

## FRESNO COUNTY MENTAL HEALTH PLAN

## OUTCOMES REPORT- Attachment A

### PROGRAM INFORMATION:

|                             |   |                            |  |
|-----------------------------|---|----------------------------|--|
| <b>Program Title:</b>       | Cultural-Based Access Navigation and Peer/Family Support Services (CBANS)   | <b>Provider:</b>           | Fresno American Indian Health Project (FAIHP)                                      |
| <b>Program Description:</b> | The program is aimed at reducing risk factors and stressors, building protective factors and skills, and increasing social supports access for all age groups, through individual and group peer support, community awareness, and education provided in culturally sensitive formats and contexts. | <b>MHP Work Plan:</b>      | 3-Culturally and community defined practices<br>Choose an item.<br>Choose an item. |
| <b>Age Group Served 1:</b>  | ADULT   | <b>Dates Of Operation:</b> | October 11,2011 - Present  |
| <b>Age Group Served 2:</b>  | TAY   | <b>Reporting Period:</b>   | July 1, 2017 - June 30, 2018   |
| <b>Funding Source 1:</b>    | Prevention (MHSA)   | <b>Funding Source 3:</b>   | Choose an item.  |
| <b>Funding Source 2:</b>    | Early Intervention (MHSA)   | <b>Other Funding:</b>      | Click here to enter text.  |

### FISCAL INFORMATION:

|  |          |                               |             |
|--|----------|-------------------------------|-------------|
| <b>Program Budget Amount:</b>                              | \$75,206 | <b>Program Actual Amount:</b> | \$73,884.27 |
| <b>Number of Unique Clients Served During Time Period:</b> | 525      |                               |             |
| <b>Number of Services Rendered During Time Period:</b>     | 3,604    |                               |             |
| <b>Actual Cost Per Client:</b>                             | \$140.73 |                               |             |

### CONTRACT INFORMATION:

|   |                              |                         |   |
|---|------------------------------|-------------------------|---|
| <b>Program Type:</b>                                | Contract-Operated            | <b>Type of Program:</b> | Other, please specify below             |
| <b>Contract Term:</b>                               | July 1, 2016 – June 30, 2021 | <b>For Other:</b>       | Prevention and Early Intervention (PEI) |
|   |                              | <b>Renewal Date:</b>    | June 30, 2021                           |
| <b>Level of Care Information Age 18 &amp; Over:</b> | Choose an item.              |                         |   |
| <b>Level of Care Information Age 0- 17:</b>         | Choose an item.              |                         |   |

Level of Care information above does not apply.

**TARGET POPULATION INFORMATION:**

Target Population: American Indian / Alaska Native

**CORE CONCEPTS:**

- **Community collaboration:** individuals, families, agencies, and businesses work together to accomplish a shared vision.
- **Cultural competence:** adopting behaviors, attitudes and policies that enable providers to work effectively in cross-cultural situations.
- **Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services:** adult clients and families of children and youth identify needs and preferences that result in the most effective services and supports.
- **Access to underserved communities:** Historically unserved and underserved communities are those groups that either have documented low levels of access and/or use of mental health services, face barriers to participation in the policy making process in public mental health, have low rates of insurance coverage for mental health care, and/or have been identified as priorities for mental health services.
- **Integrated service experiences:** services for clients and families are seamless. Clients and families do not have to negotiate with multiple agencies and funding sources to meet their needs.

**Please select core concepts embedded in services/ program:**

*(May select more than one)*

Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services

Cultural Competency

Community collaboration

Choose an item.

