, or fixing identified errors and resubmitting the data. In a large county with numerous providers serving many clients, this process takes an extensive amount of time. Thus, there can be a lag between when providers originally submit their data and when County M is able to successfully submit the data through the DCR.

As a result, data such as client counts for previous years may change over time. This is not ideal. Changing counts can cause the public to question the accuracy of the data shared by the Commission through its online Transparency Suite. County M is not the only county who experiences this kind of lag due to the extended data validation process. However, this is an issue more common to large counties. The process for data collection and reporting for small counties is such that data lag is not as pressing of an issue. That does not mean that small counties do not face other challenges.

Inefficiency and Redundancy

It can be a long and complex journey for client data between the clinician who records the data to the moment it reaches the DCR. Both County M and County S use multiple systems for data tracking. This is partly because the DCR was never intended to be a performance management software, a quality improvement software, or even an outcome tracking software. The DCR is a one-way transmission of information. Providers who seek to track their client's progress have little choice but to employ a second or even a third data collection program.

County M records and tracks their data universally with all the providers inputting their data directly into a county specific program, which, eventually – for the most part – handshakes with the DCR. County S has multiple methods for submitting data, with Provider C submitting data directly to the DCR, and Provider A submitting data to a provider specific program and *then* entering the information again into the DCR. Provider A, much like County M, reaps many benefits through their internal data collection, tracking and monitoring software, such as being able to catch errors through the reports their systems create, which allows them to work with providers to fill in missing information *before* submitting to the DCR. But this does not erase the administrative burden of having to enter duplicate data into the DCR or guarantee that their submissions will be accepted by the DCR system.

Administrative Burden

As previously mentioned, there is often little to no training on how data is entered and stored into the DCR, what validation rules are necessary to successfully submit data, and more importantly, where the data goes and how it is used. Once the information is submitted, the submitter is either notified that the submission was successful, or if unsuccessful, the DCR will generate a validation report. This might sound helpful and valuable, but validation reports from the DCR system do not provide clarification into what caused the error. Users simply get a flag that the file is not able to be

successfully submitted due to an error. Users can locate additional information on individual errors, but the process is not intuitive and must be done for every flag.

"If they have some really clear, simple directions for it, it would probably be easier, but it is a lot of clicking around and figuring out what you are doing." – Tiffany, County S

Instead, staff find themselves spending a considerable amount of time self-learning and identifying errors and then navigating multiple systems to correct the errors. Often, providers have to re-enter the information and/or start the entire form all over again due to the inflexibility of the system posed by its validation rules.

"I have never seen [a training manual]. And honestly, the information and the processes that I've learned is by trial and error. It is just going into the system and oh, that didn't work. Getting these validation errors. It is just trial and error, there is no real training regimen. It is here is the DCR, we need this information, it is in your contract, do it." – Bethenny, County S

Commission researchers did locate a 2020 version of the DCR training manual, but multiple service providers we spoke to were unaware of its existence. In addition to the training manual, DHCS also offered a webinar in 2021 on the latest version of the manual. Despite these efforts there remains a gap in knowledge regarding the DCR.

Similarly in County M, despite having had the resources to build their own internal system that could incorporate data validation and formatting that aligns with DCR requirements, there are still errors that stall the submission process. Jose laments, *"the State system needs to be rebuilt or something. But they put, I don't know why they put so many checks on our data."*

Data Reporting and Monitoring

As data ongoingly gets collected and entered, FSP data gets used for reporting and monitoring purposes. The Mental Health Services Act requires that counties submit a 3-year plan for all programs, as well as annual updates. Both require counties to report aggregated data on program demographics and outcomes. Determining what to include in these reports is, often, at the mercy of the data that counties have in their possession and/or what they can obtain from their own systems or in collaboration with individual providers.

Having already entered these data into the DCR, the reporting process would seem simple and intrinsic. However, this is simply not the case due to a few reasons: not all essential staff have access to the DCR, not all of the required report information is located in the DCR, and it is either impossible or staff have not received the proper training on how to extract data from the DCR. These reasons create substantial administrative burden upon an already limited staff.

As mentioned, extracting the data and writing the reports require a great deal of staff resources. Sonia, the director for Provider A in County S, wrote, *"We can answer these questions if we want to, and the tools that we have to do it just don't meet the need, and it's painful. It takes a lot of brains to sit down and go, this is the question, how are we going to answer it? And who is going to analyze it? Who is going to clean it? Where are we going to pull it? Can we piece this together? It takes a lot of effort."*

Similar sentiments were shared by Tabatha in County M whose team she prides in being able to collaborate and problem-solve. *"[Our department] here is just so understaffed. It's just really hard. I think just the fact that we get our submission out is a miracle."*

Before reports can even be written, providers find themselves first contemplating where exactly they are going to get the necessary data to highlight the phenomenal work that is being done, especially when those data are not readily accessible.

Inability to Pull Data

"[The] DCR is kind of like a black hole. You put stuff in, but I don't ever get anything out."
– Victoria, County S

If there was one overarching theme common among both providers and counties, it would be the inability to access the data they spent numerous hours collecting, cleaning, validating, and correcting. Due to systematic requirements, access to the DCR is extremely limited. County officials designate who can access the system, but increasing access to the DCR wouldn't change these frustrations. Pulling data – raw data, to be exact – is not possible for providers. This lack of reciprocity raises frustrations, as service providers do not have access to their own data.

The DCR is not the only data system failing to meet the needs of providers. Provider A, who pays to have their own systems in addition to the DCR, still experiences roadblocks to getting the data they need. Provider A was promised a system that would not only be user friendly for clinicians and providers but would also make accessing the data they needed possible.

"But a lot of things we had in the past from other systems, they are not built or ready yet. And that' s the reporting aspects of data in, we can't get it out. So, that's probably my biggest frustration with all the systems. Data is in. We know we are putting the data in the system. There is not an easy way to pull the data out." – Thalia, Provider A, County S

Lack of Good Data

The FSP data that is submitted to the DCR is the same data used to tell a statewide story of the impact of FSPs. Unfortunately, there are numerous ways the system works against collecting quality data. FSP forms (PAF, KET, and 3M) are not the most user friendly and, at times, unclear. For

example, the KET, which collect life events both positive and negative is vitally important in determining changes in levels of care and tracking when a crisis occurs in an individual's life. However, providers who are inundated with entering data into multiple systems or keeping paper forms for client records, can be discouraged from completing KETs as often as they should.

Provider C in County S shared that, unfortunately, they do not track the positive events of a client's life, such as obtaining a job or graduating. This is because key events cannot be accessed through the DCR and Provider C must keep paper forms of their KETs, creating stacks of key events and counting by hand to provide the county with unduplicated numbers of the negative outcomes. Keeping paper forms for positive outcomes would double the stacks of papers they must manually count. Thus, many of the positive life changes Provider C's clients may be experiencing go undocumented. Collectively, what is left is what both providers and counties agree on: a lack of good data. Incomplete data can mask positive outcomes, presenting a distorted picture that shows the opposite of what is happening.

Point-in-time counts are another way data can distort what's happening on the ground. These counts do not always capture the full picture of a client's journey in a program. Instead, Provider A of County S must rely on describing the nuances of their client's experiences in narrative form and hope their data team can translate these nuances into outcomes that are tracked. Thalia recounts, *"we look at the data and like, okay, you're not accounting for this many people that we know came in unhoused and we housed in the course of a few days. Sometimes they come in and we house them immediately and that doesn't get captured. So, it just looks like poor performance."*

The only "good data" is data that is being used. But because providers are not able to directly access and use the data from the DCR, it seemingly becomes a useless system that collects information for compliance purposes only.

"We pretty much collect the DCR data, because it is in our contract, and we have to. We don't do much of anything with it, to be honest. … Capturing it in this external system that doesn't have much to do with our client record or really influence the course of our services or anything like that, it really, it feels like paperwork to staff more than anything." – Phyllis, Provider C Manager

Aspirations

Despite the challenges that the DCR system presents, staff members understand the goal around its creation and have an overall positive attitude toward the potential that the system – or *a* system – can have in improving the services they provide. From direct service providers to county administrators, everyone shared aspirations for a data system that could make data collection and reporting efficient and useful. They want a system that not only tracks client outcomes and illustrates the impact of FSPs but shares information between counties to encourage collaboration and innovation. These aspirations can be highlighted in two different themes: making the system useable and finding IT solutions to make it more dynamic.

Make it Useable

Providers from County S expressed that one of the most vital ways to make the DCR system useable is by having clinicians and those using the system on a day-to-day basis included in the development of the data system. *"I think really having the providers at the table when this is being built out and speaking to what a day looks like and where things fit within the system of their day would make a huge difference – it doesn't make sense [to have] PAFs in one area and a million miles away from a KET or something. It has to be all in one place where it makes logical sense to go and access things."*

Making a system useable also means what is being inputted into the system needs to be user-friendly and intrinsic in daily work. Making forms – PAF, KET, 3M – less burdensome and as universal as possible across all clients would be a good start. Currently, for example, a PAF can be between 10 to 12 pages long, and some providers have noted that not all the information included is utilized. More importantly, this it is a lot of information to gather from families and clients during their first meeting.

Finally, the system should be accessible to all staff and track not only the outcomes mandated by the State but also additional outcomes meaningful to individual providers. A key component to access is having access to the raw data needed to conduct different types of analyses. For example, Carrie mentioned that County S would *"want to be able to slice and dice the data however we want. So, if it's by tenure, if it's by age group, if it's by some sort of other demographic … raw data is essential at that point."*

IT Solutions to Data Systems

To make a system useable, providers, and counties understand that it will require IT solutions, such as ensuring that local data systems are compatible with the state system. Rey from County S suggests, *"if we do build a new system, it would be nice [if] it can talk to EHRs. It is my understanding that DCR has no capability right now to talk to any of the systems."*

Within this system, providers aspire for a tracking function that would notify them when forms are missing for a client. This would help lessen the backlog that is created when new providers are unable to enter information due to outstanding forms.

Probably the most agreed upon solution to many of the challenges experienced in working with FSP data and the DCR would be automation. Providers, particularly, aspire for a system in which data entered by a clinician would make its way into the DCR, and in turn, reduce the need to double and triple enter information.

"[Automation] would be incredibly helpful because that is one less thing that we would have to [do]." – Sonia, Provider A Director

Chapter 4: Beyond the Data

"The thing with the travel time, since this is an intensive outpatient program, is that we need to have people out in their cars. And we aren't able to bill for that. There's just not as much money." – FSP provider

A Multi-layered Analysis

OUR PROCESS: Chapters 1 through 4 used client data from various sources to describe who receives Full Service Partnership (FSP) services, and the service usage of those individuals prior to and after joining an FSP. Chapters 5 and 6 highlighted the challenges of the current data collection and reporting system for service providers through a combination of quantitative analysis of administrative data, case study analysis, and key informant interviews. This chapter brings together findings from a multi-county deep-dive into FSP service delivery and contracting, a statewide survey of service providers and county behavioral health directors, and key informant interviews with a wide variety of stakeholders. To learn more about who participated in each of these phases of analysis, please see Appendix B.

FSP Service Delivery and Models

FSPs can be very effective at supporting individuals with serious mental illness, and reducing the negative outcomes often associated with such challenges. How FSPs achieve these outcomes varies by provider. FSPs differ not only in their client population, but in the suite of services offered to those clients.

For example, one young man enrolled in a child/Transitional Age Youth FSP the Commission visited voiced how important the social aspect of his FSP was for him, as he was otherwise isolated and confined at home due to his extensive health challenges. For him, the only time he was able to leave the house was with his FSP caseworker. Like any other aspect of FSP service delivery, there is variability in how FSPs engage clients socially. Not all FSPs have community building activities, but some host support groups, recreational activities, field trips or social outings for clients.

Balancing Flexibility and Structure

Providers, clients, and other experts consistently cited the importance of FSP's flexible "whatever it takes" approach in driving positive outcomes for clients and communities. Providers, clients, county staff, and others particularly valued that FSP programs can provide a wide range of resources, including support for basic needs, (e.g., sleeping bags, tents, subsidized housing), socialization support, medication assistance, and variety of behavioral health interventions. The "whatever-it-takes" nature of the FSP model enables providers to meet people where they are: physically, circumstantially, and clinically. Outreach in the community, "house calls," or other in-the-field services reduce barriers to care and make it more likely clients will attend their clinical appointments. Particularly in rural counties, resources to support in-the-field care are a crucial element of program success.

Even as they highlighted the importance of flexibility in shaping their approach to FSP, interviewees across the FSP ecosystem expressed a need for a common definition of FSP that would enable providers to offer consistent and evidence-based care in support of improved outcomes, share best practices across the state, and provide consistent quality assurance and training to provider staff. Since FSPs are locally operated and controlled, they differ significantly in structure across counties, which makes it difficult to ensure high-quality care statewide and to compare outcomes or practices. Some FSP programs adhere closely to a single evidence-based treatment framework (e.g., Assertive Community Treatment [ACT]), while others take a more eclectic approach to care delivery.

Many of those with whom the Commission spoke felt that FSP programs would benefit from more structure in both process and approach to service provision. Some policy and data experts recommended that the State should select specific service models to underpin the functions of FSPs and take steps – including offering additional guidance, support, and funding – to encourage fidelity to whatever model is chosen. Providers and experts also called for better-defined eligibility criteria for FSPs. Clarified criteria would ensure the correct individuals are being served through FSPs and create a shared understanding of the role of FSPs in the broader behavioral health ecosystem.

Interviewees emphasized that any State guidance around FSPs must balance standardization with retaining the flexibility and adaptability that enables FSP programs to serve a range of individuals with significant and varying needs.

Assertive Community Treatment

Many individuals we spoke with suggested ACT as a common treatment model. Interviewees recommended ACT for its diversity of included services, team approach, and ability to adapt to client needs. Even though ACT was popular among service providers, there are some aspects of ACT that require consideration. ACT tends to have higher costs, mostly due to the caseload ratio of 1:10

required by the model. ACT also requires multidisciplinary teams, meaning any staff vacancies can affect the fidelity of the model.

While ACT may be well suited to many clients, it may not be appropriate for all clients. Some clients may not require the intensity of ACT and could be effectively served by lower-cost models, and other clients may not want to work with a large group or receive the full suite of services that ACT provides.

Collaboration

Providers consistently noted that collaborating with clients on their care and adapting service plans to address individualized wellness goals were essential to a high-quality FSP. A behavioral health director shared the importance of this approach in fostering engagement and person-centered progress: *"What is the goal of the person in care? It doesn't have to be the goal of the State. What do they want out of [FSP] and are we meeting their goals? If you don't start with that, I don't know how you are going to get anyone to engage. One of the person's goals was to have teeth so they could smile. That was their whole goal from the FSP. Then they could go for a job and show up and be present. If you don't focus on that, celebrate it, and work on it, you'll never get to the downstream goals [like housing stability]."*

Staffing and Resources

Vacancies and Recruitment

Both the Commission's statewide survey and conversations with providers and county staff confirmed that FSP programs are operating with high numbers of staff vacancies, and staff and programs are being further strained by broader shifts in community needs, including more individuals seeking behavioral health services, and higher levels of complexity and acuity among those seeking services. It was reported that the vacancy rates are highest on the most intensive services, with up to 50 percent of positions unfilled on stabilization services (i.e. short-term assistance for people leaving the hospital). Some providers reported extended times for vacancies, reaching up to 250 days.

Some interviewees and survey respondents pointed to the extra challenges of rurality, and others to the very high costs of city living. However, the biggest variance appears to be between providers, reflecting different organizational cultures and employment practices. The service providers with the lowest turnover use several different strategies. They try and over-recruit throughout the year. They may use an external recruitment company or increase their use of accredited peers or paid interns (many of whom progress to permanent positions).

Contributing Factors

One major factor contributing to staff vacancies is pay and benefits, which are typically low when compared to the cost of living. Private practice, other social work employers, and even other county FSP programs are outcompeting some FSP programs for staff by offering better salaries. In addition, FSP programs typically do not provide workplace perks that align with those offered elsewhere in the workforce, particularly the option to work from home. There has been a general labor market shift towards wanting the option to work remotely, but telehealth is not suitable to the needs of many FSP clients and many FSP programs have not implemented strategies for offering remote work.

FSP work can be particularly grueling compared to other behavioral health care roles, as it requires engaging directly with individuals experiencing significant challenges and experiencing symptoms that may be difficult for both provider and client to manage. Peers and other FSP staff spoke to the need to process the challenging emotions that came up as part of their jobs.

FSP work can lead to significant burnout and secondary trauma among providers. In addition, ongoing staff vacancies contribute to pervasive staff burnout by straining the remaining staff members. Providers also mentioned the inability to bill for non-direct services, overwhelming amounts of paperwork, the high rate of homelessness in California (and its attendant challenges for FSP care), and frustrations caused by recent policy changes as contributing to burnout.

When FSPs are able to fill vacant positions, it is often with staff who are newer to the field. Many only stay long enough to gain the experience necessary to be secure positions that offer a better salary, better hours, or are less emotionally demanding. High turnover compromises continuity of care and reduces institutional knowledge. We spoke with one client who very clearly stated that low staff turnover was the single greatest indicator of a successful FSP.

Resources

Many interviewees identified the need for better and more frequent staff training to help keep teams aligned during this period of high turnover. Topics that were commonly requested include billing, data collection and reporting, acquiring and securing housing, and best practices for treatment of individuals with substance use disorders. These are also areas where Proposition 1 has an increased focus.

To bolster the workforce overall, several interviewees mentioned their desire to see stronger connections with local universities resulting in more intentional training and internship programs. Training programs could include courses on frequently requested areas like data collection and reporting, and internships could help students understand the value of FSP programs while also preparing them for careers as service providers. In addition to traditional university programs, interviewees suggested investing more heavily in peer certification programs, allowing providers

and counties to recruit peers to the FSP workforce, where those peers' lived experiences can help build connections between clients and clinical staff.

The use of peers appears to be growing, and models such as Club House appear to deliver strong outcomes. This may be because peers are more likely to match their client demographic, and as such, may have better engagement.

Funding

Given the substantial financial investment California has made in FSPs, it might seem counter intuitive that FSPs would struggle with securing sustainable funding, but a consistent sentiment from providers was the need for clarity and technical assistance on who to bill for services and how to bill for services. Most FSP providers with whom the Commission spoke were successfully braiding funds to support service provision. For example, of the 121 survey respondents who answered questions related to braiding funding, the vast majority (88 percent) stated they were leveraging Medi-Cal reimbursement as part of their funding strategy. However, 11 percent of respondents were not braiding additional funding and were only using Community Services and Support funds to support FSP service.

Providers were also vocal about the need for support navigating the numerous recent changes to funding brought about through CalAIM payment reform and Proposition 1. Almost unanimously, FSP providers expressed significant anxiety about how these changes were affecting FSP programs' abilities to provide quality care. While DHCS has provided clarification to counties around CalAIM payment reform (the letter may be read online), FSP providers indicate that more support and guidance is needed to understand its complexity and nuance.

Counties also shared that FSP funding shortages are limiting the type of services they can offer. One county reported that a general lack of funding was preventing them from establishing program models like Intensive Outpatient Care. They also noted that a lack of funding is preventing other programs in the region from reaching the 1-to-10 staff-to-client ratio considered ideal under the ACT model. Other interviewees predicted that payment reform would incentivize a shift to clinic-based services, as opposed to the field-based engagement model that is part of ACT and that most FSP providers consider best practice, which could have a disproportionately negative impact on rural services and outreach.

There was general uncertainty among program staff about how to approach billing after recent reforms. Some interviewees speculated that there might be "less obvious" ways to bill for activities like transportation and documentation, but did not feel programs were prepared to do so. Additionally, interviewees expressed uncertainty about what activities were, and were not, included within the new Proposition 1 statutes. This is especially essential information for smaller and rural counties, which experts and FSP staff agree are likely to be most heavily impacted by the Proposition 1 guidance. In the past, smaller, rural counties have typically spent less of their BHSA

funding on housing than larger, urban counties, and so smaller counties will need to shift a larger proportion of their funding from FSPs to housing. FSP providers – both contracted and county-run – indicated a clear and immediate need for additional guidance and technical assistance around how to use new fundings structures to ensure FSP services remain "whatever it takes".

Relatedly, interviewees reported that it was extremely challenging to identify which funds should be used for which FSP clients, since many funding streams have highly specific eligibility criteria. The complexity of the eligibility requirements and vast recent changes to the billing systems are creating significant administrative burdens that FSP providers feel are preventing them from maximizing the use of their staff time and funding to provide care to clients.

This section has outlined the confusion on the part of service providers and counties around how best to structure payment to maximize service quality in the wake of payment reform and in anticipation of BHSA statutes. DHCS is preparing to release initial guidance on BHSA statutes for public comment by the end of 2024. Feedback and public comment will be incorporated into the guidelines and released to counties in early 2025, well in advance of when changes under the BHSA are set to go into effect.

Performance Management and Outcome-Based Contracting

To better understand how contracting practices influence client outcomes, the Commission conducted a series of "deep dives" on county contract practices with service providers. The "deep dives" discovered that current contracting practices do not prioritize client outcomes and do not provide a substantial enough incentive to encourage providers to meet client goals. What we found instead, was a strong focus on billable services and the rate of reimbursement for those services.

