



Strengthening Statewide Mental Health Data Collection, Reporting, and Quality Improvement Systems



WELLNESS • RECOVERY • RESILIENCE

CSS Tracking, Monitoring, and Evaluation Project

- **Contractor:** University of California, San Diego / Health Services Research Center
- **PI:** Dr. Andrew Sarkin
- **Timeframe:** May 2014 – June 2016



MHSOAC Data Strengthening Efforts

- MHSOAC has committed over \$2.5M over past few years to supporting and strengthening the DHCS-owned data collection and reporting systems
 - Resources, training, and technical assistance to counties
 - Revisions to IT infrastructure
- The current state-level systems have not been well maintained and do not fully meet needs of providers, counties, or the State.
- Attempts to strengthen thus far used a “band-aid” approach. MHSOAC needs to truly strengthen system so that it meets our collective needs of promoting positive outcomes across our mental health system.



Contract Research Questions

- What statewide methods should be employed to ensure proper tracking, monitoring, and evaluation of adults receiving CSS services?
- What policies, practices, systems, and infrastructure should be created and/or modified to better track, monitor, and evaluate adults receiving CSS services?
- How effective are CSS services for adults who receive less comprehensive services than what is provided via Full Service Partnerships?
- What policies, practices, systems, and infrastructure should be created and/or modified to better serve adults within the CSS component?



Contract Scope of Work

- Development and implementation of a data collection system for adults receiving MHSA CSS services that allows for evaluation of those clients and services, applicable to both Full Service Partnerships and less intensive programs.
- Propose a system that could replace the current DCR and CSI data collection and eliminate redundancy, and would be integrated into any Electronic Health Record (Avatar, Anasazi, etc.).
- Creation of policy and practice recommendations for how to improve upon current CSS services evaluation and quality improvement systems.



Project Deliverables and Timeline

1. Report of Proposed System; due April 2015
2. Report of Proposed Implementation Plan to Pilot the System; due May 2015
3. Report of Evaluation Plan; due November 2015
4. Report of Evaluation Results; due April 2016
5. Report of Policy and Practice Recommendations for How to Improve CSS Services, Evaluations, and Systems; due April 2016



Developing the Proposed System

- Goal: Identify what data needs to be collected (and used by providers, counties, and most importantly the State) to ensure the successful recovery of consumers (i.e., to ensure that access to and quality of our mental health services and systems can be continuously assessed and improved upon)
 - Opportunity for counties and providers and all other stakeholders to provide input regarding system requirements
 - ◆ Utility of current State/County/Provider requirements
 - ◆ Additional needs/desires/preferences
 - Stakeholder survey was disseminated statewide
 - Interviews and focus groups will continue to be conducted



Contributing Stakeholders

- MHSOAC
- DHCS
- REMHDCO
- California Mental Health Planning Council
- County Administrators and Contract Supervisors
- Clinicians and Staff
- Subject Matter Experts
- Policy Makers (Bruce Bronzan, Rusty Selix, more)
- People with lived experience who use services
- Family members of people with lived experience
- Evaluation Advisory Group



Evaluation Advisory Group

- Includes people from various stakeholder groups
- Evaluation Advisory Group Working Groups:
 - Cultural Competence
 - Data Quality and Planning
 - End Users
 - Informatics
 - Lived Experience and Family
 - Mental Health Measures
 - Policy
- EAG members also acted as our champions in recruiting pilot counties to participate and getting the measures into their Electronic Health Records.



