California Behavioral Health Planning Council

Performance Outcomes Committee Agenda

Monday, September 25, 2023
Virtual meeting
Zoom Meeting Link
Call In #: +1 669 900 6833
Meeting ID: 819 1788 5253
Passcode: 211654
2:00pm to 3:00pm

2:00 pm	**Welcome and Introductions / Setting the Stage for Today's Meeting** *Susan Wilson, Chairperson*	
2:05 pm	**Performance Outcomes Measures: Next Steps**	**Tab 1**
2:50 pm	**Next Steps and Planning for Future Activities** *Susan Wilson, Chairperson*	
2:55 pm	**Public Comment**	
3:00 pm	**Adjourn**	

The scheduled times on the agenda are estimates and subject to change.

Performance Outcome Committee Members
Chairperson: Susan Morris Wilson
Chair-Elect: Noel O'Neill
Members:

Karen Baylor
Steve Leoni
Catherine Moore
Uma Zykofsky
Erin Franco
Darlene Prettyman
Walter Shwe

Invited External Partners
Theresa Comstock, CA Association of Local Behavioral Health Boards/Commissions
Samantha Spangler, California Institute for Behavioral Health Strategies

Council Staff
Justin Boese
Linda Dickerson

If reasonable accommodations are required, please contact the Council at (916) 701-8211, not less than 5 working days prior to the meeting date.

TAB 1

California Behavioral Health Planning Council
Performance Outcomes Committee
Monday, September 25, 2023

Agenda Item: Performance Outcomes Measures: Next Steps

Enclosures: Excerpt of Meeting Minutes from April 2023 General Session

How This Agenda Item Relates to Council Mission

To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides the opportunity for council members to discuss the definition and scope of performance outcomes measures in order to better evaluate the behavioral health system.

Background/Description:

The California Welfare and Institutions Code gives the California Behavioral Health Planning Council the responsibility and authority to review program performance in delivering mental health and substance use disorder services. This includes:

- Reviewing and approving performance outcomes measures
- Reviewing performance outcomes data and other reports from the State Department of Healthcare Services and other sources
- Reporting findings and recommendations on the performance of programs to the Legislature, DHCS, and the local boards

The lack of consistent performance outcomes measures has been identified as significant issue in the public behavioral health system in California. The committee organized a 2-day event for the April 2023 CBHPC General Session, consisting of:

- A moderated panel of experts to discuss performance outcomes, including defining and identifying performance outcomes measures.
- A council member led discussion of performance outcomes measures to identify priorities and next steps for the Planning Council.

The committee will spend time discussing the “next steps” for the ongoing project of addressing performance outcomes measures.

Excerpt of Meeting Minutes from CBHPC April 2023 General Session: Performance Outcomes Measures

Day 1: Panel on Performance Outcomes Measures

Susan Wilson, Chairperson of the Performance Outcomes Committee, moderated a panel discussion on Performance Outcomes Measures with panelists Tara Niendam, Samantha Spangler and Debbie Innes-Gomberg.

Tara Niendam introduced is a child clinical psychologist and a professor in the Department of Psychiatry at U.C. Davis Medical Center. She stated that evaluating outcomes is critical for our mental health system and her entire career has been around evaluating outcomes, particularly as it pertains to youth with serious mental illness. Her area of expertise is early psychosis. She is a researcher, the Executive Director of the Early Psychosis Programs at U.C. Davis, and a Sacramento County contract provider of early psychosis services. Tara is also the Director of EPI-CAL which is a new MHSOAC and DHCS funded training and technical assistance and outcomes evaluation collaborative across the state of California.

Samantha Spangler is the founder of The Behavior Health Data Project, which is a consulting firm. Her academic background is in neuroscience and about 10 years ago she transitioned into health and human services consulting work. Prior to starting her own consulting firm, she was the Research and Evaluation Director at the California Institute for Behavioral Health Solutions. She is not a primary researcher, but she often works with service providers and with counties and state governments to help them use the data that they must analyze how well things are going and to communicate back to the people that need to know.

Debbie Innes-Gomberg is a Deputy Director with the Los Angeles County Department of Mental Health. She has worked for the Department for 30 years. She oversees quality outcomes and training and became involved with outcomes in 2006 dealing with the Mental Health Services Act. She shared that she would be very happy to see a statewide outcomes system that is about functional outcomes.

Susan expressed the importance of Performance Outcomes Measures to the Planning Council and that it is the Council's responsibility is to review program performance in delivering mental health and substance-use disorder services by annually reviewing performance outcome data.

The Council is tasked with the following list of actions:

- Review and approve the performance outcome measures which we do not have.
- Review the performance of mental health and substance-use disorder programs based on the performance outcome data and other reports from the State Department of Health Care Services and other sources.

- Report findings and recommendations on the performance of programs annually to the legislature, to the State Department of Health Care Services and the local mental health boards and to post those findings and recommendations annually on its internet website. We have tried to meet this by doing the Data Notebook.
- To identify successful programs for recommendation and for consideration of replication in other areas as data and technology are available, identify programs experiencing difficulties.

Susan also acknowledged some of the challenges the Council has in fulfilling these responsibilities are not having enough Council staff, the Data Notebook depending on other people for data that varies in its validity and reliability, and issues with the age of the data when using data from big organizations such as the Department of Health Care Services.

Panel Discussion

Question 1: How do you define performance outcome measures? And what are two or three examples of something that you have collected? And how long did you spend collecting them? How did you manage them?

Samantha replied that she takes a broad approach to defining a performance outcome measure. A performance outcome can be anything that you use to measure whether you are achieving your goals. For behavioral health services the primary goal should always be improving the lives of the people served. She is currently evaluating a 12-clinic, 18- month collaborative that aims at improving recovery-oriented outcomes and equitable access to care using behavioral telehealth. That collaborative has three primary outcome measures.

Debbie stated that outcome measures can help define the effectiveness of the care that is delivered. She made a distinction between system performance and outcomes measures, which provides data at the client level. As an example, a system could have good timely access to care but that does not tell you anything about the quality of that care the client is receiving. An example of a performance outcome measure is a combination of symptom-based measures and functional outcome measures. Functional outcomes are extremely important because that tells you about how somebody is recovering in the environment, they live in. Symptom-based outcome measures could be the Patient Health Questionnaire, for depression. An outcome measure is the Work and Social Adjustment Scale (WSAS), which is five items completed by the client. It is a very compelling measure because it focuses on how somebody is doing in their environment, their social connectiveness, their ability to maintain the place that they live and all those functional abilities. It is very powerful if you are seeing somebody for cognitive behavioral therapy to be able to go over their Patient Health Questionnaire every week and see trends then talk to the clients about the difference and contributing factors to this difference.

