Research and Evaluation Committee Meeting

February 16, 2022
1:00 pm to 4:00 pm

Itai Danovitch, MD, MBA, Chair

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MHSOAC
Mental Health Services
Oversight & Accountability Commission

DRAFT
Research and Evaluation Committee Meeting Agenda
Wednesday, February 16, 2022, 1:00 – 4:00 PM
MHSOAC: Zoom Teleconference
Note: The meeting audio will be recorded.
Link: https://mhsoac-ca-gov.zoom.us/j/84322612671?pwd=S2tOY0lRZW5seHhTak9zbzBSUzNJdz09

Meeting Purpose and Goals:

This meeting will be the first in a two-part meeting series. The meeting goals are to:

- Present the Commission's research agenda and goals.

- Provide an update on the Triage Summative Evaluation plan.

- Present on the child/youth behavioral health measures collected in California and identify measures for the Commission to elevate.

- Present short-term research and evaluation deliverable options for the Committee to consider and recommend prioritization to the Committee Chair.

TIME	TOPIC	Agenda Item
1:00 PM	**Welcome** *Commissioner Itai Danovitch, Chair* *Commissioner Steve Carnevale, Vice Chair* Welcome, opening remarks, and review of the agenda.	
1:10 PM	**Action: Approval of September 1, 2021 Meeting Minutes** *Commissioner Itai Danovitch, Chair* The Research and Evaluation Committee will consider approval of the minutes from the September 1, 2021 meeting teleconference. • **Public comment** • **Vote**	**1**
1:20 PM	**Information: The Commission's Research and Evaluation Division's 2022 Strategic Portfolio** Presenters: *Commissioner Itai Danovitch, Chair* *Brian Sala, Ph.D., Deputy Director for Research and CIO* The Committee Chair and Commission's Deputy Director will present the Research and Evaluation Division's Strategic Portfolio and discuss activities underway, highlighting Commission mandated evaluations and "big picture" questions centered on children and youth.	**2**

TIME	TOPIC	Agenda Item
1:45 PM	**Information: Update on the Commission's Triage Summative Evaluation Plan** Presenter**:** *Kallie Clark, PhD, Senior Research Data Analyst* Commission staff will present on how Committee and public member feedback was incorporated into the Triage summative evaluation plan, and the progress made in data collection and implementing the evaluation.	**3**
2:05 PM	**Break**	
2:10 PM	**Information and Discussion: Transforming California's Mental Health System and the Need for Robust, Comprehensive Metrics** Presenters**:** *Lishaun Francis, MPP, Director of Behavioral Health, Children Now* *Fatima Clark, MSW, Associate Director, Health & The Children's Movement Equity Fellowship, Children Now* Ms. Francis and Ms. Clark will present on children's mental health measures collected in California, the importance of comprehensive and unified measures to tell the story about how children are faring, and measurement gaps and opportunities, particularly in light of the transformation underway in the children's mental health system. Discussants: *Lynn Thull, PhD, President, LMT & Associates, Inc.* *Katherine Watkins, MD, MSHS, Senior Physician Policy Researcher, RAND Corporation* Following, the Committee will hold a discussion. Questions to guide this discussion include: 1. What are the most important community indicator domain areas in children and youth behavioral health that the Commission can contribute to? 2. What are the biggest near-term opportunities for the Commission to improve public access to and understanding of key children and youth behavioral outcomes? Should outcomes be defined for specific subpopulations (e.g., foster youth)? - **Public comment**	**4**
3:50 PM	**Wrap-Up** *Commissioner Itai Danovitch, Chair*	
4:00 PM	**Adjourn**	

AGENDA ITEM 1

Action

February 16, 2022 Research and Evaluation Committee Meeting

Approval of Meeting Minutes

Summary: The Commission's Research and Evaluation Committee will review the minutes from the September 1, 2021 Committee teleconference meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting.

Presenter: None

Enclosures (1): September 1, 2021 Meeting Minutes.

Proposed Motion: The Committee approves the September 1, 2021 meeting minutes.

Research and Evaluation Committee Teleconference Meeting Summary
Date: Wednesday, September 1, 2021 | Time: 9:00 a.m. – 12:00 p.m.

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

****DRAFT****

Committee Members:	Staff:	Other Attendees:
Itai Danovitch, Chair Ken Berrick, Vice Chair Rikke Addis Sergio Aguilar-Gaxiola Robert Brook Eleanor Castillo Sumi Jonathan Freedman Sharon Ishikawa Bridgette Lery Gustavo Loera Belinda Lyons-Newman Mari Radzik Katherine Watkins	Toby Ewing Maureen Reilly Brian Sala Norma Pate Dawnte Early Kai LeMasson Tom Orrock	Tiffany Carter Kenna Chic Stacie Hiramoto Nina Moreno Josh Morgan Elizabeth R. Stone Zoey

Committee members absent: April Ludwig, Laysha Ostrow, Ruth Shim, and Lonnie Snowden, Jr.

Welcome

Commissioner Itai Danovitch, Committee Chair, called the meeting to order at 9:01 a.m. and welcomed everyone. He reviewed the meeting protocols and meeting agenda. Today's meeting objectives were to advise the Research and Evaluation Division on a strategy to evaluate the impact of Mental Health Services Act (MHSA) programs and services on school-age children and youth and to review and provide guidance on a proposed plan for evaluating the Triage Crisis Service Program.

Kai LeMasson, Senior Researcher, called the roll and confirmed the presence of a quorum.

Agenda Item 1: Action – Approval of Meeting Minutes

Chair Danovitch asked for a motion to approve the meeting minutes from the June 17, 2021, Research and Evaluation Committee teleconference meeting.

Vice Chair Berrick made a motion to approve the minutes as presented. The motion was seconded by Committee Member Aguilar-Gaxiola.

Vote recorded with participating members as follows:

- Approve: Committee Members Addis, Aguilar-Gaxiola, Brook, Castillo Sumi, Freedman, Ishikawa, Lery, Loera, Ludwig, Lyons-Newman, and Radzik, Vice Chair Berrick, and Chair Danovitch.

Agenda Item 2: Information – Triage Crisis Services – An Overview of the Triage Grant Program and Preliminary Findings from the Evaluation of Triage Program Implementation

Presenters:

- Tom Orrock, MHSOAC Chief of Operations and Grants Division

- Kai LeMasson, MHSOAC Senior Researcher

Chair Danovitch stated the Committee will hear a presentation on the background and description of the Senate Bill (SB) 82/833 Triage Grant Program and discuss the preliminary findings from the statewide formative and process evaluations. He stated the goal is to provide an overview of the Triage Grant Program and its implementation to inform the discussion of the evaluation of the Triage Grant Program. He asked staff to present this agenda item.

Tom Orrock, MHSOAC Chief of Operations and Grants Division, provided an overview, with a slide presentation, of the background, objectives, funding, lessons learned, and evaluation of the SB 82 Investment in Mental Health Wellness Act of 2013. He stated input on the evaluation of these programs is important as funding for Round 3 for mental health crisis programs around the state is being planned.

Kai LeMasson, Ph.D., MHSOAC Senior Researcher, continued the slide presentation and discussed the Commission evaluation of triage program implementation for Round 2, data sources, triage program features, key factors affecting program implementation, and early lessons learned. She stated a Request for Application (RFA) is currently being developed for Round 3 funding.

Discussion

Chair Danovitch asked how programs in Round 2 were structured and if there were similarities between them.

Mr. Orrock stated there were mainly two types of triage programs: mobile crisis units and set-ups in access points such as hospital emergency rooms, with law enforcement, or in school-based services.

Chair Danovitch asked for input on how to evaluate a program to determine what was impactful about it, its strengths and weaknesses, what should be scaled, and what was learned from this effort in order to strengthen the ability to do crisis services.

Committee Member Freedman wrote in the chat section about the 988 system in development for California and nationally and about the recent school mental health

initiative, which contemplates a digital portal. He asked if new and existing entry points are being considered in future evaluations. He suggested that current and new "doors" should be examined to see whether or not they are linked to field response, direct services, and recovery supports.

Committee Member Aguilar-Gaxiola asked if there are outcomes related to the implementation of these programs and the presented objectives.

Mr. Orrock stated each county submitted their own Annual Program Effectiveness Report to the Commission. Due to the variance of items being measured, this information could not be put into statewide evaluation guidance.

Committee Member Aguilar-Gaxiola stated, given the lack of uniformity, it may be helpful to develop diverse measures or to at least link certain measures to specific objectives or goals such as to what extent the implementation of those programs reduced the number of crises services utilization and increased outpatient services.

Ms. LeMasson added that some of the legislative objectives such as the reduction of unnecessary hospitalizations and law enforcement involvement will be addressed through the Summative Evaluation Plan, which will be presented later in today's agenda.

Committee Member Brook stated the purpose for formative evaluation is to feed information back to the programs quickly to make improvements. He stated he did not see this in the presentation. The evaluation that was done identified rudimentary and fundamental problems but no improvements. He noted that it is dangerous to do a systematic evaluation at this moment because it will produce negative results since the programs have not matured enough and the follow-up system is not sufficiently in place to get a positive result. He asked the team that did the formative evaluation if these programs are ready to do a sophisticated outcome evaluation to understand impacts or if it is premature.

Mr. Orrock stated it would be valuable to identify counties that have a full continuum of care that have significant diversion options available with the three main pieces in place – diversion, mobile crisis, and call center – available beyond 9 to 5 and to identify impacts in those programs when there is a sufficient continuum of care in place.

Committee Member Brook asked the formative evaluation team if there is a program in the state where they did a formative evaluation that meets those criteria.

Ms. LeMasson stated staff will reach out to the UC Davis and UCLA evaluators with this question.

Vice Chair Berrick stated no county has a perfect continuum because it is not possible under current structures, but there are counties that are close. Having a broad format for evaluation in place and a process over time will provide progressively more information over time.

Committee Member Loera asked if there is a program at the school level that is working on how to do something more economically that focuses on early prevention for children and youth who may not be at the crisis stage yet to curb that cycle.

Mr. Orrock stated that is taking place in four of the counties funded with the school-county collaboration. Much can be learned from those programs about how they address the early signs of mental health conditions with children and youth. This is one of the areas where it is necessary to look at how triage programs connect with early psychosis programs around the state and how they can collaborate and work together to ensure that individuals involved in those programs are getting the support they need in the community.

