



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 state-level systems had not been well maintained for some time during transition from DMH, and they do not fully meet needs of providers, counties, or the State.
- DHCS has done a lot to strengthen these systems, but these attempts were more of a “quick fix” than a long-term solution to the systems’ underlying weaknesses. MHSOAC is attempting to truly strengthen system so that it meets our collective needs of promoting positive outcomes across our mental health system.



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 could 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.



Developing the Proposed System

- Goal: Identify what data need 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
 - MHSOAC and DHCS 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



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



Measuring Participant Characteristics

- Access issues: Who are we serving?
 - Demographics:
 - ◆ Improved Ethnicity categories
 - ◆ Improved Gender Identity
 - ◆ Sexual Orientation
 - ◆ Military Status
 - ◆ Languages
 - ◆ Education
 - ◆ Age, etc.
 - Diagnosis
 - Special Needs Served (languages, disabilities)
 - Penetration rates relative to local population



Measuring Program Characteristics

- Access issues: What are we providing?
 - 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
 - Types of treatment provided to people:
 - ◆ Evidence-based
 - ◆ Recovery-oriented
 - ◆ Integrated care
 - ◆ Culturally appropriate
 - ◆ Complementary and alternative options



What might be assessed for MHSA CSS programs less intensive than FSPs?

- 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

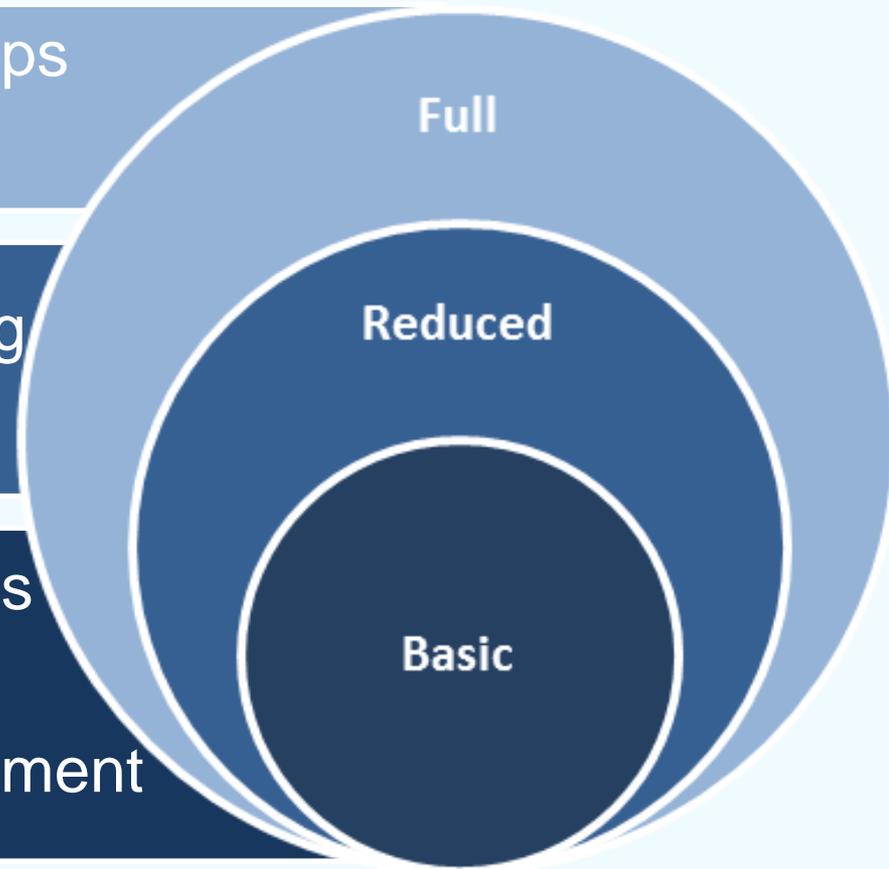


Three Main Levels of Assessment Based on Program Intensity

- Full service partnerships
- Intensive programs

- Less intensive ongoing treatment programs

- Low intensity programs
- Support programs
- Outreach and Engagement

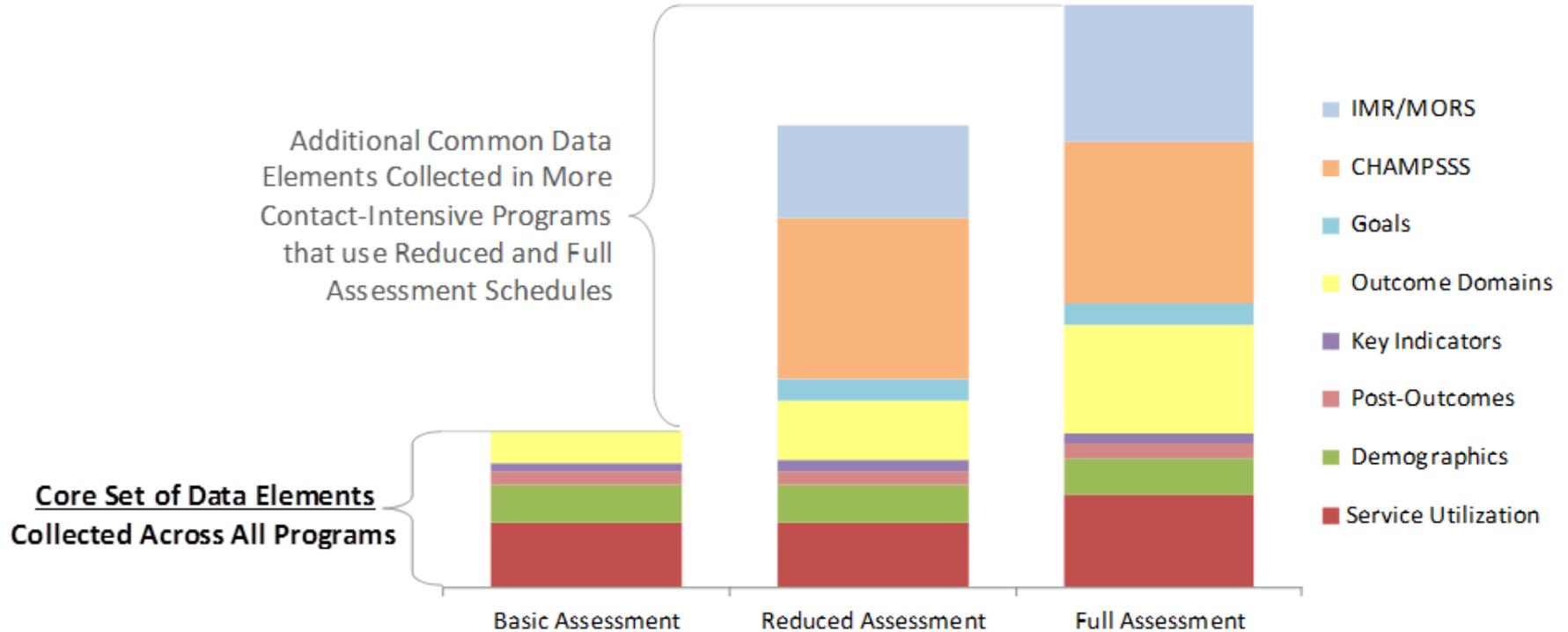


Determining Level of Assessment

- Much of the information is pulled from current Electronic Health Records where possible, but some information must be collected by staff.
- Additional data collection is based mostly on the service frequency and intensity.
- Some programs may have multiple tiers.
- Level of assessment then may have standard 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 it easy to determine assessments.