Tara agreed with the previous definitions for outcomes. Outcomes as they pertain to a system can be timeliness and can also be access. On client-based measures you can think about clinician-based and community-based measures. One of the most important things about outcomes is identifying who it matters to and what you trying to satisfy with the data that is being collected. As a clinician and as someone who runs a clinic and as part of a large health system, those decisions are often made at a very high level and are often driven by system needs, financial needs, not stakeholder needs. One of the things that is very important is making sure that we identify folks that are being served and are disenfranchised, disadvantaged, disempowered, and amplifying their voices and their needs in combination with the needs of other partners. The whole system should be moving together towards improvement. An example is the statewide evaluation of early psychosis programs, which were developed collaboratively. There were close to 30 focus groups in English and Spanish with clients, families, providers, leadership and state and county leadership to determine the outcomes that would be measured.

Question 2: What is the lens through which you collect performance outcome measures? Who and what do you have in mind when you choose and collect measures?

Debbie stated that perceived or real clinician burden as it relates to adding on another thing to do is something to think about. There is a real concern among clinicians on how they will get their work done if they are given another thing to do. She emphasized that what is collected must have utility for the clinician and it must make sense for the client. Data should be used to make decisions and engage clients. As a consumer the data should also be easy to understand and use to communicate with your care team. She shared that there is a lot of literature on measured-based care and different names for it such as, feedback-informed care, measurement-based care, practice-outcome monitoring, and data-driven decision-making. All of those things are really about the same thing, and that is, using data an element to tell you how treatment is going – to start a dialogue with a client about where they are right now in relation to where their goals are. Administering something with the frequency with which you see the client and can plot that out over time is important. Ongoing contributing factors can be discussed in real time. Feedback and engagement are strengthened to help clients understand their trajectory and what interventions might be most appropriate.

At the same time, you can look at the system and you can look at being able to aggregate that data up which is what we do with our early intervention and evidenced-based practices. We have general measures and then we have treatment-specific measures. We look at how a client was doing before they entered the practice and at the end of practice we report in our annual updates and three-year plans. There is usually a very significant progress. With this data it can be said that the practice is working, and it is working for these sorts of populations and our system is making a difference. This is critical because over the 18 years that the Mental Health Services Act has been in existence, the Achilles heel for it, besides money that fluctuates, has been the lack of systemic, outcome measures, aside from FSP. There was scrutiny after the MHSA Audit and the Little Hoover Commission Report, which both reported there were not outcomes to demonstrate the impact that the act is having on your communities. These resulted in the creation of a data system. An enhanced partner-level data template was used for the counties to submit data into a spreadsheet that used to demonstrate effectiveness. Demonstrating effectiveness at the state and county level and at the client level is currently missing.

Tara stated the lens depends on whether it is the client's, the clinician's, the state's, or the community's perspective being taken and whose outcomes matter. She emphasized that this is an important question that we have not thought enough about and that certain voices are prioritized over others. We have for too long focused on clinician-collected measures and it is time to think about it from a client's perspective. It is also important to think about proximal issues and contextual issues such as how the data will be shared, if it will be used in care, and what we expect people to do with it.

Samantha stated that her experience aligns with what the other two panelists described. She emphasized that the two things that come up most often in her work are the perceived and/or actual burden of collecting data and the complaint of the data being collected and then never seen again. She emphasized the importance of knowing your audience (the legislature, clinicians, the community, etc.) before you start trying to figure out how to collect and measure data. Once the audience is known the measures should be developed to communicate to that audience. Samantha also stated that qualitative information is critically important. Some issues she has seen in the quality of data are that it might have been collected unevenly and sometimes the timeline of events can be a factor.

Question 3: How should we expect quality performance outcomes measures be collected, analyzed, and shared throughout the system? Where is the data that might be useful to us?

Tara stated that if we want to show data on hospitalization and justice involvement to the legislature, one way that can be done is by doing that is by getting access to state-level data from OSHPD or Medi-Cal. You can look and see how many people in which places were hospitalized with which diagnoses. This is state-level data that is available. There is also Justice data, but it is available in individual counties. There might be some state-level data, but you cannot get that data. So, this is the data is there, but it is hiding, and you can't get it. Then you can do things at the individual level. From the client's perspective, what they care most about is their quality of life. So then, you must decide how that is defined.

Samantha stated that if you are looking for state-level health care data, DHCS is going to be the best source for the most part and the OAC will have some data. One of the challenges with that is the data is three to four years old at best. You may be able to negotiate data sharing agreements where you can look at health care claims on only on a one to two-year lag. DHCS does not consider health care data claims closed and final for two years. Claims are complicated data to analyze. Most of the time if you are trying to get faster data, it is very hard to get up-to-the-minute data from a statewide perspective because the organizations that have the up-to-the-minute data are the ones who are collecting it. California is much too large to collect data from all these different levels, but they are the ones that have the up-to-the-minute data on what they are doing. Timely data is very hard to capture as it is happening. The usual state agencies are the ones with the broad datasets and most of them will provide the data. It is challenging and usually on a big lag.

Debbie shared that her dream would be for three measures: the PHQ-9, the GAD-7, and the Work and Social Adjustment Scale (WSAS) to be implemented statewide. These three are in the public domain and 45 to 50 percent of county clients have a mood or an anxiety disorder including bi-polar disorder. DHCS would need to get some infrastructure money to be able to create the data portal. This is her recommendation.

Samantha said she would endorse that vision especially if we could emphasize quality of life data. People often tell us that symptoms such as depression might be lessened but they still do not feel they have a good quality of life or vice versa. There is significant evidence that people can live with high symptomology and still have a high quality of life.

Questions from Council Members for Panelists

Moderator Susan Wilson asked: How can you differentiate between process and outcome measures?

Debbie said that when I think of process measure, I think of a measure of like a systems sort of measure; a measure of how one is doing something. One of the process measures I think about is something like access to care versus an outcome that is really focused on the impact we have on a client as measured in some way. A process measure could also be fidelity to a practice. When I think about an outcome measure, I think about, is the client getting better? Are they achieving their recovery goals? That is my key distinction there.

Tara stated that I tend to think of process measures as the things you can change. And then the outcome measures are the things you want to change. I would define it a bit more broadly. These are things you can change and things you want to modify. What do you want to see differences in as a result of those changes?

Samantha said that I am very well aligned with that. I think of process measures as measuring what you do and outcome measures as measuring what happened because of what you did.

Uma Zykofsky asked: How would you categorize the number of assessments counties report that they did? Is it really a measure of any quality or is it just a quantitative measure of something?

Samantha said that if I am picking between process and outcome, that is a process that you did this many. And the problem is, what do you do with this? It doesn't really tell you anything. You need other pieces of information to make that particular measure make any sense. You need to know why you are doing an assessment and what that assessment tells you. And what does research tell you about how frequently you should be doing assessments?

Moderator Susan Wilson asked: How can the Planning Council collect useful qualitative data? What is a valid way to analyze qualitative data?

