MHSOAC
Mental Health Services
Oversight and Accountability Commission

DRAFT
EVALUATION COMMITTEE DISCUSSION DOCUMENT
INITIAL RECOMMENDATIONS
REGARDING FY 2011-12
MHSOAC EVALUATION PRIORITIES
June 21, 2011

Following is a list of initial recommendations by the current Evaluation Committee and other sources for A) prioritizing uses of MHSOAC funding available for evaluation, B) thoughts for structuring decision-making for evaluation efforts and C) suggestions for ongoing data collection and evaluation efforts.

A. RECOMMENDED PRIORITY EVALUTION EFFORTS

This list is intended as a resource for discussion by the MHSOAC Evaluation Committee for the initial discussion regarding the $875,000 in expanded MHSOAC evaluation resources. Recommendations that are/will be under contract by 6/30/11 have not been included. The list is not in any specific order.

1. PROVIDER LEVEL DATA REPORTS—
   a. Data and report availability from counties is a critical issue for the provider community. For example, providers do not currently receive "regular and routine" data files or written reports from the state or county interfaces that give clear information regarding data completeness, data quality, and results. At a minimum, providers need ready access to their own data through data exports so they can analyze data in ways that make sense "on the ground" and inform program operations for ongoing quality improvement.
   b. Evaluation of the reports to identify the factors that led to the best results in each category and recommendations on improvements for other providers and counties.
   c. The data should evaluate each provider based upon: i) Improvement in school performance—-if applicable to the level needed to eliminate need for special education, ii) if applicable, restoration of full custody for parent, iii) cost per child for each year of service, iv) length of service to achieve positive results and v) administrative costs for provider and county per child

2. COMPARISONS ACROSS COUNTIES/PROVIDERS--Establish guidelines, standards and capacity for making comparisons across agencies or program types so that evaluation procedures are legitimate, robust, and fair.

3. BUILD LOCAL EVALUATION CAPACITY—

a. Dedicate resources to providing counties technical assistance on how best to design evaluation studies; collect and analyze data; and report, disseminate, and utilize findings. The technical assistance should be tailored to the existing capacity of counties so that smaller counties, for example, receive technical assistance that is customized to their needs.

b. Build analytic/interpretative capacity that engages and trains relevant stakeholders in the process of using client profile, utilization and outcome data to assess program effectiveness.

4. IDENTIFY CSS BEST PRACTICES—

a. Develop reporting and evaluate CSS Target Population Providers and Counties to identify best practices. There should be a more thorough evaluation of the effectiveness of services delivered under the County mental health program.

b. Determine where are the most effective and efficient FSPs for adults. Disaggregate reports to individual providers to measure each provider based upon their relative level of success in the following categories (with reports also measuring differences by race/ethnicity): improvement in employment, independent living; reduction in incarceration hospitalization and homelessness; cost per client for each year of care; and length of service to achieve positive results

c. Determine where are the most effective and efficient children's providers of services to children with SED with adjustments for age upon initiation of care and each type of placement – Special Education, Child Welfare Wrap Around, Child Welfare Residential, Ward of Court Juvenile Justice, other? (Note: Most likely this data is not currently being collected so the first step is collecting the data and then after a year there should be the first reports with more complete reports taking several years).

5. EXPANSION OF CLIENT AND FAMILY DRIVEN SERVICES

Evaluate the expansion of client and family driven community mental health services. Results of the study will show how one of the major values of the MHSA is being implemented and can provide information on how to increase implementation of these types of program services. The study would measure changes in client and family member employment, client-run and family-run and self-help programs, including implementation of client residential programs and community education programs. Evaluator could select a sample of counties and collect the relevant data.

6. EXPANDED CONSUMER OUTCOMES

a. Direct more resources to the rigorous evaluation of consumer outcomes across counties in the domains for which the amount of supporting evidence is limited (e.g., physical health emergencies, education, mental health functioning and quality of life, and employment), assuming that they are among the priority indicators ultimately defined. Ideally, there would be

a synergistic relationship between building the evaluation capacity of counties and building a stronger evidence base on consumer outcomes.

b. Begin to survey physical health data points (per population group) to help guide the mental health system toward assembling information needed to support planning for healthcare integration.

c. Evaluate reductions in substance abuse.

7. PEI BASELINE ON MHSA OUTCOMES--Establish PEI Baseline conditions by identifying current or most recently available data by county on suicides and suicide attempts (by age group if available), involuntary hospitalizations, special education placements due to serious emotional disturbance, child welfare placements due to serious emotional disturbance, average duration of untreated psychosis for new clients diagnosed with schizophrenia, proportion of the population receiving specialty mental health services-if possible including by age group and ethnicity and if possible obtaining private health plan data. (Note: some of these measures included in the UCLA contract.) Measure progress over time in improving these results and evaluate performance to determine best practices which lead to best results.

