EVALUATION MASTER PLAN SUMMARY OF INTERVIEWS

MHSOAC EVALUATION COMMITTEE
JUNE 20, 2012

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AGENDA: SUMMARY OF INTERVIEWS

- Who has been interviewed
- Some overall impressions
- Data system issues
- Levels of evaluation and use of information
  - Client level evaluation issues
  - System level evaluation issues
  - Community level evaluation issues
- Local oversight
- Other areas of interest
- Evaluation efforts not widely known or used
- Next steps

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WHO HAS BEEN INTERVIEWED

- Numbers
  - To date have interviewed 34 people/groups
  - Two people still to be scheduled
- Who
  - MHSOAC Commissioners (4)
  - MHSOAC Evaluation Committee members (10)
  - State level organizations
    - NAMI
    - CMHDA
    - CalMHSA
    - CiMH
    - Planning Council
    - EQRO
    - MHAC
    - REHMCO
  - Counties (2)
  - Consultants, evaluators, state data staff (5)

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SOME OVERALL IMPRESSIONS

- Surprising amount of agreement on most things
- Considerable interest and commitment to evaluation and using the results to improve services
  - State level organizations promoting enhanced role and investment in evaluation – OAC, Planning Council, CMHDA, CalMHSA, CiMH
  - Some counties developing their own robust evaluation systems
  - Larger provider organizations expending resources on evaluation
- General consensus that the major use of evaluation should be to support efforts at continuous quality improvement
  - Means looking for levers that can create change
  - Relies largely on motivation to use information internally to do a better job
  - Strongest argument for providing program level data

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SOME OVERALL IMPRESSIONS (CONT)

- General view that audiences for OAC evaluation efforts are the legislature and the general public
  - Some support idea that OAC should "tell the story" about the status of the mental health of the population and the mental health system in California
  - Disagreement about how strongly OAC should use evaluation results to advocate for the mental health system; fear that this could threaten its credibility
- With the shift to greater control at the county level there is an accompanying need for effective local oversight
- Many existing evaluation products are either not used at all or not used effectively
- Appreciation that some questions are better addressed through focused special studies than by analysis of routinely collected data

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SOME OVERALL IMPRESSIONS (CONT)

- Need for collaboration
  - The statewide organizations have different missions and viewpoints and will therefore want to have their own evaluation plans,
  - But there should be opportunities to work more closely together to minimize conflict and duplication and to maximize the usefulness of evaluations
- A clear statement of what it takes to have effective use of evaluation results
  - Data you can trust
  - A culture that supports evaluation and the use of data
  - Technical expertise at using data
  - Leadership that is interested in evaluation
  - Money to support the necessary infrastructure
- "Can't do any of this on the cheap"

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DATA SYSTEM ISSUES

- "Everything starts and rests on the data"
- Many expressed the belief that we need an entirely new enterprise data system
  - Our data systems use antiquated technology
  - Our most important data systems include only part of the population we serve and/or part of the information we need
  - Health reform encourages development of better data systems
  - Creating an entirely new system would be very expensive and time consuming
  - My view: We need to start thinking about this but in the current fiscal climate launching such an effort may be unrealistic
- In any case we are stuck with what we have for the near term future so how do we make it better

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DATA SYSTEM ISSUES (CONT)

- Four major data sources that we use and need
  - CSI –
    - Additional work needs to be done to get race and ethnicity assessed and entered correctly
  - DCR
    - Sac State work has been effective and appreciated
    - Sac State has recommended some changes to the system which can improve accuracy and
    - Sac State could do more including helping counties learn how to access and use their data
    - The system can be built upon to incorporate additional information
  - Consumer Perception Surveys
    - This is moving to CiMH
    - Will move to one-week random sample
    - Potential to use this data source to gather additional information
  - Short/Doyle –Medi-Cal claims data
    - Important source for EQRO reviews
    - Combination of new state system and evolving county systems has created problems
  - All systems must be supported better by DHCS than they have been by DMH

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DATA SYSTEM ISSUES (CONT)