Tara stated that a valid way to analyze qualitative data was an interesting question. So, in qualitative research, you put together an interview guide that is guided by the questions that you want answered. Usually, you build that guide in collaboration with experts and, hopefully, people who represent the groups you want to collect data from. Then you set up focus groups if you want opinions that are representative of the population of interest. You may modify the questions you ask until you get, “saturation”. You are starting to hear the same responses repeatedly. You take all that data and have it transcribed. You then go through and systematically code it. You train people in a coding scheme and they systematically code it. You then look for, “themes” that emerge over the topics of interest. There is a whole literature and world of qualitative data collection and analysis. You can also do this with interviews if you want to get an individual’s experiences. There are different ways depending on the data you want. You end up coding it and being able to distill it down to themes. I find this particularly helpful when I am trying to build a study to understand what matters to people. This is then used to guide quantitative data, collection or analysis. When I build studies, I always have qualitative and quantitative at all levels of the study. I am always getting the story behind the numbers by getting feedback from the client if my data makes sense. It helps me to make sure that I am making sense of the data I am collecting.

Samantha added that good, qualitative data analysis takes multiple longer steps than good qualitative data analysis. It is very time-consuming. It takes a lot of people and it needs to be very consistent. It needs to be very collaborative so that it is not just one person’s opinion of things. The data in and of itself is subjective. It is subject to interpretation.

Debbie added that when you are querying stakeholders, say, in more of a county setting and trying to understand what is important to stakeholders, qualitative data can be super helpful. Oftentimes, stakeholders want to know that you have recorded the information that they said. That is important and that tells them something. Being able to articulate that document is important.

Moderator Susan Wilson asked: How can the Planning Council collect useful qualitative data?

Samantha said that she gave steps on how to create the questions that you want to ask. The other piece and sometimes the hardest piece is, finding the people that you want to talk to and getting them to come to you or you go to them in a way that they feel comfortable speaking to you and that you reach broad categories of people that you want to reach.

Tara noted that you could use that for qualitative data analysis. You can take that data and code it. It is as good as a focus group – no. You do not get the focus group interactions in a survey. Sometimes a survey is a great place to start.

Debbie stated that every year I wind up organizing the Data Notebook in LA. I think it is an opportunity to talk about data. I think it is an opportunity at the county level to talk about – what does this mean? Maybe here, what are we learning about where the counties are at? And how are they responding to these Notebooks and why are we not getting greater participation?

Part of it is engaging people in getting curious about data. In Los Angeles we ask all the time – what does this data we are collecting mean? Is this helpful to you. These sorts of questions could happen at all sorts of level related to the Data Notebooks.

Council Discussion

Susan noted that one of the problems is how the Data Notebook is handled at the local level. Sometimes, it may never even gets to the board. It is answered by a quality improvement person somewhere in the system.

Vera Calloway asked: How do you ensure that the outcomes are equitable, or the studies are equitable if you are comparing the two? Would the research be the same of you would measure it the same or differently?

Debbie stated that I know that you have done work in Los Angeles. Back in 2008 when CIBHS was CIMH, we employed them to help us with identifying our evidence-based practices and our community-defined, evidence-based practices. They helped us build the portfolio practices that became Prevention and Early Intervention initially.

What we also did, and we did this in conjunction with our providers, was, we looked at outcomes based on the focus of treatment. So, if the focus of treatment was on depression, then we had that measure. If the focus of treatment was on disruptive behavioral disorders, then we had another focus. So, this is how we categorized them was based on the focus of treatment regardless of whether it was more community-defined or evidence-based with trials.

Tara stated that it is very important to respect that a community-defined, that practice and that outcome in a very specific way. When we think about evidence-based practices, we are coming from an RCT, (Randomized Controlled Trial), of people into different arms of a study and looking at change over time. That does not work in some studies or for some folks. If the outputs or the outcomes would be measured in numbers, and that fits for that community-defined practice, then you can find ways to measure that in numbers. If the outcome is defined in story or storytelling or meaning making – you are going to want to have a different outcome measure which may fit a more qualitative measure. I can think of some of the community-defined practices that are really about building connection to your cultural heritage, and how that means something to you as a growing adult in your community – I don't even know if there is questionnaires that get at that that would fit. In wanting to understand the impact, I would come at that with more of a storytelling approach. Tell me how this, engaging in this circle with your community elders changed your view of yourself and your future? That is a qualitative evaluation where maybe we will make meaning of that in themes that we see as valuable or maybe we will find a quantitative way to measure it.
One of the most important pieces here is that our tendency to value numbers over stories is a problem and will continue to diminish the outcomes we see in community-defined practices. So, we must change how we value and describe data so that we can amplify the outcomes and the changes that we see with these practices.

Samantha agreed with her fellow panelists' statements. One of the things we would never recommend somebody do is sort of force a measure that worked for an evidence-based practice on a community-defined practice to then somehow measure its efficacy because it is likely to work in the opposite direction of promoting equity to do that. The measures that have been used to define those evidence-based practices most likely do not relate to the goals of the community-defined practice. If we did want to define a quantitative outcome measure that we could use to compare, we would want to work the community to make sure that the measure we picked is one that actually did work with their goal, aligned with their cultural beliefs, and the language they use – the way they speak about their program and what they are trying to do. The thing that I would really focus on is making sure that we use sound research methodology and analysis methodology whether that is through a quantitative measure that we were able to select or through qualitative storytelling-type measures. You cannot impose a rigid, scientific structure on a community-defined practice and expect it to come out well. But you can build off of the foundations of what makes good science and then help to communicate more broadly about the effectiveness of the community-defined practices.

Karen Baylor asked: Have you have thoughts about how we can tell the story of how effective behavioral health intervention is, knowing that there are relapses? How do we tell this story to people who do not understand this, especially with really busy people like the legislature? How do we show that their money is going to good services and good treatment in a way that they would understand it?

Samantha noted that being succinct is a key with the legislature. You must go through those lengthy reports and analyses and come up with the one thing that we want them to repeat that will make sense to them. A lot of what is important here is bounding the effectiveness of what we do. Divorcing homelessness from mental health would be tremendously helpful. In communicating our effectiveness, we need to make sure that we also communicate our scope. We have to communicate what behavioral health does and what behavioral health can help. The only way we are going to end homelessness is by making housing affordable. As long as we are measuring the effectiveness of behavioral health services by reductions in homelessness, we are going to have to a really big problem in the legislature. But if we go in and say, people who are able to step down from an FSP, Full-Service Partnership, to a less intensive form of treatment is definitive. People who report improvements in their quality of life as a result – symptom measures sometimes speak better to the legislature, less depression, less anxiety – those kinds of things, and really bound them in the things that we directly influence and in a really quick and succinct way that they can then repeat to the people that are pressuring them.

