COUNTY OF SAN MATEO
HEALTH SYSTEM

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Dear Colleagues and Community Partners,

This past year, the Behavioral Health and Recovery Services (BHRS) set out to better understand the impact that Mental Health Services Act (MHSA) outreach and engagement efforts are having in terms of increasing access and improving linkages to behavioral health services for underserved communities, specifically from two community outreach collaboratives, the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC).

The MHSA was approved by California voters in 2004 and provides funding for mental health services by imposing a 1% tax on personal income in excess of $1 million. Activities funded by MHSA are grouped into components with the largest component, Community Services and Supports (CSS), intended to provide direct services to individuals with severe mental health challenges. A service category under CSS is Outreach and Engagement (O&E). In San Mateo County, O&E strategies include the community outreach collaboratives, pre-crisis response and primary care-based efforts.

Starting in 2015, the American Institute on Research (AIR) has provided BHRS with technical assistance on the EPAPMHO and NCOC data collection and reporting. AIR provides a summary of the data submitted on an annual basis. To enhance the learnings from this data, BHRS contracted with an independent consulting firm, Harder+Company Community Research, to conduct a formal qualitative evaluation. The final reports from both AIR and Harder+Co are available on our MHSA website, www.smhealth.org/mhsa.

Here are a few highlights across both reports:

- Activities and events organized by each collaborative are driven by and responsive to the community needs in terms of the resources provided and the alignment of cultural, social and linguistic supports.
- The strong collaborations have facilitated warm hand-offs between agencies and have provided a gateway to a range of services to support wellness, recovery and access.
- In FY 2015-16, between the two collaboratives, 5,556 individuals were engaged through meaningful outreach. Of these, 51% represented underserved ethnic communities including specifically African-American, Mexican, Filipino, Chinese, Tongan, Samoan and multiracial communities.
    - EPAPMHO individual outreach efforts included 26% mental health referrals, 30% substance abuse referrals and 1,416 social service referrals to 749 individuals including medical care, housing and food services.
    - NCOC individual outreach efforts included 45% mental health referrals, 14% substance abuse referrals and 483 social service referrals to 353 individuals including legal, housing and financial services.

MHSA OUTREACH COLLABORATIVE EVALUATION COVER LETTER

It is clear that much has been accomplished in terms of education and awareness for underserved communities and referrals to services focused on the whole person's needs. Yet, it is difficult to measure the direct impact these efforts are having on complex barriers to care, such as stigma and cultural and ethnic disparities to access.

While specific recommendations have been identified in each report based on the data collected, it is important to concurrently consider the overall challenges evoked by both reports, the expanded outreach supports since the launch of the outreach collaborative strategy in 2006 and broader BHRS efforts. In particular, how we integrate the Network of Care, Community Service Areas, the Office of Diversity and Equity, Health Equity Initiatives and the Outreach Worker Program and other efforts implemented since 2006. Following are overall considerations to be able to continue supporting and improving the outreach collaborative strategy and better integrate across the system:

- ✓ Coordinate and articulate the goals of the outreach collaborative strategy across both the north county region, including Pacifica and the East Palo Alto community.
    - o Benchmarks and activities are expected to look different given the unique needs and demographics of each community but the overall goals should align.
    - o Integrate broader outreach and support goals and activities, recognizing the intersection of outreach to increase access for individuals with severe mental illness (SMI) and outreach efforts for prevention, stigma reduction and meaningful engagement.
- ✓ Identify meaningful indicators of success for the outreach collaboratives including tracking SMI referral follow through where appropriate.
- ✓ Integrate efforts and activities to include special populations as identified in the AIR report, at-risk for homelessness, older adults and emerging communities and expanded needs in the broader San Mateo County (e.g. Arab-American, LGBTQ, geographically isolated communities, etc.)
- ✓ Coordinate and articulate MHSA-wide efforts and indicators to measure stigma reduction and improvements in cultural and ethnic disparities as they relate to access to behavioral health services in San Mateo County.

To support the findings of these reports as outlined above, a priority recommendation was put forward through the MHSA Community Program Planning process for consideration.

We anticipate this report will provide additional considerations to our ongoing dialogue with community partners, clients/consumers, family members, service providers and others about best practices in outreach and engagement. We welcome your comments and suggestions by emailing Doris Estremera, MHSA Manager at mhsa@smcgov.org.

Thank you for your continued support.

Stephen Kaplan, LCSW
Director, Behavioral Health and Recovery Services

San Mateo County Mental Health Services Act

Community Outreach & Engagement

Findings from interviews with North County Outreach Collaborative & East Palo Alto Partnership for Mental Health Outreach members

January 31, 2017

harder + co | community research

Embracing Diversity Advancing Equity

Behavioral Health & Recovery Services

SAN MATEO COUNTY

Office of Diversity and Equity

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Executive Summary

Background

The San Mateo County Behavioral Health and Recovery Services (BHRS) Outreach and Engagement strategy works to increase the awareness of and access to behavioral health services for underserved communities within San Mateo County. San Mateo BHRS does this by funding two Outreach Collaboratives, the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC). Wanting to learn more about the work of these two collaboratives, San Mateo BHRS contracted with Harder+Company Community Research, and independent consulting firm, to conduct an evaluation.

The findings presented in this report were gathered from interviews with EPAPMHO and NCOC members, and focused on developing an understanding of the identified goals of each collaborative; processes and activities each collaborative is implementing as they work toward their goals; strengths and successes of each collaborative; and additional resources or support that would benefit the collaboratives.

Key Highlights

Perspectives shared by interviewees suggest that members of NCOC and EPAPMHO are collectively working to increase access to mental health services among community members, while also providing information focused on reducing the stigma associated with mental health. Key findings include:

- **EPAPMHO and NCOC members demonstrate a commitment to serving the community members of their respective regions.** The activities and events organized by each collaborative are driven by community need. Furthermore, the strong relationships each of the collaboratives have with community members and community-based service agencies within each of their respective communities allows them to create and provide resources that are aligned with the cultural, social, and linguistic needs of East Palo Alto and North County residents.

- **The successes NCOC and EPAPMHO have experienced can be attributed to the strong relationships members have been able to form with one another.** These strong inter-collaborative relationships facilitate warm hand-offs between agencies and encourage information and resource-sharing among member agencies.

- **NCOC and EPAPMHO members are committed to providing opportunities for authentic community engagement.** Interview findings reflect a high level of commitment among NCOC and EPAPMHO members, as evidenced by regular attendance at quarterly and/or monthly meetings and participation in outreach events and activities.

Recommendations

After reviewing the information gathered during interviews with NCOC and EPAPMHO members, the following recommendations emerged.

- **Each collaborative, in partnership with San Mateo BHRS, should establish regular (e.g., annual) review of each collaborative's goals.** While NCOC and EPAPMHO members are able to articulate their respective goals, setting aside time to review goals and reflect on progress would provide opportunities for reflection and refinement.

- **Each collaborative should develop internal indicators to track and monitor progress.** While NCOC and EPAPMHO members often pointed to individual contract goals as benchmarks of progress, developing indicators to track each collaborative's efforts as a whole would be beneficial.

- **Develop additional data collection activities to assess the over-arching goals of the collaboratives.** After developing internal indicators, additional data will need to be collected to help measure progress.

- **Consider assessing whether benefits of participating in the collaboratives extend beyond the participating members to the organizational level.** While interviewees noted strong relationships and understanding of the services member agencies provide, it would be worth exploring how staff members at the member agencies perceive and understand the work of each collaborative.

- **The San Mateo BHRS MHSA Manager should continue to attend NCOC and EPAPMHO meetings.** Members noted having regular communication with San Mateo BHRS is necessary to the collaboratives' success.

- **San Mateo County BHRS should consider providing additional resources and supports that will build capacity within each outreach collaborative.** While interviewees often mentioned the need for increased funding, they would also like to receive other resources such as an Outreach & Engagement intern.

- **Develop an inter-agency client referral form.** The current level of collaboration among members would be conducive to the development of a form and would help agencies record and monitor their outputs.

Introduction

The Mental Health Services Act

In 2004, Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters to provide funding to counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. Activities funded by MHSA are grouped into five components: 1) Community Services and Supports; 2) Prevention and Early Intervention; 3) Innovation; 4) Capital Facilities and Technological Needs; and 5) Workforce Education and Training[1]. The Community Services and Supports (CSS) component was created to provide direct services to individuals with severe mental illness and is focused on community collaboration and serving unserved and underserved populations. Counties are able to apply for CSS funds from three different service categories: 1) Full Service Partnerships; 2) General System Development; and 3) Outreach and Engagement[2].

MHSA Outreach and Engagement Strategy

The San Mateo County Behavioral Health and Recovery Services (BHRS) MHSA Outreach and Engagement strategy works to increase access and improve linkages to behavioral health services for underserved communities. BHRS has observed increases in representation of these communities in its service system since the outreach strategy was deployed. Community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (hereafter referred to as EPAPMHO or the Partnership) and the North County Outreach Collaborative (hereafter referred to as NCOC or the Collaborative), with each working to engage with particular underserved populations and communities. EPAPMHO focuses their outreach efforts on at-risk youth, transitional-aged youth (TAY), and underserved adults, with a specific focus on Latino, African American, Pacific Islander, and LGBTQ communities. While NCOC focuses their community engagement efforts on rural and/or ethnic communities, including Chinese, Filipino, Latino, Pacific Islander, and LGBTQ populations in the North County region of San Mateo.

The outreach collaboratives are intended to facilitate a number of activities focused on community engagement, including outreach and education efforts aimed at decreasing stigma related to mental illness and substance abuse; increasing awareness of and access to behavioral health services; advocating for the expansion of local resources; gathering input for the development of MHSA-funded services; and linking residents to culturally and linguistically competent public health and social services.

Report Purpose

Wanting to learn more about the work of their two Community Outreach Collaboratives (North County Outreach Collaborative and the East Palo Alto Partnership for Mental Health Outreach), San Mateo BHRS contracted with Harder+Company Community Research to conduct an evaluation. The goals of the evaluation were to:

[1] http://www.mhsoac.ca.gov/components

[2] http://www.dhcs.ca.gov/services/MH/Documents/FSP_FAQs_04-17-09.pdf

- Better understand the work and processes of each of the collaboratives
- Assess the level of collaboration within each collaborative
- Identify recommendations for the collaboratives to consider as they continue to plan and conduct community-based outreach activities and events

After attending meetings with NCOC and the EPAPMHO, Harder+Company determined individual interviews would be the most effective process for gathering information from collaborative members. Further details regarding the interview and analysis processes are described in Appendix 1. The following sections of the report present findings gathered from interviews with collaborative members and include recommendations for San Mateo BHRS and the outreach collaboratives to consider as they further develop and define their outreach and community engagement efforts.

East Palo Alto Partnership for Mental Health Outreach

History of the East Palo Alto Partnership for Mental Health Outreach

As described in the methods section (Appendix 1), Partnership members and San Mateo BHRS staff noted that key to the Partnership's success to date is the improved relationship between San Mateo BHRS and East Palo Alto community members. As such, a subset of interviews were conducted with key EPAPMHO partners to understand the history between San Mateo BHRS and East Palo Alto. Findings from these interviews are documented in the timeline included in Appendix 2.

Key Themes

A number of key themes emerged from interviews with Partnership members. These themes provide perspectives about the benefits of participating in the Partnership, Partnership goals and how they are created, and strengths and successes of the Partnership.

Benefits of participating in the Partnership

Interview participants were asked to explain the benefits of participating in the Partnership. The themes that emerged from the interviews are described below.

Participating in the Partnership has enabled members to develop strong interagency bonds and gain an increased understanding of each individual agency's work. These dynamics ultimately help the members effectively refer clients to the services they need.

- **Engaging in the Partnership has provided opportunities for members to learn from one another.** Several participants expressed that a key benefit of participating in the Partnership is that they have been able to connect with one another and learn about the services each of the member agencies provide. As a result, they are better able to help community members access services in a streamlined way through what some refer to as "warm handoffs". One participant explained: "We benefit, also, from the partnership in terms of the accessibility. We know the names of the people that we work with, the therapist that they are working with, that facilitates an easy access when we have a patient that needs to be seen for mental health issues or services."

- **Clients are the primary beneficiaries of the Partnership.** Aside from the benefits that participating in the Partnership provides among the agencies, several participants emphasized that clients ultimately benefit from the Partnership the most. The Partnership's outreach and education activities focused on reducing the stigma associated with seeking mental health services aims to facilitate the process of connecting community

> **"I think the biggest benefit [is that] clients are benefitting from the Partnership… Whenever someone is in need of a referral, we provide the referral. We [will] walk them to the clinic."**

members to services. In particular, their interagency relationships serve to guide clients along the right channels in order to attain the specific services that they need. One participant described the mutually beneficial dynamic of the Partnership: "If community members come to us through different services, [we are] like a gateway to other services. The biggest thing is we educate the clients on stigma and mental health issues. At the same time… [if] someone is in need of a referral, we provide the referral."

Goals of the Partnership

Participants were asked to describe the primary goals of the Partnership and how they were identified, as well as any indicators that had been developed to measure progress towards achieving their goals. The key takeaways from their responses include the following:

- **All members interviewed were aligned in their definitions of the Partnership's primary goals.** Overall, the participants described similar goals the Partnership is working towards, as articulated by one participant: "It's stigma reduction, communitywide and also as individualized client services that we provide. Stigma reduction, education, and information dissemination to the different segments in the community." A few participants also underlined their function of serving as a "bridge to specialized services that are needed" by community members. These participants also noted that without the collaboration between Partnership members, this function would not be able to occur.

"[Our goals are] stigma reduction, education, and information dissemination to the different segments of the community."

When participants were asked to describe how the Partnership's goals were identified, mixed viewpoints were shared. Some believe they were determined at the Partnership's inception, while others explained that they were developed over time through communication with fellow agencies and/or San Mateo BHRS.

- **Some Participants were unsure how the Partnership's goals were identified, and noted that the goals were already established prior to them joining the Partnership.** One participant stated that he did not know how the Partnership's goals were identified, as he had only been working in his role for one year and felt that he had "walked into an already established program." Another inferred that the need for access to services by community members, stigma reduction, and mental health education inspired the formation of the Partnership, and thus the Partnership's goals are grounded in working to answer the following questions: "How do we break the stigma?", "How do we educate?", and "How do we access services?" Another shared that there have been difficulties in coming to a consensus about the Partnership's goals due to differing experiences and viewpoints among the partners. She explained: "We came in and battled it out. I tell you it was not an easy thing. We were not on the same page in a lot of ways." However, during these discussions members were able to come together to "decide on goals and our purpose" and develop a course of action based on identified community need.

- **Other participants mentioned coming together as a group to develop goals by discussing needs and challenges that the community members are faced with.** One participant explained that the Partnership shares identified community needs with each other and/or San Mateo BHRS, which prompts a collaborative effort among partners with certain specialties to organize an action plan, such as strategies for outreach. Furthermore, this participant emphasized the framing of their

efforts based on the needs of the community. She described the process of serving as a community "safety net" which, over time, evolves into establishing "systems or interfaces to both communicate and provide service[s]" to community members. Participants were asked to share how they assess whether their goals have been met. All participants had a clear sense of how their work is measured. There was a consensus among members interviewed that the indicators for achieving their goals were centered on meeting numerical benchmarks in their individual contracts.

- **Individual agencies have their own contractual requirements regarding outreach and referrals.** Participants explained that according to their contracts, they are prompted to reach particular numbers of outreach and referrals each year as a way to gauge their success as it relates to the Partnership's goals. One participant shared: "Individualized, as an agency, we have a certain commitment that we have to comply with every year. In terms of how many people do we provide education, how many people we do provide successful referral? We keep track of that on a monthly basis." Keeping track of these objectives each month helps members document their efforts and review progress to date. The Partnership also uses the annual Family Awareness Night event as a time to reflect on the work the Partnership has accomplished over the year and assess progress towards reaching their goals. While Partnership members use individual contract numbers to determine progress, having indicators to track the Partnership's progress as a whole would be beneficial.

Strengths and Successes of the Partnership

Participants pinpointed Partnership processes that are working well, which contributes to their key successes:

- **Regular meetings among members of the Partnership have helped their relationships improve over the years.** One participant felt that remaining apprised of each other's work, concerns, and challenges through their regular meetings have been a positive and conducive experience: "The meetings we have quarterly that we all come and discuss the changes, the updates, sharing our own particular issues that we may have, I think that's a good thing." Other participants specified that the quarterly meetings in particular "help facilitate the work" moving forward, which contributes to their success because they are able to learn from each other, and that these regular meetings have also enabled members of the Partnership to reach a stage where they are "now open to each other than before." Another participant felt that consistent attendance at these regular meetings (i.e., quarterly meetings) signifies the commitment of the members: "I think there is a very authentic involvement of all the partners in providing services that can make a difference in the community. That's one. Also the commitment to participate in all the meetings and the planning process to facilitate the services."

"I think there is a very authentic involvement of all the partners in providing services that can make a difference in the community."

- **Communication with mental health providers to connect clients to services has been particularly successful.** One participant highlighted that her experience partnering with a mental health provider, has led to a mutual collaboration for successfully identifying the needs of clients. She said: "For me what's working effectively is that we have a very good system of communicating with the Palo Alto Community Counseling Center." This partnership allows providers in EPAPMHO to regularly meet with staff from the Counseling Center to discuss client needs and identify community services that will help address these needs. Furthermore, she notes that where "the Partnership for us has been very successful is the

accessing of services." The communication Partnership members have with providers has strengthened over time and has led to successful working relationships among various community-based agencies.

- **While the commitment of the Partnership members has been strong, members may benefit from more opportunities to come together and reflect on the work that has taken place.** One participant commended fellow members of the Partnership for their strong commitment and work-ethic, and feels that it is important to engage in activities that help to re-invigorate everyone's commitment by reflecting on their past work. She explained: "I think anytime you are tackling a challenging issue and you are successful in getting people to engage in working through those challenges, and [when] that work takes place over many years there is a need for rejuvenation. Probably even in rejuvenation, re-commitment."