Domains and Data Elements

- Review of relevant documents and guidelines
 - Mental Health Services Act requirements and goals
 - Bronzan-McCorquodale and other laws
 - MHSA and MHSAOC goals
 - National Behavioral Healthcare Quality Framework
 - Relevant published work on measuring outcomes
 - Results of other similar projects
 - ◆ MOQA, MHDATA DCR, County-level efforts, SAMHSA, etc.
- Input from stakeholders with surveys, focus groups, interviews, Evaluation Advisory Group
- Review of current systems such as CSI, DCR, and the Electronic Health Records being used
- Review and comparison of validated measures



Validated Measures Review

- Contract requires the use of validated measures.
- Data elements in the DCR have mostly not been validated, and some indicators have been shown to have significant validity problems.
- No validated measure would cover everything, so we had to supplement with DCR-type items.
- Validated measures allow for standardized comparisons to other programs, and data-based performance criteria.
- Assessment Instrument Quality Checklist (AIQC)
- Measures Viewer Survey with stakeholders



Sample of Extra Features

- The MOQA domains are covered by system.
- AOT (Laura's Law) reporting requirements.
- The system is compatible with data being collected in CSI and DCR, with the ability to import CSI and DCR data and incorporate it into reports to compare FSP to non-FSP programs.
- Short client measure promotes recovery orientation, plus optional family/friend measure.
- Able to perform cost effectiveness analysis, penetration analyses, and other important calculations to support evaluation efforts.



Data For All Program Assessments

- Personal Characteristics of Participants
- Service Utilization
- Access to Services
- Satisfaction
- Impact of Services
- Level of Care
- Cost Effectiveness
- Accomplishing MHSA Goals
- Recovery-Oriented Outcomes Measures

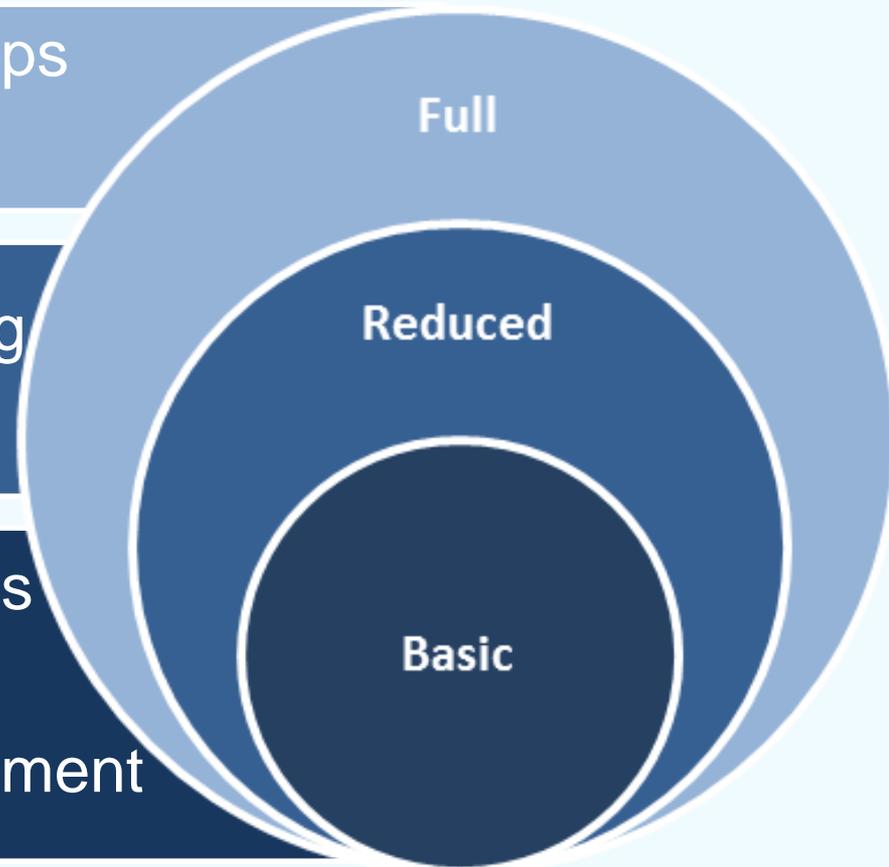


Three Main Levels of Assessment Based on Program Intensity

- Full service partnerships
- Intensive programs

- Less intensive ongoing treatment programs

- Low intensity programs
- Support programs
- Outreach and Engagement



What might be assessed for MHSA CSS programs less intensive than FSP's?