Tara stated that I talked to the legislature on Monday night. Your point is really good about because we talk about three take-aways. For the legislature you have to make it very clear and maybe just one take-away is enough. One of our challenges is that, we as a collective, need to think about what it is we want from that. We need to try to make sure that we are crafting our message to that. One of the things we have to keep in mind is that they are coming from a very specific lens. They are doctors. They are lawyers. They are people who come with privilege, many of whom are not always tied to communities of color or communities of need. A lot of my work is about trying to increase the voice and access of individuals with lived experience and getting them front-and-center. Monday night when I talked to the legislature, I took a mother and her seriously mentally ill child and had them talk to the legislature. And the legislature listened to them. I could have put a bunch of graphs up and they would probably not have listened and let me know that they wanted to hear from the constituents in the room. Sometimes we are not very calculated or as strategic as we could be in how we present what we want and to whom. There are legislatures that know stuff and are very well informed. If we are talking to these legislators, we can talk at a different level. Some other legislators are not very well informed, and we have to be strategic. We have to be tailored to the audience we are trying to communicate with. The messaging to a particular audience is something that we could work better on.
For instance, I am tired of mental health and gun violence. And it keeps money going to mental health. How do we reconcile that? That is terrible. It is the same thing for homelessness. How do we know how people make sense of these things? I think we have work to do on what we think, and how we want to communicate that and what data we need and who is the best person to deliver that message? If I had put that mom up there spewing stats, the legislature would probably not been very attentive taking in those stats. So, I think we could be more strategic in how we communicate those things.

Uma asked Debbie: is to Debbie. What is your data saying about the inter-connectivity of data systems? Have you produced any reports at the county level which pulls on that inter-connected data to tell a story?

Debbie answered that in Los Angeles we work with some informatic folks at the Chief Executive Office, CEO's Office. There is something called a, Master Person Index, in Los Angeles. That contains multiple data sources from DPSS, from mental health, and it has homeless information in it. I know that there have been informatics people in our department in mental health who have done queries and produced analyses. The Master Person Index and the ability to create health information exchanges particularly as part of the Cal-AIM, there is a lot of potential there particularly around modeling of information. A missing part of this is information on an individual from multiple sources. We are part of a learning collaborative on reducing disparities that Solano County has initiated with U.C. Davis and part of what we are hearing is that, when you look at penetration rates, they only tell part of the story. It may be that people are receiving care in other parts of the system, other parts of the county, that then tell a much broader story than just your Medi-Cal beneficiaries and mental health kind of thing.

Tara added that one of the pieces we also have to be mindful of is that people do not trust us. If we start putting all of their data together, then it becomes, The Man. There needs to be transparency in how we go about these processes so that we can – can people get their own data? Do they know that you are accessing their data? Do they know that you are putting their data together, their mental health data, and where they live data? For us, making sure that we are informing folks about how we are using their data. Making sure that it is in their language. Making sure that it is understandable and then giving them a choice about how their data is used or not used. In an ethical perspective, we must take this into mind.

Catherine Moore asked: Did the MHSA make any difference? Were you able to find data and show that there was a level change? How did you get that data? What was that process?

Debbie explained that our situation really highlighted the limitations of the Department of Health Care Services at the time. The Oversight and Accountability Commission contracted with Kate Cordell to mine data from DHCS, FSP data, so that is the only outcome data that is transmitted to the state. That was the data that has been transmitted. What Kate did is she downloaded it into a digestible format that the counties could then access. CIDHS was also involved. We were able to do that. And then, what we did, is through the MHSA Committee we identified – this is what we need to ask counties to give to us, meaning, we are going to create a place to send the data that was secure. We identified the fields that we needed. I was so surprised. The counties had an incredible commitment to this. We crunched the data and had several meetings with the Steinberg Institute to make sure we were all on the same page. The data we pulled out were things like the number of clients that are homeless that became housed. There might have been employment data. I can send the Council the report. The take-away was, FSPs reduce homelessness. They increase employment. They reduce incarcerations. We knew this intuitively at the county level. You have to be able to produce data.

Catherine asked: Did they had this in the medical record?

Debbie replied that when FSP was developed in the Act and then in regulation, there were things that the counties had to collect. State DMH at the time, and then DHCS, they created a data collection reporting system with all of those fields. Counties opted to either enter data directly into that or enter it via an electronic transmission process called, DXML.

Samantha stated that it was caught in data migration from DMH to DHCS, it was like system migration. It was on a data transition between counties and the state. There were a lot technical challenges. There were also a lot data quality challenges to make sure that when we reported, we reported on people who had sufficient data and of sufficient quality to really feel good that when we said we were reducing homelessness, we were actually reducing homelessness.

Steve Leoni stated that the panelists are doing a wonderful. I just want to make a point and hear your reaction to it. A lot has been talked about qualitative research and this has been a big push of mine largely without getting anywhere in most circumstances. A process measure talks about how you relate to the person and that is a qualitative measure. Your outcomes may be different depending on what that qualitative process was. I just wanted to emphasize this point.

Tara responded to Steve's comments. Some of what you are capturing is that connection between the client and the service or the client and the clinician and whether they felt like they were being heard, respected, whether things were available in their language of choice. Did I hear you correctly?

Steve answered that this is a good part of it. A lot of times programs that do not do that right will not get the right outcomes where another program that does do that right – will. I think this is all too often neglected.

Tara stated that she completely agreed. This goes beyond what we would typically think of as service satisfaction. It is really trying to get into that relationship. This was brought up by consumers and survivors as part of our qualitative work, that they really wanted to be able to comment on their relationship and to also for us to understand from the clinician's perspective.

To Steve's point, you are not going to get good outcomes when the relationship is not right. This was a very important point that did come up in our work in early psychosis that we did include in our outcomes battery. We also worked with our partners to understand, where would we start to see evidence that this was fraying? And we have an intent to continue treatment measures. Do I plan to come to my next session? Do I plan to continue my medication? This was done in work with folks with lived experience who are also researchers who had been researching in this peer space and bringing that work into what we're doing.

Arden Tucker stated the question is around BIPOC people and the trust issue and asked: How do you actually know that data that you are mining, evaluating, researching and all of that, how do you know that it is actually valid?

Tara stated that this is a really important topic. Racism is inherent in everything. It is steeped in our structure. We have to accept that and that is the foundation of where we are starting. We have to question everything from that lens.As we were building our outcomes data collection knowing that this is the case, I was very hesitant to include much from a clinician perspective. Because if I am asking clinicians to rate someone's symptoms, it is going to be through that lens. Are we going to be more likely to see black men as paranoid? Is that because that is the clinician's perception of their fear of their environment? It is a very true fear, right. So, how are we going to do that? My response was to say, let's ask the people what their symptoms are and try to do as best as we could to account for those experiences that they may have such as experiences with the police or not feeling safe in their community or feeling targeted – include that in the data. Then if they are reporting paranoia, we can say, but wait, there are all these things happening to them. Maybe this makes sense and we have to take that into account. I chose to address that by trying to focus heavily on the report of the individual and having individuals look at the questions that we were asking and say, yes – this seems like something I would be honest on. We still have people who are really worried about their data and where it is going to go and how it is going to be used. More often, I hear it coming from our folks who are undocumented and being very concerned. This is an issue and how we break that down, we need people sitting at the table who represent those groups at the beginning helping us understand their concerns. Are we only asking questions to reify our white, dominant, power culture or are we asking questions to dismantle that and break that down? Are we only trying to ask questions that keep our clients in a disenfranchised space? They are scary. They are sick. They are homeless. Are those the questions we are asking or are we asking questions that elevate their power? We do not do enough of that as scientists. That is a really important call to action that we all have to accept.