Committee Member Lyons-Newman stated she was struck by the fact that the objectives mostly focused on the absence of hospitalizations, justice interactions, and other problems. She asked about measures such as quality of life, employment, or friends and family connections – things related to a meaningful life, not just the absence of problems.

Mr. Orrock stated the objectives include a general satisfaction of services measure. He agreed that it would be helpful to learn if individuals are linked to those kinds of community-based supports after services are provided.

Committee Member Lyons-Newman asked if lives were made better by being linked to these community-based services. It is important to seek more from these programs than to keep individuals out of hospitals or jails.

Chair Danovitch stated the objectives shared in the presentation are the objectives of the legislation and not necessarily of the evaluation, which will include what will produce an impactful finding.

Committee Member Radzik asked about services provided to individuals in Rounds 1 and 2 in order to maximize what worked in the next round, especially in terms of linkage. She asked why some counties did not apply for these grants when every county needs these services.

Agenda Item 3: Information – An Approach to Statewide Evaluation with an Application to Triage Programs

Presenters:

- Mike Howell, MHSOAC Research and Data Integration Manager
- Denis Hulett, MS, MHSOAC Researcher
- Heike Thiel de Bocanegra, PhD, MPH, MHSOAC Researcher Manager

Chair Danovitch stated the Committee will hear a presentation on the data infrastructure the Commission has developed through partnerships with state agencies to link statewide data. A plan for evaluating Triage Program outcomes (the summative evaluation) will be presented and can serve as an overarching strategy for evaluating children and youth programs.

Chair Danovitch asked Committee Members to keep the questions raised in Agenda Item 2 in mind about what objectives should be for the evaluation, what objectives are capable of being met now, and what evaluation questions should be answered. He stated, as the proposal for what can be evaluated is presented, to consider if it is feasible, if it is evaluating the right thing, and if something else should be evaluated.

Dawnte Early, Ph.D., Chief, Research and Evaluation, introduced the speakers for this agenda item and asked them to give their presentation.

Denis Hulett, MHSOAC Researcher, provided an overview, with a slide presentation, of the triage summative evaluation and application to triage evaluation.

Mike Howell, UC Research and Data Integration Manager, continued the slide presentation and discussed the evaluation methodology of statewide databases and linking to outcome data.

Heike Thiel de Bocanegra, Ph.D., MPH, MHSOAC Researcher Manager, continued the slide presentation and discussed the application to the Mental Health Student Services Act (MHSSA).

Public Comment

The following public comments and Committee Member responses were written in the chat section:

Elizabeth R. Stone asked why referrals and linkages to services are measured when the quality and point of services ultimately is improved quality of life.

Committee Member Lery responded that, although important, it would take an additional approximately $500,000 to do a statewide survey of quality of life.

Elizabeth R. Stone stated the issue is that "available" data is continually collected, which self-perpetuates omitting measures that are most important to users of services.

Josh Morgan stated implied quality of life through data integration can also be useful. There are proxies that can indicate quality of life and meaning toward wellness instead of just symptom reduction. The speaker noted that Child and Adolescent Needs and Strengths (CANS) data for children can also be quite valuable.

Vice Chair Berrick agreed and stated he did not think the presenters meant to be dismissive of wellness outcomes. He stated there are opportunities to carefully craft questions and fund some of these most important questions.

Josh Morgan posted links of some of the work of their organization in the chat section, which was largely based on existing data: https://www.sas.com/en_be/customers/san-bernardino-county-health.html and https://www.cdss.ca.gov/inforesources/foster-care/cans/the-cans-tool/cans-resources.

Committee Member Radzik stated CANS is used in the Los Angeles County Department of Mental Health for all recipients.

Committee Member Lery stated CANS is a good start.

Vice Chair Berrick agreed.

Josh Morgan stated it would also be useful if the Department of Health Care Services (DHCS) would get more detailed data of service types. The speaker noted that procedure codes from claims data were quite useful in providing a more complete story, such as noting increases in collateral contacts with family members and loved ones who were actively involved.

Elizabeth R. Stone asked if other counties encounter agencies reporting providing services when they are not offered or are so minimal that it is difficult to consider potential impacts.

Josh Morgan stated, even with short-term services, including a residential treatment facility, CANS was useful in demonstrating non-pathology changes and developmental differences of transition-age youth (TAY) consumers versus traditional adult consumers. This helped demonstrate the need for TAY specific CRTs versus general ones. It also helped lay a foundation for other strengths increased, such as relationships, employment, and optimism. The speaker stated it can also be implied that increases in these skills should decrease pathology and acute services and increase employment, which leads to Medicaid cost savings.

Zoey stated they are currently working with the DHCS to obtain collected CANS information.

Elizabeth R. Stone asked about the biggest barriers to collecting/accessing data from counties and if it seems that counties have staff with sufficient training to collect and/or analyze data.

Committee Member Radzik stated barriers include added burdens on already overworked/burdened direct/frontline staff. CANS is a clinical measure that administrative staff cannot administer.

Josh Morgan agreed.

Elizabeth R. Stone asked if intervention is a workforce and training issue or if it is a management issue for allocating resources.

Committee Member Radzik stated it is both.

Elizabeth R. Stone asked how this can be improved and if there is guidance to address it.

Josh Morgan stated they see it more as a symptom of the lack of priority on data and analytics across behavioral health. This is common nationwide. The speaker noted that this is changing, but trying to find funding for this work is challenging for many because it is a different way of approaching and conceptualizing the business model in the first place. For example, electronic health records (EHRs) are a cost of doing business but did not get much reimbursement, especially for behavioral health. These things will be standard, but it takes time and money.

Committee Member Lery agreed and stated it would take an extra $200,000 to get data use agreements with each individual county. She added that statewide data is incredibly useful.

Break

Agenda Item 4: Action – Triage Summative Evaluation Plan

Chair Danovitch stated, through facilitated discussion, Committee Members and stakeholders will provide feedback on the summative evaluation plan presented in Agenda Item 3. He stated the Committee will receive public comment and then vote through a poll

on whether to endorse the proposed summative evaluation plan, perhaps with recommendations for improvements. He asked staff to present this agenda item.

Brian Sala, Deputy Director of Research and CIO, asked a series of questions to facilitate the discussion and Committee Members provided feedback as follows:

1a. <u>Are we asking important evaluation questions</u>? <u>What suggestions do you have for improving the framing of those questions, given our charge to conduct a statewide evaluation of highly heterogeneous grant programs</u>?

- Consider other models when there is heterogeneity to the extent that there are specific outcomes to specific objectives, such as the California Reducing Disparities Project (CRDP) and its statewide core measures.

- Pre-set, agreed-upon evaluation questions and measures are critical.

- Linking variables to outcomes is a concern, especially for the Latinx population. To what extent does this exclude some populations or to what extent will the data be of quality so that the variables can be linked?

Mr. Hulett stated there are some databases where Social Security is allowed to match social security numbers, such as the Department of Justice. A secure information transfer has been set up. He agreed that there are certain populations that are not well-represented. Results may need to be weighted or contributing analyses may need to be done in those instances.

Dr. Early stated future evaluations will potentially need qualitative aspects built in as it relates to outcomes.

- Ensure that services being given to individuals in the triage program are not taking away services from the control individuals who were not part of that program. Measures such as the amount of backlog there is to routine follow-up care in public programs would add context.

- Measure whether the hiring issue is more of an efficiency or effectiveness problem and if individuals who do this care are different from the limited supply of individuals to treat this population.

- Context is important during the evaluation. For example, individuals in neighboring states may be attracted to come to California by the amount of funding being provided for these services so the net result will appear that California's shortages became greater.

- Conduct an in-person meeting between the individuals doing the triage and the summative evaluation to learn as much as possible prior to finalizing this evaluation rather than relying only on reports.

- Learn how the system design model is architected in the local ecosystem and how it plays a role here. Operational control is in the counties in California, which looks uniform on paper but is highly variable in practice. Does this play a role in how individuals access services, whether services are effective, and whether individuals

can be accommodated going forward? Are there model or design effects that influence engagement and responsiveness?

1b. <u>Given the program constraints and the data constraints, how would you suggest we refine our methods to answer these important evaluation questions</u>?

- The proposed approach is fine and is generally what must be done to deal with the fact that implementation was rolled out in a way that was not systematic with an evaluation in mind. The details of how to do that need to be considered.

- Organize evaluation in multi-level design with discrete time models, which can look at random effects.

- How are comparison client events indexed? Comparison clients need to be within the same county.

Dr. Sala agreed that this is a critical question that goes back to the core of what is meant by mental health crisis, which focuses on more of a continuum rather than focusing solely on a triggering event that may directly lead to an arrest or hospitalization. This is one of the broad challenges of the triage program in general.

Mr. Hulett agreed but stated the proportional hazard model may not be possible. He stated the index will be set for the control group by trying to match as many things as possible that can be considered an anchor, such as an encounter with law enforcement or a hospitalization. Individuals who call a triage line but have no law enforcement or hospitalization involved can be matched with a control person who matched this scenario on the same date. This is a limitation of the study.

Dr. Sala stated it will be a core methodological challenge to defend the techniques for finding a control population and matching. Many things may need to be done in order to circle around being able to answer important questions.

1c. <u>What is your advice regarding the overall evaluation plan</u>? <u>Are there major outcome domains that we are missing and what are your recommendations?</u>

<u>Are there major confounders that we are missing and what are your recommendations?</u>

- One of the great services that could be done for the state of California would be to indicate how this would have been much easier if the evaluation was planned prior to or at the same time as the program planning process.

- Perhaps the best thing that can come out of this evaluation is to indicate to the Legislature, the Governor, and the parties how to avoid these kinds of difficult problems by thinking about and working on evaluation up front and to require the programs to endeavor to do things that would make learning from them easier. It is hard to consider the evaluation after the fact.

- Keep the workforce in mind who are providing these services and how well that workforce can provide the things that they are being asked to do that will be measured in the evaluation.

- Sit down after the fact with the providers and receivers of these services in a focus-group format to see what worked for the triage contract and what did not. A confound will not necessarily be about whether a client did or did not receive services but it will be about how impacted individuals are in providing and receiving those services. Are the barriers in the workforce about providers being overburdened or about clients not following-up?

