

**Mental Health Services Act Evaluation:  
Templates for Reporting Priority Indicators  
Contract Deliverable 2B, Phase II**



**UCLA Center for Healthier Children, Youth and Families**



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Mental Health Services Oversight and Accountability Commission.

## Focus

The Mental Health Services Act (MHSA) evaluation team was charged with developing templates and reports on statewide and county specific data that would improve understanding of how the MHSA impacted consumers. Per contract language, the team will:

*Design and complete statistical analyses and reports that measure impact of MHSA at individual and system levels on indicators specified in the Matrix of California's Public Mental Health System Prioritized Performance Indicators at the state and county levels. Draft templates, documentation of analysis, and initial statewide reports will be circulated to key stakeholders and made available to the public for input by posting on the web and making a hard copy available upon request.*

*Individual client outcomes for full service partnerships (FSPs) by age group must be addressed for each domain (education / employment, homelessness / housing and justice involvement) as specified. Note: this impact analysis at the individual level is limited to available data (i.e., a small segment of public mental health clients, and full services partners, is reflected in this data.) Mental Health system performance must address family/client/youth perception of well-being, demographics of FSP population, FSP access to primary care, penetration rate and changes in admissions for the entire public community mental health population, involuntary care, and annual numbers served through [Community Services and Supports programs] CSS.*

The evaluation team submits the following report, which incorporates stakeholder insights, in fulfillment of this charge.

## Stakeholder Feedback

As noted in the contract language, input from key stakeholders and mental health service advocates is key to developing final reports. To this end, all reports that the evaluation team submits to the Mental Health Services Oversight and Accountability Committee (MHSOAC) – including earlier versions of this report – are considered drafts until such input is received and incorporated, to a reasonable extent, into subsequent reports. The evaluation team enlisted feedback about this report from a wide range of stakeholders from July 29, 2011 through August 31, 2011 to create a more comprehensive, accurate report. Stakeholders received an e-mail announcing the report's availability on both the MHSOAC<sup>1</sup> and UCLA<sup>2</sup> web sites. A call for feedback and an illustration of how the evaluation team would develop the report using stakeholder input were embedded in the report introduction to clarify stakeholders' roles in report creation and to increase transparency about this process (see Illustration 1). A complete account of organizations whose representatives responded to correspondence is included at the end of this report (see Appendix D).

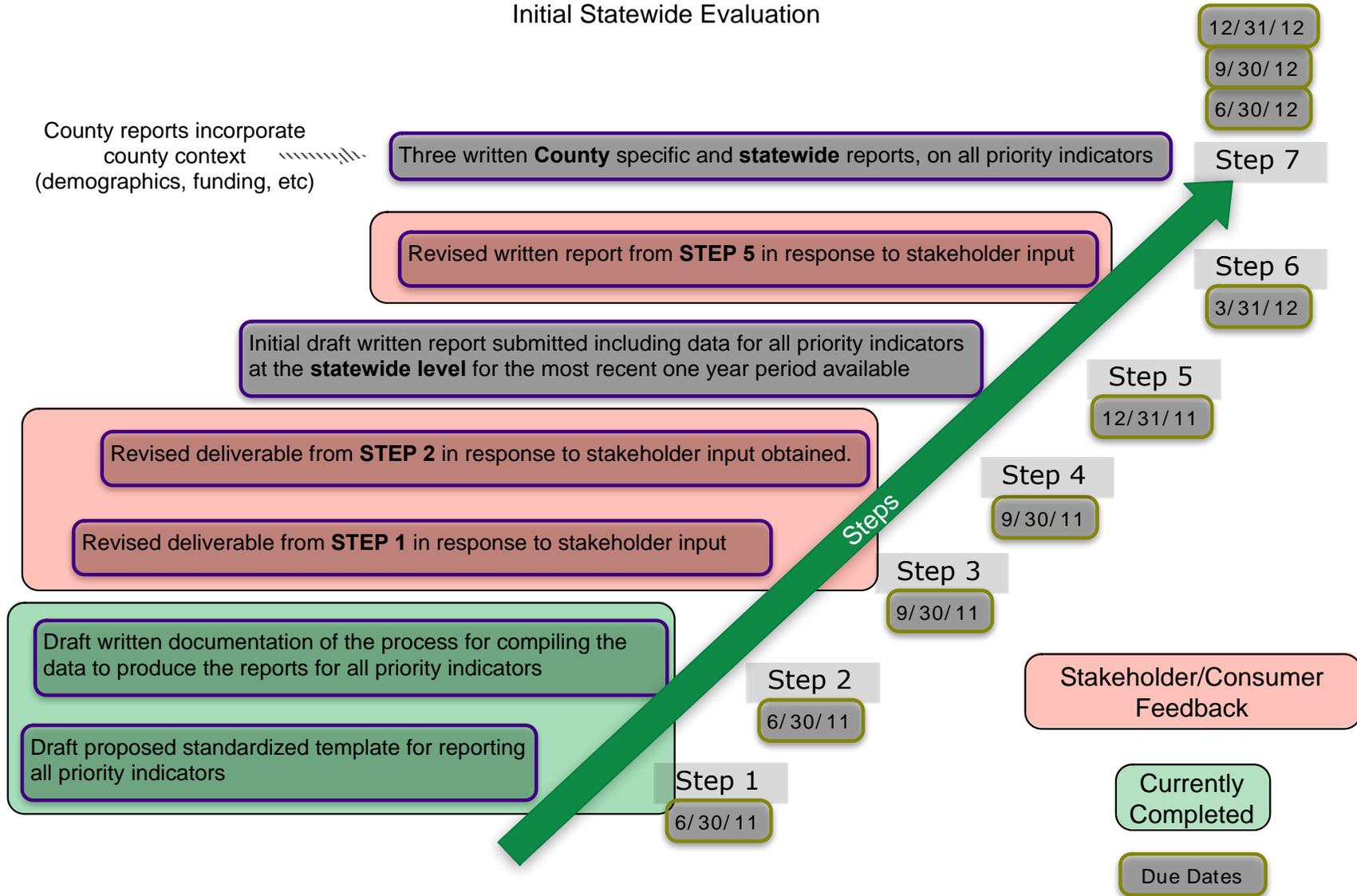
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<sup>1</sup> <http://www.mhsoac.ca.gov/Announcements/announcements.aspx>

