

POLICY AND SYSTEM DEVELOPMENT YEAR END REPORT
California Mental Health Planning Council
2010

The Policy and System Development Committee is responsible for examining critical system issues, changes in the mental health system and key elements of the system. In 2010, the Committee focused on what could be learned about county mental health systems and how they used their data to inform their policy decisions. This inquiry was stimulated by concerns about changes that were being made due to funding pressures and how those changes were impacting MHP programs. The Committee also continued its work to advocate for improved housing programs through examination of county programs and state policies. Housing for persons with mental illness is considered a key element in quality mental health systems.

**SECTION I – UNDERSTANDING WHAT IS HAPPENING IN
COUNTY MENTAL HEALTH PROGRAMS AND THE DATA DISCONNECT**
What the state requires for tracking vs. what counties need for planning

“The state data I get back helps about 5%. It needs to be more thorough, the results displayed more predictably, and more timely”.¹

BACKGROUND:

During 2010, the Policy and System Development Committee (PSDC) made an effort to solicit input from counties on their data collection systems and how they used data to inform their policy decisions. The significant role it plays in helping counties determine which programs merit retention or expansion increases as budget cuts continue to threaten the breadth and depth of mental health services offered at the local level. This focus was inspired by and reinforced during the year by other presentations in other committees in which the reports produced by counties provide a clearer description of what the state of mental health services is in California than that which is provided by the state. The Department of Mental Health (DMH) is not providing counties with reports on the data that is collected.

In 2010, Orange County and Placer County made presentations to the PSDC on how they collect their data and what information they seek in order to evaluate the quality of their programs. Despite the stringent reporting requirements of DMH, both counties have had to develop their own internal data systems in order for it to be useful. The PSDC also learned about the different data batches collected by the State DMH and how the state and counties interact with each other.

¹ Comment from mid-size county representative on DMH data services

ORANGE COUNTY

Orange County is a strong believer that data collection and display keeps stakeholders informed and the programming process transparent. To that end, each FSP program has its own data analyst and outcomes are displayed on a dedicated webpage accessible by the public. FSP data collection is based on the old CAMINAR system used to document AB 2034 outcomes, but modified to inform at the local level and to update changes in consumer status as they occur. The county uses the “Mile Stones of Recovery Scale” (MORS) across the system to ensure members are served based on their level of need and are moving across the continuum of recovery. It also collects and reviews data on levels of housing to ensure movement towards independence and satisfaction with housing situation. Lastly, it reviews degrees of financial independence to ensure the system is supporting members towards being evermore self sufficient and less dependent on the system.

Orange County focuses on some specific indicators from the statewide data systems: type of mental illness, average days of incarceration (and reduction in incarcerations); days of homelessness, percentage of members who remained housed; employment status; education and training status.

Along with identifying and reinforcing successful program strategies, data also helped them recognize weaknesses in their service delivery system. Their data demonstrated that their outreach into the less acculturated Latino population was not effective, so they improved their penetration rate by contracting with a community based organization familiar with that population segment. The low rate of employment led to the creation of a survey that measured current satisfaction against aspiration. When asked if work or education was tied into their program, some consumers replied no or did not know. Orange County developed a 14 question Likert scale asking consumers to measure their current situation and aspirations, and 75% said they wanted to work. They found that aspiration decreased with age, although it also related to the type of program in which the consumer was enrolled. Orange County also noted that state data reporting requirements does not appear to relate treatment goals to education and employment, despite their strong and positive influence on recovery.

PLACER COUNTY

Placer County has integrated all of their social services under the Health and Human Services umbrella that co-locates environmental health, animal control, and community health with human services, adult and children’s systems of care. Two years ago adult mental health reincorporated crisis services and Adult Protective Services into the Adult System of Care, which has resulted in only a two-year span for tracking the data under that configuration of services. All services are team-based and designed so that there are no “wrong” doors to access the services that are needed.