- Include safe elements in schools to have conversations about mental health and its impacts. Having a safe person to talk to on campus can be the difference in changing a person's path from someone who will be involved in crisis services to someone who learns coping and other skills. An example of a safe program is NAMI on Campus.

- Keep an inventory about what mattered to various counties as a way to create statewide core measures and to learn about commonalities between counties.

- Measure the number of consumers who use county outpatient services and whether that number increases while at the same time other points of access such as emergency rooms, crisis counseling, or law enforcement decrease due to crisis services.

- Counties should determine quality benchmarks, such as the number of days it takes from the client's first contact to the completion of the intake assessment, which should be within ten business days, and the average duration between accessing services and starting an assessment appointment.

- Knowing the services that work to help someone succeed in a follow-up measure or questionnaire would be most important so it can be maximized. Compile a dataset of what the counties are providing and the maximum number of events that were most successful.

Issues of health equity are of high interest to the Commission.

2a. How can we improve this evaluation's attention to equity?

2b. What lessons can and should we apply to future evaluation efforts about how to better build equity considerations in from the start?

2c. How will the results allow us to inform, practice, policy, and improve equity?

- It is important to focus on mental health equity. There is more work to be done to address the inequities in access to care, which have increased due to the COVID-19 pandemic.

- Health equity includes the social determinants of health, structural racism, and overlap across different systems such as the prison, school, and mental health systems. How that data is massaged and taken in the end is what is the best fit for the patient population such as client and provider matching and LGBTQ and Black, indigenous, and people of color (BIPOC) populations who do not have matching in terms of their services in the community.

- Do focus groups to learn about health equity and look at the data in a grounded-theory format to take themes out of those discussions.

- Ensure that key inequity variables are being collected by participating counties.

- The proposed approach that does not immediately look for the outcome or the solution but looks at how to inform practice, policy, and how to improve equity is important.

- It is important not only to see and hear the indicators that counties find important but also how they were measured, how they operationalize variables, outcomes, and processes, what obstacles were faced during the collection process and how those obstacles were overcome, learn to identify commonalities on similar types of metrics, and find ways to apply those common operationalizations in the next phase of grant funding.

- Ask applicants to build in a readiness to collect and report data in ways that would be useful for statewide evaluation on different metrics and to indicate what technical assistance may be needed in order to collect the data in a uniform way.

- Gather and summarize lessons learned over the evolution of the triage grants and the MHSSA grants to help inform policy makers so they can begin to build those lessons learned into new opportunities, policies, and realms of legislation.

Dr. Sala stated a lesson learned that may come out of this is the need for further investment in technical assistance.

Public Comment

Stacie Hiramoto, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), thanked the Chair, staff, and Committee Members for their conversation on evaluation research. The speaker stated individuals of color, especially those from Black and brown communities, are not diverted as often or given opportunities to avoid the most restrictive treatments or even incarceration. The speaker stated they are interested in learning if the triage programs are helping to reduce disparities and whether BIPOC and LGBTQ individuals are being served proportionately by these triage programs.

Tiffany Carter, Cal Voices, suggested that this Committee provide guidance for a check-box system of what innovation looks like and what it requires in order to be more equitable with the innovation plans that come before the Commission.

Chair Danovitch stated the Innovation Subcommittee has been working on a project to improve the definition of Innovation and to improve the development and approval process for Innovation plans.

The following public comments and Committee Member responses were written in the chat section:

Elizabeth R. Stone stated they agree with looking at system-level issues rather than place the "problem" within the individual who has been diagnosed and is receiving services. It would be nice for peer programs to shy away from the medical model. The speaker noted that it can be counter-productive for youth to teach each other about having an illness,

when often their distress is a healthy reaction to external factors. Preventative care is always less traumatic for the individual and less resource intensive.

Nina Moreno suggested disaggregating data by race/ethnicity.

Elizabeth R. Stone agreed and suggested including SES, rural/suburban, parents' educational attainment, and standard definitions in the race/ethnicity category.

Kenna Chik suggested better understanding that cultural differences create different manifestations of mental health conditions, and many members of the BIPOC community identify their mental health symptoms as physical health problems. The language used in questions or surveys to collect data is important. For example, collecting data on suicide ideation may be difficult when clients of color are aware that they could be forcibly hospitalized if they are considered a danger to self or others.

Committee Member Radzik stated this is correct.

Elizabeth R. Stone stated Kenna Chik's example of disclosing suicidality is a universal concern that prevents many individuals from raising this issue, especially if they have tried to discuss their feelings and been forced to sign a no-harm contract or are suddenly contacted by law enforcement.

SurveyMonkey Poll

Chair Danovitch invited Committee Members to participate in a poll as a way to get a pulse from the group on how everyone feels about moving forward with the proposed evaluation plan.

Chair Danovitch asked for direction from Committee Members, given the complexities and challenges as discussed, on whether to move forward with the proposed evaluation plan with a plan to incorporate feedback given in this meeting, or if there is sufficient concern about the fundamental premise that the objectives need to be reconsidered and the approach changed to determine the questions that need answering.

Chair Danovitch stated the poll, which was generated on SurveyMonkey, will allow Committee Members and members of the public to consider the strengths and weaknesses of the proposed evaluation plan to help the evaluation team better understand how to move forward.

The poll question was as follows: Please select a response option below that best represents your position on the Triage Summative Evaluation Plan.

Poll Results

After the poll was taken, Chair Danovitch announced that the poll results indicated an endorsement to move forward with the proposed evaluation plan.

Wrap-Up

Vice Chair Berrick highlighted some of the feedback heard during this meeting:

- Integrate clear definitions of terms for both the maturity level and contents of county systems of care.

- Integrate quality-of-life measures in a different way.

- Use the quality-of-life measures to correlate with system-level measures about system impact such as incarcerations, school attendance, and juvenile justice involvement.

- Measure and identify exterior outcome variables that can impact state and county abilities to perform such as the COVID-19 pandemic. Impact variables must be identified when looking at systemic and individual program performance.

Chair Danovitch added one of the themes heard was whether a piece of legislation or policy and its implementation or the programs that are funded by that policy are being evaluated. There is work to be done to disentangle these two issues because the measures used for each one is different.

Chair Danovitch encouraged all meeting participants to fill out the survey. He asked individuals who responded that they were neutral, opposed, or strongly opposed to move forward with the plan to fill out why in the comment section of the survey and to include a recommendation of what can be done to address it.

Adjourn

Chair Danovitch adjourned the meeting at approximately 12:00 p.m.

AGENDA ITEM 2

Information

The Commission's Research and Evaluation 2022 Strategic Goals

February 16, 2022 Research and Evaluation Committee Meeting

Summary: The Committee Chair and Commission's Deputy Director will present the Research and Evaluation Division's Strategic Portfolio and discuss activities underway, highlighting Commission mandated evaluations and "big picture" questions centered on children and youth.

Presenters: Commissioner Itai Danovitch, Chair
Brian Sala, PhD, Deputy Director for Research and CIO

Enclosures (1): (a) The Commission's Research and Evaluation Division's Strategic Portfolio

Handouts (2): PowerPoint presentation; Evaluation Planning, Research and Evaluation Committee Activities

MHSOAC Research and Evaluation Division Strategic Portfolio
October 6, 2021

The Research and Evaluation Division seeks to improve outcomes, promote opportunities for prevention and effective intervention, and reduce disparities by analyzing data, consulting with experts, and engaging communities to produce information and recommendations that empower community members and inform policymakers and practitioners. The division has <u>five primary activities</u> that are strategically designed to increase public understanding and reduce stigma, document the impact of existing policies and programs, provide the information required for robust community involvement and continuous improvement in services and outcomes, and inform the Commission's agenda.

1. **Tracking community indicators to increase public understanding and awareness.** The Commission reports population-level data on significant outcomes associated with mental health, including hospitalizations, criminal justice involvement and suicide. These dashboards reveal trends and allow for comparisons across counties and with other states.

2. **Curating an inventory of county plans and programs to improve community planning.** The Commission aggregates data on MHSA-supported programs, including three-year plans and annual reports, data and outcomes reported for Prevention and Early Intervention programs and Innovation projects, program descriptions and outcomes, revenue and expenditures. The information enables community members and practitioners to assess services and the allocation of resources; identify opportunities for prevention and other systems improvements; develop new strategies and partnerships; and, design new programs and services.

3. **Recommending ways to improve mental health strategies and outcomes.** The Commission compiles data and research with public input to align and adapt statewide policies and community programs with effective approaches to improve outcomes. For example, the Commission's recommendations for reducing criminal justice involvement prompted a $5 million investment in county efforts to adapt proven diversion programs. The Commission crafted – and is now implementing – a statewide suicide prevention strategy, resulting an Office of Suicide Prevention and ongoing funding and staffing for statewide suicide prevention. Its school mental health report inspired the Mental Health Student Services Act. Recommendations are being developed to improve prevention and early intervention and workplace mental health strategies.

4. **Linking consumer-level data across service systems to understand the impact of mental services.** The Commission links consumer-level data across service systems to understand how mental health needs and services impact the health, safety, education, and employment of Californians. This information is used to inform the Commission's own research and the research of others, as well as state and community choices intended to improve outcomes for individuals.

5. **Evaluating new initiatives to accelerate learning, adaptation, and scaling.** The Commission selectively evaluates existing and pilot interventions to determine effectiveness and identify opportunities for prevention, improvement and replication. The Commission is evaluating the impact of $75 million in "Triage" grants provided to communities and will soon begin evaluating $250 million in grants provided by the Mental Health Student Services Act. The Commission also will be launching an effort to assess the collective impact on systems improvements of Innovative projects and collaboratives. The outcomes of these efforts could guide future Commission funding and resource allocation to promote continuous quality improvement and systems change.

Status of Projects and Activities

These projects and activities are intended to improve public understanding, empower all voices to advocate for improvements, and enable decision-makers and practitioners to design and manage strategies and services that improve results for all consumers. Overtime, the division seeks to improve the value of these projects and activities by better understanding and meeting the data and information needs of users, and facilitating learning and continuous improvement among public agencies and service providers.

1. Tracking community indicators to increase public understanding and awareness. The Commission reports population-level data on significant outcomes associated with mental health, including homelessness, criminal justice involvement and suicide. A series of dashboards are being developed that reveal trends and allow for comparisons across counties and with other states.

