



DRAFT

Performance and Outcomes System Plan for Medi-Cal Specialty Mental Health Services for Children & Youth

(Version 5 – for Stakeholder Advisory Committee)

July 18, 2013

Submitted by the Department of Health Care Services
In Fulfillment of a Requirement of
Senate Bill (SB) 1009 (Chapter 34, Statutes of 2012)

Note to members of the Stakeholder Advisory Committee:

- DHCS is asking for your feedback and review before we provide the System Plan to the Legislature.
- Please provide your feedback using the Comments Form located on the DHCS website <http://www.dhcs.ca.gov/individuals/Pages/PerformanceandOutcomesSystemforMedi-CalSpecialtyMentalHealthServices-StakeholderAdvisoryCommittee.aspx>
- Email the Comments Form to the Children's Mental Health Performance and Outcomes System mailbox at cmhpos@dhcs.ca.gov no later than August 9, 2013. Thank you.

Table of Contents

Concepts and Acronyms	3
Executive Summary	4
Purpose and Legislative Requirement:.....	5
Objective.....	5
Background.....	5
Approach and Activities.....	6
Stakeholder Process and Input.....	6
Initial Steps Taken To Gather Information	8
Performance and Outcomes Matrix Development	10
Performance and Outcomes Matrix.....	11
Values Inherent in the Matrix	11
Definition of Matrix Terms.....	12
Next Steps/Implementation Strategy.....	17
Next Steps.....	17
Program and Fiscal Impact	22
Appendices	23
Appendix A: Legislation.....	24
Appendix B: Project Work Plan	26
Appendix C: List of Committee Members	40
Stakeholder Advisory Committee Meeting Participants.....	40
Subject Matter Experts Workgroup Members	43
Measurements Task Force Members	44
Appendix D: List of Meetings Held	45
Dates of Stakeholder Advisory Committee Meetings	45
Subject Matter Expert Workgroup.....	45
Measurements Task Force	45
Appendix E: Survey and Research Summary	47
Appendix F: Performance and Outcomes Matrix	52

Concepts and Acronyms

- **Domain:** Describes a global category of things within which to identify performance and outcomes and their indicators.
- **EBP/EBT:** *Evidence-Based Practice or Evidence-Based Treatment* (aka “best practice” or “preferred” approach): (APA) “the synthesis of empirical evidence, clinical expertise, and patient values in implementing treatments”; i.e. scientific evidence (clinical trials) demonstrating that a specific assessment or treatment approach works well.
- **EPSDT specialty mental health services history:** *Early and Periodic Screening, Diagnosis and Treatment (EPSDT)* In 1995, the State expanded Medi-Cal services to Medi-Cal beneficiaries less than 21 years of age who need specialty mental health services, whether or not such services are covered under the Medicaid State Plan.
- **EPSDT POS:** *Early and Periodic Screening, Diagnosis and Treatment Performance and Outcomes System:* a comprehensive set of measures or indicators designed to collect and analyze data concerning performance and outcomes as a result of specialty mental health services provided to children and youth through county Mental Health Plans. (MHP).
- **EQRO:** *External Quality Review Organization:* Federal Medicaid laws and regulations require states that operate a managed care program to provide for an external, independent review of their managed care organizations.
- **Indicator:** Describes specific subcategories within each domain; a performance measure used to monitor the outcomes of a process.
- **Outcome measure:** Outcomes reflect changes in the child and family’s life and functioning. They capture the end result of services in terms of the consumer’s expectations, needs, and quality of life; typically gathered with tools or instruments used at the individual consumer level; e.g. level of care, functioning, diagnosis, symptoms.
- **Performance and outcomes measure:** A measure which can be used for both purposes; e.g., penetration rate disparity measure as a comparison ratio, measured before and after an improvement project.
- **Performance measure:** Outputs (i.e. counts, percentages, ratios) by which to assess the quality of the organization and its work units; typically used at the Treatment or Program level; e.g., access, timeliness, retention, completion.
- **Performance measure system:** An interrelated set of process measures and outcome measures that facilitates internal measurement data on performance over time as well as external comparisons of an organization’s performance.
- **Process:** The domain that describes what happens during service provision. The term “appropriateness” is often used interchangeably with “process.”
- **Reliability:** Used to describe overall consistency of a measure: produces similar results under consistent conditions. For example, measurement of a person’s height and weight are often very reliable.
- **Tool, measure or instrument:** Standardized test, questionnaire, or survey which measures outcomes at the individual consumer level (for example., CANS, CALOCUS, CAFAS, YOQ, and many others)
 - CANS: Child & Adolescent Needs and Strengths Assessment-Mental Health
 - CALOCUS: Child & Adolescent Level of Care Utilization System
 - CAFAS: Child and Adolescent Functional Assessment Scale
 - YOQ: Youth Outcome Questionnaire
- **Validity:** Degree to which the tool measures what it claims to measure. Validity is important in determining what types of tests to use.

Executive Summary

This System Plan provides a status of activities and accomplishments to date as well as a plan for the development of a performance and outcomes system for Medi-Cal specialty mental health services provided to children and youth.

First, it looks to the future and what we want to measure. Mental health subject matter experts representing counties, providers, advocates, and the State developed a framework that describes the universe of information desired. The framework is an ideal and a work in progress; the methodology for creating it and the current version are included. The framework, referred to as the Performance and Outcomes Matrix, defines the outcome areas desired for decision-making to improve mental health outcomes for children and youth receiving Medi-Cal specialty mental health services.

Second, this Plan describes what other organizations are doing to measure performance and outcomes. The Department of Health Care Services (DHCS) performed research and used surveys to understand assessment tools used by counties and the performance and outcomes systems used by other states.

Third, the Implementation Strategy presents a phased approach to creating the Performance and Outcomes system (POS system). It describes the steps to move from the conceptual framework of the Performance and Outcomes Matrix to an information technology structure to support it.

The objectives of the legislation are to:

- Achieve high quality and accessible services for children and youth;
- Establish information that improves the practice at the individual, program and system levels;
- Minimize costs by building upon existing resources to the fullest extent possible; and
- Obtain reliable data that is collected, analyzed and compared in a timely fashion.

To achieve these objectives, DHCS will:

1. Collaborate with stakeholders to define the information needed in the Performance and Outcomes System
2. Assess what information is currently available at DHCS, the counties and providers
3. Identify an option for the first iteration of the system
4. Design, develop and implement the system
5. Prepare and train DHCS staff and collaborate with counties on the necessary training for county staff who will analyze and make decisions based on the outcomes information
6. Identify system improvements and methods to include additional data

DHCS and the stakeholders are working on the first three tasks and progress to date is documented in this System Plan.

Purpose and Legislative Requirement:

Senate Bill (SB) 1009 (Chapter 34, Statutes of 2012) requires DHCS to develop a plan for a performance and outcomes system (POS) for Medi-Cal Specialty Mental Health Services for children and youth. The statute requires that a system be developed using reliable, accessible data to inform decision-making, with the ultimate goal of improving quality of services and lowering cost of care.

Specifically, the legislation states:

Commencing no later than September 1, 2012, the department shall convene a stakeholder advisory committee comprised of representatives of child and youth clients, family members, providers, counties, and the Legislature. This consultation shall inform the creation of a plan for a performance outcome system for EPSDT mental health services.

The State Department of Health Care Services shall provide the performance outcomes system plan, including milestones and timelines, for EPSDT mental health services described in subdivision (a) to all fiscal committees and appropriate policy committees of the Legislature no later than October 1, 2013.

The complete language of the Legislation is included in Appendix A, Legislation.

Objective

This document provides the Legislature with a report on progress toward developing the performance and outcomes system. It includes a plan for developing the POS system with milestones and timelines for the next steps. It describes a framework for the performance and outcomes values and results to be measured and it describes research performed to understand how other organizations gather this information.

This System Plan is a predecessor of the System Implementation Plan which is due to the Legislature on January 10, 2014. The System Plan describes the intentions of DHCS and stakeholders whereas the System Implementation Plan will be more concrete and describe the steps necessary for doing it.

Background

In California and nationally, there has been a growing trend towards the measurement of consumer outcomes and cost effectiveness in mental health service systems. In 1991, California's Bronzan-McCorquodale Act, also known as "Realignment," shifted management, service delivery and funding responsibilities to counties, while State oversight was to focus on outcomes and performance-based measures.

In 1995, the State agreed to provide general funds to counties as an expansion of Medi-Cal specialty mental health services for beneficiaries under the age of 21, commonly referred to as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mental health services. One aspect of the Medi-Cal specialty mental health managed care program in California is the ongoing review by state and federal policy makers and stakeholder groups with the objective of continuous quality improvement. In this System Plan, we use the term “Medi-Cal specialty mental health services for children and youth” instead of EPSDT, as EPSDT is broader than mental health services.

This report is the first step toward meeting the requirements of Senate Bill (SB) 1009 (Chapter 34, Statutes of 2012) to develop a plan for a performance and outcomes system for Medi-Cal specialty mental health services for children and youth.

The legislated objectives for the project are to:

- Achieve high quality and accessible services for children and youth;
- Establish information that improves the practice at the individual, program and system levels;
- Minimize costs by building upon existing resources to the fullest extent possible; and
- Obtain reliable data that is collected, analyzed and compared in a timely fashion.

DHCS, in collaboration with the California Health and Human Services Agency (CHHS), and in consultation with the Mental Health Services Oversight and Accountability Commission (MHSOAC), has

- Formed a Stakeholder Advisory Committee
- Convened a work group and a task force of subject matter experts
- Drafted a phased implementation strategy to develop a POS system for specialty mental health services provided to eligible Medi-Cal beneficiaries under the age of 21.

Approach and Activities

As required by the implementing legislation, SB 1009,

The plan for a performance outcome system for EPSDT mental health services shall consider evidence-based models for performance outcome systems, such as the Child and Adolescent Needs and Strengths (CANS), federal requirements, including the review by the External Quality Review Organization (EQRO), and, timelines for implementation at the provider, county, and state levels.

This section describes the department’s work with external stakeholders and the research performed.

Stakeholder Process and Input

DHCS has established an inclusive process, which began with the formation of a Stakeholder Advisory Committee, to review and provide feedback on work products. Smaller, working sub groups and task forces of Subject Matter Experts (SMEs) were formed subsequently to provide their expertise in formulating and organizing performance and outcomes measures as well as

making significant contributions to this System Plan. In addition DHCS contacted the counties directly via surveys and conference calls.