Tara added that we are talking about racism, but I also want us to acknowledge that we also hold significant stigma towards our clients. So, the things that we fight against, we actually believe. Believing people can work. Believing people are safe. And we have data to show that in early psychosis programs the providers hold stigma.

Samantha added that it is not reasonable to expect people to be able to self-advocate.

Debbie said that listening is so important. Whether it is at an administrative level, whether it is at a clinician's level, being able to listen and not make assumptions is super important.

Noel O'Neill asked Debbie: How can we select which performance outcomes that we would want to query the counties about?

Debbie commented about Cal-AIM and the impact that it is having on counties, particularly as we move into payment reform. When you think about access to care, network adequacy, and the incredible challenges people are having trying to increase their workforce because so many have left, we have to put all these things together. Maybe doing a little bit of check-in with CBHGA about, where are your pain points? And then, what data do we have? We have network adequacy data. We have timely access to care, time and distance, all those things that we have to collect. A growing number of things that we are going to have to be collecting in the near future around quality and certain HEDIS measures; and so, maybe just CBHGA around, where are those pain points? And what can this Council do to look at the data across the board and think about a quality improvement sort of strategy. I think about examples like CAQIC, California Quality Improvement Committee, that meets annually. I think that would be a help to counties. It would be significant for all of you to be a part of in guiding us.

Tara was struck by there are a lot of different organizations and everybody has a different agenda. All of that flows down to the providers. As a provider, I would really like to ask folks to come together and make a decision. We are the ones that carry the burden. It is why people are leaving. Really, if you all could just get on the same page about top three goals that you want to see, if that is even possible and then pick together about what data matters to you and let the rest go. Much of the data collected is redundant and counties just make reports with it. Counties have told me that they don't really look at the reports but produce them it is a requirement. I want to amplify for you that the decisions you make have real consequences on the providers and the clients. And we spend an inordinate amount of time doing paperwork not providing care. If you all could pool your efforts and decide on what is important, we would all appreciate it.

Monica Caffey asked: How do you advocate to change the reality as researchers to articulate in the best way possible how this marginalizes communities, impacts them from actually wanting to receive behavioral health services or any other services?

Samantha stated that it is the biggest thing I hear these days in my work. On one hand, that is great because it becomes so much more visible in the last few years. This has always existed, but the platform to talk about it has gotten a lot bigger in the last few years. The importance of people like us who had a platform before and continue to have one to amplify that and get to build on this really important issue. There are a few things that I personally try to do to advocate for that. One, when I am working with funders, when I do have the opportunity to shape a grant that is coming to us or research that is going to be done, we try to make sure that we start with engaging the community. I do not develop the research. I do not develop the plan. We go and talk to the community about what they need. And then we present that to the funder. That is an unusual circumstance that the funder allows us to have that level of latitude, but we do try to do that when we can. When we do have those grids we build into you build that into your research plan and make sure that at every step of the way you have budget and time to talk to the community to make sure you are measuring the right things and that you have time to go back and communicate with them about the measures and outcomes, both to say, does this make sense to you? And also really makes sure that they know that if they gave you information, this is what you did with it, and this is what you did not do with it. Making sure that from the beginning, every time you ask somebody for data, ask the community for data, you are transparent with them about how you are going to collect their data, why you are asking for the data, what you will and will not do with the data, and what happens with their data when you are done. Who gets it? Who does not get it? Who can see it identified? Who can see it aggregated? What kind of analyses that you are interested in doing and why. And how does it benefit them? When we are doing research involving real people and real data, the reason you are doing it is to benefit those people, not because I am a curious person and I just wanted to know. Always keep that in mind and always go back to them and make sure that they know what you are doing and that they know what is being communicated for them and about them. To the extent that can while protecting privacy, making sure that when you do that kind of work, it gets out into the public. A lot of times we write a report, and it just goes on a shelf somewhere. To the extent possible making sure that we are out in public and present on social media saying, hey, did you know that African American people in California are this much more likely to be diagnosed with schizophrenia than white people showing the exact same behaviors? It is true. We need to make sure that we get that out in ways that people can see it. We are sitting here as three white women, and sometimes our voices get heard more. And we need to make sure that there are people who look like us who say those things.

Tara agreed with all of what Samantha said. I have tried to be incredibly intentional about including people who I am representing in my team and in my leadership. We also have a DEIA, Diversity, Equity, Inclusion, and Access. We need to make sure that we are, those voices are at the table and that they are deciding everything that we do and that they are sharing those messages in the community. Every chance I get, I put them out to go share stuff so it is not white lady talking about this stuff, right. I always work very hard to humble myself before them. It is for them, it is not for me.

Debbie opined that follow-up and feedback is so critically important. That is something that we are trying to do at the county level. You never ask for anything that you cannot give back and you cannot validate.

Marina Rangel stated that she is a licensed clinical social worker working for CDCR. I work with our statewide Mental Health Peer Release Program. The cases that come to my attention are the most severely mentally ill population that is releasing to the community. I have experience within the government system and also as a private practitioner. What is frustrating from both areas is, we see the data. We see these things happening. As a clinician, as a provider, it is very frustrating when you have all these people right in front of me that this data is not helping their situation. The data is useless for me to pay attention to because it is not making down to the reality of what is really going on that you see coming through your office or the cases that you are seeing. Sometimes, I feel like we over-diagnose, and folks come through and they might be describing symptoms that can sound like an anxiety disorder or a depressive disorder, but it is situational. If you had domestic violence in your home, you are probably not going to feel very good most days. But does it mean you have a mental illness? You are struggling with your job and it is overwhelming, does not mean you have an anxiety disorder and you need medication right away. There are things that the data does not collect. Sometimes I think the data does not collect in that regard because clinicians and providers have had to put a diagnosis down and so now there could be over-reports of certain diagnoses because you had to put a diagnosis. I know Cal-AIM is supposed to fix some of that, hopefully, but sometimes the data can actually hurt the view of what is really going on because it can look like we have an over-abundance of something when it is very much the environment, the situational components going on within the home, within school, within the neighborhood, and that is where I feel like sometimes data fails especially in cultures that do not go seek help. The other communities, there are people who are being left out of the data because culturally they are not going to be at the table. And they are not going to be in any of these forums where they can speak for what is going on. That is something I wanted to bring up. The other thing is, I imagine somebody has collected data to see the trends of the increase of access to technology, social media, specifically. I feel like there is a strong correlation between that and the increase in the mental health crisis we are seeing in our country. Has any data been collected about that? Sometimes too much information and exposure can definitely impact mental health.