**Please describe how the selected concept (s) embedded :**

The CBANS program applies all core concepts in all areas of service. A large focus of programming is working with individuals and families on improving overall wellness. This is addressed in a variety of domains that focus on educational workshops and activities. Additionally, programming helps to connect elders to youth in order to bridge the generational gap and allow for cultural teachings and activities. All activities are held in regard to culture, mental health, and resiliency. CBANS also strives to create a larger connection with networking and building resource capacity for our clientele. We commit to linking individuals to their culture and local resources to build resiliency. Through providing culturally appropriate services and linkage, community members are able to build and strengthen both their sense of belonging and identity; which also increase mental wellness. Our agency focuses on the idea of “culture is prevention.” This value continues to be kept at the forefront of how all services are developed and implemented. By focusing on this concept and also staying family and individual focused, the CBANS program is able to provide training

and activities that focus on increasing cultural competence of community members and service providers. Through collaborating with other community partners, networking is strengthened. Additionally, when this is strengthened, clientele are provided with more services that may meet their needs. Engagement with community includes collaboration with Department of Social Services, educating agencies on cultural values and principles, crisis intervention trainings, raising awareness to other agencies about mental health and stigma reduction. By including other service providers, we help to improve and create mobilization in the Native community. Working with local agencies including Sierra Tribal Consortium, WestCare, Owens Valley Career Development Center, North Fork TANF, Big Sandy Rancheria, Cold Springs Rancheria, Fresno County DSS, and the Fresno Discovery Center has helped to bridge a resource gap to our community members. It has helped to provide access and awareness of mental health stigma, leadership in the community, increased outreach, and being advocates of wellness and recovery.

**PROGRAM OUTCOME & GOALS**

- Must include each of these areas/domains: (1) Effectiveness, (2) Efficiency, (3) Access, (4) Satisfaction & Feedback Of Persons Served & Stakeholder

- Include the following components for documenting each goal: (1) Indicator, (2) Who Applied, (3) Time of Measure, (4) Data Source, (5) Target Goal Expectancy

Overall, CBANS outcomes and goals were efficiently met. CBANS demographics information highlights specific age groups served and ethnicity specific to unique/unduplicated numbers are listed below.

Demographics of the Population Served in FY 2017/2018

| Ages Served  | Served |
|--------------|--------|
| 0-15         | 27     |
| 16-25        | 26     |
| 26-64        | 218    |
| 65+          | 78     |
| Unreported   | 176    |
| Total Served | 525    |

| Ethnicity              | Served |
|------------------------|--------|
| African American/Black | 9      |
| Asian/Pacific Islander | 1      |
| Caucasian/White        | 6      |
| Latino                 | 33     |
| Native American        | 236    |
| Other Ethnicity        | 7      |
| Unreported             | 233    |
| Total Served           | 525    |

*Goal 1: Increase knowledge of risk and resilience/protective factors.*

#### Effectiveness

**a). Indicator** – Percent of individual clients level of stress decreased on a scale of 1 (not at all stressed) – 6 (extremely stressed)

\*Refer to Chart 1\*

**b). Who Applied** – Active CBANS clients.

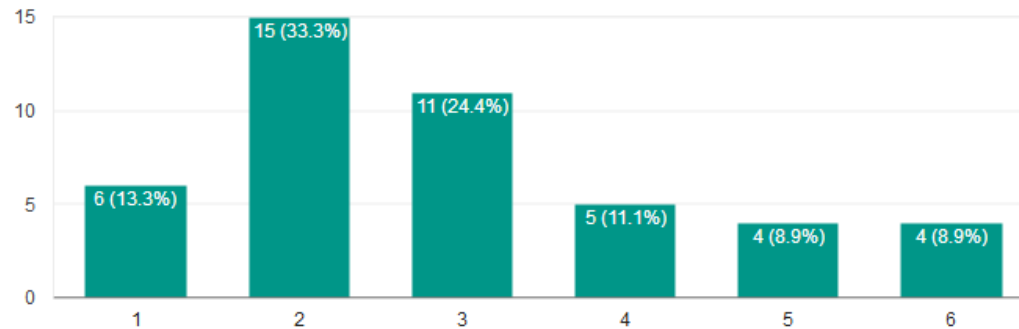
**c). Time of Measure** – Surveys were collected during this reporting period.

**d). Data Source** – Needs/Stressors form and Wellness Survey

**e). Target Goal Expectancy** – Reduce the number of self-reported stressors for 60% of clients within a six month time frame.

**f). Outcomes** – Community Health Worker and Family advocate were able to identify with clients their needs and stressors at initial intakes or during crisis response walk-ins. Through this, both were able to work collaboratively with clients and decrease stressors over the span of the clients case (time frame varies per case).