- Greater attention needs to be paid to quality of data entry
  - People who enter data have little incentive to do so accurately or promptly
  - There are few feedback loops when data that is sent up the ladder appears incomplete or unreasonable
  - Getting data reports back incentivizes accurate data entry but this is generally lacking
- County data systems
  - Three large vendors developing EHR systems for most of the counties
  - Installation and support of the systems is time and people intensive
  - Installations can create problems for accurate and timely state data
  - Systems have to be modified to facilitate data needed by the state
  - Some larger counties rely on their own data systems and do not need or want access to state data

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LEVELS OF EVALUATION ACTIVITY AND USE OF INFORMATION

- The OAC overall evaluation framework includes measuring and evaluating outcomes at three levels
  - Client level
  - System level
  - Community level
- The information resulting from these evaluations can be used by entities at all levels
  - Summative information (county summing outcomes of programs, state summing outcomes of counties)can be used to report on progress, to identify issues of concern, and to raise questions about unexpected or unclear results
  - Everyone is concerned about comparing results across entities (programs or counties) because of diversity of populations, services, funding, and other contextual factors. Will be resistance to setting benchmarks until this issue is addressed.
  - Agreement that comparison information can be useful internally for quality improvement based on everyone's desire to do a good job
- General agreement that data quality issues always critical to acceptance of evaluation results

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CLIENT LEVEL EVALUATION ISSUES

- UCLA study
  - Will report individual outcomes by county on selected key indicators – education/employment, housing situation, justice involvement for FSP clients and hospitalization rates for all clients
  - Will be on FSP enrollees only from DCR data except for hospitalizations which will include all clients
  - Will be status at a point in time not measurement of individual change over time
- Desire to collect the same kind of outcomes for more of the clients
  - The DCR can be expanded to do this
  - Would have to decide on what to measure and how often
- Measurement of change over time that has been done so far has been 12-month pre to 12-month post. Need to expand to include more than first 12 months
- Would like to be able to identify characteristics of persons and characteristics of programs that show improvement. Doing this would require better linkage of DCR to CSI
- Types of individual outcomes included in DCR need to be expanded to incorporate more recovery-oriented and more physical health measures
- There is a desire for FSP program level data. While the state would likely never use this data it could produce it for use by programs and counties.
- Given diversity of clients and programs there may be value in developing a risk adjustment strategy

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SYSTEM LEVEL EVALUATION ISSUES

- The forthcoming UCLA report will include a number of system indicators
  - Basic characteristics of system performance are included in the OAC and Planning Council adopted Performance indicators
  - Examples of indicators for assessing access and performance
    - Numbers and demographic profile of persons served
    - Rates of involuntary care
    - Access of FSP clients to primary care
    - Rates of 24-hour care
    - Penetration rates of all and new clients overall and by ethnicity
    - Client satisfaction with services
- EQRO reports include many system level indicators
  - Indicators based on clams data cover only Medi-Cal clients but assessment of other system characteristics assessed for whole county system
  - Examples of claims based: hospital recidivism, time to first appointment from hospital discharge
  - Examples of general: use of data to inform decisions, monitoring of penetration rates, tracking no-show rates, collecting and using data from consumer surveys
- Data challenges
  - Failure to complete all fields in CSI submissions
  - Difficulty linking CSI and DCR largely because of failure to include client # on DCR forms
  - For some indicators no current data available or data would need to be augmented to provide a valid picture

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SYSTEM LEVEL ISSUES (CONT)

- Major question for many (not all) interviewees is "Has the system been transformed? "
  - Basically two questions
    - Has there been a change?
    - What has been the impact of the change?
  - Areas of inquiry relate to underlying values and processes of the MHSA, e.g.
    - Was the local planning process effective and has it been maintained?
    - Are clients and families more involved in determining their needs and services?
    - Are there more peers and family members employed in the system, how are they doing, and what kind of impact have they had?
    - Are services more wellness, recovery, and resilience oriented?
    - Are services more coordinated?
    - Are services more culturally competent? Has this resulted in greater satisfaction with services?
  - Acknowledgment of major analytic and methodological problems
    - We don't know yet how to measure many of these factors
    - We lack information that links changes in these factors of system performance to outcomes for clients
    - This would seem to require at least some exploratory special studies

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COMMUNITY LEVEL EVALUATION ISSUES