Samantha stated that there is one source in California where you can access the data. The California Health Interview Survey is done by U.C.L.A. does ask about does ask about social media use and mental health. There is a way to look at that data in combination with one another. There is a ton of research going on that, but I do not know how publicly accessible all that stuff is. On your second point, I am the family member of a person who receives his mental health services in prison and recognize just how horribly and how different that system of care is from the way we measure data and also the stigma from it. My family member is not one who will be looking to be integrated back into society but how the extra stigma of the mental health diagnosis they get in prison can follow them after being released in addition to the stigma of their justice involvement. It is a huge problem. We are aware of it. I do not have a solution to it. I am very cognizant of it and it is very important to me.

Tara stated that it is very hard to randomize people to social media versus no social media. All the data we have is correlation and it does not mean causation. That is a big limitation that we have.

Vera asked: How do you design outcome measures or queries in terms of getting the correct data to show the outcomes for the Governor Newsom's CARE Court, and also his proposed changes to MHSA?

Tara said that this has been a brilliant conversation. I am thrilled at the level of depth of the questions. There is no easy answer here. I am very interested in supporting this body and the state of California in answering this question. This is important to the people I represent. I see this as a beginning of a conversation. We have opened an important box.

Day 2: Performance Outcomes Measures Discussion

Susan Wilson, Chairperson of the Performance Outcomes Committee, welcomed everyone back for day two of the Performance Outcomes Discussions. Susan gave kudos to the previous day's presenters. She mentioned that the question-and-answer session was most productive and informative. Susan gave an overview of this agenda item. Toby Ewing, Executive Director of the Mental Health Services and Oversight and Accountability Commission (OAC) gave a 15-minute overview of performance outcomes and what the OAC has done around performance outcomes. Theresa Comstock of the California Association of Local Behavioral Health Boards and Commissions, (CALBHB/C) provided her perspective, and members of the Performance Outcomes Committee also participated in the panel discussion.
Issues addressed included:

- Where do we get good data that is reliable, valid, and timely?

- Getting and evaluating the data to determine the next steps.

- What does the Council want to do around performance outcome measures?

The panel discussion of experts from the previous day gave members an idea of what a performance outcome measure is and the difficulty in collecting the data to evolve that into a performance outcomes measure. The panel discussion also addressed talked presenting the data to the world. The questions used to address the key issues are as follows:

- What are your perspectives when it comes to performance outcomes data?
- What kinds of outcomes does the Planning Council really want to measure?
- What data is already being collected that aligns with the measures?
- What is the Planning Council's role in the process?
- What might be some next steps?

Toby Ewing addressed the Council and thanked them for the invitation to present. Toby started by grounding this conversation in, why we do this. He believes that the why questions really are the most important area that the Council should focus on as they shape the responses to the specific questions about what data to collect and how?

Toby started with the role of the Commission as it relates to data. From the Commission's perspective, we really see our origin story as coming from two opportunities. One is to build political capital for California's behavioral health system. Twenty years ago, the mental health community was fighting just for pennies. Mental health was funded with what was left over from the budget after funding other services. The Commission was formed in part to elevate understanding, elevate support, and elevate political capital so that we had a seat at the table. It is important to have that voice in terms of the decisions that are being made. The first thing the OAC thinks about in terms of data is really supporting understanding. The second mission of this

Commission because it is an oversight and accountability Commission is public confidence. How do we build support and trust among taxpayers?

It is about public understanding and support for the broad mental health endeavor. Are we getting the job done? When we talk to members of the public who are not part of the mental health system, they just want a system that works. They want to know that people can get what they need. The answer to this is - no. We look through these lenses of how we shape understanding. How do we support awareness of what is working and what is not working? How do we elevate the significance of what is working and what is not working in the interests of policymakers, the public, and related decision-makers? According to Toby, this conversation around metrics and measures really starts in three domains. The OAC is trying to make progress in these three domains. The first is finance. We need to create broad awareness and understanding of funding – all types of funding. The second is the service delivery system. What are we paying for? The third piece is, what are the outcomes being delivered?

The work of OAC work has been trying to change the culture in our community around data being valuable. We must start with funding because the data is easier. It is just cleaner than – how are you feeling about the service you got? That is really a messy kind of data.

The second thing that we are trying to do, is separate these conversations from population-based data versus program data versus outcome data. We have been trying to push on all three of these fronts. The folks who have the data do not always want to share it. There are lots of rules around the data. The OAC is trying to map people through systems.

Toby shared other ideas to consider

- Are we doing the upstream work to prevent the need?
- There is a longtime conversation around, are we having psych beds?
- We want to have a conversation around; how do we reduce the need for psych beds?

Toby Ewing went on to say that we must tell that story differently. We must use data to actually shape our understanding of opportunities. In the Department of Aging, we have a partnership where we have invested funding to expand a couple of evidence-based practices providing incentive grants to community partners to expand two community programs that are highly effective that target older adults. We want to use information and data and not just performance metrics. It really comes back to that origin story. In terms of your five questions, I would say, don’t get caught up in the details of the data. Really have a strong foundation in what your goal is. Pick a handful of things.

Toby Ewing addressed the Council saying, you must ask yourself, what matters most to you as a human being? Who is your audience?

He stated that the Council's audience needs to be the average person walking down the street whom you care about whether they are making the progress we expect.

Moderator Susan Wilson asked of the Panel, what is your perspective or lens when it comes to performance outcomes?

As Executive Director of CALBHBC, California Association of Local Behavioral Boards and Commissions, I support the boards and commissions, 59 of them. I hear from many of their chairs about how frustrated they are that they are trying to comment on performance outcomes data through a survey from the Planning Council that does not have performance outcomes data in it, but it has data, and it is important information.

I have been trying to understand the role of the state in this – The Department of Health Care Services, MHSOAC, The Planning Council, and CBHDA. I listed the duties of these agencies in this paper. This calls out who should be establishing the performance outcomes measures and that is DHCS, MHSOAC in collaboration with the County Behavioral Health Director's Association, and then the Planning Council should be approving those measures.

Theresa Comstock shared that a couple of years ago she conversation with Dr. Pfeifer from DHCS who told me she was very interested in performance outcomes data. She asked me, can you tell me what is out there already? At that point, I started looking at what is out there. We have culled that information and that is my second goal as the Executive Director, supporting the counties trying to get to performance outcomes data.

Another area that shapes Theresa Comstock's lens is, she is a member of the State Rehabilitation Council (SRC). About 25 percent of the people, they serve have psychiatric disabilities. They have 137 or more points of data that are federally mandated but some of it is performance outcomes data.

Panelist Uma Zykofsky stated that she has been dedicated to public behavioral health for most of her career. I work in the community-based organizational sector as well as in public mental health in New York and in California. It struck me that we have come to this incredible place now which is, we ask everybody for outcomes. We talk about outcomes, but the community does not believe any of the data we give them. It is partly because we should collect things that matter, and that is the bottom line. Uma explained that we built layers on layers of very segmented systems. The concept of the OAC is very similar to the concept of the Planning Council which is you have different partners from different places – education, aging, consumers, and family members who all are invested in knowing what is happening in this area. And yet, all the data we have is still fragmented from the old systems that we get it from.