Stakeholder Advisory Committee

The Stakeholder Advisory Committee is comprised of members who represent providers, counties, academics, and the legislature. An initial group of stakeholders was identified based on their knowledge and previous input to the department. Additional stakeholders have been added over time and the committee is very open to new participants. At first it was difficult to identify child and youth clients and family members, but participating advocacy groups representing the family voice have contacted members, and since April 2013 family members are represented in the Stakeholder Advisory Committee.

Stakeholder Advisory Committee meetings were held on October 4, 2012, April 30, 2013 and July 23, 2013. Meetings were open to the public as required by the Bagley-Keene Act. At the meetings, DHCS staff and SMEs presented the Performance and Outcomes Matrix, the Project Work Plan and related work products, and asked for feedback. During each meeting there was an opportunity for stakeholder and public comment during the “Question and Answer” period. Meeting materials including the work plan were provided to the Committee prior to the meetings and were posted on the DHCS website. The primary function of the Stakeholder Advisory Committee has been to review and provide feedback on materials and concepts. Committee meetings have been scheduled periodically.

The work plan is available in Appendix B, Project Work Plan. Members of the Stakeholder Advisory Committee and the list of organizations they represent are in Appendix C, List of Committee Members. Committee meeting dates are included in Appendix D, List of Meetings Held.

Subject Matter Expert Workgroup

In January 2013, DHCS formed a SME work group to develop the over-arching view of the POS system, which initially involved identifying performance and outcomes indicators for specialty mental health services. The primary function of the SME Workgroup has been to provide DHCS with recommendations on defining the domains, outcomes, sample indicators, and rationale for the information that will be needed in the system.

In order to develop the performance and outcomes matrix, a group of stakeholders was identified based on their experience and expertise in mental health performance and outcomes measures. The SME Workgroup meets, on average, two times a month.

A significant work product produced by the SME Workgroup has been the Performance and Outcomes Matrix, which provides a framework for the information desired in the Performance and Outcomes System. The Matrix outlines key domains for possible performance and outcomes indicators used to identify the effectiveness and efficiency of programs and services provided to help children and youth meet their mental health and wellbeing goals.

The SME Workgroup has also provided considerable feedback and made additions to this System Plan. Members of the SME Workgroup and the list of organizations they represent are in Appendix C, List of Committee Members. Committee meeting dates are included in Appendix D, List of Meetings Held.

Insert XX current status of workgroup/matrix in mid August.

Measurements Task Force

In June 2013, a second, smaller work group, the Measurements Task Force, was established to review several of the primary measurement tools currently used by mental health professionals at the county level. The members of the taskforce are experts familiar with the primary assessment tools used by counties and their providers.

The task force is charged with identifying assessment tools and data systems that capture the data described in the Performance and Outcomes Matrix. This data inventory will assist in determining: (a) what specific client and program level information could be collected and analyzed by the department to follow the mandate of minimizing costs through the use of existing resources; and (b) what gaps exist in data collection that will require mitigation in the future in order to adequately assess clients' progress and the effectiveness of specialty mental health services. The work will assist the larger SME Workgroup in identifying commonalities and differences among county data systems and measures.

Members of the Measurements Task Force and the organizations they represent are in Appendix C, List of Committee Members. Committee meeting dates are included in Appendix D, List of Meetings Held.

Insert XX current status in mid August.

Initial Steps Taken To Gather Information

State staff conducted surveys, research, and interviews of experts to enhance the work of the SME Workgroup and to provide to the Stakeholder Advisory Committee.

Surveys

Three surveys were conducted:

- Stakeholder Survey
- Mental Health Plan (MHP) Survey
- National Association of Medicaid Directors (NAMD) Survey

Stakeholder Surveys

DHCS conducted a survey to obtain stakeholders' feedback from counties, providers, and local organizations regarding existing POS systems. Five stakeholders responded to the survey which polled their opinions on the quality of children's Specialty Mental Health Services (SMHS) and what they would like to see in a POS. The survey, which was posted on the DHCS website, consisted of five questions as follows:

1. Do you perceive a problem in the quality of Medi-Cal specialty mental health services provided to children and youth (hereafter called "children's")? If so, how would you describe the problem?
2. How would you define quality for children's specialty mental health services?
3. How would you define desired outcomes for a children's specialty mental health system?
4. What would you want to see from a performance and outcomes measurement system for children's specialty mental health services?
5. Do you have an example of a good performance and outcomes system for children's specialty mental health services that you can share with us?

The respondents perceived problems in the quality of Medi-Cal specialty mental health services provided to children and youth which endorsed the need for a revised system of performance and outcomes. More information on the survey and responses are included in Appendix E, Survey and Research Summary

Mental Health Plan Survey

DHCS contacted MHPs in order to better understand their use of measurement tools, including the Child and Adolescent Needs and Strength (CANS) and Child & Adolescent Level of Care Utilization System (CALOCUS), Youth Outcome Questionnaire (YOQ), and other tools. Of the 56 MHPs, 54 responded.

The survey results revealed that county MHPs use a wide variety of tools and administer them inconsistently. In cases where MHPs use the same tools, they may differ in when and how they administer them; therefore, the information gathered may be difficult to compare. CANS is used by about thirty-seven percent of the MHPs and YOQ is used by MHPs with the largest percentage of clients. Four MHPs indicated they do not use a tool. As MHPs use measurement tools for different purposes, there may be limitations in data comparisons across MHPs.

National Association of Medicaid Directors (NAMd) Survey

This survey was conducted by the National Association for Medicaid Directors on behalf of DHCS. The survey requested information on performance measurement systems for mental health services from other states. Nineteen states responded and DHCS conducted follow up interviews with two states, New York and Maryland, to learn more about their performance and outcomes systems. The survey consisted of five questions:

1. Does your State's Medicaid program have a performance or outcomes measurement system for child or adult mental health services?
2. Which providers report performance data for the above services?
3. Is reporting on performance measures for mental health services required or voluntary?
4. How often does your state's Medicaid program collect performance measures for children's mental health services?
5. How often does your state's Medicaid program collect performance measures for adult mental health services?

Seventeen of the nineteen states have performance and outcomes systems for children and only one does not have a system for either children or adults. Most states require community mental health providers and health plans to report performance data at least annually. Some require reporting monthly or quarterly. More detail on the survey and information on the interviews with New York and Maryland are included in Appendix E, Survey and Research Summary.

Research

DHCS also conducted conference calls with mental health and quality improvement professionals in several counties (Los Angeles, San Francisco, Sonoma, Ventura, and San Bernardino). DHCS used a questionnaire with specific topics including; background on how each county MHP uses the tools, opinions on what counties do and do not like about their systems, how long it took to implement the system, and recommendations for DHCS.

Interviewees were very forthcoming about challenges they face and they had several recommendations. Recurring themes in their recommendations included:

- Determine what outcomes are important and need to be measured to demonstrate client progress
- Choose assessment tools and outcomes measures which demonstrate client progress and inform clinical practice
- Choose a performance and outcomes system which includes a “feedback loop” from the State to the counties and back again, so that the data or information can be used to guide changes in clinical practice and clinical decision-making
- Develop a performance and outcomes system that moves away from simply using anecdotal reports about children’s/youth’s clinical and functional progress to a more data-driven decision-making process

In addition, DHCS researched:

- Federal & State Statutes & Regulations
- Past performance and outcomes systems such as the California Children’s System of Care
- Performance and outcomes systems used by other states
- Materials from published national organizations such as CMS, SAMSHA, HRSA
- Literature reviews of POS systems and POS tools

State staff presented summaries of the research at the second Stakeholder Advisory Committee meeting. A summary is included in Appendix E, Survey and Research Summary. This background research assisted us in the writing of this report and will be used to develop the Implementation Plan.

Performance and Outcomes Matrix Development

The SME Workgroup, composed of California leaders in the field of children and youth mental health services, collaborated over the course of six months to develop a conceptual framework that identified ideal outcomes and performance measures. The resulting framework, the Performance and Outcomes Matrix, is described in detail in the Performance and Outcomes Matrix section of this document.

The process of developing the Matrix began with the SME Workgroup, which conducted an internet review of outcomes measurement systems used in other states. Measures were identified that addressed three global areas: child clinical status, child context (e.g., family, school), and system (e.g., access, timeliness, effectiveness). These candidate outcomes were arrayed in a matrix that displayed the candidate outcomes against the following variables:

- Rationale for why the outcome is important
- Measurement option or existing data
- Level of measurement (i.e. system, agency/provider, child clinical)
- State Authority
- Federal Authority

The SME Workgroup reviewed the draft matrix and grouped the candidate outcome measures into five domains: access, engagement, service appropriateness to need, service effectiveness and linkages. This built on a framework currently used by one of the larger counties and introduced by a member of the SME Workgroup. The framework was developed to better

understand the experiences of children and youth receiving Medi-Cal specialty mental health services.

Members of the SME Workgroup collaborated extensively to refine the matrix. In April 2013, representatives of the SME Workgroup presented the matrix to the Stakeholder Advisory Committee and answered questions. The SME Workgroup and the Measurements Task Force will use the Performance and Outcomes Matrix as a framework of measures; and then identify best methods for gathering data on each outcome measure.

Data Sources:

One of the next steps is to identify data sources that might yield the desired outcomes measures identified in the Matrix. The Measurements Task Force was created to review some of the data currently collected by counties in order to identify candidate measurement tools. A Data Workgroup will be formed to identify data currently collected from counties and providers by DHCS. The Data Workgroup and the Measurements Task Force, operating in parallel, will identify data measures and the systems that hold them which could be used in the POS System.

Performance and Outcomes Matrix

The Performance and Outcomes Matrix provides a structured overview of the performance and outcomes desired. The framework represents an ideal universe of information; however it may not be feasible or cost-effective to gather all of the performance outcomes measures described. It is anticipated that subsequent work by workgroups and stakeholders, will determine the feasibility, the priorities, and the impacts and costs that affect what can realistically be achieved. Furthermore, the framework and sample measures contained in the Matrix are not intended to be requirements, or to dictate or constrain care; nor do they represent a commitment by DHCS to implement each and every measure contained in the Matrix.

The Performance and Outcomes Matrix includes:

- Outcomes domains that encompass the client experience of care and which provide structure for identifying client outcomes
- Levels at which the indicators must be collected
- Federal and state authority which mandate the collection of measurements

A number of people gave generously of their time and expertise in proposing options and drafting materials; the Matrix represents the gift of many hours and much dedication by a number of individuals in the SME Workgroup.

Values Inherent in the Matrix

In the process of creating a state-wide framework, the SME Workgroup drew on the available formal and informal knowledge regarding the types of indicators which are most important to collect, measure, and communicate. As a result, indicators were chosen which reflect the values of systems of care, the decision-making needs of multi-level stakeholders, and the primacy of improving client outcomes.