Much of what is deemed important to measure for performance is influenced – if not directly determined – by the structure of service delivery contracts. Currently, contracts for service providers are highly complex documents including up to 13 pages of "look up tables" describing the billable activities and their codes. These billable codes set a tone for what is valued by the county and the state. If providers cannot be reimbursed for certain activities it is difficult for providers to prioritize those activities or offer them at all.

Payment to service providers is currently a "pay for service" type model, not a pay for performance model. However, some counties have piloted the use of incentive payments to providers for process-or compliance-oriented outcomes, such as time taken from referral to program start, level of interaction with service users and maintenance of the required documentation. These supplementary payments can amount to 2 percent to 10 percent over and above the contract value.

In one county, a provider can earn an additional $1,500 for each person they step down from the program; however, it is difficult to meet all the necessary criteria, and most incentives go unpaid.

When performance metrics were included, they often focused on activities and not outcomes.

For instance, the principal performance measures used by most counties and providers on a day-to-day basis were:

- Total number of clients
- The total number of staff and their caseload
- Amount of staff time, and dollars, billable to Medi-Cal.

Many counties measure additional activities and outputs, such as the time to process referrals, and timely completion of mandated documentation, but these measures vary vastly across counties.

Provider performance is also shaped by the extent to which provider leadership engages in performance management. When done well, performance management is about setting clear goals and objectives and working with staff to identify their strengths and available resources to meet these goals. It gives staff clarity about how and where to focus their energy, and recognizes the fruits of their efforts, thus increasing motivation.

Despite its potential positive impact on performance and morale, the use of performance management varies between counties in frequency, detail, and result. In some cases, an annual report is produced by an external unit, one entirely separate from the county's FSP contract management team. In one county the Commission visited, this report was based on a combination of aggregate data from their data collection system and data self-reported by providers. However, the reports were not used to set goals or track provider performance in an ongoing manner.

In another county, staff conducted monthly performance reviews with all providers. This is a large county with the resources to manage such an undertaking. Each month, staff reviewed data, looking at client outcomes for incarceration and hospitalization, and tried to understand any changes or trends. They also administered regular client satisfaction surveys. While no direct causal affect should be implied, it should be noted that this county does appear to have higher performing FSPs and falling rates of homelessness.

The level of engagement and active performance management mentioned for the large county above appears to be the exception rather than standard practice. This may be partially due to budget and staff constraints. For example, a small county the Commission visited had to rely on a trust-based relationship as they were stretched too thin for systematic performance management.

Funding is just one reason counties may shy away from consistent, in-depth performance management. Other reasons include:

- A lack of positive outcomes to measure. Exclusively measuring performance against negative outcomes such as hospital admissions can be demoralizing for staff.
- Concern that staff may perceive performance management as a negative experience and thus increase staff turnover.
- A lack of confidence or experience in engaging in performance management,
- A work culture that is resistant to performance management.

Chapter 5: Recommendations

"I just wonder what the ultimate goal of FSP is? We should have measures that capture the goal of getting people better." – BHSA Coordinator

Proposition 1 creates pathways for Full Service Partnerships (FSPs) to meet the rising needs of Californians with serious behavioral health challenges. If implemented effectively and with fidelity, FSPs can be a keystone in reducing homelessness, incarcerations, and repeat hospitalizations in California. The recommendations and next steps outlined in this chapter are informed by the Commission's extensive engagement with service providers, county behavioral health staff, content experts, clients, families, and peers. These findings stem from a robust, mixed methods approach including: key informant interviews, case studies, site visits, focus groups, and a statewide survey. The Commission is confident that these recommendations consider a wide range of perspectives and experiences, and include diverse voices across age, gender, race and ethnicity, region, and lived experience. For more information on the Commission's engagement efforts please visit the Commission's website.

Statewide Data Infrastructure

A substantial portion of this report is dedicated to the challenges that current data collection and reporting processes pose for FSP providers and counties. Providers are swimming in the administrative burden that results from redundant data entry with no practical purpose or benefit to clients. Providers are left to either keep secondary paper copies of forms and hand calculate client outcomes or pay for supplementary software to track their client's progress.

Proposition 1 makes clear that accountability and transparency are foundational to behavioral health transformation. It is the Commission's goal to highlight the implications of the current data system and elevate solutions for the Department of Health Care Services to consider as they shape the future of data collection and reporting for FSPs.

Recommendation

The Commission's findings suggest the existing DCR system is not sufficient for capturing accurate, high-quality data necessary for statewide accountability and transparency of FSPs. The Commission recommends that the existing DCR system be replaced with a more flexible, adaptive, provider-centered system or be overhauled to have the following features at its core:

- Functionality
    - Allows providers to edit previous submissions to correct errors in client information.
    - Provides flags for information that does not meet submission standards before data is submitted, instead of having files rejected after submission.
    - At a minimum, programs need to allow raw data to be extractable, and preferably, software needs to have performance and outcome analytics built in, as well as the ability to generate customizable reports at the provider level.
- Brevity
    - A small set of key client outcomes should be identified, and forms should be streamlined to focus on these key items. Forms should only collect what is essential for tracking client progress and eligibility and remove all unessential content.
    - Forms should be customized by client age group and have separate, clearly labeled sections of forms for questions that pertain to children versus parents/guardians. This would reduce confusion and increase the accuracy of client data.
- Customizable
    - Allow providers to add additional customized outcomes for each client. This would maintain the standardization necessary for tracking across the state while supporting the unique needs and goals of each client.
- Interoperability
    - Counties have core electronic health record (EHR) systems, including the semi-statewide EHR that CalMHSA facilitated for 25 counties. Counties often use supplementary data warehouse and visualization tools and participate in their county health information exchanges. Any statewide system should consider interoperability with existing data and reporting systems, allowing batch uploads or real-time linking of data to streamline the submission process.

While the Commission is aware that this suggestion is not one that can be implemented easily, or quickly, it also recognizes it is essential to reducing administrative burden on service providers and counties alike and improving the quality of data necessary for accurate accountability and transparency under the Behavioral Health Services Act.

Performance Management

Performance management focuses efforts on getting clients to their goals in a timely and efficient manner. It prioritizes client outcomes over all else and creates an avenue of accountability for providers. Performance management is key to ensuring inputs produce results, but performance management does more than improve client outcomes. When executed with care and fidelity performance management can reduce provider stress by concentrating energies where they will have the greatest impact on target goals. It can offer clarity and direction in an industry where providers often feel overwhelmed with a seemingly endless cycle of work. Performance management should be viewed as a tool with equal benefit to clients, supervisors and staff.

Recommendation

This report's findings suggest most counties are not currently engaged in substantive performance management practices. Lack of funding and resources is partially responsible but equally so is the hesitation of many providers to engage in performance management. The Commission recommends California launch a statewide learning community where county behavioral health staff and providers can gain greater knowledge of the potential benefits of performance management for their teams and better understand the resources necessary to undertake performance management with fidelity. Furthermore, the Commission suggests an evaluation of the plausible impact and resources needed to create scalable performance management statewide.

The Commission suggests any performance management efforts incorporate the following:

- Accurate Data Collection and Analysis
    - Providers need substantial technical assistance and capacity building around data collection and analysis, including how to keep accurate and thorough records on all services clients receive, key events in clients' lives (both positive and negative), client outcomes, and engagement activities. Such records are necessary to set helpful goals for clients and providers.
- Consistent and Thorough Review
    - Providers must have access to user friendly data collection tools, and supervisors must frequently review trends and progress towards goals. Frequent (e.g. monthly or quarterly) performance reviews should be completed by a performance advisory group, and include representation from the county, clients, family members and peers. The advisory group should review and set goals at all levels (individual staff member, team, provider level). The goal of these reviews is to identify successes, while also continuously adjusting goals to drive improvement. Aggregate (program or provider level) results should be shared with the public.
- Engaged Leadership
    - Service providers can only be successful if they have the right resources, and the right support. Proper training and capacity building opportunities must be provided and encouraged by the State and counties. An annual statewide survey of supervisors and service providers should be administered to identify where additional resources are needed and who should be targeted for such resources.

Outcomes Contracts

The current contracting practices between counties and providers does not place a strong enough focus on outcomes. The Commission recommends counties include performance metrics into their future contracts with service providers, thus incentivizing improved client outcomes. Outcome based contracting should be thoroughly vetted and an evaluation should be conducted to identify:

1. Impacts on providers, both immediate and long term
2. Disproportionate impacts on certain demographic groups and regions
3. Impacts on both state-specified and client-specified outcomes
4. Impacts on retention, step down, and service utilization
5. Sustainability and scalability of such models statewide

When designing outcome-based contracting models, the following should be addressed:

- What defines success
    - Contracts should clearly define what success is and how it will be measured. County behavioral health leadership, service providers, clients, family members and peers should all participate in the development of these measures.
- Specifics of compensation
    - Compensation metrics should be verifiable, easy to understand, limited in number, assessed at the individual service user level, and should focus on outcomes as much as appropriate. Selected metrics should support a culture of high-quality service that drives frontline behavior and can serve as the basis for performance management with staff.
    - Compensation should incentivize performance and drive efficiencies. The goal of this work is to obtain the best outcomes possible for the money available.
- Roles and involvement
    - Contracts should designate advisory roles for clients, peers, and families throughout the program design and performance review process. Clients should be central to deciding the performance metrics from which providers are measured and compensated.
- Specify target population
    - Contracts should clearly state how the target population for each contract will be determined and ensure enough flexibility, so these parameters can be reviewed regularly to ensure they meet the needs of the county.
- Ensuring accountability
    - Providers need to have in place a robust, systematic process to verify the deliverables/outcomes that are claimed including the quality of the service received by each client. Counties should undertake periodical auditing to ensure accuracy and quality.

Funding

Contracted providers shared their confusion around how to maximize FSP dollars, including what services were billable and to whom. The Commission was surprised to learn that about one in 10 providers were funding FSP services strictly through CSS funds and not billing Medi-Cal. Even

providers who were successfully braiding funding were overwhelmed with changes to billing through CalAIM and the potential funding changes through the Behavioral Health Services Act.

Recommendation

The Commission suggests strong technical assistance and training for counties and service providers on:

- Braiding funding and sustainability
- Clarity around Medi-Cal billable services
- Impacts of CalAIM: Developing new county-to-provider payment models that support FSP service delivery and account for technical changes that occurred as part of CalAIM payment reform.
- Impacts of Proposition 1

FSP Service Delivery Models

Perhaps the most prominent characteristic of FSPs, and potentially their key to success, is their flexible nature, allowing providers to customize a "whatever it takes" approach to meet client needs. But flexibility without parameters can leave providers and clients uncertain about whether they are meeting goals in a timely manner. Our extensive conversations and information gathering suggests most service providers would benefit from increased structure in both process and approach to service provision. Guidance on what service delivery models are best suited to particular populations, and best practices within these models, could go far in providing the kinds of supports service providers have requested. Under the new BHSA, each county will be required to implement the following models through their FSPs: Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Individual Placement and Support model of Supported Employment, and High Fidelity Wraparound. As currently written, counties with under 200,000 residents may be granted an exemption from this requirement by DHCS.

Although not specific to FSPs, DHCS is establishing Centers of Excellence (COEs) as part of their expansion of evidence-based practices under Medi-Cal through BH-CONNECT. This is reflective of DHCS' efforts to support training, guidance, and fidelity monitoring for service delivery through BH-CONNECT.

The Commission will supplement these efforts by providing a toolkit specifically for FSP service providers, with concrete and actionable tools they can use to improve service delivery. Additional information on these efforts will be discussed later in this chapter.

Recommendation

The Commission recommends California develop and disseminate clear service model guidelines for FSP programs statewide, including:

- A clear definition of what an FSP is, and what the shared goals of FSPs are.
- Clear and specific eligibility requirements for FSP clients to reduce wait times and ensure individuals are connected to the correct resources from day one.
- Recommended evidence-based practices for treatment models specified in BHSA
- Guidance on selecting an appropriate treatment model.

Staffing and Resources

The ongoing workforce crisis significantly affects all aspects of FSP programs. FSP providers repeatedly called for solutions to address persistent staff shortages and guidance on how to better leverage current staff resources. Training and capacity building alone will not be sufficient to alleviate the current strain on FSP providers or alleviate the resulting turnover.

Recommendation

The Commission suggests the State invest significant resources in identifying scalable solutions that can:

- Widen the Pipeline
    - Create a stronger behavioral health workforce pipeline by building relationships with local universities and developing internship programs specifically tailored to prepare future clinicians to succeed in FSP settings.
- Increase Incentives /Benefits
    - Provide financial resources for counties to raise wages in areas most struggling to fill positions or offer workforce incentives like subsidized housing, loan repayments or paid internships.
- Reduce Provider Stress
    - Support counties in developing trainings on specific high-stress and high-priority topics, including billing, documentation and data entry, housing, and serving individuals with SUDs.
- Utilize Peers
    - Invest in expanding peer certification and placement programs, including licensing, training, and post placement supports. Peers are more than a workforce shortage solution; they are key to increasing client retention and ultimately improving client outcomes.

Next Steps

This report has laid out, as clearly and practically as possible, the Commission's recommendations for bringing transformational change to FSPs. Below, the report detail the Commission's current and forthcoming efforts to make these recommendations a reality.

In February of 2024, the Commission allocated $20 million in Mental Health Wellness Act funds towards a technical assistance and capacity building strategy to:

- Advance sustainable funding solutions through the restructuring of current funding models to increase efficiency and impact.
- Strengthen the workforce by identifying innovative, scalable workforce development solutions to increase capacity and reduce turnover.
- Improve accountability by developing metrics of success, identifying key client outcomes, and improving data collection and reporting practices.
- Fortify current infrastructure by strengthening service delivery models connected to the broader continuum of care.

The Commission is currently developing a request for proposals, not to exceed $10 million, for technical assistance and capacity building.

This substantial investment in technical assistance and capacity building is in direct response to the feedback the Commission received from service providers and county staff. Interviewees were clear in their need for technical assistance and capacity building to strengthen their FSP programs, meet increasingly complex consumer needs, and navigate the changing regulatory landscape. They were equally clear that any technical assistance needed to consider their limited time and capacity. As such, the Commission recommends all technical assistance and capacity building efforts supported with public funds adhere to the following guiding principles:

- Be concrete
    - Generalized trainings are time-consuming and difficult to translate into immediate action. Trainings should provide immediate tools and answers to specific challenges providers face.
- Leverage what works
    - County departments and providers frequently expressed a desire to learn from one another. Creating facilitated and intentional spaces for discussion can bring common concerns to the forefront and highlight field-tested solutions that were developed locally.
- Reflect reality
    - Consider the everyday constraints and challenges FSP service providers face and provide reasonable and practical solutions that incorporate FSP provider voice.
- Be manageable

- FSP providers are often doing the jobs of more than one person due to staff vacancies. As much as counties want support, technical assistance will only be as useful to them as their capacity to genuinely engage with the content. Trainings and supports should be compact, clear, and have an immediate benefit.

Complementing the MHWA funds for technical assistance and capacity building, the Commission has several additional projects underway aimed at improving FSPs. The first is a best practices toolkit for service providers, currently in development in collaboration with Third Sector Capital Partners. This toolkit will bring together recommendations and best practices identified by FSP service providers and county behavioral health staff into a single resource that will be widely available for public use.

The toolkit will focus on the following five topics and is expected to be available in summer of 2025:

- Peer and paraprofessional supports in the workforce
- Services and treatment for individuals with substance use disorders
- Collaboration with community and cultural partners
- Step down-levels of support
- Outreach and engagement

Simultaneously, the Commission launched two pilot projects with Healthy Brains Global Initiative (HGBI) to provide performance management capacity building and technical assistance to FSP service providers in Sacramento and Nevada counties. In these pilots, counties and service providers work together to identify performance goals and develop performance monitoring tools to track progress towards these goals. Results from these pilots will also be available in the summer of 2025.

It is important to note that the kind of transformational change the Commission is advancing cannot be implemented or catalyzed by any single entity or organization. California will only achieve these efforts through a statewide collaboration and coordinated effort of DHCS, HCAI, the Commission, county behavioral health departments and the numerous advocacy organizations that seek to support change for Californians with unmet behavioral health needs. The Commission is committed to meeting the challenge ahead and recognizes the commitment of its partners at every level.

Currently, DHCS is undertaking extensive steps to meet the needs of counties and service providers. An example of such is the establishment of Centers of Excellence (COEs) aimed at improving service delivery across the continuum of care. These COEs will provide training and technical assistance to county behavioral health programs and Medi-Cal specialty behavioral health providers. While these COEs are not specific to FSPs, they certainly encompass them and will undoubtedly be a valuable resource as providers navigate the transition to the BHSA.

They always see the bad things, but we never really highlight some of the amazing success stories that we have and that we have done working with FSPs […] They have got amazing success stories with clients. That to me [means] we're on the right path, that we're doing the right thing. There's no such thing as a perfect system. There's always room for improvement. And we have to work collaboratively with other departments [to get there]"

– FSP Programs Director

Commission for Behavioral Health

PART 2

THE STATE OF FULL SERVICE PARTNERSHIPS: CLIENT CHARACTERISTICS, SERVICE USE, AND OUTCOMES

Commission for Behavioral Health

Chapter 6: The State of Full Service Partnerships

"For every 10 people we are housing, 16 more are going homeless. … No matter what we do we are always getting further behind." – County behavioral health leader

Who is included in this chapter?

PARTNERSHIPS: The information presented in this chapter is for partnerships not clients. This is because an individual may participate in more than one Full Service Partnership (FSP) program in their lifetime. They may move counties and partner with a new provider, or they may simply exit and FSP and then re-enter an FSP down the road. If an individual is separated from an FSP for more than a year and returns, they are assigned a new identification number and are established as a new partnership. In total there have been 244,179 partnerships for 222,145 FSP clients through December 31, 2022, meaning 22,034 partnerships were held by clients who had previously been enrolled in an FSP. The Commission's data stop at 2022 as many counties have substantial lag in the Data Collection and Reporting (DCR) data they report and newer data is unreliable.

LAST FIVE YEARS: When the Commission examines a more recent state of FSP clients, it presents data on partnerships in the last five years, between 2018 and 2022. This gives the Commission enough data to tell an accurate story (especially for underrepresented groups that may not have high enough numbers to be included within a single year) but is recent enough to capture current trends including the COVID-19 pandemic. Commission analysts do their best to examine and report any shifts in client demographics and outcomes that clearly differ post the onset of the pandemic. If you want to see detailed information about differences over time, click the corresponding hyperlink in the text and you can examine these data in more depth.

EVER CLIENTS: When the Commission wants to speak about the experiences or characteristics of *all clients ever served* in FSP partnerships (up to 2022) you will see it use the term "Ever Clients." Ever Clients includes data on all partnerships ever established since the onset of FSP.

AGE: FSP clients are divided into four age groups, and the services they receive differ largely by age. Client's age is determined at time of entry into the FSP. See Chapter 4 for more information about types of FSPs.

- Child: Below 16 years old
- Transition Aged Youth (TAY): 16 to 25 years old
- Adult: 26 to 64 years old
- Older Adult: over 65 years old

Statewide Snapshot

One of the central directives of our mandated reporting to the Legislature is to provide an overview of who is being served by FSPs, and the experiences of those individuals. This chapter provides a statewide snapshot of FSP clients and their experiences with homelessness, emergency department visits, and psychiatric holds.

There are numerous ways to describe who is being served. The Commission approached this task by balancing comprehensiveness and clarity, electing to focus on key characteristics like age, race and ethnicity, gender, psychiatric diagnoses, primary language spoken and place of birth. You will see statewide averages for all FSP clients ever served, recent trends in characteristics, and regional and county differences that are worth noting. A full description of methodology for each characteristic and figure can be found in the corresponding hyperlinks.

Overview of FSP Partnerships

To date, FSPs have served more than 222,145 clients, averaging tens of thousands of clients each year, ranging in age from infants to seniors. About two-thirds of Full Service Partnerships are with clients over the age of 16 and one-third are with clients 15 and under, which is important as FSP service delivery largely differs by age group. Below is a brief description of each of the five categories of FSPs. Of these five, four are age specific and one is focused on justice-involved adults.