> **For example: Suicide Prevention**
>
> In 2019, at the request of the Legislature, the Commission produced and adopt a state strategy for preventing and reducing death by suicide.
>
> The Commission in 2020 was directed to begin implementing the plan.
>
> In 2021, the Commission engaged deeply with community members and evolved the analysis by UCLA to develop a public-facing dashboard tracking one of the seven negative outcomes.

    a. Who is being served: This information is intended to inform consumers and advocates, to inform the Commission's agenda and engagements, and to guide state and local priorities and actions.

    b. Status: The Commission contracted with UCLA to engage a diverse group of experts, conduct a literature search, analyze easily available data sets, and recommend population-level indicators for each of the seven negative outcomes identified in the MHSA.

The Commission staff engaged community members involved in suicide prevention to review possible indicators for that outcome and developed a "beta" dashboard. Community members and working partners were engaged again to determine if the data and presentation captured the lived experience and would accurately inform public discussions and planning, as well as program design and management. The suicide prevention dashboard was posted in September 2021.

A plan is being developed to evolve the balance of UCLA's work product for the other six indicators into public dashboards. The staff is considering how to sequence the development of the dashboards, how to effectively incorporate public engagement into the process, and whether to prioritize this project by reallocating staff resources.

    c. Success metrics: Data are being used by advocates and incorporated into community planning and state policy proposals and analysis. Users report the data is valuable to their planning, analysis and advocacy.

<u>**Aspirational goal:**</u> Community mental health indicators are reported and discussed on parity with health, employment, safety and other societal measures.

2. Curating an inventory of county plans and programs to improve community planning.

The Commission has begun efforts to aggregate and analyze data on MHSA-supported programs, including information from three-year and annual plans, Prevention and Early Intervention and Innovation plans that captures program descriptions and outcomes, revenue and expenditures. The information would enable community members and practitioners to assess services and the allocation of fiscal resources; develop new strategies and partnerships; and, design new programs and services.

a. Who is being served: Consumers and advocates at the community level; practitioners and county staff responsible for developing community-informed plans; the Commission and county partners interested in working together to develop better practices.

b. Status: The Commission's website has an inventory of all county three-year and annual plans; revenue and expenditure reports, PEI and Innovation plans. The staff piloted an effort to glean data and information from county plans to enable users to use data more efficiently from the reports for planning, advocacy and evaluation. The staff, however, found it extremely difficult and time consuming to glean any consistent and reliable data. While, community members have told the Commission this data would be valuable, the current reporting regulations and practices do not result in usable data.

To begin addressing this issue, the staff is developing a template that would improve data the counties report regarding those who receive services funded through the PEI and Innovation components. While this is a narrow data set, it would begin an evolution toward improved data quality and the Commission's ability to identify needs and gaps.

> **For example: Fiscal Transparency**
>
> Over the last six years, the Commission responded to calls for more transparency regarding the expenditure of MHSA funds, and the size of reservices, in particular.
>
> Dashboards have been developed that show the revenue, expenditure by major program area and reserves for each county over time.
>
> The Commission is now working with state and county partners, which gather and provide the data to the Commission, to reconcile differences in the data and increase the frequency in reporting.

The most recent available financial data is from 2017 and county behavioral health directors and the state Health and Human Services Agency do not agree on the accuracy of key data elements. The Commission is working with the counties and state agency to reconcile the differences and be able to provide more current data.

Community members and working partners have affirmed they would find significant value in high quality data on the quality and outcomes of services that are offered, as well as who is being served by those programs. A long-term plan is needed to evolve the data reporting requirements to support that goal.

c. Success metrics: Data are being accessed by consumers, advocates, county staff and policymakers; users report the information is valuable to their planning, analysis and advocacy.

Aspirational goal: Advocates, analysts and practitioners are using the tools and information to inform fiscal and program decisions. The Commission and other governmental and civic partners are using the tools and information to focus technical assistance and capacity building activities.

3. Recommending ways to improve mental health strategies and outcomes.

The Commission compiles data and research with public input to align and adapt statewide policies and community programs with effective approaches to improve outcomes. For example, the Commission recommended ways to reduce criminal justice involvement, which informed significant new spending on mental health diversion programs. The Commission crafted and is implementing a statewide suicide prevention strategy. Its school mental health review and report inspired the Mental Health Student Services Act.

a. Who is being served: Consumers and advocates impacted by intended outcomes; policymakers and analysts concerned about specific outcomes. Public partners concerned with specific outcomes.

b. Status: The Commission has completed three projects that produced comprehensive recommendations for state policy and community practice: Reducing criminal justice involvement, preventing suicide and supporting mental wellness in students. All three reports catalyzed significant implementation efforts. The Commission in the next few months is expected to finalize two reviews requested by the Legislature and issue recommendations on a state strategy for advancing prevention and early intervention in mental health and for improving work-related mental health supports. The Commission staff is developing ways to strengthen internal capacity to develop these reviews and leverage more change.

c. Success metrics: Recommendations are incorporated into policies, county plans and practices; outcome indicators show improvement.

> **For example:**
> **Reducing Incarceration**
>
> The Commission deployed its own recommendations through an "Innovation Incubator" that helped more than two dozen counties develop system-level changes to reduce the arrest and incarceration of people with unmet mental health needs.
>
> The counties participated in one or more of six different collaborative projects that built capacity for data and fiscal analysis, comprehensive crisis response strategies, continuous improvement of FSPs, and deploying psychiatric advanced directives.
>
> Nearly every county in the state participated in follow up webinars and virtual workshops to understand how they could replicate the improvements.

Aspirational goal: The Commission is a trusted source of data, information and analysis and its policy recommendations are driving policy and system changes that improve desired results.

4. Linking consumer-level data across service systems to understand the impact of mental health needs and services.

The Commission links consumer-level data across service systems to understand how mental health challenges and services impact the health, safety, education, and employment of Californians. This information is used to inform the Commission's own research and the research of others, as well as state and community choices intended to improve outcomes for individuals.

> **For example:**
> **Full Service Partnerships**
>
> The Commission's analysis of "Full Service Partnerships" revealed that individuals who stayed in these comprehensive programs were less likely to be incarcerated.
>
> But the analysis also revealed room for improvement. The Commission engaged a set of counties to pilot better data collection.
>
> The Commission, through its Innovation Incubator, also supported a six-county collaborative to develop Innovation plans crafted to improve outcomes and reduce disparities. Several other counties are considering joining the collaborative effort, with one county establishing its own Innovation project to do so.

a. Who is being served: Consumers and advocates; policymakers and analysts; the Commission and local planning councils.

b. Status: The Commission has assembled the following data sets and is in the process of analyzing and releasing informational dashboards that show the relationship between services and outcomes.

> ➢ Health and Human Services Agency mental health consumer data. Every six months, the Commission receives data on individuals who received services through the specialty care (Client Service Information or CSI data set) and Full Service Partnerships (FSPs). The data sets provide a foundation for establishing linkages to other service systems.

> ➢ Birth records. The Commission has received birth records for the previous 20 years. The staff needs to clean, match and analyze to surface information regarding for example maternal mental health.

> ➢ CA Department of Education student data. The Commission has received three of five requested data sets. The staff is cleaning and matching the data, which will allow a baseline analysis of the educational outcomes of students with mental health needs.

> ➢ Employment Development wage data. The Commission has received its first batch of employment data and has requested updated quarterly wage data. The staff is cleaning and matching the data and will then analyze the data to explore the relationship between services and employment.

> ➢ Department of Justice arrest and incarceration data. In 2016 the Commission received three decades of data and is in the processing of developing a new data use agreement with the Department of Justice. The data revealed a strong connection between participating with Full Service Partnerships and reducing arrests and incarceration. But the analysis also catalyzed efforts by the Commission, working with counties, to better

understand when and how FSPs were effective and how to improve outcomes. Analysis also has revealed that those who have been served in an FSP or by specialty care were, upon arrest, much more quickly found to be incompetent to stand trial. The data also revealed racial disparities, with more time passing for Black defendants before an IST finding was made. The Commission is assessing the implications of the data.

➢ Death records. The Commission has death records for the previous 20 years. The data needs to be cleaned and will be matched to reveal relationships between mental health services that are offered and the age and manner, such as homicide and suicide, and cause of death, such as by gunshot wound.

The Commission also is requesting the following data sets from other state agencies:

➢ Department of Social Services Child Welfare Data. This data would begin to reveal the relationship between mental health services and out-of-home placements.

➢ Hospitalization data from the Department of Health Care Access and Information (formerly the Office of Statewide Health Planning and Development.) The Commission has requested this data, but the department turned down the request. The data would reveal how often mental health clients visit emergency departments and are hospitalized.

➢ Medi-Cal usage data. The Commission has requested data on who has received mental health services funded by Medi-Cal, which would enable analysis regarding those who have received treatment for mild and moderate conditions.

c. Success metrics: Data are being accessed and found to be valuable by consumers and advocates; county staff, practitioners and state policymakers and analysts.

Aspirational goal: The Commission's data and analysis are promoting models for whole person care and informing state-level efforts to integrate and coordinate services in ways that improve the quality of life for mental health consumers.

5. Evaluating new initiatives to accelerate learning, adaptation, and scaling.

To drive transformational change, the Commission seeks to accelerate learning by improving evaluations and distributing learnings. Some of those evaluations are required as part of Innovation projects or other community programs. Some of those evaluations include projects managed by the Commission.

a. Who is being served: Consumers and advocates impacted by intended outcomes; policymakers and analysts concerned about specific outcomes. Public partners concerned with specific outcomes.

b. Status: The Commission selectively evaluates existing and pilot interventions to determine effectiveness and identify opportunities for improvement and replication. The Commission is evaluating the impact of $75 million in "Triage" grants provided to communities and will soon begin evaluating $250 million in grants provided by the Mental Health Student Services Act. The Commission also will be launching an effort to assess the collective impact on systems improvements of Innovative projects and collaboratives.

c. Success metrics: Recommendations are incorporated into policies, county plans and practices; recommendations guide future funding decisions; and outcome indicators show improvement.