<sup>2</sup> [http://healthychild.ucla.edu/MHSA\\_evaluation.asp](http://healthychild.ucla.edu/MHSA_evaluation.asp)

Illustration 1

## Steps Leading to Statewide and County Specific Data Reports Initial Statewide Evaluation



Webinars were also conducted for two groups – MHSA stakeholders and the California Mental Health Directors Association Indicators, Data, Evaluation, and Accountability (IDEA) Ad-Hoc Committee – to describe the reports’ purposes, input needs, and feedback process. Webinars were not designed to collect feedback; rather they were intended to provide a visual synopsis of deliverables. Given the number of webinar participants, it was not feasible to account for all stakeholders’ comments. The evaluation team requested that all feedback be written and shared through e-mail correspondence. The evaluation team encouraged all stakeholders to respond to points of interest in the reports as well as use the accompanying guidance document to think critically about questions posed by the evaluation team. Groups were invited to use their existing internal processes for reviewing and responding to mental health-related reports; the evaluation team did not impose any review protocol. The team only requested that feedback be specific (e.g., noting page numbers, specific priority indicators, or specific measures), rather than a set of general comments, to optimize feedback use. Stakeholders largely accommodated this request.

The nature of responses ranged greatly. A table illustrating the types of feedback garnered by each indicator and measure is located in Appendix E. Among stakeholder input were direct responses to guidance questions, feedback that provided historic reasons for data quality, concerns about the accuracy of particular indicators given data quality, and even the ramifications of a university group assessing mental health service consumer outcomes instead of the consumers themselves. The evaluation team anticipated feedback diversity – particularly recommendations that would be at odds with each other – and devoted ample time to negotiating what could and could not be addressed given the available time and data with which we were provided to conduct the evaluation. The team articulated this point early in the reports in the service of transparency and to moderate expectations.

## Overview

The following report outlines a strategy to assess the Mental Health Services Act (MHSA) impact throughout California. The strategy would be used to create county-level and state-level reports on outcomes related to Community Services and Supports (CSS) program outcomes using data that all counties collect regularly. The report summarizes how impact would be measured across four target age groups – children, TAY, adults, and older adults – using “priority indicators” that reflect target domains in which MHSA impact should be evident. Thus, the report does not include data analysis; rather it explains data that exists.

The report begins with a brief history of priority indicators and their intended use. After explaining select terms that the evaluation team will use throughout this and other reports, we more fully describe priority indicators, including the criteria used for review and the data that could be used to create priority indicators, and insights about the state of this data per stakeholders. We then describe the indicators in detail, including their relevant measures, data sources, and limitations. Detailed justification of each priority indicator follows. The report concludes with possible, practical ways the indicator set can improve what we know about MHSA impact. The report should be read as one step in a process toward creating measurable

indicators of consumer outcomes and mental health system performance with available data. The report is not a culmination; rather it explores what exists at this early stage of the process that could prove useful in developing a statewide evaluation.

### ***Background: Priority Indicators***

To capture how the MHSA impacts consumers throughout the state, the California Mental Health Planning Council (referred to throughout as *The Planning Council*) proposed a set of performance outcomes for CSS programs. The CSS outcomes were re-conceptualized as indicators for mental health activities and services throughout California. These *priority indicators* are broadly defined as key measures of MHSA impact – the reduction of negative outcomes or increase in positive outcomes at the individual (consumer outcomes), system (county mental health system performance), and community levels. For example, rates of consumer homelessness and incarceration should decrease under the MHSA while client satisfaction with services and mental health promotion throughout communities should increase.

The set of priority indicators was derived from discussions involving the Planning Council and mental health service stakeholders with the goal of streamlining the MHSA’s monitoring and planning activities. The need for such indicators was also discussed in the report *Evaluation Brief: Summary and Synthesis of Findings on CSS Consumer Outcomes*, submitted in preparation for the MHSA evaluation. The Planning Council decided to create priority indicators using data that was already collected across counties, reflected current statues related to the Act, was included in the federal data reporting system, and seemed intuitive to mental health service consumers and other stakeholders. The current indicator set – ultimately adopted by the Mental Health Services Oversight and Accountability Commission – is illustrated in Appendix A and has since garnered attention as a way to monitor quality improvement. The Planning Council sees the benefit of these indicators stating,

*Tracking one’s performance on key indicators over time and/or across programs and/or against other comparable counties can provide useful information to those planning, operating, and monitoring services.<sup>3</sup>*

This report further hones the indicator set. Through data sorting and verification, the indicator set is revised to give a fuller picture of how MHSA contributes to consumers’ lives and shapes mental health service system performance.

