TUOLUMNE COUNTY BEHAVIORAL HEALTH ADVISORY BOARD
REGULAR MEETING AGENDA

Time: Wednesday, October 2, 2024 @ 4:00 p.m.
Place: Tuolumne County A.N. Francisco Building - 48 Yaney Ave., 3rd Floor, Committees & Commissions Conference Room, Sonora, CA 95370

In order to assure public participation for Tuolumne County citizens, this Behavioral Health Advisory Board meeting will be available in person to the public at the address identified above. However, the public may participate and comment on any item via teleconference, U.S. Mail, email, or video conferencing through the Zoom platform at the following link:

Zoom (Video or Audio):
https://tuolumne-ca-gov.zoom.us/j/82093545402?pwd=ShPPXVISRDbPl7HS4beCg7e6VlZSzI.1
Meeting ID: 820 9354 5402 Passcode: 044368
Telephone (one tap mobile) +16694449171,,82093545402#,,,,*044368# US
Or Dial by your location +1 669 444 9171 US

Email: Email your comments to Attn: Pandora Armbruster at behavioralhealth@tuolumnecounty.ca.gov
U.S. Mail: Mail your comments to Attn: Behavioral Health Advisory Board, 2 S. Green St., Sonora CA 95370. Written comments must be received no later than 8:00 a.m. on the morning before the noticed meeting.
Important Public Notice: Under CA Assembly Bill 2449's amendments to the Brown Act, through very limited circumstances, some members of the Tuolumne County Advisory Board may participate by teleconference.

AGENDA

BOARD OF SUPERVISOR'S REPRESENTATIVE/ CHAIRPERSON
Ryan Campbell

ALTERNATE REPRESENTATIVE/ VICE CHAIR
Daniel Anaiah Kirk

MEMBERS
Cathie Peacock
Elizabeth Marum
Jenn Salazar
Marshall Romeo
Maureen Woods
Sherry Bradley
Terry Garcia
Valerie Shuemake

1. **CALL TO ORDER**
2. **CONSIDERATION AND APPROVAL OF SHERRY BRADLEY'S REQUEST TO APPEAR REMOTELY FOR "JUST CAUSE" UNDER GOVERNMENT CODE §54953.**
3. **ROLL CALL & INTRODUCTIONS**
4. **GENERAL PUBLIC COMMENT** (3 minutes per person)
   Members of the public may be heard on any item, **not** on the Board's Agenda. A person addressing the Board will be limited to three minutes. Comments by members of the public on any item on the agenda will only be allowed during consideration of the item by the Board.
5. **APPROVAL OF MINUTES**
   - Draft Minutes of the September 4, 2024, Meeting
6. **BEHAVIORAL HEALTH DIRECTOR'S REPORT** - Tami Mariscal
7. **BEHAVIORAL HEALTH STAFF REPORT** – Lindsey Lujan
8. **NEW BUSINESS**
   - 2024 Data Notebook – Review data and complete survey questions.
9. **CONTINUED BUSINESS**
   - Update on Site Visit @ Aegis Medication Assisted Treatment (MAT) Center: Site Team = Supervisor Ryan Campbell, Marshall Romeo, Maureen Woods, Elizabeth Marum, Cathie Peacock (alternate).
   - Update on the Annual Report to the Board of Supervisors
10. **BEHAVIORAL HEALTH ADVISORY BOARD MEMBERS' REPORTS**
11. **NEXT MEETING -** Wednesday, November 6, 2024 @ 4 pm – Tuolumne County A.N. Francisco Building – 3rd Floor Committees & Commissions Conference Room
12. **ADJOURNMENT**

Tuolumne County Behavioral Health Advisory Board
(Minutes of the meeting of September 4, 2024)
DRAFT

2024 BHAB Membership	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Ryan Campbell - BOS	Meeting Cancelled	✓	✓	✓	Meeting Cancelled	✓	✓	✓	✓			
Anaiah Kirk – BOS Alt		E	E	E		E	E	E	E			
Cathie Peacock		E	✓	E		✓	✓	✓	E			
Elizabeth Marum		E	✓	E		E	E	✓	✓			
Jenn Salazar		✓	E	✓		✓	✓	✓	E			
Maureen Woods		✓	✓	✓		✓	✓	✓	✓			
Marshall Romeo		---	✓	✓		✓	✓	✓	✓			
Sherry Bradley		✓	E	✓		✓	✓	✓	E			
Terry Ann Garcia		✓	✓	✓		✓	✓	E	✓			
Valerie Shuemake		✓	E	✓		E	✓	E	✓			

Present = ✓ Absent = A Excused = E Virtual Attendance = V 9 MHAB Members, 1 BOS Alternate

Tuolumne County Staff in Attendance
Tami Mariscal, Director – Behavioral Health Department
Pandora Armbruster, Administrative Technician – Behavioral Health Department
Others in Attendance
Mystery Bradford, community member
Katrina Olvera, Executive Director – CalPride Sierras
Marisa Caratachea, Behavioral Health Director - Tuolumne Me-Wuk Indian Health Center
One other community member was also in attendance who chose not to introduce themselves

1. CALL TO ORDER & ROLL CALL/INTRODUCTIONS

Behavioral Health Advisory Board Chair, Ryan Campbell, called the meeting to order at 4:19 pm. Six members were present and accounted for at the time of roll call, completing a quorum for the Board. Those present were Ryan Campbell-District 2 Supervisor, Elizabeth Marum, Marshall Romeo, Maureen Woods, Terry Ann Garcia, and Valerie Shuemake. Cathie Peacock, Jenn Salazar, and Sherry Bradley were not in attendance.

The Behavioral Health Advisory Board members in attendance introduced themselves to all present.

Introductions were made by Tuolumne County staff in attendance, as follows: Tami Mariscal, Behavioral Health Director; and Pandora Armbruster, Administrative Support to the Behavioral Health Advisory Board.

2. GENERAL PUBLIC COMMENT:

Members of the public may be heard on any item not on the Board's Agenda. A person addressing the Board will be limited to **three minutes**. Comments by members of the public on any item on the agenda will only be allowed during consideration of the item by the Board.

Mystery Bradford commented on the current sweep of the homeless camp that started at 9 am today and should be complete by 3 pm. She expressed concern that RV placements are given priority to be placed in shaded areas vs. those housed in tents. She would also like to see more behavioral health outreach efforts at community events such as the local Farmer's Markets.

A community member shared concern regarding the Board of Supervisors proclamation for Suicide Prevention Month being scheduled for the end of the month. She feels that the proclamation should be in place at the beginning of the month to improve awareness.

3. APPROVAL OF MINUTES

A motion was made by Maureen Woods and seconded by Valerie Shuemake to accept the July 3, 2024, Behavioral Health Advisory Board Meeting Minutes as amended and to approve the August 7, 2024, Behavioral Health Advisory Board Meeting Minutes as presented. The motion passed.

(Ayes: 6 – Supervisor Campbell, Cathie Peacock, Jenn Salazar, Maureen Woods, Marshall Romeo, and Sherry Bradley. Nays: 0 Members Absent: 3 – Elizabeth Marum, Terry Ann Garcia, and Valerie Shuemake)

4. PUBLIC SPEAKER PRESENTATION – Marisa Caratachea, MSC, LMFT – Director of Behavioral Health for Tuolumne Me-Wuk Indian Health Center

After an introduction by Marshall Romeo, Behavioral Health Advisory Board member, Marisa Caratachea, Director of Behavioral Health for Tuolumne N\Me0Wuk Indian Health Center, shared a PowerPoint presentation with the group that provided an overview of her department. A copy of that PowerPoint will be included within these minutes.

The group discussed the services and staff coverage at the clinic. Several questions were posed regarding timeliness of service delivery and acceptance of different types of insurance. It was noted that they are still pending Drug Medi-Cal certification.

The group thanked Marisa for her time and the information shared. She was invited to attend future meetings if interested.

5. BEHAVIORAL HEALTH DIRECTOR'S REPORT – Tami Mariscal, Behavioral Health Director

Tami Mariscal, Behavioral Health Director, informed the group that September is Suicide Prevention Month, a time dedicated to raising awareness, promoting resources, and fostering conversations to help prevent suicide. It's an opportunity to support those struggling with mental health challenges and to remind everyone that help is available, and hope is possible. To make the conversation about suicide less intimidating there are countless efforts underway through Behavioral Health and other community partners such as:

Columbia College Wellness Fair Sept. 10, 10-2pm; Hope and Honor Walk Sept. 14th 9-11am; Youth MH First Aid Sept. 26th 8-4:30pm; TCBH Suicide Prevention Awareness Month Event 27th 10-2pm; MH Coffee Talk, last Friday of each month 8-10am.

Since August 7th, Behavioral Health has conducted outreach at the homeless encampment near the Justice Center every Wednesday. So far, we have engaged with 9 individuals, providing them with information about available resources and our services. Along with the information, the Crisis Access Intervention Program (CAIP) team has distributed essential items like water, granola bars, and mandarin oranges. The individuals we encountered were generally welcoming, and staff felt appreciated. The outcomes of these outreach efforts vary—some individuals expressed interest in coming in for services soon, while others declined but shared their needs such as tarps and water. Additionally, some mentioned that Social Services visits weekly. The team noted the presence of several veterans, two of whom shared they are working to regain their benefits. Interestingly, we also encountered several people who are either Walmart employees or fast-food workers who live in the camp. In addition to outreach efforts, various Behavioral Health staff regularly visit the camp as they continue the delicate and often lengthy process of building engagement with individuals.

