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

November 1, 2013

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

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Executive Summary

In 2012, the State enacted a process for the Department of Health Care Services (DHCS) to develop a plan for a Performance Outcomes System for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services to support the improvement of outcomes at the individual, program and system levels and to inform fiscal decision-making related to the purchase of services[1]. Specifically, Welfare and Institutions Code, Section 14707.5, set forth three major requirements: 1) convene a stakeholder advisory committee no later than September 1, 2012; 2) submit to the Legislature by October 1, 2013, a Performance Outcomes System Plan; and 3) to submit to the Legislature by January 10, 2014, a Performance Outcomes System Implementation Plan[2]. Accordingly, this report describes the development and activities of the stakeholder advisory committee, sets forth a System Plan that, consistent with the statute, considers evidence-based models and federal requirements, and includes an implementation timeline at the provider, county and State levels.

Stakeholder Advisory Committee and Working Subgroups

To ensure a transparent process, DHCS convened the Stakeholder Advisory Committee in September 2012, and held the first meeting in October 2012 to discuss how best to approach the development of a Performance Outcomes System to evaluate California's Medi-Cal specialty mental health services for children and youth. This Committee included participation by representatives of youth family members and/or caregivers; county staff; child/youth advocates; other California State-level entities, including the Legislature, and the Mental Health Services Oversight and Accountability Commission (MHSOAC); as well as other members of the interested public. As committee meetings have included individuals representing over one hundred organizations, it was necessary to form smaller working groups: the Subject Matter Expert (SME) Workgroup and the Measures Task Force. The SME Workgroup identified relevant performance outcomes domains and indicators. This workgroup will continue to provide input to DHCS. The Measures Task Force is currently working to identify functional outcomes that may be used to assess child/youth progress and provider performance. The Stakeholder Advisory Committee has been given the opportunity to provide input on work products developed by DHCS and the workgroup subgroups and provided feedback, meeting three times between October 2012 and July 2013.

Evidence-based Models and Federal and State Requirements

DHCS staff reviewed the latest trends in performance and outcomes measurement through discussion with subject matter experts, reviews of research papers, information from other states available on-line, and a survey administered by the National Association of Medicaid Directors on behalf of DHCS. This review determined that some

[1] Welfare and Institutions Code, Section 14707.5 (Senate Bill [SB] 1009, Committee on Budget and Fiscal Review, Chapter 34, Statutes of 2012). The complete language of the Legislation is included in Appendix A, Legislation.

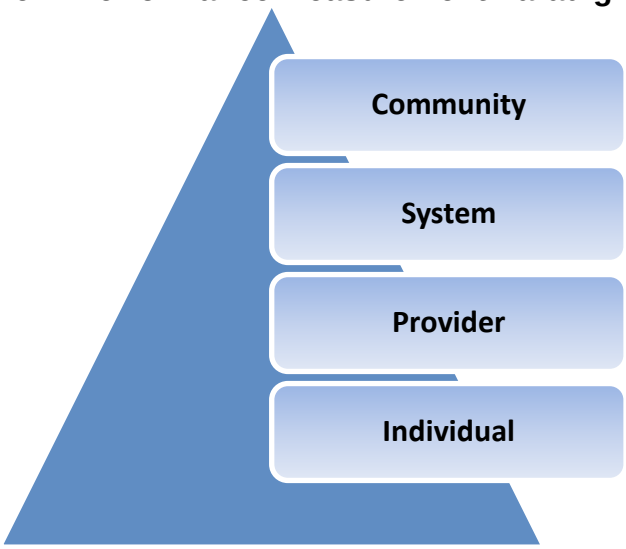
[2] For simplicity, the Performance Outcomes System Plan is referred to as the System Plan and the Performance Outcomes System Implementation Plan is referred to as the System Implementation Plan.

states have spent multiple years refining their measures and developing methods for capturing and sharing information. DHCS surveyed Mental Health Plans (MHPs) to learn about the measurement tools currently being administered and to better understand current practices by California counties. Fifty-four of 56 MHPs (96.4 percent) responded to the survey. The responses show that most MHPs have performance outcomes systems and use a variety of evidence-based tools, some to assess overall functioning and others specific to symptoms or diagnoses. This information will assist in establishing a basis from which to develop the Performance Outcomes System methodology. Finally, DHCS reviewed federal and State laws and regulations relevant to Medi-Cal specialty mental health services quality assurance requirements and outcomes to ensure that the Performance Outcomes System will meet existing data collection and data reporting requirements.

California's Performance Outcomes System Plan

The System Plan approaches evaluation of California's specialty mental health services for children and youth from a broad-based perspective that seeks to satisfy the intent of Senate Bill 1009, and support other important evaluation efforts such as the MHSOAC Evaluation Master Plan and Katie A. implementation activities. The DHCS Performance Measurement Paradigm, builds upon the Mental Health Services Act measurement paradigm, and specifies that outcomes be measured at four levels: Individual (youth/family), Provider, System, and Community (public) levels (see Figure 1).

Figure 1. Performance Measurement Paradigm



DHCS, working with stakeholders and partners, has established a framework for outcomes measurement by identifying seven domains as key areas to assess:

- ✓ Access;
- ✓ Engagement;
- ✓ Service Appropriateness to Need;
- ✓ Service Effectiveness;
- ✓ Linkages;
- ✓ Cost; and
- ✓ Satisfaction.

Not only does this System Plan set forth a framework from which specialty mental health services outcomes may be measured, it also describes steps that must be taken to identify an evaluation methodology (e.g., specifying the evaluation questions,

identifying the target population, selecting valid and reliable measurement tools) and to develop a continuous quality improvement process using Performance Outcomes System-generated reports. There are several DHCS data systems that capture information, which may be used for outcomes evaluation. However, data integrity issues and additional data needs are currently unknown. Data integrity will be addressed jointly with the counties and DHCS will work with stakeholders to identify and mitigate data gaps.

As part of a comprehensive system of reporting, analysis, and improvement, DHCS will develop a quality improvement process by leveraging current quality assurance programs at the State, county, and provider levels. Through outcomes reporting, the State and counties will be able to identify strengths and opportunities for improving practice across the assessment domains of mental health services. These outcome findings will inform the development of Quality Improvement (QI) Plans that ensure consistent, high quality, and fiscally effective, services are delivered to children/youth and their families and that these services improve functioning in all areas affecting the lives of children and youth including school performance, home environment, child safety, and juvenile justice.

Implementation Timeline

With this System Plan, DHCS sets forth its commitment to develop and implement initial Performance Outcomes System reporting in Fiscal Year (FY) 2014-15, using existing data, and comprehensive, statewide Performance Outcomes System reporting in FY 2015-16, that gives the State, counties, providers, and the public useful information with which to measure the performance of Medi-Cal specialty mental health services provided to children and youth. DHCS will work with its county partners and stakeholders to develop a Performance Outcomes System Protocol to outline the evaluation methodology, improve data integrity, and design and produce Performance Outcomes System reports for use in the continuous quality improvement processes. When the Performance Outcomes System is fully operational, California will have an ongoing system of quality improvement supported by Performance Outcomes System reporting and an infrastructure of technology, expert workgroups, training, Performance Outcomes System protocols, and Performance Outcomes System QI Plans.

Conclusion

Through continued collaboration with partners/stakeholders and subject matter experts, and with input from the Stakeholder Advisory Committee, DHCS will continue to develop implementation strategies, which will be used to provide details on the implementation schedule, communication plan, risks/issues, assumptions/constraints for the System Implementation Plan, which will be submitted to the Legislature by January 10, 2014.

I. Background

Legislation Overview

Welfare and Institutions [W&I] Code, Section 14707.5 (added by Senate Bill [SB] 1009, Statutes of 2012, and amended by Assembly Bill [AB] 82, Statutes of 2013) requires DHCS, in collaboration with the California Health and Human Services Agency and in consultation with the MHSOAC, to create a plan for a Performance Outcomes System for Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) mental health services[3]. The statute requires that a performance outcomes system for Medi-Cal specialty mental health services for children and youth be developed to improve outcomes at the individual, program, and system levels and to inform fiscal decision-making related to the purchase of services. In developing the System Plan, the primary objectives are to: 1) promote high quality and accessible services for children and youth; 2) provide information that improves practice at the individual, program, and system levels; 3) minimize Performance Outcomes System costs by building upon existing resources to the fullest extent possible; and, 4) use reliable data that are collected and analyzed in a timely fashion. Regarding the timeline to develop the System Plan, the statute states:

> *Commencing no later than September 1, 2012, the department shall convene a stakeholder advisory committee comprised of representatives of child and youth clients, family members, providers, counties, and the Legislature. This consultation shall inform the creation of a plan for a performance outcome system for EPSDT mental health services.*
>
> *The State Department of Health Care Services shall provide the performance outcomes system plan, including milestones and timelines, for EPSDT mental health services described in subdivision (a) to all fiscal committees and appropriate policy committees of the Legislature no later than October 1, 2013.*

The complete language of the statute is included in Appendix A, Performance Outcomes System Statute.