The matrix takes into account the diversity of children, youth, families, and caregivers in California, with the explicit intent to better empower them so that children and youth lead successful lives in the community. The framework respects diversity of youth in terms of their unique experiences and characteristics in at least three ways:

1. All indicators in the matrix can be analyzed by relevant cultural / linguistic or demographic characteristics, allowing for a more-in-depth understanding of disparities or equalization.
2. The matrix emphasizes both universally important outcomes of care, such as symptom relief and improved functioning, as well as the process of achieving those outcomes. This is most clearly seen in the inclusion of a domain of indicators tracking child and caregiver engagement throughout the treatment process.
3. Culturally and linguistically diverse caregivers and youth have strongly indicated the need to include both indicators of need, and indicators of client and family strengths in formulating effective treatment strategies and assessing outcomes. This feedback is reflected in matrix items regarding both assessing strengths and needs, and in utilizing this information to inform treatment.

In summary, the intent of developing this matrix is to describe essential, actionable information to persons at all levels of the system in order to achieve a singular goal: to better help California's children and youth reach their potential as functioning, contributing members of their peer group, family, culture, and society.

Definition of Matrix Terms

The matrix is organized as a series of decision points which are encountered across an episode of care. The decision points typically unfold in sequence and continue throughout the care experience. Client experience at each decision point has implications for both the process and outcome of care. The working definition of each decision point is:

- **Access** refers to provision of services in a timely manner, appropriate to the client's individual needs.
- **Engagement** is defined as child and caregivers' participation and empowerment in treatment sufficient to meet the child's goals.
- **Service Appropriateness to Need** involves the matching of services to the individual child's needs and strengths, according to system-of-care values and scientifically-derived standards of care.
- **Service Effectiveness** refers to the impact of treatment on a child's mental health symptoms and functioning at home, in school, and in the community.
- **Linkages** are defined as the provision of coordinated care during and after an episode of care.

Exhibit 1: The Performance and Outcomes Matrix is a conceptual framework of the ideal for measuring outcomes. It provides a framework of outcomes measures grouped in domains as well as examples of the indicators that could be captured to measure the outcomes. The matrix speaks to evaluation, not to service delivery and it is not a list of system requirements.

Note: This exhibit is a subset of the information in the Matrix. The complete matrix is in Appendix F: Performance and Outcomes Matrix.

Domain	Outcomes	Examples of indicators/measures All by age, gender, ethnicity, language, area, etc
Access (provision of services in a timely manner)	Children served and not served (Penetration rate) A & B	Relative to estimated prevalence, % of Medi-Cal beneficiaries who receive treatment - (Penetration rate)
	Timeliness	Wait time for evaluation, treatment (Provider access)
	Service denials	Service modifications, reductions or terminations, are lessened
Engagement (child and caregivers' participation and empowerment in treatment)	Children and Caregivers participate in services	Children and Caregivers perceive services as necessary, collaborative and useful
	Services are maintained	Percent of clients served in a year with >1 mental health contact
	Collaborative assessment of environmental factors	Evaluate family functioning, relationships, community support etc
Service Appropriateness to Need (Matching of services to child's needs and strengths and should include cultural appropriateness of service/language)	Quality of Care Standards	% of MH clients whose TX matches their DX, Symptoms or Needs
	Treatment consistent with treatment plan	Quantity, duration, and frequency of service is appropriate to the client's need. Continuity of care
	Child's clinical status	A Diagnosis (include substance use/abuse) B Symptomatology (severity)
	Functional status	A Individual client B Family: assess family strengths and challenges
	Psychotropic medication	The medication is appropriate for the child's DX
	Modality of care (e.g. individual, family, group therapy)	Treatment modality and level of care (LOC) (e.g. out-patient, community-based, residential etc)
	Ongoing engagement, empowerment	Families give <u>and</u> receive adequate information

Domain	Outcomes	Examples of indicators/measures All by age, gender, ethnicity, language, area, etc	
Effectiveness (Impact of treatment on child's mental health symptoms and functioning)	Fidelity to treatment model of practice standard	Continuous quality improvement. Use of EBPs when appropriate	
	Child symptomatology	Clinical evaluation and standardized measures	
	Child level of functioning	Clinical evaluation and standardized measures	
	Increased natural supports and social integration	Shared data from partner agencies, and clinical re-assessment	
	Family mental health/substance abuse and relationship status	- If a family member has a mental disorder they are receiving treatment - Family relationships improve - Family is better able to meet the child's emotional and behavioral needs	
	Collaborative re-assessment of environmental factors. This includes A -F	A-Children and youth function in community settings with optimal independence from formal service systems.	
		<u>B- Housing/Placement:</u> Avoid preventable out-of home placement	
		<u>C- School:</u> (a) optimize functioning in school, (b) % who receive special education services (IEP or 504)	
		<u>D- Juvenile Justice involvement:</u> reduce or prevent	
		<u>E- Employment/</u> Employment attachment (TAY)	
<u>F- Safety:</u> CPS involvement, freedom from exploitation, satisfaction with personal safety			
Linkages (provision of coordinated care)	Care coordination or integration A and B	A- Treatment plan indicates coordination with other partner agencies as needed (e.g. schools, primary care provider, CSS, JJ) B- Track youngsters as they step down from higher to lower levels of care	
	Health status	Percent of Medi-Cal children and youth who receive mental health services during the year that also received physical health care services through Medi-Cal.	
	Family/ Caregiver health status	Client record to include information about family health status	

Levels

As directed in SB 1009, and to fully understand the client experience of care, outcomes will be measured from several different perspectives:

- Level 1
 - Child's clinical status: i.e. both symptoms and functional status which might include measurement of family relationship
 - Child's Context: Family/caregiver, school, neighborhood

- Level 2
 - Provider/Clinic level care: Provider's capability of providing the level and quality of service needed, and cultural competency of services
- Level 3
 - System performance to serve child and family, i.e. is adequacy of funding and sufficiency of support, ability to evaluate performance and identify opportunities for change.

Refinement and the addition of detail to the Performance and Outcomes Matrix will continue as the Implementation Plan for the POS system is developed. At a high level, tasks completed to date include:

- Identification of values and results recommended by the SME Workgroup relating to the mental health delivery system to address the Legislature's objectives
- Creation of a matrix of measures to provide a framework for the information in the POS

The following tasks are being initiated.

- Assessment of the matrix measures to determine which are already being collected
- Evaluation of the matrix measures to establish priorities
- Assessment of feasibility for implementation based on access to the data necessary for the matrix measure, funding, technology, resources, timing and other considerations

A sample page of the Performance and Outcomes Matrix is included in Exhibit 2; the entire matrix is in Appendix F, Performance and Outcomes Matrix.

Exhibit 2: Performance and Outcomes Matrix

The first page of the Performance and Outcomes Matrix displays the Access domain and part of the Engagement domain. The entire matrix is in Appendix F.

DOMAIN/ OUTCOME		RATIONALE	Examples of indicators/measures All by age, gender, ethnicity, language, area, etc	LEVEL			Authority	
				1 Child Fam	2 Pro- gram	3 Sys- tem	STATE	FED
ACCESS	Children served and not served (Penetration rate) A & B	System should be adequate to need. Untreated individuals have higher health etc. costs	Relative to estimated prevalence, % of Medi-Cal beneficiaries who receive treatment - (Penetration rate)	x	x	x	x	x
	Timeliness	Delayed care increases MH & partner services costs	Wait time for evaluation, treatment (Provider access)	x	x	x	x	x
	Service denials	Any eligible child	Service modifications, reductions or terminations, are lessened	x	x	x	x	x
ENGAGEMENT	Children and Caregivers participate in services	System able to serve beneficiaries: related to both dropout and treatment success	Children and Caregivers perceive services as necessary, collaborative and useful	x	x	x	x	x

Next Steps/Implementation Strategy

The project's next steps are to pursue a flexible implementation strategy with three primary goals.

1. Provide periodic reports which can be used to improve outcomes and inform fiscal decision-making with the data currently available to DHCS
2. Assess opportunities for providing additional outcomes information through understanding existing county data and systems
3. Explore opportunities for identifying new data and developing new systems

The project will work toward these goals in parallel. There are unknowns that constrain them, including – compatibility of data between counties, compatibility of county systems, availability of funds, and technology that is acceptable to stakeholders. As a result, DHCS is considering three possible phases. DHCS will pursue Phase One as a short term solution and will begin defining requirements immediately. DHCS will also continue, in consultation with stakeholders, making the assessments which will lead to the identification of options for next phase.

At an increasing cost, starting with Phase One, each phase provides increasing information relevant to the five domains and the sample indicators as described in the Performance and Outcomes Matrix. Phase One strives to minimize costs by building on existing resources to the fullest extent possible.

- **Phase One: Existing Information Available to DHCS**
DHCS assesses the ability of current systems and reliability of data currently submitted by the counties to provide information in the five domains. This phase represents the least cost and can be implemented the most quickly.
- **Phase Two: Modify Existing DHCS and County Systems**
DHCS and the counties assess the ability of current county systems and data to augment information currently submitted to DHCS. There will be costs to access and analyze the county data, modify existing systems, and create or modify interfaces.
- **Phase Three: Create a new POS system and/or assess opportunities for integration and interoperability between DHCS and county systems**
With additional funds, DHCS and the counties can explore opportunities for a higher level of system integration or possibly, a new system.

Next Steps

The intent of the specialty mental health services POS system is to improve outcomes at the individual and system levels and inform fiscal decision-making related to the purchase of services. DHCS' POS system will be directed towards providing information that can be used to improve quality, cost effectiveness and access. Regardless of the information provided, how it is used by decision makers; at the State, county, provider, advocate or family level, is what will improve services.

In addition to the mandates of the legislation, DHCS will strive to:

- Collect and analyze reliable and valid data that meets HIPAA/confidentiality requirements.
- Provide data that is current and actionable through multiple methods for administrative, quality assurance and other purposes.
- Recognize the differing needs of state, counties - large and small, providers, advocates, family, and youth for data/indicators.
- Gather data on children and youth mental health services, regardless of source, to reflect youth experience.
- Establish feasibility, including estimation of cost, additional workload for rendering counties, clinicians, and other impacts.

Phase One Timelines and Milestones

One assumption underlying Phase One is that data currently collected by DHCS from the counties can be analyzed and used to create reports that will address indicators in the five domains, though not to the detail described in the Performance and Outcomes Matrix. The data currently collected is not expected to be sufficient and there will be gaps in the performance and outcomes, particularly in the Linkages domain. However, as performance and outcomes measures are dependent on tracking trends over time, it is important to begin gathering and sharing the data available as soon as possible.

At a high-level, DHCS will undertake the following steps.