- Illness Management and Recovery Scales
- Milestones of Recovery Scale
- Progress towards goals
- Clients do CHAMPSSS measure if willing and able
- Outcomes of housing, employment, acute settings
- Demographics and personal characteristics
- Utilization and service characteristics
- Satisfaction and client-perceived impact of services
- Program characteristics and access issues
- Movement between levels of care, and discharge



What would be additionally assessed for the usual FSP-like program?

- Illness Management and Recovery Scales
- Milestones of Recovery Scale
- Progress towards goals
- Clients do CHAMPSSS measure if willing and able
- Although Key Event Tracking is still required during the pilot, the proposed system might replace KETs and greatly reduce the length of the Quarterly Assessment at 3, 9, 15 months, etc. (while it would remain similar to the current length at 0, 6, 12, 18 months).
- DHCS requires pilot participants still complete all DCR forms during the pilot, so it is difficult to truly judge the system for FSPs in terms of workload.



Measuring Participant Characteristics (Access)

- Access issues: Who are we serving?
- Demographics:
 - Improved Ethnicity categories
 - Improved Gender Identity
 - Sexual Orientation
 - Age, military status, other current requirements
- Diagnosis
- Special Needs Served (languages, disabilities)
- Penetration rates relative to local population



Program Characteristics

- Some of these address access issues
- Access to 24/7 services (could be in partnership)
- Access to translators
- Geographically close access
- Services available for specific needs
- Services available for specific populations