This System Plan establishes the context by which the Performance Outcomes System will be designed and is a predecessor to the required System Implementation Plan, which is due to the Legislature on January 10, 2014. While this System Plan describes the conceptual framework for the Performance Outcomes System envisioned by DHCS and stakeholders, the System Implementation Plan will describe the steps necessary to achieve the operational system.

[3] In this System Plan, the phrase "Medi-Cal specialty mental health services for children and youth" is used instead of EPSDT, as EPSDT is a benefit that extends beyond mental health services.

History of Major California Performance Outcomes Measurement Initiatives

The first Children and Youth Performance Outcome System, launched in 1998, was based on the Children's System of Care model, and included youth served under EPSDT. It mostly consisted of a set of standardized measures that were implemented statewide to measure child and youth[4] functioning from multiple perspectives (clinician; parent/caregiver; and youth, when appropriate). After one year, a statewide Survey on the Existing Children and Youth Performance Outcome System was administered to county staff, families/caregivers and youth (the majority of respondents were clinicians). Survey respondents overwhelmingly reported that most of the measures were too labor intensive, costly, and lacked the information that was either desired or useful for evaluating outcomes. The top five criteria identified by respondents as being most important were that measurement tools should: 1) collect information from multiple informants, 2) be psychometrically valid and reliable, 3) be short and relatively easy to administer, 4) have little or no purchase cost (public domain preferred) and 5) be cost-effective. The initial Children and Youth Performance Outcome System was operational until 2002, at which time performance outcomes measurement by the State shifted to the bi-annual Consumer Perception Survey[5] that is still in use today.

Assembly Bill (AB) 34 (Steinberg. Chapter 617, Statutes of 1999) and AB 2034 (Steinberg and Baugh. Chapter 518, Statutes of 2000), established and expanded community mental health treatment programs for people who were homeless or at risk of homelessness and continued the objective of continuous quality improvement through reporting. AB 34 began with a limited pilot in several counties and at its height, was operating in 32 counties serving 5,700 individuals. Data collection and reporting were integral to the program and made it possible to document improved outcomes for individuals and systems as well as to demonstrate programmatic accountability and cost effectiveness. A small client population and a simple questionnaire capturing a limited number of items, which grew gradually, contributed to the strength of the outcomes aspect of the project. The collaborative process for data review and program improvements between the counties, data consultants, and the former Department of Mental Health, was key to program success. Together, these entities established a process for the submission of high quality data on a monthly basis with monthly data reviews and discussion of program best practices. The pilot programs were very successful in reducing the number of homeless days, jail days, and psychiatric hospital days. AB 34 and AB 2034 later served as the foundation of the Mental Health Services Act evaluation efforts, which are still underway.

[4] Data were captured on seriously emotionally disturbed children and youth, as defined by Section 5600.3(a) of the Welfare and Institutions Code.

[5] The Consumer Perception Survey is an extended version of the Mental Health Statistics Improvement Program survey mandated as part of the Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant.

The challenges faced and the lessons learned from the implementation of these early outcomes evaluation efforts, coupled with national outcomes measurement trends, provide a foundation from which to build a sophisticated, streamlined and efficient system to track and measure California's Medi-Cal specialty mental health system performance and child and youth treatment outcomes.

II. Evidence-based Models for Performance Outcomes Systems

This section reviews trends in performance outcomes measurement at the national, State, and county levels, with a focus on evidence-based practice. Evidence-based practices have become part of the mental health landscape. As issues related to quality of care and systems accountability receive more emphasis, the inherent effectiveness of evidence-based practices is attractive to policymakers and purchasers of services. This trend in mental health parallels a similar trend in general health where there is increasing emphasis on healthcare outcomes.

In terms of national trends and mental health outcome measurement, testing to establish evidenced-based practices requires the use of clinical outcome data. In other words, one natural application of outcome data, as it accumulates, is identification of evidence-based practices. The hope is that by scientifically testing various approaches to care, all mental health treatments will eventually become truly evidence-based, and in turn, those that are ineffective will be identified and replaced. It has even been suggested that in the not-too-distant future, mental health insurers will require that all covered services consist of evidence-based practices.[6]

National Evaluation Efforts

Over the last ten years, mental health performance measurement has made tremendous strides. Accreditation agencies such as the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations have implemented performance measurement systems that explicitly include a behavioral health component. Several organizations such as the Institute of Medicine and the American College of Mental Health Administrators have proposed performance indicators for mental health, although these have neither been defined as measures nor have they been implemented.

The model of the future mental health system envisioned by National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute focuses on quality and accountability, with performance measurement, evidence-based practices, and quality improvement as key components. This vision has been reinforced by the recommendations of The President's New Freedom

[6] Magnabosco, Jennifer and Manderscheid, Ronald (2011). *Outcomes Measurement in the Human Services: Cross-Cutting Issues and Methods in the Era of Health Reform* (2nd ed.). Washington DC, NASW Press.

Commission Report (2003) and through several grant initiatives developed by the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS).[7]

Progress in standardization efforts have been coordinated by CMHS through the Performance Measurement Forum, the 16-state (not including California) performance indicator feasibility study[8], and the Mental Health Statistics Improvement Program Consumer-Oriented Report Card. While there is convergence on the areas that need to be monitored, the actual measures and the methodologies for their measurement remain diverse. This creates issues related to both the credibility and the comparability of mental health performance measures.

SAMHSA developed national outcome measures (NOMs) for mental health services that include important service considerations such as use of hospitalization, use of evidence-based practices, and overall program cost-effectiveness. SAMHSA is encouraging state mental health agencies to begin using these key outcome measures, which include decreased symptomatology, improved functionality at work or school, improved stability/functionality at home, client perception of care, abstinence from drug and alcohol abuse (if applicable), decreased criminal justice involvement (if applicable), reduced use of psychiatric inpatient beds (if applicable), use of evidence-based practices and cost effectiveness. NOMs represent the first time the federal government has successfully promoted a credible set of standardized clinical outcome measures for nationwide use. It is an action that many health researchers and advocates have been calling for and working toward for years.[9] This data will be used by the State in the development of the Performance Outcomes System.

State Evaluation Efforts

DHCS staff surveyed Medicaid Directors in other states and California MHPs in November 2012, to learn about performance outcomes systems currently in place across the nation. Through this exercise, DHCS ascertained information about how states and California MHPs collect mental health outcomes data, what tools they use, and what standards they follow. These surveys provided insight into a variety of strategies for developing a performance outcomes system for Medi-Cal specialty mental health services.

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[7] Vijay Ganju, Quality and Accountability: An Agenda for Public Mental Health Systems ; A Paper Developed for the Institute of Medicine's Meeting on "Crossing the Quality Chasm – An Adaptation to Mental Health and Addictive Disorders," September 13-14, 2004, Washington, D.C.

[8] Lutterman T, Ganju V, Schacht L, Shaw R, Monihan K, et.al. Sixteen State Study on Mental Health Performance Measures. DHHS Publication No. (SMA) 03-3835. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003

[9] Corrigan et al., 2005; Drake et al., 2005; Evans et al., 2005; Evans et al. 2000; Grob & Goldman, 2006; Kelly, 1997, 2000, 2003, 2009; Manderscheid, 1998, 1999, MHSIP Taskforce, 1996; New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services, 1999) (Magnabosco & Manderscheid, 2011.

Performance Outcomes System Survey to Medicaid Directors

On behalf of DHCS, the National Association for Medicaid Directors surveyed state Medicaid Directors to determine if other Medicaid programs have child and adult performance outcomes systems, if reporting is mandatory or voluntary, and from whom and how often they collect data. Nineteen states (38 percent) responded.

- Sixteen of the 19 states reported having a performance outcomes system for children, two reported having only a system for adults, and one does not have a system for either children or adults.
- Eleven collect data for children annually. Of these 11 states, 7 require community mental health providers and health plans to report performance data at least annually, while 4 require monthly or quarterly reporting.
- Eleven collect data from one source only and 6 collect from multiple sources.
- The two most commonly used sources of data are health plans (12 states) and mental health plans (9 states). Some states gather data from both health plans and mental health plans.