Adult system of care data tracks traditional, clinical mental health service services, such as 5150 assessments, psychiatric facility admissions, outpatient services and substance abuse treatment services along with MHSA services and LPS conservatorships. The data needed to inform program design and evaluation did not necessarily align with what DMH requires, so Placer identified its own indicators and developed its own set of indicators to evaluate program effectiveness. Tracking the incidents of

readmission drew the county's attention to a program weakness that resulted in a modification and improved outcomes.

The FSP data Placer County collects is not part of the state's data bank due to compatibility issues and implementation challenges. On the adult side, the FSP outcomes focused on people who were in IMDs and locked facilities. There has been a significant reduction in people who reside in IMDs and also the number of readmits, which is due to better discharge planning and step down services.

Placer County developed its own consumer satisfaction survey based on the DMH Consumer Perception of Care and Quality Improvement survey. This has provided strong feedback on the consumers' perception of care over three years. Care dimensions included access, quality & appropriateness, perceived outcomes, treatment planning participation, and general satisfaction of consumers at the five outpatient sites. The verbatim comments of the consumers from the five outpatient sites are highly valued by Placer County.

As a mid-size county, Placer has struggled with complying with the data requirements imposed by DMH. Unlike small counties, which are exempted, and larger counties who have their own MIS staff, Placer has had to rely on vendors to meet the changes, which creates an additional fiscal and systemic burden and any data sets released by the state are typically too outdated to be of use.

State Data

*"There seems to be kind of a disconnect between the data requirements that the state requests and that counties report, and the data the state reports back - it does not truly reflect the counties."*²

The DMH employs eight different databases to collect, connect, and arrange the data it requests from counties. Of these, the Client and Services Information System (CSI) has the longest reach that connects to both MHSA services and Medi-Cal mental health services. Despite the several avenues available for information to travel into the DMH data bases, the reports that come out are considered by the counties to be out of date, and not truly reflective of the information they need to evaluate their presence or effectiveness in the community.

DATA SYSTEMS

- The Client Services and Information System (CSI): Client level data submitted upon admission and each time a service is rendered. Contains demographic data, such as age, gender, race/ethnic; and services provided. Annually, data on employment status education, living arrangement reported
- Data Collection on Reporting System (DCR): Client level longitudinal outcomes data on Full Service Partnerships in Mental Health Services Act. Data collected for each target population. Data gathered at admission, as key events occur for some indicators, and on a quarterly basis for other indicators
- Web-based Data Reporting System (WBDRS): Used to collect Consumer Perception of Care data, providing information about satisfaction with mental health services and quality of life for each target population

² Comment from county service provider.

- ☑ Short-Doyle Medi-Cal Approved Claims: Compilation of cost of specialty mental health services data for individuals who qualify for Short-Doyle Medi-Cal
- ☑ Medi-Cal Eligibility File (MEF): Contains eligibility and demographic information on Medi-Cal beneficiaries
- ☑ MHSA Annual Revenue and Expenditure Report: provides a summary of money received and spent by each county for MHSA programs and services
- ☑ MHSA Exhibit 6: Aggregate counts of individuals served by Community Services and Supports, General Systems Development, and Outreach and Engagement; submitted on a quarterly basis and the final report of the year is an unduplicated count of individuals served each fiscal year

THE CONNECTIONS:

- ☑ The CSI system employs unique client identifiers that link demographic data to other systems, such as the DCR for Full Service Partnerships and WBDRS for Consumer Perception of Care.
- ☑ The DCR links to other state data systems, such as the Consumer Perception of Care data, using the unique client identifier.
- ☑ Short-Doyle Medi-Cal Approved Claims measures service delivery and links to the Medi-Cal Eligibility database and the CSI for demographic information.
- ☑ With the MHSA Annual Revenue and Expenditure Reports current efforts are aimed at adapting the format to enable statewide data aggregation.