### ***Objectives***

The objectives of this report are two-fold. The evaluation team was charged with examining 1) if data already collected by county agencies could sufficiently measure individual-level and system-level priority indicators, identifying gaps and redundancies among indicators (if any). Using these findings, and with stakeholder input, the evaluation team would 2) create data templates for reporting priority indicators.

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<sup>3</sup> From the report “Performance Indicators for Evaluating the Mental Health System” published by the California Mental Health Planning Council (January 2010; p.3).

## Creating a Measurement Framework

### *Defining Terms*

The evaluation team aims to increase understanding around this and other deliverables related to the MHSA evaluation. To ensure that language is clear and accessible to readers throughout the report, we include a glossary for reference (Appendix B). When possible, our team shares how we interpret terms to include the reader and aid understanding especially where concepts become more complex.

### *Conceptualizing “Individual-level” and “System-level” Indicators*

The performance indicator framework developed by The Planning Council distinguishes between “individual-level indicators” and “system-level indicators.” These terms are widely used in performance monitoring systems, but it is important to clarify the terms to ensure understanding of their relevance, relationship, and priority in the measurement system described here.

The individual receiving mental health services is considered the consumer whether they are a child, transition age youth (TAY; 16-25 years of age), adult, or older adult. A review of relevant documents indicates that methods of measuring individuals’ mental health vary and can include indicators such as fixed attributes a consumer brings to services (i.e., demographics, education level); internal attributes (i.e., psychological and social development); behavior (i.e., the extent to which one exercises self-restraint); or one’s perception (i.e., assessment of personal growth). Each measurement is a mental health indicator that is specific to and bound by the consumer. To achieve a broader understanding of the consumer, individual-level indicators can be derived from the target person or others in immediate contact with the consumer; a parent or teacher might provide responses about a target child, for example, who might also provide feedback about his or her behavior. Based on these points, we define individual-level indicators as measurement of mental health and cues of mental health service impact on consumers (and by extension, their families).

Mental health systems can be explained as the overall context (service, procedures and policies) within which mental health service agencies operate. Systems encompass all agencies, the consumer and families they serve, their operations (service delivery, budgeting, administration, client and staff satisfaction, etc.), and the resources and policy supports required to maintain these systems. Researchers have offered a handful of indicators that better craft what is meant by “system-level.” These include,

*Formal commitments to a [mental health services] approach, sustainability of an initiative or policy agenda, incentives to encourage incorporation of [mental health] principles at the [agency] level, opportunities for [stakeholder engagement] in governance and policy*

*making, and accountability for positive [consumer] development outcomes and provision of essential supports at system and [agency] levels.<sup>4</sup>*

In sum, we define system-level indicators as aggregated measures of the service population, the structure and process of mental health services, and the outcomes and experiences of care.

We recognize that overlap exists between indicator levels when responses are aggregated. For example, individuals' self-reported rates of well-being – an individual-level indicator – can provide an assessment of system-level performance when combined as a group response. Whereas, a system level indicator such as the number of mental health consumers served is not useful as a consumer level indicator. System indicators entail a level of measurement or aggregation of consumer-level data at the system level, and measurement of consumer or agencies is necessary for individual level indicators.

## **Reviewing Priority Performance Indicators, Measures and Data Sources**

The UCLA/EMT team considered several performance measurement criteria (outlined below) when evaluating the quality and utility of existing County Mental Health System Performance Indicators (i.e., consumer and system level indicators; see Appendix A). To ensure consistency with, and build upon, previous work to develop a comprehensive performance measurement framework, we reviewed the criteria used by the California Department of Mental Health's Quality Improvement Committee<sup>5</sup> (QIC) and The Planning Council<sup>6</sup> to establish indicators for the MHSA performance measurement system. The team also conducted a thorough review of literature regarding mental health service performance measurement. The review provided necessary background to evaluate the criteria used by the QIC and The Planning Council as well as identify gaps and redundancies among the performance indicators those criteria were used to develop. In this manner, a wide set of mental health consumer and system level measurement domains and relevant indicators were cast. The quality and utility of measures and data sources that could potentially be used to operationalize indicators was reviewed according to several criteria outlined below. The data quality/utility review revealed that there are key elements of service delivery and outcomes for which data sources do not contain adequate measurement properties or are not readily available. In such cases additional data collection options are presented. These methods and criteria guide systematic evaluation of consumer and system level indicators and their underlying measures, to ensure all relevant domains of County Mental Health Systems are captured in the most rigorous and comprehensive manner possible to ultimately produce meaningful and actionable results for users (e.g., consumers/families, policymakers, and providers) who strive to improve the quality of mental health services. Specific criteria used to evaluate each indicator, measure and data source are detailed below.