8. PEI EVALUATION FRAMEWORK--After analyzing existing plans, evaluation and study reports of Prevention and PEI programs, including required single program evaluations in individual counties, develop recommendations for evaluation scheme for PEI services and interventions to follow the work being done for CSS.

9. SUMMARIZE INNOVATION EVALUATIONS and develop strategy for evaluation of implementation and impact of INN. Compile a summary of county evaluations completed and planned.. Summarize lessons learned from review of county evaluations.

10. EXPAND PARTICIPATORY RESEARCH
Participatory research (included in the UCLA contract) should be understood by all involved, participants should have enough training and technical assistance to effectively participate and have the complete backing of contractor to accomplish these goals. Revise the time limits, structures and funding to ensure the appropriate ways of achieving consensus among all groups participating.

a. Increase the funding for the MHSOAC funded, UCLA – Phase 3 Contract, Deliverables 2.a) 1. and 2.b).1 to support the full and effective achievement of contracted deliverables

b. In addition to providing review and input, to secure full participation/involvement of individuals living with mental illness, their families and personal caregivers in the public mental health system in all aspects of the evaluation process.

c. To ensure and enhance validity and reliability through the application of the values and principles of PAR: participatory; cooperative, engaging

community members and researchers in a joint process in which both contribute equally; a co-learning process for researchers and community members; a method for systems development and local community capacity building; an empowering process through which participants can increase control over their lives by nurturing community strengths and problem-solving abilities; and a way to balance research and action (Merkley,2000).

11. REDUCTION OF DISPARITIES
    a. CSS and PEI--Measure each county and service provider's percentages of major racial and ethnic groups.
    b. Compare counties and programs to outreach and engage in reducing disparities in access to services by underserved communities and determine the effectiveness of different MHSA strategies and programs in reducing disparities including assessing the changes in workforce composition and training that reduces disparities in access and result.
    c. Multidimensional analyses may improve the evaluation of disparities (or the lack of disparities) by race/ethnicity/nativity, gender, age, and other characteristics. One-way tabulations of one or two outcome measures by a single demographic characteristic (e.g., race/ethnicity alone) may be insufficient to fully understand disparities. While we recommend multidimensional analyses over the geographic landscape of California, we also note that such analyses will require large and complete datasets. The California Department of Mental Health's Client and Services Information (CSI) database and the state's Medi-Cal billing and pharmacy databases are "gold mines" for assessing disparities, and should be better utilized. Ideally, these datasets should be merged to provide an opportunity to conduct the multidimensional analyses.
    d. Develop a logic model for conducting disparities assessments (differential access, engagement/retention, outcomes) with multi-cultural stakeholder input, including their recommendations regarding data elements and reports.

12. EXPAND DATA AND ANALYSIS OF MENTAL HEALTH SERVICES NEED AND UTILIZATION IN CALIFORNIA.
    a. Obtain an Accurate "Baseline" Assessment of Mental Health Services Need and Utilization in California through an enhanced CHIS mental health survey which include a follow-back study, increased CHIS sample size for low-income persons and key sub-populations.
    b. Develop a Mental Health Tracking System for California. There are statistically different levels of access to and utilization of mental health care services. Census tract level data allows for a community level analysis to be performed. This might be considered an ideal geographic level for understanding health disparities in this population since it is said that census tracts mimic neighborhoods in their homogeneity. The "hot spot" maps provide an opportunity to look at patterns within the state (still

analyzed at the community level) in which statistically significant clusters of high and low access and utilization of mental health care services exits. Recommendations for continued tracking of mental health care in California include i) Merging of the Medi-Cal and CSI data will provide a more complete picture of mental health services in California, ii) Medi-Cal should change its definition of Hispanic to classify it as an ethnicity and not as a race. iii) Older adults (65 and over) should be also included in the analysis. Such an analysis would be most useful if it included Medicare patients as well as Medi-Cal, iv) To facilitate geographic analyses, data should be geocoded at the source.

13. DEVELOP INTEGRATED PRIORITY INDICATORS--Prioritize outcomes and indicators,) for MHSA as a whole, in collaboration with the CMHPC. This would provide a framework for oversight and accountability.