- **Partnership events such as the annual Family Awareness Night have consistently been recognized as a key success of the Partnership.** Most participants distinguished Family Awareness Night as a key success of the Partnership, as it serves as an opportunity to engage with various communities through a number of educational activities. Participants noted that the event continues to expand each year and now includes several activities that provide community members with "hands on experience of wellness." Another participant emphasized the positive impact that the event has on both the Partnership members and the community: "[The event is] a very authentic involvement of all the partners in providing services that make a difference in the community." When reflecting on factors contributing to the success of Family Awareness Night, one Partnership member explained that the "collective voice" the Partnership is able to represent allows for the representation of "bilingual and bi-cultural issues" that historically are not considered when planning and organizing community-based events. The Partnership's commitment to aligning services and information with the cultural, linguistic, and social practices of the populations they aim to serve contributes to successful outreach and engagement within the community.

"The clients come out, and they have a great time…Since last year, we've been doing these hands on experience of wellness and the partners are just bringing in more and more of their clients. That stands out every year for the partners. Bringing out their client and having them experience this great night of community with everybody."

Relationship with San Mateo Behavioral Health and Recovery Services

Participants were asked to reflect on how the Partnership's relationship with San Mateo BHRS has changed over time and any additional supports the County could provide to help the Partnership achieve its goals.

- **Partnership members recognize that San Mateo BHRS has contributed to the Partnership's work, and thus appreciate the various levels of participation by the staff.** Overall, members of the Partnership feel that that their relationship with San Mateo BHRS has been positive and helpful. One participant expressed: "I think it's really important. They are the drivers. They've got the funding for resources. They have opened their doors to us, their hearts to us." Furthermore, she remarked: "They meet with us. They are there; they are supporting our efforts…" A few other participants explained that the Partnership has been able to leverage their relationship with San Mateo BHRS to engage staff in their various efforts & initiatives (e.g., Family Awareness Night). Another participant mentioned that his agency benefits directly from the participation of key BHRS staff, including the MHSA Manager as well as clinical practitioners, who have been involved in "providing training and facilitating different activities and also participating in the meetings."

Furthermore, he described his appreciation for having "access to [San Mateo BHRS] staff," noting that the open working relationship between the County and local service providers helps Partnership members connect community members to services.

- **Although San Mateo BHRS's presence and various levels of involvement with the Partnership have been helpful, some feel that challenges still exist.** Some participants feel that there are constant changes in processes that are difficult to keep up with, and thus would like to be informed about the changes in order to effectively carry out their work. One participant explained: "We have our challenges. The constant changing can be a challenge at times, trying to keep up with the new requirements that are imposed on [San Mateo BHRS], that they have to incorporate in our contract and the work we do for them." Additionally, interviewees noted they would like to see BHRS offer additional County resources to the Partnership, such as placing an intern within the Partnership: "I know that BHRS has an internship program…but we haven't [been connected] with any of the interns."

- **Funding emerged as a major challenge for a few participants.**[3] Funding has been specified by several participants as a major challenge among the Partnership members. One participant noted having to pay for items using their personal funds: "There's this ongoing conversation with my staff about the funding resources available to do the work. There hasn't been an increase in funding, I know, since the contract was issued." While the Partnership's contract with the County is only intended to provide outreach-related funds, and is not intended to provide resources to individual agencies, it is important to consider how the financial constraints Partnership members may be working under influences the outreach activities they are able to commit to.

[3] When asked about challenges, most participants identified challenges within their own organizations and few challenges experienced with the Partnership. Only challenges related to the Partnership are included in this report.

North County Outreach Collaborative

Key Themes

Benefits of participating in the Collaborative

Interview participants were asked to explain the benefits of participating in the Collaborative. Interview responses indicate that regular meetings and learning about the work of partner agencies has led to the development of strong relationships among NCOC members.

Collaborative members have built strong relationships with one another while increasing knowledge and awareness about the services that each member agency offers. Together, these factors help Collaborative members effectively connect clients to services.

- **Regular check-ins at meetings, working together on projects, or tabling at various events have been important relationship-building activities.** One participant used the word "family" to describe the Collaborative, and reflected on the value of building various relationships with fellow members as well as their constituents. She explained how "working with each other as individuals and as a collective to see what our strengths are and how we can help" allowed members to interact with community members "as a full force, not just as one person," which has contributed to stronger connections with community members in need of services.

- **Learning about the work of other partners provides perspective on how the Collaborative is a dynamic team working toward common goals with respect to mental health services.** One participant remarked: "Each of us filled a niche for mental health services in a different way. I think it really gave [us a] better perspective as to where people in the city can seek services; how we can better work together to make sure that we're hitting all the underserved communities in our area." The interactions between Collaborative members have particularly helped reflect their unified commitment to the communities they serve. One participant commented on the value of NCOC members being "a vast network of people doing like-minded work across the county. It allows us to do warm hand-offs for outreach efforts for referrals, and I think that has really benefitted our community." She also highlighted the benefit of members being visible and serving various communities across the county, and felt that the level of collaboration among NCOC members has allowed the Collaborative to develop a strong presence in each of the communities members work within, "so everybody who's involved in the North County Outreach Collaborative has a presence wherever we go."

- **The Collaboration between the agencies has been valuable, especially with regards to making referrals to one another in an efficient manner.** One participant remarked that having a strong understanding of the services provided by each member agency has enabled her to refer clients to fellow NCOC member organizations that

"Because there are so many agencies involved, it's connected all of us to the work that we each do in our separate communities so that we have a presence in each of our communities, so everybody who's involved in the North County Outreach Collaborative has a presence wherever we go."

provide the particular services a client may requesting. The relationships and knowledge of one another's work has allowed members to easily contact a member organization to present the client's needs and inquire whether they can provide assistance. Another participant expressed that "the monthly meetings [have] enabled me to connect so much deeper with the other organizations involved. It really does feel like collaboration. We've been able to not only refer the clients to each other [but] we've [also] been doing more outreach together. It's really strengthened our collaboration."

- **Through outreach activities, members are also able to learn about the needs of community members/groups.** Being part of the Collaborative has enabled partners to have opportunities to interact with the communities they are working to serve. These interactions allow NCOC members to ascertain the service needs of the various populations they are working to serve. One participant expressed that as a liaison between the community and local government, "the biggest benefit is that I get to talk to the people in the community, and know their needs, in terms of mental health. Then through that I also build really good connections with other service providers."

Goals of the Collaborative

Participants were asked to describe the primary goals of the Collaborative and how they were identified, as well as indicators for achieving their goals. Interviewee responses indicate a unified understanding of the Collaborative's goals but also point to a lack of clarity regarding how the goals were developed.

- **All members interviewed were aligned in their definitions of the Collaborative's primary goals.** Participants articulated that the primary goals of the Collaborative include decreasing the stigma of seeking mental health services, and increasing access to mental health services. Some participants emphasized the importance of conducting outreach to underserved communities who would not usually seek mental health services. One participant explained that an important facet of the Collaborative's efforts is to "connect people to services where they're needed, so going out into the community and meeting people where they are [is] really important because people have a hard time accessing services because there's such a stigma around accessing services."

There were mixed responses when participants were asked about the process of identifying the Collaborative's goals, as two different viewpoints were expressed:

- **Some members perceive that the goals are prescribed by the County.** These participants conveyed that the goals of the Collaborative were in existence as recurring contractual goals since the Collaborative was established, with newer members expressing that the goals were developed prior to their involvement with the NCOC.

- **Other members described a strategic planning process that was used to determine the Collaborative's goals.** Some participants shared that the goals of the Collaborative have been regularly discussed and reassessed through various meetings and retreats. One participant stated: "We meet every year to look at what worked, what didn't work, and what our goals are going to be for this year." These yearly meetings are particularly beneficial in helping to identify changes that need to be made or services that need to be provided for certain communities. She

"I think the primary goal of the Collaborative is to connect people and share resources and then connect people to services where they're needed, so going out into the community and meeting people where they are [is] really important because people have a hard time accessing services because there's such a stigma around accessing services."

explained that as a result of collaborative efforts, and in response to community need, goals of the Collaborative have also shifted: “We’ve had to amend our contracts a little bit each time, because that’s changed according to the need, and according to what we’ve already done. There have been things that we’ve done and done really well, and the community is now doing them, so we have to work on a different part of the community where there’s a need.”

Participants were asked to share how they assess whether their goals have been met. A few had a clear sense of how their work is measured.

- **Some members shared that the primary indicator for assessing whether goals have been met can be attained from assessing outreach numbers through monthly reporting.** For a few participants, the indicators used to gauge whether their goals have been met are through what has been reported on a monthly basis, for example: how many families that they were able to complete outreach for, or the number of client referrals they’ve had. Discussions about this during general meetings have been helpful, but the Collaborative is still determining the best way to track each agency’s outreach efforts and how these efforts reflect the work of the entire Collaborative.

Many participants, however, commented on the complexities that arise when tracking their work, as they did not feel that there was a clear uniform procedure for tracking outreach contacts and monitoring outreach data. Limitations and challenges concerning the processes of completing current outreach forms and data entry on SurveyMonkey were also mentioned.

“There’s a half-sheet that we have to have everyone fill out that we speak to, and that’s been extremely difficult to do. It’s almost like a little invasive.”

- **Creating measurable objectives has been a challenge.** Many participants expressed challenges in measuring the extent to which their goals have been met. Reasons for this include the lack of a tracking process for a variety of activities specific to their organization’s work, including measures in place to indicate if they are reaching a particular population, verifying the sources of their referrals, and gathering how many contacts are connected or linked to services. One participant shared: “We are able to show that we have our flyers and make referrals, but to then track, 'Yes, this client went here and this linkage was made' has been challenging. That's been an ongoing problem because our services typically don't enable that to happen. That's something that has been communicated since I have been involved in this grant."

- **It has been difficult to record the work being done.** Considering the dynamic nature of their work internally and externally, some participants expressed the difficulty of recording the work that they have done, as there are certain pieces that are hard to track, such as outreach events where members are speaking to large groups or classrooms. As one participant explained, it can often feel like an invasion of privacy when asking an event attendee to complete an outreach form: “There’s a half-sheet that we have to have everyone fill out that we speak to, and that's been extremely difficult to do. It's almost like a little invasive." Another participant expressed her desire for real-time access to the SurveyMonkey data members of the Collaborative submit to the County. Having timely access to the data would allow Collaborative members to utilize the data to help inform outreach events and activities.

- **Information may be recorded, but how the output translates as markers for achieving goals is not clear.** A participant expressed the challenge of tracking and measuring referrals, as well as how it relates to

whether goals are being met: “I know that when we do our stats, we turn them in, but I don’t know if it really identifies if we are really reaching this population. How do you measure the referral coming back?” Another participant said: “I feel like in the past we’ve had these big overarching goals but have had a harder time really being able to measure them to concrete number or actions that we’re doing it cause increasing access and decreasing stigma are really overarching ideas.”

- **Utilizing an inter-agency referral form amongst the Collaborative would be mutually beneficial for the members and their clients.** One participant suggested the development and usage of a client referral form, which could become a best practice for tracking information to improve organization methods and outcomes. The participant explained: “Something that's been talked about from the beginning has been making an inter-agency referral form and I have yet to see that actually happen. I feel like at this point, especially with the fact that our collaboration is so strong and the fact that we meet so regularly, I feel like that we now could actually carry that out. "

There is a great deal of work being done to meet the Collaborative goals, but challenges also exist. Participants described some of the challenges they have experienced with regards to stigma reduction and community outreach.

- **Breaking down stigma relating to mental health services has been difficult but the dynamic work of the Collaborative is helping address these challenges.** Several participants noted that while the stigma associated with seeking mental health services is a common challenge across cultural groups and populations the teamwork between Collaborative members is helping address these challenges. “I may be doing [work with one population] and [other members] may be doing [work with another community], but we’re always keeping each other abreast of what’s going on. We each come [to this work] with a special part, each with the common goals of how to do better outreach, how to better connect with folks, how to get folks more engaged…”

- **While community events are central to the Collaborative’s goals, there is often limited capacity to staff and attend events.** The Collaborative has identified outreach opportunities and community events that are important activities for meeting their goals, but experience challenges with respect to time limitations, as well as the agencies’ staffing capacity for attending or participating in the various events. One participant mentioned that personnel resources can be strained, as many staff members wear multiple hats. Additionally, events may be focused on populations that fall outside of an agency’s target groups, but as NCOC members, staff are still expected to participate. She explained that “it is a Collaborative, and so when we have these events, which may really not serve any of the population that we serve, we still show up because of the fact that you can’t staff your event without the whole.” She also noted that individuals who staff the events tend to be the same few Collaborative members and that the work could be more evenly distributed among all members.

“It is a Collaborative, and so when we have these events, which may not serve any of the population we serve, we still show up because of the fact that you can’t staff your event without the whole.”

Strengths and Successes of the Collaborative

Participants pinpointed Collaborative processes that are working well, which not only reflects the level of collaboration among NCOC members, but also contributes to their key successes:

- **The Collaborative members have been able to form relationships with other community organizations.** Two participants shared that their key successes thus far have included making successful connections with faith leaders in the community. One participant mentioned: "...we made [connections] with a couple of churches and had some great conversations with churches and are looking at presenting at some of their youth groups." Another participant also considered engaging the faith community (as well as other community leaders) to be a big success: "I think you need to highlight that, because it's been really hard to do. For us, personally, we've been able to create relationships between our community-based organizations, and we've been able to create relationships with our city leaders, our city manager, and our city council-members, to where they're starting to work together on policy initiatives for rent and affordable housing, so that's all because of our outreach [efforts]."

- **Consistency in the Collaborative's events and activities has helped their outreach efforts.** One participant noted how regular meetings and events have allowed Collaborative members to establish strong working relationships and develop a unified vision for their work. These regular meetings have "…manifested in us doing more outreach together. We're more visible at different community events by having a table. We've done a lot more around branding ourselves…It seems like we have more of a common voice and vision…" These activities in turn have resulted in the Collaborative having a recognizable presence among community members.

"What's been working well is the consistency around collaboration…All the organizations continue to come to the table on a monthly basis, wanting to work together. That's manifested in us doing more outreach together. We're more visible at different community events by having a table. "

Relationship with San Mateo Behavioral Health and Recovery Services

Participants were asked to reflect on how the Collaborative's relationship with San Mateo BHRS has changed over time and any additional supports the County could provide to help the Collaborative achieve its goals.

- **San Mateo BHRS's relationship with the Collaborative has improved for some, as the County has begun to provide more guidance and rationale regarding decision-making processes; however, others feel that challenges still exist.** Most participants expressed that the Collaborative's relationship with San Mateo BHRS is continuing to improve, as opposed to earlier years where there was more of a "disconnect" between assigned goals and the Collaborative's ability to accomplish them. However, some participants shared that they would like San Mateo BHRS to help them "brainstorm [measurable] objectives" and would like more guidance and direction from the County about work the Collaborative should be expected to achieve within a year and how the Collaborative could measure their success.

- **The MHSA Manager's presence at Collaborative meetings is valued.** Participants are particularly satisfied with the presence and guidance that the MHSA Manager provides regarding their work, and feel that she is more clearly defining expectations for the Collaborative. She has been described as a "real advocate" and has positively made a "big difference". One participant explained: "She's been really great in keeping contact with us and keeping us updated…She's been really good about that…The communication [from the County] was not [always] consistent."

"I think [the MHSA Manager] who has been our liaison now has been really helpful. She's been really great in keeping in contact with us and keeping us updated and if she needs something she'll let us know. If there's a change she'll let us know."

- **Participants' responses were mixed regarding the challenges they have experienced, as many addressed issues related to funding.** When speaking about funding, participants noted two distinct funding-related issues, funding individual programs receive and funding provided to the Collaborative. Some participants recognized that funding for their services will be an ongoing challenge, and hope that San Mateo BHRS can assist in that area. Given that the focus of the interviews was understanding challenges related to the Collaborative, we have only presented funding-related challenges that are relevant to NCOC. One participant shared that San Mateo BHRS has "made it easier for us to do our job by continuing to renew this funding with less effort on our part…I feel like them renewing the grant ongoing like this has really, really helped us do our work more effectively. You don't see that very often. That's a big thing to credit them on." Another participant observed an overall imbalance with regards to the distribution of resources and funding in North County: "North County seems to continue to have fewer resources and less funding. This has been something that we have been communicating for a while now. A lot of services and funding tends to go more towards central and especially the southern parts of San Mateo County. The northern part has seemed to have less. We've really been advocates for more services to come up north. BHRS has helped that, but I think we could continue to use even more of their support. To have services and funding be distributed more equally throughout the county."

- **There is a variety of additional supports that participants feel would be helpful. Despite some expressing an overall appreciation of San Mateo BHRS's assistance, some also felt there are particular aspects that could be improved.** One participant would find it helpful to be supplied with updated, educational resources and handouts: "BHRS providing outreach materials once a year, or at the beginning of the year, such as pamphlets that provide information about their services [that] could be passed out and shared with the community."

"Because we've been able to get our reports in, keeping them up to date…I feel like them renewing the grant ongoing like this has really, really helped us do our work more effectively."

Recommendations

Perspectives shared by interviewees suggest that members of the North County Outreach Collaborative and East Palo Alto Partnership for Mental Health Outreach are collectively working to increase access to mental health services among community members. Collaborative and Partnership members noted that many of the successes of the respective collaboratives can be attributed to the relationships members have been able to establish with one another. As NCOC and EPAPMHO continue to work towards reducing the stigma associated with mental health and accessing services, as well as provide outreach and education about mental health and County- and community-based services, we offer the recommendations listed below for San Mateo BHRS, NCOC, and EPAPMHO to consider.

- **Establish regular (e.g., annual) review of each collaborative's goals.** While both NCOC and EPAPMHO members were unified in defining their respective goals, members were not aligned regarding the process for defining and reviewing goals. Setting aside time each year to review goals will not only establish an internal process, but will also provide dedicated time for collaborative members to reflect on the work from the previous year and refine goals as needed.

- **Develop internal indicators to track and monitor progress.** Although NCOC and EPAPMHO members submit data to the County, several interviewees noted a lack of clearly defined indicators to track and monitor their progress. Indicators could include items such as number of outreach events attended each month, approximate number of outreach participants at each event, number of new partnerships formed with other agencies, number of events attended by each collaborative member, etc. Progress and updates regarding each indicator could be reviewed during monthly meetings. Furthermore, indicators would also provide key information related to progress made on achieving each collaborative's broader goals.