#	Description of Step	Proposed Timeline	Proposed Milestones
	Design, Develop and Implement		
1	Assess DHCS current data and systems	June – October 2013	
2	Develop requirements for reports	July – October 2013	
3	Identify costs and funding	August – October 2013	
4	Review report requirements with SMES and Stakeholder Advisory Committee		October 2013
5	Design and develop reports	November 2013 – March 2014	
6	Review report mockups with SMES and Stakeholder Advisory Committee		February 2014
7	Test reports	April 2014	
8	Train county and DHCS staff on using the reports	May 2014	
9	Provide initial reports to counties		June 2014
	Maintain and Operate		
10	Support county and DHCS staff decision-making	On-going	
11	Modify & develop reports	On-going	
12	Identify methods to increase data access and assess possibilities for additional DHCS systems interfaces	On-going	

The Timelines and Milestones will be confirmed in the System Implementation Plan which is due on January 10, 2014.

Plan for Phase One

DHCS is currently identifying data fields in the statewide DHCS systems that can be used as direct or proxy measures. There are numerous other assessments to make, such as capability and capacity for reporting, frequency of reporting, level of detail, and quality of data. Data collected and methods used by the EQRO will be evaluated for inclusion. DHCS will consult and collaborate with the Mental Health Services Oversight and Accountability Commission (MHSOAC). Some development work may be required such as interfaces between DHCS systems.

There are recognized constraints to the information available, for example, all DHCS systems do not have data feeds to the data warehouse. Deciding which interfaces to build will depend on the relative value of each system's data. The universe of desired data will not be available, however, key data, such as, Client Information Number (CIN), provider number, dates of service, procedure codes, reimbursed amounts, and some pharmacy data is available. This information can answer some outcomes questions and provide a starting point for the POS system.

In collaboration with the SME Workgroup and the Stakeholder Advisory Committee the current data will be reviewed and analytics discussed. Working with stakeholders, DHCS will develop report requirements, including frequency of reporting, report layouts and agreement on how to interpret existing data. DHCS will work with the SME Workgroup to review requirements and has set milestones for the review of report requirements and mockups of reports.

County and DHCS staff will participate in review and testing of reports. Once the initial reports are provided, county and state decision-makers will require support in using the reports. To facilitate practice improvements within and between counties, DHCS may need to offer training, hold forums, and facilitate the exchange of information and decision-making about changes to practices.

On an on-going basis, change requests will be reviewed and reports modified, as appropriate.

Most critically, working with our stakeholders, DHCS will strategize and identify options to transmit/disseminate POS system data back to county MHPs and billing providers, accommodating for any HIPAA/confidentiality requirements. DHCS will develop standardized data reports, templates or dashboards for state analysis and for the counties.

It is anticipated that the reports will provide answers to questions such as:

- Are clients moving through the system in a rational, timely manner?
- Does access to community-based services differ by cultural group or geographic location?
- Are clients currently engaged/participating in care?
- Is length of stay within range expected for effective treatment at this level of care?
- How quickly are supports in place for clients to transition to more independent functioning?

Simultaneous to the implementation of Phase One, the assessment for Phases Two and Three will be in development.

Assessment for Phases Two and Three

To undertake the next level of assessment, DHCS assumes there will be some level of funding available to support bringing together disparate data from the counties. During the assessment two possibilities will be explored: Phase Two, which is probably lower cost and relies on modifying existing DHCS and county systems and Phase Three, which would enable the implementation of a new system for the collection of outcomes.

At a high-level, DHCS will undertake the following steps within the next two years.

#	Description of Step	Timeline
	Assess	
1	Assess county data	June – September 2013
2	Research technology counties use to capture and store data	October - January 2013
3	Assess options/technology to interface, capture, store, and report on county data	January - July 2014
4	Review lessons learned from Phase One and identify critical data gaps	June – September 2014
5	Establish priorities for indicators	July – September 2014
6	Identify funding	May – September 2014
7	Develop feasibility study report	July 2014 – March 2015

Develop Options

DHCS and the recently formed SME Measurements Task Force, is identifying a sample of the county data currently collected relative to the Performance and Outcomes Matrix. Even early in the assessment it is clear there are a variety of tools, collection timelines and methods as well as interpretations of the same measure between counties. Data that the counties and providers currently collect will be assessed for suitability as data fields. It will also be necessary to understand the extent of implementation of local EHRs and the data elements collected, as well as how they are collected and stored.

Taking into account any HIPAA/Confidentiality requirements, possible linkages will be explored to the:

- California Department of Social Services (CDSS)
- Child Welfare Services/Community Support Services (CWS/CSS)
- Data base for child welfare services
- California Department of Education (CDE) data for educational status

Working in collaboration with the SME Workgroup and taking into account any HIPAA/confidentiality requirements, DHCS will identify potential direct and proxy measures based on state level data, local EHR data, CWS/CSS or CDE data available that could be implemented.

We will also need to assess the methods for centralizing the data into one system. For example, we may look at the potential for:

- Adding data feeds and data fields from counties/providers, CWS/CSS or CDE to the DHCS systems
- Including county/provider EHR, CWS/CSS or CDE data elements in the SD2 and MIS/DSS Medicaid HIPAA-compliant 837 transaction claim
- Adding functional status data elements to an existing system
- Integrating/migrating CSI system information into MIS/DSS data warehouse at DHCS. This option would only be useful if DHCS could increase the reliability of county CSI reporting which varies greatly between counties.
- Or other possible methods

Lessons learned from the implementation and reports developed in Phase One will feed into establishing priorities for indicators and data. Working with the SME Workgroup and with review from the Stakeholder Advisory Committee we will establish the priorities for potential state-level, local EHR, CWS/CSS or CDE measures to develop the core measures to be implemented in the POS system.

Select Option

DHCS will generate options for systems that reflect: i) the lowest cost; ii) the lowest cost with the best outcome data; and iii) the best outcome data. Due to our mandate to minimize costs by building on existing resources, we may link the options so that the data is collected in stages, depending on accessibility of data and system cost.

As appropriate, DHCS will develop an FSR to evaluate options. The options and the selected option will be presented to the Stakeholder Advisory Committee.

It is anticipated that the new system, with the addition of treatment data, will provide answers to questions such as:

- Does increased accessibility lead to more rapid clinical and functional improvement?
- Are we serving people in need of specialty mental health services?
- Do children receiving first-line treatments experience more efficient, effective care?
- Is treatment cost-effective?
- Are service transitions related to change in clinical symptoms and functioning?
- Is perceived access post-discharge related to clinical and functional outcomes?
- Is time to step-down services related to clinical and functional outcomes?

The System Implementation Plan will describe the implementation steps and timeline needed to achieve the selected option.

Program and Fiscal Impact

As DHCS and the stakeholders continue to explore options and understand what is feasible, the program and fiscal impact is difficult to project. However, the department anticipates that the development of this system will have a fiscal and programmatic impact at the State as well as at the county level.

The department projects there will be resource needs for full time and part time staff at the State and local level regardless of the approach and infrastructure selected. Phase One focuses on using existing resources, however, due to systemic changes such as building interfaces and creating reports, additional staff and financial resources will be required. The fiscal and programmatic impact will not only depend on the accessibility of the performance and outcomes data but also on the changes needed to current data systems at both the State and the counties.

If only limited performance and outcome measures, as defined in the POS Matrix (such as indicators obtained from claims data) are collected, the fiscal impacts will be reduced. If the measures that are more complex to define and to capture (such as functional assessment data for individual children) are included, the greater the need will be for financial and human resources to develop interfaces and system infrastructure.

The department will continue to explore implementation strategies and activities in the next several months and will outline specific fiscal and programmatic impact estimates in the System Implementation Plan due to the Legislature on January 10, 2014.

Appendices

Appendix A: Legislation

Appendix B: Project Work Plan

Appendix C: List of Committee Members

- Stakeholder Advisory Committee Meeting Participants
 - List of organizations whose members participated in Committee meetings
- Subject Matter Expert Workgroup Members
- Measurements Task Force Members

Appendix D: List of Meetings Held

Appendix E: Survey and Research Summary

Appendix F: Performance and Outcomes Matrix

Appendix A: Legislation

SB 1009, SEC. 248 contains the following language.

Section 14707.5 is added to the Welfare and Institutions Code (WIC), to read:

(a) It is the intent of the Legislature to develop a performance outcome system for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services that will improve outcomes at the individual and system levels and will inform fiscal decision-making related to the purchase of services.

(b) The State Department of Health Care Services (DHCS), in collaboration with the California Health and Human Services Agency (CHHS), and in consultation with the Mental Health Services Oversight and Accountability Commission (MHSOAC), shall create a plan for a performance outcome system (POS) for EPSDT mental health services provided to eligible Medi-Cal beneficiaries under the age of 21 pursuant to 42 U.S.C. Section 1396d(a)(4)(B).

(1) Commencing no later than September 1, 2012, the department shall convene a stakeholder advisory committee comprised of representatives of child and youth clients, family members, providers, counties, and the Legislature. This consultation shall inform the creation of a plan for a performance outcome system for EPSDT mental health services.

(2) In developing a plan for a performance outcomes system for EPSDT mental health services, the department shall consider the following objectives, among others:

(A) High quality and accessible EPSDT mental health services for eligible children and youth, consistent with federal law.

(B) Information that improves practice at the individual, program, and system levels.

(C) Minimization of costs by building upon existing resources to the fullest extent possible.

(D) Reliable data that are collected and analyzed in a timely fashion.

(3) At a minimum, the plan for a performance outcome system for EPSDT mental health services shall consider evidence-based models for performance outcome systems, such as the Child and Adolescent Needs and Strengths (CANS), federal requirements, including the review by the External Quality Review Organization (EQRO), and, timelines for implementation at the provider, county, and state levels.

(c) The State Department of Health Care Services shall provide the performance outcomes system plan, including milestones and timelines, for EPSDT mental health services described in subdivision (a) to all fiscal committees and appropriate policy committees of the Legislature no later than October 1, 2013.

(d) The State Department of Health Care Services shall propose how to

implement the performance outcomes system plan for EPSDT mental health services described in subdivision (a) no later than January 10, 2014.

DRAFT

Appendix B: Project Work Plan

Work Plan: Performance and Outcomes System for Medi-Cal Specialty Mental Health Services for Children and Youth

This Work Plan is updated and modified as necessary on a regular basis.