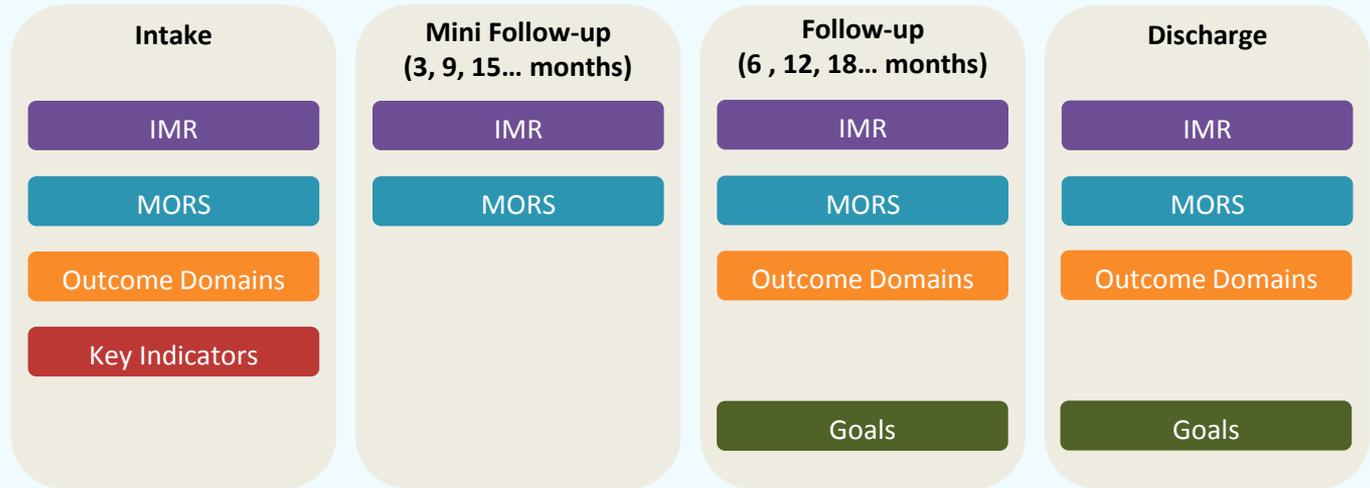
Relative Number of Data Elements within Basic, Reduced, and Full Assessments