- **Develop additional data collection activities to assess the over-arching goals of the collaboratives.** Although interview findings indicate that collaborative members are satisfied with the work they are doing towards reaching their high-level goals (e.g., stigma reduction, increased awareness about services) there is little data about how effective these efforts are. Additional data collection efforts aimed at understanding effectiveness would help identify how the collaboratives are working towards these goals. Data collection efforts could include interviews or focus groups with individuals that have accessed services as a result of information provided by the collaboratives, or surveys with staff members working at agencies that receive clients referred to services by the collaboratives. The survey administered during the Family Awareness Night would serve as a starting point for EPAPMHO members when considering additional data they may want to collect from attendees.

- **Consider assessing whether benefits of participating in the collaboratives extend beyond the participating members to the organizational level.** While interviewees noted that a common benefit to participating in the collaboratives have been the relationships members have established with one another, it would be worth exploring if these benefits extend to the organizations members work for. In order for the benefits of participating in the collaborative to be sustainable, they must

extend beyond the participating member to the member agency as a whole. This could be assessed in a number of ways, such as conducting surveys or interviews with member agency staff about their perspectives of the collaborative, including perceived benefit of having staff participate, benefits to clients, and/or information or resources they would like the collaborative to provide.

- **The San Mateo BHRS MHSA Manager should continue to attend NCOC and EPAPMHO meetings.** Having the MHSA Manager regularly attend collaborative meetings helps maintain regular communication between the collaboratives and San Mateo County BHRS. During these meetings the MHSA Manager is able to clarify expectations and provide updates to members. Regular data sharing would also be valuable during these meetings and allow NCOC and EPAPMHO members to receive outreach summary data in a timely manner.

- **San Mateo County BHRS should consider providing additional resources and supports that will build capacity within each outreach collaborative.** While both collaboratives noted improved relationships with San Mateo County BHRS, members would like access to additional County resources, such as having an intern work with the respective collaboratives. Additionally, NCOC members in particular noted they would like support from San Mateo BHRS to help develop and articulate measureable goals and objectives. Providing opportunities for collaborative members to review outreach data submitted to the County in the context of goals (e.g., stigma reduction, increased awareness of services) would help collaborative members identify connections between data and outcomes, but would also encourage identification of indicators or benchmarks to help determine progress.

- **Develop an inter-agency client referral form.** NCOC interviewees noted that Collaborative members have discussed the idea of creating an inter-agency client referral form for a number of years. Members also noted that the current level of collaboration among members would be conducive to the development of a form, with many noting that they would like the Collaborative to take steps to developing the form. Improved tracking methods between Collaborative members, such as inter-agency client referral forms, would help agencies record and monitor their outputs, which can serve as indicators to gauge whether outreach goals are being met. While EPAPMHO members did not specifically discuss creating an inter-agency client referral form, this type of tool would provide members with valuable information regarding the types and number of linkages to services that are made when Partnership members refer clients to one another.

Appendix 1: Methods & Interview Protocols

In collaboration with the San Mateo County BHRS Mental Health Services Manager and the Director of the Office of Diversity and Equity, Harder+Company developed an interview protocol that asked collaborative members to reflect on their involvement with NCOC or EPAPMHO. The questions asked interviewees to describe the primary goals of their collaborative, internal processes for organizing events and identifying community partners, as well as challenges facing the collaborative.

Before interviews were scheduled, the Executive Director and the Special Projects Consultant from One East Palo Alto, the San Mateo BHRS Mental Health Services Manager, and members of the Harder+Company team met to review the interview protocol and list of interview participants. During this meeting, One East Palo Alto and San Mateo BHRS staff noted that it would also be worthwhile to document the series of events that led to the creation of the East Palo Alto Partnership for Mental Health Outreach. One East Palo Alto provided a list of four individuals who would be able to speak to the history of the Partnership. Harder+Company developed a separate protocol for these interviews that focused on identifying the elements that contributed to the development of the Partnership.

Following development of the interview protocol, the Harder+Company research team sent interview invitations to seven individual members of NCOC and ten individuals (six current members of the Partnership and four past members) associated with the EPAPMHO. The lists were compiled in collaboration by San Mateo Behavioral Health and Recovery Services and collaborative members. All 17 invited interviewees agreed to participate in a 20-30-minute phone interview with a Harder+Company team member. With permission from the participants, interviews were recorded for note-taking and transcription purposes.

After the audio files were transcribed, content analysis was employed to identify and categorize themes that emerged from the interviews. Two members of the Harder+Company research team separately reviewed and identified thematic codes for each of the interview transcripts. Following this review process, the team members came together to discuss common themes and develop a report outline.

Findings from the subset of interviews documenting the establishment of the EPAPMHO are documented in the timeline included as Appendix 2. These interviews highlighted how the County's relationship with East Palo Alto shifted as a result of planning for the award of State Mental Health Services Act funds.

Interview Protocol: Collaborative Members

Introduction

Thank you for taking the time to speak with me today. I work for Harder+Company Community Research, a consulting firm that is conducting interviews with participants of the [East Palo Alto Partnership for Mental Health Outreach/North County Outreach Collaborative] on behalf of the County of San Mateo Behavioral Health & Recovery Services. San Mateo BHRS seeks to better understand and support the work [Partnership/Collaborative] members are engaged in. During the interview I will ask you to reflect on work that has taken place, about your experience and perspective of the [Partnership's/Collaborative's] efforts, as well as future goals of the [Partnership/Collaborative].

This interview will take approximately 30 minutes. I encourage you to be as honest as possible in your responses. If there is a question you prefer to not answer, please let me know. Everything we talk about today is confidential, meaning that we won't use any identifying information when presenting our findings.

For notetaking purposes, I would like to record today's conversation. Is that OK? Only the Harder+Company team and our transcription service will have access to this recording. The recording will be deleted once our work is complete.

Do you have any questions before we begin?

Background

1. To start, can you tell me a little bit about your role with the [East Palo Alto Partnership for Mental Health Outreach/North County Outreach Collaborative]?

    a) How long have you been a member of the [Partnership/Collaborative]?

    b) During the time you have been a member of the [Partnership/Collaborative], has your role changed? If so, how?

2. I'm interested in learning about the benefits participating in the [Partnership/Collaborative] provides to both you and your organization. What are some of the key benefits participating in the [Partnership/Collaborative] provides?

[Probes: exposure to new organizations, learning from others, cross-sector engagement, opportunities to partner with other organizations, coordination of services and referrals, etc.]

Understanding the Partnership/Collaborative

3. How would you describe the primary goals of the [Partnership/Collaborative]?

    a) How were these goals developed/identified?

    b) How is the [Partnership/Collaborative] working to meet these goals?

    c) How will the [Partnership/Collaborative] know if goals are met/ achieved? [Probe: Has the [Partnership/Collaborative] identified indicators? Does the [Partnership/Collaborative] have a process or structure in place to review and refine goals?]

4. Given the [Partnership's/Collaborative's] goals you described above, are there processes/activities you see as working particularly well or not well within the [Partnership/Collaborative]?

[Probes: What do you see as working well? What do you see as not working well? What type of improvements should be made to ensure the [Partnership/Collaborative] is working toward its goals?]

5. How would you describe San Mateo Behavioral Health & Recovery Services' role in your [Partnership/Collaborative]? [Probes: advisor, institutional support, service/referral oversight, etc.]

a) What would you say they are doing well?

b) Where have there been challenges? Has BHRS done anything to help address these challenges?

c) Are there supports you would like BHRS to provide?

6. It is my understanding that a key priority for the [Partnership/Collaborative] is to organize community outreach activities. Can you tell me about the types of community outreach activities that are co-organized and/or co-sponsored by the [Partnership/Collaborative]?

a) What is the planning and implementation process like? (e.g., Are members assigned roles? How are decisions made? How, if at all, do members share about upcoming events their respective organizations are hosting?)

7. What do you see as the most important challenge facing current outreach efforts?

a) How might these challenges be addressed?

8. Based on the types of outreach activities your organization and the [Partnership/Collaborative] engage in, would you say there are current gaps in services for specific populations (e.g., transitional-aged youth, homeless/unstably housed, etc.)?

a) How might these gaps in services be addressed?

9. Who are the key community-based partners the [Partnership/Collaborative] works with (this can include any community-based entity that are or are not current members of the Partnership, e.g., CBOs, churches, non-traditional partners, etc.)?

a) How were these partnerships established?

b) Does the [Partnership/Collaborative] have a process for identifying potential new community partners?

c) Are there any community partners that should be involved who currently are not? What are challenges to their involvement?

10. Thinking about the work that has taken place this year, can you tell me about a key success of the [Partnership/Collaborative]?

a) What factors contributed to this success?

b) How does this success relate to the goals of the Partnership?

11. How is information shared among [Partnership/Collaborative] members? Among community partners?

a) Do you have recommendations for improving how information is shared?

12. Those are all my questions. Is there anything else you would like to share that you haven't yet had a chance to discuss?

Interview Protocol: Additional EPAPMHO Interviews

Introduction

Thank you for taking the time to speak with me today. I work for Harder+Company Community Research, a consulting firm that is working with the County of San Mateo Behavioral Health & Recovery Services. We are currently conducting interviews with members of the East Palo Alto Partnership for Mental Health Outreach to better understand the work Partnership members are engaged in. San Mateo BHRS is also interested in documenting the history of the Partnership. Kava and Dr. Faye recommended we speak with you in order to better understand your role in the development of the Partnership. During the interview I will ask you to reflect on how the Partnership was established, the work that has taken place, and your experience and perspective of the Partnership's efforts.

This interview will take approximately 20 minutes. I encourage you to be as honest as possible in your responses. If there is a question you prefer to not answer, please let me know. Everything we talk about today is confidential, meaning that we won't use any identifying information when presenting our findings.

For notetaking purposes, I would like to record today's conversation. Is that OK? Only the Harder+Company team and our transcription service will have access to this recording. The recording will be deleted once our work is complete.

Do you have any questions before we begin?

Background & Involvement with the Partnership

1. To start, can you tell me a little bit about your background and the organization you currently work for?

These next few questions ask you to reflect on the processes and decisions that led to the establishment of the East Palo Alto Partnership for Mental Health Outreach.

2. To begin, can you tell me a little bit about your role with helping establish the East Palo Alto Partnership for Mental Health Outreach?

    a) Are you currently involved with the Partnership? If so, how?

3. What elements were in place that allowed for the establishment of the Partnership to take place?

[Probes: Funding? Community need? Key players?]

4. Is there anything you would have changed about how the Partnership was established?

Understanding the Partnership

5. How would you describe the initial goals of the partnership?

6. Thinking about the work that has taken place, can you tell me about a key success of the Partnership?

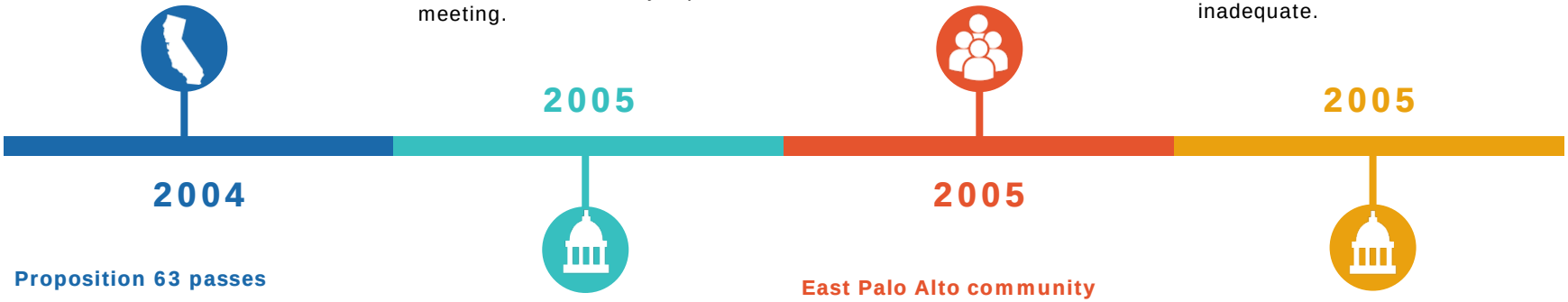
    a) What factors contributed to this success?

    b) What would you say are some of the challenges for future successes and achievements for the Partnership?

7. From your perspective, has San Mateo County BHRS' relationship with East Palo Alto providers changed as a result of the partnership? If so, how? [Probes: Helped establish trust? Increased institutional support provided by the County? Helped establish partnerships between service providers and contract partners?]

8. Those are all my questions. Is there anything else you would like to share that you haven't yet had a chance to discuss?

Appendix 2: History of San Mateo BHRS & EPAPMHO



2004

Proposition 63 passes

The Mental Health Services Act (MHSA) passes in 2004, signaling the first opportunity in many years for the California Department of Mental Health (DMH) to provide funding and resources to County mental health programs.
To receive MHSA funds, the County must collaborate with community members and stakeholders to develop plans for how funding would be used.

2005

San Mateo County MHSA planning begins

In preparation for receiving MHSA funds, the County begins to host meetings with community agencies to better understand unmet community needs.
County identifies East Palo Alto as a high-need community and schedules a community-input meeting.

2005

East Palo Alto community agencies organize

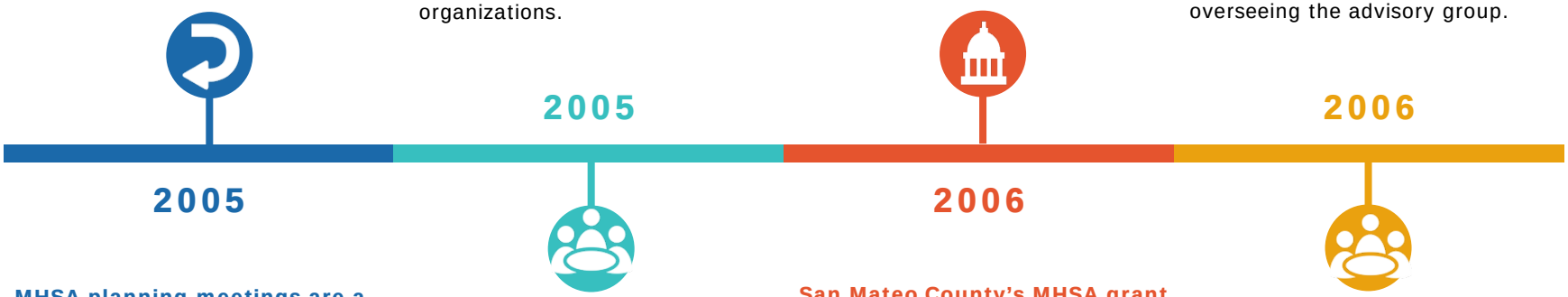
A community member involved with County MHSA-related criminal justice meetings alerts other community agencies & leaders to the potential opportunity the MHSA planning meeting will have on EPA resources.
As a result, EPA community leaders organize other key agencies and community members to attend the County MHSA planning meeting.

2005

San Mateo County holds MHSA planning meeting in EPA

EPA community members express concerns about the adequacy of the County's proposed MHSA plan to address critical needs of the EPA community. Community members also note that the County's process for understanding community need is inadequate.

"What we heard was: 'You all are not present in this community. You are not partners'…That was really the turnaround…we want[ed] to enter into a different kind of relationship." – San Mateo BHRS staff member



MHSA planning meetings are a turning point in the County's relationship with EPA

During the initial planning meeting, County employees recognized a necessary shift needed to occur in how the County engages with EPA residents & organizations. County staff expressed a commitment to work with the community to determine how to move forward, and follow-up meetings were organized to further discuss issues and concerns raised by community members.

One East Palo Alto serves as convening agency

OEPA hosts follow-up meetings with County and EPA community members. Meetings include representatives from key organizations throughout the community such as: Ravenswood Family Health Center, Free At Last, and faith-based organizations.

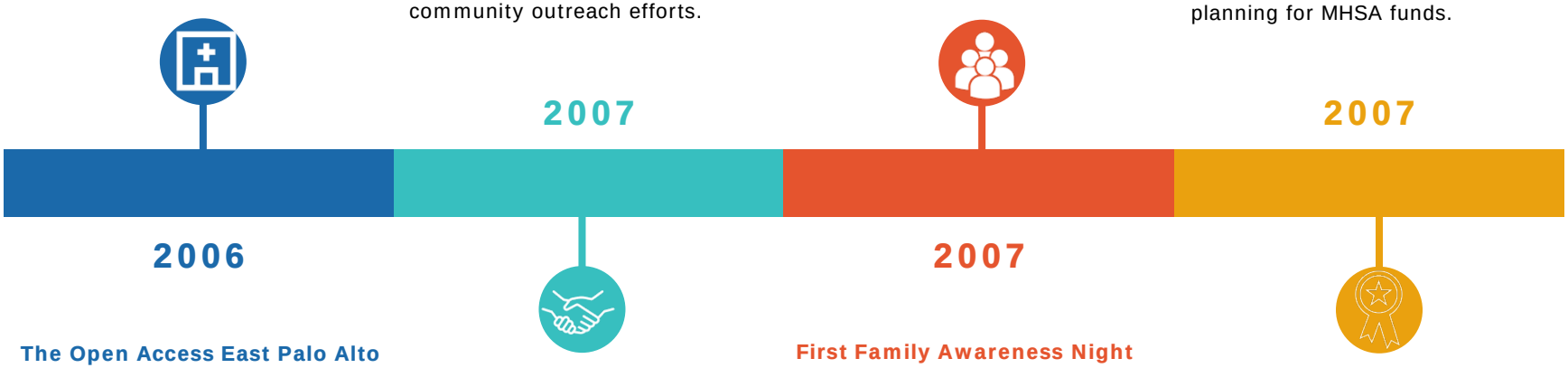
San Mateo County's MHSA grant proposal is approved

In preparation for receiving funds, conversations shift as EPA community members begin discussing specific initiatives to fund. Proposed activities reflect two primary goals held by EPA community members: 1) Provide equitable access to mental health services for un-served/under-served EPA residents; and 2) Ensure County staff is culturally competent and ethnically diverse.

East Palo Alto Behavioral Health Advisory Group (EPABHAG) is established

EPA community members and County staff recognize the need to formally establish an advisory group that will oversee the design of mental health services and programs for EPA residents. OEPA's convening role posits them to serve as the lead agency overseeing the advisory group.