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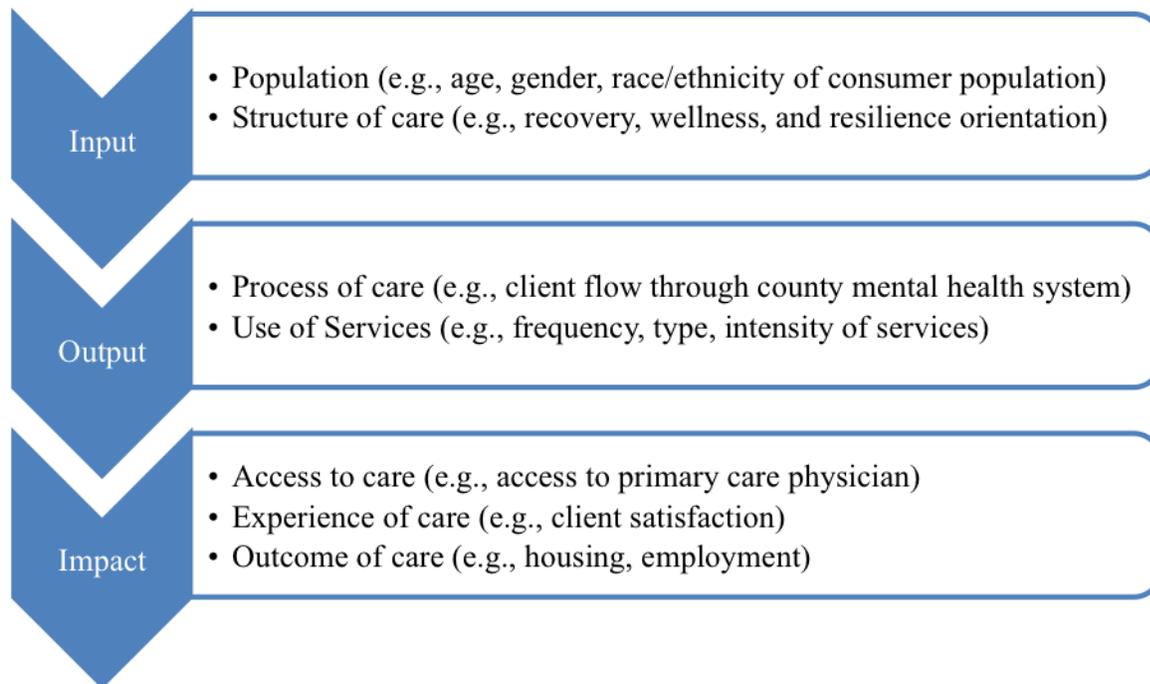
<sup>4</sup> John W. Gardner Center for Youth and Their Communities (2009, October). Positive youth development: Individual, setting and system level indicators (Issue Brief). Stanford, CA: Dukakis, K., London, R., McLaughlin, M., & Williamson, D.; p. 5.

<sup>5</sup>Chapter 93, Statutes of 2000, an omnibus Health Trailer Bill to the Budget Act of 2000, recognized the Quality Improvement Committee (QIC) in law.

<sup>6</sup>California Mental Health Planning Council's Performance Indicators for Evaluating the Mental Health System, January 2010.

### Criteria Used to Assess Performance Indicators

**Performance Indicator Coverage.** To ensure all actionable points in the process of MHSA implementation are assessed, measures of County Mental Health System Performance should pertain to one of the following domains:<sup>7</sup>



**Performance Indicator Quality.** County Mental Health System Performance measures were evaluated for:

- *Quality*, or the extent to which they are meaningful, unambiguous and widely understood by all stakeholders, and drive improvement;
- *Support in the research base*, suggesting the indicator had been informative and useful across different mental health systems;
- *Ability to be operationalized* using data accessible/obtainable by the evaluation team, such as existing databases, or additional primary data collection, so as not to add significant burden to the measurement framework;
- *Based on a high level of data integrity* (i.e., data collection is embedded within the normal procedures of County MHSA program, collected with fidelity, reliability), so as not to impress undue burden on the evaluation resources of counties;
- *Linked to critical goals and key drivers of MHSA* (i.e., core values), such that the measurement framework is reflective of the overall orientation of the MHSA initiative.

<sup>7</sup> Lutterman, T., Ganju, V., Schacht, L., Shaw, R., Monihan, K. (2003). 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.

**Performance Indicator Practicality.** Measures were also assessed for their practicality, or the extent to which they are useful for evaluation purposes and statistical analysis. These relate largely to the degree which indicator concepts are clearly defined, evidence-based, feasible in terms of data availability, understandable and actionable. Indicators must provide information to help improve and maintain MHSA services as well as provide statistical indication of change in services and their impact in consumers and families. Among evaluative needs, indicators should reflect the following criteria:

- Able to drive improvement (e.g., produce actionable results)
- Useful for identifying opportunities for improvement (e.g., gaps or redundancies in services)
- Useful for tracking and comparing performance against both internal (e.g., organizational goals) and external standards (e.g., national benchmarks)

**Data Quality.** Data used to represent priority performance indicators must also be evaluated for quality and utility. Specifically, data must be consistent, trustworthy, and hold properties which allow for the creation of each indicator and robust statistical analysis. Criteria used to evaluate measures and data sources of each measure include:

- Adequate *base rate* (i.e., how often an event occurs, or level at which a scaled response is given on average, must not be so low as to make the indicator useless or meaningless)
- Adequate *variance* (i.e., values of a given measure must be sufficiently distributed about the mean such that statistical analysis can be conducted; values cannot all be clustered at the same point)
- Validity
  - The measure is *face valid*, can conceptually and logically be said to measure what it was intended to;
  - The performance measure is *internally valid* and can logically be tied to a particular program intervention or outcome;
  - The indicator is *externally valid* and can logically be generalized to other populations or programs.
- Reliability (i.e., the indicator is consistent across time and cases)
- Availability and completeness (i.e., indicator relevant data must be obtainable and complete for populations of interest for the period of time under study)

### **Review of Performance Indicators**

A systematic review of existing public mental health system prioritized performance indicators (see Appendix A) was conducted utilizing the indicator coverage, quality, practicality, and data quality criteria specified above. This review yielded several distinct areas of measurement (e.g., education, housing, justice involvement, service access and performance), as well as gaps and redundancies in the existing measurement framework. The review of consumer and system level indicators and proposed additional areas of measurement is summarized below.