DHCS will review the survey in detail as part of the implementation plan.

Internet Review of State Mental Health Departments

DHCS sought to identify performance outcomes system trends through a review of the information available on the internet for other states, in addition to review of numerous research articles.

As of 2004, 48 of the 50 states, including California, are reporting SAMHSA NOMs data. SAMHSA's intention is for states to use NOMs (or equivalent measures) on a regular basis, thus generating detailed and comparative clinical outcome data that will help promote system improvements and identify which intervention(s) work best for a specific client/mental health disorder.[10] As mentioned before, California will use the NOMs data that it currently collects to inform the development of the Performance Outcomes System and to provide data for outcomes.

There is consensus and remarkable consistency across jurisdictions and stakeholders regarding the outcomes that mental health systems and services are intended to achieve:

- ✓ improved functioning;
- ✓ reduction in symptom distress;
- ✓ building social supports;

[10] Magnabosco, Jennifer and Manderscheid, Ronald (2011). *Outcomes Measurement in the Human Services: Cross-Cutting Issues and Methods in the Era of Health Reform* (2nd ed.). Washington DC, NASW Press.

- ✓ community participation;
- ✓ improvement in work or school performance;
- ✓ reduced hospitalization;
- ✓ well-being and positive health; and
- ✓ decreased contact with criminal and juvenile justice systems.

Over the past few years states, with only modest federal support, have worked to develop performance measurement systems that incorporate these indicators. A handful of states, including Ohio, Texas, Colorado, Washington, and Oklahoma have implemented systems to obtain these outcomes on a statewide basis, but the majority of states are currently in the process of building such systems. As an example, Missouri is actively implementing a NOMs based outcomes system and has published information that demonstrates the challenges they face in identifying indicators for each measure. They have also identified goals, performance measures, indicators and data for each. The work that these states have performed will assist California in the challenging task of defining measures and indicators for the State.

DHCS staff reviewed 30 states via an Internet search; only 12 display information about performance and outcomes systems specific to children and youth. Most states reviewed have information in addition to the NOMs available on-line, such as penetration rates or satisfaction survey results, although the age of the data varies from one month to several years old, and is not necessarily focused on children and youth. New York and Maryland have robust, interactive systems that provide a rich set of data and allow the user to select parameters for data display. Florida provides in-depth information on each indicator. The systems implemented by these states will function as potential models for California's Performance Outcomes System in regards to measures and indicators as well as options for the development of a data dashboard.

States use multiple assessment tools, including the following:

- Strengths and Difficulties Questionnaire:
- Child and Adolescent Service Intensity Instrument:
- Early Childhood Service Intensity Instrument:
- Child and Adult Integrated Reporting System (CAIRS);
- Indicators, Youth Assessment of Care Survey (YACS) and Family Assessment of Care Survey (FACS);
- Child and Adolescent Needs and Strengths (CANS); and
- Child and Adolescent Level of Care Utilization System (CALOCUS).

States also use satisfaction tools to measure perception of care. DHCS plans to continue efforts to learn more from other states about the systems and information technology structures that they use to collect information.

Focus on New York and Maryland

DHCS conducted a more in-depth study of New York and Maryland, whose websites reflect extensive performance outcomes information. Members of the Subject Matter Expert Workgroup also indicated both that these states have made significant progress in developing performance outcomes systems.

New York

In New York "Phase One," released in 2009, included CAIRS data collected from 2002 to the present, as well as the YACS and FACS survey results from 2006 to 2008. The surveys covered youth demographics, survey response rates and family satisfaction of services. "Phase Two," released in the summer of 2010, included the addition of CANS reports to the CAIRS system. The CANS information is recorded upon admission and discharge of programs and when necessary. It includes information about problem presentation, risk behaviors, care intensity, caregiver capacity, functioning and strengths. Also during this phase, the surveys were significantly improved to not only cover the basic information covered in the 2006 to 2008 reports, but became dynamic reports which show youth and family satisfaction by agency, program, program type, and geographic region (statewide, region, and county) and by youth demographic characteristics (age, gender, and race/ethnicity).

Maryland

Maryland initiated its statewide Outcomes Measurement System (OMS) on individuals 6-64 years of age in September 2006; this initial phase lasted until 2008. This phase provided information about individuals who are receiving mental health services, based on the most recent OMS questionnaire. Demographic information (e.g., gender, race, age) as well as information regarding life domains (e.g., living situation, employment, school attendance, and substance use) was available.

Maryland reorganized its system based on stakeholder feedback in 2010 and the second phase was launched in 2012. With the improved OMS, state and county administrators, behavioral health care providers and the general public are able to access a web-based dashboard that displays aggregated trends regarding outpatient consumers' progress in various aspects of their lives, such as housing, employment or school, psychiatric symptoms, substance use, overall functioning, legal involvement and physical health. Users are able to select a variety of analyses, such as time period, geographic region and consumer demographics.

It is notable that it has taken both New York and Maryland several years to create and establish the performance outcomes system currently in place. Each used a phased approach to system implementation and added levels of measures over the years. Both also developed an on-line dashboard to ensure transparency. Maryland has taken a simple approach and presents information on a limited number of topics whereas New York has a very complex and interactive dashboard. The two approaches to the public dashboard present DHCS with two unique performance outcomes system models, each with different benefits and resource implications.

County Evaluation Efforts

DHCS reached out to California MHPs and other stakeholders to learn about the use of measurement tools and to gather feedback on local performance outcomes systems.[11] In November, 2012, DHCS contacted MHPs in order to understand their use of performance outcomes system measurement tools, including CANS, as identified by statute.

Mental Health Plan Survey

Of the 56 MHPs in California, 54 (96.4 percent) responded; 6 counties (11 percent) do not have a performance outcomes system for children's mental health services. The survey results revealed that county MHPs use a variety of evidence-based tools and most are measures of overall functioning as well as measures focused on specific symptoms or diagnoses. Between MHPs, there are differences in what tools are used and how they are administered, thus it is difficult to compare information across MHPs.

The CANS is used by about 37 percent of the MHPs, the CALOCUS is used by 17 percent and 44 percent use other tools. Four MHPs (2 percent) indicated they do not use a tool. The largest group by population, Los Angeles, uses the Youth Outcome Questionnaire, as well as other tools. Some of the other tools listed by the 44 percent of MHPs include: Child Behavior Checklist, Children's Functional Assessment Rating Scale, Ohio Scales, Strengths and Difficulties Questionnaire, and the Center for Epidemiological Studies Depression Scale.

DHCS also conducted follow up interviews with counties who operate a performance outcomes system (Los Angeles, San Francisco, Sonoma, Ventura, and San Bernardino) to gain more in-depth knowledge about their measurement tools, opinions on what they do and do not like about their systems, how long it took to implement their system, and recommendations for the development of a

[11] DHCS attempted to conduct a survey to obtain stakeholders' feedback from counties, providers, and local organizations regarding existing performance and outcomes systems. The survey was posted on the DHCS website and emailed to members of the Stakeholder Advisory Committee. Because only five of approximately 75 (6.7 percent) stakeholders responded to the survey, results are not presented in this System Plan.

statewide Performance Outcomes System. DHCS conducted several conference calls with mental health and quality improvement professionals. Overall, interviewees provided the following recommendations:

- Choose assessment tools and outcomes measures that demonstrate client progress and inform clinical practice;
- Implement a "feedback loop" from the State to the counties and back again, to guide changes in clinical practice and clinical decision-making; and
- Develop a performance outcomes system that moves away from simply using anecdotal reports about children and youth's clinical and functional progress to a more data-driven decision-making process.

The survey and interviews illuminated some of the challenges in gathering comparable information from all counties due to the variety of tools employed. They also provide insight to the desire to receive information from DHCS that will support the improvement of local service and practices.

III. Federal and California State Laws Related to Performance Measurement

DHCS conducted a review of federal laws and regulations related to the development of the Performance Outcomes System. DHCS and the MHPs have responsibilities regarding activities related to performance, outcomes and quality assurance activities mandated both by the State and federal government.

Pursuant to federal Medicaid requirements for managed care programs (Title 42, Code of Federal Regulations, Part 438, §§438.200 through 438.242), DHCS is required to implement quality assessment and performance improvement strategies to ensure the delivery of quality health care by MHPs.

Specifically, DHCS is required to:

- Ensure the use of evidence-based mental health practices appropriate to client needs (over and underutilization);
- Demonstrate effectiveness and positive client outcomes; and
- Encourage timely data submission.