"One East Palo Alto as the convening organization provides structure to whatever the community is trying to do…they [provide] the structure for us so we're focused on whatever the issue is at the time." – EPABHAG member



The Open Access East Palo Alto Project launches

In partnership with the EPABHAG, San Mateo County begins providing same-day access to mental health services at their EPA clinic. This requires staff training and a redesign of the clinic environment. Within the first seven months of providing same day services, there was a 30% increase in the clinic's caseload. EPABHAG members were essential to ensuring services were culturally appropriate and sensitive.

East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) is established

Recognizing the importance of community engagement in connecting EPA residents to services, San Mateo County provides additional funds to lead agency, OEPA, to oversee community outreach efforts.

First Family Awareness Night event is held

In partnership with One East Palo Alto, the EPABHAG organizes and hosts the first Family Awareness Night community event.
The event provides community members with information about mental health, mental health illness, stigma, and services available within the community. The success of the first Family Awareness Night resulted in the event becoming an annual function.

The Partnership & San Mateo County Behavioral Health and Recovery Services are recognized for their collaborative efforts

The Partnership and San Mateo County jointly apply for a STAR award documenting the success of the Open Access Project. Partnership and County staff are invited to speak with San Diego County regarding the success of the Open Access Project. The presentation also documents how the County's relationship with East Palo Alto shifted as a result of planning for MHSA funds.

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San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Efforts

FY 2015-2016

Anita Poon; Wendy Lee, MPH; Grace Wang, PhD, MPH

JANUARY 2017

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Contents

Executive Summary

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. The Community Services and Supports (CSS) component of MHSA was created to provide direct services to individuals with severe mental illness and included Outreach and Engagement activities.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) funds the North County Outreach Collaborative (NCOC) and the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) to provide outreach and engagement activities throughout San Mateo County.

This report summarizes overall collaborative and provider-specific outreach efforts across individual and group outreach events that occurred in fiscal year (FY) 2015-2016 (July 1, 2015 through June 30, 2016). We also present some historical data from FY 2014-2015 to show how outreach has changed over time.

Total Attendance

For FY 2015-2016, SMC BHRS providers reported a total of 5,556 attendees at all outreach events. Of these, 1,102 attendees were reached through individual outreach events and 4,454 attendees were reached across 107 group outreach events.

Demographics of outreach attendees

NCOC

NCOC individual outreach attendees were primarily adults and transition-age youth (84%) and with unknown insurance (59%). Individual and group outreach attendees were typically female (56%). Almost half of attendees were White or Filipino (46%). Attendees also reported being part of one or more special populations (i.e., homeless, at risk for homelessness, vision impaired, hearing impaired, veterans). Of those reporting special population status, 58% were homeless or were at-risk for homelessness.

EPAPMHO

EPAPMHO individual outreach attendees were largely adults and transition-age youth (92%) and without insurance (46%). Individual and group outreach attendees were usually female (57%). Almost half of attendees were Black or Mexican (48%). Of those reporting special population status, 80% were homeless or were at-risk for homelessness.

Outreach event characteristics

NCOC

The average length of NCOC individual outreach events was 34.9 minutes in FY 2015-2016. Of the 353 individual outreach events, most occurred in other community locations not listed (50%),

used Medicaid Administrative Activities (MAA) code 401 (Discounted Medi-Cal outreach, 37%), were conducted in English (94%), and included mental health outreach (35%) and mental health referrals (31%). Providers also made 483 referrals to other services, including legal services and housing.

NCOC group outreach events lasted 103.1 minutes on average. Of the 4,391 group outreach events, most were conducted in English (96%) and held in other community locations not listed (52%). These events most frequently used MAA code 401 (Discounted Medi-Cal outreach, 56%).

EPAPMHO

The 749 EPAPMHO individual outreach events were an average of 37.2 minutes each. These events were typically administered in English (67%), in the office (31%), and using MAA code 400 (Medi-Cal outreach, 72%). EPAPMHO individual outreach events also included mental health outreach (40%) and substance abuse outreach (22%). A total of 1,416 referrals were made to other services, including medical care and housing.

Of the 63 EPAPMHO group outreach events, the average event lasted 48.1 minutes. Half of group outreach events were conducted in Samoan (50%) and in homes (50%). These events used MAA code 400 (Medi-Cal outreach, 100%).

Recommendations

Based on FY 2015-2016 data, we recommend the following to enhance outreach and improve data collection. To enhance outreach, we suggest that SMC BHRS work with providers to:

- Tailor or increase outreach efforts for specific demographic groups, such as older adults and Latino/Hispanic persons from Central America.
- Identify housing-related resources that may be especially useful for those who are homeless or at risk for homelessness.
- Share best practices across providers for reaching special populations.

To improve data collection, we recommend SMC BHRS work with providers to:

- Minimize missing data.
- Treat race/ethnicity as mutually exclusive categories.
- Report data collection and entry challenges as they occur.

Introduction

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. Activities funded by MHSA are grouped into components, and the Community Services and Supports (CSS) component was created to provide direct services to individuals with severe mental illness. CSS is allotted 80% of MHSA funding for services focused on recovery and resilience while providing clients and families an integrated service experience. CSS has three service categories: 1) Full Service Partnerships; 2) General System Development Funds; and 3) Outreach and Engagement.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) MHSA Outreach and Engagement strategy increases access and improves linkages to behavioral health services for underserved communities. Strategies include community outreach collaboratives, pre-crisis response, and primary care-based efforts. SMC BHRS has seen a consistent increase in representation of underserved communities in its system since the strategies were deployed.

In particular, community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO), which targets at-risk youth, transition-age youth and underserved adults [Latino, African American, Pacific Islander, and Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ)] in East Palo Alto, and the North County Outreach Collaborative (NCOC), which targets rural and/or ethnic communities (Chinese, Filipino, Latino, Pacific Islander, and LGBTQ) in the North County region including Pacifica. These collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, education and outreach to decrease stigma related to mental illness and substance abuse. They work to increase awareness of and access and linkages to culturally and linguistically competent behavioral health, Medi-Cal and other public health services, and social services. They participate in a referral process to ensure those in need receive appropriate services. Finally, they promote and facilitate resident input into the development of MHSA funded services and other BHRS program initiatives.

Providers reported fiscal year (FY) 2015-2016 (July 1, 2015 through June 30, 2016) outreach data using an electronic form first implemented in quarter four (Q4) of FY 2014-2015. AIR created this form based on interviews with San Mateo County staff and focus groups with providers. This collective effort sought to improve the data collection process so that SMC BHRS and its providers could better understand the reach of their outreach efforts. After data are entered, AIR cleans the data and calculates aggregated counts and percentages to describe outreach activities. Please see Appendix A for information about calculations.

This report focuses on EPAPMHO and NCOC's outreach events that occurred during FY 2015-2016 and outreach event attendees. We also present some historical data from FY 2014-2015 to show how outreach has changed over time. Counts of attendees do not necessarily represent unique individuals because a person may have been part of more than one outreach event, taken part in both individual and group outreach events, and/or interacted with different providers. Provider summaries are also available to help SMC BHRS and its providers better understand each individual provider's outreach efforts. Please refer to Appendix B to I.

Overall Outreach

During FY 2015-2016, SMC BHRS outreach providers reported a total of 5,556 attendees at outreach events—1,102 attendees reached through individual outreach events and 4,454 attendees reached across 107 group outreach events. Each individual outreach event occurs with a single attendee. Group outreach events include multiple attendees. An attendee is not necessarily a unique individual because a person may have been a part of multiple individual or group outreach events.

Table 1 shows outreach attendees, by collaborative, provider, and event type (i.e., individual or group) for FY 2015-2016.

Table 1. Outreach Attendees, by Collaborative, Provider, and Event Type, FY 2015-2016

Provider Organization	Number of Individual Outreach Attendees	Number of Attendees at Group Outreach Events	Total Attendees Reported Across All Events**
North County Outreach Collaborative (NCOC)			
Asian American Recovery Services	150	1,502	1,652
Daly City Peninsula Partnership Collaborative	61	140	201
Daly City Youth Health Center	23	476	499
Pacifica Collaborative	23	2,069	2,092
Pyramid Alternatives	96	204	300
Total (NCOC)	**353**	**4,391**	**4,744**
East Palo Alto Partnership for Mental Health Outreach (EPAPMHO)			
El Concilio	53	0*	53
Free at Last	373	0*	373
Multicultural Counseling and Education Services of the Bay Area	323	63	386
Total (EPAPMHO)	**749**	**63**	**812**
Total (NCOC and EPAPMHO)	**1,102**	**4,454**	**5,556**

Notes: *Providers did not report data for FY 2015-2016. **Counts are not necessarily unique individuals.

Compared to FY 2014-2015, the total number of NCOC outreach attendees increased, whereas EPAPMHO outreach attendees decreased. Between FY 2014-2015 and FY 2015-2016, NCOC individual outreach attendees decreased from 450 to 353, and NCOC group outreach attendees increased from 3,939 to 4,391. In contrast, EPAPMHO individual outreach attendees increased from 451 to 749, and EPAPMHO group outreach attendees decreased from 497 to 63.

Table 2 presents outreach event attendees' race/ethnicity for FY 2014-2015 and FY 2015-2016 within each collaborative. Increases of 5% or more between the two years are shaded in green; decreases are shaded in red. Additional details on race/ethnicity by quarter for FY 2015-2016 are presented later in the report (pages 8 and 15).

Table 2. Race/Ethnicity by Collaborative, FY 2014-2016

	NCOC		EPAPMHO	
Race/Ethnicity	**FY 2014-2015**	**FY 2015-FY2016**	**FY 2014-2015**	**FY 2015-FY2016**
Black	172 (5%)	153 (3%)	131 (14%)	77 (9%)
White	335 (10%)	1,501 (32%)	39 (4%)	194 (24%)
American Indian	7 (<1%)	48 (1%)	0 (0%)	0 (0%)
Middle Eastern	7 (<1%)	60 (1%)	0 (0%)	7 (1%)
Mexican	144 (4%)	260 (5%)	44 (5%)	195 (24%)
Puerto Rican	1 (<1%)	6 (<1%)	1 (<1%)	1 (<1%)
Cuban	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Other Latino	273 (8%)	87 (2%)	150 (15%)	4 (<1%)
Filipino	577 (17%)	678 (14%)	12 (1%)	18 (2%)
Chinese	192 (6%)	246 (5%)	0 (0%)	2 (<1%)
Japanese	14 (<1%)	30 (1%)	0 (0%)	0 (0%)
Korean	21 (1%)	29 (1%)	0 (0%)	0 (0%)
South Asian	26 (1%)	16 (<1%)	0 (0%)	2 (<1%)
Vietnamese	35 (1%)	23 (<1%)	1 (<1%)	2 (<1%)
Cambodian	18 (1%)	1 (<1%)	0 (0%)	0 (0%)
Hmong	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Laotian	1 (<1%)	2 (<1%)	0 (0%)	0 (0%)
Mien	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Tongan	183 (5%)	236 (5%)	283 (29%)	85 (10%)
Samoan	353 (10%)	343 (7%)	106 (11%)	117 (14%)
Fijian	9 (<1%)	24 (1%)	1 (<1%)	0 (0%)
Hawaiian	48 (1%)	29 (1%)	3 (<1%)	13 (2%)
Guamanian	10 (1%)	25 (1%)	1 (<1%)	6 (1%)
Multi-racial	72 (2%)	428 (9%)	39 (4%)	2 (<1%)
Other Race	432 (13%)	95 (2%)	26 (3%)	4 (<1%)
Unknown Race	504 (15%)	440 (9%)	131 (14%)	83 (10%)
Total	**3,434**	**4,760**	**968**	**812**

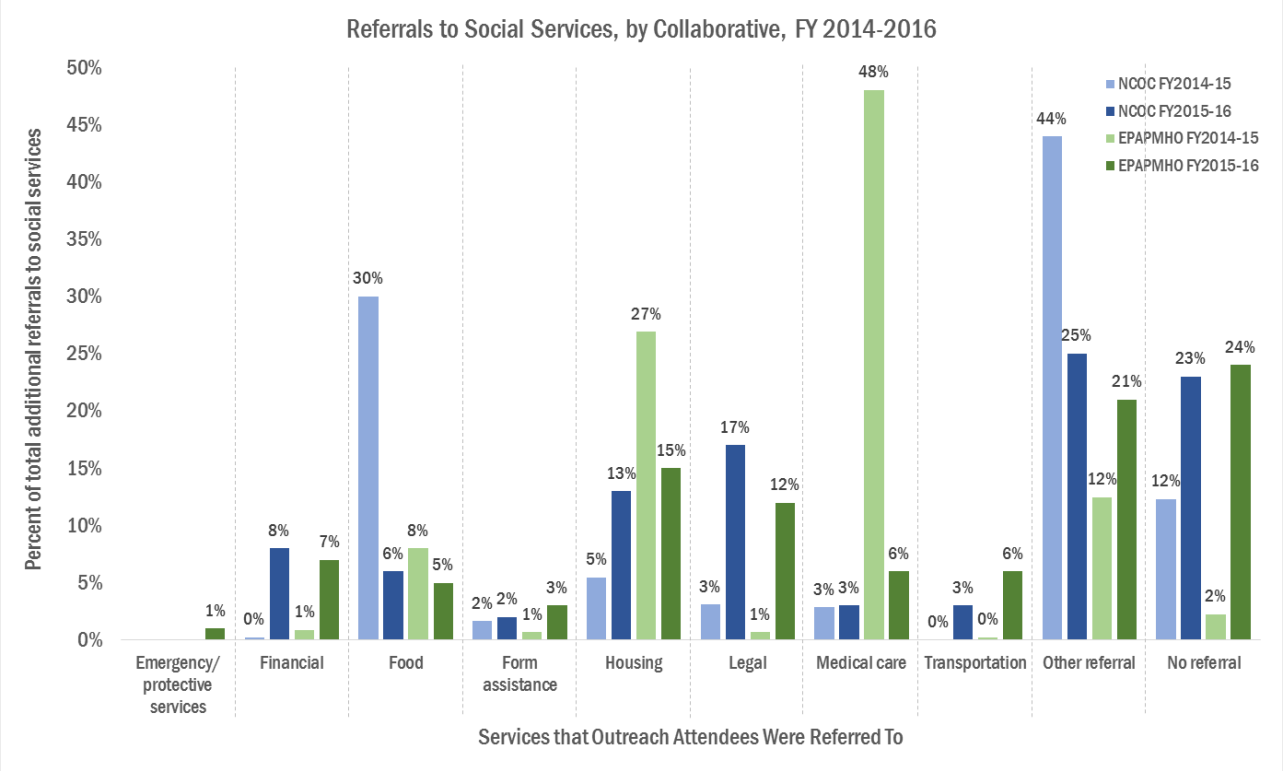
Note: Percentages may not sum to 100% because of rounding.

Figure 2 presents referrals to social services, by collaborative for both FY 2014-2015 and FY 2015-2016. The percentages shown represent percent of total referrals to social services. Both NCOC and EPAPMHO had increases in the numbers of referrals to social services.

- In FY 2015-2016, NCOC had 629 referrals to social services, as compared to 423 referrals in the prior FY. In FY 2015-2016, EPAPMHO had 1,527 referrals to social services, as compared to 450 referrals in the prior FY.
- As a percent of all referrals, both NCOC and EPAPMHO had increases in Financial, Legal, and Transportation referrals between FY 2014-2015 and FY 2015-2016.

- In FY 2015-2016, NCOC had decreases in the percent of food and other referrals compared to FY 2014-2015. In FY 2015-2016, EPAPMHO had decreases in the percent of housing and medical care referrals compared to the prior FY.

Figure 2. Referrals to Social Services, by Collaborative, FY 2014-2016



Note: Percentages may not sum to 100% because of rounding.

NCOC

In FY 2015-2016, there were 4,744 attendees at individual and group outreach events across the five provider organizations in the NCOC.

Demographics

Age: NCOC individual outreach attendees were adults (26-59 years, 59%), transition-age youth (16-25 years, 25%), older adults (60 years or older, 5%), and children (0-15 years, 2%) in FY 2015-2016. Nine percent of attendees were of an unknown age. See **Table 3** for the number of individual outreach attendees representing each reported age group, by quarter. Providers were not asked to report group outreach data on age for FY 2015-2016.

Table 3. Age of Individual Outreach Attendees Served by NCOC, FY 2015-2016

Age Group	Q1	Q2	Q3	Q4	Total
Adults (26-59)	91 (52%)	43 (74%)	32 (62%)	43 (62%)	209 (59%)
Transition-age youth (16-25)	44 (25%)	12 (21%)	15 (29%)	16 (23%)	87 (25%)
Unknown age	31 (18%)	0 (0%)	1 (2%)	0 (0%)	32 (9%)
Older adults (60+)	8 (5%)	3 (5%)	4 (8%)	4 (6%)	19 (5%)
Children (0-15)	0 (0%)	0 (0%)	0 (0%)	6 (9%)	6 (2%)
Total	**174**	**58**	**52**	**69**	**353**

Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on age for FY 2015-2016.

Gender: Attendees across NCOC individual and group outreach events were females (56%), males (38%), and other genders (6%) in FY 2015-2016. See **Table 4** for the number of individual and group outreach attendees reporting each gender type, by quarter.

Table 4. Gender of Outreach Attendees Served By NCOC, FY 2015-2016

Gender	Q1	Q2	Q3	Q4	Total
Female	419 (58%)	818 (57%)	695 (49%)	710 (61%)	2,642 (56%)
Male	234 (33%)	561 (39%)	588 (42%)	440 (38%)	1,823 (38%)
Other gender	64 (9%)	66 (5%)	131 (9%)	18 (2%)	279 (6%)
Total	**717**	**1,445**	**1,414**	**1,168**	**4,744**

Note: Percentages may not sum to 100% because of rounding

Race and ethnicity: In FY 2015-2016, the three largest racial/ethnic groups represented by all NCOC attendees were White (32%), Filipino (14%), and multi-racial (9%). Nine percent of attendees were of an unknown race. See **Table 5** for the number of attendees representing each reported racial/ethnic group, by quarter.