Aspirational goal: Timely evaluations are promoting refinements to policy, supporting continuous improvement in implementation, and enabling the adaptation and replication of effective strategies and services

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For example: Evaluating Triage

The Commission administers the S.B. 82/833 Triage grant programs, which funds local capacity for a continuum of crisis services (e.g., crisis intervention and treatment, case management, referral and linkage).

The Commission is conducting a formative/process evaluation to understand barriers and facilitators to program implementation, and a summative evaluation to understand the programmatic impact on client outcomes (e.g., reducing ER visits, inpatient hospitalization, and arrests).

AGENDA ITEM 3

Information

Update on the Commission's Triage Summative Evaluation Plan

February 16, 2022 Research and Evaluation Committee Meeting

Summary: Commission staff will present on how Committee and public member feedback was incorporated into the Triage summative evaluation plan, and the progress made in data collection and implementing the evaluation.

Background: The Mental Health Services Oversight and Accountability Commission (Commission) leads the statewide evaluation of SB 82/833 Triage Crisis Services (Triage) grants to counties. These grants allow counties to increase local capacity by hiring personnel to provide crisis intervention, diversion from jails and hospitals, and linkages to mental health treatment appropriate in the community.

The Triage Summative Evaluation Plan seeks to understand the impact of Triage crisis services on post-crisis emergency department use and hospitalization, arrests and recidivism, employment, and educational outcomes (for children).

Commission staff presented the draft Triage Summative Evaluation plan to the Research and Evaluation Committee on September 1, 2021. The Committee discussed the complexities and challenges of the evaluation and endorsed moving forward with the proposed evaluation plan with the recommendation to incorporate feedback given in the September 1, 2021 meeting.

Presenter: Kallie Clark, PhD, Commission Staff and Senior Research Data Analyst

Enclosures (2): (a) Executive Summary of Triage Summative Evaluation Plan; (b) Summary of Responses to Committee and Public Member Comments

Handout (1): PowerPoint presentation

BRIEF OVERVIEW: STATEWIDE EVALUATION PLAN FOR SB 82/833 FUNDED TRIAGE PROGRAMS

BACKGROUND: Senate Bills (SB) 82 and 833 provide funds to local behavioral health departments to hire personnel to provide crisis intervention, treatment, and case management services to adults, transition age youth (TAY) ages 16-24, and children experiencing mental health crises. The legislative objectives of SB 82 /833 are to expand crisis treatment services, reduce unnecessary hospitalizations and inpatient stays, reduce recidivism, improve client experience, and expand the continuum of care to include early interventions and treatments to improve client outcomes. Funds provided under SB 82 / 833 are referred to as Triage grants, while the services provided with them are called Triage services, and programs implemented pursuant to the grants are referred to as Triage programs.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) is conducting a statewide impact evaluation of Triage services. The evaluation is in response to a state audit which found inconclusive impacts of the first round of grants provided through SB 82. The current evaluation focuses on the second round of Triage grant funds which were provided to 19 counties and the City of Berkeley. The 20 grantees provide a total of 30 Triage programs: 15 for adult/TAY clients, 11 for children and families, and four to school-county collaboratives. Grantees are allowed great flexibility to customize services to meet the needs of clients. This is important as it allows Triage funds to be targeted where and to whom there is the greatest need within each region. However, this flexibility also presents challenges when trying to determine if Triage funds have an impact on client outcomes.

DATA: Conducting a statewide evaluation of this magnitude and breadth requires bringing together data from numerous state agencies including the Department of Health Care Services (DHCS), Employment Development Department (EDD), Department of Social Services (DOS), Department of Health Care Access and Information (HCAI), Department of Justice (DOJ), California Department of Education (CDE), and the California Department of Public Health (CDPH), and Client Services Information (CSI) from individual counties.

**OUTCOMES:** To measure the legislative goals of SB 82/833, the following questions will be addressed:

1) Do Triage programs:
   a) Reduce psychiatric hospitalizations?
   b) Reduce the rate of mental health emergency department encounters?
   c) Reduce arrests and recidivism (for adults and youth)?

d) Increase participation in gainful employment (for adults and youth)?
e) Increase school participation (for children 16 and under)?
f) Increase academic performance (for children 16 and under)?
g) Provide linkages to other behavioral health services and increase provision of those services?

METHODS: To measure the potential impact of SB-82/833 funded programs, outcomes for individuals who receive Triage services will be compared to outcomes for individuals who do not receive Triage services. While such a comparison might sound simple, this evaluation poses numerous challenges. First, as grantees are encouraged to customize services as needed, there is no singular program model. The wide variation in services provided makes it difficult to assess whether Triage services overall have an impact. It could be that certain types of services for certain populations have an impact where others do not. Second, clients who receive Triage services may differ from individuals who do not receive Triage services, making a comparison between the two groups difficult. Third, clients who received Triage services could have received them at any point during the grant cycle. Time-related differences in environmental factors, such as the COVID-19 pandemic, mean clients who received Triage services near the start of the grant may have experienced different external factors than clients who received Triage services later in the grant cycle. To address these potential issues, one or both of the following methods may be used in the evaluation:

Difference-in-Differences (DID): DID is a method that compares outcomes for groups of people over time, specifically before and after an intervention. For example, City A and City B share a police force. City A is interested in reducing speeding violations and installs newly designed speed limit signs. To see if the speed limit signs have an impact, researchers could compare City A's pre- and post- citation rates to neighboring City B's citation rates over the same time. It is not necessary that City A and City B have identical citation rates, only that *trends (ups and downs)* in citation rates *before* the intervention are similar. If the trends follow similar paths it indicates that both cities are responding to changes in the environment similarly. If they are, then trends after the intervention can also be compared to see if the trends continue to follow a similar path (the intervention had no impact) or different paths (the intervention had an impact).

Figure 1: Example of Difference-in-Differences Method

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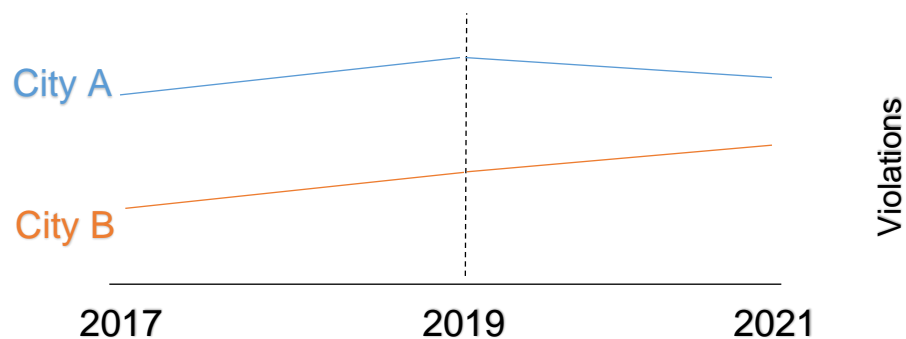
Propensity score matching: The accuracy of the DID method is dependent on the similarities between the intervention and comparison groups. In the example above, this would mean drivers in City A must be like drivers in City B in key ways that we believe might impact their response to the environment. What if drivers in City A, on average, have higher incomes and have higher levels of education than drivers in City B? It may be that post 2019, residents of City A were more likely to work from home during to the COVID-19 pandemic. In this case, the "impact" we see could really be the work of socioeconomic disparities and not new signage. When the two groups researchers want to compare are different in important ways, a method called propensity score matching can be used to account for these differences. Propensity score matching calculates each individual's likelihood of experiencing the intervention and then matches individuals in the intervention group with individuals in the comparison group who have similar scores. In the example above, this would mean calculating the likelihood that individuals would live in City A, regardless of where they actually live, then matching each individual in City A with a similar individual in City B. Once the groups are balanced, researchers can then compare citations for individuals in the two groups.

Between-group differences: This evaluation seeks to understand the impact of Triage grant-funded services statewide across several outcomes. Given the differences in Triage services offered and populations served across counties, it would be surprising if Triage services have a measurable impact overall. It is more likely that some programs may have impacts for some subgroups of individuals. For instance, it could be that Triage services have an impact for children in school-based programs; however, the number of children who receive Triage services in schools is not large enough to see an increase overall across the state. Therefore, in addition to a statewide overall evaluation, MHSOAC researchers will also examine outcomes by geographic region, program type, and several client characteristics including age, gender, race and ethnicity, primary diagnosis, whether clients have multiple diagnoses, trauma exposure, country of birth, and primary language. Identifying subgroups of individuals impacted by Triage services could aid counties in better targeting Triage services to maximize impact. It could also inform areas where innovation might be used to better impact subgroups of clients with unmet needs.

TIMELINE: Data collection, linking, and analyses is an iterative and ongoing process, occurring concurrently with stakeholder feedback. The preparation phase for the final summative report is projected to end in early 2023, and the final report is scheduled for public dissemination by June 2024

LIMITATIONS: Receiving accurate and complete data from state agencies and counties is bedrock to the success of this evaluation. Excessive missing, incomplete, or inaccurate data would hinder the accuracy of the evaluation. In addition, it is imperative that intervention and comparison groups be similar enough to draw comparisons. It is possible, even with propensity score matching, that individuals who receive Triage services may differ from individuals who do not receive Triage

services in ways that aren't measured in the data. Lastly, there is some concern of "spillover effects," where individuals who receive Triage services may have an impact on individuals who do not receive Triage services, thus reducing the estimated impact of Triage services. This would be most prevalent for individuals living in the same home or sharing the same social group. Researchers expect the likelihood of spillover to be nominal in an evaluation of this scale.