Full Assessment Schedule

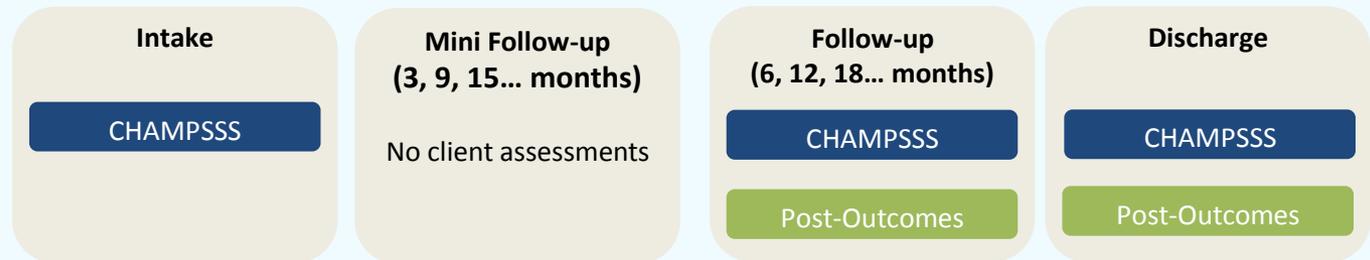
Clinician Assessment

Completed by
Clinician



Integrated Self-Assessment

Completed by
Client



Optional Family Member/Friend Assessment

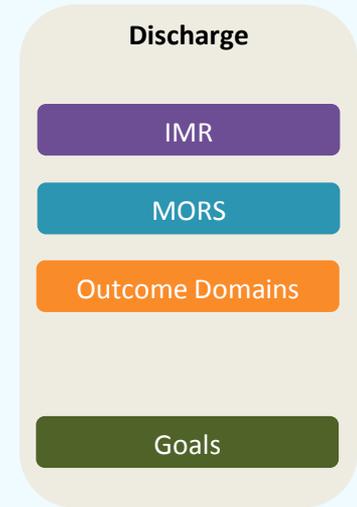
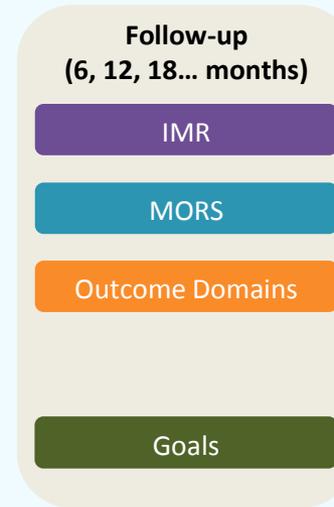
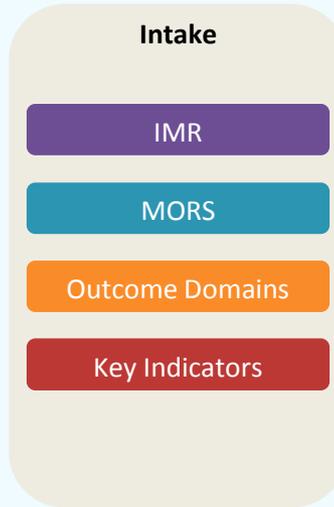
Completed by
Family
Member/Friend



Reduced Assessment Schedule

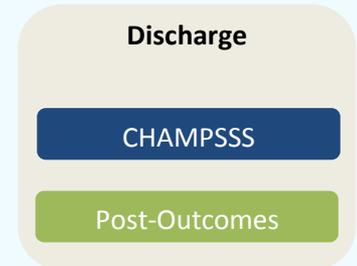
Clinician Assessment

Completed by
Clinician



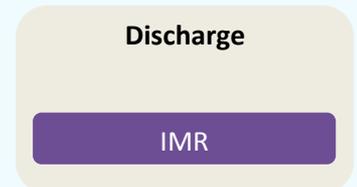
Integrated Self-Assessment

Completed by
Client



Optional Family Member / Friend Assessment

Completed by
Family
Member/Friend



Basic Assessment Schedule

Clinician Assessment

Completed by
Clinician

Intake

MORS

Outcome Domains

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

MORS

Outcome Domains

Discharge

MORS

Outcome Domains

Integrated Self-Assessment

Completed by
Client

Intake

No client assessment

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

Post-Outcomes

Discharge

Post-Outcomes



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



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	<p>Possible domains:</p> <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	<p>Possible domains:</p> <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.



Family and Friend Version of the Illness (Wellness) Management and Recovery Scales

- Only one page front and back with 16 items.
- Data is comparable to a variety of state and national data being collected using the IMR.
- Recovery-oriented and measures strengths.
- More culturally competent than other measures, and will be available in multiple languages.
- Substance abuse questions and relapse alert.
- Scales combine items to measure:
 - Symptom Management
 - Participation in Wellness Activities
 - Substance Abuse