#### CHART 1



### Efficiency

**a). Indicator** – Percent of individual clients utilizing and being educated on community resources due to CBANS assistance increased on a scale of 1 (not at all knowledgeable) to 6 (extremely knowledgeable) \*Refer to Chart 2\*

**b). Who Applied** – Active CBANS clients.

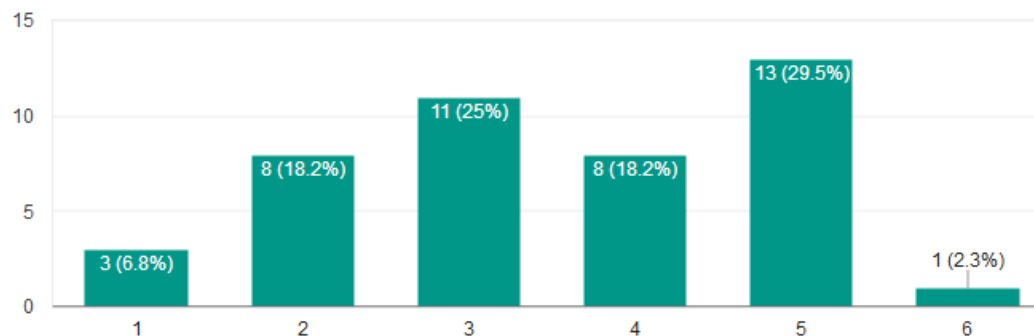
**c). Time of Measure** – Surveys were collected during this reporting period.

**d). Data Source** – Needs/Stressors form and Wellness Survey

**e). Target Goal Expectancy** – Increase efficiency methods with staff and providing services to clients in a timely manner in order to meet needs.

**f). Outcomes** – Community Health Worker and Family Advocate consistently implement required surveys monthly in order to identify needs and stressors. Efficiency of the surveys being implemented is monitored through bi-weekly chart audits. Through efficient implementation of surveys, client's become resilient and self-sufficient in obtaining other community resources.

### CHART 2



Access

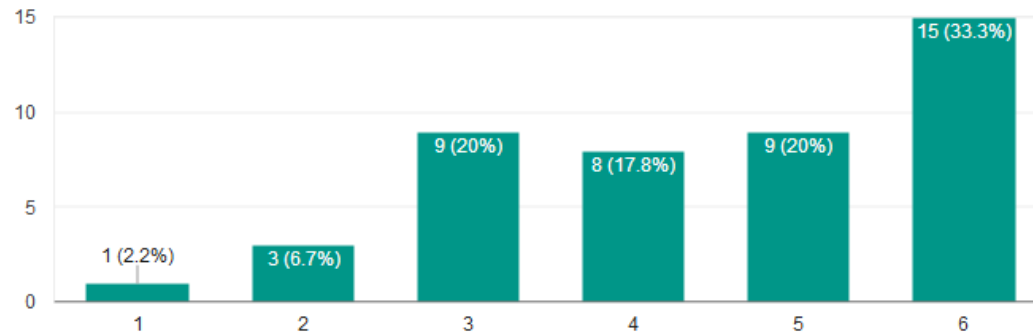
- a). **Indicator** – Client access to services continued to increase throughout the reporting period, totaling to 35 new client intakes. Additionally, the total amount of presentations to community providers and members totaled to 13 presentations completed. Lastly, the total amount of outreach events totaled to 15 events attended.
- b). **Who Applied** – Categories included active CBANS clients and individuals at presentations or outreach events.
- c). **Time of Measure** – Surveys were not completed for presentations or events attended for outreach. However, all CBANS intakes consisted of Needs/Stressors form and Wellness Survey.
- d). **Data Source** – Needs/Stressors form and Wellness Survey
- e). **Target Goal Expectancy** – Ongoing goal is to continue providing access to services for clients and be a linkage to resources when applicable. As a result, Community Health Worker and Family Advocate also implement field-based visits with client if necessary.
- f). **Outcomes** – FAIHP continues to provide access to services for clients and linkage to outside agency resources as needed.