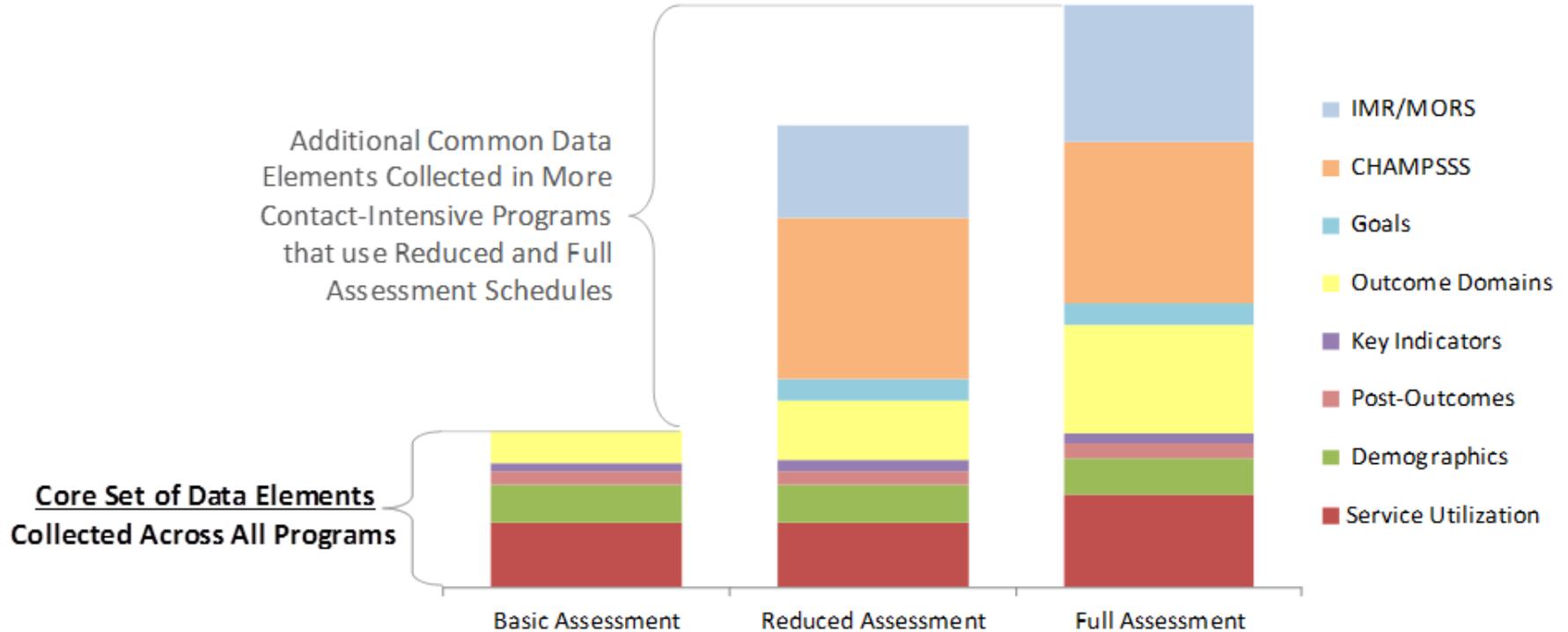


Determining Level of Assessment

- Much of the information is pulled from current Electronic Health Records where possible.
- Additional data collection is based mostly on the service frequency and intensity.
- Some programs may have multiple tiers.
- Level of assessment then may have modifications based on specific program type.
- There is high agreement between people when assigning level of assessment and program type modifications, indicating that the system is quite objective and easy to apply.



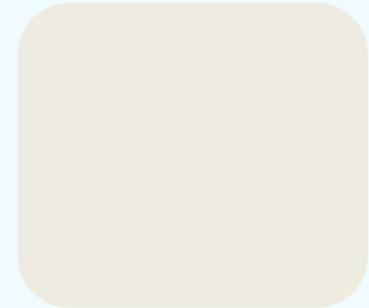
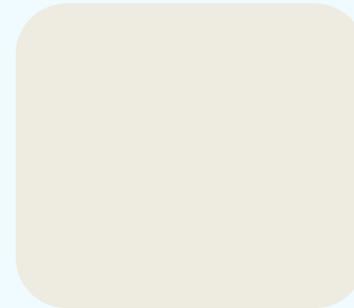
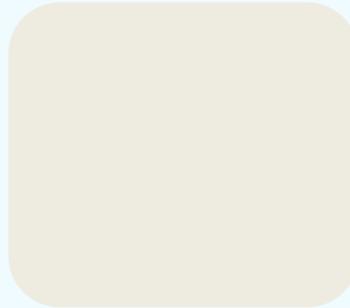
Relative Number of Data Elements within Basic, Reduced, and Full Assessments



Basic Assessment Schedule

Clinician Assessment

**Completed by
Clinician**



Integrated Self-Assessment

**Completed by
Client**

Intake

No client assessment

**Follow-up
(6, 12, 18... months)**

Post-Outcomes

Discharge

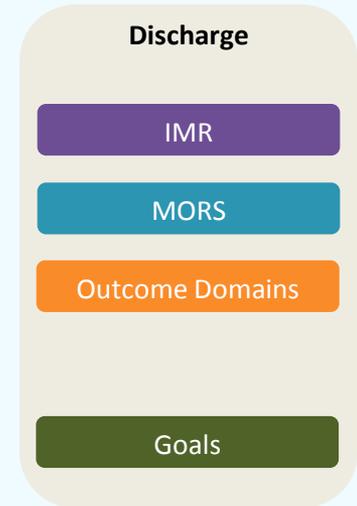
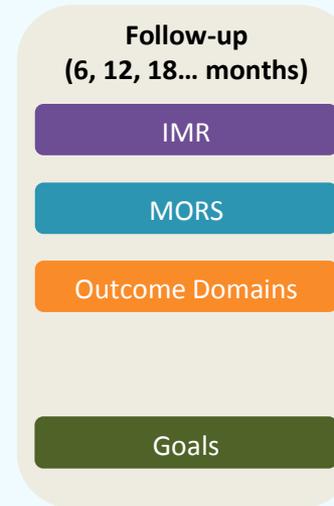
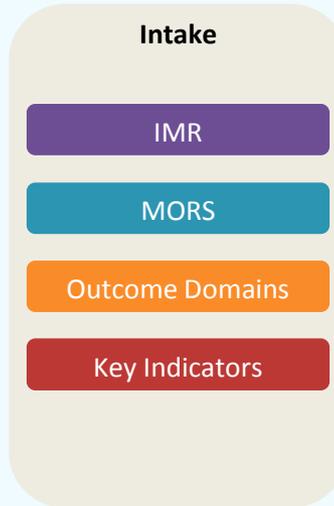
Post-Outcomes