MHSOAC
Mental Health Services
Oversight & Accountability Commission

SUMMARY OF COMMITTEEAND PUBLIC FEEDBACK ON TRIAGE SUMMATIVE EVALUATION PLAN
From September 1, 2022 Research and Evaluation Committee

FEEDBACK THEME	FEEDBACK (SUMMARIZED)	HOW WILL THE FEEDBACK BE ADDRESSED?
Evaluation Design	Suggestions for ways you might additionally organize your data: multi-level / discrete time models.	We anticipate using hierarchical models to disentangle county level differences. We also anticipate using discrete time models.
	How do you index that initializing event for comparison clients?	An important feature of matched clients is the assignment of an initial Triage event date to both Triage and non-Triage controls. A window of time (depending on the type of event) will be used to match Triage to non-Triage clients.
	Recommend comparison clients are within the same county... the benefits of this approach outweigh any 'spillover' limitations mentioned.	Where possible this will be done. However, this may not be possible for smaller counties who may not have a large enough sample.
	One of the great services you could do for the people of CA is to indicate to them how this would have been much easier if the evaluation was planned from before or at the same time as the program was planned.	We will discuss this point in the report. Due to circumstances, the evaluation did not begin until after the programs were planned and implemented. To address this Commission researchers are providing standardized data definitions and outcome variables.
	Overarching support for and desire to include Whole Person Wellness / Quality of Life outcomes measures. Keep a focus on consumer centered / wellness outcomes / satisfaction measures.	This is an important consideration. The Triage grants did not require a standardized quality of life (QoL) assessment to be administered to Triage clients. A core component of the evaluation is comparing outcomes for Triage to non-Triage clients. As we are not able to assess QoL measures for individuals who do not receive Triage services, we are not able to assess improvements of QoL resulting from participation in a Triage program.

Data Quality / Source		
	Incorporate CRDP statewide evaluation core measures.	The California Reducing Disparities Project is a helpful resource to guide evaluation design and interpretation of results. Unfortunately, individual-level data on core measures are not available to evaluators. Thus, we will mention this in the limitation sections.
	To what extent does this summative evaluation methodology exclude a population due to missing SSNs?	With enough client-level data, we can link some data bases without SSN. However, certain database linkages (DOJ and OSHPD) rely on SSN. Part of our initial assessment is an examination of what populations are over/underrepresented in each data set. This is critical to understanding the limitations of the evaluation. This concern will be addressed in baseline equivalence and limitations section.
	Difference in difference design – I am concerned that services given to people in Triage group are taking away services available for-control group.	By design the DiD evaluates trends before and after an intervention. If resource rationing is occurring, and a shift in resources is happening from control group to Triage group, we should see evidence of such reflected in the trends.
	Peer to peer for youth. Look at youth ambassador programs and what they are doing / what impact they are having.	We plan to evaluate whether programs that incorporate a peer-to-peer component have a differential impact on Triage clients' outcomes.
	It would be helpful to have an inventory of what Triage counties are doing and did (Round 1 Round 2) and what mattered to the various counties and perhaps come up with this notion of core measures.	We are currently working with partners on a categorization of Triage programs. This will help us make meaningful interpretations of results. Comparing the effects associated with point of access would be an important feature we plan to pursue.
	Knowing what services were successful is important. If you could compile a dataset that tells us what the counties are providing and what was the maximum number of events that was most successful, we could funnel resources into that direction.	Identifying the type and number of services provided to Triage clients could be informative. While evaluating post-Triage services is not the focus of this summative evaluation, this could inform an exploration of best practices.
	Applicants should build in a readiness component on how ready they are to report on metrics and what their tech assistance needs would be to collect data in a more uniform way.	While outside the scope of the summative evaluation, these are important questions to consider during the application review process. Some of this may also fall within the scope of the formative evaluation being conducted by UCLA and UC Davis.

	Include Child and Adolescent Needs and Strengths (CANS) data andC18)	We have explored whether we can integrate CANS and ANSA in the evaluation but not all county programs administer and/or document CANS and ANSA. We will include this information in the limitation section, as there is no uniform way to assess QOL in the MHSA programs.
	Here's a story of some of the work we did, largely based on existing data. Some of the programs referenced here and in the video were INN and SB82 programs we had. https://www.sas.com/en_be/customers/san-bernardino-county-health.html	While there is not the level of detail to include in our evaluation plan it is helpful to see what best practices others are implementing.
	If/when DHCS can get more detailed data of service types, that can also be useful. We had procedure codes that were quite useful in providing a more complete story.	We must agree with the counties which detailed data we want to universally collect (prioritize needs). Efforts to improve and standardize the information provided to DHCS could allow for more meaningful evaluation of services funded through the MSSA would be welcome.
Equity	Make sure whatever key variables will be collected be standardized from the beginning. Making sure the data is there.	We are providing grantees with data dictionaries and templates to increase standardization of variables.
	As far as Triage, it's my impression that people of color are not diverted as often or given opportunities to avoid things like incarceration. I'd be interested to see if Triage serve BIPOC populations proportionally.	We plan to do sub analysis to see whether BIPOC populations receive services proportionally and /or impacted differently than their non-BIPOC peers.
	Disaggregate data by race/ethnicity	We will do sub-analysis by race/ethnicity and other demographic and clinical categories
	Standardize definitions and within race/ethnicity: SES, rural/suburban, parents' educational attainment	This is key to the sub analysis. Race and ethnicity are self-identified. SES, rural/suburban and education are all standardized.
	Understand that cultural differences create in different manifestations of MH conditions, and many BIPOC identify their MH symptoms as physical health problems.	The underreporting of mental health conditions among BIPOC is a great concern. This evaluation is looking at whether additional funding improved outcomes for those that do receive services. It is a limitation that we cannot speak to those that do not.

Workforce or System Issues		
	Do you think that system design / how a model is architected in a local ecosystem plays a role here?	How a Triage program is implemented and the mental health infrastructure within a county will certainly affect the outcomes being measured. To the extent possible, Triage program type and county mental health infrastructure will be accounted for in the multilevel statistical models. Thus, between county effects will be considered. Moreover, since Triage clients and their controls are from the same county, the effects of mental health infrastructure upon the Triage clients and their controls within a given county are similar.
	988 will significantly impact how folks access care so keep that in mind. There is a 988 system in development for Calif (and nationally), and the recent school MH initiative contemplates a digital portal.	The 988 system and the Governor's Child and Youth BH Initiative will not be fully implemented in time to impact the Triage round II programs
	My recommendation and thought about this are to keep in mind the impact on the workforce who is providing these services... a confound will be not so much that a client did or did not receive a service but how overburdened staff is in providing these services.	This point is important for how individuals interpret potential null results. The formative evaluation may shed light on workforce issues and quality of service delivery. The formative evaluations are being conducted by UCLA and UC Davis. We will work to communication between evaluators and stakeholders when framing findings.
	Look at system-level issues rather than place the 'problem' within the individual who has been diagnosed and is receiving services	The evaluation is examining whether additional funding through SB 82/833 improves outcomes for individuals with unmet mental health needs. Therefor the conclusions from this evaluation are not at the individual level, but rather whether increasing funding to the system leads to better outcomes for individuals.
	Capacity Issues for data and reporting. Symptom of the lack of priority on data and analytics (research, evaluation, quality improvement, etc.) across behavioral health (and frankly broader healthcare). This is common nationwide (and internationally).	The change to more data-driven decision-making takes time and resources. The Commission had done the first steps at the statewide level, and we must carefully evaluate the yield (meaningfulness, ability to inform decisions) considering the grantee effort of additional data collection and reporting.

AGENDA ITEM 4

Information and Discussion

Transforming California's Mental Health System and the Need for Robust, Comprehensive Metrics

February 16, 2022 Research and Evaluation Committee Meeting

Summary: The Committee and public will hear a presentation from representatives of Children Now on children's mental health measures collected in California, the importance of comprehensive and unified measures to tell the story about how children are faring, and measurement gaps and opportunities, particularly in light of the transformation underway in the children's mental health system.

Background: The Mental Health Services Act (MHSA) was crafted to support transformational change in mental health care and the Mental Health Services Oversight and Accountability Commission was given the authority and responsibility to drive that change across service systems. The Commission works through partnerships to catalyze transformational changes across service systems so that everyone who needs mental health care has access to and receives effective and culturally competent care.

In 2021, California recommitted to driving transformational change in the mental health system with a focus on children and youth. The Governor's *Children and Youth Behavioral Health Initiative (CYBHI)* is a 4.4 billion investment to reimagine the systems that support behavioral health and wellness for California's children and youth into an innovative, up-stream focused, ecosystem which are inherent to MHSA.

Given these changes underway, policy makers and children's advocates have called for the establishment of shared statewide goals and metrics for the children's mental health system that all state and local agencies and their partners can collaborate on and are responsible for.

Presenters: Lishaun Francis, MPP, Director of Behavioral Health, Children Now
Fatima Clark, MSW, Associate Director, Health & The Children's Movement Equity Fellowship, Children Now

Discussants: Lynn Thull, PhD, President, LMT & Associates, Inc.
Katherine Watkins, MD, MSHS, Senior Physician Policy Researcher, RAND Corporation

Children Now is highly respected across California for their research, policy, communications, and network building expertise on child-serving systems, financing, programs, and practices. For more information about Children Now, please visit their website at www.childrennow.org/.

Enclosures (1): (a) Children Now's Report *Robust Data Systems Needed for California's Child Behavioral Health*.

Handout (2): PowerPoint presentation; Research and Evaluation Division Staff Deliverable Options.

Additional Reference (1): California Behavioral Health Measures for Kids (Table). (**Link:** https://airtable.com/shrSPVt7cy7ZMifTX/tblEafwxQgQ9YooMD) This is an addendum to Children Now's Report, *Robust Data Systems Needed for California's Child Behavioral Health*

Robust Data Systems Needed for California's Child Behavioral Health

November 2021

Children Now®

Introduction

Recent news reports highlight the negative behavioral health outcomes that many children, youth, and families are experiencing in California. However, the state government is failing to move beyond these important media anecdotes to understand what's really happening with kids via the collection and analysis of timely, comprehensive data. Statewide monitoring and reporting are critical activities for promoting positive policy outcomes, yet historically there has been little focus on collecting metrics that would help California understand whether certain investments had the desired outcomes. Children Now examined the current data metrics collected by the State on children's mental health and substance use, and identified the major gaps that must be closed to allow California to not only track its progress, but also be specific in the outcomes it seeks. Currently, state data reports do not show how children are faring in a comprehensive way – instead, they are a collection of data points lacking a specific goal or outcome that would allow the State, children, and families to determine if needs are being met. A better data system is needed in order to track outcomes as well as identify emerging population needs for diverse groups of children so that effective supports can be expanded.