The Behavioral Health Department has regularly scheduled hours set at the Community Resilience Centers to increase outreach efforts. Those hours are as follows:

Tuolumne – Second Friday of each month 9-12pm

Groveland - Third Thursday of each month 1-4pm

The Behavioral Health dedicated office in Tuolumne will also be available for one on one meetings.

Leadership recently analyzed the no show rate compared to the Tuolumne County Behavioral Health Assessment calendar to ensure proper capacity to meet the rate of requested services. It was determined that there are 25 intake slots per week that can meet the current demand.

Tami provided the group a progress report on the Behavioral Health Bridge Housing (BHBH). She noted that there is significant progress being made in preparing the property for occupancy. The housing team has completed the administrative infrastructure required to manage tenants, including drafting key documents such as tenant agreements, leases, housing rules, the Tenant House Manual, and policies and procedures. Additionally, a dedicated phone line for housing concerns has been established. At Parrots Ferry Property, House Two is nearly ready, pending a gas line inspection. Once approved, two tenants are prepared to move in. So far, 17 housing applications have been completed.

6. BEHAVIORAL HEALTH STAFF REPORT

No Staff Reports were received at this meeting.

7. NEW BUSINESS

Marshall Romeo shared the Sexual Orientation & Gender Identity (SOGI) Data Action Plan with the group. A copy of that plan is included within these minutes. The group discussed the Behavioral Health Department's compliance with this plan and the need for this information. It was noted that the department has been collecting this type of

data for quite some time. The department relayed that what information that can be shared is contained within the External Quality Review Organization (EQRO) reports. As a small county, some numbers may not be revealed as the department cannot disclose them due to privacy concerns.

8. CONTINUED BUSINESS:

The group discussed potential dates for the next Site Visit scheduled at the Aegis Medication Assisted Treatment (MAT) Center. A tentative date was proposed for Monday, September 23, 2024, at 1:00 pm to the Site Visit Team (Supervisor Campbell, Marshall Romeo, Elizabeth Marum, and alternates Cathie Peacock, and Maureen Woods) to determine their availability. Once an official date and time has been confirmed with the provider, Pandora will reach out to the team with directions, a copy of the contract, Site Visit forms and protocol instructions.

7. BEHAVIORAL HEALTH ADVISORY BOARD MEMBERS' REPORTS:

Valerie Shuemake provided an update on a concern raised by the public about security guards located at the Adventist Health Sonora Hospital. She informed the group that security is in place to assure the safety of the public and staff. Their presence is mostly a deterrent, they are not police. She also shared information of new grant funded positions for substance use disorder navigators and additional funding in place for a housing specialist.

8. NEXT MEETING

The next regular Tuolumne County Behavioral Health Advisory Board meeting is scheduled for October 2, 2024, at 4:00 pm. Detailed meeting information will be provided on the October Behavioral Health Advisory Board Meeting Agenda.

9. ADJOURNMENT

The September 4, 2024, Behavioral Health Advisory Board meeting was adjourned at 5:35 pm.

TUOLUMNE ME-WUK INDIAN

HEALTH CENTER

BEHAVIORAL HEALTH

BEHAVIORAL HEALTH SITES

Sonora BH

Tuolumne BH

MEWUYA SUD/BH

Mariposa

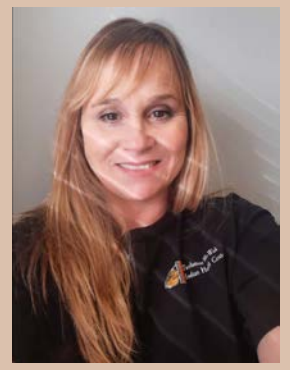
Virtual appointments available

Behavioral Health Director/Therapist
Marisa Caratachea LMFT, MSC

10+ years of experience providing mental health services to underserved and vulnerable populations in the field, school setting and office. Highly skilled in trauma informed care and trauma focused modalities to provide effective treatment to individuals, children and families. Utilizes EMDR, client centered, creative, and strategic interventions to assist clients healing and recovery. Focused on collaborating with a multi-diciplinary team in a clinical setting that encourages innovative and eclectic approaches to providing effective therapy to clients.

BEHAVIORAL HEALTH TEAM

Tonya Bybee, BH PSR



Carla Milner, BH PSR

Shere Padilla,
LPCC
BH Therapist

Yeb Raven,
APCC,BH Therapist

Sara Croteau,
SUD Counselor

Dr. Erica Vega
Psychiatrist

Lauren Trask, LCSW,
Virtual BH Therapist

Amy Olsen, LMFT
Virtual BH Therapist

Kimberly Thurman,
LMFT, BH Therapist

Robin Altheide
Certified SUD
Peer Support Specialist

Ephraim Delgadillo
SUD Counselor,
CADC II

SKILLS AND EXPERIENCE

- Trauma related disorders
- Depression
- Anxiety
- Family stress
- LGBQT +/Neurodiversity
- ADHD
- Grief and loss
- Panic
- Anger management
- BH provides: Medication Management (psychiatry), Child therapy, Individual therapy, Couples therapy, Family therapy and Case management, using an eclectic array of clinical interventions and techniques from but not limed to; EMDR, EFT, client centered, TF-CBT, DBT, Play therapy, creative therapy, solution focused, strategic, family systems, and object relations.

We are accepting new referrals for BH Therapy, SUD, and Psychiatry

Questions?

Sexual Orientation and Gender Identity (SOGI) Data Action Plan

The U.S. Department of Health and Human Services (HHS) mission is to enhance the health and well-being of all Americans by providing effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services. Healthy People 2030 defines 'health equity' as "the attainment of the highest quality of health for all people." Demographic data collection on sexual orientation and gender identity (SOGI) metrics helps HHS achieve its mission and its Healthy People 2030 goals by identifying disparities in health and human services. As identified in the Federal Evidence Agenda on LGBTQI+ Equity, this departmental SOGI Data Action Plan seeks to *improve the health and well-being of lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) people*.

The National Academies of Sciences, Engineering, and Medicine (NASEM)[1] considered measures across three broad categories of SOGI data: data collection in surveys and research settings, clinical and medical settings, and administrative settings. All three categories are necessary to better understand the needs, care, and services of people of all identities and the extent to which there may be disparities in health, services, and access to care challenges across LGBTQI+ populations. Precision public health is the emerging practice of utilizing specific data elements about targeted populations to ensure that HHS responses are directed where they are most needed. SOGI data collection is a necessary foundational element in the use and expansion of precision public health. It ensures intersectional understanding of how disparities are present in race, age, gender identity, and sexual orientation, for example how cancer screening disparities may be increased for people of color who are also LGBTQI+. It also ensures that health promotion efforts and human services for LGBTQI+ people are more accurately targeted.

For the purposes of this action plan, SOGI data means self-reported sexual orientation and gender identity demographic data and sex characteristics data as outlined in the Federal Evidence Agenda on LGBTQI+ Equality, when appropriate, and always on a voluntary basis (when not otherwise required by law or to carry out operations). This includes in Federal Statistical Surveys, as outlined by the Office of Management and Budget (OMB).[2] While research is still needed in some areas like proxy reporting, youth, and language other than English, evidence-based measures that work in a variety of contexts exist for adults whose primary language is English. To encourage interoperability of SOGI data, agencies should consult recent publications that outline best practices guidance in SOGI data collection. These include the OMB Best Practices for Collecting SOGI Data in Federal Statistical Surveys,[2] the Federal Evidence Agenda on LGBTQI+ Equity (for administrative data systems), [3] and the 2022 NASEM report,

[1] National Academies of Sciences, Engineering, and Medicine. 2022. Measuring Sex, Gender Identity, and Sexual Orientation. Washington, DC: The National Academies Press. https://doi.org/10.17226/26424.

[2] RECOMMENDATIONS ON THE BEST PRACTICES FOR THE COLLECTION OF SEXUAL ORIENTATION AND GENDER IDENTITY DATA ON FEDERAL STATISTICAL SURVEYS, OMB, available from: https://www.whitehouse.gov/wp-content/uploads/2023/01/SOGI-Best-Practices.pdf

[3] Federal Evidence Agenda on LGBTQI+ Equity, National Science and Technology Council, 2023. Available from: https://www.whitehouse.gov/wp-content/uploads/2023/01/Federal-Evidence-Agenda-on-LGBTQI-Equity.pdf

Measuring Sex, Gender identity, and Sexual Orientation.[1] For the purposes of this action plan, data instruments are any tools utilized to solicit information from a respondent. This action plan refers to data collection developed or funded by HHS.

Hundreds of thousands of health care providers benefit from the U.S. Core Data for Interoperability (USCDI), which defines a baseline set of data elements for interoperable health data exchange (i.e., laboratory test results, medications, immunizations, and allergies) across the health system. USCDI helps build the foundation for the provider community to start systemizing the capture and use SOGI data in the clinical setting. However, the USCDI does not define or suggest validated questions for how to gather information in data instruments. Where possible, HHS should seek to test and incorporate measures of sex characteristics (including self-identification of the intersex population) and additional SOGI measures, such as self-identification of two-spirit populations, in collections that include demographic data. It is important for OpDivs and StaffDivs to recognize that different types of data collections might need slightly different SOGI questions, which is why each OpDiv and StaffDiv have flexibility to create their own workplan.