THE DISCONNECTS:

- ☒ MHSA Exhibit 6 Quarterly Reports provide aggregated counts on the number of people receiving MHSA services by component, but do not include demographic information.
- ☒ While the CSI does report out on services rendered, the system does not link to reimbursements and some demographic fields are poorly reported. For example, the percentage of client records displaying as “invalid race” in FY07-08 was nearly 18.5% and somewhat improved in FY08-09 to nearly 12%.
- ☒ CSI reporting is incomplete. In fiscal year 2006-07, the system reported that 591,000 clients were served; in fiscal year 2008-09, the system reported that 433,000 clients were served. This reduction does not reflect an actual reduction in clients served because other data systems that report clients served, such as the Short-Doyle Medi-Cal Approved Claims file showed a jump in expenditures during this period from \$680 million to \$760 million. EPSDT claims showed a similar increase.
- ☒ For the Web Based Data Reporting System, the county was required to conduct Consumer Perception of Care and Quality of Life surveys in their communities twice a year for two week sample periods. The process was burdensome for both the county and consumers. The state is in the process of converting to random sampling, which is preferred by SAMHSA. However,

this change means that satisfaction and quality of life data will no longer be available at the county level.

- ⊗ MHSAs Revenue and Expenditure Reports are not standardized across counties. Formatting can change from county to county and from year to year. Client-level cost information is not broken out.
- ⊗ With the MHSAs Exhibit 6, the counts of people are not unduplicated because they may be counted in the General System Development, and again in Outreach and engagement and the Community Services and Supports. Service category counts are broad and do not include types of services provided within the category.
- ⊗ Amongst the MHSAs population data bases, the counts on Active Unduplicated FSPs vary between the DCR and the Exhibit 6.
- ⊗ The MHSAs Annual Revenue and Expenditure and the MHSAs Exhibit 6 reports link to each other but neither of them link to the CSI or other data systems.

The DMH is starting to develop reports using FSP data. The Planning Council has developed a set of performance indicators for evaluating the MHSAs and the public mental health system. It has selected a smaller set of prioritized indicators for which the DMH is developing reports. To date, they are working on number of arrests and residential status. Once the state level reports are completed, the DMH is going to generate county level reports on these indicators.

Overall, the message from both counties was that DMH collects a lot of data that does not benefit the counties. There is a measure of inflexibility in the data reporting systems that make updates and modifications difficult. DMH needs to collect the data and clean it in a timely manner. It also needs to produce county level, user friendly reports in a timely manner. By the time the data is collected, cleansed, and reported out, it is usually outdated. In order to make the collected data timely, meaningful and useful for program planning, counties have had to develop their own data reporting systems.

Conclusions and Recommendations:

- Counties, of necessity, create data reporting systems that help them manage and evaluate their programs. From the presentations that the Planning Council has seen, (not just in this committee but in all presentations to the Planning Council) the quality of the data and its usefulness at the county level far exceed that which is aggregated statewide from the state data systems. This is due to the complexity, size and diversity of California counties and the problems with cleaning, aggregating and reporting data in a way that is meaningful to constituents. The Planning Council should explore the implications of this reality by:
 - Supporting counties in their efforts of data collection, supporting policies that contribute to the ease of data collection, and highlighting innovative and informative data collection by counties and their reporting to constituents, legislators, DMH and other interested parties.
 - At the state level, focus on key indicator approaches such as the performance indicators developed by the Planning Council and its prioritized set of indicators; keep these indicators at a minimum. As needed, develop additional indicators in the context of the

Affordable Care Act and its impact on Medi-Cal and Medicare populations (e.g. HEIDIS indicators)

- Continue working with DMH on its recent efforts to produce statewide and county level data
- Recognize the resource limits of DMH in producing data, and use as much as possible existing quality statewide data, such as that developed by the External Quality Review Organization.