DHCS promotes the use of performance improvement projects by the MHPs, whenever possible, and ensures that MHPs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve these requirements. In addition, there is a federal mandate for an independent external quality review. The State of California contracts with an External Quality Review Organization (EQRO), currently APS Healthcare, to fulfill these requirements.

DHCS also conducted a review of state laws and regulations related to the development of the Performance Outcomes System. Based on this review, the following represent areas that are considered in the selection of the performance outcomes indicators:

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

As performance outcomes measures are identified, DHCS will review federal and State requirements to ensure that all data collection requirements are fulfilled.

IV. Development of California's Performance Outcomes System Plan

Developing the Performance Outcomes System is a multi-layered effort and implementing it includes stakeholders, data, and technology capabilities. To date, the project has benefited from the involvement of dedicated stakeholders whose input and guidance have been invaluable. This coordination and collaboration is expected to continue. Simultaneously, DHCS is building its capacity for data mapping and analysis, report development, and training and technical support for the MHPs. DHCS is also undertaking a review of the capacity and data of current information technology staff and systems to support performance outcomes system activities. In addition, DHCS is considering the broader needs and implications of efforts such as the implementation of the Katie A. settlement[12] and the MHSOAC Evaluation Master Plan[13].

Stakeholder/Partner Involvement

The continuous collaboration between DHCS and stakeholders/partners is critical to the development and maintenance of the Performance Outcomes System. Stakeholders/partners include representatives and advocates of child and youth clients;

[12] Katie A. etc., et al. v. Diana Bonta etc., et al, CLASS ACTION SETTLEMENT AGREEMENT (Case No. CV-02-05662 AHM [SHx]) A primary objective of this agreement is to facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery, and transition into a coherent and all-inclusive approach for children in foster care. This includes the provision of intensive home-based services, intensive care coordination, and therapeutic foster care.

[13] The MHSOAC has developed a statewide community mental health system evaluation master plan. The plan focuses on individual, system, and community outcomes; provides specific evaluation activities and a general system by which to prioritize evaluation activities; and identifies completion strategies.

family members and/or caregivers; county staff; child/youth advocates; other California state-level entities, including representatives of the Legislature, and the MHSOAC; as well as other members of the interested public.

To ensure that the Performance Outcomes System reflects the needs and values of all partners and stakeholders and that it aligns with the legislative mandate for this project, DHCS established an inclusive stakeholder process that began with the formation of a Stakeholder Advisory Committee in September of 2012. With a high level of stakeholder interest, the Stakeholder Advisory Committee has included participation by representatives from over 100 organizations. Due to the complexity of this project subject matter expertise was critical for moving the process forward in a timely manner. As a result, the following two working subgroups were formed to support the Stakeholder Advisory Committee: the Subject Matter Expert (SME) Workgroup and the Measures Task Force.

The working subgroups are designed to develop and present work products to the Stakeholder Advisory Committee members, who, in turn, review and provide their comments/feedback.[14] Appendix B, Stakeholder Advisory Committee Members, provides a list of organizations represented on the Stakeholder Advisory Committee. Appendix C, Subject Matter Expert Workgroup and Measures Task Force Members, provides a list of members and organizations represented in the subgroups.

Stakeholder Advisory Committee

The Stakeholder Advisory Committee is comprised of members who represent providers, academia and researchers, counties, MHPs, advocates of child and youth clients, family members and/or caregivers. Representatives from the Legislature and other State entities such as the California Department of Social Services, and the Department of Finance are also included. APS Healthcare which conducts the EQRO reviews for Medi-Cal specialty mental health services and the MHSOAC are also committee participants. An initial group of stakeholders was identified based on their knowledge and previous input to the department. Additional stakeholders were subsequently added and the Committee continues to welcome new participants. At the outset, it was difficult to identify children and youth and their family members. Fortunately, participating child/youth advocacy groups provided support by contacting and engaging family members, who began participating in the Stakeholder Advisory Committee in April 2013. The broad representation and varied experience of the Stakeholder Advisory Committee participants reflects the relevance and far-reaching importance of this new Performance Outcomes System.

Stakeholder Advisory Committee meetings were held on October 4, 2012, April 30, 2013, and July 23, 2013. DHCS staff and members of the SME Workgroup presented updates and work products, to which Stakeholder Advisory

[14] The Measures Task Force has not yet presented to the SME workgroup or Stakeholder Advisory Committee it is still working on its tasks. Updates have been provided, but not products.

Committee Members were asked to provide feedback. Information presented included the results of the Medicaid Directors and MHP surveys, as well as information gathered about the performance outcomes system implementations of other states. Committee meetings were open to the public, as required by the Bagley-Keene Act. These meetings were interactive and a "Question and Answer" period was provided at each meeting as an opportunity for stakeholder input and public comment. Stakeholder Advisory Meeting materials were provided to the Committee prior to the meetings and were also posted on a DHCS website created for the Stakeholder Advisory Committee.[15]

Subject Matter Expert (SME) Workgroup

In January 2013, DHCS formed a SME Workgroup, comprised of Stakeholder Advisory Committee members who represent counties, academics, APS Healthcare, the MHSOAC, and child/youth advocates, to develop an over-arching vision for the Performance Outcomes System. SME Workgroup participants have extensive experience in prior and/or current local and national efforts on the development and establishment of outcomes and quality improvement measures. The SME Workgroup meets approximately two times per month.

The primary function of the SME Workgroup has been to provide DHCS and the Stakeholder Advisory Committee with recommendations, including their rationale, for defining the domains, outcomes, and sample indicators, necessary to evaluate system performance and youth outcomes to quantify the effectiveness and efficiency of programs and services provided to children and youth to meet their mental health and well-being goals.

Measures Task Force

In June 2013, the Measures Task Force was established to review tools currently used by specialty mental health professionals to assess client clinical and functional status over time. Members are experts familiar with the primary assessment tools used by counties and their providers.

The Measures Task Force is charged with identifying child/youth and provider-level mental health indicators currently tracked by counties, including whether or not indicators are comparable and what gaps exist in current data collection that will need to be addressed in the future. The goal of selecting the appropriate indicators is to ensure that child/youth progress, and provider performance is accurately assessed.

[15] Materials are posted on the DHCS internet site at:
Link to webpage of Medi-Cal Specialty Mental Health Services Stakeholder Advisory Committee

The work of this task force will support the larger SME Workgroup's efforts to identify commonalities and differences among county assessment tools. The Measures Task Force review focuses largely on functional outcomes to complement the Medi-Cal claims information already captured by DHCS.

Information Technology (IT)/Data Workgroup

In July of 2013, DHCS established the IT/Data Workgroup, which consists of DHCS staff, to assess existing IT systems for outcomes data at both the state and county levels. Given that most State and local data systems are built on operational processes, it is anticipated that much of the available data will reflect system performance measures; however, it is possible that current IT systems may also capture a limited amount of child/youth outcomes data.

The objective of this Workgroup is to support the development of reports that may be used by the State, counties, providers, families and advocates to better understand and compare system performance and child/youth outcomes. In addition, this Workgroup will assist in proposing modifications to existing state data systems, as well as identify alternative data systems to capture additional outcomes data. In future, the membership of the Workgroup will be expanded to include stakeholder data experts, particularly from the counties and the EQRO.

Performance Outcomes System Evaluation Methodology

Establishment of a clear methodology is at the core of any successful evaluation. Broadly, this involves specifying the questions to be answered (e.g., are Medi-Cal specialty mental health services resulting in improved functioning for children/youth); identifying the target population (e.g., children and youth who receive Medi-Cal specialty mental health services); determining what tool(s) will be used to capture information to answer the questions (e.g., functional assessment tools that are valid, reliable, and sensitive to change); how often data should be collected (e.g., three months, six months, annually); what mechanisms will be used to capture and transmit data (i.e., a data system infrastructure); and designing the final reports. The importance of these methodological components cannot be understated as each exerts an impact on the final results/reports that will be used to inform decision-makers as they work to address important mental health issues.

During the past year, the SME Workgroup has spent a considerable amount of time and effort identifying relevant segments of the mental health service delivery systems and processes (i.e., domains). Section V presents an in-depth discussion about these Performance Outcomes System domains and indicators. The concepts developed by the SME Workgroup have been shared with the Stakeholder Advisory Committee and are serving as a foundation from which to build the Performance Outcomes System. DHCS will continue leveraging these collaborative efforts to ensure a strong evaluation methodology, which will be documented in a Performance Outcomes System Protocol.