According to Executive Order 14075, agency heads shall include in their agency's annual budget submission to the Director of OMB a request for any necessary funding increases to support improved SOGI data practices. SOGI data collection will inform answers to the Learning Questions posed in Section 2 of the Federal Evidence Agenda on LGBTQI+ Equity (APPENDIX 1), will improve HHS's ability to make evidence-informed decisions related to HHS programs, policies, operations, regulations, and other actions, and will improve the ability of our federal partners to make similar evidence-informed decisions.

Evidence-Building Activities

ACTION ITEM 1: Developing Division-level Workplans

The goal of the HHS SOGI Data Action Plan is to better understand the needs, care, and services of people of all identities and the extent to which there may be disparities in health, services, and access to care across LGBTQI+ populations. Data protections should be in line with existing standards and requirements for data security. This plan is the beginning of expanding SOGI data collection, not the end, and HHS will continue to track and monitor progress on an ongoing basis. Collecting SOGI data are not enough; once collected, data should be analyzed and reported out to help make evidence-based decisions and develop programs for improving the health, wellness, and livelihood of all people, including LGBTQI+ people. **To build evidence related to the Learning Questions of the Federal Evidence Agenda on LGBTQI+ Equity, over the next 12 months, each OpDiv and StaffDiv at HHS will develop a workplan via a template provided by the HHS LGBTQI+ Coordinating Committee for their division to address the activities laid out in this Action Plan. The workplan will connect data instruments to the relevant Learning Questions. Additionally, each workplan will outline a reasonable timeline for implementation of each item.**

- HHS instructs each OpDiv and StaffDiv to catalog all their data instruments implemented by their division, including those used in surveys and research settings, clinical and medical settings, and administrative settings.

- Each OpDiv and StaffDiv should review all their data instruments implemented by their division from their catalog to assess whether data collected include any demographic information.
    - If no demographic data are collected, no further action related to this policy is necessary.
    - If the data instrument captures demographic information, assess whether all the demographic information collected is related to determining program eligibility, operations, or compliance (i.e., Ryan White program eligibility requires HIV status and income verification). If the only demographic information collected is directly related to program eligibility or program compliance, no further action related to this action plan is necessary unless SOGI information is required for making eligibility determinations.
    - If the data instrument captures demographic information that is unrelated to program eligibility or compliance, (i.e. information might be collected for surveillance/monitoring purposes, research purposes, or otherwise) a plan should be developed to include SOGI data, and the information collection request (ICR) should include the addition of SOGI questions, in consultation with the Federal Committee on Statistical Methodology (FCSM) SOGI Research Group or the HHS LGBTQI+ Coordinating Committee Subcommittee on Research and Data (unless there is a compelling legal reason not to collect such data). Wherever possible, the ICR should include the data elements to be collected and specify how they are interoperable with HHS-adopted or recommended standardized data classes (e.g., USCDI).
    - OpDivs and StaffDivs should understand that terminology occasionally changes and are encouraged to consider testing more expansive measures that keep up with emerging preferred terminology to have more opportunities to implement them.
    - For communicable disease-related data, 'mode of transmission' data are not a substitute for sexual orientation data. While collecting mode of transmission data may be valuable for other reasons, these data instruments should be updated to include sexual orientation as well.
- Each HHS OpDiv and StaffDiv should include in their workplan an outline of which data instruments for administrative data have been reviewed, which have plans in place to begin collecting SOGI data, and the anticipated timeline for doing so with each data instrument.

ACTION ITEM 2: Addressing Prioritized Data Instruments

All data instruments utilized by HHS collect incredibly important information. However, certain data instruments bring unique urgency regarding the collection of SOGI data. **The following actions should be prioritized to begin the process of adding SOGI data elements. It is understood that the process will be different for each item highlighted below, as well as for additional, non-specified items.** Data protections should be in line with existing standards and requirements for data security. These actions should be taken to the extent permitted by federal law or in a manner consistent with applicable federal law, to ensure consideration is given to existing legal requirements and limitations.

High-priority action items for HHS include:

- The Assistant Secretary for Administration (ASA), Office of the White House Liaison, and each OpDiv human resource office should incorporate/update SOGI data elements, as well as pronouns and chosen names, into new hire, onboarding, and employee benefit forms considering any

relevant guidance from the Office of Personnel Management (OPM) and Equal Employment Opportunity Commission (EEOC).

- Each HHS OpDiv and StaffDiv should develop a timeline to add SOGI data elements to all public health surveillance, epidemiology, and laboratory collections of adults implemented by their division. For instance:
    - Centers for Disease Control and Prevention (CDC) should add SOGI data elements to all HIV and sexually transmitted infections/disease case reports and will explore doing so for all case reports.
    - CDC should develop a timeline for including SOGI data elements into data use agreements for vaccine administration, within the confines of state and federal data authorities.
- Centers for Medicare & Medicaid (CMS) should identify opportunities to add SOGI data elements to applicable coverage programs and surveys.
- Indian Health Service (IHS) should incorporate SOGI data into their electronic health record.
- Each OpDiv and StaffDiv should encourage data collection supported by HHS-adopted data elements or consensus-based standard terminology to enable analysis and reporting requirements for evidence-based decisions in clinical settings.
- Each OpDiv and StaffDiv will consider use of elements adopted pursuant to Section 3004 of the Public Health Service Act (PHSA) when implementing, acquiring, or upgrading health IT systems used for the direct exchange of individually identifiable health information between agencies and with non-Federal entities to achieve consistent use of interoperable SOGI data elements.

ACTION ITEM 3: Exploring SOGI Data in Contractor and Grantee Datasets

Across HHS, many datasets are collected by contractors and grantees. Technical assistance may be needed for contractors and grantees, and further research may be needed to address non-English data collection, and measures of intersex and two-spirit populations. **At the next opportunity to modify or negotiate contracts, each OpDiv and StaffDiv should begin the following.** These actions should be taken to the extent permitted by federal law or in a manner consistent with applicable federal law, to ensure consideration is given to existing legal requirements and limitations.

- Add SOGI data elements to funding opportunities of contractor and grantee program participants (not including clinical trials).
    - For existing contractors and grantees: If they do not report any demographic data back to HHS, no further action is necessary.
    - For existing contractors and grantees: If they report only demographic data related to program eligibility, operations, or program compliance, no further action is necessary.
    - For existing contractors and grantees: If they report demographic data for reasons other than program eligibility, operations, or compliance, each OpDiv and StaffDiv should ask current grantees to voluntarily begin adding SOGI demographic data to data collections.
    - For new contractors and grantees: Each HHS OpDiv and StaffDiv should consider adding SOGI data reporting requirements in any new Notice of Funding Opportunities, contract agreements, and grant agreements where contractors and grantees are asked to report demographic data (other than solely for program eligibility) back to HHS.

    - Where demographic data are collected about award grantees and contractors, SOGI data should also be collected via self-report.
- Each OpDiv and StaffDiv that conducts clinical trials should explore whether SOGI data are able to be incorporated in future studies.
- National Institutes of Health (NIH) should explore funding opportunities to advance research on SOGI measurement development. In particular, research is needed to test and advance our understanding of SOGI measures in languages other than English and testing demographic questions relevant two-spirit populations as well as sex characteristics measures. Additionally, priority SOGI measure testing should include questions designed for children and adolescents.
- Each HHS OpDiv and StaffDiv should explore field and cognitive testing of SOGI questions in languages other than English within their current surveys offered in languages other than English, when feasible. Results of non-English field and cognitive testing should be shared with the HHS LGBTQI+ Coordinating Committee Subcommittee on Research and Data.
- Each HHS OpDiv and StaffDiv should identify and work with other federal agencies where joint data collections take place or where SOGI data information sharing would be beneficial.
- Each HHS OpDiv and StaffDiv should provide robust technical assistance for states, tribes, territories, localities, and other service providers (sub-state grantees) on the collection of SOGI data across the life course.
- Each HHS OpDiv and StaffDiv should report annually to the HHS LGBTQI+ Coordinating Committee Subcommittee on Research and Data their evidence-building activities that they plan to conduct, such as:
    - Adding SOGI data elements to existing surveys and forms
    - Developing new SOGI data research projects
    - Seeking out SOGI data from non-HHS federal government sources (i.e., Census Bureau)

ACTION ITEM 4: Reviewing Current Usage of Binary Gender and Sex Questions

On an ongoing basis, each HHS OpDiv and StaffDiv should explore the following activities:

- When possible, any current usage of binary gender and sex data in HHS developed or funded data instruments and should be reviewed and replaced with tested and inclusive gender identity (which may include sex assigned at birth) data measures. If using a two-step gender identity question, ensure historical binary sex or gender questions are moved next to other gender identity questions or replaced to limit redundancy. Identify continued research in best practices for administrative SOGI data collection, following Federal Evidence Agenda guidelines.