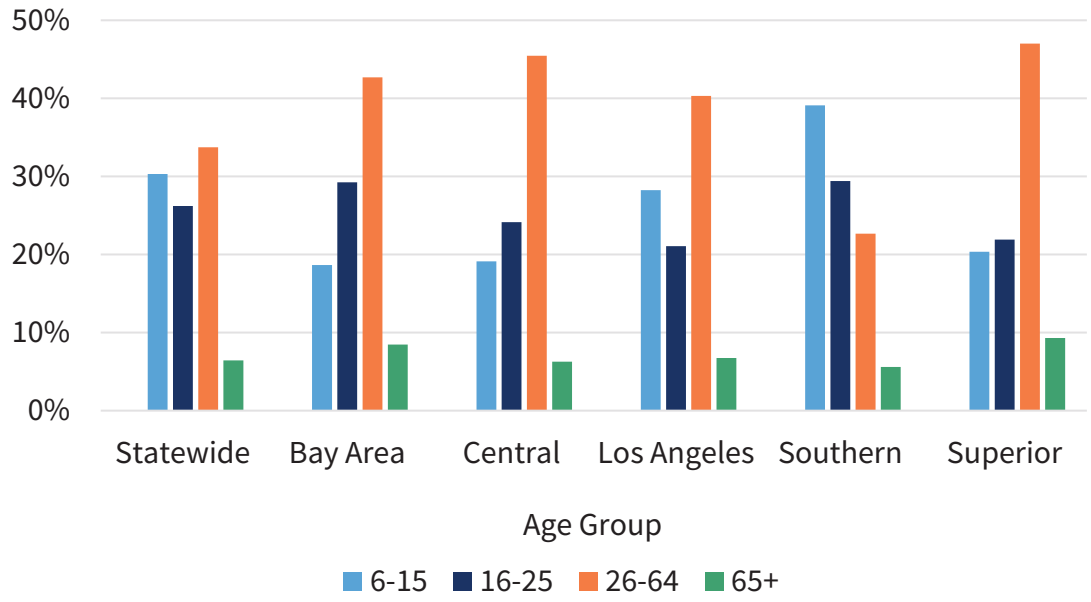
- Child FSPs provide intensive, in-home mental health services for children ages 0-15 and their families. Using a wraparound approach, these FSPs work with children and families on goals that support safety, wellbeing, health, and stability of the family.
- Transition Aged Youth (TAY) FSPs provide comprehensive, high-level outpatient mental health services that use a team approach to meeting the behavioral health needs of youth ages 16-25 experiencing social, behavioral, and emotional distress.
- Adult FSPs are designed for adults ages 26-59 who have been diagnosed with a serious mental illness. Adult FSPs assist with housing, employment, and education, as well as mental health and substance use services when needed.
- Older adult FSPs are for adults 60 and older with histories of homelessness and/or incarceration. These FSP programs often use the Assertive Community Treatment (ACT) model.
- Forensic FSPs serve justice-involved adults with serious mental health needs and co-occurring substance abuse disorders.

Race and ethnicity of FSP clients can vary vastly by region. Statewide, more than half of FSP clients are people of color. However, white clients remain the largest single racial or ethnic consumer group in every region apart from Los Angeles.

Demographics

For the demographics section we will look at the characteristics of every *partnership* ever recorded in the DCR (N=244,179). This captures the characteristics of the individuals being served through FSPs, and as such some individuals will be captured more than once as they entered into more than one partnership.

Figure 3: Age Composition of Full Service Partnerships

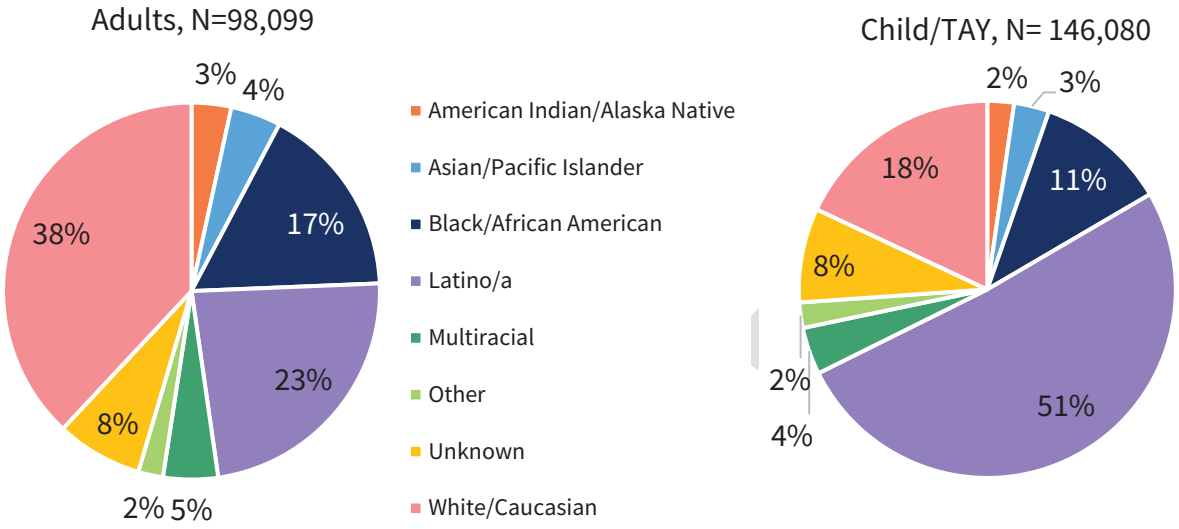


Notes: N=244,179. Data Tables can be found here. Age is age at completion of PAF. For more information on methodology for demographic reporting visit here.

Since their earliest inception, FSPs have served a diverse group of clients across California. The statewide average paints a picture of relative uniformity, where partnerships are split similarly between children, TAY, and adult clients. However, this statewide story is a combination of two different patterns. For most of the state, the Central Valley, Los Angeles, and Superior regions the composition of partnerships leans heavily toward adult clients, with adult and older adult partnerships together outnumbering child and TAY partnerships by up to 25 percentage points. In the Bay Area this gap is a little smaller at 14 percentage points. However, the Southern region shows an opposite trend, with most partnerships held by child clients, outnumbering all other groups by six percentage points.

With regards to race and ethnicity, Figure 4 illustrates how the racial and ethnic composition of adult (26+ years old) and child/partners. Statewide, people of color make up more than half of all Adult FSP partnerships. However, the largest single racial or ethnic consumer group for adults is white consumers, comprising 38 percent of all partnerships. For most regions of California this pattern holds true. The exception to this is Los Angeles, where partnerships held by Black/African American consumers slightly outnumber those held by white and Latino/a consumers.

Figure 4: Statewide Race and Ethnicity Composition of Full Service Partnerships



Notes: N=244,179. Data tables can be found here. For more information on methodology for demographic reporting visit here.

The pattern differs substantially for children and TAY where Latino/a clients comprise the greatest percent of partnerships both at the state level and within nearly every region, with the exception of the Superior region. The dark gray portion of pie graph in Figure 4 demonstrates a fundamental concern when reporting on FSP clients: unknown data. While we know a lot there is some we don't know, and what we don't know can make a big difference. For example, 20 percent of children/TAY in the Bay Area have no race or ethnicity information at all – that's about one in five children. The Commission has no way of knowing whether those children reflect the rest of the clients served in the region or if their racial and ethnic composition is completely different. This matters when researchers are trying to tell a story of who is being served. It also matters because the Commission – and the behavioral health system at large – know individuals have better participation and outcomes when they receive culturally competent services.

The number of partnerships for whom the Commission does not have race and ethnicity data *increased* in recent years. Even still, the drop in partnerships exceeds the gain. In fact, between 2019 and 2022 the Commission saw an overall loss of 4,667 partnerships, with the loss being fairly steady year-to-year and across age groups. Given the pandemic, it is possible that data tracking and input suffered as service providers had to adapt to virtual delivery models and increased staff turnover.

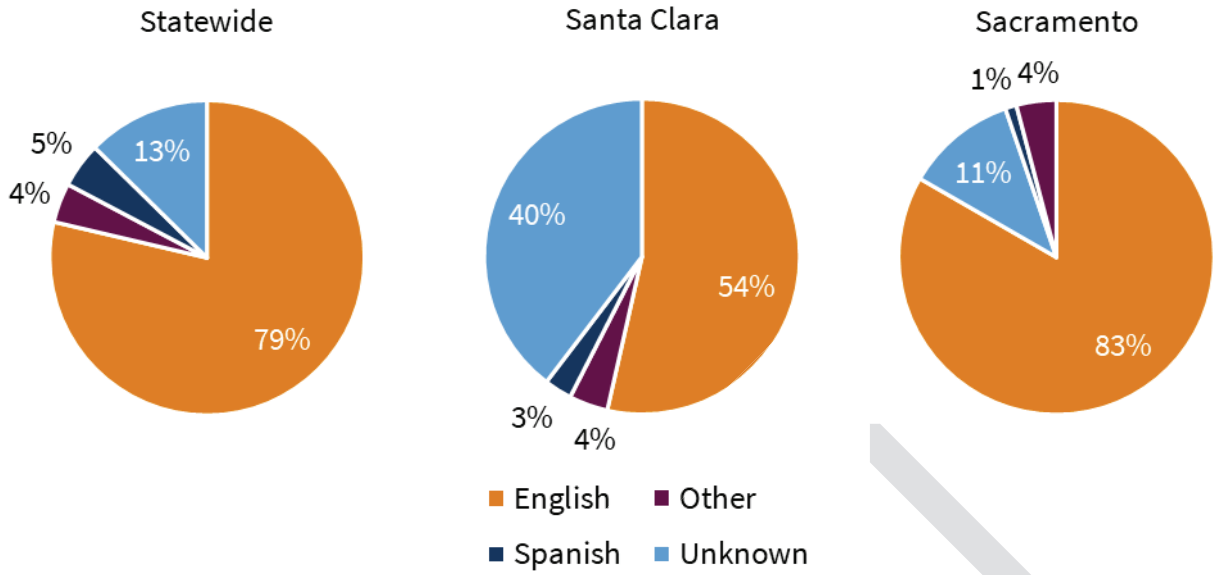
Overall, a blip in a single county or a single region, or even for a single year is expected from time to time, especially during environmental, social, or political unrest. However, this blip is a small illustration of much larger concerns in the quality of the data the State receives from counties.

Data on gender appears slightly more reliable and generally unremarkable. The split of partnerships by gender falls mostly to male clients, with 52 percent of adult partnerships attributed to clients identified as male, 43 percent to clients identified as female, and the remaining 5 percent unknown. There was a small number of clients who identified as "other" gender, but those numbers were not large enough to be reported here without risking client privacy. As with race and ethnicity there are regions with higher percentages of unknown gender, mostly concentrated in the Bay Area and Los Angeles. There are no striking differences in gender composition between adult and child/TAY clients, at least at the regional level. A county level table on gender composition is available here.

Another area where the Commission see the impact of missing data is in the primary language spoken by clients. The majority of partnerships are held by clients whose primary language is English. This is true across regions. However, there is extreme variation in the accuracy of this estimate. In some counties like Mendocino and Humboldt, data are nearly complete, and 96 percent of clients are primary English speakers, with the percent unknown coming in at under 5 percent. Sacramento has a smaller percent of primary English speakers at 83 percent, and yet has just 1 percent unknown, with 4 percent Spanish speakers, and the remaining 11 percent attributed to other languages. These examples illustrate the kind of variation researchers expect when data is nearly complete. Alternatively, when data is incomplete, it makes assessing the language needs of clients statewide nearly impossible.

There are many counties where missing data for primary language exceed 20 percent – 15 counties for adults and 32 counties for children/TAY. In some, such as Modoc, Fresno, and Santa Clara counties, the percent of unknown for child/TAY clients reaches nearly half. Examining just the partnerships where English is the primary language, it would appear that half of partnerships in these counties is with a child whose primary language is other than English. If this were true this would be incredibly important information for resource allocation, staffing decisions and local and state policy. However, because the remainder of partnerships are reported as "unknown", the Commission cannot know whether the substantially lower percent of reported English speakers truly reflects their clients or if it is simply a biproduct of poor record keeping.

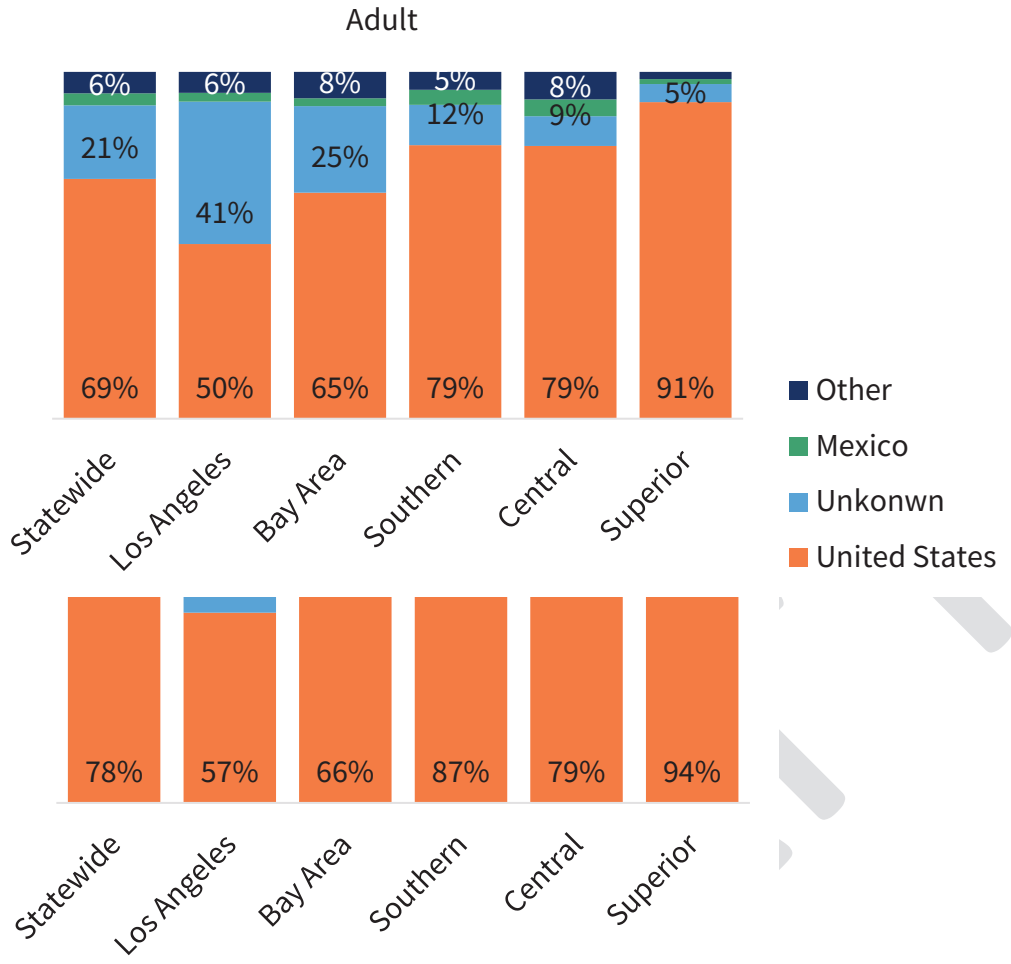
Figure 5: Counties Vary Drastically in the Percent of Missing Data They Report



Notes: N=244,179. Data tables can be found here. For more information on methodology for demographic reporting visit here.

The same scenario applies to place of birth. Again, the majority of partnerships are held by clients who were born in the United States, but the percent of "unknown" ranges from 5 percent in the Superior region to more than 40 percent in Los Angeles for both adult and child/TAY clients. Place of birth data can be sensitive to collect, and it is not surprising that certain regions of the state serve more immigrant clients, but it is difficult to know how great the need for additional services are when the Commission has incomplete data.

Figure 6: The Vast Majority of FSP Clients are Born in the United States



Notes: N=244,179. Data tables can be found here. For more information on methodology for demographic reporting visit here.

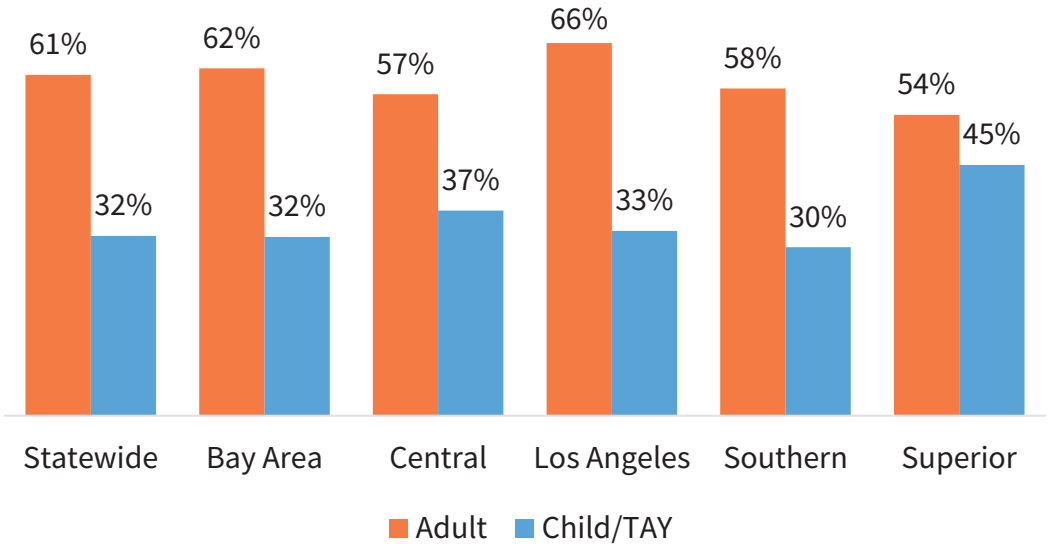
Individuals eligible for FSPs are more likely to be homeless, more often to seek out emergency room services, and more likely to be incarcerated than the general public. While we do not currently have updated incarceration and recidivism data on FSP clients, we do know that statewide, nearly 80 percent of unhoused individuals in California have a previous incarceration, and approximately 30 percent had been detained during their most recent experience of homelessness. This suggests a strong relationship between living unhoused and being involved in the criminal justice system. Beyond this general statement The Commission is limited on what it can say about FSP clients and their criminal justice background or outcomes. The Commission does, however, have data on emergency department visits and, to some extent, a rough measure of housing instability.

Housing insecurity occurs when someone does not have safe or stable housing. This report measures housing insecurity instead of homelessness because it more closely aligns with the intent of FSPs to divert individuals from becoming homeless or to help individuals who are currently

homeless. Homelessness is often not a linear trajectory with individuals cycling in and out over time. The Commission really wants to measure the portion of FSP clients who have a tenuous housing situation and are at risk of becoming homeless or who are currently homeless. To do this the Commission brings together multiple data sources that measure multiple types of homelessness and housing insecurity. You can read the Commission's methodology on measuring housing insecurity here.

The resulting data show that at a minimum 61 percent of adult client and 32 percent of child/TAY clients are or were housing insecure. The Commission expects that this number underestimates the actual count as data on homelessness is often incomplete. Figure 7 shows how this breaks down by age group.

FIGURE 7: Percent of FSP Partnerships Where Clients are Housing Insecure or Homeless

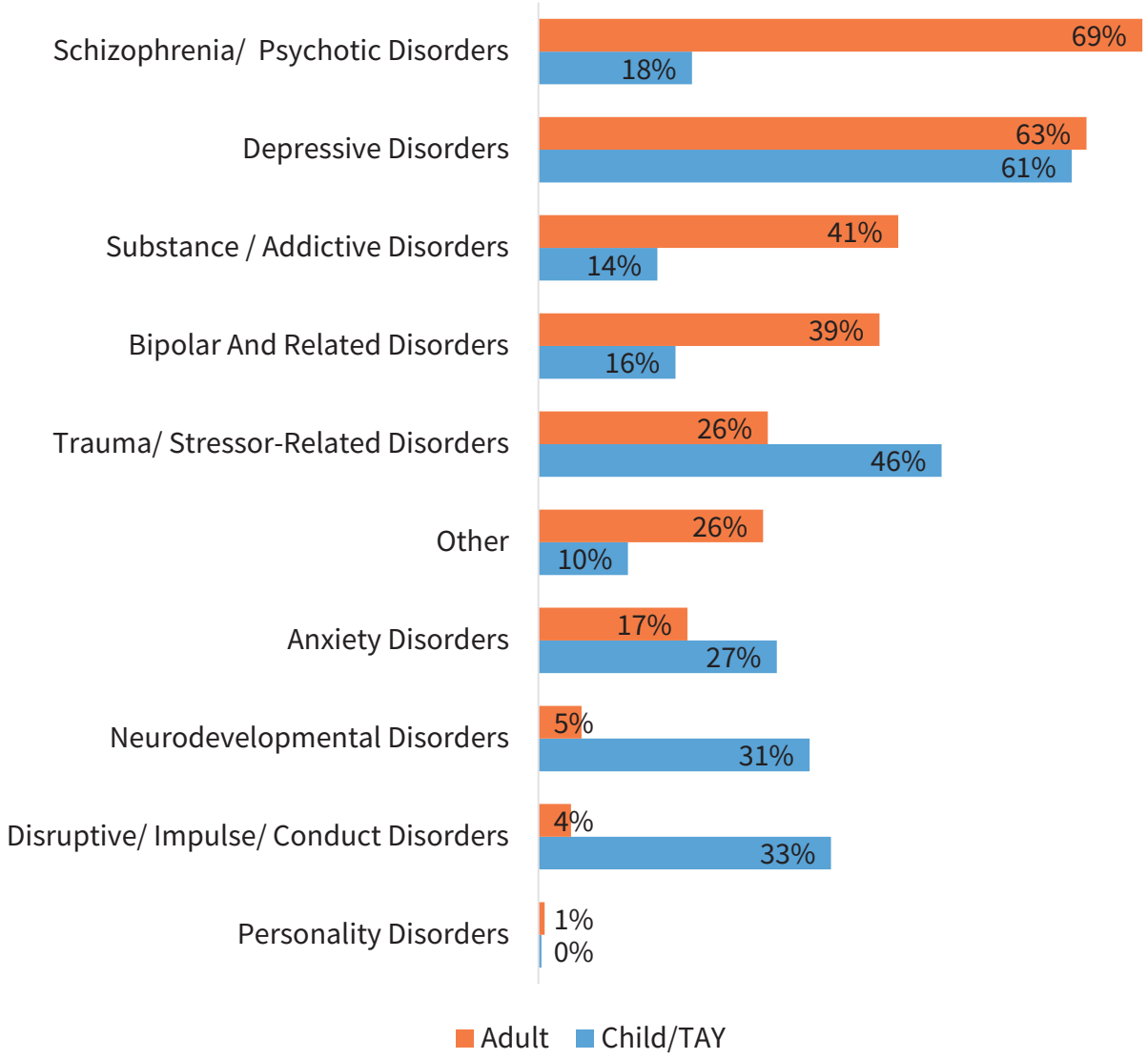


Notes: N=244,179. Data tables can be found here. For more information on methodology for demographic reporting visit here.