Data Collection and Analysis

Counties currently report to DHCS a number of data elements that are relevant to outcomes measurement. DHCS will examine its current data systems to identify these data elements, as well as assess data integrity. DHCS is aware that there may be gaps in existing statewide data collection efforts that may result in the need to expand data collection (e.g., clinical functioning). DHCS will continue to compile and analyze data as it becomes available.

DHCS Data Systems

In an effort to determine what data are currently available to measure identified performance outcomes indicators, the DHCS Mental Health Services Division, Mental Health Analytics Section, is currently conducting a comprehensive review of existing DHCS databases. A brief overview of each DHCS system identified thus far, along with a brief description of the type of information captured, is provided below.

Short Doyle/Medi-Cal Claiming System

The Short-Doyle/Medi-Cal (SD/MC) claiming system enables California MHPs to obtain reimbursement of federal funds for medically necessary Medi-Cal specialty mental health services provided to Medi-Cal beneficiaries, including the recently transitioned Healthy Families Program for children with Serious Emotional Disturbance. The SD/MC claiming system provides information about who is receiving services, how often the services are received, and the amount claimed for federal reimbursement of services to Medi-Cal beneficiaries. DHCS receives this data continuously. The types of data that are provided to this system include client demographics, service types, dates of services, and approved claim amounts.

Client and Services Information System

The Client and Services Information System collect data pertaining to all mental health clients and the services they receive at the county level. The system provides information about non-Medi-Cal mental health services and Medi-Cal specialty mental health services. DHCS receives this data monthly. In addition to dates and types of services, the types of data captured in this system are more extensive than the SD/MC system regarding client demographics, diagnoses, living arrangement, service strategy, race/ethnicity, employment, and education level.

Web-Based Data Collection Reporting System - Consumer Perception Surveys

The Web-Based Data Collection Reporting System collects data reported from the Consumer Perception Surveys. The system provides information about the client's/family member's perception of satisfaction with regards to services and also provides information about perceived impacts to quality of life. The surveys are administered during a two-week sampling period and the client is not required to complete the survey. DHCS has been receiving this data annually but plans to

administer surveys twice a year, beginning in 2014. The types of data that are captured in this system include consumer satisfaction with services across seven domains; general satisfaction, access, quality/appropriateness of care, social connectedness, client functioning, criminal justice, and quality of life. Other data include perceived impacts to quality of life across these seven domains; general life satisfaction, living situation, daily activities and functioning, family and social relations, finances, legal and safety, and health.

Data Collection and Reporting System

The Data Collection and Reporting System collects data pertaining to any client enrolled in a Mental Health Services Act funded Full Service Partnership program. The system provides the primary source of outcomes data for Full Service Partnership programs. The information is collected at the client's intake. DHCS receives this data 60 days post intake. The types of data that are captured in this system relate to the eight domains; residential status, education, criminal justice, legal designations, co-occurring disorders, source of financial support, and emergency intervention.

Management Information System/Decision Support System

The Management Information System/Decision Support System (MIS/DSS) is a subsystem of the California Medicaid Management Information System and serves as the DHCS's Medi-Cal Data Warehouse. The MIS/DSS system provides data pertaining to eligibility, provider, and claims information for the Medi-Cal Program. The MIS/DSS is the largest Medicaid data warehouse in the nation and the data is integrated from many different sources. The types of data that are captured in this system are claims and encounter data (mental health Medi-Cal, Drug Medi-Cal, managed care, pharmacy, fee-for-service Medi-Cal), Medi-Cal eligibility data, provider data, and other reference data such as National External Norms and Benchmarks.

V. Framework for the Performance Outcomes System

The purpose of the Performance Outcomes System is to promote and encourage improvements to California's mental health system. The goals are to provide information and subsequent system improvements that strive to ensure children and youth receive the Medi-Cal specialty mental health services they need, that help providers and MHPs achieve positive outcomes on behalf of children and youth, and provides transparent reporting on the performance of the California Medi-Cal specialty mental health system. An effective system may be used by the State, counties, providers, consumers, and the public to ascertain whether the services and systems are achieving the desired outcomes, encourages and rewards systems that demonstrate positive outcomes, and provides incentives for improving for those that do not.

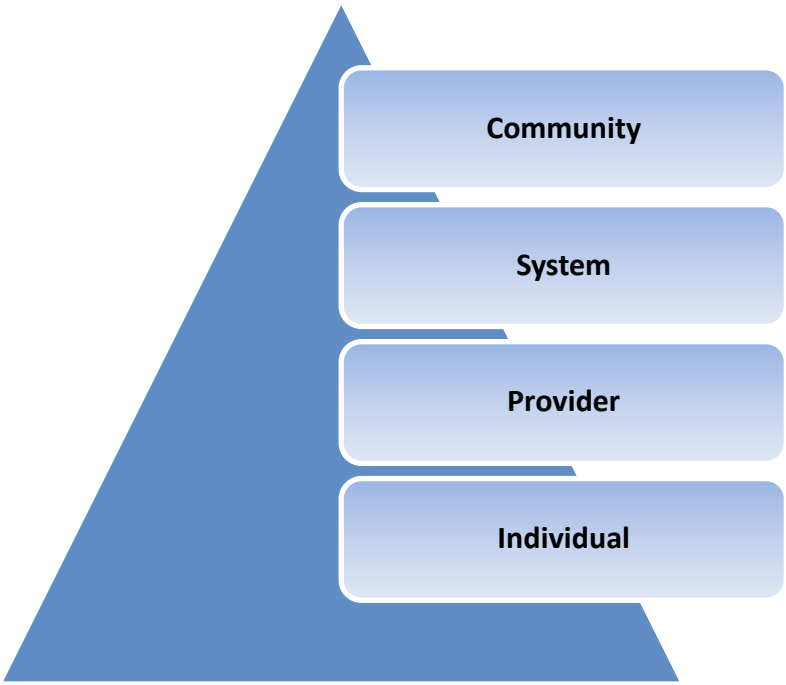
While the focus of the Performance Outcomes System is children and youth receiving Medi-Cal specialty mental health services, DHCS is taking a more comprehensive view and developing the system with the potential to expand and address additional important mental health outcomes evaluations. Targets include the assessment of performance and outcomes for other populations of children such as children in foster care receiving non-Medi-Cal mental health services. The Performance Outcomes System will also be synchronized with and support the MHSOAC Evaluation Master Plan and EQRO annual reporting to allow each to focus on areas of strength and specialty. Other areas which the Performance Outcomes System may be able to support include Full Service Partnership evaluation, Mental Health Services Division oversight reviews, and evaluation efforts for substance use disorder and physical health systems.

Conceptual Framework: The Performance Measurement Paradigm

Key to the development of a performance outcomes system is a conceptual framework from which a variety indicators and measures are identified and may be expanded over time. Based on prior services evaluation efforts for the Mental Health Services Act, DHCS developed such a conceptual framework, the Performance Measurement Paradigm, for the Mental Health Services Division.

The EPSDT Performance Outcomes System statute specifies that outcomes be measured at the individual, system and program level. DHCS envisions a comprehensive Performance Outcomes System that is based on an expanded Performance Measurement Paradigm that also includes the community level (Figure 1). Outcomes for each level will answer a variety of evaluation questions (see examples in Figure 2).

Figure 1. Performance Measurement Paradigm



The foundation of the Performance Outcomes System is based on the experience of the individual. The experience of mental health care and an individual's outcomes drive the other levels. For the purpose of this plan, the levels are defined as follows:

- **Individual Youth/Family Level**

  Outcomes and results for those who receive direct mental health services.

- **Provider Level**

  Outcomes and results for those individuals or groups who provide direct mental health services to the individual youth/family level. This level is also referred to as the Program level.