#### **Consumer-level Indicators**

Consumer outcomes identified by The Planning Council reflect three broad, accessible indicator

categories of desired mental health intervention outcomes to be examined primarily across Full Service Partnership consumers. The categories (i.e., Education / Employment, Homelessness / Housing, and Justice Involvement) stem from previous studies and policies (e.g., Assembly Bill 2034) and were informed by indicators already in place for children’s systems of care (later applied to systems for TAY, adults, and older adults). That is, consumer outcomes were grounded in the premise that children should have stable homes, be in school, and stay out of trouble. Similarly, TAY and adults should have stable homes, be employed, and stay out of trouble. The Planning Council further limited indicators to those for which data was already systematically collected across counties.

We suggest adding one indicator to the three proposed consumer outcome categories (home, school/employment, justice involvement). Averting psychiatric hospitalizations is a factor to consider when describing desired outcomes for mental health consumers. We are particularly interested in consumers’ visits to and reliance on emergency facilities like hospitals and psychiatric centers to manage their mental health – arguably the point at which management has failed. Thus, we note that Emergency Care (e.g., the reduction of visits to related centers) should be considered as an individual-level (consumer) outcome.

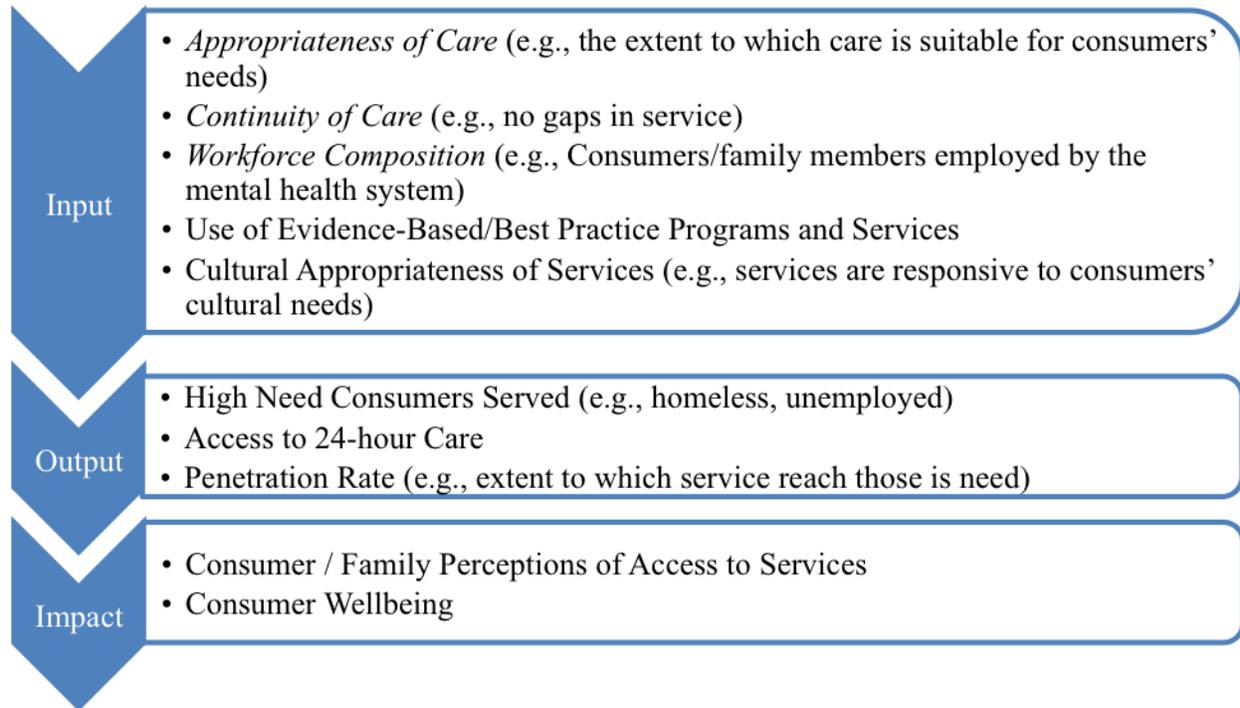
*Feedback.* Some stakeholders provided counterpoints to the ways by which consumer-level indicators would be measured, yet their responses generally indicated agreement with the four proposed indicators. As is detailed in the following pages, concerns emerged about the completeness of the Emergency Care priority indicator. As the evaluation team defined it, Emergency Care examines the number of visits to emergency facilities (e.g., hospitals and psychiatric centers) for mental health management. Stakeholders noted that reasons for emergency visits should also include physical injuries that can co-occur with mental health episodes. Thus, a more complete Emergency Care priority indicator examines mental health emergencies and the physical injuries or physical health disorders that co-occur with these emergencies.

Stakeholders offered a fifth consumer-level indicator, which could arguably be categorized as a consumer-level or system-level indicator. Social connections that might nurture associations within families and communities were suggested as an additional strategy to evaluate MHSA impact on its consumers. Whether or not these social connections are fostered through mental health service organizations was not described in the feedback, leaving much to be discussed. However, there is obvious use in considering social connections as a priority indicator given the need for consumers to sustain mental health using this safety net.