This next section looks at what common diagnoses FSP clients have received over time and examines emergency department and inpatient psychiatric holds for clients in the five years leading up to joining an FSP.

FSPs are designed to serve individual with serious mental illness and serious emotional disturbances. Figure 8 shows an overview of the primary and secondary diagnoses of FSP partners. As diagnoses can change over time and by attending medical provider, clients could receive more than two primary and secondary diagnoses in the data. It is common for individuals experiencing mental health challenges to also experience substance use disorders (SUD), and thus SUDs are included in Figure 8.

Figure 8: Percent of Partners with a Given Diagnoses by Category and Age Group



Notes: N=244,179. This figure presents the percent of partnerships where the client received a given diagnoses at any time between 2000 and 2022. Diagnoses are not mutually exclusive and are calculated at the partnership level. Only primary and secondary diagnoses are included. It is possible that a client may have more than two psychiatric diagnoses. Data tables can be found here. For more information on methodology visit here.

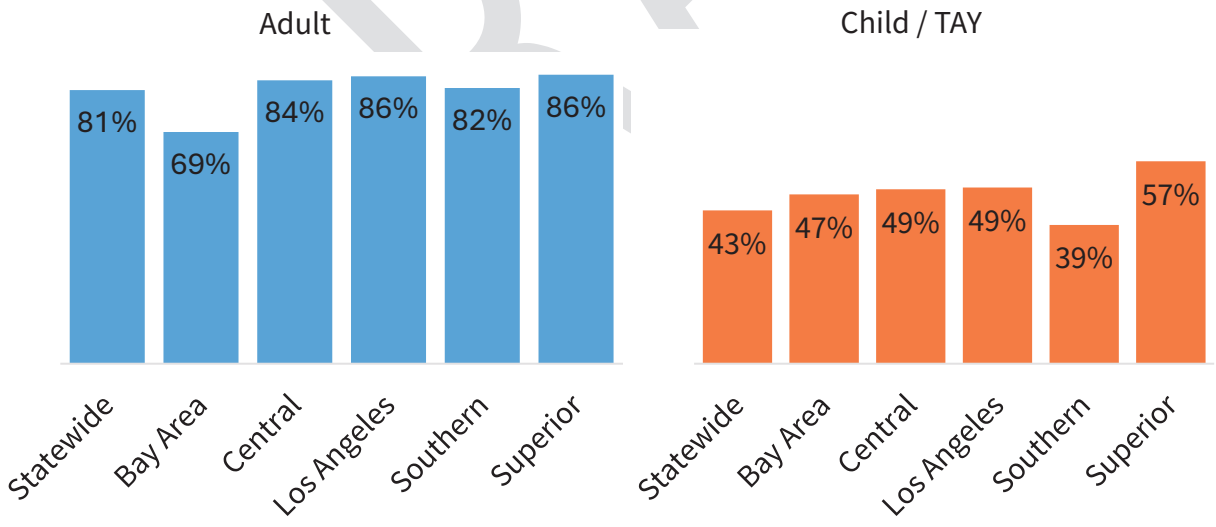
Importantly, this overview is for *every time a unique primary or secondary diagnosis was assigned to a client between 2000 and 2022 and* is not one diagnosis per client. For adults, the most common primary and secondary diagnoses are: 1) schizophrenia/ psychotic disorders; 2) depressive disorders; and 3) substance-use/ addictive disorders. This aligns with the aims of FSPs and suggests that adult services are reaching the intended population.

The data for children/TAYs presents a different pattern. The most reported diagnoses are: 1) depressive disorders; and 2) trauma/stressor-related disorders. These are followed by disruptive/ impulse-control/ conduct disorders, neurodevelopmental disorders, and anxiety disorders. While these diagnoses speak to the deep emotional and psychological needs of the young people being served by child/TAY FSPsit is unclear why Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) funded services do not currently meet these needs.

Individuals who have unmet mental health needs are more likely to seek treatment for psychiatric care through emergency services. In later chapters this report will examine whether clients have lower emergency department usage after joining an FSP, but this chapter establishes who FSP clients are and what their service use looks like leading up to joining an FSP.

Statewide, 81 percent of adult FSP clients had at least one visit to the emergency department for psychiatric reasons in the five years prior to joining an FSP, with the average number of visits for those clients being 16. However, in some regions and in some counties this number is much higher, reflecting differences in the client needs and available resources. For instance, in San Francisco County, 87 percent of FSP clients had visited an emergency department for psychiatric reasons in the five years prior to joining an FSP, and for those clients the average number of emergency department visits was 38. One could argue that at least part of this higher average is due to increased homelessness and substance use found in bigger cities.

Table 9: Percent of Clients with at Least One Emergency Department Visit for Psychiatric Reasons in the Five Years P



Notes: N=244,179 Data are at the partnership level and represent the percent of partnerships where the client had at least one emergency department visit on the five years prior to joining an FSP. Data tables can be found here. For more information on methodology visit here.

These numbers are much lower for child/TAY FSP clients. Statewide, 43 percent of child/TAY clients had visited an emergency department for psychiatric reasons in the five years prior to joining an

FSP, with the average number for these clients being 5 visits. The highest county for emergency department visits was Shasta County, where 63 percent of child/TAY clients had visited an emergency department for psychiatric reasons in the five years prior to joining and FSP, with 14 average visits for these clients. At first glance, this looks like thankful news: younger clients are experiencing fewer emergency department visits than their more senior counterparts. But considering that younger clients have also had less time to accrue a higher count of emergency department visits, the trend is concerning.

Now this report will examine the total number of holds FSP clients experienced over time. Hold data is incredibly unreliable, with numerous counties reporting no holds at all, and about half reporting hold numbers so low they are most likely inaccurate. This hampers the ability to tell an accurate statewide story. For instance, only 3 percent adult FSP clients in Los Angeles County had a psychiatric hold on file in the five years prior to joining an FSP, a number so low Commission researchers question its accuracy. For adults in Los Angeles County who did have holds, their average number of holds was two. Numbers for children and TAY in Los Angeles are even lower with 0.7 having a hold on file in the five years prior to joining, and the average number being 1.7 for this group. Compare this with Humboldt County, which had the highest hold numbers of the 44 counties with psychiatric hold data. In Humboldt County 88 percent of adult FSP clients had a psychiatric hold on file in the five years leading up to joining an FSP, with the average number of holds being 3.3 for this group. The percent of child/TAY clients with a psychiatric hold on file in the five years prior to joining an FSP was slightly lower at 76 percent, and the average number of holds being 4.2 for this group. These two counties illustrate the vast range of hold data the Commission receives.

Commission for Behavioral Health

Chapter 7: Service Utilization and Outcomes

"If I don't make suggestions and phone calls to contact people [to ask for services], I can get lost in the system and things become unreliable and uncertain." – FSP client

Who is included in this section of the report?

The previous chapter looked at the characteristics of the nearly quarter-million Californians who have joined Full Service Partnerships (FSPs) since their inception more than two decades ago. This chapter looks at a subset of those clients; those who have received at least one service in the last year. The Commission refers to these clients as *active clients.* Appendices A describes how the Commission determines who an active client is, why it prefers to report on active clients rather than total clients when reporting on outcomes, and how its methodology results in different client counts for some counties. If you would like to read more about how the Commission determines who is an active client before reading this chapter, you can find that information here.

Where do we get our data?

The data from the previous chapter largely come from the Client Services Information (CSI) and the Data Collection Reporting (DCR) data sets, both managed by the Department of Health Care Services (DHCS). All the demographic data this report presents, other than date of birth, come from the CSI, and FSP service information comes from the DCR. Therefore, it is important that we are able to match clients in both data sets to get a full picture. Currently, the Commission is able to match about 91 percent of its FSP clients to the CSI data.

This chapter looks at service use such as number of crisis services used, emergency department visits, and psychiatric hospitalizations before and after joining an FSP. These data come from a variety of sources including CSI data and Department of Health Care Access Information (HCAI) data. HCAI data include information on hospitalization, emergency department visits, and in-patient psychiatric holds.

For more information on methodology please visit here.

Participation

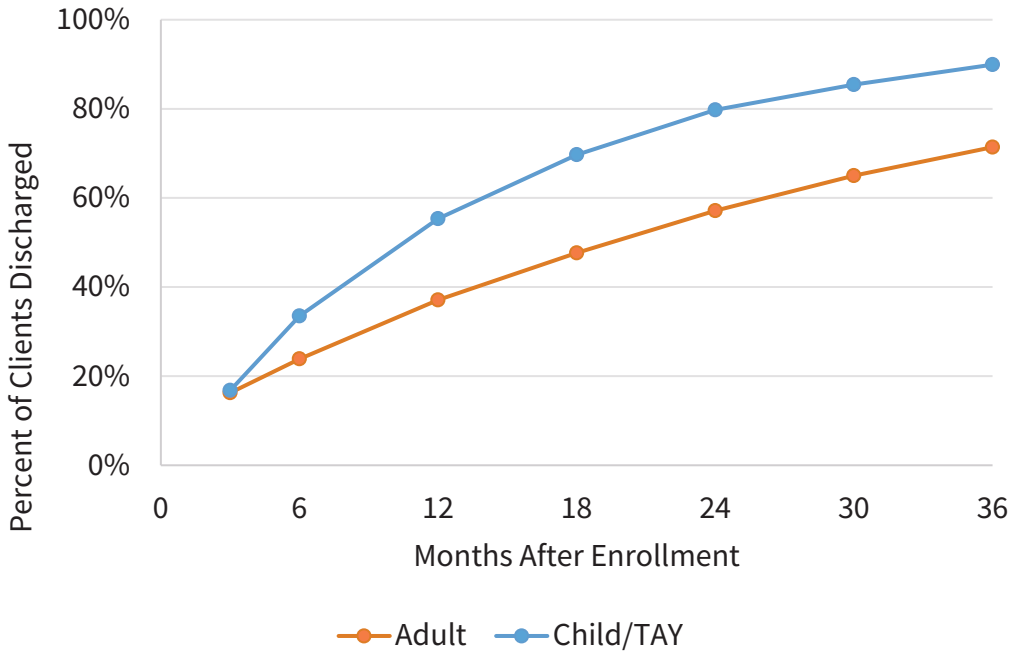
Joining an FSP can be an incredibly important step towards stability and health for many people living with serious mental illnesses and/or substance use disorders. But joining an FSP is just the first step. Clients must stay long enough to reap the full benefit of the services provided. How long a client stays in a partnership is impacted by numerous factors including level of need, ability to access services, available time and capacity to prioritize FSP services, perceived benefit of those services, and environmental, financial and social barriers to receiving services.

One characteristic that does seem to relate to how long clients are attached to an FSP is age. As Figure 10 below shows, child and TAY clients tend to have shorter enrollment periods than adults. The blue and orange lines represent individuals who joined an FSP between 2018 and 2020. The height of the line represents the percent of clients who exited the FSP over time. We can see the lines start at the 3-month mark and increase rapidly. At the two-year mark, 50 percent of adult clients were no longer active members of their FSP partnership. Compare this to child and TAY clients where 77 percent were no longer actively enrolled by the two-year mark.

Part of this difference may be due to aging out of TAY services. For example, if a TAY client joined an FSP on their 23rd birthday they would have a maximum of two years to receive services before no longer being eligible through that specific FSP. They could, in theory, move to an adult FSP, but the Commission's conversations with service providers indicate this is not common. Regardless of the reason, child and TAY clients become disconnected from FSP services sooner than adult clients. A positive interpretation of this might be that younger clients are reaching their goals faster than older clients. A more concerning explanation might be that children and youth are becoming lost in the system or are not responding to FSP service providers.

The lower retention rates for TAY clients begs the question of why clients are leaving. This report next looks at the documented reasons for individuals who exited FSP partnerships. It is important to note that this data below can only speak to those individuals for whom the Commission has a documented exit reason or who have been discontinued by the county for inactivity. Individuals who have stopped receiving services but haven't been officially discharged or discontinued would not have an official exit reason and are therefore not included.

Figure 10: Percent of Client Discharged/Disenrolled Over Time

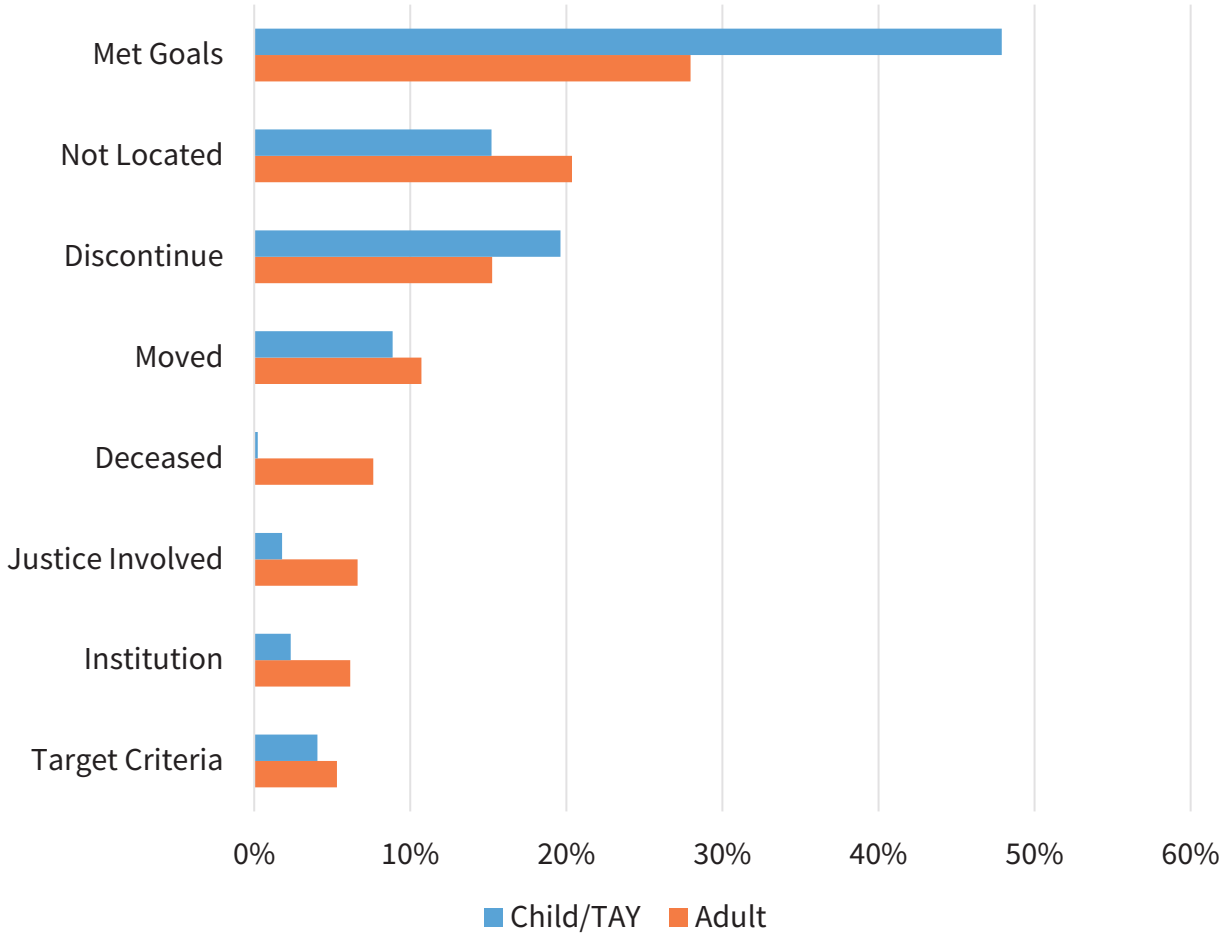


Notes: N= 21,186. The above data are restricted to the 2019 cohort to allow for at least 36 months of data. Tables can be found here. For more information on methodology visit here.

Overall, the most common reason for exiting an FSP partnership is meeting one's goals. This is the most ideal situation. And while the Commission does not have detailed information about what each client's individual goals are, it can at least characterize these departures as positive, and indicative of a positive outcome for clients. Figure 11 below illustrates the composition of exit reasons for adult clients vs child/TAY clients. A greater percentage of child/TAY clients exited their partnership because they met their goals.

The next most common reasons for both child/TAY clients and adult clients ending an FSP are not being able to locate the client or the client being discontinued. A client is discontinued when the county has determined that the client is no longer receiving services and has not met their goals. It is not possible to know what happened to these clients, and, at least for adult clients, that more clients were lost or discontinued than met their goals. When interpreting these numbers keep in mind the challenges providers face when serving such high need clients, and the difficulties in staying connected with individuals who are experiencing homelessness.

Figure 11: Meeting One's Goals was the Most Common Exit Reason



Notes: N=244,179 Data are at the partnership level. Clients may enter into more than one partnership. Data tables can be found here. For more information on methodology visit here.

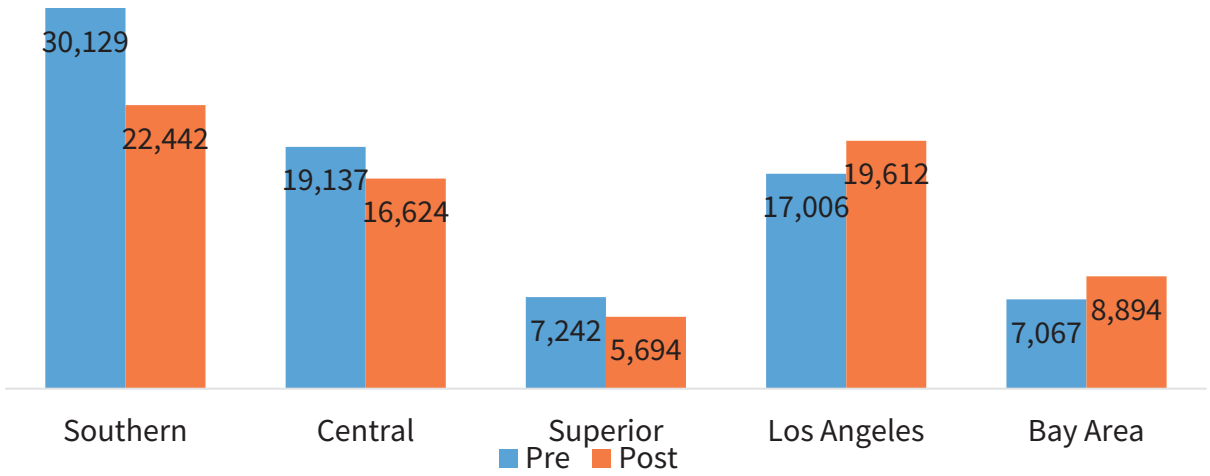
Outcomes

Next, this report examines client's outcomes. Because clients can enter into FSPs with different needs and histories of engaging services, we compare client's use of services one year prior to becoming connected with an FSP to one year afterwards. This gives us the best measure of what kind of immediate change a client may be experiencing in services after joining an FSP.

Figure 12 below presents pre- and post-crisis service use for individuals enrolled in an FSP between 2019 and 2022. The blue bar represents the total crisis services FSP clients used one year prior to joining an FSP, and the orange bar represents the total services used in the year after joining an FSP. If service use was the same before and after, the orange and blue bars would be at the same height. Rather, in the Southern, Superior, and Central regions clients had higher service use prior to joining

an FSP. This is a different pattern than in Los Angeles and the Bay Area, where clients' service use went up after getting connected to an FSP.

Figure 12. Crisis Service Usage Pre and Post FSP Enrollment Varies by Region

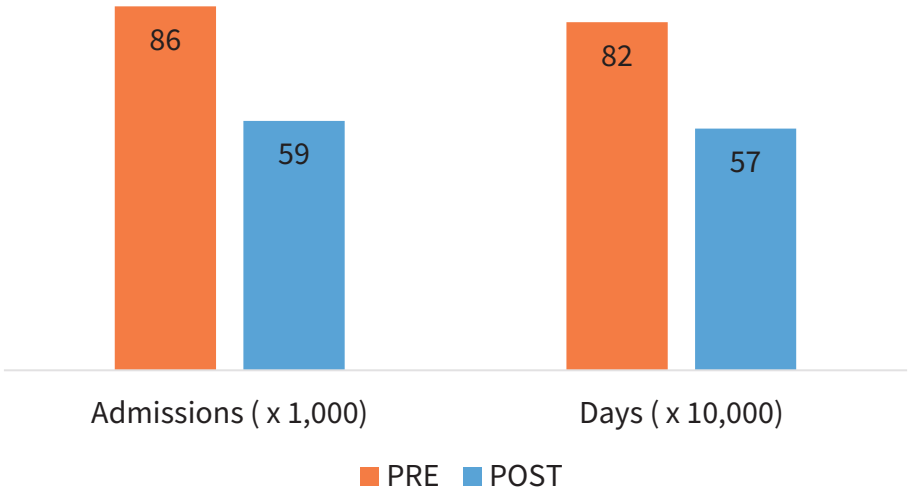


Note: Data for this figure is restricted to clients who entered a partnership between 2012 and 2022 as hospitalization data is not available prior to 2011.