- Goal of statewide PEI projects and some county PEI projects is to have positive impact on community attitudes, behaviors, and policies toward persons with mental health problems
- RAND's PEI Evaluation Framework
  - Includes population-based measures of community outcomes
  - Has compendium of measures including many that would be appropriate for community level indicators
- RAND's evaluation of the PEI statewide projects will include assessments of results of efforts to influence community attitudes, behaviors, and policies

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LOCAL OVERSIGHT

- With demise of DMH and removal of approval authority over MHSA plans, control of the mental health system has devolved to the county level
- Boards of Supervisors are ultimate county authority
- Local Mental Health Boards and Commissions currently provide a local oversight function, but as an advisory board only
  - Legislatively mandated to have at least 51% consumers and family members
  - Effectiveness varies substantially across counties with the differences possibly due to the following factors
    - How much membership fluctuates, whether there are any steady members
    - How sophisticated members are about data, whether there are at least a few who have experience and some expertise
    - How the county director uses the Board, e.g. to help advocate for needs of the system; to visit programs; to engage in serious discussion about plans, budgets, new programs, and evaluation results
  - Training efforts by the Planning Council and CiMH have had mixed results

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LOCAL OVERSIGHT (CONT)

- The MHSA created a strong role for local planning to include a broad base of stakeholders
  - The MH Boards and Commissions in some instances led this planning effort in conjunction with additional stakeholders. In most instances, however, separate planning group(s) were established
  - This local planning process is generally viewed as having been robust, energetic, and effective
  - The ongoing role of these local planning efforts after the transition from planning to implementation has not been studied, e.g. have they transitioned to an oversight role?
- Basic question: How can we ensure and support a viable local oversight function which can effectively use evaluation results

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OTHER AREAS OF INTEREST

- The integration of behavioral health care with physical health care creates threats and opportunities with regard to evaluation
  - General view: We need to focus more attention on the implications of this integration for our data systems and evaluation efforts
  - Threat: How do we maintain the data systems essential for evaluating the effectiveness of our services?
  - Opportunity: How can we use evaluation to demonstrate to local health plans the cost effectiveness of including a robust set of mental health services
- How can we better understand and deal with unmet needs
  - Should the state move to CHIS from Holtzer to document need?
  - How do we best continue our efforts to understand why people do not seek care?
  - How can we understand better and build upon the use of natural supports that are used by people with mental health problems?

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OTHER AREAS OF INTEREST (CONT)

- Interest in exploring possible immediate feedback evaluation systems
  - An example would be asking clients at every visit if they are getting what they need/want
- Interest in participatory research
  - Continue to evolve current project methodology
  - Include more persons with lived experience in all evaluation efforts
- Interest in the idea of regional data and evaluation support networks
  - Perceived value in having people with direct responsibility for data systems and evaluation issues share their experiences
  - Prior experience with this type of sharing on a state committee (IDEA committee) seen as productive
  - For best results need the participation of IT, evaluation, and program people
  - Some of this will occur through CalMHSA with PEI evaluation efforts

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EVALUATION EFFORTS NOT WIDELY KNOWN OR USED

- EQRO
  - County reports generally seen as a good tool for quality improvement; examples include foster children placements and ethnic penetration rates
  - State level report not widely used
- FSP Performance Measurement Toolkit about to be released
- CiMH
  - Palettes of Measurement strategy; Los Angeles using this to evaluate 10 early intervention projects
  - Learning Collaboratives on 12 EBPs for children and families involving 350 sites; almost all include collection of outcome data; estimate these cover roughly 1/3 of the children receiving mental health services in the state
  - Breakthrough Series collaboratives focused on setting specific program goals and measuring achievement of them
- Some larger provider organizations conduct their own rigorous evaluations of their programs
- *California Mental Health and Substance Use Needs Assessment (1/30/12)* by TAC and HSRI for Medi-Cal 1115 Waiver
- Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System (URS)

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NEXT STEPS

- Work plan includes conducting high level review of data systems and evaluation activity of a few counties. Suggestions included:
  - Mentioned by more than one interviewee
    - Los Angeles
    - Orange
    - San Mateo
    - Riverside
    - Santa Clara
  - Mentioned by one interviewee
    - Napa
    - San Bernardino
    - Marin
    - San Francisco
    - Humboldt
    - Modoc
    - Contra Costa
    - Nevada
- Work plan includes a high level review of data and evaluation systems in a few other states

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