Evidence-Building Infrastructure

Evidence-building activities often require infrastructure – policies, processes, staff, and resources – to successfully execute them. To support the evidence-building activities described above HHS will explore the following activities over the next 12 months:

- Policy:

    - The Assistant Secretary for Planning and Evaluation (ASPE) and the Office of the Assistant Secretary for Health (OASH) will develop guidelines for division consideration to collect SOGI data in all information collection requests (ICR) where other demographic information is collected for purposes other than program eligibility, operations, or compliance. SOGI data should only be included where there are other demographic questions available because there aren't other instances where only one type of demographic data would be collected without other demographics (except in cases or program eligibility, operations, or compliance). Each ICR, including surveys, intake forms, and any other information collection that requires clearance from the Office of Management and Budget (OMB) under the Paperwork Reduction Act (PRA), should be assessed for inclusion of SOGI questions during the clearance process for its initial creation or renewal.
    - ASPE should develop a toolkit for HHS staff, contractors, and grantees with information and approaches to encourage high response rates to SOGI data elements.
    - The HHS LGBTQI+ Coordinating Committee Subcommittee on Research and Data will develop and conduct a comprehensive education and outreach program to help OpDivs and StaffDivs understand the need for and value in including and/or updating SOGI data where appropriate, including the importance of data measurements on intersex and two-spirit populations.
- Staff:
    - HHS is one of few departments that already has a position created and filled for an LGBTQI+ Senior Advisor within the Assistant Secretary for Health's Office at the Secretary level.
    - Each HHS OpDiv and StaffDiv will identify an LGBTQI+ data point person who can serve as a central contact and coordinating point of contact for implementation of the HHS SOGI Data Action Plan on the OpDiv / StaffDiv level. Each HHS OpDiv and StaffDiv's LGBTQI+ data point person will also be asked to represent their OpDiv/StaffDiv on HHS LGBTQI+ Coordinating Committee Subcommittee on Research and Data to ensure cross-departmental collaboration about SOGI data implementation at HHS. Separate funding does not exist to support this. OpDivs and StaffDivs are asked to identify a person with existing, similar responsibilities.
- Process:
    - Within the next three months, OASH will initiate conversations with OMB about the approval process for any non-substantive change in data elements to expedite the many places in HHS data collections where a binary sex and gender question may be replaced by a tested and inclusive gender identity measure, and when possible, measures for sexual orientation and sex characteristics.
- Within the next 12 months, HHS will develop and implement a process for tracking both survey and administrative data implementation of SOGI data across HHS. The tracking tool will be developed by the HHS LGBTQI+ Coordinating Committee Subcommittee on Research and Data and approved by the co-chairs of the HHS LGBTQI+ Coordinating Committee. Once the tracking tool is completed, each HHS OpDiv and StaffDiv should report their evidence-building activities to the HHS LGBTQI+ Coordinating Committee Subcommittee on Research and Data.

Evidence Use Activities

To ensure that evidence generated related to the Learning Questions is used in decision-making, HHS will explore the following activities over the next 12 months:

- Each HHS OpDiv and StaffDiv will conduct a review of areas where other demographic data are utilized in programmatic decision-making, but SOGI data are not collected.
- Deidentified SOGI data should be shared with the public as public health trends are identified, in contexts where other disparity information is shared, and following established (or work to establish appropriate) data standards (such as for small cell sizes) for other disparity groups in the specific data collection context, in accordance with data sharing protocols established by each OpDiv or StaffDiv.

Monitoring Progress

Milestones and metrics: HHS will use the following milestones or metrics to ensure progress is made in implementing the activities laid out in the SOGI Data Action Plan:

- Key milestones will be communicated to the White House Office of Science and Technology Policy (OSTP) on an ongoing basis regarding major progress, such as inclusion of SOGI data in key surveys and forms, the recruitment of SOGI data subject matter experts, and successful testing of new measurements on intersex data.
- HHS will provide an annual update to OSTP Subcommittee for Equitable Data on agency progress regarding implementation of the SOGI data action plan.

APPENDIX: Learning Questions from Section 2 of the Federal Evidence Agenda on LGBTQI+ Equity

1. **To what extent can the Federal Government protect and strengthen equitable access to high-quality and affordable healthcare for LGBTQI+ people across the lifespan?**
   Illustrative Questions
   • To what extent do federal policies and programs affect choice, affordability, and enrollment among LGBTQI+ individuals and families in high-quality healthcare coverage?
   • To what extent do federal programs and policies improve quality of healthcare services for LGBTQI+ people?
   • To what extent do federal programs and policies support and promote gender-affirming care and improved health outcomes for transgender, intersex, and non-binary individuals?
   • To what extent do federal programs and policies strengthen and expand access to mental and behavioral health services, primary care, and preventive services for LGBTQI+ people?
   • What role do local, state, and federal laws play in restricting or enhancing equitable access to quality and affordable healthcare for LGBTQI+ individuals and families?
   • To what extent do restrictions and criminalization of healthcare receipt affect health outcomes for LGBTQI+ people?
   • To what extent do LGBTQI+ people experience disparate rates of access to health insurance coverage? Does coverage for LGBTQI+ people differ compared to other insured people?
   • To what extent do LGBTQI+ people face disproportionate denials of health insurance claims? To what extent do these denials impact health outcomes for this population?
   • Which federal programs and policies advance equitable access of culturally and clinically competent health care to various vulnerable subpopulations, such as LGBTQI+ older adults or LGBTQI+ youth engaged in the foster care system?
   • How can disparities experienced by LGBTQI+ youth be mitigated to reduce suicide risk among various subgroups?

2. **To what extent can the Federal Government safeguard and improve health conditions and outcomes for LGBTQI+ people?**
   Illustrative Questions
   • To what extent are improvements to federal capabilities needed to predict, prepare for, respond to, and recover from public health emergencies and threats to LGBTQI+ people in the nation and across the globe?
   • How effective are federal programs and policies at protecting LGBTQI+ people from infectious disease and preventing non-communicable disease through development and equitable delivery of effective, innovative, and readily available treatments, therapeutics, medical devices, and vaccines?
   • How do federal policies and programs enhance promotion of healthy behaviors and wellness among LGBTQI+ people to reduce occurrence of and disparities in preventable injury, illness, and death?
   • How effective are federal programs and policies at mitigating the impacts of occupational and environmental factors, including climate change, on health outcomes among LGBTQI+ people?

• What training do medical providers receive in cultural competency and health care for LGBTQI+ people? To what extent does this training affect care and health outcomes for LGBTQI+ patients?
• What barriers do LGBTQI+ minors and LGBTQI+ adults with disabilities face in accessing health services that require participation from guardians?
• To what extent do elder LGBTQI+ people experience differential treatment and services in long-term care settings? What effect, if any, do these disparities in treatment and services have on their well-being?
• To what extent do health outcomes for LGBTQI+ people vary by geographic region?
• To what extent do health outcomes for LGBTQI+ people vary by demographic characteristics, including, but not limited to, race and ethnicity, age, and whether the individual has a disability?
• What progress has been made in achieving national, state, and local health objectives for LGBTQI+ youth?
• What improvements would strengthen public health surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions that impact LGBTQI+ people?

3. **How can the Federal Government increase housing stability and security for LGBTQI+ people?**
Illustrative Questions
• What is the prevalence of homelessness among LGBTQI+ adults? How does this compare to their non-LGBTQI+ peers?
• How does the prevalence of homelessness vary among subgroups within LGBTQI+ populations (e.g., by age, by race and ethnicity, for particular populations such as youth in the foster system, by geography, etc.)?
• What barriers do LGBTQI+ individuals and families face in accessing homelessness services, especially federal services related to shelter access and housing affordability? Do those barriers vary among subgroups within the LGBTQI+ population (e.g., transgender or non-binary individuals, LGBTQI+ families, younger or older LGBTQI+ people, LGBTQI+ people in urban or rural areas)?
• What are the experiences of LGBTQI+ people during episodes of housing instability?
• Which approaches and/or strategies are effective in reducing homelessness and/or increasing access to safe and stable housing for LGBTQI+ people?
• How do housing outcomes among LGBTQI+ youth vary across geographic areas? What factors contribute to or are associated with better or worse outcomes?
• What is the rate of home ownership among LGBTQI+ people? How does this compare to their non-LGBTQI+ peers?
• Are there differences in rates of homeownership among different groups within the LGBTQI+ population (e.g., transgender or non-binary individuals, LGBTQI+ people of different races and ethnicities)?
• What factors contribute to home ownership rates among LGTBQI+ people?
• How does rent burden differently impact LGBTQI+ people?
• How do the housing experiences of elderly LGBTQI+ people differ from elderly non-LGBTQI+ people (e.g., aging in place, social supports, housing insecurity and stability, home equity, and reverse mortgages)?

4. **How can the Federal Government reduce the incidence of housing-related discrimination experienced by LGBTQI+ people?**
   Illustrative Questions
   • To what extent do LGBTQI+ people experience discrimination when renting or buying a home?
   • Are there differences in rates of reporting discrimination when renting or buying a home among different groups within the LGBTQI+ population (e.g., transgender, non-binary individuals, youth vs. older populations, etc.)?
   • What other types of discrimination do LGBTQI+ people face related to housing (e.g., in long-term care facilities or in rent burden)?
   • To what extent do LGBTQI+ people face barriers in access to mortgage financing? To what extent do these barriers differ among different subgroups (e.g., transgender individuals, non-binary individuals, low-income LGBTQI+ people)?
   • What policies, programs, or interventions are effective to counter housing-related discrimination for LGBTQI+ people?