- **Mental Health System Level**

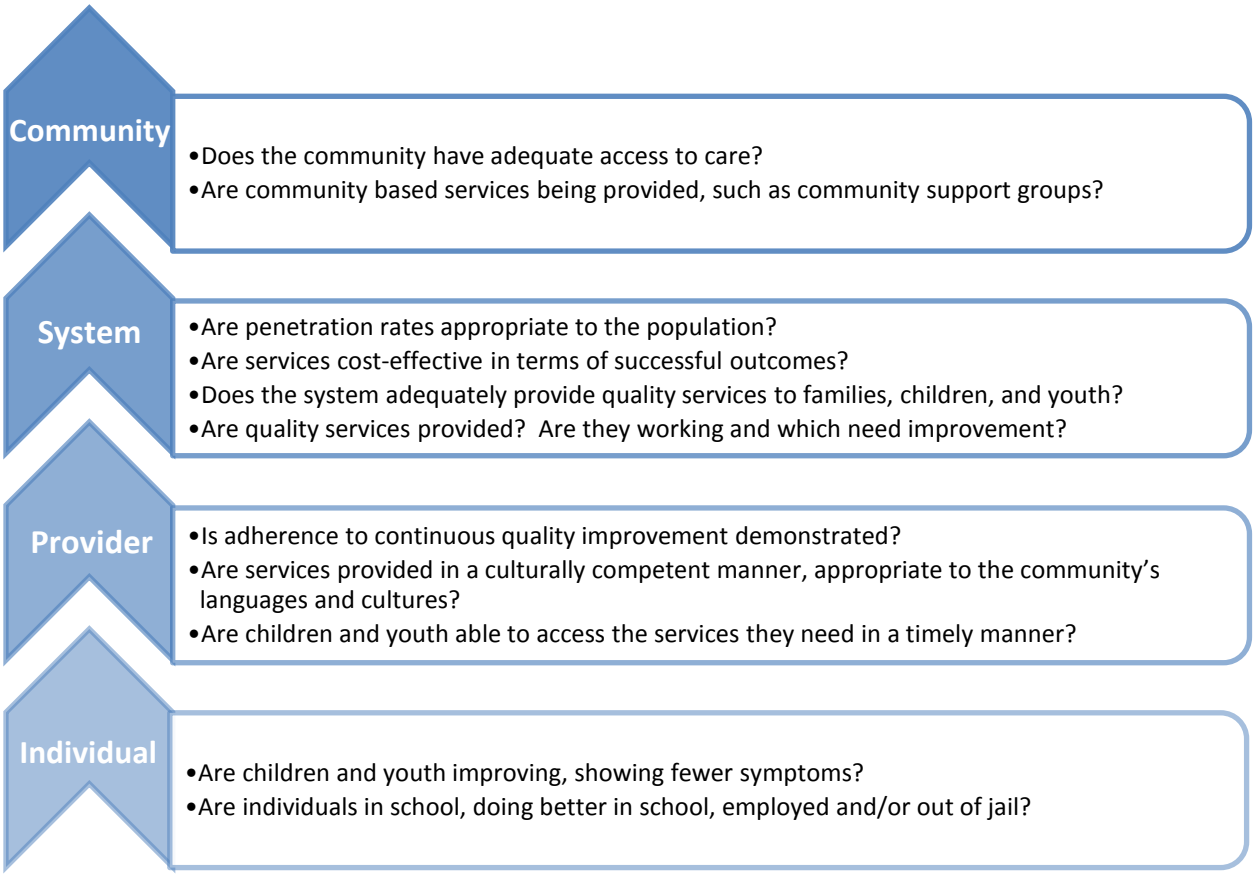
  Outcomes and results for those individuals or groups who provide the infrastructure support to the provider level. This level is also referred to as the State level.

- **Public/Community Level**

  Outcomes and results for all; both those who do not receive direct mental health services as well as those who do. The community level is outside the scope of this initial Performance Outcomes System effort as the outcomes will require additional measures and protocols.

  Several questions are provided to illustrate outcomes for each level. Provider and System may have interchangeable questions, but differ in their population/context; the system population is at the State level and the provider population is a one or a group of providers.

Figure 2: Example Performance Measurement Paradigm Evaluation Questions



Performance Outcomes System Domains

There are seven domains that will anchor the Performance Outcomes System. These reflect the domains established at the national level by SAMHSA. The Performance Outcomes System will be used to evaluate access, engagement, service appropriateness to need, service effectiveness, linkages, cost effectiveness and satisfaction. The first five domains are organized as series of decision points which are encountered across an episode of care. The decision points typically unfold in sequence and continue throughout the care experience. Client experience at each decision point has implications for both the process and outcome of care. Domains may cross more than one level, thus service effectiveness could provide information about the provider, system and public/community levels.

The following is a list of the seven domains, along with a brief description:

1. **Access**

   Access is the feasibility and delivery of care and coordination of services to the child/youth. Sample domain categories are children and youth being served or not being served, timeliness of services being delivered, and denial of services.

2. **Engagement**

   Engagement is the participation and empowerment by the child/youth and caregivers with treatment and services. Sample domain categories are participation of children and caregivers in services and the maintenance of services.

3. **Service Appropriateness to Need**

   Service Appropriateness to Need is the determining if services match the individual child/youth's needs and strengths in accordance with system-of-care values and scientifically derived standards of care. Sample domain categories are the standard of quality of care, consistency with treatment and treatment plan, the clinical status of the youth/child, functional status, modality of care or care options, the fidelity of the treatment model to the practice standard, and psychotropic medication.

4. **Service Effectiveness**

   Service Effectiveness is the influence of treatment on a child/youth's mental health symptoms and functioning at home, in school, and in the community. Sample domain categories are the symptomology of the child/youth, the functioning level of the child/youth, the support and social integration, the relationship with family mental health/substance abuse and the child/youth, housing situation, educational progress, juvenile justice involvement, employment, and overall child/youth safety.

5. **Linkages**

   Linkage is the fostering, coordinating, and monitoring of connections with groups outside the mental health system. This includes academia, public health, healthcare, education, social services, and corrections, with the goal of building on the services and programs for the child/youth. A sample domain category is success in dual program services.

6. **Cost-Effectiveness**

   Cost-Effectiveness is measuring whether the dollars invested have produced the best outcomes possible. A sample domain category is reduced cost to the state by youth being in school, employed and out of jail. Another would be comparing the costs of treatments to identify those that are most successful and cost-effective.

7. **Satisfaction**

   Satisfaction is the perception that the child/youth's needs are being met. A sample domain category is the integration and coordination of care.

Guiding Principles

The system will be established through the use of objective, standardized and uniformly applied performance outcomes measures. While current measures for the same domain may vary statewide, the Performance Outcomes System will use standard measures and equivalent measures, where proven and practical. The reported information will be available to the public, policymakers and clients for the purpose of reviewing the effectiveness of care across mental health programs within California. DHCS, working together with our partners and stakeholders, will build a robust Performance Outcomes System within the next three years that includes development of routine performance outcomes reports accompanied with technical assistance to ensure a process of continuous quality improvement.

Guiding principles for the Performance Outcomes System include:

- Data must be gathered to reflect the experiences of children and youth who are served by the public mental health system;
- The differing needs for data/indicators for the state, counties (large and small), providers, advocates, family and/or caregivers, and youth must be recognized and considered;
- Feasibility, including estimation of cost, additional workload for rendering counties, clinicians, and other impacts, must be established and acknowledged.
- Data collected must be valid and reliable;
- HIPAA/confidentiality requirements for data collection and sharing must be met; and
- Data and reports must be current and relevant for reporting for administrative, quality assurance and other purposes.

VI. Key Components of the Performance Outcome System

Reporting

DHCS and the Stakeholder Advisory Committee Workgroup and subgroups will develop a standardized report(s) template. The frequency of the report(s) deliverable will be dependent on the comprehensive review of the data systems. The specific data system areas that will be reviewed are data collection and reporting times, quality, and uniformity. This review is important to ensuring that the report(s) can be useful for all stakeholders and can be comparable statewide and countywide. The specific types of

report(s) and the frequency of report(s) deliverables will be included in the implementation plan. A general review of DHCS's data systems suggest that there are some common standardized data elements that are reported and can be used to generate immediate high level information to the stakeholders.

The goal of the report(s) is to show the impact of mental health services and programs and to identify areas that need improvement. The usefulness of the report(s) to the stakeholders and partners is important and DHCS understands the need for continuous stakeholder and partner input in the development, analysis, and enhancement of the report(s) product. DHCS will make the report(s) available to the public via accessible locations, such as the DHCS website.

Continuous Process for Quality Improvement

Data reporting is necessary to support the State and counties in their informed decision-making process. DHCS staff will continue the collaborative process by providing technical assistance and training to county staff on how to interpret and utilize the data to support services and programs.

Per W&I Code 14707.5, DHCS will leverage existing processes to develop a quality assurance and improvement process. The primary objectives of the process will be to ensure that consistent, high quality services are delivered to children/youth and their families and to improve the functioning in all areas affecting the lives of children and youth including school performance, home environment, child safety and juvenile justice system. DHCS's ultimate goal is to implement and maintain a statewide quality assurance and improvement process that allows DHCS to evaluate the effectiveness of service provision, promote continuous improvement, and support opportunities for continuous learning.