Ideally, crisis service use would go down after FSP enrollment, but depending on the needs of the clients, it might be appropriate to see a short-term bump in such services while clients and providers work together to coordinate the client's care. For instance, if a client with coexisting conditions of a mental health diagnosis and substance use disorder enters into an FSP they may temporarily see a spike in crisis service use while they are connected to the appropriate array of health care providers. However, the goal of an FSP is to reduce crisis service use over time.

Data shows a decrease in both number of inpatient psychiatric admissions and in total days clients spent in the hospital for those stays. FSP clients experienced 85,590 psychiatric hospital admissions in the year prior to joining an FSP compared to 58,638 in the year after joining an FSP, a reduction of 41 percent. Similar trends exist for days spent in the hospital for those admissions, with hospital days in the year prior to joining an FSP coming in at 818,653 versus 568,348 afterwards, a reduction of 31 percent. This pattern appears strong, regions varying by no more than two or three percentage points.

Figure 13: Comparing Psychiatric Hospitalization Pre and Post Joining an FSP



Note: Data for this figure is restricted to clients who entered a partnership between 2012 and 2022 as hospitalization data is not available prior to 2011.

As mentioned in Part One, the ability to tell a statewide story is limited by access to high-quality data. DHCS is currently in the process of reworking FSP data collection and reporting procedures to ensure accuracy and completeness of the data collected by providers and received by DHCS. Such an undertaking is key in supporting the goals of transparency and accountability of Proposition 1, and in turn the ability of providers to ensure high quality service delivery and outcomes for clients.

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APPENDICES

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Appendix A: Analytic Methods

Appendix A1: Operational Definition and Parameters

Demographics – All demographics are calculated based on the total partnerships since the inception of FSPs through December 31, 2022 (N= 244, 179). Of these 98,099 were adult clients (26 years and older), and 146,080 were child or TAY clients (0 to 25 years).

Age Group: Refers to the age at intake, based on the following DCR codes:

- 1 = Child PAF
- 4 = TAY PAF
- 7 = Adult PAF
- 10 = Older Adult PAF

Age: Calculated based on date of birth in DCR.

Gender: Based on DCR as primary source and CSI as secondary source. Gender categories are male, female, other, and unknown.

Primary language: Coded from CSI file variable "prim language" and coded according to BHSOAC category practices. Categories are: English, Spanish, Other, and Unknown.

Place of birth: Coded from CSI data element "Place of Birth". Categories capture the most frequently occurring country categories: Mexico, United States, Other and Unknown.

Race / ethnicity: Coded from CSI variables to identify race and ethnicity. Race / ethnicity categories are exclusionary based on the following rules.

a. If a partner ever self-reported American Indian or Alaska Native then the partner is flagged as American Indian or Alaska Native.
b. If a partner is not in Category A and they self-reported as "Hispanic" then the partner is flagged as Latino.
c. If a partner is not in Category A or B and more than one race indicated, the client is flagged as Multiracial.
d. Otherwise, the value is flagged as reported.

Area/Region/County: Data is reported for the county where the partner is enrolled in an FSP. County data is aggregated to a regional level.

Diagnoses: Diagnoses are based on CSI variables “Principal Mental Health Diagnosis” and “Secondary Mental Health Diagnosis”. ICD9 and ICD10 code groupings were created by BHSOAC clinical staff. Diagnoses are not mutually exclusive and are calculated at the partnership level. Only primary and secondary diagnoses are included. It is possible that a partner may have more than two psychiatric diagnoses. Any primary or secondary psychiatric diagnoses received by a partner for any service between 2000 and 2023 is included. However, a given diagnosis is only counted once per partnership regardless of how many times a partner received said diagnosis.

Service Usage

Crisis Services: Crisis services data are restricted to outpatient services (Mode=15) with Service Fact IDs codes between 70 and 79, and include all partnerships originated between Jan 1 2012 and Dec 31 2022. CSI data is not reliably available before 2012. Services designed to provide short-term or sustained therapeutic intervention for persons experiencing acute and/or ongoing psychiatric distress (Cal. Code Regs. Title 9, Section 543). Furthermore, crisis services are short-term (lasting less than 24 hours), urgent services that cannot wait for a regularly scheduled visit. Services typically involve assessment, collateral services and therapy.

Services received prior to FSP partnership are calculated as the total services received between the date of partnership and 365 days prior. Services received post FSP partnership are calculated as total services received within 365 days after the date of partnership. Number of admissions is calculated based on the hold’s admission date.

Inpatient Holds: Inpatient holds are calculated for the five years prior to partnership date for partnerships originated between January 1, 2018 through December 31, 2022. Holds are derived from the CSI “Legal Class-Admission" and include the following “involuntary civil” hold codes:

- 72 Hour Evaluation and Treatment for Adults (W&I Code, Section 5150)
- 72 Hour Evaluation and Treatment for Children (W&I Code, Section 5585)
- 14 Day Intensive Treatment (W&I Code, Section 5250)
- Additional 14 Day Hold (W&I Code, Section 5260)
- Additional 30 Day Hold (W&I Code, Section 5270.15)
- Additional 180 Day Hold (W&I Code, Section 5300)
- Other involuntary civil status

“Involuntary criminal” holds for person’s held for psychiatric reasons related to criminal justice involvement are not included.

Ever Homeless: In this report we combine measures of homelessness and housing insecurity into a single variable that captures a lack of stable housing. Homelessness is often cyclical, and

individuals who were previously homeless are likely to be homeless again in the future. Therefore, we define someone as "Ever Homeless" if they meet any of the following criteria:

- Referred to an FSP from a homeless shelter (source: PAF)
- Client indicated they are or were homeless, or in are or were in a shelter (source PAF)
- Client indicated they are currently living in a shelter (source KET)
- HCAI data indicates zip code for Emergency Department visit or Inpatient Psychiatric Hold as "ZZZZZ" or ICD-10 code as Z590
- California Department of Education records indicate the client meets/met the definition of homeless according to McKinney-Vinto Act.

Emergency Department Visit: Restricted to partnerships established between 2018 and 2022 and are presented as the sum of all visits for the five years prior to entering into the FSP partnership.

Discontinue Reason: Partnership discontinuation reason is determined based on the following codes in the DCR:

- Code 7- Met Goals Met Goals
- Code 2- Discontinued/Lost Contact
- Code 4- Not Located Discontinued/Lost Contact
- Code 5- Institution Jailed/Institution
- Code 6- Serving in Jail Jailed/Institution
- Code 9- Placed Juvenile Hall Jailed/Institution
- Code 10- Placed DJJ Jailed/Institution
- Code 11- Serving Prison Jailed/Institution
- Code 1- Target Criteria Not Met Other
- Code 3- Moved Other
- Code 8- Deceased /other

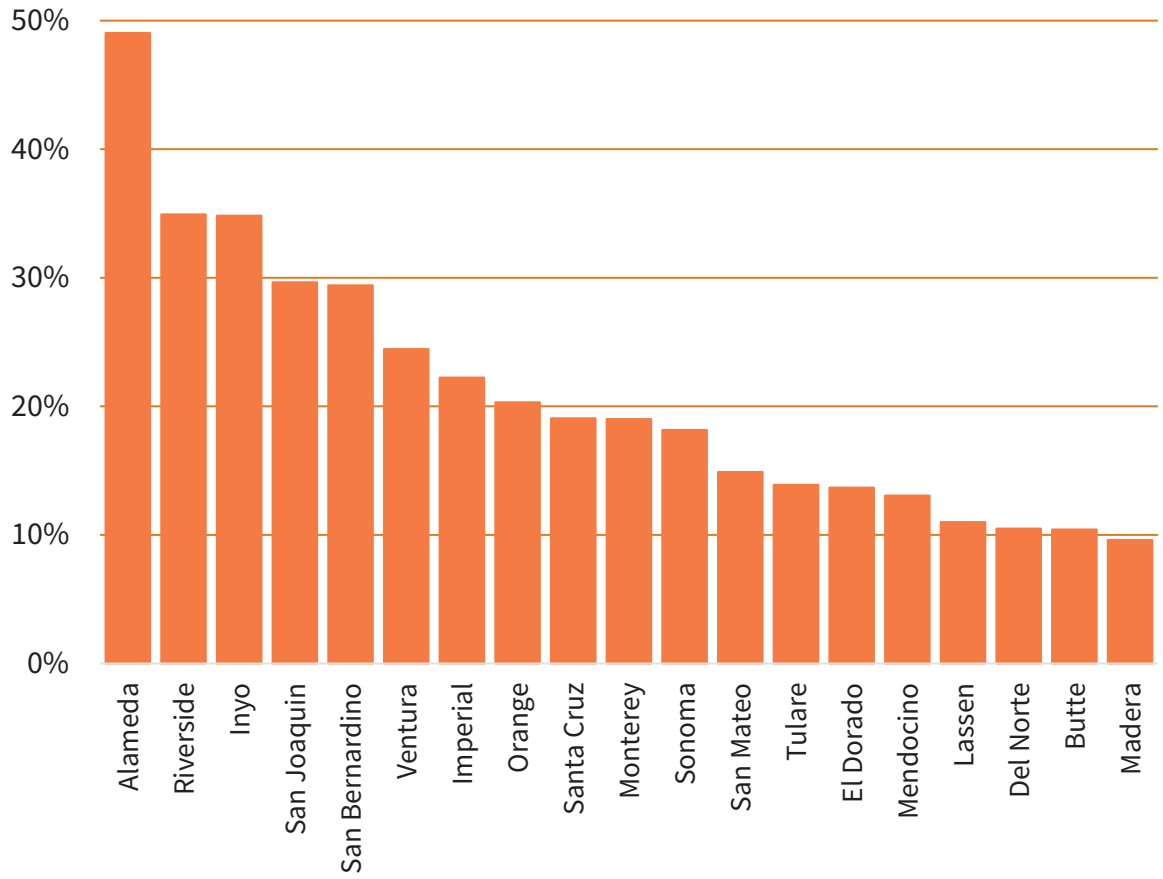
In this analysis we combine codes 6, 9, 10 and 11 as "Justice Involved."

Appendix A2: Defining Active Partnerships

As of 2019, there have been 244,179 partnerships since data reporting started in 1991, with all but five of these partnerships beginning after 2001. When a client enters a Full Service Partnership (FSP) they are assigned an ID number, and this ID number is specific to that partnership only, not the individual. Each partnership is tracked separately over time. When a client exits a partnership, they are no longer counted as active. Counties report this number through the Data Collection and Reporting system (DCR) to the Department of Health Care Services (DHCS). However, there are several reasons why the numbers received by the State may differ from those tracked internally by partners and counties.

First, an issue arises when partners stop receiving services but are not exited out of their partnership. If a partner doesn't receive an exit code and has not received services for an extended time, counties may flag those partnerships as discontinued. As the previous chapter noted, a large portion of partnerships end up being discontinued.

Figure X: Percent of Reported Active Partnerships Deemed Inactive by the Commission



Even still, around 1 percent to 2 percent of partnerships that should be labeled as inactive slip through the cracks each year. Over time, this adds up. As of 2022, 15 percent of all partnerships submitted through the DCR had to be reclassified as inactive by the Commission. These are partnerships where the client did not receive any DCR reported services for at least 18 months. We refer to these partnerships as "administratively discharged" to distinguish them from those discontinued by the county. Figure X depicts counties where the Commission had to reclassify more than 10 percent of the enrollment data submitted. In total, out of the 58 counties, all but 28 needed some level of recalculating of their enrollment counts.

The Commission considers any partnership that does not have an exit code, is not labeled discontinued by the State, and has not been reclassified as administratively discharged by the Commission as "active." Table X provides an annual summary of total FSP partnerships created (in blue), followed by the number of partnerships with exit codes or were discontinued by the county, and those who were administratively discharged by the Commission (in green). The number in the blue column, minus the total from both green columns provides the calculated "active clients" found in the orange column.

Of the near quarter of a million partnerships that have been established over time, 189,980 have been exited or discontinued by the county, and 25,878 have been administratively discharged by the Commission, leaving 28,321 as active. As previously stated, about 15 percent of the active records the Commission receives are recoded as administratively discharged.

In addition to issues around calculating the number of active partnerships, there are questions about the number of *clients served* by FSPs. This arises because clients may have multiple IDs. If an individual joins FSP 1 in County A, and then later joins FSP 2 in County A they would receive two partnership IDs. Because one person may have more than one partnership over time, counties try and match multiple partnerships to the same person by assigning a client ID as well. This means each client within a county has one client ID but may have multiple FSP partnership IDs.

Sometimes a client relocates to a different county. When this happens, the client is given a new client ID specific to that county and new partnership IDs for each partnership within that county. Counties collect and report their own data, so they have no way of matching the records for their county to those of another county. This means a single individual may have multiple client IDs and partnership IDs. These data are submitted to the DCR and the Commission, in turn, receives these data from the DHCS.

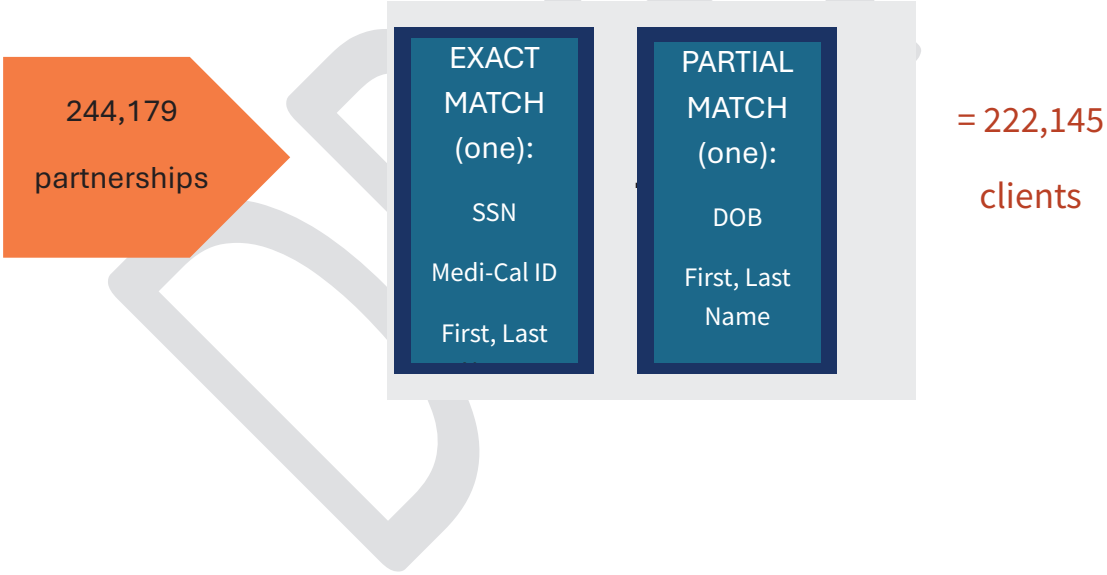
Table X: The Number of Clients Administratively Discharged Compiles Over Time

Year	Total Created	Exited or Discontinued	Administratively Discharged	Continued Partnerships
2001	65	0	0	0
2002	89	0	0	0
2003	108	0	0	0
2004	138	0	0	0
2005	196	1	3	192
2006	1,594	83	19	1,492
2007	10,329	1,534	112	8,683
2008	21,590	6,152	386	15,052
2009	35,170	13,946	904	20,320
2010	48,258	23,819	1,495	22,944
2011	60,440	34,857	2,109	23,474
2012	72,790	45,527	2,888	24,375
2013	86,640	56,947	4,073	25,620
2014	100,675	70,258	5,067	25,350
2015	114,284	83,072	5,923	25,289
2016	131,040	96,224	6,691	28,125

The Commission's job is to take these various records, determine how many records belong to the same individual across counties, and estimate how many clients are being served at any given time. This ends up being a multi-step process. The Commission identifies clients with multiple client IDs as the same person if they meet two criteria. First, they must have an *exact* match on one of the following: Social Security number, Medi-Cal ID number, or first and last name. Then they must have a close (but not necessarily exact) match on a second criteria, including name and date of birth. For example, if two client IDs have the exact same Social Security number and birthdates that are similar (but maybe slightly off), the Commission would assume that is the same individual and one of those birthdates was probably entered incorrectly. Alternatively, if two client IDs had the exact same first and last name but had completely different birthdates, the Commission would not match those records as the same person, and they would remain in Commission data as two separate records. This process is run up to 60 times to be sure the Commission captures clients that may have had multiple partnerships in multiple counties.

After completing this matching process, the Commission now has information on the number of partnerships and an estimate of the number of clients served. Figure X illustrates this process and how the Commission arrives at its final client count.

Figure X: Matching Clients Across Counties Is a Multi-step Process



Appendix B: List of Counties and Organizations Engaged (all projects)

Counties Engaged

1. Alameda
2. Butte
3. Del Norte
4. El Dorado
5. Fresno
6. Glenn
7. Humboldt
8. Imperial
9. Lake
10. Lassen County
11. Los Angeles
12. Madera
13. Marin
14. Mendocino County
15. Merced
16. Modoc
17. Monterey County
18. Napa
19. Nevada
20. Orange
21. Placer
22. Plumas
23. Riverside County
24. Sacramento
25. San Benito
26. San Bernardino
27. San Diego
28. San Francisco
29. San Luis Obispo
30. San Mateo
31. Santa Barbara
32. Santa Clara
33. Santa Cruz
34. Shasta
35. Siskiyou County
36. Solano
37. Stanislaus
38. Stanislaus County
39. Sutter
40. Tehama County
41. Trinity County
42. Tulare
43. Ventura
44. Yolo
45. Yuba

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Organizations Engaged

1. Abode
2. Alameda County Behavioral Health Care Services
3. Amiyoko A. Shabazz
4. Association of Community Human Service Agencies
5. Aviva
6. Bay Area Community Services (BACS)
7. BHSD Santa Clara County
8. Black Men Speak
9. Cal Voices
10. California Association of Local Behavioral Health Boards and Commissions (CalBHBC)
11. California Association of Mental Health Peer-Run Organizations (CAMHPRO)
12. California Department of Corrections and Rehabilitation (CDCR)
13. California Department of Social Services (CDSS)
14. California Health and Human Services (CalHHS)
15. California Hospital Association (CHA)
16. California Mental Health Services Authority (CalMHSA)
17. Casa Ubuntu
18. Catalyst
19. Center Star ACT
20. Child and Family Center
21. Children's Institute
22. Coloma Center-Homeless Intervention - Turning Point
23. Community Solutions
24. Comprehensive Youth Services
25. Corporation for Supportive Housing (CSH)
26. County Behavioral Health Directors Association (CBHDA)
27. County of Marin Behavioral Health Recovery Services
28. County of Santa Clara Behavioral Health Services
29. CRF Behavioral Health Care
30. CRF Behavioral Health Care, South Bay Guidance Center
31. Del Norte County Behavioral Health Services
32. Department of Health Care Services (DHCS)
33. Disability Rights
34. Downtown Women's Center
35. El Dorado County Health and Human Services Agency (HHSA): Behavioral Health
36. Exceptional Parents Unlimited
37. Felton Institute
38. Glenn County Behavioral Health
39. Hillsides
40. Hope Cooperative
41. Hope Horizon Mental Health
42. Housing and Community Development
43. Imperial County Behavioral Health Services
44. Indian Health Center of Santa Clara Valley
45. Los Angeles County Department of Mental Health
46. Lassen County Behavioral Health
47. Masada Homes
48. Mental Health America of Los Angeles
49. Mental Health America of Northern California
50. Mental Health Data Alliance / Opeeka

51. Mental Health Systems/TURN
52. Mesa FSP
53. NAMI
54. Nevada County Behavioral Health Department
55. No Place Like Home Program at the California Department of Housing and Community Development
56. Orange County BH Department
57. Pathways
58. Seneca Family of Agencies
59. Steinberg Institute
60. Telecare Corporation
61. Vanna Health
62. Youth Leadership Institute
63. Victor Community Services

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Appendix C: Analytic Tables

Appendix C1: Annual Enrollment of Full Service Partnerships by Age Group

ENROLLMENT BY YEAR AGE GROUP AT ENTRY					
YEAR	CHILD	TAY	ADULT	OLDER ADULT	TOTAL
1991	1				1
1994	1				1
1996			1		1
1999	1				1
2000			1		1
2001	3	3	53	1	60
2002	1	3	12	8	24
2003		2	16	1	19
2004	2	1	26	1	30
2005	7	9	40	2	58
2006	198	324	767	109	1,398
2007	1,609	2,012	4,323	791	8,735
2008	2,679	2,681	5,003	898	11,261
2009	2,957	3,503	6,167	953	13,580
2010	4,038	3,380	4,754	916	13,088
2011	3,675	3,312	4,350	845	12,182
2012	4,160	3,376	4,093	721	12,350
2013	4,398	3,508	4,978	966	13,850
2014	5,053	3,445	4,670	867	14,035
2015	4,658	3,445	4,556	950	13,609
2016	6,649	3,779	5,375	953	16,756
2017	8,178	4,042	5,468	1,142	18,830
2018	8,407	4,104	5,218	1,186	18,915
2019	8,766	4,763	6,362	1,295	21,186
2020	7,503	4,127	5,699	1,100	18,429
2021	7,643	4,648	5,820	1,149	19,260
2022	7,374	3,652	4,626	867	16,519
Grand Total	87,961	58,119	82,378	15,721	244,179

Note: The above table depicts partnerships not clients. Clients can be enrolled in more than one partnership. There have been 244,179 partnerships for 222,145 FSP clients through December 31, 2022.