WORK PLAN MILESTONES AT-A-GLANCE

Milestone	Description
1	Convene a Stakeholder Advisory Committee comprised of representatives of child and youth clients, family members, providers, counties, and the Legislature in accordance with W&I Code §14707.5
2	Formation of a work group to develop the recommendations regarding the Performance and Outcomes Systems and implementation plans.
3	Conduct research on Performance and Outcomes Systems and develop recommendations
4	Use stakeholder and SME feedback to write the Performance and Outcome System (POS) plan and submit it to the Legislature
5	Development of the implementation plan proposal

ACRONYMS

CALQIC	California Quality Improvement Coordinators
CaMH	California Institute for Mental Health
CMHDA	County Mental Health Directors Association
DHCS	Department of Health Care Services
EQRO	External Quality Review Organization
FMOR	Fiscal Management and Outcomes Reporting
ITSD	Information Technology Services Division
MHP	Mental Health Plan
POS	Performance and Outcomes System
SME	Subject Matter Expert
SMHS	Specialty Mental Health Services

MILESTONE 1: Convene a Stakeholder Advisory Committee comprised of representatives of child and youth clients, family members, providers, counties, and the Legislature in accordance with W&I Code §14707.5.			
Goals and Objectives	Tasks	Deliverable(s)	Timeline
<p>1. Convene a Stakeholder Advisory Committee comprised of representatives of child and youth clients, family members, providers, counties, and the Legislature in accordance with W&I Code §14707.5.</p> <p>1.1 Stakeholder participation and collaboration in the development of children's performance and outcome system (POS).</p>	<p>1. Develop a stakeholder process composed of representative stakeholders and convene first meeting by September 1, 2012.</p> <p>2. Identify purpose, goals and objectives for the first stakeholder meeting.</p> <p>3. Plan the presentation and identify presenters.</p> <p>4. Develop meeting agenda and power point presentation.</p> <p>5. Send notification and meeting documents to stakeholders and post on DHCS website.</p> <p>6. Convene the first stakeholder meeting.</p> <p>7. Create a written summary of stakeholder comments and recommendations.</p>	<p>1. Identify and establish a Stakeholder Advisory Committee list of representative members.</p> <p>2. Establish a Department of Health Care Services (DHCS) In-box to receive stakeholder comments and recommendations.</p> <p>3. Conduct the first stakeholder meeting.</p> <p>4. Post Stakeholder Advisory Committee summary on the DHCS website.</p>	<p>1. August - September 2012</p> <p>2. October 2012</p> <p>3. October 4, 2012</p> <p>4. January 2013</p>
<p>1.2 Conduct a conference call with stakeholders to share the project work plan, responses to surveys with counties and other states, along with the responses to the 5 stakeholder questions, and the ongoing various research being conducted on performance and outcomes systems.</p>	<p>1. Define purpose, goals and objectives for the stakeholder conference call.</p> <p>2. Plan the presentation and identify presenters.</p> <p>3. Develop meeting agenda and power point presentation (if applicable).</p> <p>a. Discuss the responses to the 5 questions sent to the stakeholders.</p> <p>b. Discuss the county survey responses.</p> <p>c. Discuss the state survey responses.</p>	<p>1. Post notification and conference call documents on DHCS website and conference call notification sent to stakeholders.</p> <p>2. Conduct the conference call.</p> <p>3. Post meeting summary on the DHCS website.</p>	<p>Projected February 2013</p> <p>The Stakeholder Advisory members were updated via meetings and email notification. This options was not pursued as of yet.</p>

MILESTONE 1: Convene a Stakeholder Advisory Committee comprised of representatives of child and youth clients, family members, providers, counties, and the Legislature in accordance with W&I Code §14707.5.

Goals and Objectives	Tasks	Deliverable(s)	Timeline
	<p>d. Share a summary of the research conducted on performance and outcomes systems.</p> <p>e. Share the work plan and obtain stakeholder input.</p> <p>4. Create a written summary of stakeholder comments and recommendations.</p>		
<p>1.3 Conduct a Stakeholder Advisory Committee meeting to provide stakeholders with a status update on the research being done by the state and to share results of the research.</p>	<p>1. Define purpose, goals and objectives for the stakeholder meeting.</p> <p>2. Plan the presentation and identify possible subject matter expert (SME) presenters.</p> <p>3. Develop meeting agenda and power point presentation (if applicable).</p> <p>a. DHCS share research and findings with stakeholders.</p> <p>Hold a panel discussion consisting of subject matter experts on the matrix and the foundation for a statewide performance and outcomes system.</p>	<p>1. Post notification and meeting documents on DHCS website and conference call notification sent to stakeholders.</p> <p>2. Conduct the meeting.</p> <p>3. Post meeting summary on the DHCS website.</p>	<p>Projected March 2013 Meeting was held April 30, 2013.</p>
<p>1.4 Conduct a Stakeholder Advisory Committee meeting to update stakeholders on state recommendations for the POS and solicit stakeholder input.</p>	<p>1. Define purpose, goals and objectives for the stakeholder meeting.</p> <p>2. Plan the presentation.</p> <p>3. Develop meeting agenda and power point presentation (if applicable).</p> <p>a. Share recommendations with stakeholders and solicit input from stakeholders. (For further details, see milestone 3, objective 3.5)</p>	<p>1. Post notification and meeting documents on DHCS website and conference call notification sent to stakeholders.</p> <p>2. Conduct the meeting.</p> <p>3. Post meeting summary on the DHCS website.</p>	<p>Projected Late April/Early May 2013 Meeting will be held July 23, 2013 to discuss and receive feedback on the draft EPSDT POS Plan due to the Legislature October 1, 2013.</p>

MILESTONE 1: Convene a Stakeholder Advisory Committee comprised of representatives of child and youth clients, family members, providers, counties, and the Legislature in accordance with W&I Code §14707.5.

Goals and Objectives	Tasks	Deliverable(s)	Timeline
	4. Create a written summary of stakeholder comments and recommendations.		
1.5 Discuss with stakeholders the draft POS and implementation plans	1. Define purpose, goals and objectives for the stakeholder meeting. 2. Plan the presentation. 3. Develop meeting agenda and power point presentation (if applicable). <ul style="list-style-type: none"> a. Share the DHCS draft plans. b. Solicit input from stakeholders. 	1. Post notification and meeting documents on DHCS website and conference call notification sent to stakeholders. 2. Conduct the meeting. 3. Post meeting summary on the DHCS website.	Projected June 2013;
1.6 Additional Stakeholder Advisory Committee meetings or conference calls as needed.	1. Provide updates and solicit feedback from stakeholders.	1. Post notification and meeting documents on DHCS website and conference call notification sent to stakeholders. 2. Conduct the meeting/conference call. 3. Post meeting summary on the DHCS website.	December 2012 - December 2013 Meeting held April 30, 2013; next meeting scheduled for July 23, 2013.

MILESTONE 2: Formation of a work group to develop the recommendations regarding the Performance and Outcomes Systems and implementation plans.			
Goals and Objectives	Tasks	Deliverable(s)	Timeline
2. Form the work group	<p>1. Establish role of the work group, define the purpose, responsibilities, and tasks of the work group.</p> <p>2. Determine who the various participants of the work group will be, based upon the areas of expertise (e.g. Clinicians, Information Technology Services Division (ITSD), Fiscal Management and Outcomes Reporting (FMOR), Data Experts, County Representatives, External Quality Review Organization (EQRO)).</p> <p>3. Determine the work group formats, frequency, schedule and number of work group(s) based on purpose, responsibilities and deliverables assigned to the work group.</p> <p>4. Establish the work group and provide notification, agenda, handouts and schedule of meetings to work group members.</p> <p>5. Identify, analyze and advise options for data reporting that will be two-way, real time, and would both acknowledge and utilize relevant federally accessible databases required for HIE. Two way refers to both within and between various levels of data reporting including providers, MHPs and the State. The system will leverage both the current and known, future technology horizons.</p>	<p>1. Convene no later than January 2013.</p> <p>2. Develop recommendations for the POS plan and implementation plan.</p>	<p>1. Start January 2013</p> <p>Since January 2013 the work group met at least on a bi-weekly basis; Next meetings are scheduled for July 17, July 31, and August 14, 2013.</p> <p>In June 2013, a second taskforce, the Measures Taskforce, was created to review current assessment tools available to the counties to capture identified performance and outcomes measures. This taskforce meets on a bi-monthly basis as well.</p>

MILESTONE 3: Conduct research on Performance and Outcomes Systems and Develop Recommendations for the EPSDT POS Plan due to the Legislature by October 1, 2013. .			
Goals and Objectives	Tasks	Deliverable(s)	Timeline
<p>3. Provide recommendations, for a statewide Performance and Outcomes System that will improve outcomes at the individual, program and system levels and will inform fiscal decision making related to the purchase of services, based upon the research conducted in objectives 3 .1 through 3.4 and the recommendations from the work group.</p> <p>3.1 Identify federal and state laws and regulations and authorities on quality assurance, improvement and other related activities to determine state responsibilities and compliance.</p>	<p>1. Review federal and state laws and regulations, the MHP contract, the Specialty Mental Health Services (SMHS) waiver and the State Plan.</p> <p>2. Compare requirements with current practice.</p>	<p>1. Development of a fact sheet to analyze requirements and determine if they are currently being met.</p>	<p>Projected January 2013; the recommendations were incorporated into the current version of the draft EPSDT POS plan due to the Legislature October 1, 2013.</p>
<p>3.2 Identify local and multi-state activities regarding Performance and Outcomes Systems, including existing data collection sources, the types of data collected, and their applicability to the development of a statewide performance and outcomes system.</p>	<p>1. Send out the following: County MHP Survey - Goal is to determine what systems counties are currently using for performance and outcome measures. State Medicaid Directors Survey - Goal is to determine what systems other states are currently using for performance and outcome measures. Stakeholders Questions - Goal is for stakeholders to provide DHCS with what they feel needs to be/can be done in order to improve upon the system.</p> <p>2. Review survey/question responses and related documents received from states and counties and summarize findings and recommendations.</p> <p>3. Conduct a literature review using various resources (e.g., State Library, Internet searches, and</p>	<p>1. Prepare and send out the various surveys and questions.</p> <p>2. Summarize and present the survey results to stakeholders.</p> <p>3. Summarize the findings to determine possible POS measures applicable to California and present the information at the work group meetings.</p> <p>4. Present the assessment tool summary to</p>	<p>1. November 1, 2012</p> <p>2. Projected January 2013</p> <p>3. November 2012 - April 2013</p> <p>4. Projected January 2013</p> <p>5a. January – July 2013</p> <p>5b. January - July 2013</p>

MILESTONE 3: Conduct research on Performance and Outcomes Systems and Develop Recommendations for the EPSDT POS Plan due to the Legislature by October 1, 2013. .