### *System-level Indicators*

A review of existing county mental health system performance indicators across all mental health service consumers (see Appendix A) using the criteria specified above yielded three domains of measurement, including system Access, Performance and Structure. Within each domain the existing indicators are focused on measurement of system processes (e.g., services administered, consumers reached) or system outcomes (e.g., consumer/family satisfaction, penetration rate). These domains and levels of measurement are in line with previous

evaluations of mental health systems.<sup>8,9</sup> However, a review of the mental health system measurement literature revealed several gaps or redundancies among existing system performance indicators. To reduce conceptual and measurement redundancy, and address gaps in system performance measurement, additional or revised indicators proposed, include:



All proposed Priority System Performance Indicators are outlined in Template 2 and detailed below.

*Feedback.* Stakeholders largely expressed agreement that proposed system level indicators are comprehensive and appropriate for monitoring mental health system processes. Most stakeholders articulated concern regarding the use of specific existing data as the primary sources for compiling system indicators, citing issues with data availability and reliability. Stakeholders also provided feedback suggesting revisions to a limited number of system indicators. Specifically, stakeholders asked us to consider alternative time periods with which to measure and compare events or services, such as the number of new or high need consumer served currently or over the past year. Some also proposed examining consumer wellbeing among specific consumer groups (e.g., age groups, ethnic groups).

<sup>8</sup> Lutterman, T., Ganju, V., Schacht, L., Shaw, R., Monihan, K. (2003). 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.

<sup>9</sup>Hermann, R.C., Mattke, S., Somekh, D., Silfverhielm, H., Goldner, E., Glover, G. Pirkis, J., Mainz, J., Chan, J.A. (2006). Quality indicators for international benchmarking of mental health care. *International Journal for Quality in Health Care*, September 2006, 31-38.

## *Orientation to Templates*

The subsequent templates represent a framework of proposed Priority Consumer and System Performance Indicators. The templates are intended to represent a menu of indicators, selected through a detailed review of existing and potential indicators against the indicator coverage, quality, practicality, and data quality criteria specified above. The columns from left to right detail the measurement domains, performance indicators, potential measures, and potential or proposed data sources. Additional data collection options are proposed for further consideration, where supplementary data may strengthen an indicators or existing data is insufficient. Proposed indicators, which are revisions of or complements to the performance indicators established by the California Mental Health Planning Council are highlighted. Proposed external data sources (e.g., California Health Interview Survey) or new primary data collection are identified where necessary.<sup>10</sup>

Two templates, reflecting consumer level priority indicators (Template 1) and mental health system level indicators (Template 2) are presented. Each template includes 1) the domain in which MHSA impact should be evident (e.g., education and employment), 2) priority indicators that reflect said domains, 3) possible ways to measure the priority indicator, and 4) every potential data source that includes at least one variable deemed useful in calculating the priority indicator. Although the Planning Council envisioned consumer outcomes to be measured across Full Service Partnership consumers (children, TAY, adults, and older adults) and system outcomes to be measured across all mental health service consumers (see Appendix A), data sources in both tables reflect possibilities for outcome calculations across all mental health services consumers (via the Consumer Services and Information [CSI] system) as well as persons enrolled in Full Service Partnerships (via the Data Collection and Reporting [DCR] system). Templates developed using a thorough review of all data dictionaries related to mental health services, should be read as an inventory of available information. These templates have been revised to reflect stakeholder feedback regarding data source appropriateness and validity. Blue fields indicate stakeholder feedback. Identifying this information is one step in a process toward sorting and selecting variables, verifying data collection associated with selected variables, and testing data fidelity and reliability in an evaluation of MHSA impact.

Please note that templates are not analysis plans that describe what can be learned for specific mental health consumer groups (e.g., women, Native Americans, "high need," etc.). Rather, they present priority indicators and their proposed measurement across four prescribed age groups – children, TAY, adults, and older adults. Attention to consumers by demographic group exists within system level indicators (refer to Appendix A), but exactly what information indicators can provide cannot be stated without a full review of mental health service data. Following review of the data (to be received during mid-October), the evaluation team can make more definitive statements about which demographic groups (age groups excepted) can be described using existing data.

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<sup>10</sup> Contractually, the evaluation team is responsible for coordinating data collection related to the Participatory Research component of this project (Phase 3 Deliverables 2.a.1 and 2.b.2.). Beyond this requirement, the team only offers suggestions about where new data collection can create more complete mental health service datasets.

## Template 1. Initial Proposed Template for Reporting Core Priority Indicators: Individual-level (Consumer) Outcomes for Full Service Partnerships<sup>11</sup>

Blue fields indicate stakeholder feedback.