Methodology

Children Now reviewed various state agency websites to identify publicly reported data on children's behavioral health (see Table 1). In addition to state agency sites, we reviewed data reported publicly by universities or other groups in partnership with state agencies, such as the University of California, Berkeley's Child Welfare Indicators Project. Most of the measures included in our analysis are specific to mental health and substance use disorder (SUD) services, however, some measures reflect outcomes indirectly tied to mental health and substance use (e.g., missed school days). Our analysis does not include an exhaustive list of all the measures collected by state agencies because we only included those measures where data was available within the past three years. This led to some measures, such as Maternal and Infant Health Data, not being included in our analysis. The data gleaned are based on utilization, claims/expenditures, and self-reported survey responses from children and youth. Metrics collected but not reported publicly are not included in this report.

Table 1. Data: Sources & Limitations

Source	Type of Available Data	Data Limitations
Department of Health Care Services	Utilization of mental health services, most common diagnoses, health plan quality measures, timely access to mental health providers, mental health provider network availability.	Lack of data specific to pediatric populations across all public reports and data sets; Lack of consumer satisfaction, quality, and outcomes data, inconsistent race/ethnicity and geographic stratifications across all reports and data sets; Lack of disaggregated data on children and youth in foster care, children and youth with child welfare involvement, and children and youth with juvenile justice involvement, and very young children (ages 0-5) across all reports and data sets.
Department of Education	Youth self-reported mental health needs, substance use, school climate, and availability of supports.	Data disaggregation not available for all age ranges and race/ethnicity groups; Lack of disaggregated data on young children and children and youth in foster care, children and youth with child welfare involvement, and children and youth with juvenile justice involvement.

Department of Social Services (Continuum of Care Reform Dashboard)	Number/percentage of youth in foster care or with child welfare involvement who received a specialty mental health service. Number/percentage of children in foster care for whom a child welfare worker completed a required mental health screening. Data on psychotropic medication usage.	Lack of consumer satisfaction, quality, timely access, and outcomes data. Lack of data on mental health services across delivery systems or payors. Specialty mental health utilization data lacks disaggregation for certain service types. Lags in data availability. Lack of consistent data on outcome, follow up, or service receipt after a mental health screening.
Mental Health Services Oversight and Accountability Commission	Utilization of services and outcomes related to utilization.	Inconsistent availability of data specific to pediatric populations.
California Health Interview Survey (University of California, Los Angeles)	Youth self-reported mental health needs, substance use, and help seeking behaviors.	Data is often unreliable due to small sample sizes.
California Child Welfare Indicators Project (University of California, Berkeley)	Utilization of and authorization for psychotropic medications among youth in foster care and metabolic monitoring for children on psychotropic medications.	Lack of consumer satisfaction, quality, timely access, and outcomes data. Lack of data on what psychosocial services youth received in lieu of or as an adjunct to psychotropic medication. Lag times in reporting of data.
Kidsdata.org	Prevalence of youth mental health related hospitalizations and completed suicides.	Lack of race/ethnicity breakdowns and inconsistent geographic stratifications.

Results

The landscape scan identified nearly 80 metrics for analysis.[1] We categorized measures into two main groups of indicators:

Population indicators – metrics that describe characteristics of the child population with regard to behavioral health, including: Known Prevalence, System Use, Outcomes, and Early Identification.

- **Known Prevalence:** Refers to the prevalence rates of mental illnesses and substance use.

- **System Use:** Identifies the degree and manner in which consumers utilize the system.

- **Outcomes:** The impact of the health care service or intervention on the health status of patients.

- **Early Identification:** Allows providers or the system to know who is at-risk for larger behavioral health issues.

System performance indicators – metrics that describe how the child behavioral health care system is functioning, including: Access, Quality, and Consumer Satisfaction.

- **Access:** Identifies issues of coverage, the availability of services, timeliness in receiving services and the availability of workforce.

- **Quality[2]:** Identifies "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

- **Consumer Satisfaction:** Measures consumer experiences and satisfaction with services.

Within the nearly 80 metrics, the categories are not equally represented. See Table 2 for a breakdown.

Table 2. Categorized Measures

Group	Type of Domain	Number of Measures*
Population Measures	Known Prevalence	15
	System Use	24
	Outcomes	6
	Early identification	39
System Performance Measures	Access	18
	Quality	4
	Consumer Satisfaction	0

* Measures may fall under more than one domain.

View chart for full list of measures, with descriptions.

Our analysis revealed a number of metrics dedicated to Access, System Use, Known Prevalence and Early Identification, but few dedicated to Outcomes, Consumer Satisfaction and Quality. The scan also revealed significant gaps in disaggregated demographic data related to the age, race, ethnicity, sexual orientation and gender identity, and geography of those experiencing behavioral health concerns. There also remain large gaps in data available for special populations, such as children and youth in foster care; children and youth with child welfare system involvement; and children and youth with juvenile justice involvement. Finally, given the many spaces in which behavioral health needs can arise for children (at home, in community, at school), there is an abundance of data missing from non-clinical settings. Additionally, the data available is fragmented with no consistent data to show what children are receiving across delivery systems or using funds beyond Medi-Cal.

Opportunities for Better Behavioral Health Data

There are a number of challenges when it comes to improving data collection, including but not limited to: lack of technical support around data collection, lack of cross-sector data sharing, concerns around consumer privacy violations, and different sectors using differing definitions for variables, which may lead to inconsistent data collection. There are, however, major opportunities to overcome some of these challenges through new initiatives, such as the State's Children & Youth Behavioral Health Initiative and Cradle-to-Career Data System.

Children & Youth Behavioral Health Initiative. In Fiscal Year 2021-2022, the Health Omnibus trailer bill (Assembly Bill 133) established the Children & Youth Behavioral Health Initiative (CYBHI), investing over $4 billion in the children's behavioral health system. CYBHI is intended to be cross-sector and payor agnostic—great tenets for better outcomes for children and youth. The initiative also signals a desire for better data. For example, AB 133 creates an incentive program for Medi-Cal managed care plans that allow for payments to those plans that meet predefined goals and metrics associated with targeted interventions to increase access to preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers for children in schools. AB 133 directs the Department of Health Care Services, Department of Education, Medi-Cal managed care plans, county behavioral health departments, and local educational agencies to "develop the interventions, goals, and metrics used to determine a Medi-Cal managed care plan's eligibility to receive the incentive payments. Given the legislative directive, there is an opportunity to collect new data and improve existing data, activities that would help ensure the most useful metrics are adopted and accompanying programs implemented.

Cradle-to-Career Data System. In the 2019-2020 State Budget agreement, $10 million in one-time funding was provided to plan for and develop a longitudinal data system. The Cradle-to-Career (C2C) data system seeks to connect data from early education providers, K–12 schools, higher education institutions, employers, other workforce entities, and health and human services agencies. This data effort would integrate an array of information, allowing service deliverers to address disparities in opportunities and improve outcomes for all of California's youth. The system would connect some 11 major sources of data – importantly, the State is NOT

creating a new data collection enterprise, but is building on the systems that already exist – and be analyzed and managed in ways that help agencies plan for and improve delivery of service; support families and educators in identifying opportunities and making decisions; and support research on improving policies from birth through career. The C2C will create publicly accessible resources (e.g., dashboards and customizable query tools); provide community-sensitive outreach to promote awareness and understanding; and provide both training and technical assistance at every level, so that all who might benefit from this information system will be able to do so effectively. C2C has the potential to transform how children receive the host of services they need to thrive and succeed in life.

CalAIM's Population Health Management Service. As part of the major Medi-Cal package of reforms known as California Advancing and Innovating Medi-Cal or "CalAIM," the 2021-22 State Budget includes $300 million to build out a Medi-Cal Population Health Management (PHM) service that will utilize administrative and clinical data and information for the Department of Health Care Services, Medi-Cal managed care plans, counties, providers, beneficiaries, and other partners to use in support of the delivery of care for all Medi-Cal beneficiaries. The PHM service is intended to bring individual administrative functions throughout the Medi-Cal program together and provide a holistic approach to delivering Medi-Cal to Californians. At a high level, the PHM service is expected to provide the following, including but not limited to:

- Flag candidates for potential case management and indicate levels (e.g., basic, complex, or Enhanced Case Management) to result in improved care coordination, more appropriate health care utilization, and reduced low-value/high-cost care.

- Provide beneficiary-specific care manager and contact information and promote collaboration across program and administrative silos.

- Contain all Medi-Cal standard assessments to streamline impact to beneficiaries being provided multiple assessments; and support the initial and annual maintenance of assessments.

- Provide information about social determinants of health.

In addition to the CalAIM PHM, the forthcoming Medi-Cal Comprehensive Quality Strategy from the Department of Health Care Services is expected to focus heavily on behavioral health integration as one of the main pillars. Taken together these efforts – for better Medi-Cal data and a better use of the Medi-Cal data – can shift the Medi-Cal behavioral health system towards a more equitable and outcomes-focused use of resources.

Changes to Data Collection Needed

California will need to make significant changes in order to properly identify, support, and treat children. Cross-sector collaboration, oversight, and accountability are critical to ensuring the State is meeting the needs of children and youth who have a behavioral health challenge or are at high risk of developing a behavioral health need based on trauma or adverse childhood experiences. Fortunately, the State is already working on a few initiatives that have the potential to not only improve data within the health system, but across multiple sectors, reflecting the true wellness of children and youth. By focusing on improving demographic data; sharing, integrating, and matching data across sectors; tracking quality metrics; collecting consumer experiences; and stating intended outcomes, California can appropriately monitor whether its interventions are having the desired effect.

Improve Demographic Data. Making progress toward the goal of eliminating disparities requires widespread, reliable, and consistent data about the demographics of California's children. This information is needed to identify the nature and extent of disparities, target quality improvement efforts, and monitor progress. **Collecting information on the racial/ethnic, geographic, age, and sexual orientation/gender identity demographics of children and youth is vital if the State is to fulfill its equity goals.** It is particularly important for the State to take a proactive role in remedying historic and ongoing inequities related to structural racism, persistent poverty, gender-based violence, and homophobia. Measurement, reporting, and benchmarking are critical to improving care. California's current demographic data collection process falls short in its ability to adequately identify children and their possible needs. For example, state data fails to disaggregate the category "Asian-American" into its constituent groups, which can mask important and significant disparities. Within the context of behavioral health, this means that the State will be unable to understand how different ethnic groups experience systems and services, and possibly make the false assumption that access is realized under the larger Asian-American umbrella.[3] In addition to more robust data on race and ethnicity, the State does not always disaggregate data by age. Understanding the needs of children and youth based on their stage in brain development is an important part of providing the right services at the right

time. Notable gaps in existing data on age include limited information for very young children (0-5) and transition age youth (18-25)—both age groups with unique needs given their developmental stages.