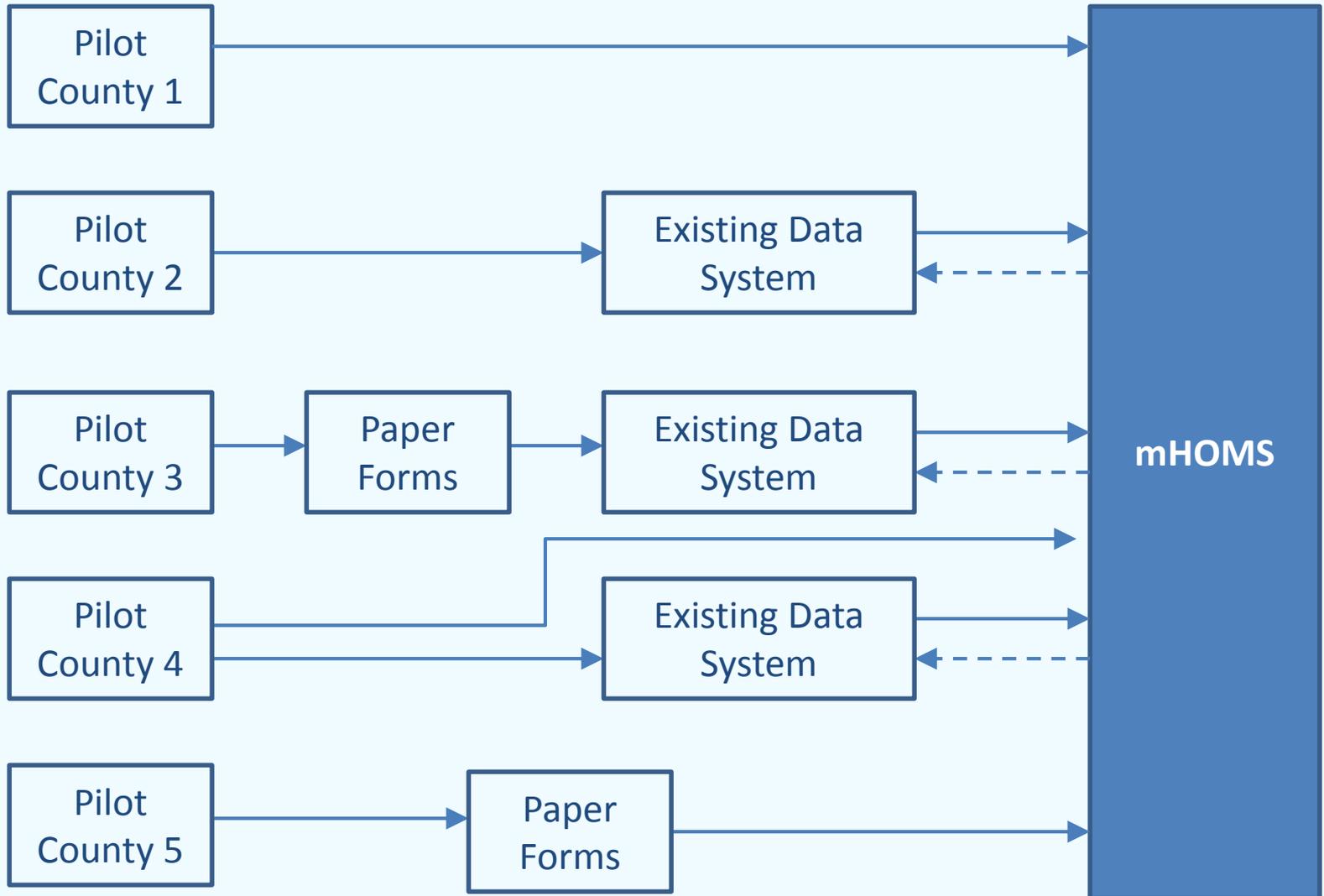


Other Data Collection

- 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



Counties Recruited for Pilot

■ Recruited

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

■ Likely

- San Francisco
- San Joaquin
- More small counties

■ Possibly

- Kern
- Mariposa
- Orange
- Other possibilities



Family Measures – Your Opinions

- Family and Friend version of the Illness Management and Recovery Scales
- Assessing involvement of others in treatment
- Self-assessment includes strengths:
 - Safe living environment
 - Social support
 - Satisfaction with social relationships
 - Ability to fulfill social roles
- Housing question does not confuse living with family as a lack of independence
- Relationships are also assessed and updated



Thank you!

Andrew Sarkin, Ph.D.