5. **How can the Federal Government promote equitable outcomes for LGBTQI+ people in income, economic well-being, and the workplace?**
   Illustrative Questions
   • What are earnings, incomes, unemployment rates, and labor force participation rates for LGBTQI+ people? How do related outcomes differ across sexual orientation and gender identities and for LGBTQI+ people who also identify as people of color? How do they differ across different occupation categories such as science, technology, engineering, and mathematics occupations?
   • How prevalent are various forms of job-related discrimination, harassment, or retaliation against LGBTQI+ people, such as discrimination in hiring, in wages, in equal employment opportunity, in fair treatment, in promotion or advancement, or in termination?
   • What is the distribution of family incomes and poverty rates for families or households that include LGBTQI+ individuals?
   • What are the income and poverty rates for LGBTQI+ people based on age? To what extent do LGTBQI+ older adults experience differential rates of poverty?
   • Do LGBTQI+ people or LGBTQI+-owned businesses face discrimination as entrepreneurs when they seek loans with which to launch a business or compete for federal and other contracting opportunities?
   • What types and levels of wealth or assets are LGBTQI+ people able to build at different stages of their life course compared to non-LGBTQI+ people?
   • What are the regional or local incidences of employment or income differences for LGBTQI+ populations? Do we observe differences in certain states, regions, or the urban/rural divide?

6. **How can the Federal Government promote equitable educational opportunities and outcomes for LGBTQI+ people?**
   Illustrative Questions
   • What is the distribution of educational attainment among LGBTQI+ people?

• How prevalent are various types of discrimination, harassment, bullying, or physical abuse experienced by LGBTQI+ people at different ages or levels of schooling? How do those experiences affect their educational outcomes?
• What institutional contexts, policies, or practices promote a positive academic environment and contribute to higher rates of LGBTQI+ student retention and graduation? What individual-level, family-level, or community-level protective factors do LGBTQI+ people employ that help them to succeed in education and the workforce?
• What are the incidences of exclusionary school discipline (including out-of-school suspension and expulsion) or chronic absence experienced by LGBTQI+ people at different ages or levels of schooling?
• What training is required or provided for teachers and school staff on creating welcoming and safe school environments and supporting equitable academic outcomes?
• To what extent does inclusion of LGBTQI+ experiences in teacher/staff training vary across geographic areas and school levels?

7. **How can the Federal Government promote equitable access to and engagement in federal programs, benefits, and funding opportunities for eligible LGBTQI+ people?**
Illustrative Questions
• What are the rates of participation for LGBTQI+ people in federal benefits programs, and how do these rates compare to their non-LGBTQI+ peers? Do these participation rates differ by geographic units such as states, regions, or the urban/rural divide?
• What social, economic, and programmatic factors can account for observed differences between LGBTQI+ people and their non-LGBTQI+ peers in observed rates of participation in federal programs, benefits, and funding opportunities? In observed engagement rates?
• How well do LGBTQI+ populations understand the federal programs and benefits they are eligible for and how to access them? How are understanding levels impacted by factors such as low literacy and language access needs? Examples of such programs include the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF); Medicaid; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); unemployment insurance; Supplemental Security Income; Social Security Disability Insurance; Head Start and Early Head Start; benefits in various forms for veterans; and the Earned Income Tax Credit, among others.
• To what extent do award rates differ for LGBTQI+ applicants to federal funding opportunities, holding other characteristics constant? Do these rates differ for subgroups of the LGBTQI+ population?
• How do discrimination and lack of cultural competency in healthcare and human services affect LGBTQI+ people's ability to apply for benefits?
• How do federal agencies communicate to and tailor communications about their programs and benefits to LGBTQI+ people?
• To what extent does having identity documents that do not reflect an individual's affirmed name or gender affect access to benefits and programs? To what extent can the Federal Government mitigate barriers related to acquiring or updating identity documents?
• To what extent do LGBTQI+ people experience challenges in receiving benefits compared to their non-LGBTQI+ peers?
• To what extent do LGBTQI+ older adults experience disparate access to benefits and services?

• To what extent do LGBTQI+ people report discrimination or mistreatment when accessing benefits? Do rates of discrimination or mistreatment experienced by LGBTQI+ people differ from rates experienced by non-LGBTQI+ people? Do rates of discrimination or mistreatment experienced by LGBTQI+ people of color differ from rates experienced by other LGBTQI+ people or from non-LGBTQI+ people of color?
• To what extent do LGBTQI+ minors or LGBTQI+ people with disabilities face barriers in accessing federal programs and benefits that require participation from guardians?
• To what extent does collection and use of SOGI data affect the customer experiences of LGBTQI+ populations when accessing federal services and programs?
• What is the likelihood among LGBTQI+ populations to avoid seeking services or programmatic access due to concerns about being asked questions about sexual orientation or gender identity or due to other concerns around processes?

8. **How can the Federal Government support equal access for LGBTQI+ people to shared public space, especially public spaces that provide services like transportation?**
Illustrative Questions
• To what extent do LGBTQI+ people feel safe in public spaces? What factors contribute to their feelings of safety?
• What types of social barriers do LGBTQI+ people experience to participating safely in their communities?
• How do feelings of safety and security affect LGBTQI+ people's participation in society?

9. **How can the Federal Government help ensure equal treatment of LGBTQI+ youth and promote inclusive environments for them?**
Illustrative Questions
• What are the trends in risk behaviors among LGBTQI+ youth compared with their non-LGBTQI+ peers?
• Which school- and community-based supports for LGBTQI+ youth are effective at reducing risk behaviors among youth?
• Which school- and community-based supports for LGBTQI+ youth are effective at increasing or supporting positive behaviors among youth?

10. **To what extent can the Federal Government understand LGBTQI+ children, youth, and families that touch the child welfare and foster care systems, improve any potential disparities in treatment while in care, and address potential disparate outcomes after leaving these systems?**
Illustrative Questions
• To what extent do the experiences of LGBTQI+ youth that led them to be in contact with the foster care system differ from their non-LGBTQI+ peers?
• To what extent do the relationships between the experiences of LGBTQI+ foster youth (e.g., number of placements, placement in a group home, kinship placements) and their outcomes differ from those of their non-LGBTQI+ peers?
• To what extent are there disparities in experiences and outcomes of specific subgroups of LGBTQI+ foster youth, including transgender or non-binary foster youth, LGBTQI+ youth living in rural areas, or LGBTQI+ youth of color, during and after their time in care?

• What programs, services, or other approaches are effective in improving outcomes for LGBTQI+ youth who come into contact with the child welfare system?
• To what extent do LGBTQI+ families that come into contact with the child welfare system experience differential treatment and disparate outcomes?
• To what extent do rates of removal differ for LGBTQI+ parents? Do these rates differ amongst specific subgroups of LGBTQI+ parents (e.g., by race or ethnicity or for individuals with disabilities)? What, if anything, contributes to these rates of removal?

11. **What can be done to reduce the disproportionately high rate of violent crime committed against LGBTQI+ people?**
Illustrative Questions
• To what extent do LGBTQI+ people experience a higher rate of intimate partner violence or domestic violence compared to the general population?
• To what extent do LGBTQI+ people experience bias-motivated hate crimes?
• What have been effective or promising practices that prevent or interrupt violent crime targeting LGBTQI+ people?
• To what extent do LGBTQI+ people utilize crime victim service assistance compared to the general population?
• To what extent do LGBTQI+ students experience bullying compared to the general student population?
• How effective are bullying interventions for LGBTQI+ youth compared to non-LGBTQI+ youth?

12. **To what extent do LGBTQI+ people have different experiences inside the criminal justice system compared to non-LGBTQI+ people?**
Illustrative Questions
• To what extent do LGBTQI+ people have different experiences with law enforcement than non-LGBTQI+ people?
• To what extent do LGBTQI+ people have different experiences with the correctional system (e.g., prisons, jails, juvenile facilities) than non-LGBTQI+ people?
• What are the differences in rates of recidivism for LGBTQI+ people compared to non-LGBTQI+ people?
• To what extent do intake assessments and safe housing policies impact rates of violence and victimization for LGBTQI+ people in incarceration?
• To what degree and in what forms do LGBTQI+ adults in incarceration experience victimization as compared to the total population of people in incarceration?
• To what extent do LGBTQI+ young people in incarceration experience more victimization compared to all young people in incarceration? Does this differ by type of facility (e.g., facilities that primarily house adults vs. those that house youth)?
• What have been effective or promising practices that improve the conditions of confinement in jails and prisons for LGBTQI+ persons?
• To what extent does law enforcement engage with LGBTQI+ stakeholders to solicit their recommendations on how law enforcement officials can improve their investigative, prosecutorial, and victim services response?

13. **To what extent can the Federal Government promote inclusive environments and equitable outcomes for LGBTQI+ people in the immigration and asylum systems?**
    Illustrative Questions
    • How many immigrants in the United States identify as LGBTQI+?
    • To what extent are LGBTQI+ people's experiences of harassment and victimization impacted by their immigration status?
    • To what extent do the outcomes of asylum seekers and refugees differ for subpopulations that identify as LGBTQI+?