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Appendix C2: Enrollment by Age Group, Region and County

		Age Group					
		0-5	6-15	16-25	26-64	65+	Total
Statewide	California	8,034	74,018	64,028	82,378	15,721	244,179
Region	Bay Area	260	5,114	8,015	11,698	2,319	27,406
	Central	1,898	7,265	9,175	17,277	2,383	37,998
	Los Angeles	2,222	17,222	12,845	24,582	4,112	60,983
	Southern	3,530	42,644	32,084	24,724	6,097	109,079
	Superior	124	1,773	1,909	4,097	810	8,713
County	Alameda	20	49	523	1,287	287	2,166
	Alpine		*	*	*	*	0
	Amador	*	39	54	153	**	246
	Berkeley City	*	**	60	148	45	253
	Butte	25	448	471	465	198	1,607
	Calaveras	*	81	116	223	**	420
	Colusa		41	**	52	*	93
	Contra Costa	20	504	757	778	48	2,107
	Del Norte	*	*	53	236	22	311
	El Dorado	35	338	270	447	39	1,129
	Fresno	1,269	836	1,504	3,121	120	6,850
	Glenn	20	267	202	327	35	851
	Humboldt			70	457	100	627
	Imperial	*	548	1,765	1,199	**	3,512
	Inyo	*	*	20	50	15	85
	Kern	108	1,575	2,269	2,462	648	7,062
	Kings	18	290	187	548	71	1,114
	Lake	*	**	114	290	79	483
	Lassen		*	23	69	*	92
	Los Angeles	2,222	17,222	12,845	24,582	4,112	60,983
	Madera	*	232	292	424	**	948
	Marin	*	**	505	578	287	1,370
	Mariposa	*	114	64	72	*	250
	Mendocino		*	160	236	**	396
	Merced	57	672	310	188	18	1,245
	Modoc		11	41	162	22	236
	Mono	*	14	38	90	**	142
	Monterey	55	326	605	772	206	1,964
	Napa	*	211	301	382	**	894
	Nevada	55	647	337	326	52	1,417

Continued on next page…

	Age Group					
	0-5	6-15	16-25	26-64	65+	Total
...continued						
Orange	79	1,798	4,660	3,486	535	10,558
Placer	73	563	396	640	94	1,766
Plumas		47	46	164	23	280
Riverside	461	1,766	4,058	3,289	1,412	10,986
Sacramento	62	869	1,993	3,614	708	7,246
San Benito	*	118	145	159	21	443
San Bernardino	517	6,272	4,835	3,326	418	15,368
San Diego	2,297	29,341	12,081	6,924	1,986	52,629
San Francisco	73	1,045	1,159	1,385	322	3,984
San Joaquin	163	1,944	1,667	3,565	538	7,877
San Luis Obispo	18	320	359	442	95	1,234
San Mateo	**	460	568	*		1,028
Santa Barbara	*	375	365	906	**	1,646
Santa Clara	17	979	2,140	4,375	386	7,897
Santa Cruz			221	231	130	582
Shasta	*	**	117	375	65	557
Sierra		*	*	43	*	43
Siskiyou	17	188	151	635	108	1,099
Solano	15	697	509	974	193	2,388
Sonoma	32	493	522	628	208	1,883
Stanislaus	*	337	977	2,292	456	4,062
Sutter/Yuba	118	397	321	180	37	1,053
Tehama		*	73	190	**	263
Tri-City	36	510	731	1,274	160	2,711
Trinity	*	*	22	70	14	106
Tulare	54	348	722	935	56	2,115
Tuolumne	*	82	91	195	**	368
Ventura		139	961	1,416	422	2,938
Yolo	22	101	150	531	62	866

*Note: N=244,179. Client's age is determined at time of entry into the FSP. * Groups with 10 and under are suppressed for client privacy. ** Data has been secondarily suppressed to ensure suppressed cells cannot be deduced mathematically.*

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Appendix C3: Percent of Full Service Partnerships Missing CSI Number

YEAR	PARTNERSHIPS	MISSING CSI NUMBER	% MISSING
1991	1	0	0.0%
1994	1	0	0.0%
1996	1	0	0.0%
1999	1	0	0.0%
2000	1	1	100.0%
2001	60	0	0.0%
2002	24	0	0.0%
2003	19	0	0.0%
2004	30	0	0.0%
2005	58	1	1.7%
2006	1398	8	0.6%
2007	8735	105	1.2%
2008	11261	298	2.6%
2009	13580	238	1.8%
2010	13088	381	2.9%
2011	12182	433	3.6%
2012	12350	506	4.1%
2013	13850	534	3.9%
2014	14035	533	3.8%
2015	13609	534	3.9%
2016	16756	590	3.5%
2017	18830	722	3.8%
2018	18915	613	3.2%
2019	21186	762	3.6%
2020	18429	611	3.3%
2021	19260	616	3.2%
2022	16519	726	4.4%
Total	244179	8212	3.4%

Notes: The table above depicts the number and percent of Full Service Partnerships without a Client Services Information number used to link DCR data to other state data sets. Clients may be enrolled in more than one partnership and therefor may be counted more than once.

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Appendix C4: Percent of Partnerships Administratively Discharged by County

REGION	SIZE	COUNTY	% ADMINISTRATIVELY DISCHARGED
Bay	Large	Alameda	49%
Southern	Large	Riverside	35%
Central	Small	Inyo	35%
Central	Large	San Joaquin	30%
Southern	Large	San Bernardino	29%
Southern	Large	Ventura	24%
Southern	Small	Imperial	22%
Southern	Large	Orange	20%
Bay	Medium	Santa Cruz	19%
Bay	Medium	Monterey	19%
Bay	Medium	Sonoma	18%
Bay	Large	San Mateo	15%
Central	Medium	Tulare	14%
Central	Small	El Dorado	14%
Superior	Small	Mendocino	13%
Superior	Small	Lassen	11%
Superior	Small	Del Norte	10%
Superior	Medium	Butte	10%
Central	Small	Madera	10%
LA	Large	Los Angeles	9%
Central	Small	Kings	8%
Central	Large	Fresno	8%
Bay	Large	Santa Clara	7%
Central	Medium	Placer	7%
Central	Small	Mariposa	6%
Central	Small	Alpine	6%
Central	Medium	Yolo	6%
Southern	Medium	Santa Barbara	5%
Bay	Medium	Marin	5%
Bay	Small	Napa	5%
Southern	Medium	Tri-City	4%
Southern	Medium	San Luis Obispo	3%
Superior	Small	Tehama	3%
Central	Large	Sacramento	2%
Bay	Medium	Solano	2%
Central	Medium	Merced	1%
Superior	Small	Lake	1%

Notes: See Appendix A.2 for definitions and methodology for administratively discharging clients. The following counties have no administratively discharged partners and are therefore not show above: San Francisco, City of Berkeley, San Diego, Contra Costa, Nevada, Kern. Amador, Calaveras, Colusa, Glenn. Humboldt, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter/Yuba, Trinity, Tuolumne

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Appendix C5: Partner Enrollment Status by Year

YEAR	New Partnerships	Discontued Partnerships	Last Service	Inactive Partners	Actvie Partnerships	Met Goals	% Met Goals
1991	*	*	*	*	*	*	*
1994	*	*	*	*	*	*	*
1996	*	*	*	*	*	*	*
1999	*	*	*	*	*	*	*
2000	*	*	*	*	*	*	*
2001	60						
2002	24						
2003	19						
2004	30						
2005	58	*	*	*	191	*	
2006	1,398	82	19	101	1,488	12	15%
2007	8,735	1,451	191	1,642	8,581	255	18%
2008	11,261	4,618	480	5,098	14,744	1,089	24%
2009	13,580	7,794	519	8,313	20,011	2,338	30%
2010	13,088	9,873	613	10,486	22,613	3,616	37%
2011	12,182	11,038	640	11,678	23,117	4,203	38%
2012	12,350	10,670	972	11,642	23,825	4,133	39%
2013	13,850	11,420	1,294	12,714	24,961	4,715	41%
2014	14,035	13,311	860	14,171	24,825	5,616	42%
2015	13,609	12,814	667	13,481	24,953	6,445	50%
2016	16,756	13,152	1,122	14,274	27,435	5,973	45%
2017	18,830	14,989	2,233	17,222	29,043	6,206	41%
2018	18,915	16,042	1,748	17,790	30,168	7,441	46%
2019	21,186	16,956	2,548	19,504	31,850	7,657	45%
2020	18,429	15,366	3,331	18,697	31,582	6,877	45%
2021	19,260	16,297	6,025	22,322	28,520	7,816	48%
2022	16,519	14,106	5,034	19,140	25,899	6,727	48%
Total	244,174	189,979	28,296	218,275		81,119	33%

*Note: N=244,179. Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once. * Groups with 10 and under are suppressed for client privacy. Discontinued partnerships are partnerships that have been ended with an exit category from the county. Last Service depicts individuals who do not have an exit code but have ceased receiving services. Inactive Partnerships is the total of Discontinued and Last Service. Active Partnerships are all partnerships that*

have not been discontinued and continue to receive services. Met Goals are individuals who were exited from their partnership with an exit code to indicate they met their service goals.

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Appendix C6: Length of Enrollment by Age Group

Months	Adult Number	Adult Cumulatice Percent	Child/TAY Number	Child/TAY Cumulatice Percent
0	289	1.4%	538	1.4%
1	1412	6.8%	2723	7.2%
2	2618	12.6%	4926	13.1%
3	3286	15.8%	7033	18.7%
4	3906	18.7%	9525	25.3%
5	4528	21.7%	12014	31.9%
6	5107	24.5%	14371	38.1%
7	5661	27.1%	16251	43.1%
8	6156	29.5%	18006	47.8%
9	6609	31.7%	19619	52.1%
10	7100	34.0%	21060	55.9%
11	7578	36.3%	22464	59.6%
12	8112	38.9%	23929	63.5%
13	8623	41.3%	25147	66.8%
14	8999	43.1%	25988	69.0%
15	9343	44.8%	26682	70.8%
16	9796	47.0%	27623	73.3%
17	10147	48.6%	28274	75.1%
18	10445	50.1%	28871	76.6%
19	10938	52.4%	29616	78.6%
20	11206	53.7%	30082	79.9%
21	11472	55.0%	30571	81.2%
22	11850	56.8%	31134	82.6%
23	12129	58.1%	31582	83.8%
24	12378	59.3%	32030	85.0%
25	12722	61.0%	32470	86.2%
26	12958	62.1%	32775	87.0%
27	13156	63.1%	33036	87.7%
28	13432	64.4%	33387	88.6%
29	13671	65.5%	33606	89.2%
30	13878	66.5%	33838	89.8%
31	14132	67.7%	34114	90.6%
32	14328	68.7%	34348	91.2%
33	14483	69.4%	34514	91.6%
34	14705	70.5%	34715	92.2%
35	14885	71.4%	34878	92.6%
36+	20860	100.0%	37670	100.0%

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Appendix C7: Race and Ethnicity of Adult Full Service Partnerships by County

ADULT									
		American Indian/Alaska Native	Asian/ Pacific Islander	Black/ African American	Latino/a	Multiracial	Other	Unknown	White/ Caucasian
Statewide	California	3,342	4,237	16,306	22,936	4,612	2,086	7,266	37,314
Region	Bay Area	464	716	1,976	2,540	817	168	2,734	4,602
	Central	942	1,480	2,485	4,686	741	262	1,134	7,930
	Los Angeles	556	1,327	8,327	7,309	1,249	1,269	1,356	7,301
	Southern	896	680	3,417	7,970	1,631	367	1,776	14,084
	Superior	484	34	101	431	174	20	266	3,397
County	Alameda	50	100	627	152	102	62	48	433
	Alpine	*			*				*
	Amador	11		*	16	*		*	128
	Berkeley City	*	*	39	*	*	*	85	46
	Butte	39	*	31	55	17	*	33	481
	Calaveras	23		*	19	*		*	199
	Colusa		*		17	*	*	*	27
	Contra Costa	37	38	211	161	65	11	*	293
	Del Norte	33	*	*	15	*	*	*	191
	El Dorado	12	*	*	41	15	*	13	389
	Fresno	80	128	458	1,057	94	46	539	839
	Glenn	26	*	*	74	14	*	*	234
	Humboldt	78	*	15	32	12		*	407
	Imperial	**	*	51	995	34	29	66	235
	Inyo	*			*		*	19	35
	Kern	77	51	378	979	61	41	60	1,463
	Kings	14	*	61	196	13	*	81	238
	Lake	24	*	11	47	17	*	*	263
	Lassen	*			*	*		*	52
	Los Angeles	556	1,327	8,327	7,309	1,249	1,269	1,356	7,301
	Madera	14	*	38	175	20	*	60	165
	Marin	18	23	58	94	49	12	91	520
	Mariposa	*	*		*	*		*	66
	Mendocino	31	*	*	21	*	*	21	184
	Merced	*	*	23	71	*	*	*	89
	Modoc	23	*	*	13	11		*	124
	Mono	*		*	15	*		*	69
	Monterey	**	29	50	329	33	*	164	348
	Napa	30	*	13	99	20	*	54	342
	Nevada	34	*	*	27	15		19	280

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ADULT								
…continued	American Indian/Alaska Native	Asian/ Pacific Islander	Black/ African American	Latino/a	Multiracial	Other	Unknown	White/ Caucasian
Orange	154	143	206	837	442	37	125	2,077
Placer	34	*	17	89	38	*	43	505
Plumas	11		*	14	*		16	141
Riverside	118	62	657	1,135	197	87	278	2,167
Sacramento	167	665	875	506	216	58	181	1,654
San Benito	*	*	*	95	*	*	*	71
San Bernardino	123	46	667	951	146	36	131	1,644
San Diego	276	296	1,098	1,761	548	46	666	4,219
San Francisco	46	82	389	241	142	26	185	596
San Joaquin	329	525	725	1,159	132	84	41	1,108
San Luis Obispo	37	*	12	66	24	*	*	391
San Mateo							**	*
Santa Barbara	18	25	64	291	37	*	**	640
Santa Clara	159	362	238	1,061	254	25	1,893	769
Santa Cruz	*	*	*	47	*	*	59	223
Shasta	21	*	*	12	12	*	113	273
Sierra	*			*			*	40
Siskiyou	114	*	22	60	24	*	*	501
Solano	**	57	316	163	92	*	97	379
Sonoma	37	*	27	94	39	*	43	581
Stanislaus	120	102	175	775	105	43	18	1,410
Sutter/Yuba	*	*	*	31	13		15	136
Tehama	33	*	*	27	23		*	145
Tri-City	36	22	195	451	76	55	351	248
Trinity	*		*	*	*	*	*	54
Tulare	50	**	47	378	31	*	55	413
Tuolumne	20	*	*	19	*		*	183
Ventura	37	33	89	504	66	28	81	1,000
Yolo	35	*	43	124	32	*	45	298

*Note: N= 98,099. Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once * Groups with 10 and under are suppressed for client privacy. ** Data has been secondarily suppressed to ensure suppressed cells cannot be deduced or mathematically calculated. Data above represent the age of every client at time of partnership. Methodology for determining race and ethnicity can be found in Appendix A1: Operational Definition and Parameters.*

Appendix C8: Race and Ethnicity of Child/TAY Full Service Partnerships by County

CHILD/TAY									
		American Indian/Alaska Native	Asian/ Pacific Islander	Black/ African American	Latino/a	Multiracial	Other	Unknown	White/ Caucasian
Statewide	California	3,339	4,428	16,452	74,630	5,913	3,182	11,818	26,318
Region	Bay Area	386	502	1,862	4,958	764	185	2,731	2,001
	Central	669	900	1,995	6,156	827	237	2,995	4,559
	Los Angeles	275	1,023	6,274	18,461	812	1,444	1,259	2,741
	Southern	1,607	1,972	6,253	44,279	3,328	1,299	4,651	14,869
	Superior	402	31	68	776	182	17	182	2,148
County	Alameda	29	44	244	101	51	23	16	84
	Alpine	*						*	*
	Amador	*		*	20	*		*	59
	Berkeley City	*	*	21	*	*	*	51	12
	Butte	106	**	35	214	67	*	28	471
	Calaveras	15		*	26	*		*	141
	Colusa	*		*	33	*	*	*	17
	Contra Costa	66	34	248	594	119	15	21	184
	Del Norte	14	*		*			*	40
	El Dorado	39	*	16	104	23	*	74	378
	Fresno	54	65	233	1,084	70	54	1,635	414
	Glenn	34	*	*	182	*	*	*	248
	Humboldt	14			*	*		*	38
	Imperial	20	*	40	1,998	**	50	51	119
	Inyo	*			*			*	*
	Kern	66	36	467	2,084	100	79	76	1,044
	Kings	20	*	59	218	18	*	70	104
	Lake	12		*	35	11	*	*	99
	Lassen	*		*	*			*	17
	Los Angeles	275	1,023	6,274	18,461	812	1,444	1,259	2,741
	Madera	19	*	31	308	16	12	33	106
	Marin	*	*	43	377	25	*	93	138
	Mariposa	13			30	*	*	*	133
	Mendocino	25		*	27	*	*	*	90
	Merced	26	14	55	569	47	*	105	213
	Modoc	*			*	*	*	*	27
	Mono	*			22			*	21
	Monterey	12	13	22	643	34	30	141	91
	Napa	13	*	11	264	12	*	72	138
	Nevada	102	*	*	166	37	*	44	673

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CHILD/TAY								
…continued	American Indian/Alaska Native	Asian/ Pacific Islander	Black/ African American	Latino/a	Multiracial	Other	Unknown	White/ Caucasian
Orange	171	539	168	3,472	530	62	268	1,327
Placer	38	11	37	201	46	13	149	537
Plumas	*			13	*		*	69
Riverside	96	51	719	3,281	210	190	618	1,120
Sacramento	139	536	715	642	226	46	138	482
San Benito	*	*		182	*	*	*	57
San Bernardino	292	107	1,800	5,348	432	220	838	2,587
San Diego	874	1,202	2,873	26,413	1,869	532	2,296	7,660
San Francisco	45	174	770	607	195	30	295	161
San Joaquin	125	192	675	1,288	206	52	570	666
San Luis Obispo	35	*	*	193	44	*	*	399
San Mateo	21	45	82	328	49	23	319	174
Santa Barbara	21	*	19	445	22	*	31	206
Santa Clara	48	126	82	1,079	91	11	1,524	175
Santa Cruz	*	*	*	95	*	*	35	74
Shasta	*		*	16	11		48	78
Sierra	*		*	*				*
Siskiyou	54	*	*	38	16		14	222
Solano	71	32	299	329	119	17	71	283
Sonoma	57	14	35	354	55	13	89	430
Stanislaus	42	50	91	680	56	**	*	379
Sutter/Yuba	51	**	30	219	50	*	20	443
Tehama	*			18	*		*	38
Tri-City	*	15	120	562	50	146	302	77
Trinity	*			*	*	*	*	15
Tulare	44	*	30	642	28	*	123	245
Tuolumne	*	*	*	22	*	*	*	130
Ventura	27	*	39	483	34	13	164	330
Yolo	17	*	17	76	17	*	40	97

Note: N= 146,080. *Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once. * Groups with 10 and under are suppressed for client privacy. ** Data has been secondarily suppressed to ensure suppressed cells cannot be deduced or mathematically calculated. Data above represent the age of every client at time of partnership. Methodology for determining race and ethnicity can be found in Appendix A1: Operational Definition and Parameters.*

Appendix C9: Gender Composition of Full Service Partnerships by County

		Adult				Child / TAY			
		Female	Male	All Other	Unknown	Female	Male	Other	Unknown
Statewide	California	42,261	51,150	44	4,644	62,116	76,377	166	7,421
Region	Bay Area	4,673	6,888	*	**	4,923	6,290	*	**
	Central	9,071	9,836	*	**	6,968	9,037	15	2,318
	Los Angeles	12,217	16,431	17	29	14,179	18,023	38	49
	Southern	13,857	15,696	17	1,251	34,332	41,059	93	2,774
	Superior	2,443	2,299	*	**	1,714	1,968	*	**
County	Alameda	**	984		*	209	383		
	Alpine	*	*			*	*		*
	Amador	99	70			59	35		
	Berkeley City	36	73		84	22	23		51
	Butte	305	358			**	496		*
	Calaveras	126	129			110	**	*	
	Colusa	**	26		*	**	35		*
	Contra Costa	**	459		*	634	642	*	*
	Del Norte	135	123			32	32		
	El Dorado	**	275		*	298	329		16
	Fresno	1,011	1,755		475	**	1,343	*	1,575
	Glenn	238	**		*	255	231		*
	Humboldt	226	331			23	47		
	Imperial	673	719		39	**	1,379		*
	Inyo	19	30		16	*	15		*
	Kern	1,540	1,527	*	**	2,004	1,911	*	**
	Kings	285	258		76	186	251		58
	Lake	200	**		*	101	62	*	*
	Lassen	44	28			13	15		
	Los Angeles	12,217	16,431	17	29	14,179	18,023	38	49
	Madera	194	229		58	202	291	*	**
	Marin	387	442		36	237	432		36
	Mariposa	47	35			**	115		*
	Mendocino	122	149			70	91		
	Merced	**	124		*	**	499	*	87
	Modoc	121	**		*	28	**		*
	Mono	54	**		*	**	35		*
	Monterey	467	511			**	528		*
	Napa	259	262	*	**	213	259	*	**
	Nevada	147	218		13	414	585	*	**