Uma Zykofsky shared that many years ago, it was said to her, you know Uma, if you are going to work in this field, you should be collecting four things: one is, homelessness issues, two, is someone in a state hospital, the third is, are they alive – that is deaths, and then, what is the quality of their life? And this was in 1995 that I had this conversation. This resonated with what Toby said a little earlier. Those are pretty much the outcomes that matter to people. And this is at the individual level as well as a system level and community level. The huge outcry around homelessness and people on the streets and so forth is significant. And so okay, this connection that they are unhoused so they must be mentally ill. And we all fight that tooth and nail. We do not want the stigma attached to all of that.

Uma continued to say that we have a lot of descriptive data everywhere. The Council really must decide on two or three goals and then just speak to those. Uma Zykofsky commented on how the OAC has tried to connect data systems and said she would like to hear a little bit about that because data only makes sense now if you tell people a story about an interconnected society or community. And if you do not do that, then people do not trust your data.

The last thing Uma shared is that she has become more suspicious about data because I think this conversation around black and brown people, how is data collected, who is it speaking to, and what its motivation is really a big issue. According to Uma, we should always be including this information in whatever we decide our data to be.

Panelist Karen Baylor stated that she appreciated the attendees patiently listening to the conversations. She went on to say that the question that has been asked about, why is this important? This is a question that we need to consider and have more conversations among the Planning Council. Karen Baylor shared that years ago when she was a director, California External Quality Review Organization (CalEQRO), would come in every single year and ask, how are you making decisions based on data? And I had no data. We had clinical judgment. When we finally got an electronic health record system and we would show data to the Mental Health Board and our Quality Assurance Committees and we were able to see that one of the outpatient clinics was really struggling with keeping up with timeliness on assessments, we were able to move some staff up to that clinic and make it more balanced. Karen states that that was impactful for the people they served.

Karen Baylor also shared her experience doing accreditations. Per Karen, there are some states out there that have fabulous data collection. We are California and we do not have the infrastructure to collect the kind of data that you could easily show. She added, wouldn’t it be great to be able to pull up a map of California, run your mouse over the county, and up pops all this data and outcome data, and demographic data that you ever wanted but in California, we do not have it. The closest thing to this currently is the OAC transparency suite and that is mostly finances, it is not the big picture. This is because OAC has one piece, DHCS has another piece, HCAI has another piece, and the Department of Public Health has another piece – so the data is fragmented, and it is old. How do make decisions on old data? In summary, the data must be relative to the community that you serve. The Planning Council has a role to play in this and Karen Baylor stated she is excited about that opportunity as we move forward. She also thinks there needs to be some thoughtful discussion about what it is the state really needs to be able to produce validated data that you can have some confidence in.

Moderator Susan Wilson combined the next two questions. What kinds of outcomes does the Planning Council want, need, should, could measure, and What data is already being collected that would align with those measures?

Theresa stated that there is one page on her handout that summarizes the data currently reported by the counties. On our website we have all 59 jurisdictions. They are required to have performance outcomes data related to hospitalizations with Medi-Cal. They have requirements in terms of the Mental Health Services Act although those are not standardized. They have some measures with SAMSA grants.

So, what we have done is we have gone through each of the jurisdictions, and we have collected that information and put it on a page for each jurisdiction. So, we have 59 pages.

The other five pages that are attached is a sampling. So, this shows you what is being collected. We included information for Children and Youth we show what Merced County is collecting. For Criminal Justice Involvement we have Alameda, Merced, and Yolo Counties shown. These are just samplings, and other counties are also collecting this data. In Employment we are showing data from Alameda, Butte, Calaveras, and LA Counties.

We also show samplings pertaining to hospitalizations. One thing on this page is that points to how important it is to be looking at this data, is Alameda County. With the Mental Health Services Act funds, they have been doing a lot of decreases in hospitalization admissions within their statistics. But when you look at their Medi-Cal data, they are showing a high percentage of rehospitalizations compared to the state. Having that kind of information side-by-side is important to kind of flesh it out and understand – how are they leveraging those MHSA dollars? Is this effective?

Maybe what they are doing is just funding programs straight from MHSA and not connecting it with Medi-Cal. I do not know but it would be interesting to see why that is the case. It looks like they are starting to do a trend toward correction with the Medi-Cal, but they are still much, much higher in rehospitalizations.

The last page is housing and homelessness. And I will point out that Calaveras County is there is spite of their small size.

Moderator Susan Wilson then asked, what performance outcomes do we want to look at? Do we even know?

Theresa Comstock referenced the document she shared with the Council. First, the data should include outcomes specific to culture, race, ethnicity, LGBTQ, and age whenever possible. Very small counties usually report trends because some are so small, we would know who that person is.

Toby Ewing stated that the best data is data that you are going to use. That is the most important issue. You can live with messy data, funky data, even old data – you can find a way to use it. If you are not using it, it is not good data. Secondly, you must differentiate between audiences. Historic trends of rehospitalizations relative to the state context is an important data point for someone who is working to reduce rehospitalizations. He encouraged the Council to recognize that good data is in the eyes of the beholder. Who is your beholder? First start with, who is your audience? Different groups want to see different types of data. The bottom line, I would not start with the inventory of all the data because it is too much. You are the Planning Council, pick a couple of things to start with. The Planning Council should pick no more than four or five outcome measures to look at and stick to them and figure out how to do it.

Uma Zykofsky reiterated that picking our audience is important. Right now, our audience is the community that influences what the legislatures think. The legislatures respond to communities. And that has become very visible in terms of issues relating to behavioral health. This idea that the things we want to collect that the man on the street, or the legislature wants to know, haven't changed all that much. These are the things that people care about. What can you tell me about that in your community or statewide?

Uma went on to say that one of the things that one our panelists, Tara, said yesterday is on the mental health side, we rarely have access to school data. We still have these sectored ways that people have data. But the thing we want to know is are we doing well as a community? Are our kids better? The irony is that this crisis in children's wellness, the suicide rates and all that, has really made us wonder, has made us pause and say, that many kids/teenagers are feeling this way? What is going on in our society? We must find a way to connect the dots right now.

Uma Zykofsky stated that she totally supports the idea that the Planning Council takes a few things and finds a way to either qualitatively or quantitatively collect data and just stick to that for a little while. The other thing Uma wanted to say in defense of the Data Notebook is that it is a qualified defense. In the last couple of Data Notebooks, they have had counties give a lot of qualitative examples of what they are doing. You want to hear from the field. That doesn't always speak with data. It speaks with the voices of consumers or programs that were developed at the local level in response to consumers. Uma shared she would hate for us to lose that piece of the eye from the field from different counties because we can learn from each other's efforts.