DATA NOTEBOOK 2024

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Prepared by California Behavioral Health Planning Council, in collaboration with:
California Association of Local Behavioral Health Boards/Commissions

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

For general information, you may contact the following email address or telephone number:
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For questions regarding the SurveyMonkey online survey, please contact Justin Boese at Justin.Boese@cbhpc.dhcs.ca.gov

NOTICE:

This document contains a textual **preview** of the California Behavioral Health Planning Council 2024 Data Notebook survey, as well as supplemental information and resources. It is meant as a **reference document only**. Some of the survey items appear differently on the live survey due to the difference in formatting.

DO NOT RETURN THIS DOCUMENT.

Please use it for preparation purposes only.

To complete your 2024 Data Notebook, please use the following link and fill out the survey online by **November 30, 2024**:

https://www.surveymonkey.com/r/MFGJBYT

Table of Contents

CBHPC 2024 Data Notebook: Introduction

What is the Data Notebook? Purpose and Goals

The Data Notebook is a structured format to review information and report on aspects of each county's behavioral health services. A different part of the public behavioral health system is addressed each year, because the overall system is large and complex. This system includes both mental health and substance use treatment services designed for individuals across the lifespan.

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local behavioral health boards to complete and submit to the Planning Council. Discussion questions seek input from local boards and their departments. Planning Council staff analyze these responses to create annual reports to inform policy makers and the public.

The Data Notebook structure and questions are designed to meet important goals:

- To help local boards meet their legal mandates[1] to review and comment on their county's performance outcome data, and to communicate their findings to the Planning Council;
- To serve as an educational resource on behavioral health data;
- To obtain opinion and thoughts of local board members on specific topics;
- To identify successes, unmet needs and make recommendations.

In 2019, we developed a section of the survey ("Part I") with standard questions that helped us detect any trends in critical areas affecting our most vulnerable populations. These included foster youth, individuals experiencing homelessness, and those with serious mental illness (SMI) who need housing in adult residential facilities (ARFs) and some other settings. These questions assisted in the identification of unmet needs or gaps in services that may occur due to changes in population, resources, or public policy. The Part I questions were used from 2019-2023. In addition to these standardized questions, each Data Notebook focused on a different topic of interest. Survey questions for these topics have been referred to as "Part II."

[1] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

What's New This Year?

For the 2024 Data Notebook, the Planning Council will no longer include the standardized Part I questions in the survey. This change will give us the opportunity to develop a new set of important and timely performance outcomes measures that can be tracked over time. We also aim to shorten the overall length of the survey to make it more accessible for participating counties. A complete analysis of the data collected over that five-year period is forthcoming, but some of the data regarding housing and homelessness are discussed later in this document.

The topic selected for the 2024 Data Notebook is "homelessness within the public behavioral health system." The Planning Council recognizes that this complex issue is the subject of much discussion, advocacy, and policy across the state. Our goal is to gather information about how counties address the issue of homelessness and housing among people served in their behavioral health systems and identify what data counties collect on this topic. There are also several questions at the end of the survey asking for your input on what topics or performance outcomes you would like us to focus on next year.

How the Data Notebook Project Helps You

Understanding data empowers individuals and groups in their advocacy. The Planning Council encourages all members of local behavioral health (BH) boards/commissions to participate in developing the responses for the Data Notebook. This is an opportunity for local boards and their county behavioral health departments to work together to identify critical issues in their community. This work informs county and state leadership about local behavioral health programs, needs, and services. Some local boards use their Data Notebook in their annual report to the County Board of Supervisors.

In addition, the Planning Council will provide our annual 'Overview Report,' which is a compilation of information from all of the local behavioral health boards/commissions who completed their Data Notebooks. These reports feature prominently on the website[2] of the California Association of Local Mental Health Boards and Commissions (CALBHBC). The Planning Council uses this information in their advocacy to the legislature, and to provide input to the state mental health block grant application to SAMHSA[3].

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[2] See the annual Overview Reports on the Data Notebook posted at the California Association of Local Behavioral Health Boards and Commissions website.

[3] SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For reports, see www.SAMHSA.gov.

What are Performance Outcomes?

While local behavioral health boards and commissions are required to review performance outcomes data for their counties, there is some ambiguity about what constitutes a "performance outcome measure." Outcome measures are one of several kinds of measures used to evaluate the quality of health care organizations and services. According to the Agency for Healthcare Research and Quality, a common classification of quality measures[4] includes:

- **Structural Measures** provide data on the capacity, systems, and infrastructure of a health care provider to gauge their ability to provide care. Examples of structural measures would be the ratio of providers to patients, or whether the organization uses electronic medical records.
- **Process Measures** indicate that a provider is using evidence-based best practices and processes to achieve a positive impact on people's health or reduce harmful outcomes. Examples of process measures are the number of patients who receive recommended health screenings, appointment wait times, or frequency of follow-up appointments.
- **Outcome Measures** evaluate the impact a service or intervention has on an individual's health status and recovery, whether positive or negative. Examples of outcome measures include evaluations of symptom severity, rates of hospital readmissions, and quality of life.

Of these three kinds of quality measures, outcome measures are arguably the most valuable for assessing the effectiveness of a health care service or intervention. However, they are also the hardest to evaluate. A big challenge with outcome measures is that there are many factors that influence health outcomes besides the treatment or services that an individual receives. It is beneficial to evaluate outcome measures in the context of structural and process measures, as they are closely related. Improving processes and system capacity within a health care organization can result in improved outcomes.

Patient-reported outcomes are important for assessing the quality of care that patients receive. These are outcome measures of an individual's health, quality of life, and their experiences regarding the care they receive, using information gathered directly from the patient and/or their caregivers. Examples include patient reports of how well they feel their provider listens to them during appointments, or how effective they feel their treatment has been over the past 6 months.

A **performance indicator** is a specific measure, whether quantitative or qualitative, that is used to determine if a service or program is achieving their desired outcomes. During the evaluation process, the organization reviews their indicators to assess the

[4] Types of Health care Quality Measures, by the Agency for Healthcare Research and Quality.

effectiveness of their processes, policies, and services. It is important to also review the indicators themselves at regular intervals to determine if those indicators are working as intended, or whether the indicators need to be modified to better serve the evaluation plan. Note that it may be difficult to draw sound conclusions from qualitative indicators.

In behavioral health care, there are many potential outcome indicators that can be used to evaluate the impact of programs and services. The California Association of Local Behavioral Health Boards and Commissions published an issue brief[5] on the topic of performance outcome data that includes suggested data points for county behavioral health agencies. The Agency for Healthcare Research and Quality also has publicly available resources on how to choose health care quality measures.[6] We recommend that local behavioral health boards and commissions and behavioral health agencies familiarize themselves with these resources when considering what data to collect or use.

[5] Performance Outcome Data Issue Brief, published by the California Association of Local Behavioral Health Boards and Commissions.
[6] Key Questions When Choosing Health Care Quality Measures, by the Agency for Healthcare Research and Quality.

CBHPC 2024 Data Notebook: Homelessness in the Public Behavioral Health System

Homelessness is a multifaceted and longstanding phenomenon in United States, and California in particular. The state of California is home to the largest number of individuals experiencing homelessness in the nation. Our state makes up about 12% of the total population of the United States, yet accounts for 31% of the nation's homeless population and 49% of the unsheltered population as of 2023. The combination of low income and a lack of affordable housing continues to be the largest contributing factors for homelessness. However, there are many other factors that play a role in this issue including incarceration, racial disparities, physical and mental health, and domestic violence.

The intersection of homelessness and behavioral health is a complex topic, and has been the subject of increasing public discussion, political debate, and legislation. Rates of homelessness have continued to increase at alarming rates, exacerbated by the effects of the COVID-19 pandemic. As public concerns about homelessness have grown, so have statewide efforts to reform behavioral health services in California. While the Planning Council does not share or endorse the view that mental illness is the primary cause of homelessness, the public behavioral health system does play a vital role in serving individuals experiencing homelessness.

The California Behavioral Health Planning Council has a long history of advocacy regarding housing and homelessness within the public mental health system. In 2016, the Planning Council published a report[7] highlighting programs and policies that looked promising for ending homelessness for those with severe mental illness and substance use disorders. This report was the result of multiple panel presentations in 2015 involving people with lived experience, providers, advocates, and other stakeholders. More recently, our Housing and Homelessness Committee published an issue brief[8] in 2020 highlighting services available to prepare persons experiencing homelessness for successful transitions to housing.

For the past 5 years, the Data Notebook survey has included an item asking counties to report on new or expanded services for homeless behavioral health clients. We have also included data from the federal Department of Housing and Urban Development (HUD) Point-In-Time counts for California. By making this topic the primary focus of the

[7] Hope for the Hopeless: Effective Programs that Promote Real Change. Published January 2016 by the California Behavioral Health Planning Council.
[8] The Crisis of Housing and Homelessness: Effective Programs to Bridge the Gap from Homelessness to Housing. Published May 2020 by the California Behavioral Health Planning Council.