Reduced Assessment Schedule

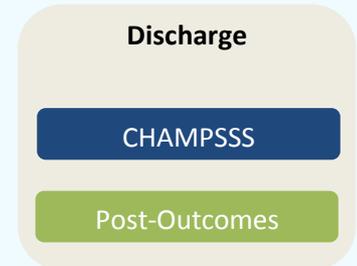
Clinician Assessment

Completed by
Clinician



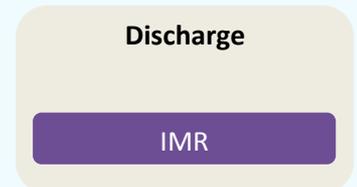
Integrated Self-Assessment

Completed by
Client



Optional Family Member / Friend Assessment

Completed by
Family
Member/Friend



Full Assessment Schedule

Clinician Assessment

Completed by
Clinician

Intake

IMR

MORS

Outcome Domains

Key Indicators

**Mini Follow-up
(3, 9, 15... months)**

IMR

MORS

**Follow-up
(6, 12, 18... months)**

IMR

MORS

Outcome Domains

Goals

Discharge

IMR

MORS

Outcome Domains

Goals

Integrated Self-Assessment

Completed by
Client

Intake

CHAMPSSS

**Mini Follow-up
(3, 9, 15... months)**

No client assessments

**Follow-up
(6, 12, 18... months)**

CHAMPSSS

Post-Outcomes

Discharge

CHAMPSSS

Post-Outcomes

Optional Family Member/Friend Assessment

Completed by
Family
Member/Friend

Intake

IMR

**Mini Follow-up
(3, 9, 15... months)**

IMR

**Follow-up
(6, 12, 18... months)**

IMR

Discharge

IMR



Outreach and Engagement Assessment Schedule

Staff Assessment

Completed by
Staff

Intake

MORS

Outcome Domains

Linkage and Referral Tracker (Complete at each encounter)

Encounter Form (Complete at each encounter, if not collected in EHR)

Follow-up (6, 12, 18... months)
and/or Discharge

MORS

Outcome Domains

Integrated Self-Assessment

Completed by
Participant

Intake

(No participant assessment)

Follow-up (6, 12, 18... months)
and/or Discharge

Post-Outcomes



Program Type Variations

- Specific program types have minor variations to account for their specific goals. For example:
 - Court-related programs have extra tracking of legal issues
 - Transitional Age Youth programs have additional tracking of education and employment activities
 - Integrated physical healthcare programs have extra tracking of physical health issues, including access and utilization of physical healthcare
 - Clubhouses are not required to complete the MORS
 - Work-related programs do more employment items



Actual Pilot Program Examples

- Full Service Partnership
- Ongoing Case Management
- Residential Crisis Care
- Peer Outreach, Engagement, and Navigation
- Wellness Maintenance
- Housing and Employment Support
- Traditional Clubhouse
- Ethnicity and Age-Group oriented programs
- Integrated Care with Physical and/or Substance



Accommodating ALL programs

- What if I have a Transitional Age Youth Peer-Run Integrated Care Outreach and Engagement Program? Are we going to have to create a new assessment schedule for that?
- No Problem! We use the Basic Level Outreach and Engagement Schedule, using the wordings for “peer support specialists” and “participants” in terms of language even though it is same items.
- We add a few items that are specific to Transitional Age Youth and to Integrated Care programs, which are very brief and modular.