Goals and Objectives	Tasks	Deliverable(s)	Timeline
	<p>SME recommendations).</p> <p>4. Review and identify the strengths, challenges and commonalities of the various assessment tools (e.g. diagnostic, level of care, behavior scales) being used by the counties to find common core components that can possibly be incorporated into the POS and implementation plans.</p> <p>5a. Consult with the Information Technology Services Division (ITSD) and Fiscal Management and Outcomes Reporting (FMOR) staff to identify the types of mental health related data currently collected by DHCS and MHPs and their applicability as performance and outcome indicators and measures.</p> <p>5b. Consult with ITSD and FMOR staff, in addition to, external subject matter experts on data sources and systems and provision of information on data selection criteria and construction of statistically valid tools and processes to measure performance and outcomes data.</p>	<p>stakeholders.</p> <p>5a. Hold meetings with county and provider organizations and summarize the recommendations made to DHCS.</p> <p>5b. Incorporate recommendations in the draft POS and implementation plans.</p>	
<p>3.3 Identify and meet with subject matter experts recommended by stakeholders, County Mental Health Plans, mental health organizations such as County Mental Health Directors Association (CMHDA), California Institute for Mental Health (CiMH), California Quality Improvement Coordinators (CALQIC), Mental Health Services Oversight and Accountability Commission, EQRO</p>	<p>1. Identify specific expertise/skills and subject matter experts essential to the development of the performance and outcome system.</p> <p>2. Create a matrix that will document the recommendations from the subject matter expert meetings to present to the work group.</p> <p>3. Determine appropriateness of each SME for future panel discussions with stakeholders.</p>	<p>1. Have subject matter experts present at a stakeholder meeting.</p> <p>2. Present the matrix to the work group.</p>	<p>November 2012 - July May 2013</p> <p>Two workgroups were created:</p> <p>A. EPSDT POS SME Workgroup – January 2013</p> <p>B. Measures Taskforce – June 2013</p>

MILESTONE 3: Conduct research on Performance and Outcomes Systems and Develop Recommendations for the EPSDT POS Plan due to the Legislature by October 1, 2013. .			
Goals and Objectives	Tasks	Deliverable(s)	Timeline
3.4 Based on the work in 3.1 and 3.5, develop criteria to measure performance and outcome data on the individual, program and system levels.	<ol style="list-style-type: none"> 1. Analyze and identify similarities and differences in the data being collected and the data systems utilized by DHCS and MHPs and provide an analysis of how these similarities and differences impact the development of a statewide performance and outcome system. 2. Analyze current data and identification of information that can be utilized as performance and outcome measurements and indicators. 3. Identify core performance and outcome data applicable on the individual, program and system levels. 4. Develop a plan to select, identify, utilize and incorporate existing applicable data to the performance and outcome measurement system. 	1. Develop plan and recommendations to identify core performance and outcome indicators and measures on the individual, program and system levels.	<p>Projected March 2013;</p> <ol style="list-style-type: none"> 1. EPSDT performance and outcomes measures presented as a matrix to the Stakeholder Advisory Committee on April 30, 2013; 2. Recommendations were incorporated into the current draft EPSDT POS plan due to the Legislature October 1, 2013.
3.5 Summarize research findings and develop recommendations for a POS.	<ol style="list-style-type: none"> 1. Draft recommendations and incorporate them into the EPSDT POS plan due to the Legislature by October 1, 2013 including options regarding the implementation of the system plan. <ol style="list-style-type: none"> a. Minimization of costs by building upon existing resources to the fullest extent possible. b. Understand the interface between DHCS data and the Mental Health Plan (MHP) data systems in the development of performance and outcome measurement. c. Identify the essential components and criteria of a performance outcome system and the steps in the selection process. 	1. Present the recommendations to stakeholders.	Projected March 2013; EPSDT POS plan in progress; the draft plan will be presented to stakeholders no later than July 23, 2013.

MILESTONE 4: Use stakeholder and SME feedback to write the Performance and Outcome System (POS) plan and submit it to the Legislature.			
Goals and Objectives	Tasks	Deliverable(s)	Timeline
4. Draft the plan for children's performance and outcomes system in collaboration with stakeholder and subject matter expert recommendations.	<ol style="list-style-type: none"> 1. Using stakeholder feedback and DHCS management direction, define the purpose, goals and objectives of the POS plan. 2. Develop and outline the steps and tasks in the development of the POS plan including timelines/milestones. 3. Gather and review recommendations and findings from subject matter experts, stakeholders, research findings and other documents. 4. Collaborate with ITSD, DHCS Research and Analytic Studies Branch (RASB) and the CMHDA IT Committee to identify process for county reporting to the Department. 5. Identify key components and content areas of the POS plan. 6. Write the POS plan. 7. Review of the POS plan by DHCS and edit plan as recommended. 8. Obtain discussion and feedback from subject matter experts, stakeholders and DHCS staff. 9. Gather and organize the feedback received from subject matter experts, stakeholders and departmental staff regarding the POS plan. 	1. Send initial draft out to stakeholders for feedback	July 2013
4.1 Revise the draft POS plan.	1. Incorporate stakeholder feedback into the draft POS plan.	1. Send final draft out to stakeholders for feedback	July 2013
4.2 Finalize the POS plan.	1. Incorporate stakeholder feedback into the final draft POS plan.	1. Provide final plan to DHCS management	August 2013

MILESTONE 4: Use stakeholder and SME feedback to write the Performance and Outcome System (POS) plan and submit it to the Legislature.

Goals and Objectives	Tasks	Deliverable(s)	Timeline
	2. Obtain management sign-off of final draft.	2. Submit the plan to the Legislature.	

DRAFT

MILESTONE 5: Development of the Implementation Plan Proposal.			
Goals and Objectives	Tasks	Deliverable(s)	Timeline
5. Write the implementation plan proposal.	<ol style="list-style-type: none"> 1. Using stakeholder feedback and DHCS management direction, define the purpose, goals and objectives of the implementation plan. 2. Develop and outline the steps and tasks in the development of an implementation plan including timelines/milestones. 3. Gather and review recommendations and findings from subject matter experts, stakeholders, research findings and other documents. 4. Collaborate with DHCS Information Technology Services Division (ITSD), DHCS Fiscal Management and Outcomes Reporting (FMOR) and the CMHDA IT Committee to identify process for county reporting to the Department. 5. Identify key components of the implementation plan and content areas of the plan. 6. Write the implementation plan to include the phases of implementation for the POS system, such as planning, designing, developing, testing and evaluating. 7. Review of the implementation plan by DHCS and edit plan as recommended. 8. Obtain discussion and feedback from subject matter experts, stakeholders and DHCS staff. 9. Gather and organize the feedback received from subject matter experts, stakeholders and departmental staff regarding the POS plan. 	1. Send initial draft out to stakeholders for feedback	August 2013
5.1 Stakeholder review of the proposed implementation plan.	<ol style="list-style-type: none"> 1. Incorporate stakeholder feedback into the draft implementation plan. 	1. Send final draft out to stakeholders for feedback.	October 2013

MILESTONE 5: Development of the Implementation Plan Proposal.			
Goals and Objectives	Tasks	Deliverable(s)	Timeline
5.2 Finalize the implementation plan proposal to submit to the Legislature.	<ol style="list-style-type: none"> 1. Incorporate stakeholder feedback into the final draft implementation plan. 2. Obtain management sign-off of final draft. 	<ol style="list-style-type: none"> 1. Provide final plan to DHCS management 2. Submit the plan to the Legislature. 	January 10, 2014

DRAFT

Timeline and Deliverables: August 1, 2012 through January 10, 2014

2012

August	<ul style="list-style-type: none"> Identify and establish a Stakeholder Advisory Committee list of representative members. (See Milestone 1, Goal 1)
October	<ul style="list-style-type: none"> Establish a Department of Health Care Services (DHCS) In-box to receive stakeholder comments and recommendations. (See Milestone 1, Goal 1) First Stakeholder Advisory Committee held on October 4, 2012
November	<ul style="list-style-type: none"> Research and collection of national and state survey information (See Milestone 3, Goal) Meetings with subject matter experts in the field of mental health performance and outcomes data (See Milestone 3, Goal 3.2)
December	<ul style="list-style-type: none"> Development of a fact sheet to analyze requirements and determine if they are currently being met. (See Milestone 3, Goal 3.1) Hold meetings with the subject matter experts to gather pertinent EPSDT POS information. (See Milestone 3, Goal 3.2)

2013

January	<ul style="list-style-type: none"> Convene no later than January 2013. (See Milestone 2, Goal 2) Present research and survey results to stakeholders (See Milestone 3, Goal 3.2) Formation of a Work Group with subject matter experts (See Milestone 2)
February	<ul style="list-style-type: none"> Ongoing Work Group meetings (See Milestone 2)
March	<ul style="list-style-type: none"> Develop recommendations for the POS plan and implementation plan. (See Milestone 2, Goal 2) Have subject matter experts present at a stakeholder meeting. (See Milestone 3, Goal 1) Present the matrix to the work group. (See Milestone 3, Goal 1) Develop POS plan and recommendations to identify core performance and outcome indicators and measures on the individual, program and system levels. (See Milestone 3, Goal 3.4) Present the recommendations to stakeholders. (See Milestone 3, Goal 3.5)
April	<ul style="list-style-type: none"> Conduct Stakeholder Advisory Committee meeting with expert panel discussion (See Milestone 1, Goal 1.3) Ongoing work group meetings (See Milestone 2) Stakeholder Advisory Committee meeting (See Milestone 1, Goal 1.4)

2013

May	<ul style="list-style-type: none">• Ongoing Work Group meetings (See Milestone 2)• Draft POS Plan
June	<ul style="list-style-type: none">• Ongoing Work Group meetings (See Milestone 2)• Present assessment tool summary/analysis to stakeholders (See Milestone 3, Goal 3.2)• Revise Draft (See Milestone 4, Goal 4.1)
July	<ul style="list-style-type: none">• Conduct Stakeholder Advisory Committee meeting. (See Milestone 1)• Ongoing Work Group meetings (See Milestone 2)• Revise Draft (See Milestone 4, Goal 4.1)
August	<ul style="list-style-type: none">• Ongoing Work Group meetings (See Milestone 2)• Write Implementation Plan and send initial draft out to stakeholders for feedback. (See Milestone 5, Goal 5.1)
October	<ul style="list-style-type: none">• Incorporate recommendations and draft EPSDT POS Implementation plan. (See Milestone 3, Goal 3.2)• Submit the POS plan to the Legislature. (See Milestone 4, Goal 4.2)• Send final Implementation Plan draft out to stakeholders for feedback. (See Milestone 5, Goal 5.1)

2014

January	<ul style="list-style-type: none">• Submit the Implementation Plan to the Legislature. (See Milestone 5, Goal 5.2)
---------	--

Appendix C: List of Committee Members

This Appendix includes lists of the members of the committees of external stakeholders. The committees are:

- Stakeholder Advisory Committee
 - List of organizations whose members participated in Committee meetings
- Subject Matter Expert Work Group Members
- Measurements Task Force

Stakeholder Advisory Committee Meeting Participants

List of Organizations represented by the Stakeholder Advisory Committee Participants at the October 4, 2012 Meeting.