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	Adult				Child / TAY			
	Female	Male	All Other	Unknown	Female	Male	Other	Unknown
Orange	1,601	2,320		100	2,420	3,852		265
Placer	290	444			**	617		*
Plumas	97	76	*	**	**	44		*
Riverside	2,243	2,447		11	2,567	3,701		17
Sacramento	2,066	2,243		13	**	1,761		*
San Benito	106	**		*	139	**		*
San Bernardino	1,987	1,677		80	4,879	6,341		404
San Diego	3,677	4,612	*	**	19,984	22,010	87	1,638
San Francisco	550	1,099	*	**	855	1,285		137
San Joaquin	2,233	1,856		14	1,704	1,695		375
San Luis Obispo	280	255	*	*	290	401	*	*
San Mateo	*			**	368	467		206
Santa Barbara	554	**		*	340	404		*
Santa Clara	976	1,661		2,124	705	810		1,621
Santa Cruz	**	226		*	**	154		*
Shasta	157	176		107	49	70		45
Sierra	**	17		*	*	*	*	
Siskiyou	438	**		*	176	**		*
Solano	446	640		81	536	624		61
Sonoma	**	461		*	**	558	*	*
Stanislaus	1,384	1,355	*	*	**	719	*	
Sutter/Yuba	103	99		15	338	486	*	**
Tehama	122	**		*	28	45		*
Tri-City	531	575		328	515	495		267
Trinity	**	46		*	**	14		*
Tulare	485	453		53	488	514		122
Tuolumne	126	**		*	**	87	*	
Ventura	771	1,024		43	402	565		133
Yolo	253	324		16	94	153		26

*Notes: N=244,179. Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once. * Groups with 10 and under are suppressed for client privacy. ** Data has been secondarily suppressed to ensure suppressed cells cannot be deduced mathematically. Methodology for determining gender can be found in Appendix A1: Operational Definition and Parameters.*

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Appendix C10: Country of Birth Composition for Full Service Partnerships by County

		Adult				Child/TAY			
		Mexico	Other	United States	Unkonwn	Mexico	Other	United States	Unkonwn
Statewide	California	3,387	6,063	67,839	20,810	3,200	2,867	113,651	26,362
Region	Bay Area	316	1,068	9,133	3,500	358	447	8,829	3,755
	Central	945	1,563	15,464	1,688	274	326	14,468	3,270
	Los Angeles	716	1,739	14,449	11,790	402	567	18,489	12,831
	Southern	1,341	1,591	24,313	3,576	2,118	1,500	68,291	6,349
	Superior	69	102	4,480	256	48	27	3,574	157
County	Alameda	20	132	1,159	263	*	30	469	83
	Alpine			11				*	*
	Amador	*	*	165	*	*	*	91	*
	Berkeley City		*	99	88	*	*	42	51
	Butte	*	12	637	*	*	*	904	24
	Calaveras	*	*	246	*	*	*	194	*
	Colusa	*		42	**			**	*
	Contra Costa	38	77	618	93	83	38	1,028	132
	Del Norte		*	233	20		*	61	*
	El Dorado	*	*	470	*	*	*	615	20
	Fresno	109	98	2,529	505	38	23	1,959	1,589
	Glenn	24	*	320	*	19	*	463	*
	Humboldt	*	**	522	18		*	66	*
	Imperial	233	15	1,094	89	136	*	2,128	**
	Inyo			48	17	*		19	*
	Kern	184	114	2,690	122	90	42	3,772	48
	Kings	21	11	492	95	*	*	414	71
	Lake	*	*	345	*	*	*	158	*
	Lassen	*	*	69	*			28	
	Los Angeles	716	1,739	14,449	11,790	402	567	18,489	12,831
	Madera	**	*	362	65	**	*	454	45
	Marin	*	94	654	108	59	84	504	58
	Mariposa		*	77	*	*	*	176	*
	Mendocino	*	*	259		*	*	155	
	Merced	20	**	166	*	**	*	908	107
	Modoc	*	*	169	*	*		46	*
	Mono	*	*	88	*	*		46	*
	Monterey	33	33	507	405	**	*	514	435
	Napa	38	27	446	57	35	15	409	62
	Nevada	*	*	353	14	*	*	990	38

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	Adult				Child/TAY			
	Mexico	Other	United States	Unkonwn	Mexico	Other	United States	Unkonwn
Orange	78	345	2,684	914	287	293	4,302	1,655
Placer	*	19	638	71	11	20	859	142
Plumas	*	*	164	18			**	*
Riverside	155	191	4,152	203	100	49	5,997	139
Sacramento	34	666	3,580	42	17	162	2,720	25
San Benito	28	*	141	*	13	*	248	*
San Bernardino	87	117	3,115	425	167	73	9,817	1,567
San Diego	426	646	6,957	881	1,227	1,003	39,501	1,988
San Francisco	23	172	1,269	243	23	113	1,638	503
San Joaquin	472	498	2,638	495	75	53	2,647	999
San Luis Obispo	*	18	492	22	18	*	657	**
San Mateo				*	16	*	336	**
Santa Barbara	29	26	1,006	34	23	*	708	**
Santa Clara	96	420	2,270	1,975	58	104	1,434	1,540
Santa Cruz	*	**	219	121	*	*	131	78
Shasta	*	*	310	123		*	111	**
Sierra	*	*	44	*			12	
Siskiyou	*	14	715	**	*	*	344	*
Solano	14	69	974	110	12	29	1,080	100
Sonoma	12	15	777	32	*	11	996	30
Stanislaus	123	162	2,235	228	32	24	1,209	57
Sutter/Yuba	*	14	181	17	*	*	785	39
Tehama	*	*	217	*	*	*	67	*
Tri-City	56	41	630	707	31	20	544	682
Trinity		*	81	*			**	*
Tulare	78	23	810	80	32	*	960	128
Tuolumne		*	216	**			**	*
Ventura	88	78	1,493	179	39	*	865	**
Yolo	19	36	512	26	*	*	230	29

*N=244,179. Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once. * Groups with 10 and under are suppressed for client privacy. ** Data has been secondarily suppressed to ensure suppressed cells cannot be deduced mathematically. Methodology for determining country of birth can be found in Appendix A1: Operational Definition and Parameters.*

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Appendix C11: Primary Language Composition for Full Service Partnerships by Region

		Adult				Child/TAY			
		English	Other	Spanish	Unknown	English	Other	Spanish	Unknown
Statewide	California	77,165	3,986	4,545	12,403	101,291	2,594	13,599	28,596
Region	Bay Area	9,445	1,256	437	2,879	7,817	1,194	1,195	3,183
	Central	15,762	1,164	995	1,739	13,085	350	846	4,057
	Los Angeles	23,056	923	1,639	3,076	24,514	476	3,766	3,533
	Southern	24,782	590	1,419	4,030	53,057	553	7,694	16,954
	Superior	4,120	53	55	679	2,818	21	98	869
County	Alameda	1,449	67	42	16	546	17	24	*
	Alpine	*			*	*			*
	Amador	115	*	*	49	58			36
	Berkeley City	13			180	**	*		79
	Butte	583	*	*	64	771	*	**	128
	Calaveras	224	*	*	26	149	*	*	47
	Colusa	38		*	**	44		*	**
	Contra Costa	535	31	42	218	800	18	148	315
	Del Norte	218	*	*	38	50	*		**
	El Dorado	464	*	*	16	564	*	**	63
	Fresno	2,403	61	126	651	1,665	21	218	1,705
	Glenn	279	*	**	60	324	*	**	125
	Humboldt	538	*	*	*	66	*		*
	Imperial	1,033	*	254	**	1,620	*	457	**
	Inyo	43		*	**	15	*	*	*
	Kern	2,337	30	192	551	2,787	14	253	898
	Kings	442	*	22	152	297		28	170
	Lake	297		*	**	123	*	*	41
	Lassen	65	*	*	*	**			*
	Los Angeles	23,056	923	1,639	3,076	24,514	476	3,766	3,533
	Madera	332	*	**	107	331	*	**	163
	Marin	666	40	32	127	348	15	158	184
	Mariposa	71		*	*	126	*		**
	Mendocino	260	*	*	*	154		*	*
	Merced	176	*	*	16	617	11	51	360
	Modoc	142	*		**	26		*	**
	Mono	80	*	*	15	31		*	**
	Monterey	913	*	44	**	862	*	69	**
	Napa	385	*	**	148	274	*	**	164
	Nevada	330	*	*	43	688	*	*	341

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… continued	Adult				Child/TAY			
	English	Other	Spanish	Unknown	English	Other	Spanish	Unknown
Orange	3,455	163	94	309	4,518	197	703	1,119
Placer	705	*	*	11	908	*	**	68
Plumas	144	*	*	41	62		*	**
Riverside	4,176	67	188	270	4,961	22	517	785
Sacramento	3,602	493	50	177	2,404	189	66	265
San Benito	128		19	33	184		22	59
San Bernardino	3,166	73	93	412	8,905	39	563	2,117
San Diego	6,656	188	357	1,709	27,648	260	4,800	11,011
San Francisco	670	860	52	125	798	1,018	172	289
San Joaquin	3,086	450	514	53	3,117	81	162	414
San Luis Obispo	472	*		**	462	*	**	198
San Mateo	*				557	28	113	343
Santa Barbara	987	21	59	28	547	*	121	**
Santa Clara	2,549	190	135	1,887	1,332	63	236	1,505
Santa Cruz	323	*	**	17	190	*	19	*
Shasta	314	*	*	118	102	*		61
Sierra	45		*	*	12			
Siskiyou	589	*	*	142	282		*	**
Solano	1,014	29	19	105	992	17	75	137
Sonoma	799	11	15	11	919	*	82	**
Stanislaus	2,255	102	117	274	999	20	76	227
Sutter/Yuba	178	*	*	28	579	*	*	240
Tehama	202	*	*	20	62	*		**
Tri-City	991	18	93	332	797	*	205	272
Trinity	**			*	**			*
Tulare	822	*	**	85	849	*	**	155
Tuolumne	217	*		17	166			12
Ventura	1,509	25	89	215	812	*	**	241
Yolo	539	11	15	28	209	*	**	43

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Appendix C12: Primary Language Composition (English and Spanish) for Full Service Partnerships by Region

		Adult				Child/TAY			
		English	Other	Spanish	Unknown	English	Other	Spanish	Unknown
Statewide	California	77,165	3,986	4,545	12,403	101,291	2,594	13,599	28,596
Region	Bay Area	9,445	1,256	437	2,879	7,817	1,194	1,195	3,183
	Central	15,762	1,164	995	1,739	13,085	350	846	4,057
	Los Angeles	23,056	923	1,639	3,076	24,514	476	3,766	3,533
	Southern	24,782	590	1,419	4,030	53,057	553	7,694	16,954
	Superior	4,120	53	55	679	2,818	21	98	869

*Notes: N=244,179. Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once. * Groups with 10 and under are suppressed for client privacy. ** Data has been secondarily suppressed to ensure suppressed cells cannot be deduced mathematically. Methodology for determining primary language can be found in Appendix A1: Operational Definition and Parameters. County level composition is not presented for primary language as little county level data was shareable post data suppression. Data is suppressed for groups with 10 and under counts at the county level.*

Appendix C13: Percent of Partners with a Given Diagnosis by Age Group

	Anxiety	Bipolar And Related	Depressivs	Disruptive, Impulse-Control, Conduct	Neurodevelopmental	Other	Personality	Schizophrenia And Other Psychotic	Substance-Related And Addictive	Trauma-And Stressor-Related
					Adult					
Statewide	17%	39%	63%	4%	5%	26%	1%	69%	41%	26%
Bay Area	11%	30%	41%	3%	4%	25%	1%	62%	42%	25%
Central	19%	36%	60%	4%	6%	36%	1%	66%	39%	34%
Los Angele	13%	40%	74%	4%	3%	11%	0%	75%	35%	20%
Southern	21%	44%	65%	4%	6%	32%	1%	70%	50%	26%
Superior	23%	36%	52%	3%	9%	33%	1%	59%	28%	36%
					Child / TAY					
Statewide	27%	16%	61%	33%	31%	10%	0%	18%	14%	46%
Bay Area	24%	18%	55%	25%	25%	15%	1%	24%	17%	49%
Central	22%	17%	52%	30%	30%	13%	0%	21%	13%	48%
Los Angele	23%	19%	74%	46%	36%	6%	0%	24%	11%	48%
Southern	31%	13%	59%	31%	30%	10%	0%	13%	14%	44%
Superior	34%	19%	60%	29%	30%	16%	1%	18%	12%	57%

*Notes: Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once. * Groups with 10 and under are suppressed for client privacy. ** Data has been secondarily suppressed to ensure suppressed cells cannot be deduced mathematically. Methodology for determining primary language can be found in Appendix A1: Operational Definition and Parameters. County level composition is not presented for primary language as little county level data was shareable post data suppression. Data is suppressed for groups with 10 and under counts at the county level.*

Appendix C14: CSI Services Received by Age Group and Diagnosis Category

		Year				
	Age Group	2018	2019	2020	2021	2022
Anxiety Disorders	0-5	46	99	73	80	71
	6-15	1,877	2,405	2,149	2,129	2,122
	16-25	1,656	2,059	2,159	2,412	2,106
	26-64	1,145	1,256	1,374	1,591	1,508
	65+	241	243	250	267	262
Bipolar And Related Disorders	0-5	*	*	*		*
	6-15	203	216	222	200	154
	16-25	950	1,247	1,146	1,132	898
	26-64	3,035	3,734	3,564	3,442	3,013
	65+	455	494	470	517	435
Depressive Disorders	0-5	33	84	78	78	68
	6-15	3,864	5,444	4,966	4,724	3,944
	16-25	4,160	5,428	5,275	5,561	4,837
	26-64	4,099	5,451	5,039	4,831	4,207
	65+	823	1,013	985	995	819
Disruptive, Impulse-Control, And Conduct Disorders	0-5	77	110	72	68	52
	6-15	2,268	2,744	2,232	1,576	1,316
	16-25	891	1,149	1,079	906	633
	26-64	53	47	50	49	42
	65+	*	*	*	*	*
Neurodevelopmental Disorders	0-5	165	318	273	265	226
	6-15	2,751	3,321	3,018	2,550	2,466
	16-25	828	917	878	849	806
	26-64	273	281	291	261	232
	65+	25	20	24	26	26

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	Age Group	Year 2018	2019	2020	2021	2022
Other	0-5	13	*	16	*	*
	6-15	270	292	333	347	306
	16-25	400	477	501	591	565
	26-64	1,217	1,170	1,111	1,026	859
	65+	202	190	197	200	164
Personality Disorders	0-5					
	6-15	*	*	*	*	*
	16-25	14	27	24	22	12
	26-64	22	19	16	16	14
	65+	*	*	*	*	*
Schizophrenia And Other Psychotic Disorders	0-5	*	*	*	*	*
	6-15	130	128	140	122	110
	16-25	1,643	2,243	2,066	1,959	1,584
	26-64	10,753	13,531	13,383	13,468	12,205
	65+	1,307	1,520	1,566	1,657	1,511
Substance-Related And Addictive Disorders	0-5		*	*	*	*
	6-15	180	204	168	126	112
	16-25	1,364	1,562	1,455	1,229	852
	26-64	4,634	4,804	4,578	4,533	4,013
	65+	355	395	432	418	355
Trauma-And Stressor-Related Disorders	0-5	293	556	483	497	468
	6-15	2,762	4,300	4,185	3,855	3,543
	16-25	1,847	2,514	2,637	2,802	2,515
	26-64	2,241	2,590	2,680	2,781	2,533
	65+	205	252	231	279	247

*Notes: Data presented for all services received by individuals actively enrolled in an FSP between January 1, 2018 and December 31, 2022. * Groups with 10 and under are suppressed for client privacy. Diagnoses are not mutually exclusive and are calculated at the partnership level. Only primary and secondary diagnoses are included. It is possible that a partner may have more than two psychiatric diagnoses. Methodology for determining diagnoses can be found in Appendix A1: Operational Definition and Parameters.*

Appendix C15: Number of Holds by County Five Years Prior to Joining an FSP

		Adult			Child/TAY		
		Partnerships with at least one hold	Total Holds	% With at least One Hold	Partnerships with at least one hold	Total Holds	% With at least One Hold
	Statewide	5,739	13,337	17%	2923	5652	5%
Region	Bay Area	1,197	3,223	20%	417	988	8%
	Central	1,449	3,342	24%	530	1028	7%
	Los Angeles	269	474	3%	75	126	1%
	Southern	2,445	5,293	25%	1788	3242	5%
	Superior	379	1,005	27%	113	268	11%
County	Alameda	136	472	55%	435	1706	71%
	Alpine			0%			
	Amador			0%	*	*	*
	Berkeley City			0%			0%
	Butte	*	*	*	27	81	52%
	Calaveras	*	*	*	15	19	9%
	Colusa			0%	*	*	*
	Contra Costa	44	125	15%	121	310	43%
	Del Norte	12	42	52%	34	75	36%
	El Dorado	22	50	7%	69	174	49%
	Fresno	33	56	3%	66	116	5%
	Glenn	16	28	8%	22	32	13%
	Humboldt	22	93	88%	174	566	76%
	Imperial	*	*	*	*	*	*
	Inyo			0%			0%
	Kern	368	774	17%	576	1196	42%
	Kings	*	*	*	43	94	17%
	Lake	25	46	46%	37	94	39%
	Lassen						
	Los Angeles	75	126	1%	269	474	3%
	Madera	26	39	23%	20	47	17%
	Marin	*	*	*	12	13	4%
	Mariposa			0%	*	*	*
	Mendocino	*	*	*	*	*	*
	Merced	*	*	*	37	114	66%
	Modoc	*	*	*	16	24	29%
	Mono			0%	*	*	*
	Monterey	85	136	15%	176	365	35%
	Napa	41	65	31%	71	144	36%
	Nevada	12	21	4%	27	66	43%

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… continued	Adult			Child/TAY		
	Partnerships with at least one hold	Total Holds	% With at least One Hold	Partnerships with at least one hold	Total Holds	% With at least One Hold
Orange	18	32	1%	58	99	7%
Placer	21	50	4%	103	250	46%
Plumas	*	*	*	*	*	*
Riverside	414	765	12%	557	1425	31%
Sacramento	74	110	5%	378	660	26%
San Benito	*	*	*	*	*	*
San Bernardino	68	121	2%	118	249	16%
San Diego	799	1,287	3%	706	1159	22%
San Francisco	22	44	4%	52	93	13%
San Joaquin	70	150	5%	194	482	26%
San Luis Obispo	32	87	19%	82	237	48%
San Mateo	*	*	*			0%
Santa Barbara	33	55	9%	126	294	43%
Santa Clara	40	57	2%	170	260	6%
Santa Cruz						
Shasta	*	*	*	*	*	*
Sierra			0%	*	*	*
Siskiyou	*	*	3%	15	18	6%
Solano	32	66	7%	156	324	41%
Sonoma	*	*	*	*	*	*
Stanislaus	161	332	23%	432	1141	35%
Sutter/Yuba	61	117	25%	33	100	37%
Tehama			0%	*	*	*
Tri-City			0%	25	42	4%
Trinity			0%	*	*	*
Tulare	40	81	12%	32	98	46%
Tuolumne			0%	*	*	*
Ventura	45	92	44%	195	588	55%
Yolo	*	*	*	12	24	5%

*Notes: Data above includes individuals actively enrolled in an FSP between January 1, 2018 and December 31, 2022. Data represent the number of partnerships in each county where clients had at least one hold in the five years prior to completing a PAF. Total hold is the total holds received by those individuals in the five years prior to completing a PAF. Percent with at least one hold is the percent of total partnerships in the county where clients have at least one hold in the five years prior to completing a PAF. * Groups with 10 and under are suppressed for client privacy. Methodology for determining inpatient holds can be found in Appendix A1: Operational Definition and Parameters.*

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Appendix C16: Emergency Department Visits by County Prior to Joining an FSP

		Adult			Child/TAY		
		PARTNERSHIPS	TOTAL VISITS	% AT LEAST ONE	PARTNERSHIPS	TOTAL VISITS	% AT LEAST ONE
Statewide		27,154	431,889	81.5%	26,184	127,142	42.9%
Region	Bay Area	4,048	76,969	69.0%	2,497	16,105	47.4%
	Central	5,163	89,137	84.4%	3,462	23,162	48.8%
	Los Angeles	8,855	130,824	85.6%	5,402	27,404	49.3%
	Southern	7,881	119,971	82.1%	14,228	56,364	38.8%
	Superior	1,207	14,988	86.1%	595	4,107	56.7%
County	Alameda	571	15,393	93.6%	202	2,331	81.1%
	Alpine						0.0%
	Amador	23	180	92.0%	*	*	*
	Berkeley City	*	*	*	*	*	*
	Butte	51	994	98.1%	89	599	70.1%
	Calaveras	155	1,729	95.7%	75	513	65.2%
	Colusa	19	175	55.9%	2	17	50.0%
	Contra Costa	261	6,715	92.2%	239	2,207	80.5%
	Del Norte	84	1,176	89.4%	21	262	91.3%
	El Dorado	133	1,591	95.0%	150	787	45.5%
	Fresno	906	16,302	74.1%	423	3,615	40.5%
	Glenn	137	1,528	80.6%	102	472	49.8%
	Humboldt	211	3,070	92.1%	25	260	100.0%
	Imperial	119	1,084	77.8%	431	2,658	69.3%
	Inyo	*	*	*	*	*	*
	Kern	1,194	17,558	86.6%	1,133	6,274	51.4%
	Kings	220	3,720	85.9%	99	535	50.5%
	Lake	79	858	83.2%	37	292	68.5%
	Lassen						
	Los Angeles	8,855	130,824	85.6%	5,402	27,404	49.3%
	Madera	55	630	46.6%	45	219	40.5%
	Marin	254	3,567	77.4%	110	637	43.5%
	Mariposa	16	261	94.1%	11	57	36.7%
	Mendocino	94	1,542	92.2%	37	356	78.7%
	Merced	48	936	85.7%	116	602	47.9%
	Modoc	46	608	83.6%	*	*	*
	Mono	16	180	84.2%	*	*	*
	Monterey	437	6,160	87.6%	258	1,520	44.5%
	Napa	154	2,043	79.0%	69	289	51.5%
	Nevada	54	464	85.7%	103	538	36.4%