*Goal 2: Increase overall mental health awareness in the community.*

Effectiveness

- a). **Indicator** – Percent of individuals reported increased sense of hope on a scale of 1 (not at all hopeful) to 6 (extremely hopeful)  
\*Refer to Chart 3\*
- b). **Who Applied** – Active CBANS clients.
- c). **Time of Measure** – Surveys were collected during this reporting period.
- d). **Data Source** – Wellness Survey
- e). **Target Goal Expectancy** – At least 75% of clients shall report an increased sense of hope within a six month time frame.
- f). **Outcomes** – Community Health Worker and Family Advocate were able to increase overall mental health awareness in the community through positive outreach methods, presentations, networking, and building rapport with clients.

CHART 3



### Efficiency

**a). Indicator** – Percent of individual clients who completed the CBANS intake and follow up survey indicated an increase in hope. Through consistency of providing efficient services from Community Health Worker and Family Advocate, individuals were able to be provided with ongoing and effective services in order to meet their needs. \*Refer to Chart 3\*

**b). Who Applied** – Active CBANS clients.

**c). Time of Measure** – Surveys were collected during this reporting period.

**d). Data Source** – Wellness Survey

**e). Target Goal Expectancy** – Increase efficiency methods with staff and providing services to clients in a timely manner in order to meet needs.

**f). Outcomes** – Community Health Worker and Family Advocate consistently implement required surveys monthly in order to identify needs and stressors. Efficiency of the surveys being implemented is monitored through bi-weekly chart audits. Through efficient implementation of surveys, client's become resilient and self-sufficient in obtaining other community resources.

### Access

**a). Indicator** – Client access to services continued to increase throughout the reporting period, totaling to 35 new client intakes. Additionally, the total amount of presentations to community providers and members totaled to 13 presentations completed. Lastly, the total amount of outreach events totaled to 15 events attended.

**b). Who Applied** – Categories included active CBANS clients and individuals at presentations or outreach events.

**c). Time of Measure** – Surveys were not completed for presentations or events attended for outreach. However, all CBANS intakes consisted of Needs/Stressors form and Wellness Survey.

**d). Data Source** – Needs/Stressors form and Wellness Survey

**e). Target Goal Expectancy** – Ongoing goal is to continue providing access to services for clients and be a linkage to resources when applicable. As a result, Community Health Worker and Family Advocate also implement field-based visits with client if necessary.

**f). Outcomes** – FAIHP continues to provide access to services for clients and linkage to outside agency resources as needed.

*Goal 3: Overcome individual culture-based stigma against mental illness and mental health concerns.*Effectiveness

**a). Indicator** – Percentage of individuals reported an increase in feeling comfortable asking for help. Therefore, appearing to overcome stigma in regards to seeking mental health services and addressing concerns. Scale displays 1 (not at all comfortable) to 6 (extremely comfortable)

\*Refer to Chart 4\*

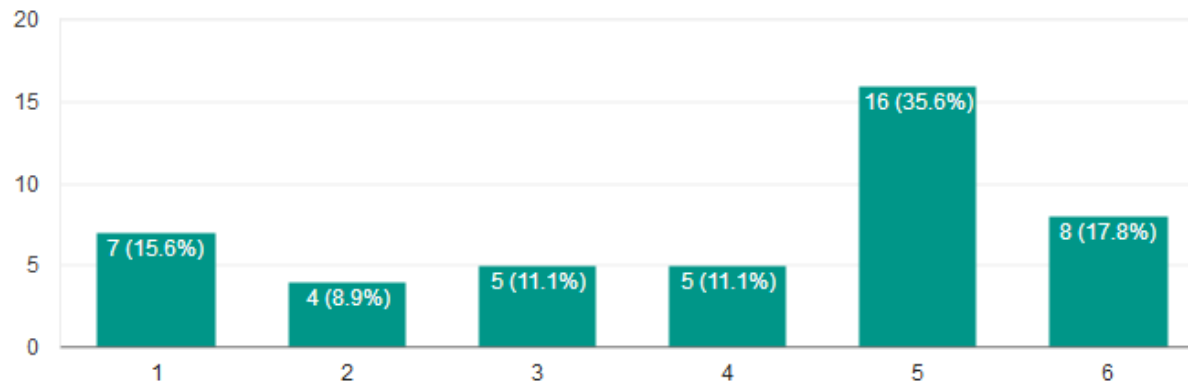
**b). Who Applied** – Active CBANS clients.