Clinician Measures

Instrument	# Items	Collection Frequency	Outcome(s) Addressed	
IMR	16	Intake Follow-up Discharge	<ul style="list-style-type: none"> • Integration into the community • Quality of care received by client • Management of symptoms • Functional impairment • Engagement with therapeutic activities • Social support and involvement • Time in structured roles • Substance and alcohol abuse 	
MORS	1	Intake Follow-up Discharge	<ul style="list-style-type: none"> • Level of care required • Improved mental health outcomes • Increased involvement in care 	
Outcome Domains	7-21	Intake Follow-up	Possible domains: <ul style="list-style-type: none"> • Housing • Legal issues • Employment • Education • Acute care setting involvement 	<ul style="list-style-type: none"> • Substance use • Physical health • Mental health • Social health/Quality of life • Independence and benefits
Key Indicators	0-4	Intake	Possible domains: <ul style="list-style-type: none"> • Education • Diagnosis 	<ul style="list-style-type: none"> • Physical health issues • Trauma
Goals	8	Follow-up	<ul style="list-style-type: none"> • Housing • Education • Mental health • Substance use 	<ul style="list-style-type: none"> • Physical health • Social health • Family unification • Employment



Additional Clinician Measures

Instrument	# Items	Collection Frequency	Outcome(s) Addressed
Linkage & Referral Tracker	Varies	Each service encounter including Intake, and Follow-up / Discharge	<p>Individual goals:</p> <ul style="list-style-type: none"> • Physical Health • Social Health • Mental Health • Substance Abuse • Housing • Occupation/Education • Financial Assistance/Benefits • Transportation • Identification • Basic Needs
Encounter Form	13	Each service encounter including Intake, and Follow-up / Discharge	<ul style="list-style-type: none"> • Access and utilization of services • Participant engagement with services • Key events in recovery



Integrated Self-Assessment

Instrument	# Items	Collection Frequency	Outcome(s) Addressed
CHAMPSSS	6-30	Intake Follow-up	<ul style="list-style-type: none"> • Mental Health • Physical Health • Social Health and Relationships • Quality of Life • Strengths • Substance use • Anxiety • Depression • Suicidal Ideation
Post-Outcomes Survey	5	Follow-up Discharge	<ul style="list-style-type: none"> • Symptom reduction and/or Reduced Impact of Symptoms • Mental and Physical Health Improvement • Coping and Ability to Participate in Activities • Satisfaction with Program Services



CHAMPSSS: Combined Health Assessment Mental, Physical, Social, Substance, Suicide

- Only one page long with simple language.
- For very impaired clients, only 6 items completed.
- Starts with PROMIS Global Health items.
- Data is comparable to a wide variety of state and national data being collected using NIH PROMIS.
- Recovery-oriented and measures strengths.
- More culturally competent than other measures, and available in multiple languages.
- Screens and alerts for suicidality and relapse.
- Optional substance abuse questions.
- The client measure allows for cost effectiveness analysis using Quality Adjusted Life Years.