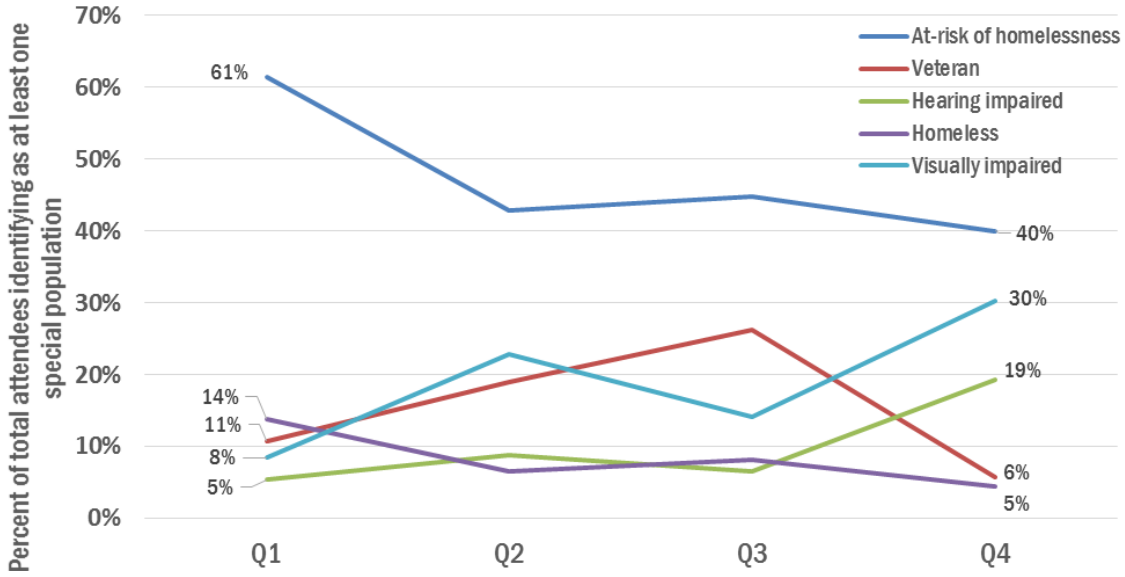
Table 5. Race and Ethnicity of Outreach Attendees Served By NCOC, FY 2015-2016

Race/ethnicity	Q1	Q2	Q3	Q4	Total
White	269 (37%)	601 (42%)	549 (38%)	82 (7%)	1,501 (32%)
Black	26 (4%)	44 (3%)	43 (3%)	40 (3%)	153 (3%)
Middle Eastern	11 (2%)	17 (1%)	18 (1%)	14 (1%)	60 (1%)
American Indian	5 (1%)	17 (1%)	20 (1%)	6 (1%)	48 (1%)
Mexican	47 (7%)	54 (4%)	37 (3%)	122 (10%)	260 (5%)
Other Latino	30 (4%)	25 (2%)	32 (2%)	0 (0%)	87 (2%)
Puerto Rican	1 (<1%)	0 (0%)	3 (<1%)	2 (<1%)	6 (<1%)
Cuban	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Filipino	89 (12%)	171 (12%)	233 (16%)	185 (16%)	678 (14%)
Chinese	31 (4%)	73 (5%)	61 (4%)	81 (7%)	246 (5%)
Japanese	13 (2%)	5 (<1%)	7 (<1%)	5 (<1%)	30 (1%)
Korean	2 (<1%)	5 (<1%)	16 (1%)	6 (1%)	29 (1%)
Vietnamese	1 (<1%)	7 (<1%)	10 (1%)	5 (<1%)	23 (<1%)
South Asian	3 (<1%)	3 (<1%)	7 (<1%)	3 (<1%)	16 (<1%)
Laotian	1 (<1%)	0 (0%)	1 (<1%)	0 (0%)	2 (<1%)
Cambodian	0 (0%)	0 (0%)	0 (0%)	1 (<1%)	1 (<1%)
Hmong	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Mien	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Samoan	47 (7%)	97 (7%)	57 (4%)	142 (12%)	343 (7%)
Tongan	15 (2%)	43 (3%)	18 (1%)	160 (14%)	236 (5%)
Hawaiian	3 (<1%)	8 (1%)	11 (1%)	7 (1%)	29 (1%)
Guamanian	0 (0%)	6 (<1%)	2 (<1%)	17 (1%)	25 (1%)
Fijian	0 (0%)	4 (<1%)	4 (<1%)	16 (1%)	24 (1%)
Unknown Race	58 (8%)	138 (10%)	236 (17%)	8 (1%)	440 (9%)
Multi-racial	51 (7%)	101 (7%)	53 (4%)	223 (19%)	428 (9%)
Other Race	15 (2%)	26 (2%)	11 (1%)	43 (4%)	95 (2%)
Total**	**718**	**1,445**	**1,429**	**1,168**	**4,760**

Note: Percentages may not sum to 100% because of rounding. ** Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special populations: NCOC individual and group outreach event attendees reported being part of one or more special populations. Of the special populations, 49% were at risk for homelessness, 18% were visually impaired, 16% were veterans, 9% were hearing impaired, and 9% were homeless. Refer to **Figure 3** for the percentage of attendees representing each special population in FY 2015-2016, by quarter.

Figure 3. Special Populations Served By NCOC, FY 2015-2016



Note: Attendees could be included in more than one special population.

Additional outreach characteristics (individual outreach events only)

Insurance Coverage: NCOC individual outreach attendees were with unknown insurance (59%), with other insurance (17%), with Medi-Cal (17%), without insurance (4%), or with Medicare (3%) in FY 2015-2016. Less than 1% of attendees reported having more than one type of insurance. See **Table 6** for the total number of individual outreach attendees reporting each insurance type, by quarter. Providers were not asked to report group outreach data for insurance coverage.

Table 6. Insurance Coverage for NCOC Outreach Attendees, FY 2015-2016

Insurance Type	Q1	Q2	Q3	Q4	Total
Unknown Insurance	104 (60%)	40 (69%)	29 (56%)	35 (51%)	208 (59%)
Other Insurance	22 (13%)	6 (10%)	7 (13%)	25 (36%)	60 (17%)
Medi-Cal	33 (19%)	10 (17%)	9 (17%)	7 (10%)	59 (17%)
Uninsured	9 (5%)	1 (2%)	5 (10%)	0 (0%)	15 (4%)
Medicare	5 (3%)	1 (2%)	2 (4%)	2 (3%)	10 (3%)
More than 1 type	1 (1%)	0 (0%)	0 (0%)	0 (0%)	1 (<1%)
Healthy Families	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Healthy Kids	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	**174**	**58**	**52**	**69**	**353**

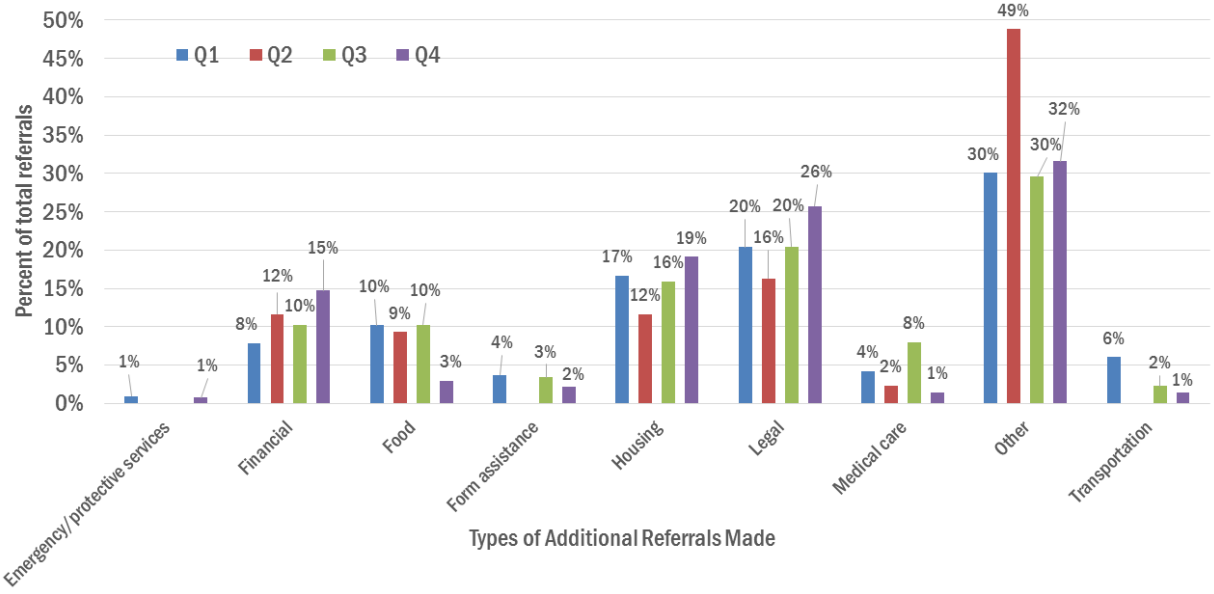
Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on insurance status/type for FY 2015-2016.

Previous contact: Twenty percent of individual outreach events were conducted with attendees who had a previous outreach contact with NCOC.

Mental Health/Substance Use Referrals: NCOC individual outreach events included mental health referrals (45%) and substance abuse referrals (14%) in FY 2015-2016.

Referrals to Social Services: Providers made 483 referrals to 353 NCOC individual outreach attendees. Of the different referral types, the top three types of referrals made for attendees were for other referrals not listed (32%), legal services (22%), and housing (17%). In **Figure 4**, we summarize the percentage of attendees receiving a given type of referral, by quarter.

Figure 4. Referrals to Social Services, FY 2015-2016



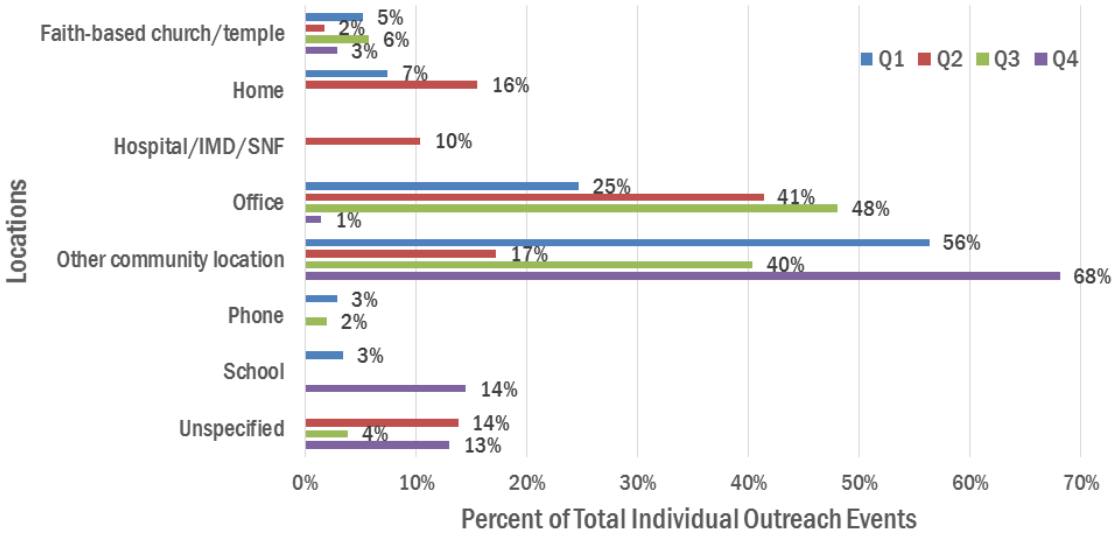
Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on referral type for FY 2015-2016.

Individual outreach event characteristics

Location: NCOC individual outreach events primarily occurred in other community locations not listed[1] (50%) and in the office (26%) in FY 2015-2016. **Figure 5** presents individual outreach event locations in FY 2015-2016, by quarter.

[1] Due to the high percentage of individual outreach events reported to be held in "other community locations," we have modified future outreach forms (starting in FY 2016-2017) to include a free-response space for providers to include additional information about these other locations. Moving forward, this will allow us to better understand what these additional outreach locations are and to meet the needs of outreach attendees.

Figure 5. Locations of NCOC Individual Outreach Events, FY 2015-2016



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2015-2016, the average length of NCOC individual outreach events was 34.9 minutes. Average length was 31.0 minutes in Q1, 42.8 minutes in Q2, 51.1 minutes in Q3, and 25.7 minutes in Q4.

MAA code: NCOC individual outreach events used MAA codes 401 (Discounted Medi-Cal outreach, 37%), 400 (Medi-Cal outreach, 32%), 403 (Referral in crisis situations for non-open cases, 5%), and 410 (Non-SPMP case management of non-open cases, 1%) in FY 2015-2016. MAA code 404 (Case management of non-open cases) was not used. Twenty-five percent of MAA codes were reported as N/A.

Language: NCOC individual outreach events were conducted in English (94%), Spanish (4%), Tagalog (1%), and Mandarin (1%). See **Table 7** for group outreach events by language.

Table 7. Number of NCOC Individual Outreach Events By Language, FY 2015-2016

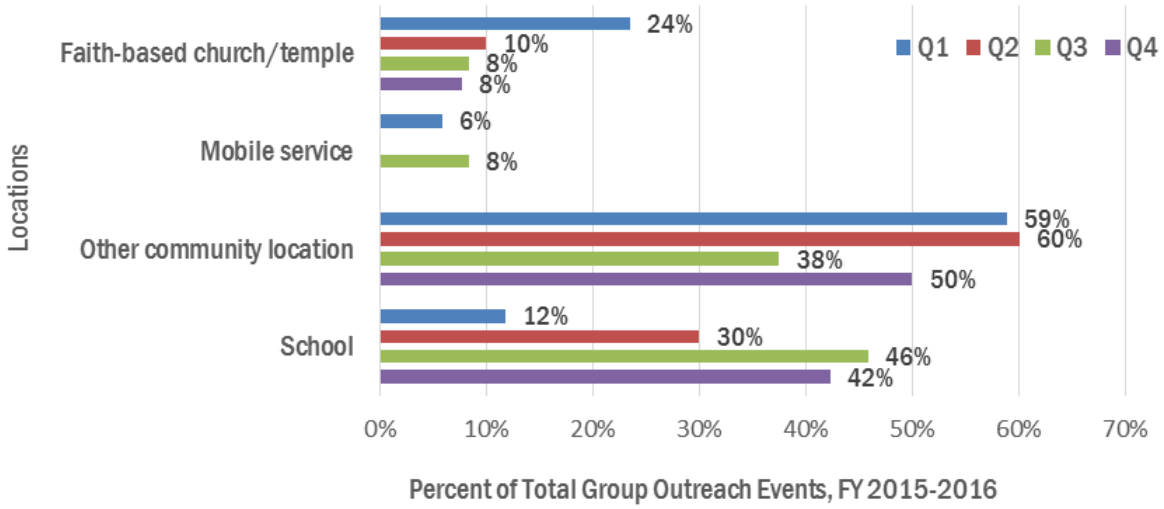
Language	Q1	Q2	Q3	Q4	Total
English	163 (94%)	53 (91%)	50 (96%)	67 (97%)	333 (94%)
Spanish	7 (4%)	5 (9%)	1 (2%)	1 (1%)	14 (4%)
Tagalog	3 (2%)	0 (0%)	0 (0%)	0 (0%)	3 (1%)
Mandarin	0 (0%)	0 (0%)	1 (2%)	1 (1%)	2 (1%)
Other	1 (1%)	0 (0%)	0 (0%)	0 (0%)	1 (<1%)
Total	**174**	**58**	**52**	**69**	**353**

Note: Percentages may not sum to 100% because of rounding. The following languages were options but were not reported by providers in FY 2015-2016: American/Other Sign Language, Cambodian, Portuguese, Samoan, Tongan, Vietnamese, and unknown language.

Group outreach event characteristics

Location: NCOC group outreach events largely occurred at other community locations not listed (52%) and at school (34%) in FY 2015-2016. **Figure 6** presents group outreach event locations in FY 2015-2016, by quarter.

Figure 6. Location of NCOC Group Outreach Events, FY 2015-2016



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2015-2016, the average length of NCOC group outreach events was 103.1 minutes. By quarter, average length of outreach was 123.4 minutes in Q1, 105.1 minutes in Q2, 80.3 minutes in Q3, and 108.4 minutes in Q4.

MAA code: NCOC group outreach events used MAA codes 401 (Discounted Medi-Cal outreach, 56%), 400 (Medi-Cal outreach, 24%), and 403 (Referral in crisis situations for non-open cases, 2%) in FY 2015-2016. MAA codes 404 (Case management of non-open cases) and 410 (Non-SPMP case management of non-open cases) were not used. Eighteen percent of MAA codes were reported as N/A.

Language: NCOC group outreach events were conducted in English (96%), Mandarin (1%), and Spanish (1%). See **Table 8** below for the breakdown of group outreach events by the language of administration.

Table 8. Number of NCOC Group Outreach Events By Language, FY 2015-2016

Language	Q1	Q2	Q3	Q4	Total
English	17 (100%)	30 (97%)	24 (100%)	24 (89%)	95 (96%)
Other	0 (0%)	1 (3%)	0 (0%)	1 (4%)	2 (2%)
Mandarin	0 (0%)	0 (0%)	0 (0%)	1 (4%)	1 (1%)
Spanish	0 (0%)	0 (0%)	0 (0%)	1 (4%)	1 (1%)
Total	**17**	**31**	**24**	**27**	**99**

Note: Percentages may not sum to 100% because of rounding. The following languages were options but were not reported by providers in FY 2015-2016: American/Other Sign Language, Cambodian, Portuguese, Samoan, Tagalog, Tongan, Vietnamese, and unknown language.

EPAPMHO

In FY 2015-2016, there were 812 attendees at individual and group outreach events across the three provider organizations in the EPAPMHO.

Demographics

Age: EPAPMHO individual outreach attendees were adults (26-59 years, 54%), transition-age youth (16-25 years, 38%), older adults (60+ years or older, 7%), and children (0-15 years, <1%) in FY 2015-2016. Less than one percent of attendees were of an unknown age. See **Table 9** for the number of individual outreach attendees representing each reported age group, by quarter. Provider organizations were not asked to report group outreach data on age for FY 2015-2016.