B. STRUCTURING STRATEGIC DECISION-MAKING FOR PRIORITIZING MHSOAC EVALUATION AND OVERSIGHT:

Focus on what information would be helpful to decision-making, and why. Some of that information will likely need to be obtained through the evaluation process, but other information might be available from other sources or through other strategies. Further, many of the topics that have been proposed as priorities have strong support, but it is not always clear how the information gathered through the proposed evaluations would be used by the Commission, local agencies or the state. It's also not clear if the information being sought through the priority list would be the product of an evaluation, but rather an information gathering function that could be done at much less cost. Specific suggestions follow:

1. The Commission should consider inviting an experienced evaluator to brief the advisory committee on the how to make the best use of limited funding for evaluation. It should consider itemizing its information needs and reframing them as either evaluation, data-based research, information gathering, or something else.
2. It also should assess the resources (not just money) that the Commission can draw upon to support its information gathering needs, including partnerships with research entities, including universities but also entities such as PPIC, access to federal and foundation grants, leveraging the work of the Little Hoover Commission, the Auditor, the Performance Review Unit in DOF, the CA State Library and the California Research Bureau, CIMH, etc.
3. Based on those assessments, of both needs and resources, the Commission may want to establish several strategies to meet its information needs, with evaluation being just one of those and reserved for those areas where the Commission is calling for an independent, third-party assessment of something.
4. The other strategies could include a research agenda, a survey and outreach strategy, an information sharing portal, a data dashboard – topics that are on the priority list for evaluations but are not traditionally thought of as evaluations.
5. Then, if the Commission is going to invest in an evaluation, research project or some other information gathering strategy, the Commission, staff and the advisory team should walk through the process before the RFP is designed. That walk-through should ensure that the information gathered will be useful to decision-making. Call it a Logic Model, decision-support tool, or something else. But before the Commission buys more research, it needs to consider how that information is going to be used to frame or guide decisions. It also has to consider who is making those decisions so that those decision-makers can buy into the information-gathering model before the information is gathered. Otherwise we run the risk that the decision-makers who are the targets for the information will not find the information valuable and will not use it, or they will not trust it because they lack confidence in the process.

C. DATA COLLECTION AND EVALUATION METHODOLOGY RECOMMENDATIONS

1. Expand Analyses. As much as possible, apply within-subjects over time in services analyses and post discharge follow-up studies versus aggregated, cross-sectional between-subjects methods.

2. Identify Best Practices. For each domain, once proper dataset and analytic procedures reign, assess best and worst outcomes that illuminate best practices for rapid implementation by practitioners most of whom are relatively new using MHSA program "tools" such as PEI strategies, FSP teams, Peer Advocates, Flex Funds, etc.

3. Improve Timeliness and Quality of Data Submission
    a. Begin the process of developing and identifying strategies to compel and encourage counties to collect outcome oriented data. AB 100 stripped the MHSOAC of its statutory authority to issue grants for PEI and INN programs but left intact the commission's statutory responsibility for conducting evaluation and oversight. Without control over MHSA programmatic funding, it will be difficult to compel counties to collect, process, and submit uniform data to the MHSOAC on a regular basis. A staff member or consultant should begin to think about what legal and administrative mechanisms exist that the MHSOAC can use to fulfill its oversight responsibility.
    b. The MHSOAC requires access to reliable, consistent data from all counties receiving MHSA funds which demonstrate counties' progress in improving outcomes for Californians receiving specialty mental health services
    c. There should be uniform statewide protocols for the collection of key measures in the CSI database and for the same measures when collected as part of the evaluation of MHSA programs. This especially includes measures of race and ethnicity (to match U.S. Census methods), and service delivery modes.

4. Continuous Quality Improvement--There has been much need for all of the evaluation endeavors to be guided through a continuous quality improvement process. There are no "shortcuts" and the idea should not be to just get evaluation "done". Evaluation is a process of discovering and understanding, and there are no "a priori" ways of determining a "right way" to do it without continuous study. Given that, we need to use resources to convene experts ongoing, to guide the QI process, and who also have analytic capabilities available (e.g., through staff or contractors). Evaluation should be addressed as an ongoing process, not as something to be solved and then ignored. Therefore, funds need to be directed to administrative and analytic tasks that keep evaluation "alive" and dynamic – always available to instruct us.

5. Improve Capacity for Geocoding—
    a. Attention should be paid to new policies planned for release by the California State Geographic Information Officer, Scott Gregory. These policies will be focused on increasing data integrity through stewardship so that users can rely on authoritative content. These new policies will help state agencies to perform geospatial analyses with trusted data and methods. The measure of access to care should include a component of population level mental health need.
    b. Perform routine geocoding of all CSI data and improve the standardization of address data.