**c). Time of Measure** – Surveys were collected during this reporting period.

**d). Data Source** – Wellness Survey

**e). Target Goal Expectancy** – Increase client's comfort level with asking for help at least 60% of active clients within a six month time frame.

**f). Outcomes** – Through survey implementation and consistent outreach efforts, Community Health Worker and Family Advocate have been able to assist in reducing stigma, empower clients, and help to increase client's level of feeling comfortable in seeking mental health resources due to the rapport built.

CHART 4Efficiency

**a). Indicator** – CBANS clients are more likely to seek out services and ask for assistance as a result of building rapport and being empowered by Community Health Worker and Family Advocate.

**b). Who Applied** – Active CBANS clients.

**c). Time of Measure** – Surveys were collected during this reporting period.



d). **Data Source** – Wellness Survey

e). **Target Goal Expectancy** – Increase efficiency methods with staff and providing services to clients in a timely manner in order to meet needs.

f). **Outcomes** – Community Health Worker and Family Advocate consistently implement required surveys monthly in order to identify needs and stressors. Efficiency of the surveys being implemented is monitored through bi-weekly chart audits. Through efficient implementation of surveys, client's become resilient and self-sufficient in obtaining other community resources.

### Access

a). **Indicator** – Client access to services continued to increase throughout the reporting period, totaling to 35 new client intakes. Additionally, the total amount of presentations to community providers and members totaled to 13 presentations completed. Lastly, the total amount of outreach events totaled to 15 events attended. Clients showed more of a likeliness to seek additional resources and support on their own after receiving initial services from Community Health Worker and Family Advocate.

b). **Who Applied** – Categories included active CBANS clients and individuals at presentations or outreach events.

c). **Time of Measure** – Surveys were not completed for presentations or events attended for outreach. However, all CBANS intakes consisted of Needs/Stressors form and Wellness Survey.

d). **Data Source** – Needs/Stressors form and Wellness Survey

e). **Target Goal Expectancy** – Ongoing goal is to continue providing access to services for clients and be a linkage to resources when applicable. As a result, Community Health Worker and Family Advocate also implement field-based visits with client if necessary.

f). **Outcomes** – FAIHP continues to provide access to services for clients and linkage to outside agency resources as needed.

### *Goal 4: Develop coping skills and build resilience for historical trauma.*

### Satisfaction and Feedback of Persons Served and Stakeholders

a). **Indicator** – Annual Client Satisfaction Questionnaire available to all FAIHP clients.

b). **Who Applied** – Any FAIHP clients can complete the survey once annually.

c). **Time of Measure** – Survey completed annually, July 1, 2017 to December 31, 2017.

d). **Data Source** – Client Satisfaction Questionnaire

e). **Target Goal Expectancy** – Goal is to have all FAIHP clients complete the questionnaire and increase participation numbers each year.

f). **Outcomes** – Per the Client Survey, 78% reported that they've obtained skills that will help them handle future problems due to the help of their Therapist/Wellness Coordinator.

### *Goal 5: To facilitate identification of early signs of mental illness for linkages to timely interventions and treatment.*

### Effectiveness

- a). Indicator** – All clients at FAIHP, including CBANS clients are required to complete an initial GPRA Health Screening; which consists of a depression screening portion (PHQ – 2). Once a client scores a 2 or more, it prompts completion of a PHQ- 9. 100% of clients complete these form as a requirement during the registration and intake process. Additionally, screening also is ongoing if needed depending on stressors or crisis that may arise. An automatic referral to FAIHP therapist is completed if scored positive.
- b). Who Applied** – Active CBANS clients.
- c). Time of Measure** – Surveys were completed during this reporting period.
- d). Data Source** – GPRA Screening and PHQ – 9 Assessment Tool
- e). Target Goal Expectancy** – 100% of clients shall be screened for depression during their intake (new clients) or within six months (established clients) and positive results shall be immediately referred to licensed mental health provider.
- f). Outcomes** – As a result of utilizing these required depression screening tools, Community Health Worker and Family Advocate are able to properly screen clients, intervene if applicable, and link to resources for appropriate treatment.