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...continued	Adult			Child/TAY		
	PARTNERSHIPS	TOTAL VISITS	% AT LEAST ONE	PARTNERSHIPS	TOTAL VISITS	% AT LEAST ONE
Orange	743	9,762	86.5%	551	2,745	38.8%
Placer	205	3,581	90.7%	220	1,173	41.7%
Plumas	62	637	83.8%	16	118	76.2%
Riverside	1,548	21,214	87.2%	1,605	7,422	48.1%
Sacramento	1,290	27,608	89.2%	989	7,239	69.9%
San Benito	61	597	83.6%	46	231	38.0%
San Bernardino	559	6,393	74.1%	1,144	4,734	30.2%
San Diego	2,577	46,513	81.3%	8,791	28,090	36.6%
San Francisco	347	13,278	86.8%	320	2,655	51.9%
San Joaquin	630	10,168	85.8%	519	2,501	33.6%
San Luis Obispo	160	3,049	94.1%	90	864	53.3%
San Mateo	*	*	*	108	390	35.4%
Santa Barbara	259	3,582	88.1%	190	1,254	52.8%
Santa Clara	1,413	19,210	51.0%	560	2,853	32.5%
Santa Cruz						
Shasta	85	1,061	78.0%	29	397	63.0%
Sierra	*	*	*	*	*	*
Siskiyou	203	2,015	87.5%	123	705	63.4%
Solano	323	5,977	85.4%	327	1,715	66.7%
Sonoma	225	4,013	90.7%	257	1,264	56.1%
Stanislaus	1,098	17,308	89.1%	423	3,505	60.9%
Sutter/Yuba	71	879	78.9%	135	750	54.4%
Tehama	56	622	94.9%	*	*	*
Tri-City	398	5,443	57.9%	223	1,533	36.5%
Trinity	20	210	83.3%			0.0%
Tulare	44	634	62.9%	120	543	34.9%
Tuolumne	70	1,168	90.9%	67	377	58.8%
Ventura	324	5,373	91.3%	70	790	68.6%
Yolo	179	2,254	81.7%	56	674	53.3%

*Notes: Data above includes individuals actively enrolled in an FSP between January 1, 2018 and December 31, 2022. Data represent the number of emergency department (ED) visits in each county where clients had at least one ED visit in the five years prior to completing a PAF. Total hold is the total ED visits by those individuals in the five years prior to completing a PAF. Percent with at least one visit is the percent of total partnerships in the county where clients have at least one ED visit in the five years prior to completing a PAF. * Groups with 10 and under are suppressed for client privacy. Methodology for determining inpatient holds can be found in Appendix A1: Operational Definition and Parameters.*

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Appendix C17: FSP Clients Who Have Ever Indicated They Were Homeless

		Adult		Child / TAY	
		Ever Homeless	% of Clients	Ever Homeless	% of Clients
	Statewide	61,315	60.8%	49,163	32.1%
Region	Bay Area	8,986	62.0%	4,474	31.9%
	Central	11,512	57.3%	6,924	36.6%
	Los Angeles	19,654	66.5%	11,029	33.0%
	Southern	18,470	58.4%	24,972	30.0%
	Superior	2,693	53.7%	1,764	44.7%
County	Alameda	1,210	75.0%	370	60.2%
	Alpine	*	*	*	*
	Amador	96	53.4%	34	34.6%
	Berkeley City	153	77.1%	32	32.4%
	Butte	314	45.4%	459	48.1%
	Calaveras	153	54.7%	105	49.3%
	Colusa	32	52.9%	19	27.4%
	Contra Costa	582	68.1%	489	37.5%
	Del Norte	164	62.5%	41	63.1%
	El Dorado	286	56.8%	308	46.8%
	Fresno	2,083	61.4%	867	23.5%
	Glenn	143	40.0%	192	38.9%
	Humboldt	364	64.5%	49	66.7%
	Imperial	343	21.9%	580	24.4%
	Inyo	20	29.2%	*	*
	Kern	1,632	52.9%	1,748	42.4%
	Kings	254	39.5%	128	26.4%
	Lake	208	55.6%	100	58.2%
	Lassen	42	56.9%	18	64.3%
	Los Angeles	19,654	66.5%	11,029	33.0%
	Madera	223	44.2%	161	29.6%
	Marin	587	66.2%	240	33.5%
	Mariposa	49	59.8%	81	43.8%
	Mendocino	175	59.9%	115	70.4%
	Merced	133	64.1%	286	26.0%
	Modoc	59	31.5%	13	26.7%
	Mono	26	24.8%	*	*
	Monterey	593	59.7%	375	35.2%
	Napa	360	61.5%	199	37.2%
	Nevada	238	62.8%	408	36.7%

…continued	Adult		Child / TAY	
	Ever Homeless	% of Ever Clients	Ever Homeless	% of Ever Clients
Orange	3,363	82.5%	3,679	55.5%
Placer	545	73.4%	396	37.2%
Plumas	81	43.3%	27	30.9%
Riverside	3,054	62.4%	2,240	34.4%
Sacramento	2,962	68.5%	1,527	51.4%
San Benito	47	24.2%	70	25.7%
San Bernardino	1,851	47.2%	4,284	36.5%
San Diego	5,611	61.6%	10,994	23.2%
San Francisco	1,367	78.8%	796	33.7%
San Joaquin	1,911	45.5%	1,502	38.5%
San Luis Obispo	389	72.4%	332	47.1%
San Mateo		0.0%	250	23.2%
Santa Barbara	512	45.3%	314	40.6%
Santa Clara	2,737	55.1%	758	23.2%
Santa Cruz	183	49.0%	100	43.0%
Shasta	267	58.3%	92	55.6%
Sierra	16	32.0%	*	*
Siskiyou	434	57.5%	164	44.0%
Solano	629	52.6%	432	32.3%
Sonoma	538	63.6%	363	33.2%
Stanislaus	1,728	60.9%	612	40.2%
Sutter/Yuba	86	36.9%	281	32.2%
Tehama	101	41.7%	45	59.5%
Tri-City	951	64.1%	461	33.8%
Trinity	55	61.6%	17	59.3%
Tulare	397	36.2%	406	34.2%
Tuolumne	132	53.6%	82	42.8%
Ventura	764	40.1%	340	29.8%
Yolo	423	71.3%	131	47.4%

*Notes: N=244,179. Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once. * Groups with 10 and under are suppressed for client privacy. Methodology for determining homelessness can be found in Appendix A1: Operational Definition and Parameters.*

Appendix C18: Annual Enrollment of Full Service Partnerships by Age Group

		Exit Reason							
	Type of Disorder	Deceased	Discontinue	Institution	Justice Involved	Met Goals	Moved	Not Located	Target Criteria
Adult	Anxiety	309	746	190	284	1,463	517	913	278
	Bipolar And Related	658	1,344	560	670	2,320	1,045	1,751	439
	Depressive	1,096	2,287	751	985	4,222	1,572	3,035	741
	Disruptive, Impulse-Control, And Conduc	71	208	99	187	319	127	312	74
	Neurodevelopmental	82	231	115	171	374	158	280	115
	Other	516	733	459	411	1,317	564	927	344
	Personality	*	24	11	14	48	16	16	*
	Schizophrenia And Other Psychoti	1,340	2,351	1,302	1,289	4,169	1,752	3,268	851
	Substance-Related And Addictive	943	1,335	682	880	2,111	1,015	2,240	547
	Trauma-And Stressor-Related	448	1,098	310	509	1,920	764	1,559	391
Child / TAY	Anxiety	21	2,752	316	236	6,921	1,116	1,969	451
	Bipolar And Related	24	839	260	197	1,198	571	644	158
	Depressive	69	5,262	799	565	11,442	2,367	3,900	894
	Disruptive, Impulse-Control, And Conduc	23	2,451	497	466	5,176	1,083	1,762	507
	Neurodevelopmental	24	2,491	430	286	6,360	1,178	1,725	535
	Other	14	612	123	79	1,232	339	398	141
	Personality		16	*	*	41	11	14	*
	Schizophrenia And Other Psychoti	40	840	257	247	1,239	573	782	169
	Substance-Related And Addictive	38	1,003	216	370	1,155	442	1,034	145
	Trauma-And Stressor-Related	41	4,059	652	465	10,024	2,142	3,055	871

*Note: N=244,179. Diagnoses are not mutually exclusive and are calculated at the partnership level. Only primary and secondary diagnoses are included. It is possible that a partner may have more than two psychiatric diagnoses. * Groups with 10 and under are suppressed for client privacy. Methodology for determining diagnoses can be found in Appendix A1: Operational Definition and Parameters.*

Appendix C19: Crisis Services One Year Prior and One Year Post Joining an FSP

		CRISIS SERVICES		
		PRE	POST	RATIO
Statewide	California	80,581	73,266	0.91
Region	Bay Area	7,067	8,894	1.26
	Central	19,137	16,624	0.87
	Los Angeles	17,006	19,612	1.15
	Southern	30,129	22,442	0.74
	Superior	7,242	5,694	0.79
County	ALAMEDA	2,179	4,783	2.20
	ALPINE	*	*	*
	AMADOR	272	207	0.76
	BERKELEY CITY	21	22	1.05
	BUTTE	2,455	2,044	0.83
	CALAVERAS	700	467	0.67
	COLUSA	71	33	0.46
	CONTRA COSTA	350	651	1.86
	DEL NORTE	521	308	0.59
	EL DORADO	807	786	0.97
	FRESNO	2,242	2,266	1.01
	GLENN	366	392	1.07
	HUMBOLDT	1,034	775	0.75
	IMPERIAL	1,456	1,422	0.98
	INYO	15	13	0.87
	KERN	2,272	2,170	0.96
	KINGS	800	576	0.72
	LAKE	283	186	0.66
	LASSEN	136	14	0.10
	LOS ANGELES	17,006	19,612	1.15
	MADERA	666	450	0.68
	MARIN	54	117	2.17
	MARIPOSA	176	51	0.29
	MENDOCINO	366	273	0.75
	MERCED	322	193	0.60
	MODOC	267	310	1.16
	MONO	15	37	2.47
	MONTEREY	1,793	888	0.50
	NAPA	115	64	0.56
	NEVADA	482	407	0.84

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	CRISIS SERVICES		
	PRE	POST	RATIO
… continued			
ORANGE	11,673	6,651	0.57
PLACER	1,024	773	0.75
PLUMAS	176	122	0.69
RIVERSIDE	4,245	4,431	1.04
SACRAMENTO	1,444	2,884	2.00
SAN BENITO	415	273	0.66
SAN BERNARDINO	4,033	2,606	0.65
SAN DIEGO	2,610	2,194	0.84
SAN FRANCISCO	231	672	2.91
SAN JOAQUIN	5,840	3,307	0.57
SAN LUIS OBISPO	601	402	0.67
SAN MATEO	*	*	*
SANTA BARBARA	1,425	896	0.63
SANTA CLARA	665	531	0.80
SANTA CRUZ	165	50	0.30
SHASTA	333	223	0.67
SIERRA	25	29	1.16
SISKIYOU	606	483	0.80
SOLANO	499	289	0.58
SONOMA	579	554	0.96
STANISLAUS	2,475	2,704	1.09
SUTTER/YUBA	226	125	0.55
TEHAMA	26	11	0.42
TRI-CITY	817	942	1.15
TRINITY	95	84	0.88
TULARE	1,262	1,097	0.87
TUOLUMNE	385	260	0.68
VENTURA	997	728	0.73
YOLO	463	425	0.92

Note: The above data include all adult (26 years and older) partnerships originated between Jan 1 2012 and Dec 31st 2022. Pre services are calculated as the total services received between the date of partnership and 365 days prior. Post services are calculated as total services received within 365 days of the day after partnership.

Commission for Behavioral Health

Appendix C20: Inpatient Psychiatric Holds Pre and Post Joining an FSP

		Admissions			Days Admitted		
		PRE	POST	RATIO	PRE	POST	RATIO
Statewide	California	85,590	58,638	0.69	818653	568348	0.69
Region	Bay Area	8,663	5,833	0.67	90902	61115	0.67
	Central	17,851	11,485	0.64	196397	139371	0.71
	Los Angeles	31,476	22,516	0.72	269234	180252	0.67
	Southern	24,686	16,888	0.68	231700	165015	0.71
	Superior	2,914	1,916	0.66	30420	22595	0.74
County	ALAMEDA	1,687	1,272	0.75	16526	12397	0.75
	AMADOR	41	36	0.88	293	252	0.86
	BERKELEY CITY	30	15	0.50	268	168	0.63
	BUTTE	854	495	0.58	8689	4888	0.56
	CALAVERAS	95	86	0.91	668	820	1.23
	COLUSA	24	13	0.54	196	45	0.23
	CONTRA COSTA	762	471	0.62	7229	4339	0.60
	DEL NORTE	106	93	0.88	1041	1303	1.25
	EL DORADO	350	320	0.91	4781	4904	1.03
	FRESNO	4,080	2,978	0.73	30740	23497	0.76
	GLENN	123	106	0.86	862	763	0.89
	HUMBOLDT	678	351	0.52	6932	6208	0.90
	IMPERIAL	294	289	0.98	1806	1655	0.92
	INYO	*	*	*	19	7	0.37
	KERN	2,761	1,827	0.66	25838	21459	0.83
	KINGS	308	208	0.68	2594	1917	0.74
	LAKE	150	106	0.71	1789	1320	0.74
	LASSEN	24	30	1.25	227	242	1.07
	LOS ANGELES	31,476	22,516	0.72	269234	180252	0.67
	MADERA	217	161	0.74	2187	1969	0.90
	MARIN	524	368	0.70	5397	4058	0.75
	MARIPOSA	40	20	0.50	351	125	0.36
	MENDOCINO	120	80	0.67	1318	777	0.59
	MERCED	320	182	0.57	2683	1412	0.53
	MODOC	66	46	0.70	735	358	0.49
	MONO	*	*	*	43	19	0.44
	MONTEREY	707	504	0.71	5862	3754	0.64
	NAPA	249	208	0.84	2160	1963	0.91
	NEVADA	177	114	0.64	1909	1571	0.82

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...continued	Admissions			Days Admitted		
	PRE	POST	RATIO	PRE	POST	RATIO
ORANGE	2,946	2,146	0.73	28129	24423	0.87
PLACER	873	512	0.59	9202	6329	0.69
PLUMAS	33	25	0.76	232	265	1.14
RIVERSIDE	3,555	2,667	0.75	27452	22673	0.83
SACRAMENTO	5,017	2,734	0.54	84183	55490	0.66
SAN BENITO	87	49	0.56	542	344	0.63
SAN BERNARDINO	2,453	1,617	0.66	15309	10202	0.67
SAN DIEGO	9,288	6,002	0.65	105722	66271	0.63
SAN FRANCISCO	1,321	941	0.71	17365	11078	0.64
SAN JOAQUIN	1,358	928	0.68	13601	7519	0.55
SAN LUIS OBISPO	598	367	0.61	4483	2258	0.50
SAN MATEO	*	*	*	*	*	*
SANTA BARBARA	747	382	0.51	7963	3890	0.49
SANTA CLARA	1,640	1,015	0.62	19018	12025	0.63
SANTA CRUZ	123	54	0.44	1168	594	0.51
SHASTA	221	180	0.81	3785	2922	0.77
SIERRA	*	*	*	66	68	1.03
SISKIYOU	221	187	0.85	1499	1290	0.86
SOLANO	994	552	0.56	10554	6614	0.63
SONOMA	537	384	0.72	4808	3781	0.79
STANISLAUS	3,629	2,334	0.64	28434	23240	0.82
SUTTER/YUBA	169	100	0.59	2442	1928	0.79
TEHAMA	72	60	0.83	642	386	0.60
TRI-CITY	1,205	980	0.81	8041	6334	0.79
TRINITY	39	19	0.49	498	189	0.38
TULARE	717	450	0.63	7453	5271	0.71
TUOLUMNE	186	152	0.82	1819	1402	0.77
VENTURA	839	611	0.73	6957	5850	0.84
YOLO	439	274	0.62	4904	3270	0.67

Note: The above data include all adult (26 years and older) partnerships originated between January 1, 2012 and December 31, 2022. Pre services are calculated as the total services received between the date of partnership and 365 days prior. Post services are calculated as total services received within 365 days of the day after partnership.

Appendix D: FSP Case Study Protocol

MHSOAC Learning Objectives:

1) What are the current processes for collecting, inputting and extracting client data?
2) What challenges exist in this process?
3) What solutions have counties developed to address these challenges?
4) How is data currently being used by providers to measure client progress?
    a. What data would be helpful to providers to better serve clients?
5) How is data currently being used by counties to measure provider success?
    a. What data would be helpful to you to counties to better measure provider progress?

Hello, my name is _____ and I'm with the Mental Health Services Oversight and Accountability Commission. One of our roles is to report to the Legislature on ways to improve outcomes for FSP partners. Over the past year, we have done extensive community engagement to better understand the needs of counties and identify ways they could be supported to improve client outcomes. We are here trying to better understand the clinical monitoring and accountability structures you currently have in place. This is not an audit in any way. It is purely a learning opportunity for us, and we are thankful for your participation. We do plan on sharing our learnings in a report, but we will not include any identifiable information about you. You should feel free to share as much information as you feel comfortable sharing. Before we proceed, do you have any questions for me?

Answer any questions they may have. If they have a question you cannot answer on the spot, ask if you can get back to them at a later date once you've had a chance to look into their question. Once their questions have been answered proceed.

Is it okay if I ask you some questions about your current data reporting and monitoring practices?

If no, thank them for their time and offer to speak with them in the future if they change their mind. Provide a business card.

If yes, proceed to the appropriate question block.

Data Collection

TIME_____ Meeting with_____

A. Do you currently collect client-level data? If yes, ask the following. If not, proceed to B.

Can you talk to me a little bit about how you currently collect client data? *For example, by hand, on a laptop etc.*

Does your data collection process differ if you are in the field versus on site somewhere? If so, how?

Do you think the data collection process could be improved? If so, how?

B. Do you currently input client data into the DCR? If yes, ask the following. If not, proceed to C.

How frequently do you enter client data into the DCR? For example, after each meeting, once a week, once a month? If you don't enter data into the DCR, how often do you input it into another data tracking system you may use?

When entering data, do you work from notes or from memory?

What has your experience been like entering data into the DCR?

Have you encountered any specific challenges or barriers to getting data into the DCR?

How do you think the state could improve its current data collection and reporting system?

C. Do you currently input client data into another EHR? If so, what system is that? If not, proceed to D.

How often do you input data into this EHR system?

When entering data, do you work from notes or from memory?

What has your experience been like entering data into the EHR?

Have you encountered any specific challenges or barriers to getting data into this EHR?

How do you think the state could improve its current data collection and reporting system?

D. Is there anything else you would like to share that I haven't asked?

Data Reporting

TIME_____ Meeting with_____

A. Do you currently pull data for FSP service providers? If yes, ask the following. If not, proceed to B.

What systems do you use to generate the data?
Can you talk to me a little bit about what data you pull and how it is used?
Do you experience any challenges in getting quality data from these systems? If so, what are those challenges?
Is there any data you'd like to have that you currently do not have access to?

B. Do you currently pull data for FSP or county supervisors or other individuals monitoring FSP performance? If yes, ask the following. If not, proceed to C.

Who are you typically pulling data for? What's their role?
Can you talk to me a little bit about what data you pull and how it is used?
What form do you usually present those data? For instance, as raw data, as tables/figures, in a short report form etc.?
Is there any data you'd like to have that you currently do not have access to?

C. Is there anything else you would like to share that I haven't asked?

Data Monitoring

TIME_____ Meeting with_____

A. Do you currently use data to measure FSP client progress or outcomes? If yes, ask the following. If not, proceed to B.

What are the key client outcomes you currently track?
Who pulls these data for you and how often?
What form do you usually get these data? For instance, as raw data, as tables/figures, in a short report form etc.?
Are there any client-level data you'd like to have that you currently do not have?

B. Do you currently set performance goals for your FSP providers? If yes, ask the following. If not, proceed to C.

What data do you currently use to set these goals?
Who pulls these data for you and how often?
What form do you usually get these data? For instance, as raw data, as tables/figures, in a short report form etc.?
Is there any data you'd like to have that you currently do not have access to?

C. Is there anything else you would like to share that I haven't asked?