2024 Data Notebook, we aim to learn more about how individuals experiencing homelessness are served within the public behavioral health system. The survey questions for this year have been written to identify the types of data being collected at the county level, as well as some basic information on county-level programs, needs, and goals regarding homelessness.

Defining Homelessness

The federal government finalized an official definition of homelessness in 2011[9] for the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. This definition states that a person or family is homeless if they fall into one of four categories:

- **Currently homeless** (lacking a fixed, regular, nighttime residence, which includes living in a car or temporary shelter program).
- **Imminent risk of homelessness** (those who will lose their nighttime residence within 14 days).
- **Homeless under other federal statutes or programs**. This includes those who have not had a permanent residence in the last 60 days.
- **Fleeing or attempting to flee domestic violence**, dating violence, or other threatening situations.

Additionally, the definition of "chronic homelessness" was clarified in 2015[10]. This definition covers individuals or families who have been homeless for at least 12 months, or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months.

Because these definitions are the ones used by the Department of Housing and Urban Development, they are the ones that we will be using for the purposes of the 2024 Data Notebook. However, we understand that many organizations and programs have different working definitions for these terms and are interested to learn how your county behavioral health agency defines homelessness in practice.

A Recent History: Housing and Homelessness Data presented in 5 years of California Data Notebook Overview Reports, 2019-2023.

Every year, the states, counties, and many cities perform a "Point-in-Time" Count[11] of the individuals experiencing homelessness in their counties, usually on a specific date

[9] The final ruling on the definition of homelessness for the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, on the HUD Exchange website.
[10] Federal definition of chronic homelessness, on the HUD Exchange website.
[11] 2023 Point-in-Time Homeless Populations and Subpopulations Reports are available on the HUD Exchange website.

in January. Such data are key to state and federal policy and funding decisions. **Table 1** provides data from the 2023 Point-in-Time Count. This data is publicly available, provided by the U.S. Department of Housing and Urban Development.

Table 1. State of California Estimates of Homeless Individuals Point in Time[12] Count 2023

Summary of Homeless individuals	SHELTERED	UNSHELTERED	TOTAL 2023	Percent Change from 2022
Persons in households without children	38,230	117,020	155,028	+ 6.6%
Persons in households with children	19,484	5,999	25,483	- 0.2%
Unaccompanied homeless youth	3,239	6,934	10,173	+ 6.1%
Veterans	3,153	7,436	10,589	+ 1.9%
Chronically homeless individuals	16,621	54,529	71,150	+ 16.8%
Total (2023) Homeless Persons in CA	57,976	123,423	181,399	+ 5.8%
Total (2023) Homeless Persons, USA	396,494	256,610	653,104	+ 12.1%

We have presented California data from the federal HUD Point-in-Time Count in each data notebook to inform the local behavioral health boards and for a basis for their discussion and responses.

The data from the past 5 years, displayed below in **Figure 1**, show increasing trends during this time span for nearly all the groups selected, including total homeless persons, those unsheltered, the chronically homeless, those served by emergency shelters, those persons with severe mental illness, and those who experienced chronic

[12] PIT Count = yearly January Point-in-Time Count of Homeless Individuals, conducted according to the guidance of the U.S. Department of Housing and Urban Development (www.HUD.gov). Sheltered persons include those who were in homeless shelters and distinct types of transitional or emergency housing.

substance abuse. The groups which did not show any major increases during this time span include those served in transitional housing at the selected point-in-time counts, and the numbers for unaccompanied youth aged 18-24, and for unaccompanied children under 18. We do not know the reason why numbers for those specific groups did not exhibit significant changes over this 5-year time span. Note the data gaps for January 2021, when COVID-19 health protocols precluded counting unsheltered individuals, and therefore impacted any data which normally would include those numbers in aggregated totals. Table 2 contains the numerical data used to construct Figure 1.

Figure 1. California Homeless Point-in-Time Counts for Several Vulnerable Populations, 2019-2023.

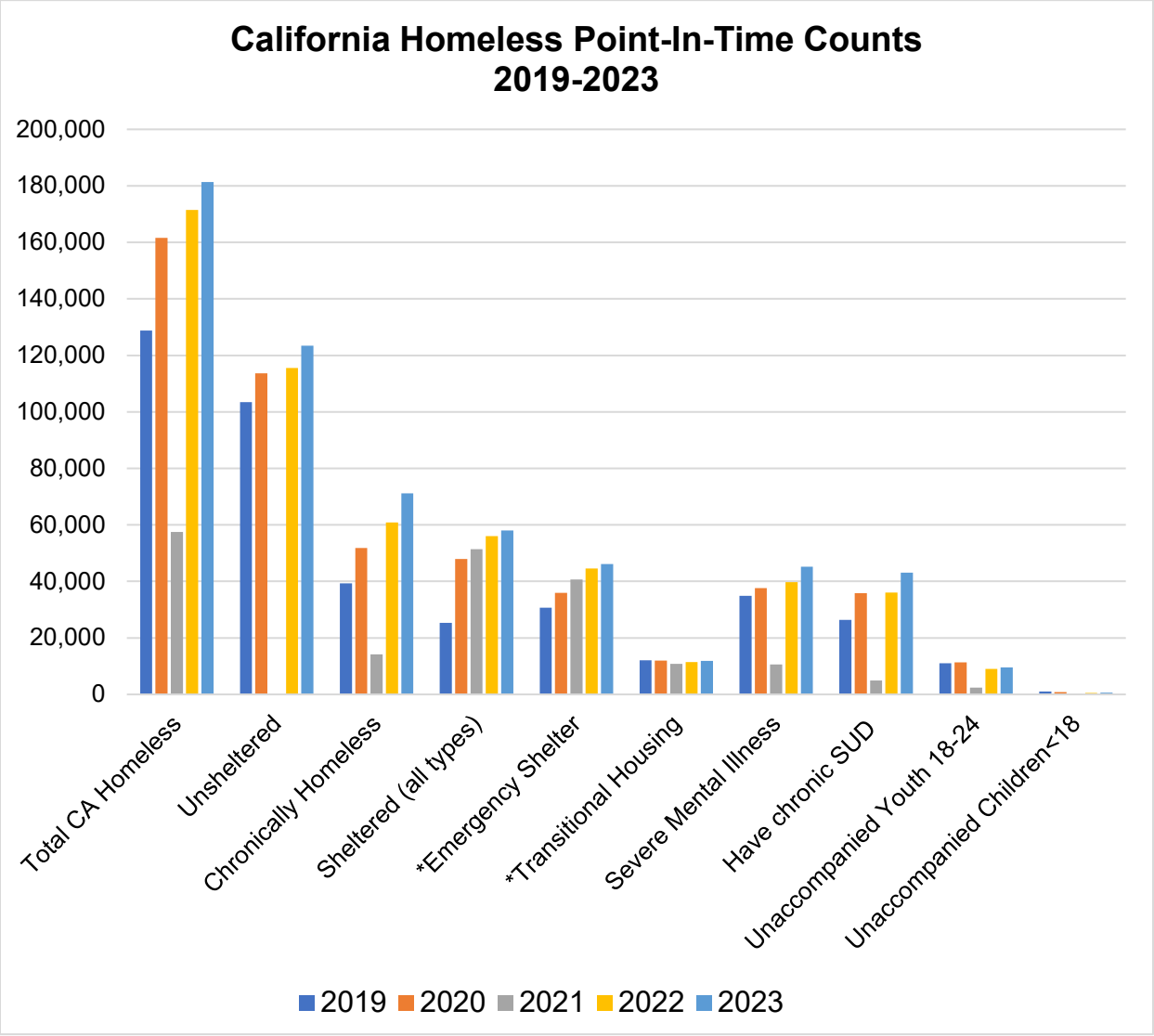


Table 2. CA Homeless Data from Annual P.I.T. Counts, 2019 – 2023.