### Efficiency

- a). Indicator** – All clients, including CBANS clients are more likely to seek mental health treatment by completing a required depression screening process. As a result, client's are identified for potential mental illness and appropriate linkage to resources and treatment is provided.
- b). Who Applied** – All FAIHP clients, including CBANS clients.
- c). Time of Measure** – Screening tools are completed as a requirement for all clients at FAIHP. These screening tools were completed during this reporting period.
- d). Data Source** – GPRA Health Screening which includes PHQ – 2, and also PHQ – 9.
- e). Target Goal Expectancy** – 100% of clients shall be screened for depression during their intake (new clients) or within six months (established clients) and positive results shall be immediately referred to licensed mental health provider.
- f). Outcomes** - As a result of utilizing these required depression screening tools, Community Health Worker and Family Advocate are able to properly screen clients, intervene if applicable, and link to resources for appropriate treatment. The process has demonstrated to be efficient in screening appropriately for depression and other mental health treatment consistently.

### Access

- a). Indicator** – 100% of clients receive the depression screening at registration and intake for services.
- b). Who Applied** – All FAIHP clients.
- c). Time of Measure** – All screenings completed during reporting period.
- d). Data Source** – GPRA Health Screening which includes PHQ – 2, and also PHQ – 9.
- e). Target Goal Expectancy** – Ongoing goal is to continue providing access to services for clients and be a linkage to resources when applicable. As a result, all clients receive the screening tool and are provided with linkage to appropriate resources for additional treatment.
- f). Outcomes** – FAIHP continues to provide access to services for clients and linkage to outside agency resources as needed. Additionally, as a result of utilizing these required depression screening tools, Community Health Worker and Family Advocate are able to properly screen clients,

intervene if applicable, and link to resources for appropriate treatment. The process has demonstrated to be efficient in screening appropriately for depression and other mental health treatment consistently.

*Goal 6: Increasing the number of culturally competent prevention and early intervention activities for the Native American community.*

#### Effectiveness

- a). **Indicator** – Through CBANS, a total of 13 presentations were conducted within the reporting period. Total attendees for the presentations totaled to 221.
- b). **Who Applied** – FAIHP clients and other community members attended presentations provided by CBANS staff.
- c). **Time of Measure** – Presentations completed during reporting period.
- d). **Data Source** – Dated sign in sheets for presentations.
- e). **Target Goal Expectancy** – Hold at least 12 educational presentations for Native American clients/community members with the goal of 25 attendees per presentation.
- f). **Outcomes** - Overall, CBANS exceeded the goal of 12 presentations by completing 13 total. However, there can be improvement with goal of having 25 attendees per presentation. Presentations varied in size of attendance.

#### Efficiency

- a). **Indicator** – Community Health Worker and Family Advocate consistently provided a sign-in sheet to all presentations. Therefore, data was available to analyze in regards to amount of attendees in attendance and amount of presentations completed.
- b). **Who Applied** – FAIHP clients and other community members attended presentations provided by CBANS staff.
- c). **Time of Measure** – Presentations completed during reporting period.
- d). **Data Source** – Dated sign in sheets for presentations.
- e). **Target Goal Expectancy** – Hold at least 12 educational presentations for Native American clients/community members with the goal of 25 attendees per presentation.
- f). **Outcomes** – Due to the efficient structure provided by CBANS staff, our goals were met and we were able to provide a total of 13 presentations. However, attendance numbers can be improved for the next reporting period.

#### Access

- a). **Indicator** – Community Health Worker and Family Advocate consistently provided a sign-in sheet to all presentations. Therefore, data was available to analyze in regards to amount of attendees in attendance and amount of presentations completed.
- b). **Who Applied** – All FAIHP clients and non-clients have access to agency educational presentations.