Table 9. Age of Individual Outreach Attendees Served By EPAPMHO, FY 2015-2016

Age	Q1	Q2	Q3	Q4	Total
Adults (26-59)	149 (70%)	88 (45%)	98 (46%)	73 (59%)	408 (54%)
Transition-age youth (16-25)	57 (27%)	94 (48%)	97 (45%)	33 (27%)	281 (38%)
Older adults (60+)	8 (4%)	14 (7%)	18 (8%)	16 (13%)	56 (7%)
Children (0-15)	0 (0%)	0 (0%)	1 (<1%)	1 (1%)	2 (<1%)
Unknown age	0 (0%)	1 (1%)	1 (<1%)	0 (0%)	2 (<1%)
Total	**214**	**197**	**215**	**123**	**749**

Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on age for FY 2015-2016.

Gender: Attendees across EPAPMHO individual and group outreach events were females (57%), males (41%), and other genders (2%) in FY 2015-2016. See **Table 10** for the number of individual and group outreach attendees representing each reported gender, by quarter.

Table 10. Gender of Outreach Attendees Served By EPAPMHO, FY 2015-2016

Gender	Q1	Q2	Q3	Q4	Total
Female	121 (51%)	139 (63%)	120 (56%)	85 (61%)	465 (57%)
Male	113 (48%)	81 (36%)	86 (40%)	53 (38%)	333 (41%)
Other gender	2 (1%)	2 (1%)	9 (4%)	1 (1%)	14 (2%)
Total	**236**	**222**	**215**	**139**	**812**

Note: Percentages may not sum to 100% because of rounding.

Race and ethnicity: In FY 2015-2016, the three largest racial/ethnic groups represented by all EPAPMHO attendees were Mexican (24%), Black (24%), and Tongan (14%). Less than one percent of attendees were of an unknown race. See **Table 11** for the number of attendees representing each reported racial/ethnic group, by quarter.

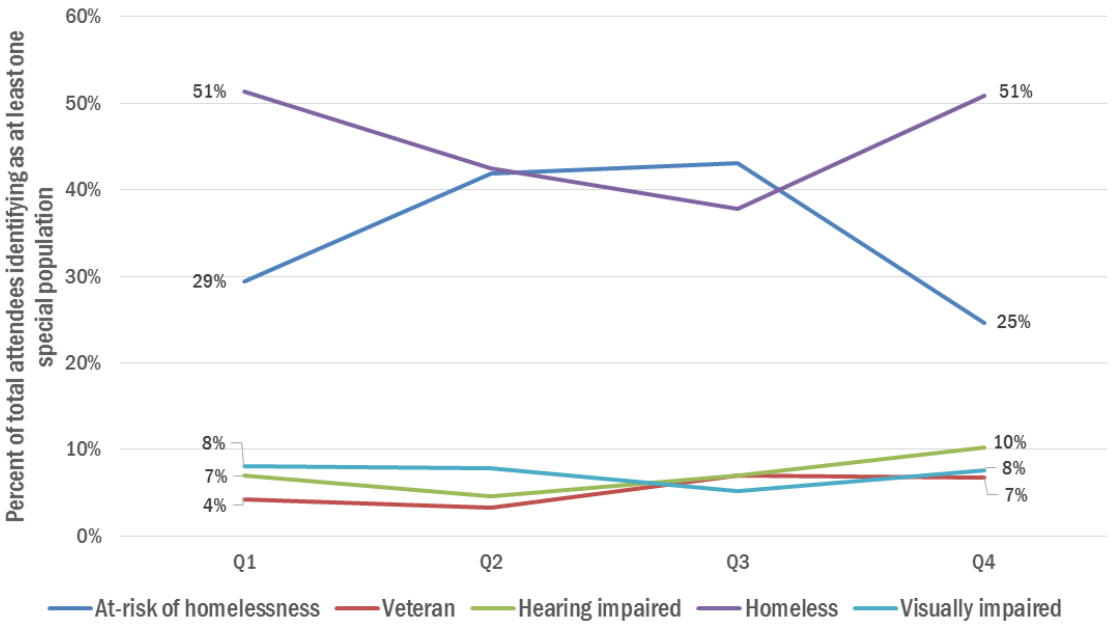
Table 11. Race and Ethnicity of Outreach Attendees Served By EPAPMHO, FY 2015-2016

Race/Ethnicity	Q1	Q2	Q3	Q4	Total
Black	54 (23%)	57 (26%)	53 (25%)	30 (17%)	194 (24%)
White	27 (11%)	16 (7%)	21 (9%)	13 (9%)	77 (9%)
American Indian	3 (1%)	1 (<1%)	2 (1%)	1 (1%)	7 (1%)
Mexican	63 (27%)	44 (20%)	53 (25%)	35 (25%)	195 (24%)
Puerto Rican	2 (1%)	0 (0%)	2 (1%)	0 (0%)	4 (<1%)
Cuban	0 (0%)	1 (<1%)	0 (0%)	0 (0%)	1 (<1%)
Filipino	5 (2%)	4 (2%)	6 (3%)	3 (2%)	18 (2%)
Chinese	1 (<1%)	0 (0%)	1 (<1%)	0 (0%)	2 (<1%)
South Asian	1 (<1%)	1 (<1%)	0 (0%)	0 (0%)	2 (<1%)
Vietnamese	2 (1%)	0 (0%)	0 (0%)	0 (0%)	2 (<1%)
Tongan	30 (13%)	35 (16%)	32 (15%)	20 (14%)	117 (14%)
Samoan	21 (9%)	24 (11%)	14 (7%)	26 (19%)	85 (10%)
Fijian	4 (2%)	6 (3%)	3 (1%)	0 (0%)	13 (2%)
Hawaiian	3 (1%)	2 (1%)	1 (<1%)	0 (0%)	6 (1%)
Multi-racial	19 (8%)	28 (13%)	25 (12%)	11 (8%)	83 (10%)
Other Race	1 (<1%)	1 (<1%)	0 (0%)	0 (0%)	2 (<1%)
Unknown Race	0 (0%)	2 (1%)	2 (1%)	0 (0%)	4 (<1%)
Total	**236**	**222**	**215**	**139**	**812**

Note: Percentages may not sum to 100% because of rounding. The following racial/ethnic groups were options but were not reported by providers in FY 2015-2016: Middle Eastern, Other Latino, Japanese, Korean, Cambodian, Hmong, Laotian, Mien, and Guamanian.

Special populations: EPAPMHO individual and group outreach event attendees reported being part of one or more special populations. Of the special populations, 45% were homeless, 35% were at risk for homelessness, 7% were visually impaired, 7% were hearing impaired, and 5% were veterans. Refer to **Figure 7** for the percentage of attendees representing each special population in FY 2015-2016, by quarter.

Figure 7. Special Populations Served by EPAPMHO, FY 2015-2016



Note: Attendees could be included in more than one special population.

Additional outreach characteristics (individual outreach events only)

Insurance Coverage: EPAPMHO individual outreach attendees were without insurance (46%), with Medi-Cal (28%), with other insurance not listed (11%), with Medicare (8%), or with unknown insurance (4%). Three percent of attendees reported having more than one type of insurance. See **Table 12** for the total number of individual outreach attendees reporting each insurance type, by quarter. Providers were not asked to report group outreach data for insurance coverage.

Table 12. Insurance Coverage, FY 2015-2016

Insurance Type	Q1	Q2	Q3	Q4	Total
Uninsured	131 (61%)	85 (43%)	89 (41%)	42 (34%)	347 (46%)
Medi-Cal	64 (30%)	49 (25%)	60 (28%)	40 (33%)	213 (28%)
Other Insurance	4 (2%)	23 (12%)	29 (13%)	23 (19%)	79 (11%)
Medicare	13 (6%)	17 (9%)	15 (7%)	12 (10%)	57 (8%)
Unknown Insurance	2 (1%)	12 (6%)	10 (5%)	3 (2%)	27 (4%)
More than 1 type	0 (0%)	11 (6%)	12 (6%)	3 (2%)	26 (3%)
Healthy Families	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Healthy Kids	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	**214**	**197**	**215**	**123**	**749**

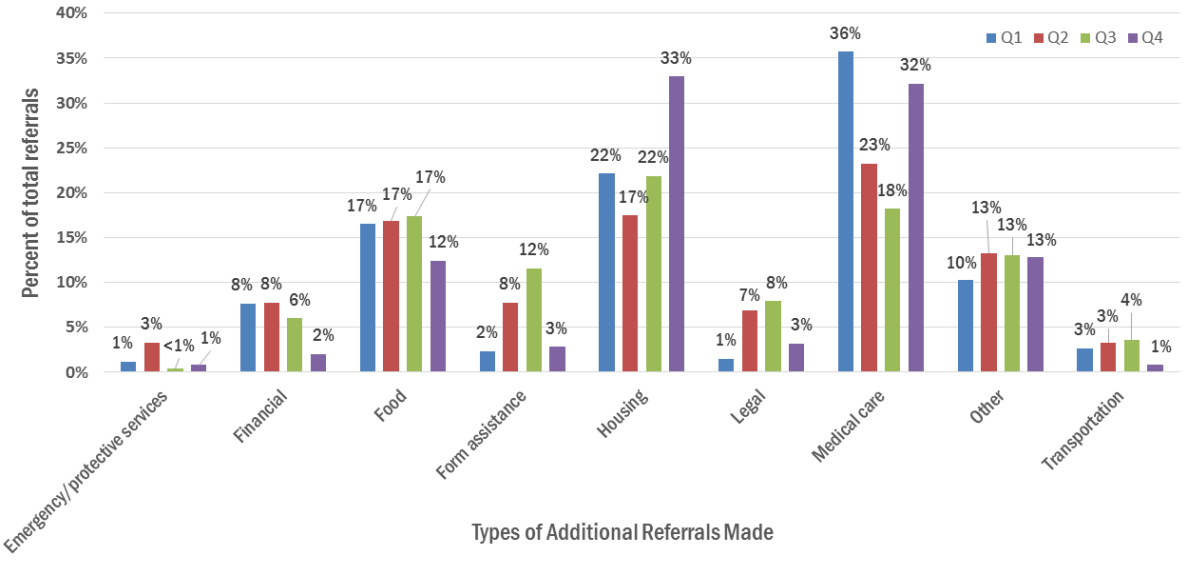
Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on insurance status/type for FY 2015-2016.

Previous contact: Thirty-three percent of individual outreach events were conducted with attendees who had a previous outreach contact with EPAPMHO.

Mental Health/Substance Use Referrals: EPAPMHO individual outreach events included substance abuse referrals (30%) and mental health referrals (26%) in FY 2015-2016.

Referrals to Social Services: Providers made 1,416 referrals to 749 EPAPMHO individual outreach attendees. Of the different referral types, the top three types of referrals made for attendees were for medical care (26%), housing (23%), and food (16%). **Figure 8** summarizes the percentage of attendees receiving a given type of referral, by quarter.

Figure 8. Referrals to Social Services, FY 2015-2016

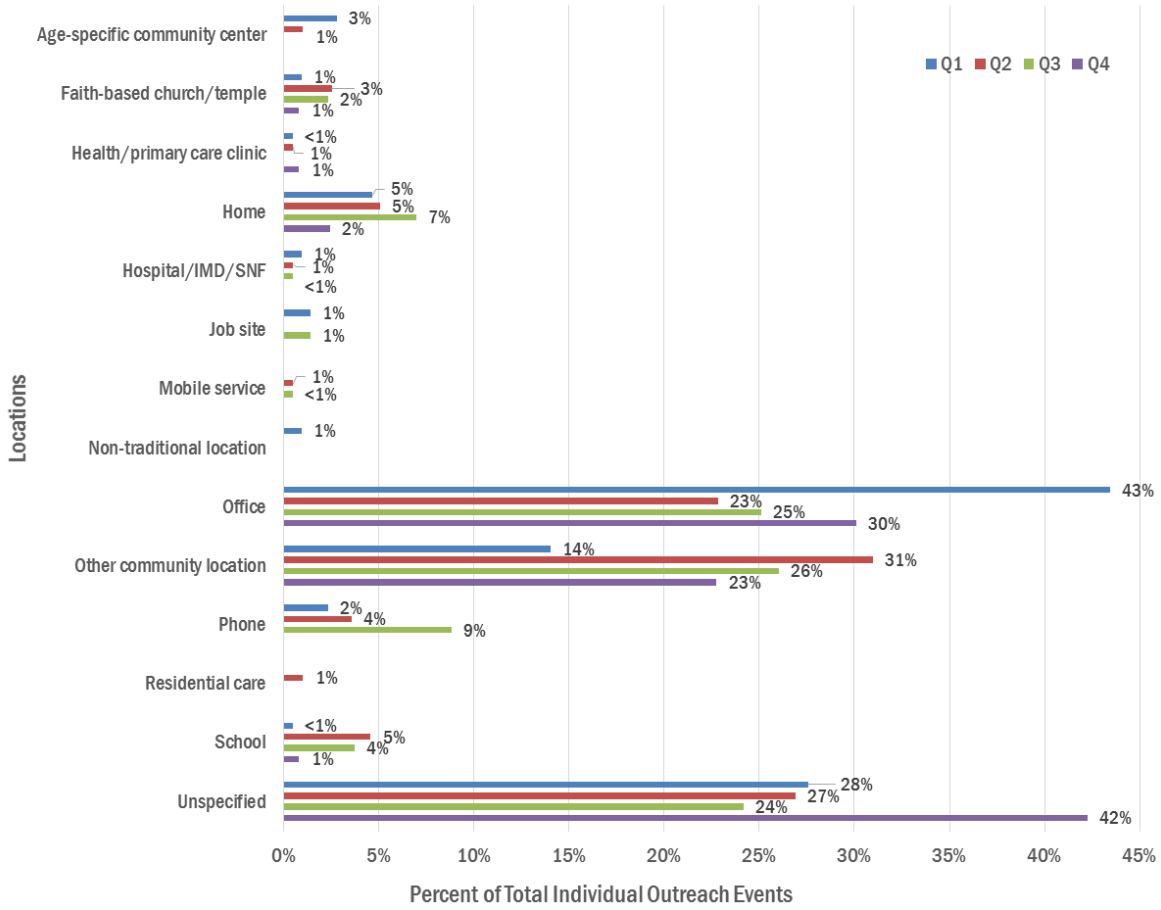


Note: Provider organizations were not asked to report group outreach data on referral type for FY 2015-2016.

Individual outreach event characteristics

Location: EPAPMHO individual outreach events typically occurred in the office (31%), unspecified locations (29%), and other community locations not listed (23%) in FY 2015-2016. See **Figure 9** for a summary of individual outreach events by location.

Figure 9. Location of EPAPMHO Individual Outreach Events, FY 2015-2016



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2015-2016, the average length of EPAPMHO individual outreach events was 37.2 minutes. By quarter, average length of outreach was 38.6 minutes in Q1, 35.5 minutes in Q2, 40.5 minutes in Q3, and 32.0 minutes in Q4.

MAA code: EPAPMHO individual outreach events used MAA codes 400 (Medi-Cal outreach, 72%), 401 (Discounted Medi-Cal outreach, 27%), and 410 (Non-SPMP case management of non-open cases, 1%) in FY 2015-2016. MAA codes 403 (Referral in crisis situations for non-open cases) and 404 (Case management of non-open cases) were not used. None of the MAA codes were reported as N/A.

Language: EPAPMHO individual outreach events were conducted in English (67%), Spanish (19%), Tongan (9%), Samoan (4%), and American/Other Sign Language (<1%). See **Table 13** below for the breakdown of group outreach events by the language of administration.

Table 13. Languages, FY 2015-2016

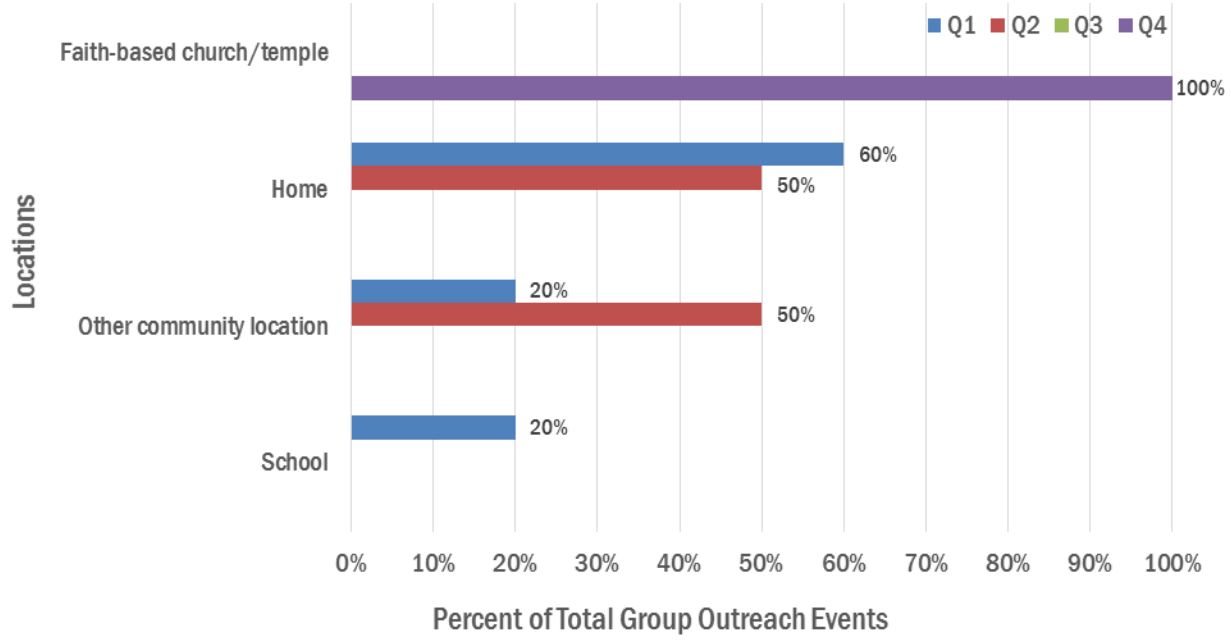
Language	Q1	Q2	Q3	Q4	Total
English	156 (73%)	140 (71%)	148 (69%)	60 (49%)	504 (67%)
Spanish	39 (18%)	32 (16%)	34 (16%)	37 (30%)	142 (19%)
Tongan	14 (7%)	16 (8%)	25 (12%)	15 (12%)	70 (9%)
Samoan	5 (2%)	9 (5%)	7 (3%)	10 (8%)	31 (4%)
American/Other Sign Language	0 (0%)	0 (0%)	0 (0%)	1 (1%)	1 (<1%)
Other	0 (0%)	0 (0%)	1 (<1%)	0 (0%)	1 (<1%)
Total	**214**	**197**	**215**	**123**	**749**

Note: Percentages may not sum to 100% because of rounding. The following languages were options but were not reported by providers in FY 2015-2016: Cambodian, Mandarin, Portuguese, Tagalog, Vietnamese, and unknown language.