Domain	Indicator	Potential Measure(s)	Potential/Proposed Data Source(s)
<b>1. Education/ Employment</b>	1.1 Average attendance – score per year	<ul style="list-style-type: none"> <li>Number (increase) of days at school annually</li> </ul>	<ul style="list-style-type: none"> <li>Data Collection and Reporting (DCR) System<sup>12</sup></li> <li>Consumer Services and Information (CSI) system</li> <li>Youth Services Survey for Families (YSS-F)</li> <li>Proposed data collection</li> </ul>
	1.2 Proportion participating in paid and unpaid employment	<ul style="list-style-type: none"> <li>Number (increase) of the consumers participating in paid and unpaid employment;</li> <li>Number of days employed</li> </ul>	<ul style="list-style-type: none"> <li>DCR</li> <li>CSI</li> </ul>
<b>2. Homelessness/ Housing</b>	2.1 Housing situation/Index – score	<ul style="list-style-type: none"> <li>Number (increase) of days that children or TAY (younger than 18 years) live in the family home or a foster home;</li> <li>Number (increase) of TAY or adults with independent residential statuses;</li> <li>Number (increase) of older adults with stable housing;</li> <li>Number of days in housing</li> </ul>	<ul style="list-style-type: none"> <li>DCR</li> <li>CSI</li> <li>Youth Services Survey (YSS)</li> </ul>
<b>3. Justice Involvement</b>	3.1 Justice involvement	<ul style="list-style-type: none"> <li>Number (decrease) of consumer arrests;</li> <li>Number (decrease) of incarcerations</li> </ul>	<ul style="list-style-type: none"> <li>DCR</li> <li>CSI</li> <li>YSS-F</li> <li>MHSIP-Adult</li> <li>MHSIP-Older Adult</li> </ul>
<b>4. Emergency Care</b>	4.1 Emergency intervention for mental health episodes	<ul style="list-style-type: none"> <li>Number (decrease) of consumer visits to the hospital or psychiatric health facility for mental health episodes annually</li> </ul>	<ul style="list-style-type: none"> <li>DCR</li> <li>CSI</li> </ul>
	4.2 Emergency intervention for co-occurring physical injury	<ul style="list-style-type: none"> <li>Number (decrease) of consumer visits to the hospital for physical injuries or physical health disorders that co-occur with mental health episodes</li> </ul>	<ul style="list-style-type: none"> <li>CSI</li> </ul>
<b>5. Social Connections</b>	5.1 Proportion who identify family <sup>13</sup> support	<ul style="list-style-type: none"> <li>Number of family members the consumer identifies as reliable supporters, or persons who are consistently present for the consumer</li> </ul>	<ul style="list-style-type: none"> <li>Proposed data collection</li> </ul>
	5.2 Proportion who identify community support	<ul style="list-style-type: none"> <li>Number of community (non-family) members that the consumer identifies as reliable supporters;</li> <li>Number of organizations the consumer identifies as providing quality services when needed</li> </ul>	<ul style="list-style-type: none"> <li>Proposed data collection</li> </ul>

<sup>11</sup> Data sources that reflect all mental health service consumers have been added in the event that knowledge broader than what is learned about Full Service Partnership Consumers is sought. Templates are arranged according to The Planning Council’s vision, illustrated in Appendix A.

<sup>12</sup>The Data Collection and Reporting (DCR) system collects data for consumers who are enrolled in Full Service Partnerships only.

<sup>13</sup> “Family” may or may not include caregivers depending on each consumer’s designation.

## Template 2. Initial Proposed Template for Reporting Comprehensive Priority Indicators: System-level Outcomes

Domain	Indicator	Potential Measure(s)	Potential/Proposed Data Source(s)
<b>6. Access</b>	6.1 Demographic Profile of Consumers Served*	<ul style="list-style-type: none"> <li>Age, gender, race/ethnicity, language spoken of consumer population (overall and FSP)</li> </ul>	<ul style="list-style-type: none"> <li>Consumer Services and Information (CSI) system;</li> <li>Data Collection and Reporting (DCR) system</li> </ul>
	6.2 New Consumers by Demographic Profile*	<ul style="list-style-type: none"> <li>Age, gender, race/ethnicity of new consumer population in comparison to those receiving services for more less than 6 months, 1 year, and more than 1 year</li> </ul>	<ul style="list-style-type: none"> <li>DCR;</li> <li>CSI</li> </ul>
	6.3 High Need Consumers Served*	<ul style="list-style-type: none"> <li>Homeless (currently and past 12 months);</li> <li>Unemployment (currently and past 12 months);</li> <li>Consumer with justice involvement;</li> <li>Consumers with multiple psychiatric hospitalizations</li> </ul>	<ul style="list-style-type: none"> <li>DCR;</li> <li>CSI</li> </ul>
	6.4 Access to Primary Care Physician	<ul style="list-style-type: none"> <li>Consumers who have a primary care physician currently;</li> <li>Consumers who have had a primary care physician for the past 12 months</li> </ul>	<ul style="list-style-type: none"> <li>DCR;</li> <li>CSI;</li> <li>Proposed data collection (e.g., surveys) recommended</li> </ul>
	6.5 Consumer / Family Perceptions of Access to Services	<ul style="list-style-type: none"> <li>Perceived access to services</li> </ul>	<ul style="list-style-type: none"> <li>YSS;</li> <li>YSS-F;</li> <li>MHSIP-Adult;</li> <li>MHSIP-Older Adult;</li> <li>Primary data collection (e.g., surveys, interviews, or focus groups; proposed data collection)</li> </ul>
<b>7. Performance</b>	7.1 Consumers Served Annually through CSS*	<ul style="list-style-type: none"> <li>Ratio – Numerator: Consumers served / Denominator: CSS consumers targeted in county plan</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly Progress Reports;<sup>14</sup></li> <li>Annual Updates</li> </ul>
	7.2 Involuntary Care*	<ul style="list-style-type: none"> <li>Ratio – Numerator: seclusions / Denominator consumers served;</li> <li>Ratio – Numerator: restraints / Denominator consumers served</li> </ul>	<ul style="list-style-type: none"> <li>Annual Report on Involuntary Detentions;</li> <li>DCR;</li> <li>CSI</li> </ul>
	7.3 24-hour Care*	<ul style="list-style-type: none"> <li>Ratio – Numerator: utilization of MHRC, SNF, SH / Denominator: TAY, Adult, Older-adult populations;</li> <li>Ratio – Numerator: utilization of CTF, RCL 14, MHRC / Denominator: Child population;</li> <li>Consumers in IMD, MHRC, SNF, SH by race/ethnicity;</li> <li>Readmission to acute care facility within 30/180 days</li> </ul>	<ul style="list-style-type: none"> <li>DCR;</li> <li>CSI</li> </ul>
	7.4 Appropriateness of Care*	<ul style="list-style-type: none"> <li>Treatment protocols for co-morbidity;</li> <li>Hospital readmission rate;</li> <li>Average length of stay in acute care;</li> </ul>	<ul style="list-style-type: none"> <li>DCR;</li> <li>CSI;</li> <li>YSS;</li> </ul>