SECTION 2 – KEY ELEMENT IN THE COUNTY MENTAL HEALTH SYSTEMS: HOUSING ISSUES IN 2010

Housing continues to be a significant priority area of concern for the PSDC. The ongoing economic downturn has impacted all aspects of mental health services, and it appears that supportive housing has borne the brunt of the hardship on counties. The diminishment of resources for counties to leverage is pervasive throughout the funding stream. The lack of housing bonds being issued for new development joins the anticipated decrease in income-tax based MHSA funding and the risk-averse banks' reluctance to finance any type of development after the housing crisis. Despite the negative fiscal environment, there have been some advances in the MHSA housing process.

- Shared housing is now a recognized option for MHSA funding. Counties wishing to utilize shared housing as a housing option now have an official application, directions, and process to follow.
- The DMH recently promulgated regulations regarding housing development using General Services Development funds. The updated regulations are intended to make it easier for counties to obtain project-based housing by offering more flexibility in how the funds are used.

In presentations to the PSDC and other committees, innovative housing models have emerged and evolved as community needs dictate. In Riverside, MHSA housing development holds a minimum increment of 15 MHSA units in order to justify/dedicate a FSP FTE for each site. The developments are located near the supportive services offered to the residents, and each region has senior housing included in its MHSA units. All are sited with easy access to public transportation. Strategies that have worked well for Riverside are

- The over the counter development application process rather than an RFP;
- Peers as on-site staff;
- Having FSP supportive services on-site; and
- Retaining the use of a development specialist for the more technical aspects of site acquisition and funding.

Keeping a firewall between the duties of the wellness partner and the housing resources specialist is essential to making the system work.

Ultimately, Riverside fell victim to the scarcity of resources and was forced to drastically cut back on the MHSA supportive housing services when the operating subsidies were depleted and the program was ordered to reduce the enrollees. The 164 people in subsidized housing were reduced down to 35 as of April 2010. Some of the residents found employment and were able to afford market rents if they teamed up with each other.

Bonita House in Alameda has been operating since it bought its first program house in 1970s. In 1991 it narrowed its focus on adults between the ages of 18 and 59. It has operated continuously through a patchwork of HCD, HUD, and MHSA housing programs and scattered site housing and collaborates with a variety of partners throughout Alameda County. All sites have rental subsidies through Section 8, Shelter + Care, MHSA, and tenants pay 30% of their own income toward the rent.

The HOST (Homeless Outreach and Stabilization Team) officially opened in spring of 2007 and had enrolled 90 people as of June 2010. Each partner gets to meet prospective landlords and visit rental units prior to deciding where they would like to live. Partners pay their rent to the program and the program pays the landlord. This has been very successful at earning and keeping the trust of the landlords, thereby ensuring that they will be open to keeping their units available to HOST partners. Should problems arise with collecting the Partner's share of the rent, eviction proceedings are handled between the Partner and the Program. The program has had a 96% retention rate and has locations in Berkeley, Alameda, Oakland, and Hayward.

Once established, residents have the option of receiving employment training or education through HOST's supported employment program. The program is consumer-driven, emphasizes choice, and has one full-time Supported Employment Specialist. Forty-seven percent of the HOST partners are enrolled in training and 60% are either seeking employment, interns, or are actively employed.

In 2010 Bonita House was also selected to provide the housing services for CHOICES, a community living program utilizing a county-wide collaborative of pooled resources. It establishes a transition route over three to five years for people who are presently well served, supporting their goal of exiting the system and opening up their supporting housing and services to others. The CHOICES housing component operates on a three year (\$600 a month) or five year (\$360) rental subsidy. Partners work with the program to determine which meets their needs the best, depending on their goals. Service partners document all services or activities on-line so that all information is shared.

The presentations on housing programs from these two counties reinforced the Committee's understanding, which has developed from presentations in previous years and from input to the Council from clients and family members, that there are good housing programs in counties which support clients in the community; that those programs need stable funding, not subject to the ups and downs of the economy, and that the state, counties, and advocates should continue to do all we can to support these programs