- Alameda County Health Care
- Alameda County Mental Health
- APS Healthcare-CAEQRO
- Behavior Health and Recovery Services Stanislaus
- CA Academy of Child & Adolescent Psychiatry (CAL- ACAP)
- CA Council of Community Mental Health Agencies (CCCMHA)
- CA Department of Social Services (CDSS)
- CA Institute for Mental Health (CiMH)
- CA Mental Health Directors Association (CMHDA)
- CA Mental Health Planning Council (CMHPC)
- California Alliance of Child & Family Services
- Children Now
- Children's Bureau Southern CA
- Children's Institute
- Department of Health Care Services (DHCS)
- Disability Rights Counsel CA
- Families First
- Family SOUP
- Gov. Policy & Strategies
- Hathaway Sycamores
- John Perez, Assembly Speaker
- Lassen County Health
- Lincoln Child Center
- Los Angeles County Department of Children and Family Services (LACDCFS)
- Los Angeles County Mental Health

- Mental Health Services Oversight and Accountability Commission (MHSOAC)
- Momentum for Mental Health
- National Alliance on Mental Illness (NAMI) CA
- National Health Law Program
- Nevada County
- Online Archive of CA (OAC)
- Pacific Clinics
- Placer County
- Rebekah Children's Services
- Riverside County Department of Mental Health
- San Benito County
- San Bernardino County
- San Diego Health and Human Services Agency Child Welfare Services (HHSACWS)
- San Francisco Department of Public Health
- San Luis Obispo County
- Santa Cruz County/CMHDA
- Senate Budget Committee
- Senate Staffer for Darrel Steinberg
- Seneca Center
- SLC Consulting
- Sonoma County
- Star View Children & Family & Services
- Sutter-Yuba Mental Health
- Tuolumne County Behavioral Health
- Voice 4 Families
- West Coast Children's Clinic
- Yolo County
- Young Minds Advocacy Project

List of Organizations represented by the Stakeholder Advisory Committee Participants at the April 30, 2013 Meeting.

- Alameda County Behavioral Health Care Services
- APS Healthcare-CAEQRO
- CA Council of Community Mental Health Agencies (CCCMHA)
- CA Department of Social Services (CDSS)
- CA Institute for Mental Health (CiMH)
- CA Mental Health Planning Council (CMHPC)
- California Alliance of Child and Family Services
- California Department of Alcohol & Drugs Program (ADP)

- California State Assembly
- CalOptima
- Cambria Solutions
- Child Welfare Services
- Children's Institute, Inc.
- Contra Costa County Public Health Department
- Contra Costa Health Services
- County of Santa Cruz Health Services Agency
- Department of Finance
- Department of Health Care Services (DHCS)
- Disability Rights California
- Early Childhood Mental Health Program
- Eastfield Ming Quong Families First (EMQFF)
- Family Member
- Fresno County Mental Health
- Health Net
- Humboldt County Mental Health
- Imperial County Mental Health
- Kern County Mental Health
- Kings View Behavioral Health
- Lake County Mental Health
- Los Angeles County Department of Mental Health
- Madera County Mental Health
- Marin County Mental Health
- Mental Health Association California
- Mental Health Services Oversight and Accountability Commission (MHSOAC)
- Merced County Mental Health
- Napa County Mental Health
- National Alliance on Mental Illness (NAMI) CA
- National Health Law Program
- Orange County Healthcare Agency
- Rebekah's Children's Services
- River Oak Center for Children
- Riverside County Department of Mental Health
- Sacramento County Mental Health
- San Bernardino County Department of Behavioral Health
- San Diego County Child Welfare Services
- San Diego County Mental Health
- San Francisco Department of Public Health
- San Joaquin County Behavioral Health Services
- San Luis Obispo Mental Health
- Santa Barbara County Mental Health

- SBC Social Services
- Senate Budget and Fiscal Review Committee
- Senate Staffer for Darrel Steinberg
- Seneca Center
- Shasta County Mental Health
- Solano County Mental Health
- UC Davis
- Ventura County Mental Health
- West Coast Children's Clinic
- Yolo County Mental Health
- Yuba City County Mental Health

List of Organizations represented by the Stakeholder Advisory Committee Participants at the July 23, 2013 Meeting.

Insert

Subject Matter Experts Workgroup Members

Abram Rosenblatt	EMQFF
Nathaniel Israel	San Francisco Department of Public Health (DPH)
Penny Knapp	UC Davis
Renay Bradley	MHSOAC
Rusty Selix	Coalition for Mental Health
Don Kingdon	CMHDA
Patrick Gardner	Young Minds Advocacy Project
Wesley Sheffield	Young Minds Advocacy Project
Jane Adcock	California Mental Health Planning Council (CMHPC)
Linda Dickerson	California Mental Health Planning Council (CMHPC)
Stephanie Oprendeck	CiMH
Michael Reiter	APS Healthcare
Saumitra SenGupta	APS Healthcare
Sandra Sinz	APS Healthcare
Ellie Jones	CDSS
Patricia Costales	The Guidance Center
Lynn Thull	California Alliance of Child & Family Services
Debbie Innes-Gomberg	Los Angeles County Mental Health
Edith Thacher	Project Manager, Cambria Solutions
Dina Kokkos-Gonzales	DHCS, Program Policy & Quality Assurance Branch (PPQAB)
John Lessley	DHCS, Quality Assurance (QA) Section
Monika Grass	DHCS, QA Unit
Sean Mulvey	DHCS, QA Unit
Susan Stackhouse	DHCS, QA Unit
Craig Harris	DHCS, QA Unit

Carol Sakai	DHCS, Program Compliance & Oversight Branch (PCOB)
Janet McKinley	DHCS, PCOB
Teresa Castillo	DHCS, PPQAB
Richard Hildebrand	DHCS, PPQAB
Mike Wofford	DHCS, Pharmacy Policy
Dorothy Uzoh	DHCS, Pharmacy Policy
Margaret Tartar	DHCS, Managed Care
Others?	

Measurements Task Force Members

Abram Rosenblatt	EMQFF
Nathaniel Israel	San Francisco DPH
Stephanie Oprendeck	CiMH
Cricket Mitchell	CiMH
Saumitra SenGupta	APS Healthcare
Debbie Innes-Gomberg	Los Angeles County Mental Health
Jason Miller	Ventura County Behavioral Health
Edith Thacher	Project Manager, Cambria Solutions
Dina Kokkos-Gonzales	DHCS, PPQAB
John Lessley	DHCS, QA Section
Monika Grass	DHCS, QA Unit
Craig Harris	DHCS, QA Unit
Others?	

Appendix D: List of Meetings Held

This appendix provides the dates of meetings held by the stakeholder committees involved in developing the system plan.

Dates of Stakeholder Advisory Committee Meetings

These meetings were held in Sacramento and both WebEx and conference call options were available to participants. Materials were provided in advance to participants. Materials are posted on the DHCS internet site after meetings at:

<http://www.dhcs.ca.gov/individuals/Pages/PerformanceandOutcomesSystemforMedi-CalSpecialtyMentalHealthServices-StakeholderAdvisoryCommittee.aspx>

- October 4, 2012
- April 30, 2013
- July 23, 2013

Subject Matter Expert Workgroup

These meetings were held in Sacramento and both WebEx and conference call options were available to participants. Materials were provided in advance to participants. Materials were shared among members between meetings and updated. Materials from the Workgroup were discussed with the Stakeholder Advisory Committee.

- January 14, 2013
- February 26, 2013
- April 12, 2013
- April 17, 2013
- April 24, 2013
- May 8, 2013
- May 28, 2013
- June 19, 2013
- July 3, 2013
- July 17, 2013
- July 31, 2013
- August 14, 2013
- August 28, 2013

Measurements Task Force

These meetings were held primarily via WebEx and conference calls. Materials were provided in advance to participants. Materials were shared among members between meetings and updated. Materials from the Workgroup were provided to the Subject Matter Expert Workgroup.

- June 10, 2013
- June 25, 2013
- July 10, 2013
- July 24, 2013
- August 7, 2013
- August 21, 2013

DRAFT

Appendix E: Survey and Research Summary

This information was presented to the Stakeholder Advisory Committee on April 30, 2013. It is posted on the DHCS internet site.

Summary of Research Conducted by the Department of Health Care Services (DHCS)

DHCS has conducted the following research regarding the development of the POS system for Medi-Cal specialty mental health services for children and youth. The purpose of this research is to determine state and national efforts and activities related to mental health performance and outcomes measures. This research also includes a review of federal and state laws and regulations related to the development of a POS system.

Research of National Efforts and Activities

A. DHCS conducted a survey of other states' activities. The survey was conducted by the National Association for Medicaid Directors on behalf of DHCS. The results of this survey are as follows:

- The following 19 states responded to the survey: AK, AZ, AR, FL, ID, IL, IA, KY, MD, MA, MI, NJ, OK, PA, TN, TX, VA, VT, and WV.
- Of these 19 states, only IL and OK reported that they do not have a POS for children.
 - OK is the only state to not have a POS for both children and adults.
- Most states require community mental health providers and health plans to report performance data.
 - AZ and OK are the only two states surveyed that do not require any reporting on performance data.
- Most states, 11 of 19, reported that they collect POS data for children's services at least annually.
 - 7 of 19 (36.84%) indicated quarterly reporting.
 - 4 of 19 (21.05%) require monthly reporting.
- This survey served as a starting point for DHCS to look into other states (such as New York and Maryland) further.

B. DHCS conducted an analysis of the state of New York's Kid's Indicators system. The results of this analysis are as follows:

- The state of New York began the development of a "[Kid's Indicators](#)" Dashboard in 2002.
 - This system was developed over a period of eight years and it consisted of two phases.
- The following four tools are used to analyze data for children, teens and families.
 - Children and Adult Integrated Reporting System ([CAIRS](#))

- Child and Adolescent Needs and Strengths – Mental Health ([CANS](#))
- The OMH Youth Assessment of CARE Survey ([YACS](#)) and
- Family Assessment of Care Survey ([FACS](#))
 - The surveys are held annually and distributed by mental health providers between the months of March and April to youth and their families.
 - Surveys are completed anonymously.
- All of the results are sent to the New York Office of Mental Health for processing and uploading to the state's portal.