Group outreach event characteristics

Locations: EPAPMHO group outreach events were held in the home (50%), at other community locations not listed (25%), at school (13%), and at faith-based churches/temples (13%) in FY 2015-2016. Refer to **Figure 10** for a breakdown of group outreach events by location.

Figure 10. Locations of EPAPMHO Group Outreach Events, FY 2015-2016



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2015-2016, the average length of EPAPMHO group outreach events was 48.1 minutes. By quarter, average length of outreach was 38.0 minutes in Q1, 75.0 minutes in Q2, and 45.0 minutes in Q4. Only Multicultural Counseling and Education Services of the Bay Area (MCESBA) reported these data and for only Q1, Q2, and Q4 of this FY.

MAA code: EPAPMHO group outreach events used only MAA code 400 (Medi-Cal outreach, 100%) in FY 2015-2016.

Language: EPAPMHO group outreach events were conducted in Samoan (50%), Tongan (38%), and English (13%). See **Table 14** below for the breakdown of group outreach events by the language of administration.

Table 14. Languages, FY 2015-2016

Language	Q1	Q2	Q3	Q4	Total
Samoan	3 (60%)	1 (50%)	0 (0%)	0 (0%)	4 (50%)
Tongan	2 (40%)	0 (0%)	0 (0%)	1 (100%)	3 (38%)
English	0 (0%)	1 (50%)	0 (0%)	0 (0%)	1 (13%)
Total	**5**	**2**	**0**	**1**	**8**

Note: Percentages may not sum to 100% because of rounding. The following languages were options but were not reported by providers in FY 2015-2016: American/Other Sign Language, Cambodian, Mandarin, Other, Portuguese, Spanish, Tagalog, Vietnamese, and unknown language.s

Outreach Summaries by Provider

We analyzed outreach efforts by provider and created provider-specific summaries to help SMC BHRS and its providers better understand each organization's outreach efforts. Please refer to **Appendix B-I** for these provider-specific summaries. In each provider summary, we highlight key observations on outreach location, language, insurance, race/ethnicity, and specific groups of interest for both individual and group outreach efforts.

Recommendations

Based on these data about SMC BHRS outreach services provided during FY 2015-2016, we recommend the following to enhance outreach and data collection efforts.

Enhance outreach

Tailor or increase outreach efforts for specific demographic groups, such as older adults and Latino/Hispanic persons from Central America. Although 19% of San Mateo County's senior (age 65 years and older) population reported needing help for emotional/mental health problems of use of alcohol/drugs in 2015, only 5% of NCOC and 7% of EPAPMHO outreach event attendees were older adults (age 60 and older).[2] Among persons who identify as Latino/Hispanic and report needing help for emotional/mental health problems of use of alcohol/drugs in San Mateo County in 2015, 57% are Central American and 14% are Mexican.[2] However, over 80% of Latino/Hispanic outreach attendees identified as Mexican among the two collaboratives combined.

Identify housing-related resources that may be especially useful for those who are homeless or at risk for homelessness. Almost 1,000 outreach attendees across both collaboratives reported being homeless or being at risk for homeless in FY 2015-2016 (467 for NCOC, and 957 for EPAPMHO). (Attendees may not be unique individuals.) However, providers documented only 400 referrals to housing resources during individual events, and it is unclear whether housing resources were offered at group events. In addition to housing resources, these specific populations may need referrals to additional services (such as food or medical care).

Share best practices across providers for reaching special populations. For example, some providers report more attendees who are at-risk for homelessness, whereas other providers report more attendees who are veterans. Providers can share what strategies have worked best for special populations.

Improve data collection

Minimize missing data. It is unclear whether quarterly changes in number of outreach events and attendees were actual changes or related to missing data. For example, some providers reported no group outreach events in some quarters, and other providers reported changes in attendee number from quarter to quarter. To ensure that these observations are not related to missing data, we recommend SMC BHRS work with providers to:

[2] UCLA Center for Health Policy Research. AskCHIS 2015. Available at http://ask.chis.ucla.edu.

- Enter outreach data immediately after the outreach event or monthly, at minimum. This may help to minimize loss of records before data entry.
- Check SurveyMonkey data quarterly with AIR support. We suggest for AIR to provide a list of events that have been entered electronically so that providers can verify that no events are missing.

Treat race/ethnicity as mutually exclusive categories. We recommend that providers include attendees who endorse multiple race/ethnicity groups only once under "two or more races" to ensure mutually exclusive race/ethnicity categories. At this time, total counts for race/ethnicity in group outreach events are larger than the total number of group outreach attendees. Providers may have classified an attendee under several race/ethnicity categories and as "two or more races."

Report data collection and entry challenges as they occur. We recommend that providers report challenges with collecting new demographic items to SMC BHRS and AIR as challenges arise so we can develop solutions together before the end of the FY. The California State Mental Health Services Oversight and Accountability Commission included new demographic requirements for MHSA prevention and early intervention reporting. For consistency across MHSA programs in San Mateo County, BHRS and AIR worked together to revise individual and group outreach forms. In brief, we added gender identity and sexual orientation categories. For disabilities, we added categories to capture client needs and groups reached. We also added county of residence. These data will be collected in FY 2016-2017.

Appendix A. Methods

For the **individual outreach forms**, we report the number and percent of attendees with a given demographic characteristic.

- Numerator = number of attendees in a given category (*e.g.*, location in the office setting), per quarter
- Denominator = total number of attendees, per quarter

For the **group outreach forms**, we report the number of group outreach events and total number of attendees during an event.

For MAA codes, location, and language, we report the number and percent of group events.

- Numerator = number of group event(s) with a certain MAA code, location, or language, per quarter
- Denominator = total number of group events, per quarter

Demographic characteristics are reported as the number and percent of attendees.

- Numerator = number of attendees in a given category (*e.g.*, race), per quarter
- Denominator = total number of attendees, per quarter

Appendix B. FY 2015-2016 Outreach, Asian American Recovery Services

Outreach Event Characteristics

For FY 2015-2016, Asian American Recovery Services (AARS) reported a total of 1,652 outreach attendees—150 individual outreach attendees and 1,502 group outreach attendees. **Table B1** shows outreach event location, MAA code, and language.

Table B1. Characteristics of AARS Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Office	19 (12.7%)	
Other community location	123 (82.0%)	40 (87.0%)
Phone	5 (3.3%)	
School	1 (0.7%)	6 (13.0%)
Unspecified location	2 (1.3%)	
Total	**150**	**46**
MAA code		
400	2 (1.3%)	
401	113 (75.3%)	45 (97.8%)
403	4 (2.7%)	1 (2.2%)
N/A	31 (20.7%)	
Total	**148**	**46**
Language		
English	150 (100.0%)	45 (97.8%)
Spanish		1 (2.2%)
Total	**150**	**46**
Average length of contact	**34.39 minutes**	**98.33 minutes**

Note: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table B2 presents the demographics for individual and group outreach attendees served by AARS. Most outreach attendees served by AARS were between the ages of 26-59 (individual outreach data only), self-reported as female (62.6%), and represented many race and ethnicities. The most frequently reported races/ethnicities were multi-racial (18.6%), Samoan (18.3%), Tongan (13.7%), and Filipino (13.0%).

Table B2. Demographics of Outreach Attendees Served By AARS, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	4 (2.7%)
Transition-age youth (16-25)	56 (37.3%)
Adults (26-59)	82 (54.7%)
Older adults (60+)	8 (5.3%)
Unknown age	0 (0.0%)
Total	**150**
Gender	
Female	1,034 (62.6%)
Male	611 (37.0%)
Other gender	7 (0.4%)
Total	**1,652**
Sexual Orientation	
LGBTQ	121 (7.3%)
Race/Ethnicity	
Black	43 (2.6%)
White	159 (9.6%)
American Indian	13 (0.8%)
Middle Eastern	8 (0.5%)
Mexican	112 (6.8%)
Puerto Rican	2 (0.1%)
Cuban	0 (0.0%)
Other Latino	2 (0.1%)
Filipino	215 (13.0%)
Chinese	97 (5.91%)
Japanese	7 (0.4%)
Korean	5 (0.3%)
South Asian	0 (0.0%)
Vietnamese	8 (0.5%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	2 (0.1%)
Mien	0 (0.0%)
Tongan	226 (13.7%)
Samoan	303 (18.3%)
Fijian	24 (1.5%)
Hawaiian	18 (1.1%)
Guamanian	25 (1.5%)
Multi-racial	308 18.6%)
Other Race	68 (4.1%)

	Total
Unknown Race	7 (0.4%)
Total	**1,652**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, AARS reported 344 outreach attendees representing special populations through individual and group outreach, most commonly reaching attendees who were at risk for homelessness (**8.2%**; n=136) or visually impaired (**6.5%**; n=108). Other attendees representing special populations were hearing impaired (**2.8%**; n=46), homeless (**1.9%**; n=32), and veterans (**1.3%**; n=22).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. The majority of individual outreach attendees received referrals to mental health services (**72.7%**; n=109). More than one in four individual outreach attendees received a referral to substance abuse services (**26.7%**; n=42). Individual outreach events also resulted in 362 referrals to social services (**Table B3**). AARS made other (35.4%) or legal (27.3%) referrals most often.

Table B3. Referrals to Social Services Provided By AARS, FY 2015-2016

Referrals	Total
No referral	*4*
Emergency/protective services	1 (0.3%)
Financial	49 (13.5%)
Food	9 (2.5%)
Form assistance	4 (1.1%)
Housing	54 (14.9%)
Legal	99 (27.3%)
Medical care	11 (3.0%)
Other	128 (35.4%)
Transportation	7 (1.9%)
Total	**362**

Note: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

Appendix C. FY 2015-2016 Outreach, Daly City Peninsula Partnership Collaborative

Outreach Event Characteristics

For FY 2015-2016, Daly City Peninsula Partnership Collaborative (DCPPC) reported a total of 201 outreach attendees—61 individual outreach attendees and 140 group outreach attendees. **Table C1** shows outreach event location, MAA code, and language. DCPPC did not report any group outreach data in Q2.

Table C1. Characteristics of DCPPC Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Home	21 (34.4%)	
Office	1 (1.6%)	
Other community location	37 (60.7%)	2 (50.0%)
School	2 (3.3%)	2 (50.0%)
Total	**61**	**4**
MAA code		
400	11 (18.0%)	4 (100.0%)
401	19 (31.1%)	
N/A	31 (50.8%)	
Total	**61**	**4**
Language		
English	46 (75.4%)	4 (100.0%)
Spanish	12 (19.7%)	
Tagalog	3 (4.9%)	
Total	**61**	**4**
Average length of contact	**30.43 minutes**	**120.0 minutes**

Notes: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table C2 presents the demographics for individual and group outreach attendees served by DCPPC. Most outreach attendees served by DCPPC were of unknown age (individual outreach data only), self-reported as female (72.6%), and represented many race and ethnicities. The most frequently reported races/ethnicities were White (23.9%), Mexican (23.4%), and Filipino (22.4%).

Table C2. Demographics of Outreach Attendees Served By DCPPC, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	0 (0.0%)
Transition-age youth (16-25)	3 (4.9%)
Adults (26-59)	25 (41.0%)
Older adults (60+)	2 (3.3%)
Unknown age	31 (50.8%)
Total	**61**
Gender	
Female	146 (72.6%)
Male	43 (21.4%)
Other gender	12 (6.0%)
Total	**201**
Sexual Orientation	
LGBTQ	7 (3.5%)
Race/Ethnicity	
Black	5 (2.5%)
White	48 (23.9%)
American Indian	1 (0.5%)
Middle Eastern	5 (2.5%)
Mexican	47 (23.4%)
Puerto Rican	2 (1.0%)
Cuban	0 (0.0%)
Other Latino	0 (0.0%)
Filipino	45 (22.4%)
Chinese	15 (7.5%)
Japanese	3 (1.5%)
Korean	1 (0.5%)
South Asian	0 (0.0%)
Vietnamese	2 (1.0%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	0 (0.0%)
Samoan	6 (3.0%)
Fijian	0 (0.0%)
Hawaiian	0 (0.0%)
Guamanian	0 (0.0%)
Multi-racial	14 (7.0%)

	Total
Other Race	2 (1.0%)
Unknown Race	5 (2.5%)
Total	**201**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, DCPPC reported 14 outreach attendees representing special populations through individual and group outreach, most commonly reaching attendees who were at risk for homelessness (**3.0%**; n=6) or hearing impaired (**2.0%**; n=4). Other attendees representing special populations were veterans (**1.0%**; n=2) or vision impaired (**1.0%**; n=2).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. Six outreach attendees received referrals to mental health services (**9.8%**; n=6). One individual outreach attendee received a referral to substance abuse services (**1.6%**; n=1). Individual outreach events also resulted in 49 referrals to social services (**Table C3**). DCPPC made other (40.8%), food (22.4%), or housing (22.4%) referrals most often.

Table C3. Referrals to Social Services Provided By DCPPC, FY 2015-2016

Referrals	Total
No referral	*31*
Emergency/protective services	0 (0.0%)
Financial	0 (0.0%)
Food	11 (22.4%)
Form assistance	2 (4.1%)
Housing	11 (22.4%)
Legal	5 (10.2%)
Medical care	0 (0.0%)
Other	20 (40.8%)
Transportation	0 (0.0%)
Total	**49**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

Appendix D. FY 2015-2016 Outreach, Daly City Youth Health Center

Outreach Event Characteristics

For FY 2015-2016, Daly City Youth Health Center (DCYHC) reported a total of 499 outreach attendees—23 individual outreach attendees and 476 group outreach attendees. **Table D1** shows outreach event location, MAA code, and language.

Table D1. Characteristics of DCYHC Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Faith-based church/temple	2 (8.7%)	1 (5.3%)
Office	5 (21.7%)	
Other community location	3 (13.0%)	1 (5.3%)
School	5 (21.7%)	15 (78.9%)
Unspecified location	8 (34.8%)	
Total	**23**	**17**
MAA code		
400	2 (8.7%)	6 (31.6%)
401		7 (36.8%)
403		1 (5.3%)
410	3 (13.0%)	
N/A	18 (78.3%)	5 (26.3%)
Total	**23**	**19**
Language		
English	22 (95.7%)	18 (94.7%)
Spanish	1 (4.3%)	
Other language		1 (5.3%)
Total	**23**	**19**
Average length of contact	**17.83 minutes**	**96.63 minutes**

Notes: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table D2 presents the demographics for individual and group outreach attendees served by DCYHC. Most outreach attendees served by DCYHC were adults aged 26-59 (individual outreach data only), self-reported as female (54.3%), and represented many race and ethnicities.

The most frequently reported races/ethnicities were Filipino (37.8%), Unknown (13.1%), and Mexican (12.3%).

Table D2. Demographics of Outreach Attendees Served By DCYHC, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	0 (0.0%)
Transition-age youth (16-25)	1 (4.3%)
Adults (26-59)	22 (95.7%)
Older adults (60+)	0 (0.0%)
Unknown age	0 (0.0%)
Total	**23**
Gender	
Female	271 (54.3%)
Male	161 (32.3%)
Other gender	67 (13.4%)
Total	**201**
Sexual Orientation	
LGBTQ	40 (8.0%)
Race/Ethnicity	
Black	25 (5.0%)
White	58 (11.5%)
American Indian	2 (0.4%)
Middle Eastern	10 (2.0%)
Mexican	62 (12.3%)
Puerto Rican	0 (0.0%)
Cuban	0 (0.0%)
Other Latino	6 (1.2%)
Filipino	191 (37.8%)
Chinese	24 (4.8%)
Japanese	5 (1.0%)
Korean	2 (0.4%)
South Asian	3 (0.6%)
Vietnamese	2 (0.4%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	0 (0.0%)
Samoan	0 (0.0%)
Fijian	0 (0.0%)

	Total
Hawaiian	0 (0.0%)
Guamanian	0 (0.0%)
Multi-racial	41 (8.1%)
Other Race	8 (1.6%)
Unknown Race	66 (13.1%)
Total	**505**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, DCYHC reported 2 outreach attendees representing special populations through individual and group outreach, reaching attendees who were at risk for homelessness (**0.2%**; n=1) or veterans (**0.2%**; n=1).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. The majority of individual outreach attendees received referrals to mental health services (**65.2%**; n=15). Two individual outreach attendees received a referral to substance abuse services (**4.3%**; n=2). Individual outreach events also resulted in 13 referrals to social services (**Table D3**). DCYHC made medical care (53.8%) and other (23.1%) referrals most often.

Table D3. Referrals to Social Services Provided By DCYHC, FY 2015-2016

Referrals	Total
No referral	15
Emergency/protective services	0 (0.0%)
Financial	1 (7.7%)
Food	1 (7.7%)
Form assistance	0 (0.0%)
Housing	1 (7.7%)
Legal	0 (0.0%)
Medical care	7 (53.8%)
Other	3 (23.1%)
Transportation	0 (0.0%)
Total	**13**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

Appendix E. FY 2015-2016 Outreach, El Concilio

Outreach Event Characteristics

For FY 2015-2016, El Concilio reported a total of 53 outreach attendees, all from individual outreach. El Concilio did not report any group outreach events during FY 2015-2016. **Table E1** shows outreach event location, MAA code, and language, reported at the attendee-level.

Table E1. Characteristics of El Concilio Outreach Events, FY 2015-2016

	Individual Outreach
Location	**Total Attendees**
Health/primary care clinic	1 (1.9%)
Office	50 (94.3%)
Phone	2 (3.8%)
Total	**53**
MAA code	
400	49 (92.5%)
410	4 (7.5%)
Total	**53**
Language	
English	15 (28.3%)
Spanish	38 (71.7%)
Total	**53**
Average length of contact	**24.58 minutes**

Notes: Only the categories where data was reported are presented.