- c). **Time of Measure** – Presentations completed during reporting period.
- d). **Data Source** – Dated sign in sheets for presentations.
- e). **Target Goal Expectancy** – Hold at least 12 educational presentations for Native American clients/community members with the goal of 25 attendees per presentation.
- f). **Outcomes** – Due to availability and access to educational presentations, clients were able to attend and receive helpful information regarding a variety of educational material and topics.

*Goal 7: Increase the number of individuals/families who receive prevention, early intervention, and linkages to community resources.*

### Effectiveness

- a). **Indicator** – CBANS served a total of 588 clients during the reporting period, including engaging and establishing services, providing prevention and early intervention services, and linkage to community resources.
- b). **Who Applied** – All FAIHP clients
- c). **Time of Measure** – Completed during the reporting period.
- d). **Data Source** – CBANS intakes and group programs.
- e). **Target Goal Expectancy** – Engage and establish services for at least 80 Native American individuals/families on an annual basis. Document approximately 150 unique contacts in the first year, with 10% increase each year thereafter.
- f). **Outcomes** – CBANS programming continued to increase with clients served; which showed continued participation and outreach with community members during the reporting period.

### Efficiency

- a). **Indicator** – Monthly CBANS narrative reports indicated an increase in clients served every month.
- b). **Who Applied** – All FAIHP clients
- c). **Time of Measure** – Completed during reporting period.
- d). **Data Source** – CBANS intakes and group programs.
- e). **Target Goal Expectancy** – Engage and establish services for at least 80 Native American individuals/families on an annual basis. Document approximately 150 unique contacts in the first year, with 10% increase each year thereafter.
- f). **Outcomes** – CBANS Narrative reports participant numbers increasing each month.

### Access

- a). **Indicator** – Community Health Worker and Family Advocate provided monthly narrative reports that detailed and tracked CBANS activities efficiently and consistently. Both were familiar with the forms and the information that needed to be gathered to generate information.
- b). **Who Applied** – All FAIHP clients

c). **Time of Measure** – Completed during reporting period.

d). **Data Source** – CBANS intakes and group programs.

e). **Target Goal Expectancy** – Engage and establish services for at least 80 Native American individuals/families on an annual basis. Document approximately 150 unique contacts in the first year, with 10% increase each year thereafter.

f). **Outcomes** – Numbers increased. However, due to staff change for Community Health Worker position during mid-year of reporting period, current Community Health Worker needed to back track on a few months of reporting that wasn't completed through the change in positions. All reporting is up to date for reporting period.

*Goal 8: Increase early onset interventions and referrals to prevent problems from getting worse and thereby requiring more extensive services from the system.*

### Effectiveness

a). **Indicator** – Reporting period of July 2017 – June 2018 indicated a total of 18 referrals for active FAIHP clients who had active case management charts were made internally to FAIHP therapy services. Additionally, through the same reporting period, a total of 35 referrals were completed for active clients for outside agency services.

b). **Who Applied** – Active CBANS clients

c). **Time of Measure** – Referrals were completed and tracked during the reporting period.

d). **Data Source** – Internal Referral Tracking System

e). **Target Goal Expectancy** – Immediately refer clients to licensed mental health professionals and other community services as the client presents the need or based off of screenings.

f). **Outcomes** – All clients refer to be screened efficiently and provided with referrals as needed, as appropriate, and as requested.

### Efficiency

a). **Indicator** – Internal referral tracking system appears to be efficient and providing accurate totals for clients referred to internal agency therapy services and outside agency collaboration. Concluding result is continued collaboration within FAIHP departments and outside agency sectors.

b). **Who Applied** – Active CBANS clients

c). **Time of Measure** – Completed and tracked during the reporting period.

d). **Data Source** – Internal Referral Tracking System

**e). Target Goal Expectancy** – Immediately refer clients to licensed mental health professionals and other community services as the client presents the need or based off of screenings.

**f). Outcomes** – Through efficient referral tracking, the needs of clients are being tended to and met within Community Health Worker and Family Advocate scope of practice.

#### Access

**a). Indicator** – Agency requirements provide initial and ongoing screening for clients; which assist in the referral process.