C. DHCS conducted an analysis of the state of Maryland's Outcomes Measurement System (OMS). The results of this analysis are as follows:

- The [OMS](#) was developed on behalf of Maryland's Department of Health and Mental Hygiene (DHMH) and the Mental Hygiene Administration (MHA) by the External Quality Review Organization (ValueOptions) and was implemented statewide in September, 2006.
- The system is designed to track how individuals receiving outpatient mental health services are doing in the following life domain categories:
 - Housing
 - School/employment
 - Psychiatric symptoms
 - Functioning
 - Substance abuse
 - Legal system involvement
 - General health
- The measures are captured using an online questionnaire conducted every six months for either the child or the caregiver.
- The results are recorded in the OMS database.
 - The OMS information, which is gathered directly through interviews between the clinician and consumer, is collected at the beginning of treatment and approximately every 6 months while receiving treatment.

Research of State Efforts and Activities

D. DHCS conducted a survey to obtain stakeholders' feedback regarding the POS system. The results of the survey are as follows:

- Five questions were sent to stakeholders and posted on the DHCS website.
- Five responses were received from the following:
 - Counties
 - Providers
 - Local Organizations
- The responses fell into the following categories:

- All perceived a problem in the quality of Medi-Cal specialty mental health services provided to children and youth. Stakeholders identified the following:
 - Lack of quality services, particularly out-of-office/in-home services.
 - Under-utilization of evidence-based practices.
 - Lack of assessing quality of services due to lack of appropriate data.
 - Respondents would like to see a standardized data collection system.
 - Identified outcome measures based on evidence-based tools and treatment approaches.
 - Need for collection of statewide performance and outcomes data for children/youth.
- Outcomes need to be tied to the child's/youth's diagnoses and treatment (i.e., reduction of symptoms).
- Data system needs to entail easy input and output and should allow for feedback.
- Integrate the POS system to other statewide data collection efforts.

E. DHCS conducted a survey of Mental Health Plans (MHPs). The results of the survey are as follows: (Note – This information has been updated since it was presented to the Stakeholder Advisory Committee as more MHPs responded.)

- 54 of 56 MHPs responded.
- MHPs are utilizing the following system(s):
 - 17% utilize the Child and Adolescent Level of Care Utilization System (CALOCUS)
 - 37% utilize the CANS
 - 46% utilize other systems including, but not limited to: the Youth Outcome Questionnaire (YOQ), the Child Behavior Checklist (CBCL), UCLA Post Traumatic Stress Disorder (PTSD) Index for DSM-IV Child, Adolescent, and Parent Version and the Vanderbilt ADHD Diagnostic Parenting Rating Scale (Vanderbilt-Parent) – (systems in the “Other” category were only included if four or more counties used the same system).
 - 4 MPH do not use a system

Research of Federal and State Laws and Regulations

F. DHCS conducted a review of federal laws and regulations related to the development of the POS system. The following is a summary of DHCS’ and MHPs responsibilities regarding activities related to performance, outcomes and quality assurance activities.

- Pursuant to federal Medicaid requirements for managed care programs (Title 42, Code of Federal Regulations, Part 438, §§438.200 through 438.242), DHCS is

required to implement quality assessment and performance improvement strategies to ensure the delivery of quality health care by MHPs.

- DHCS is required to:
 - Ensure that MHPs adopt practice guidelines which need to be based on valid and reliable clinical evidence; consider the needs of the beneficiaries; are adopted in consultation with health care professionals; and are reviewed and updated periodically.
 - Ensure that MHPs have an ongoing quality assessment and performance improvement program. At a minimum, DHCS is required to ensure that MHPs:
 1. Conduct a performance improvement project (PIP) designed to achieve significant improvement in clinical and nonclinical areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. PIPs must involve the following:
 - a. Measurement of performance using objective quality indicators.
 - b. Implementation of system interventions to achieve improvement in quality.
 - c. Evaluation of the effectiveness of the interventions.
 - d. Planning and initiation of activities for increasing or sustaining improvement.
 2. Submit performance measurement data. Annually, each MHP must:
 - a. Measure and report to DHCS its performance using standard measures required by DHCS that incorporate the requirements of §§ 438.204(c) and 438.240(a)(2);
 - b. Submit to DHCS data, as specified by DHCS, that enables DHCS to measure to MHP's performance; or
 - c. Perform a combination of the activities described in a and b.
 3. Have in effect mechanism to detect both underutilization and overutilization of services.
 4. Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees.
 - Ensure that MHPs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve these requirements.

G. DHCS conducted a review of state laws and regulations related to the development of the POS system. Based on this review, the following represent areas that may be considered in the development of the POS system:

- Level of placement
- Education
- Juvenile justice
- Client demographics
- Individual and family functional status
- Service provisions

- Consumer satisfaction

DRAFT

Appendix F: Performance and Outcomes Matrix

The Performance and Outcomes Matrix is a conceptual framework of the ideal for measuring outcomes. It provides a framework of outcomes measures grouped in domains as well as examples of the indicators that could be captured to measure the outcomes. The matrix speaks to evaluation, not to service delivery and it is not a list of system requirements.

Domain/Outcome		Rationale	Examples of indicators/measures All by age, gender, ethnicity, language, area, etc	Level			Authority	
				1 Child Fam	2 Pro- gram	3 Sys- tem	STATE	FED
ACCESS	Children served and not served (Penetration rate) A & B	System should be adequate to need. Untreated individuals have higher health etc. costs	Relative to estimated prevalence, % of Medi-Cal beneficiaries who receive treatment - (Penetration rate)	x	x	x	x	x
	Timeliness	Delayed care increases MH & partner services costs	Wait time for evaluation, treatment (Provider access)	x	x	x	x	x
	Service denials	Any eligible child	Service modifications, reductions or terminations, are lessened	x	x	x	x	x
ENGAGEMENT	Children and Caregivers participate in services	System able to serve beneficiaries: related to both dropout and treatment success	Children and Caregivers perceive services as necessary, collaborative and useful	x	x	x	x	x
	Services are maintained		Percent of clients served in a year with >1 mental health contact	x	x	x	x	x
	Collaborative assessment of environmental factors	Understanding stressors/support experienced by family	Evaluate family functioning, relationships, community support etc	x				

Domain/Outcome	Rationale	Examples of indicators/measures All by age, gender, ethnicity, language, area, etc	Level			Authority		
			1 Child Fam	2 Pro- gram	3 Sys- tem	STATE	FED	
Service appropriateness to need * (should include cultural appropriateness of service/language)	Quality of Care Standards	Adhere to practice standards and practice parameters	% of MH clients whose TX matches their DX, Symptoms or Needs	x	x	x	x	x
	Treatment consistent with treatment plan	Both under-use and over-use of treatment have been linked to negative child outcomes	Quantity, duration, and frequency of service is appropriate to the client's need. Continuity of care	x	x	x		
	Child's clinical status	Diagnosis of record should be substantiated	A Diagnosis (include substance use/abuse) B Symptomatology (severity)	x	x		X?	
	Functional status	Dx alone does not predict how severe the problem is	A Individual client B Family: assess family strengths and challenges	x	x		X?	
	Psychotropic medication	Avoid over- and under- or wrong medication & wrong med. For DX	The medication is appropriate for the child's DX	x	x	x	x	x
	Modality of care (e.g. individual, family, group therapy)	Appropriate modality and LOC for Dx & type, severity of need	Treatment modality and level of care (LOC) (e.g. out-patient, community-based, residential etc)	x	x		??	
	Ongoing engagement, empowerment	Optimize exchange of info as Tx progresses	Families give <u>and</u> receive adequate information	x				x

Domain/Outcome		Rationale	Examples of indicators/measures All by age, gender, ethnicity, language, area, etc	Level			Authority	
				1 Child Fam	2 Pro- gram	3 Sys- tem	STATE	FED
EFFECTIVENESS – To normalize child’s developmental progress	Fidelity to treatment model of practice standard	CA mental health providers should practice up to established standards of profession	Continuous quality improvement. Use of EBPs when appropriate	X			X	X
	Child symptomatology	Intervention should help to reduce symptoms	Clinical evaluation and standardized measures	X			X	X
	Child level of functioning	Intervention should increase child’s level of function or independent functioning	Clinical evaluation and standardized measures	X			X	X
	Increased natural supports and social integration	Return to positive developmental trajectory	Shared data from partner agencies, and clinical re-assessment	X	X		X	
	Family mental health/substance abuse and relationship status	Child cannot be treated as an isolated individual: treatment must address child’s context	- If a family member has a mental disorder they are receiving treatment - Family relationships improve -Family is better able to meet the child’s emotional and behavioral needs	X	X		X?	

Domain/ Outcome		Rationale	Examples of indicators/measures All by age, gender, ethnicity, language, area, etc	Level			Authority	
				1 Child Fam	2 Pro- gram	3 Sys- tem	STATE	FED
EFFECTIVENESS – continued	Collaborative re-assessment of environmental factors. This includes A -F	Understanding how family handles and increases use of supports	A-Children and youth function in community settings with optimal independence from formal service systems.	x	x		x	
		Children at home	<u>B- Housing/Placement:</u> Avoid preventable out-of home placement	x	x		x	
		Children in school and succeeding	<u>C- School:</u> (a) optimize functioning in school, (b) % who receive special education services (IEP or 504)	x	x		x	
		Children out of trouble	<u>D- Juvenile Justice involvement:</u> reduce or prevent	x	x		x	
		TAY youth able to move toward independence	<u>E- Employment/</u> Employment attachment (TAY)	x	x			
		Children safe	<u>F- Safety:</u> CPS involvement, freedom from exploitation, satisfaction with personal safety	x	x	x	x	

Domain/Outcome		Rationale	Examples of indicators/measures All by age, gender, ethnicity, language, area, etc	Level			Authority	
				1 Child Fam	2 Pro- gram	3 Sys- tem	STATE	FED
LINKAGES	Care coordination or integration A and B	MH providers work synergistically to provide for full range of child's needs	A- Treatment plan indicates coordination with other partner agencies as needed (e.g. schools, primary care provider, CSS, JJ)	x	x		x	
		Failure to provide support at this stage associated with failed placement etc.	B- Track youngsters as they step down from higher to lower levels of care	x	x	x	?	?
	Health status	Mental health services recipients should have equal access (relative to the general population) to effective general health care.	Percent of Medi-Cal children and youth who receive mental health services during the year that also received physical health care services through Medi-Cal.	x	x	x		x
	Family/ Caregiver health status	Parental illness affects capacity for parenting	Client record to include information about family health status	x	x			?