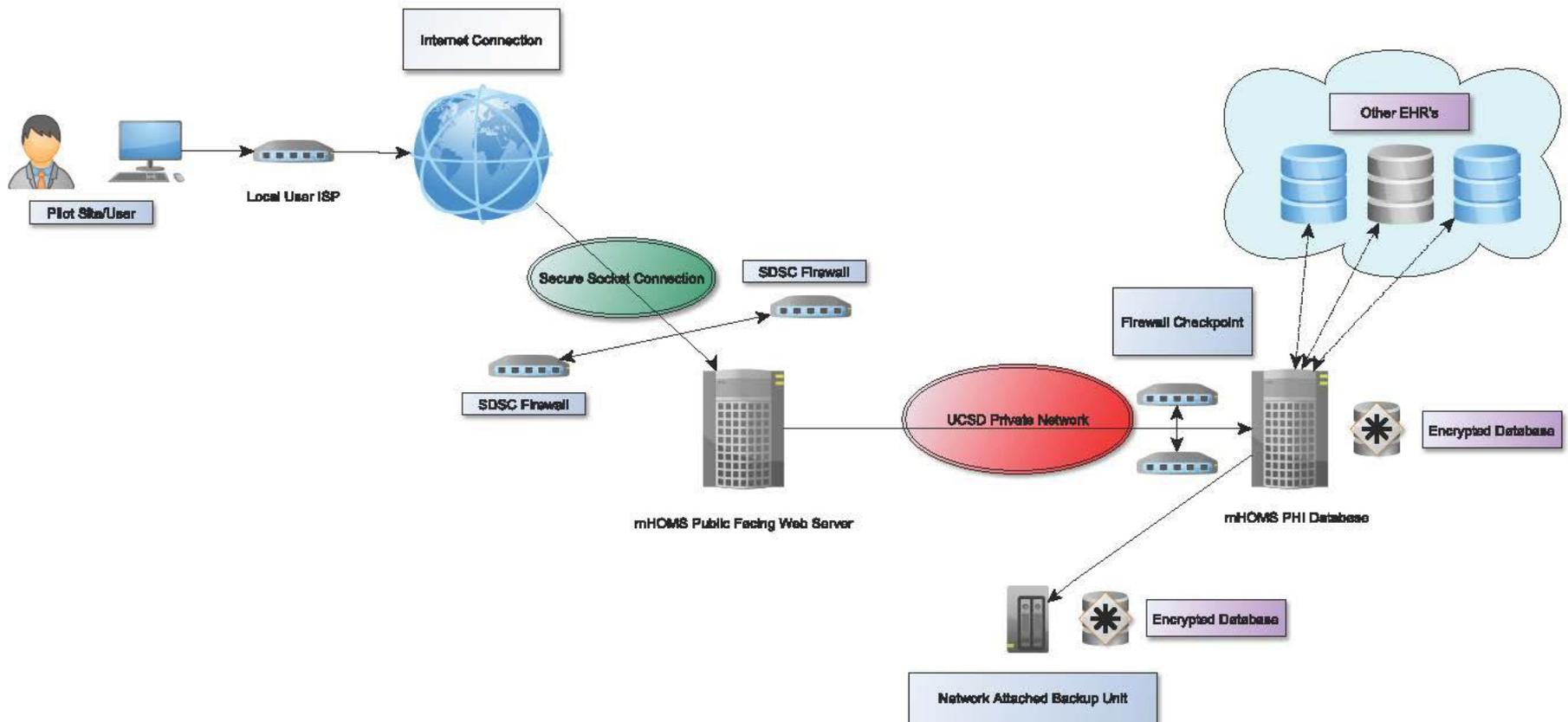
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Data Flow Diagram



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?



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



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 and increases client voice.
- Optional family/friend measure of recovery.
- Able to perform cost effectiveness analyses, penetration analyses, and other important calculations to support evaluation efforts.



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).
- Pilot participants will still be required to complete all DCR forms during the pilot, so it is difficult to truly judge the system for FSPs in terms of workload.



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.



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 diverse input to ensure that what is proposed works for you and meets your needs.
- We want counties 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.



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 was burdensome and perhaps not needed?
- Pilot programs provide input on how to best
 - Improve the system and workflow
 - Develop reports that meet your needs
 - Inform our final policy recommendations