Karen Baylor added that the comments we heard yesterday and then comments from today – I don't know that the Planning Council has identified who our audience is. I think our audience is going to be very different from the state's audience. The state's perspective of what data needs to be collected can get a little skewed versus what the Planning Council wants. The Council is 50 percent consumer family members and brings a different perspective to this conversation. Karen believes the next step is that we need to identify our audience and then we pick a couple of things that we really want to measure or monitor.

Theresa Comstock pointed out that the Planning Council in code, your audience should be the State Department of Health Care Services and the legislature, and the county boards.

Toby gave some context. He said this gets to the question of what is the role of the Planning Council in this process. In the code, it says the Planning Council shall review and approve other people's work. Here is the good news. The Planning Council has diverse responsibilities. Do that role because that is what is required. If you are not getting the information from the state, call the state out on that. The work that the Council does is not going to be the same as the work of the Association or the Commission. Toby went on to say that for Item Number 4, what is the Planning Council's role in this process? That is for you to decide. You have broad authority to not just do the things you are required to do, review, and approve – you have broad authority to advise and guide. You can step out of, and you decide what your role is.

Toby Ewing encouraged the council to pick a role that they are passionate about. Not only should you figure out what data you need to do your job, whatever that happens to be for the audience that you want, is, the more organizations that are working with data and sharing data, but we also are not trying to come up with a consensus, one data point that everybody will use. The beauty of this space is that there is plenty of opportunities for you to have information that is different from what we have. That is different from what DHCS has. It is different from what the Association has. Of course, we want to respect and understand. But if we are going to make progress, we must start. He encouraged the Council to pick something that is going to meet the Council's needs and give themselves the role they want to have in this process – and then pursue it, don't stop. Then, move forward.

Susan Wilson noted that Toby brings up a good point for all of us because that is actually what we are trying to do from the Performance Outcomes Committee. We need to say, okay, we looked at our responsibilities and said, wow, that is a big one. And where do we start? Susan said she knows some of us are asking, wow, how do we do this? And that is exactly what the Performance Outcomes Committee thinks. How do we do this? We are going to get a lot of input and move forward.

Moderator Susan Wilson then addressed the last question– what is our role in this process?

Susan Wilson acknowledged that we know that we have a very prescribed role in regulation, in 5772. So, we know we have some responsibilities here. Our responsibilities are not particularly to make the Performance Outcomes Measures, but to review the Performance Outcomes Measures. Per Susan, have three different people in our audience with the state legislature and the mental health boards, sort of at the ends of that particular responsibility. What this in mind, Susan asked each panelist to answer the question: **What is our role**? What do you think our next steps are?

Toby Ewing said, again, “I think you are looking at the wrong Code Section”. He stated that the Code Section referenced says, to react to someone else’s work. The Council also has another Code Section that says, advise. The Council can decide what “your role is. You “have to” react but nobody says, you – only – have to react. Toby encouraged the Council to Leverage the authorities that are most aligned with what they want to do. Toby shared that he would like to see the Planning Council get its back up and clear its voice and pound on the table and say, in addition to reacting to the official, right – this is a space that is left undefined. And so, define the space. Your job, like our job, is to advise and guide. And you can advise and guide by developing your own performance metrics.

Theresa Comstock stated that if you are going to be putting together your own performance metrics, it is important that be part of the conversation as the performance metrics are standardized. Theresa made it a point to remind the Council that DHCS and MHSOAC are responsible for standardizing. They would be the right place for collecting and communicating that information. Theresa Comstock shared that she believes this is part of the problem right now. All the counties are providing information, but it is not standardized. Theresa stated she thinks we need to create a form for the data to go into. Points of data need to be created. The counties have to identify ways to get that into their system so that it is collected.

Karen Baylor added that Welfare and Institutions Code 5772 also says, to identify successful programs for recommendation and identify programs experiencing difficulties. Karen would like to put that on the table as something that the Planning Council would be willing to look at. As a director, she used to come up with what was CMHDA at the time. And I would hear from other directors about programs and effective things that they were doing, and I would take it back to my county. I would say, hey, let’s do it this way and everybody would go – that’s genius – thinking I created it. I did not create it, I stole it. That is lacking – the higher up you get into state administration, the more negative things you hear about. You never hear about the positive things. Karen would really like for the Council to be able to highlight across the state, really good, effective programs that have made a difference in people’s lives and to be able to showcase that so that others can learn from that experience.

Uma Zykofsky agreed and stated we can travel to different parts of the state, and we hear of successes. Generally speaking, having worked in the county before, you really don’t want to highlight your failures. People invest a lot of time sweating tears building something and sometimes it does not work. It is really hard to own that piece.

Uma shared that she does not think we should go around trying to invent measures and outcomes. The Council needs to pick the issues that they are passionate about and then we need to sort of not let go of the fact that we have this advantage of having the consumer and family member voice on the Planning Council as well as the openness with which providers come and talk to us about what is going on at the local level. According to Uma the trick for us is going to be able to capture the excellence that is local and the statewide story.

Susan Wilson stated that Toby made a really important point that everything does not have to come through you or me or whoever – part of what we have to do is to teach people to talk to each other. One of the challenges that we face is that if we want to talk to the legislature, you almost have to talk to them one at a time. You have to show them what is there and get them to understand what we are doing and make it important to them.

Theresa stated that we know access is not good. Actually, that is something that is measured, and we look at that in the counties. And we can see that it is not good. Getting access does not mean you have had a good performance. I hear your point.

Tony stated that I appreciate the comments and the wisdom. The Council's vision states that we want to make it possible for individuals to live full and purposeful lives. How do we measure that? How do we see that? Are people living, full, purposeful lives if they are homeless or become homeless because they decompensated? Are they living a full, purposeful life if we do not intervene early on, and they end up in the justice system? The Council needs to ask that and decide where to go from there.

Council Members had the opportunity to ask additional questions of panelist that included:

- What do we need to do? What needs to change?
- How long do they have to wait when they do call?
- In some ways, the roadblocks sort of define the quality. Do they tell you what you get when you get in and what to expect?
- From a statewide perspective, those might be the best kinds of indicators. Things like, where do we get stopped up and nobody can move forward, and we get really frustrated?
- Do we ever ask, what is this data intended to do? And did it do what it was intended to do?

Toby Ewing reiterated to the members that the best data is the data that you are going to use. He added that about 90 percent of the data that the state requires everybody to gather does not do what it was intended to do. It does meet some compliance stuff. He shared that most of the data that we have was designed around compliance. We don't even ask Californians; would you know where to turn in the case of? We are not actually measuring the bad stuff that we do not know about or that has not yet happened. We are only measuring the bad stuff that did happen at our front door. We don't translate the person who is living half a block from here in a tent to the access that they didn't have three or five years ago.

Theresa Comstock shared that on the state level, when CALBHB/C advocates for legislation, they are looking at systemwide policy change that can really impact the services and we point to performance outcomes data. CALBHB/C is looking at what is actually out there and is concrete and that tells a story. It is so important to have that information.

Susan Wilson thanked the panelists for attending and sharing their perspectives.