To meet these objectives, DHCS will work closely with the counties to:

1. Identify areas of systemic strengths and weaknesses within California's mental health system and support the development of strategies to improve areas of performance.
2. Provide on-going evaluation, assessment and oversight of the strategies designed and undertaken to improve services and outcomes.
3. Facilitate on-going assessment and evaluation of outcome measurement data as they relate to children's and youth's mental health services.
4. Include internal and external stakeholders in the development and implementation of the quality assurance process.
5. Utilize strategies that are strength-based, solution-focused, culturally sensitive, action oriented and common sense driven.
6. Increase accurate data collection, verification and analysis.

7. Provide access to timely, concise information related to children/youth and families served in California.
8. Ensure transparency by posting relevant data and reports for the public.

In collaboration with the EQRO and other state agencies, such as the MHSOAC and the California Mental Health Planning Council, DHCS will identify areas for improvement and successful strategies. The identified performance and outcome measures, in addition to the qualitative information derived from the EQRO reviews, will assist DHCS in determining strengths and opportunities for improving practice across the mental health system, including access to services, timeliness of services, and overall clinical and functional improvements of children and youth. This information will be provided to MHPs and providers to help them improve services and outcomes for children and youth, as well as their families and/or caregivers, in California. Information will also be provided to counties to assist them with programmatic and fiscal decision-making.

VII. Timeline to Build the Performance Outcomes System

It is important to provide a strong foundation from which to collect high-quality data for outcomes measurement in order to develop reports that can adequately support fiscal and program decision-making. As described earlier, the DHCS Mental Health Services Division has initiated an internal assessment of the DHCS databases. This assessment will also include a data quality review.

DHCS understands that in order to ensure that the information is reliable and timely, a strong collaboration between DHCS and the counties is critical. DHCS and the counties will work together on improving the quality of the current data and building a means to collect and report additional data.

Concurrently, DHCS and its partners/stakeholders will continue working to identify quantifiable criteria specific to the seven performance outcomes domains. The Mental Health Services Division staff review of the databases will help determine clearly what information is available to address those criteria and to determine what elements are still needed.

Table 1 reflects the high-level milestones and timeframes required to build a comprehensive, statewide Performance Outcomes System.[16] Additional Stakeholder Advisory Committee meetings will take place.

[16] The implementation schedule, communication plan, risks / issues, and assumptions / constraints will be detailed in the System Implementation Plan.

Table 1. Timeline to Build the Performance Outcomes System

Milestones	Date
System Implementation Plan	
Draft System Implementation Plan	November 2013
Obtain Input on the final draft Implementation Plan from the Stakeholder Advisory Committee	December 2013
Deliverable: System Implementation Plan	**January 2014**
Establish Performance Outcomes System Methodology	
Create Stakeholder Consensus on the Performance Outcomes System Evaluation Methodology (including standardized data sources and data collection tools used for the system, frequency of administration, etc.)	July 2014
Obtain Input on the Performance Outcomes System Methodology Protocol from the Stakeholder Advisory Committee	September 2014
Deliverable: Performance Outcomes System Protocol	**October 2014**
Initial Performance Outcomes Reporting: Existing DHCS Databases	
Identify Performance Outcomes Data Elements in Existing DHCS Databases	January 2014
Assess Data Integrity	March 2014
Develop County Data Quality Improvement Reports	April 2014
Counties Remedy Data Quality Issues	Ongoing Beginning in May 2014
Develop Performance Outcomes Report Template(s)	June 2014
Obtain Input on the Report Template(s) from the Stakeholder Advisory Committee	July 2014
Deliverable: Statewide and County Reports on Initial Performance Outcomes Using Data from Existing DHCS Databases	**Ongoing** **Beginning in October 2014**
Continuum of Care: Screenings and Referrals	
Obtain Input on screening and referral information needed for the Performance Outcomes System from the Stakeholder Advisory Committee	February 2014
Deliverable: Performance Outcomes System Plan Update	**October 2014**
Deliverable: Performance Outcomes System Implementation Plan Update	**January 2015**

Milestones	Date
Comprehensive Performance Outcomes Reporting: Expanded Data Collection	
The activities associated with this task are dependent on the number and scope of additional data elements adopted as part of the Performance Outcomes System Methodology.	FY 2014-15
Obtain Input on the Report Template(s) from the Stakeholder Advisory Committee	Summer 2015
Deliverable: Statewide and County Reports on Comprehensive Performance Outcomes Using Existing and Expanded Data	**FY 2015-16**
Continuous Quality Improvement Using Performance Outcomes Reports	
Develop Trainings to Support Interpretation of the Performance Outcomes Reports (Initial and Comprehensive)	Ongoing Beginning in January 2015
Develop Quality Improvement Plan Template(s)	Ongoing Beginning in March 2015
Obtain Input on the Quality Improvement Plan Template(s) from the Stakeholder Advisory Committee	Spring 2015
Deliverable: Quality Improvement Plans	**Summer 2015**
Support and Monitoring of Quality Improvement Plans	Ongoing

VIII. Dependencies

DHCS recognizes that there are many competing priorities for the counties, providers, and the State that must be planned, managed and organized in order to develop a Performance Outcomes System, as envisioned. Among them are data from reliable data sources; data system capacity; county and DHCS staff who are trained and available; support from performance outcomes and evaluation subject matter experts; and on-going collaboration with DHCS partners/stakeholders to continuously improve mental health system and clinical outcomes. DHCS has highlighted the following areas as needing particular attention in order to effectively implement the Performance Outcomes System.

Data Integrity

Performance outcomes reports are only useful if the data reflected is valid and reliable. Therefore, it is of paramount importance that initial efforts focus on improving data quality. Failure to address data integrity issues will result in erroneous results that could risk misguiding policy-makers in their decision-making efforts.

Data System Capacity

When community mental health functions from the former Department of Mental Health transitioned to DHCS on July 1, 2012, some of the data systems were based on severely outdated technology. Regarding the Client Services Information, Data Collection and Reporting System, and Consumer Perception Survey data, improvements are needed in order to prepare the data systems for reporting within the DHCS network. The feasibility of including new data elements in the current data systems will also need to be assessed. Should the systems not be able to support expanded efforts, DHCS will have to look into developing a new system or system improvements.

DHCS Partners/Stakeholders

Maintaining an inclusive, collaborative spirit is instrumental to the process of developing and implementing the Performance Outcomes System. California' public mental health system is more likely to demonstrate its effectiveness in an organizational culture in which treatment progress and outcomes measurement is integral to clinical work.

The guidance of subject matter experts from outside of DHCS is needed to support the development of indicators and measures. As the project progresses, there will be a need to expand this knowledge within DHCS and utilize staff with expertise in areas such as information technology, specialty mental health, quality improvement, and clinical experience.

IX. Conclusion

DHCS and its stakeholders recognize this process to develop the EPSDT Performance Outcomes System as a unique opportunity that will establish standards and improved practices for Medi-Cal specialty mental health services for children and youth in California. It is also an opportunity to more closely synchronize and focus mental health evaluation efforts, such as those performed by the EQRO, MHSOAC and other efforts, such as the Katie A. implementation. With this System Plan, DHCS has demonstrated its commitment to develop and implement an initial Performance Outcomes System in Fiscal Year (FY) 2014-15, and an expanded Performance Outcomes System in FY 2015-16, that provides the counties and the public with informative and useful data with which to measure the performance of Medi-Cal specialty mental health services provided to California's children and youth.

DHCS, working with the Stakeholder Advisory Committee and subgroups, has begun the work of defining what the Performance Outcomes System will do and how it will do it. The four levels for improved results, individual (youth/family), provider, system, and the community (public) levels, provide a framework for the future system. The seven domains identify the areas of mental health activities that will be evaluated. The next

steps, which have already begun, are to take these concepts to a deeper level of detail to determine which indicators are most salient to measure as a gauge for performance at each level.

At this point, there are still complicated, outstanding decisions that will need to be made with respect to the Performance Outcomes System evaluation methodology, particularly regarding comparability across outcomes tools that measure child/youth functioning. As was found in the MHP survey, most counties currently operate performance outcomes systems, which is a significant achievement. It is hoped that there is comparability among the most commonly used functional assessment tools in California. However, if this comparability cannot be determined, then the State, counties, providers, and other key stakeholders that have been closely involved in performance outcomes system development efforts will need to explore alternative options for presenting a statewide story of mental health performance.