Provide Disaggregated Data for Special Populations (children in foster care, children with child welfare system involvement, and children with juvenile justice involvement). Children and youth under special populations have experienced abuse, neglect, family separation, and other traumas, which can lead to behavioral health challenges that may persist into adulthood. Providing timely, high-quality behavioral health services can help them heal, yet barriers, such as multiple placement changes, lack of trauma-informed providers, fragmented and siloed systems, and unavailable or incomplete health histories, often prevent them from getting needed services. In order to understand and meet the behavioral health needs of children in foster care, state data reported for children must be disaggregated and publicly reported for children and youth in foster care. **Moreover, data should more broadly be disaggregated for children with child welfare system involvement who are not in foster care and children with juvenile justice involvement to better understand and meet their unique needs.** Given their involvement in multiple systems, cross-sector collaboration, data sharing, and oversight is critical.

Use Existing Data to Prevent and Treat Trauma. In 2019, California began providing incentive payments to Medi-Cal providers who screened children and adults for trauma. On an individual level, screening children early for exposure to adverse childhood experiences (ACEs) – including the 10 original ACEs from the 1998 ACEs study as well as additional adversities shown to negatively impact health (immigration separation, discrimination, community violence, food, or housing insecurity, etc.) – can help practitioners identify kids at risk of toxic stress (a dysregulated stress response) and harm to the developing brain and body. However, **California should be using the data to better understand population needs and aligning investments to address those needs.** For example, the current questionnaire for children asks about exposure to community violence. A population-based state policy approach to that question could guide resources to certain communities to not only help children heal from trauma but also to implement new programming that could prevent and address community violence.

Gather Information on Consumer Experiences (Satisfaction). Consumer satisfaction data measures of how well a service met or surpassed the consumer's expectations, while collected in some instances, were not necessarily publicly reported or accessible. Additionally, some publicly reported measures on consumer satisfaction reflect consumer complaints or grievances, however, data breakdowns for pediatric populations were unavailable so these measures were omitted from the landscape analysis. **The State must center the voices of youth and families to fully understand how and what aspects of the behavioral health system need to be redesigned to meet their specific needs.** The landscape scan revealed that little to no data on consumer experiences navigating systems and using behavioral health services is reported publicly. Available data is limited to consumer mental health complaints and do not reflect the specific experiences of pediatric populations. For example, available data do not show whether families and youth were satisfied with the services they received, or where and why breakdowns in access to care occurred and how barriers were addressed or resolved. Understanding the experiences of consumers, in this case, children and their families, is essential to identifying and implementing system changes that will result in increased access to and use of behavioral health services.

Focus on Outcomes. Outcomes are important because they reflect whether or not an intervention, or series of interventions were successful. Usually, outcomes are for a broad population, like all children. However, outcomes that are not unique to specific sub-populations likely will not benefit those with the highest need—like by race/ethnicity, sexual identity, or involvement in the child welfare or juvenile justice systems. **The State should create a comprehensive plan that identifies target metrics to move forward on improving children's mental health outcomes, such as dramatically reducing suicide attempts among LGBTQ+ youth.** By focusing on outcomes specific to key demographics like race, ethnicity, and sexual orientation/gender identity, California can ensure it focuses its investments to improve the lives of historically underserved children.

Focus on Quality. Improving quality can be viewed on both a macro and a micro level, as something that will require large, systemic change of the entire child-serving system and as something that individuals can practice during their interactions with children, youth, and families. A focus on quality would align meaningful measures with their respective sector, for example, schools would be able to highlight the measures that reflect positive behavioral health for the education sector, requiring both the education and mental health sectors to work together to identify those metrics that are meaningful.[4] Additionally, quality would focus on those interventions that are responsive to the needs of diverse populations—ensuring best practices around cultural competency. **California must improve quality in behavioral health by focusing on those measures that reflect positive behavioral health across sectors and instituting greater transparency and accountability of the overall child-serving system,**

while being culturally competent. Accountability and transparency would require individuals who work with children to collect uniform data, regularly following up with children and families after services are delivered and connecting children/youth to the services and supports they value. By improving quality, California can ensure consumer satisfaction is high among children, youth, and families.

In order to properly determine if the behavioral health system is having the intended impact of supporting children and youth so they can lead happy and healthy lives, we developed a non-exhaustive list of metrics for collection and reporting (see Table 3 below). With new opportunities and investments described above, the State has an opportunity to begin reporting on these largely cross-sector measures to understand outcomes.

Table 3: Suggested New Metrics

Measure	Type of Domain
Percent of children 0-5 receiving support for identified developmental or behavioral health challenge	Access
Number/percent of children who want mental health services but have not been able to obtain any	Consumer Experience/Access
Number/percent of youth who want substance use disorder services but have not been able to obtain any	Consumer Experience/Access
Percent of youth satisfied with provider	Consumer Experience/Access
Percent of youth satisfied with the frequency and type of services received	Consumer Experience/Quality
Reason for satisfaction/dissatisfaction with services or provider	Consumer Experience/Quality
Percent of parents reporting concerns about their child's development	Early Identification
Percent of parents reporting need for support for their children's behavioral health but not finding it	Early Identification/Access
Percent of children 0-5 identified with a developmental or behavioral health challenge	Early Identification/Known Prevalence
Percent of children/youth with a co-occurring diagnosis of mental health and substance use disorder	Known Prevalence
Percent of children/youth screened for substance abuse	Known Prevalence
Percent of children suspended with a mental health/substance use disorder need	Outcome/Early Identification
Number/percent of young children suspended and/or expelled from child care programs due to behavioral issues	Outcome/Early Identification
Number/percent of missed school days due to mental health related issues	Outcome/Early Identification
Percent and outcome of developmental and social emotional screenings for young children	Outcome/Known Prevalence
Percent of juvenile justice-involved youth with a mental health/substance use disorder need	Outcome/Known Prevalence

Conclusion

As California invests an unprecedented amount of funds in the children's behavioral health system, the State must also match up the measures it collects with the goals it seeks to achieve. While data collection and reporting can be complex, the ability to align programs with the needs of children and families has the potential to ensure long-term success for California's most vulnerable populations. California must improve the data it currently collects, collect new data metrics, and solicit feedback from children, youth, and families to ensure new investments in programs and services are resulting in positive outcomes.

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Sources and Notes

1   Publicly reported measures include data made available through state partnerships with other entities, such as universities or research institutions or aggregated and reported by other institutions.

2   Quality Measurement and Quality Improvement. Center for Medicare and Medicaid. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Quality-Measure-and-Quality-Improvement-

3   Covid-19 Equity Data. California Pan-Ethnic Health Network. https://cpehn.org/covid-19-equity-data/

4   Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care. National Committee for Quality Assurance. May 2021. https://www.ncqa.org/wp-content/uploads/2021/07/20210701_Behavioral_Health_Quality_Framework_NCQA_White_Paper.pdf

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February 16, 2022 Research and Evaluation Committee
Research and Evaluation Division Deliverable Options

This document presents three options for deliverables the Research and Evaluation Division staff could immediately pursue and produce. These options are centered on children and youth, connected to Commission mandates, and elevate the need for greater state and local collaboration, outcome metrics, and reporting to the public.

We present the deliverable options listed below for the Committee and public to consider and give suggestions to the Committee chair and vice chair for prioritization. Each of these options would entail dashboard development and /or data briefs, with partnered youth and community engagement.

Deliverable Options

1. Leverage existing linked data between the Client Services Information System (CSI) and educational data to benchmark and track the specialty mental health service population. For children and youth receiving specialty mental health services, the Commission has also obtained their K-12 educational data through a Memorandum of Understanding with the California Department of Education (CDE) to evaluate the impact of mental health services on educational outcomes.

Commission staff could build dashboards that give the public insight into who is being served by specialty mental health services including full-service partnerships, and their educational outcomes. The CSI data include client's behavioral health diagnoses, mental health and other service needs, and service utilization. The educational data the Commission can report on these clients includes their enrollment and attendance; English language and math performance; and disciplinary offenses and outcomes. These outcomes can be examined by student characteristics available in the CDE data such as race-ethnicity, migrant status, English learner, special education, housing status, and being in foster care.

2.   Curate data from existing published sources to increase visibility and accessibility of children and youth mental health data. Several State agencies publish data on mental health needs, and screening and treating those needs. These data alone provide a fragmented understanding of how children are faring, and whether the State is reaching and effectively serving its most vulnerable children. Thus, the Commission in its role as a curator of data, could bring together data from several different sources, to provide a fuller picture of how children are being served both at the state and local level. See the Children's Now Report *Robust Data Systems Needed for California's Child Behavioral Health* for a list of data sources and indicators

Examples of data sources that Commission staff could repackage and publish include State and county rates for:

- Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT)
- Adolescent depression screening
- Screening for youth substance use
- Medi-Cal specialty mental health client penetration and engagement
- K-12 school climate, student engagement, and well-being

3. Build upon the Commission's Community Indicators Project to track *school failure*. The Commission contracted with UCLA to engage a diverse group of experts, conduct a literature search, analyze easily available data sets, and recommend population-level indicators for each of the seven negative outcomes identified in the MHSA. To date, the Commission developed a public-facing dashboard, with community member input, on one of the seven negative outcomes—suicide—that was published in September 2021.

School failure is one of the seven negative outcomes that the Commission could prioritize next given its relevance to Commission projects (e.g., Mental Health Student Services Act) and the Committee's interest in school-age youth.

UCLA recommended tracking *school failure* using a measure of the *number of missed school days* from the National Survey of Children's Health (NSCH). The NSCH is fielded annually by the U.S. Census Bureau and provides representative national- and state-level data on children's physical and mental health, access to care, and their school, neighborhood, and family context.

State-level data can be tracked and reported on the *number of missed school days* by demographic characteristics (age group, sex, race-ethnicity, and federal poverty level), by Adverse Childhood Experiences, and by mental health needs (as determined by the NSCH survey screener).

A major limitation of this survey measure is that county-level is not available.

There are other recognized indices of *school failure* such as school drop-out that could be measured and tracked as part of this dashboard.