**b). Who Applied** – Active CBANS clients

**c). Time of Measure** – Completed and tracked during the reporting period.

**d). Data Source** – Internal Referral Tracking System

**e). Target Goal Expectancy** – Immediately refer clients to licensed mental health professionals and other community services as the client presents the need or based off of screenings.

**f). Outcomes** – Clients were able to have access to ongoing case management screenings that helped identify needs; which staff were then able to address and refer as appropriate.

#### Satisfaction and Feedback of Persons Served and Stakeholders

**a). Indicator** – Referred clients based on need and results of screening tools efficiently and effectively.

**b). Who Applied** – Active CBANS clients

**c). Time of Measure** – Completed and tracked during the reporting period.

**d). Data Source** – Internal Referral Tracking System

**e). Target Goal Expectancy** – To provide an efficient tracking system for referrals and ensure appropriate case management services are provided.

**f). Outcomes** – Family Advocate is the lead for the internal referral tracking system and is familiar with tabulating results monthly.

**Goal 9: Increase cultural competency and understanding that there is no one-size-fits-all model for delivery of prevention and early intervention strategies for mental illness.**

#### Effectiveness

**a). Indicator** – FAIHP met goal of attending at least 9 Fresno community events for outreach. Goal was exceeded and totaled to 15 community events attended

**b). Who Applied** – Community Health Worker and Family Advocate

**c). Time of Measure** – Completed during the reporting period.

**d). Data Source** – Calendar of Events and monthly staff reports.

**e). Target Goal Expectancy** – Participate in at least 9 Fresno community events (like health fairs, parades, etc.) to provide information about mental health and the Native American community.

**f). Outcomes** – Goal was completed and as a result of more events attended, more community members were able to be provided with resources about FAIHP services.

### Efficiency

**a). Indicator** – All events were successfully tracked through an updated and ongoing calendar of events, along with monthly staff reports. Through this, reporting for the total number exceeded the initial goal.

**b). Who Applied** – Community Health Worker and Family Advocate

**c). Time of Measure** – Completed during the reporting period.

**d). Data Source** – Calendar of Events and monthly staff reports.

**e). Target Goal Expectancy** – Participate in at least 9 Fresno community events (like health fairs, parades, etc.) to provide information about mental health and the Native American community.

**f). Outcomes** – Through efficiently tracking in monthly reports, Community Health Worker and Family advocate can check-in monthly on goal and continue to set goals for outreach.

### Access

**a). Indicator** – Community Health Worker and Family Advocate have access to calendar of events and are both familiar and implement required monthly reporting.

**b). Who Applied** – Community Health Worker and Family Advocate

**c). Time of Measure** – Completed during the reporting period.

**d). Data Source** – Calendar of Events and monthly staff reports.

**e). Target Goal Expectancy** – Participate in at least 9 Fresno community events (like health fairs, parades, etc.) to provide information about mental health and the Native American community.

**f). Outcomes** – Due to having access, Community Health Worker and Family Advocate were able to reach a total of 390 individuals at the outreach events.

### Satisfaction and Feedback of Persons Served and Stakeholders

**a). Indicator** – Current tracking systems indicate no challenges at this time by Director of Behavioral Health. Current system in place is efficient and consistent. As a result, goal was exceeded and will continue to increase.

**b). Who Applied** – Community Health Worker and Family Advocate

**c). Time of Measure** – Completed during the reporting period.

**d). Data Source** – Calendar of Events and monthly staff reports.

**e). Target Goal Expectancy** – Participate in at least 9 Fresno community events (like health fairs, parades, etc.) to provide information about mental health and the Native American community.

**f). Outcomes** – Goal completed.

*Goal 10: Reduce mental health stigma (see goal #6)*

*Goal 11: Reduce discrimination against those with mental illness within and across diverse cultural populations (see goal #6 and #9)*

*Goal 12: Increase access to mental health treatment and services for underserved and un-served cultural, ethnic, racial, and linguistic communities (see goal #8)*

*Goal 13: Reduce duration of untreated mental illness (see goal #8)*

FAIHP will continue to work with the Department to develop outcomes as well as target goal expectancies in the next reporting cycle.

### DEPARTMENT RECOMMENDATION(S):

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