Through continued collaboration with partners/stakeholders and subject matter experts, and by reporting to the Stakeholder Advisory Committee, DHCS will continue exploring implementation strategies and activities in the next few months, which will be used to provide more detail on fiscal and programmatic impact in the System Implementation Plan in the next report, which is due to the Legislature on January 10, 2014.

Appendix A
Performance Outcomes System Statute

Welfare and Institutions [W&I] Code, Section 14707.5, added by Senate Bill [SB] 1009, Committee on Budget and Fiscal Review, Chapter 34, Statutes of 2012, amended by Assembly Bill [AB] 82, Committee on Budget, Chapter 23, Statutes of 2013.

W&I Code, Section 14707.5.

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

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

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

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

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

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

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

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

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

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

(d) The State Department of Health Care Services shall propose how to implement the performance outcomes system plan for EPSDT mental health services described in subdivision (a) no later than January 10, 2014.

(e) Commencing no later than February 1, 2014, the department shall convene a stakeholder advisory committee comprised of advocates for and representatives of, child and youth clients, family members, managed care health plans, providers, counties, and the Legislature. The committee shall develop methods to routinely measure, assess, and communicate program information regarding informing, identifying, screening, assessing, referring, and linking Medi-Cal eligible beneficiaries to mental health services and supports. The committee shall also review health plan screenings for mental health illness, health plan referrals to Medi-Cal fee-for-service providers, and health plan referrals to county mental health plans, among others. The committee shall make recommendations to the department regarding performance and outcome measures that will contribute to improving timely access to appropriate care for Medi-Cal eligible beneficiaries.

(1) The department shall incorporate into the performance outcomes system established pursuant to this section the screenings and referrals described in this subdivision, including milestones and timelines, and shall provide an updated performance outcomes system plan to all fiscal committees and the appropriate policy committees of the Legislature no later than October 1, 2014.

(2) The department shall propose how to implement the updated performance systems outcome plan described in paragraph (1) no later than January 10, 2015.

Appendix B
Stakeholder Advisory Committee Meeting Participants[17]

Partner/Stakeholder
Alameda County Health Care
Alameda County Mental Health
APS Healthcare-CAEQRO
Butte County Behavioral Health
California Academy of Child & Adolescent Psychiatry (CAL- ACAP)
California Alliance of Child & Family Services
California Council of Community Mental Health Agencies (CCCMHA)
California Department of Alcohol & Drugs Program (ADP)
California Department of Social Services (CDSS)
California Health & Human Services Agency (CHHS)
California Institute for Mental Health (CiMH)
California Mental Health Directors Association (CMHDA)
California Mental Health Planning Council (CMHPC)
California State Assembly
Calaveras County
CAlOptima
Cambria Solutions
Child Welfare Services
Children Now
Children's Bureau Southern CA
Children's Institute
Contra Costa County Public Health Department
Contra Costa Health Services
County of Santa Cruz Health Services Agency
Crittenden Services
Department of Finance
Department of Health Care Services (DHCS)
Department of Social Services/Child Welfare Services (CDSS/CWS)
Disability Rights Counsel CA
Early Childhood Mental Health Program
Eastfield Ming Quong Families First (EMQFF)
Family Member
Families First
Family SOUP
Five Acres
Fred Finch Youth Center
Fresno County Mental Health
Gov. Policy & Strategies
Hathaway Sycamores
Health Net
Humboldt County Mental Health
Imperial County Mental Health
John Perez, Assembly Speaker

[17] These meetings were held in Sacramento and both WebEx and conference call options were available to participants. Materials were provided in advance to participants. Materials are posted on the DHCS Internet site before meetings at:
Link to webpage for Medi-Cal Specialty Mental Health Services Stakeholder Advisory Committee

Partner/Stakeholder
Kern County Mental Health
Kings View Behavioral Health
Lake County Mental Health
Lassen County Health
Lincoln Child Center
Los Angeles County Department of Children and Family Services (LACDCFS)
Los Angeles County Mental Health
Madera County Mental Health
Marin County Mental Health
Mental Health Association California
Mental Health Services Oversight and Accountability Commission (MHSOAC)
Merced County Mental Health
Momentum for Mental Health
Monterey County Behavioral Health
Napa County Mental Health
National Alliance on Mental Illness (NAMI) CA
National Health Law Program
Nevada County
Online Archive of CA (OAC)
Orange County Healthcare Agency
Pacific Clinics
Placer County
Planning Council
Rebekah Children's Services
River Oak Center for Children
Riverside County Department of Mental Health
Sacramento County Mental Health
San Benito County
San Bernardino County
San Diego Health and Human Services Agency Child Welfare Services (HHSACWS)
San Diego County Mental Health
San Francisco Department of Public Health
San Luis Obispo County
Santa Clara
Santa Cruz County/CMHDA
San Joaquin County Behavior Health Services
Santa Barbara County Mental Health
SBC Social Services
Senate Budget Committee
Senate Office of Research
Senate Staffer for Darrel Steinberg
Seneca Center
Shasta County Mental Health
Siskiyou County Human Services Agency
SLC Consulting
Solano County Mental Health
Sonoma County
Star View Children & Family & Services
St. Anne's
Stanislaus Behavioral Health and Recovery Services
Sunny Hills Services

Partner/Stakeholder
Sutter County
Sutter-Yuba Mental Health
Tehama County Health Services Agency (TCHSA)
Tuolumne County Behavioral Health
UC Davis
Ventura County Mental Health
Vector Community Support Services
Voice 4 Families
West Coast Children's Clinic
Yolo County
Young Minds Advocacy Project
Youth for Change
Yuba City County Mental Health

Appendix C
Subject Matter Expert Workgroup and Measures Task Force Members

Participant	Organization	Membership	
		Subject Matter Expert Workgroup[18]	Measures Task Force[19]
Abram Rosenblatt	University of San Francisco	X	X
Nathaniel Israel	San Francisco Department of Public Health (DPH)	X	X
Penny Knapp	UC Davis	X	X
Renay Bradley	MHSOAC	X	
Rusty Selix	Coalition for Mental Health	X	
Don Kingdon	CMHDA	X	
Patrick Gardner	Young Minds Advocacy Project	X	
Wesley Sheffield	Young Minds Advocacy Project	X	
Jane Adcock	California Mental Health Planning Council (CMHPC)	X	
Linda Dickerson	California Mental Health Planning Council (CMHPC)	X	
Cricket Mitchell	CiMH	X	X
Stephanie Oprendek	CiMH	X	X
Michael Reiter	APS Healthcare	X	
Saumitra SenGupta	APS Healthcare	X	X
Sandra Sinz	APS Healthcare	X	
Ellie Jones	CDSS	X	
Patricia Costales	The Guidance Center	X	
Lynn Thull	California Alliance of Child & Family Services	X	
Jason Miller	Ventura County Mental Health		
Debbie Innes-Gomberg	Los Angeles County Mental Health	X	X
Edith Thacher	Project Manager, Cambria Solutions	X	X
Dina Kokkos-Gonzales	DHCS, Program Policy & Quality Assurance Branch (PPQAB)	X	X
John Lessley	DHCS, Quality Assurance Section	X	X
Monika Grass	DHCS, QA Unit	X	X
Reem Shahrouri	DHCS, QA Unit	X	X
Sean Mulvey	DHCS, QA Unit	X	X
Susan Stackhouse	DHCS, QA Unit	X	
Carol Sakai	DHCS, Program Compliance & Oversight Branch (PCOB)	X	
Gary Renslo	DHCS, FMORB	X	
Jennifer Taylor	DHCS, FMORB	X	X

[18] Subject Matter Expert Workgroup (SME) meetings were held in Sacramento. WebEx and conference call options were available to participants. Materials were provided in advance, and were shared among members and updated between meetings. The SME Workgroup met 13 times between January and August 2013.

[19] Measures Task Force meetings were held primarily via WebEx and conference calls. Materials were provided in advance to participants. Materials were provided in advance, and were shared among members and updated between meetings. The Measure Task Force met 7 times between June and August 2013.

Participant	Organization	Membership	
		Subject Matter Expert Workgroup	Measures Task Force
Janet McKinley	DHCS, PCOB	X	
Teresa Castillo	DHCS, PPQAB	X	
Richard Hildebrand	DHCS, PPQAB	X	
Julia Rojas	DHCS, MHSD	X	
Mike Wofford	DHCS, Pharmacy Policy	X	
Dorothy Uzoh	DHCS, Pharmacy Policy	X	
Margaret Tatar	DHCS, Managed Care	X	