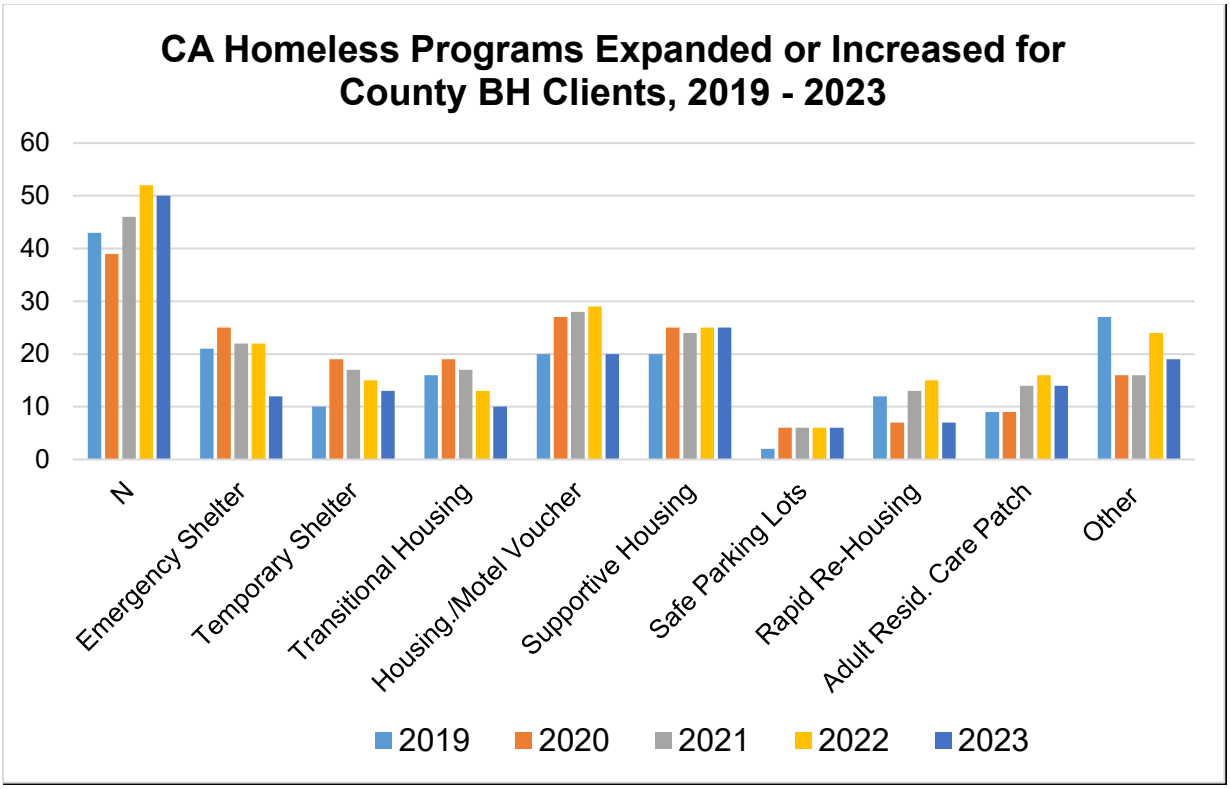
	2019	2020	2021	2022	2023
Total CA Homeless	128,777	161,548	57,468	171,521	181,399
Unsheltered	103,454	113,660	*	115,491	123,423
Chronically Homeless	39,275	51,785	14,168	60,905	71,150
Sheltered (all types)	25,323	47,918	51,429	56,030	57,976
***Emergency Shelter**	30,723	35,996	40,662	44,553	46,111
***Transitional Housing**	12,123	11,922	10,767	11,477	11,865
Severe Mental Illness	34,942	37,599	10,607	39,721	45,222
Have chronic SUD	26,410	35,821	4,970	36,096	43,047
Unaccompanied Youth 18-24	11,002	11,370	2,354	9,046	9,519
Unaccompanied Children<18	991	802	172	544	654

In addition to the HUD Point-In-Time data, previous Data Notebooks included the following survey question:

“During the most recent fiscal year, what new programs were implemented, or what existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness?”

Figure 2 shows a summary of the responses to this question from the past 5 years. The Data group labeled ‘N’ shows the number of counties which submitted responses to this question in that year’s Data Notebook. The category of ‘Other’ includes some programs which were developed with special funding (such as Project Home Key, etc.) in response to the pandemic and the economic dislocation experienced by many individuals.

Figure 2. California Homeless Programs Added or Expanded for County Behavioral health Clients, 2019-2023.



2024 Data Notebook Survey Questions

Please respond by means of the Survey Monkey link provided with this Data Notebook.

Section 1: Homelessness in the Public Behavioral Health System

1. **Please identify your County / Local Board or Commission.** *(dropdown menu)*

2. **Which of the following definitions of homelessness does your county use to identify individuals experiencing homelessness within your behavioral health system?** *(select all that apply)*
   a. The U.S. Housing and Urban Development (HUD) definition of *homelessness*, as used in the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act.
   b. The U.S. Department of Health and Human Services definition of *homeless youth* established by the Runaway and Homeless Youth Act (RHYA).
   c. The U.S. Department of Education definition of *homeless children and youths* as defined in the McKinney-Vento Homeless Assistance Act.
   d. Substance Abuse and Mental Health Services Administration (SAMHSA) definition of those who are *experiencing homelessness*.
   e. The Social Security Administration (SSA) definition of *homelessness*.
   f. Other (written response)

3. **Does your county enter data on homelessness and housing services into a Homeless Management Information System (HMIS)?**
   a. Yes
   b. No

4. **Concerning individuals currently receiving services in your county behavioral health system, is your county actively collecting data on the housing status of any of the groups listed?** *(Please check all that apply)*
   a. Foster youth
   b. Youth 18 years of age or younger
   c. Youth ages 19-24
   d. Adults ages 25-65
   e. Adults 66 years of age or older
   f. Consumers receiving mental health services
   g. Consumers receiving substance use treatment
   h. Veterans
   i. Individuals exiting incarceration from county jail
   j. Individuals exiting incarceration from prison
   k. Individuals in Institutions of Mental Disease (IMDs)
   l. Individuals in psychiatric hospitals
   m. Other (please specify)

n. None/Not Applicable

5. **What supports are necessary to provide housing to people served in your county behavioral health system for more than 6 months?** *(Please check all that apply)*
   a. Case management services
   b. Intensive case management services
   c. Health or social services access/navigation services
   d. Medication-Assisted Treatment
   e. Enhanced Care Management (ECM) and Community Supports
   f. Rental subsidies
   g. Housing vouchers
   h. Transitional and temporary housing
   i. Peer support
   j. Community health worker
   k. Supported employment services
   l. Wellness centers
   m. Full-Service Partnerships (FSPs)
   n. Other (written response)

6. **Does your county behavioral health system participate in a county-wide interagency continuum of care that meets regularly to address housing for your county residents?**
   a. Yes
   b. No

7. **For people currently receiving services from your county behavioral health system, are you actively collecting any data on whether they are homeless/unsheltered at every point of service? For example, do you check for homeless status every time you provide individuals with any service?**
   a. Yes
   b. No

8. **Please list the organizations/agencies you work with to provide housing support and services for individuals served by your county behavioral health system.** *(Written Response: please use bullet points for this list)* 

9. **Is your county behavioral health system able to use local data when making program decisions and financial investments in existing or new homelessness/housing programs?**
   a. Yes
   b. No

10. **If you answered "Yes" to the previous question, can you give an example of a program your county initiated based on data you collect or track?** *(Written response)* Behavioral Health Bridge Housing (BHBH)

11. **Does your county behavioral health department have a housing services unit or housing coordinator?**
    a. Yes
    b. No

Section 2: Performance Outcomes Data

12. **Does your behavioral health agency currently collect data for the performance indicators listed below for all adult beneficiaries?** *(Please check all that apply)*
    a. Employment status
    b. Criminal justice involvement
    c. Housing status
    d. Visits to the emergency room (ER)
    e. Psychiatric Hospitalizations
    f. Lanterman-Petris-Short (LPS) Conservatorship
    g. Rates of self-harm
    h. Rates of suicide
    i. Social functioning and community connectedness
    j. Self-reported wellness
    k. Overall patient satisfaction
    l. Other (Please Specify)

13. **Does your behavioral health agency currently collect data for the performance indicators listed below for all child and youth beneficiaries?** *(Please check all that apply)*
    a. Criminal justice involvement
    b. Housing status
    c. Visits to the emergency room (ER)
    d. Psychiatric Hospitalizations
    e. Rates of self-harm
    f. Rates of suicide
    g. School attendance/absenteeism
    h. Academic engagement
    i. Classroom behavior
    j. Social functioning and community connectedness
    k. Self-reported wellness
    l. Overall patient satisfaction
    m. Other (Please Specify)

14. **Do you utilize the performance indicators previously identified in any of the following ways?** *(Please check all that apply)*
    a. Evaluate the effectiveness of programs
    b. Make changes in spending
    c. Make changes in program planning
    d. Inform partners and stakeholders
    e. Advocate for policy changes
    f. Engage in community outreach
    g. Other (written response)

15. **Overall, do you have adequate data to evaluate and comment on performance outcomes in your county behavioral health system?**
    a. Yes
    b. No

16. **Which of the following topics or areas of interest would your county like to see future Data Notebooks focus on?** *(Please select up to 5).*
    a. Employment Status
    b. Criminal Justice Involvement
    c. Housing Status
    d. Visits to the emergency room (ER)
    e. Psychiatric Hospitalizations
    f. Lanterman-Petris-Short (LPS) Conservatorship
    g. Rates of Self-Harm and Suicide
    h. School-Based Wellness for Children/Youth
    i. Social Functioning and Community Connectedness
    j. Self-reported wellness
    k. Overall Patient Satisfaction
    l. Other (Please Specify)

Post-Survey Questionnaire

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. The questions below ask about operations of mental health boards, and behavioral health boards or commissions, etc.

17. What process was used to complete this Data Notebook? (Please select all that apply)
   a. MH board reviewed WIC 5604.2 regarding the reporting roles of mental health boards and commissions.
   b. MH board completed majority of the Data Notebook.
   c. Data Notebook placed on agenda and discussed at board meeting.
   d. MH board work group or temporary ad hoc committee worked on it.
   e. MH board partnered with county staff or director.
   f. MH board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.
   g. Other (please specify)

18. Does your board have designated staff to support your activities?
   h. Yes (if yes, please provide their job classification)
   i. No

19. Please provide contact information for this staff member or board liaison.

20. Please provide contact information for your board’s presiding officer (chair, etc.)

21. Do you have any feedback or recommendations to improve the Data Notebook for next year?