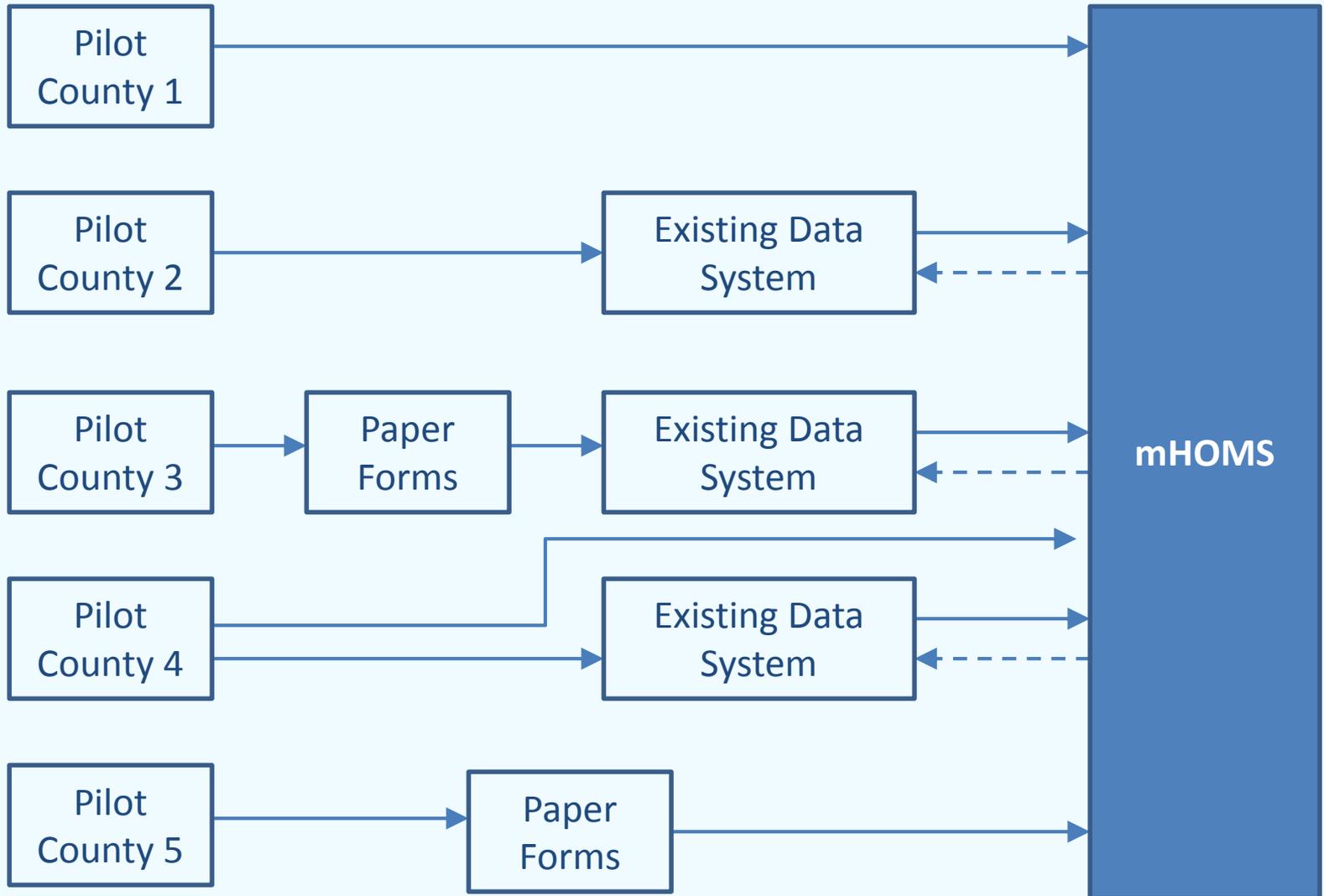


Other Data Collection

- Biannual Consumer Surveys (MHSIP or RSA)
- Annual Staff Survey (Recovery Self-Assessment)
- Annual Program Survey (MHSA Annual Report)
- Utilization and Cost Data from Health Records
- Connections to Law Enforcement, Hospitals, ER
- Wait times tracking from first contact
 - First offered appointment
 - First taken appointment
 - First assessment
 - First treatment



Data Flow Variations



Opportunity

- This is our chance to work together to build a comprehensive statewide behavioral health data collection and reporting system that can be used to promote positive outcomes across the State.
- We need your input to ensure that what is proposed works for you and meets your needs.
- We want you to have a major voice in the future of state requirements and MHSA reporting.
- Advances current outcomes systems for data collection and reporting by taking advantage of the opportunities for upgrading systems.
- Provides a meaningful evaluation of a limited sample of adult MHSA CSS programs.



Counties Recruited for Pilot

■ Recruited

- Los Angeles
- Nevada
- Santa Barbara
- San Bernardino
- San Diego
- Stanislaus

■ Likely

- Kern
- Marin
- Mariposa
- Riverside
- San Francisco
- San Joaquin



What's Involved in Being a Pilot Program?

- User training (7/15/15 – 8/15/15)
- Pilot period (8/1/15 – 2/12/16) with lots of user support and minimal burden
- Focus groups with pilot users –
 - What worked well?
 - What should be improved?
 - What is the system missing that you need?
 - What does it include that's burdensome and not needed?
- Work with us to develop reports of the pilot data to see what data meet your county's needs
- Inform our final policy recommendations



Thank you!

Andrew Sarkin, Ph.D.

Director of Evaluation Research

UCSD Health Services Research Center

asarkin@ucsd.edu



Data Flow Diagram