Demographics

Table E2 presents the demographics for individual and group outreach attendees served by El Concilio. Most outreach attendees served by El Concilio were adults aged 26-59 and self-reported as female (88.7%). Outreach attendees identified as Mexican (73.6%), Black (13.2%), or Multi-Race (13.2%).

Table E2. Demographics of Outreach Attendees Served By El Concilio, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	1 (1.9%)
Transition-age youth (16-25)	10 (18.9%)
Adults (26-59)	38 (71.7%)
Older adults (60+)	4 (7.5%)
Unknown age	0 (0.0%)
Total	**53**
Gender	
Female	47 (88.7%)
Male	6 (11.3%)
Other gender	0 (0.0%)
Total	**53**
Sexual Orientation	
LGBTQ	1 (1.9%)
Race/Ethnicity	
Black	7 (13.2%)
White	0 (0.0%)
American Indian	0 (0.0%)
Middle Eastern	0 (0.0%)
Mexican	39 (73.6%)
Puerto Rican	0 (0.0%)
Cuban	0 (0.0%)
Other Latino	0 (0.0%)
Filipino	0 (0.0%)
Chinese	0 (0.0%)
Japanese	0 (0.0%)
Korean	0 (0.0%)
South Asian	0 (0.0%)
Vietnamese	0 (0.0%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	0 (0.0%)
Samoan	0 (0.0%)
Fijian	0 (0.0%)
Hawaiian	0 (0.0%)
Guamanian	0 (0.0%)
Multi-racial	7 (13.2%)
Other Race	0 (0.0%)

	Total
Unknown Race	0 (0.0%)
Total	**53**

Special Populations

In FY 2015-2016, El Concilio reported 35 outreach attendees representing special populations, most commonly reaching attendees who were homeless (**34.0%**; n=18). Other attendees representing special populations were at risk of homelessness (**17.0%**; n=9), hearing impaired (**11.3%**; n=6), or vision impaired (**3.8%**; n=2).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. Nine individual outreach attendees received referrals to mental health services (**17.0%**; n=9). There were no referrals to substance abuse services. Individual outreach events also resulted in 57 referrals to social services (**Table E3**). El Concilio made Housing (33.3%) and Food (24.6%) referrals most often.

Table E3. Referrals to Social Services Provided By El Concilio, FY 2015-2016

Referrals	Total
No referral	*10*
Emergency/protective services	1 (1.8%)
Financial	0 (0.0%)
Food	14 (24.6%)
Form assistance	6 (10.5%)
Housing	19 (33.3%)
Legal	4 (7.0%)
Medical care	1 (1.8%)
Other	9 (15.8%)
Transportation	3 (5.3%)
Total	**57**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

Appendix F. FY 2015-2016 Outreach, Free At Last

Outreach Event Characteristics

For FY 2015-2016, Free At Last reported a total of 373 outreach attendees, all from individual outreach. Free At Last did not report any group outreach events during FY 2015-2016. **Table F1** shows outreach event location, MAA code, and language, reported at the attendee-level.

Table F1. Characteristics of Free At Last Outreach Events, FY 2015-2016

	Individual Outreach
Location	**Total Attendees**
Office	173 (46.4%)
Unspecified location	200 (53.6%)
Total	**373**
MAA code	
400	172 (46.1%)
401	201 (53.9%)
Total	**373**
Language	
English	280 (75.1%)
Spanish	93 (24.9%)
Total	**373**
Average length of contact	**24.58 minutes**

Note: Only the categories where data was reported are presented.

Demographics

Table F2 presents the demographics for individual and group outreach attendees served by Free At Last. Most outreach attendees served by Free At Last were adults aged 26-59 and self-reported as male (50.7%), and represented many race and ethnicities. The most frequently reported races/ethnicities were Mexican (34.9%) and Black (33.8%).

Table F2. Demographics of Outreach Attendees Served By Free At Last, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	0 (0.0%)
Transition-age youth (16-25)	89 (23.9%)
Adults (26-59)	261 (70.0%)
Older adults (60+)	23 (6.2%)
Unknown age	0 (0.0%)
Total	**373**
Gender	
Female	182 (48.8%)
Male	189 (50.7%)
Other gender	2 (0.5%)
Total	**373**
Sexual Orientation	
LGBTQ	80 (21.4%)
Race/Ethnicity	
Black	126 (33.8%)
White	68 (18.2%)
American Indian	3 (0.8%)
Middle Eastern	0 (0.0%)
Mexican	130 (34.9%)
Puerto Rican	3 (0.8%)
Cuban	1 (0.3%)
Other Latino	0 (0.0%)
Filipino	14 (3.8%)
Chinese	2 (0.5%)
Japanese	0 (0.0%)
Korean	0 (0.0%)
South Asian	1 (0.3%)
Vietnamese	2 (0.5%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	11 (2.9%)
Samoan	2 (0.5%)
Fijian	1 (0.3%)
Hawaiian	2 (0.5%)
Guamanian	0 (0.0%)
Multi-racial	5 (1.3%)
Other Race	2 (05%)

Unknown Race	0 (0.0%)
Total	**373**

Special Populations

In FY 2015-2016, Free At Last reported 438 outreach attendees representing special populations. The total number of special population attendees reached exceeds total attendee count, because a single attendee may identify as more than one group (*e.g.,* both homeless and vision impaired). Most commonly reached special population attendees were homeless (**56.3%**; n=210) or at risk of homelessness (**33.8%**; n=126). Other attendees representing special populations were vision impaired (**10.5%**; n=39), hearing impaired (**9.1%**; n=34), and veterans (**7.8%**; n=29).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. Eighteen percent of individual outreach attendees received referrals to mental health services (**18.0%**; n=67). The majority of attendees received referrals to substance abuse services (**59.8%**; n=223). Individual outreach events also resulted in 567 referrals to social services (**Table F3**). Free at Last made Medical Care (49.0%) and Housing (30.7%) referrals most often.

Table F3. Referrals to Social Services Provided By Free At Last, FY 2015-2016

Referrals	Total *
No referral	*80*
Emergency/protective services	0 (0.0%)
Financial	0 (0.0%)
Food	2 (0.4%)
Form assistance	0 (0.0%)
Housing	174 (30.7%)
Legal	1 (0.2%)
Medical care	278 (49.0%)
Other	111 (19.6%)
Transportation	1 (0.2%)
Total	**567**

Note: * Total number of referrals may exceed total attendee count, because an individual outreach event may have more than one referral. The percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” “Total” represents all referrals except “no referral.”

Appendix G. FY 2015-2016 Outreach, Multicultural Counseling and Education Services of the Bay Area

Outreach Event Characteristics

For FY 2015-2016, Multicultural Counseling and Education Services of the Bay Area (MCESBA) reported a total of 386 outreach attendees—323 individual outreach attendees and 63 group outreach attendees. **Table G1** shows outreach event location, MAA code, and language. MCESBA did not report any group outreach data for Q3.

Table G1. Characteristics of MCESBA Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Age-specific community center	8 (2.5%)	
Faith-based church/temple	13 (4.0%)	1 (2.2%)
Health/primary care clinic	2 (0.6%)	
Home	38 (11.8%)	4 (8.7%)
Job site	6 (1.9%)	
Mobile service	2 (0.6%)	
Office	6 (1.9%)	
Phone	29 (9.0%)	
Residential care	2 (0.6%)	
School	19 (5.9%)	1 (2.2%)
Other community location	175 (54.2%)	2 (4.3%)
Unspecified location	16 (5.0%)	
Total	**323**	**8**
MAA code		
400	322 (99.7%)	8 (100.0%)
404	1 (0.3%)	
Total	**323**	**8**
Language		
American/Other Sign Language	1 (0.3%)	
English	209 (54.4%)	1 (12.5%)
Samoan	31 (9.6%)	4 (50.0%)
Spanish	11 (3.4%)	
Tongan	70 (18.9%)	3 (37.5%)
Other language	1 (0.3%)	
Total	**323**	**8**
Average length of contact	**42.57 minutes**	**48.13 minutes**

Note: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table G2 presents the demographics for individual and group outreach attendees served by MCESBA. Most outreach attendees served by MCESBA were transition-age youth aged 16-25 (individual outreach data only), self-reported as female (61.1%), and represented many race and ethnicities. The most frequently reported races/ethnicities were Tongan (36.2%) and Samoan (23.9%).

Table G2. Demographics of Outreach Attendees Served By MCESBA, FY 2015-2016

Referrals	Total
Age (individual outreach attendees only)	
Children (0-15)	1 (0.3%)
Transition-age youth (16-25)	182 (56.3%)
Adults (26-59)	109 (33.7%)
Older adults (60+)	29 (9.0%)
Unknown age	2 (0.6%)
Total	**323**
Gender	
Female	236 (61.1%)
Male	138 (35.8%)
Other gender	12 (3.1%)
Total	**386**
Sexual Orientation	
LGBTQ	14 (3.6%)
Race/Ethnicity	
Black	61 (12.3%)
White	9 (1.8%)
American Indian	4 (0.8%)
Middle Eastern	0 (0.0%)
Mexican	26 (5.3%)
Puerto Rican	1 (0.2%)
Cuban	0 (0.0%)
Other Latino	0 (0.0%)
Filipino	4 (0.8%)
Chinese	0 (0.0%)
Japanese	0 (0.0%)
Korean	0 (0.0%)
South Asian	1 (0.2%)
Vietnamese	0 (0.0%)
Cambodian	0 (0.0%)

Referrals	Total
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	179 (36.2%)
Samoan	118 (23.9%)
Fijian	12 (2.4%)
Hawaiian	4 (0.8%)
Guamanian	0 (0.0%)
Multi-racial	71 (14.4%)
Other Race	0 (0.0%)
Unknown Race	4 (0.8%)
Total	**494**

Note: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, MCESBA reported 157 outreach attendees representing special populations, most commonly reaching attendees who were at risk of homelessness (**22.5%**; n=126). Other attendees representing special populations were homeless (**22.5%**; n=87), hearing impaired (**1.0%**; n=4), vision impaired (**1.0%**; n=4), and veterans (**1.0%**; n=4).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. More than one third of outreach attendees received referrals to mental health services (**37.8%**; n=122). Five individual outreach attendees received a referral to substance abuse services (**1.5%**; n=5). Individual outreach events also resulted in 792 referrals to social services to other services (**Table G3**). MCESBA made Food (26.9%) referrals most often.

Table G3. Referrals to Social Services Provided By DCYHC, FY 2015-2016

	Total
No referral	*21*
Emergency/protective services	19 (2.4%)
Financial	87 (11.0%)
Food	213 (26.9%)
Form assistance	91 (11.5%)
Housing	129 (16.3%)

	Total
Legal	70 (8.8%)
Medical care	91 (11.5%)
Other	56 (7.1%)
Transportation	36 (4.5%)
Total	**792**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding "no referral." Total represents all referrals except "no referral."

Appendix H. FY 2015-2016 Outreach, Pacifica Collaborative

Outreach Event Characteristics

For FY 2015-2016, Pacifica Collaborative reported a total of 2,092 outreach attendees—23 individual outreach attendees and 2,069 group outreach attendees. The following characteristics of the outreach events are presented separately for individual and group outreach because they are reported at the attendee-level for individual outreach, versus at the event-level for group outreach (**Table H1**).

Table H1. Characteristics of Pacifica Collaborative Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Faith-based church/temple	13 (56.5%)	9 (39.1%)
Home	1 (4.3%)	
Mobile service		3 (13.0%)
School		6 (26.1%)
Other community location	9 (39.1%)	5 (21.7%)
Total	**23**	**23**
MAA code		
400	2 (8.7%)	7 (30.4%)
403	13 (56.5%)	
N/A	8 (34.8%)	13 (56.5%)
Total	**23**	**23**
Language		
English	23 (100.0%)	22 (95.7%)
Other language		1 (4.3%)
Total	**23**	**23**
Average length of contact	**21.61 minutes**	**93.09 minutes**

Note: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table H2 presents the demographics for individual and group outreach attendees served by Pacifica Collaborative. Most outreach attendees served by Pacifica Collaborative were adults aged 26-59 (individual outreach data only), self-reported as female (48.8%), and represented many race and ethnicities. The most frequently reported races/ethnicities was White (54.6%).

Table H2. Demographics of Outreach Attendees Served By Pacifica Collaborative, FY 2015-2016

	Total
Age	
Children (0-15)	0 (0.0%)
Transition-age youth (16-25)	2 (8.7%)
Adults (26-59)	18 (78.3%)
Older adults (60+)	3 (13.0%)
Total	**23**
Gender	
Female	1,020 (48.8%)
Male	880 (42.1%)
Other gender	192 (9.2%)
Total	**2,092**
Sexual Orientation	
LGBTQ	95 (4.5%)
Race/Ethnicity	
Black	67 (3.2%)
White	1,147 (54.6%)
American Indian	32 (1.5%)
Middle Eastern	30 (1.4%)
Mexican	7 (0.3%)
Puerto Rican	0 (0.0%)
Cuban	0 (0.0%)
Other Latino	79 (3.8%)
Filipino	195 (9.3%)
Chinese	52 (2.5%)
Japanese	11 (0.5%)
Korean	20 (1.0%)
South Asian	5 (0.2%)
Vietnamese	10 (0.5%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	8 (0.4%)
Samoan	32 (1.5%)
Fijian	0 (0.0%)
Hawaiian	11 (0.5%)
Guamanian	0 (0.0%)
Multi-racial	40 (1.9%)
Other Race	0 (0.0%)
Unknown Race	354 (16.8%)
Total	**2,102**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, Pacifica Collaborative reported 416 outreach attendees representing special populations, most commonly reaching attendees who were at risk of homelessness (**11.7%**; n=224). Other attendees representing special populations were veterans (**4.7%**; n=98), homeless (**1.9%**; n=40), hearing impaired (**1.0%**; n=20), and vision impaired (**0.7%**; n=14).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. The majority of individual outreach attendees received referrals to mental health services (**73.9%**; n=17). Six individual outreach attendees received a referral to substance abuse services (**26.1%**; n=6). Individual outreach events also resulted in 56 referrals to social services (**Table H3**). Pacifica Collaborative made Food (26.9%) and Housing (26.8%) referrals most often.

Table H3. Referrals to Social Services Provided By Pacifica Collaborative, FY 2015-2016

Referrals	Total
No referral	*3*
Emergency/protective services	2 (3.6%)
Financial	1 (1.8%)
Food	18 (32.1%)
Form assistance	8 (14.3%)
Housing	15 (26.8%)
Legal	0 (0.0%)
Medical care	0 (0.0%)
Other	2 (3.6%)
Transportation	10 (179%)
Total	**56**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral”. Total represents all referrals except “no referral”.

Appendix I. FY 2015-2016 Outreach, Pyramid Alternatives

Outreach Event Characteristics

For FY 2015-2016, Pyramid Alternatives reported a total of 300 outreach attendees—96 individual outreach attendees and 204 group outreach attendees. **Table I1** shows outreach event location, MAA code, and language.

Table I1. Characteristics of Pyramid Alternatives Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Faith-based church/temple		1 (14.3%)
Hospital/IMD/SNF	6 (6.3%)	
Office	68 (70.8%)	
Phone	1 (1.0%)	
School	8 (8.3%)	4 (57.1%)
Other community location	4 (4.2%)	2 (28.6%)
Unspecified location	9 (9.4%)	
Total	**96**	**7**
MAA code		
400	96 (100.0%)	7 (100.0%)
Total	**96**	**7**
Language		
English	92 (95.8%)	6 (85.7%)
Mandarin	2 (2.1%)	1 (14.3%)
Spanish	1 (1.0%)	
Other language	1 (1.0%)	
Total	**96**	**7**
Average length of contact	**45.66 minutes**	**175.7 minutes**

Notes: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table I2 presents the demographics for individual and group outreach attendees served by Pyramid Alternatives. Most outreach attendees served by Pyramid Alternatives were adults aged 26-59 (individual outreach data only), self-reported as female (57.0%), and represented many race and ethnicities. The most frequently reported races/ethnicities were White (29.7%) and Chinese (19.3%).

Table I2. Demographics of Outreach Attendees Served By Pyramid Alternatives, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	2 (2.1%)
Transition-age youth (16-25)	25 (26.0%)
Adults (26-59)	62 (64.6%)
Older adults (60+)	6 (6.3%)
Unknown age	1 (1.0%)
Total	**96**
Gender	
Female	171 (57.0%)
Male	128 (42.7%)
Other gender	1 (0.3%)
Total	**300**
Sexual Orientation	
LGBTQ	14 (4.7%)
Race/Ethnicity	
Black	13 (4.3%)
White	89 (29.7%)
American Indian	0 (0.0%)
Middle Eastern	7 (2.3%)
Mexican	32 (10.7%)
Puerto Rican	1 (0.3%)
Cuban	0 (0.0%)
Other Latino	0 (0.0%)
Filipino	32 (10.7%)
Chinese	58 (19.3%)
Japanese	4 (1.3%)
Korean	1 (03%)
South Asian	8 (2.7%)
Vietnamese	1 (0.3%)
Cambodian	1 (0.3%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	2 (0.7%)
Samoan	2 (0.7%)
Fijian	0 (0.0%)
Hawaiian	0 (0.0%)
Guamanian	0 (0.0%)
Multi-racial	25 (8.3%)

	Total
Other Race	16 (5.3%)
Unknown Race	8 (2.7%)
Total	**300**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, MCESBA reported 367 outreach attendees representing special populations, most commonly reaching attendees who were vision impaired (**6.7%**; n=20). Other attendees representing special populations were at risk of homelessness (**2.7%**; n=8), hearing impaired (**1.7%**; n=5), and veterans (**1.0%**; n=3).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. Eleven outreach attendees received referrals to mental health services (**11.5%**; n=11). There were no referrals to substance abuse services. Individual outreach events also resulted in 3 referrals to social services (**Table I3**).

Table I3. Referrals to Social Services Provided By Pyramid Alternatives Collaborative, FY 2015-2016

Referrals	Total
No referral	*93*
Emergency/protective services	0 (0.0%)
Financial	0 (0.0%)
Food	0 (0.0%)
Form assistance	0 (0.0%)
Housing	0 (0.0%)
Legal	0 (0.0%)
Medical care	1 (33.3%)
Other	2 (66.7%)
Transportation	0 (0.0%)
Total	**3**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

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