<sup>14</sup> Key informants strongly suggest replacing data collected for quarterly reports (CSS Exhibit 6) with annual updates, which were not a part of the initial data dictionary review and might face a shift in standards in light of Assembly Bill 100. The evaluation team will explore the differences in the reports' data quality and regularity in future publications.

Domain	Indicator	Potential Measure(s)	Potential/Proposed Data Source(s)
7. Performance (continued)		<ul style="list-style-type: none"> <li>Consumer/family perceptions of appropriateness of care</li> </ul>	<ul style="list-style-type: none"> <li>YSS-F;</li> <li>MHSIP-Adult;</li> <li>MHSIP-Older Adult;</li> <li>Primary data collection (e.g., surveys, interviews, or focus groups; <b>proposed data collection</b>)</li> </ul>
	7.5 Continuity of Care*	<ul style="list-style-type: none"> <li>Use of crisis services;</li> <li>Services provided in community settings;</li> <li>Documented discharge plans</li> </ul>	<ul style="list-style-type: none"> <li>DCR;</li> <li>CSI;</li> <li>Consumer Satisfaction Surveys – YSS, YSS-F, Adult, and Older Adult;</li> <li>Primary data collection (e.g., surveys, interviews, or focus groups; <b>proposed data collection</b>)</li> </ul>
	7.6 Penetration Rate	<ul style="list-style-type: none"> <li>Ratio – Numerator: Consumers / Denominator: targeted for service or populations of interest (e.g., age, gender, race/ethnicity, socioeconomic status);</li> <li>Ratio – Numerator: Consumers / Denominator: Holzer Targets</li> </ul>	<ul style="list-style-type: none"> <li>DCR;</li> <li>CSS Exhibit 6 Quarterly Progress Reports;</li> <li>California Health Interview Survey (CHIS; <b>proposed external data source</b>)</li> <li>Census data</li> </ul>
	7.7 Consumer Wellbeing	<ul style="list-style-type: none"> <li>Client/family perception of improvement in functioning (current, over time, among high need groups);</li> <li>Client/family perception of quality of life (current, over time, among high need groups)</li> </ul>	<ul style="list-style-type: none"> <li>YSS;</li> <li>YSS-F;</li> <li>MHSIP-Adult;</li> <li>MHSIP-Older Adult;</li> <li>Primary data collection (e.g., surveys, interviews, or focus groups; <b>proposed data collection</b>)</li> </ul>
	7.8 Satisfaction	<ul style="list-style-type: none"> <li>Consumer/family satisfaction with the care or service</li> </ul>	<ul style="list-style-type: none"> <li>YSS;</li> <li>YSS-F;</li> <li>MHSIP-Adult;</li> <li>MHSIP-Older Adult</li> </ul>
8. Structure	8.1 Workforce Composition*	<ul style="list-style-type: none"> <li>Demographic composition of mental health workforce Ratio – Numerator: Staff / Denominator: consumers;</li> <li>Consumer/family member employment in the mental health system (i.e., number, FTE, % of workforce)</li> </ul>	<ul style="list-style-type: none"> <li>Cultural Competence Plans;</li> <li>WET Plans;</li> <li>Primary data collection (e.g., surveys, interviews, or focus groups; <b>proposed data collection</b>)</li> </ul>
	8.2 Evidence-Based/Best Practice Programs and Services*	<ul style="list-style-type: none"> <li>Use of evidence-based practices;</li> <li>Fidelity of best practices to established models;</li> <li>Receipt and experience of best practice services/supports among consumers/families</li> </ul>	<ul style="list-style-type: none"> <li>CSI;</li> <li>Primary data collection (e.g., surveys, interviews, or focus groups; <b>proposed data collection</b>)</li> </ul>
	8.3 Cultural Appropriateness of Services	<ul style="list-style-type: none"> <li>Client and family perceptions of cultural appropriateness</li> </ul>	<ul style="list-style-type: none"> <li>YSS;</li> <li>YSS-F;</li> <li>MHSIP-Adult;</li> <li>MHSIP-Older Adult</li> </ul>
	8.4 Recovery, Wellness, and Resilience Orientation	<ul style="list-style-type: none"> <li>Consumer/family member/staff perceptions of recovery orientation of system and services</li> </ul>	<ul style="list-style-type: none"> <li>Recovery Oriented Systems Indicators Measure (ROSI; <b>proposed data collection</b>);</li> <li>Developing Recovery Enhancing Environments Measure (DREEM; <b>proposed data collection</b>)</li> </ul>

\* Asterisks refer to indicators that are processes (not outcomes).

## Mental Health Indicator Detail

To clarify the meaning, importance and potential utility of each domain and indicator, this section provides detailed descriptions of the indicators summarized in the templates. This discussion is based on research and professional literature, research briefs, and technical reports.

## Individual-level (Consumer) Outcomes for Full Service Partnerships Indicator Detail

### Domain 1: Education/Employment

This domain encompasses indicators of education for children and transitional age youth (TAY) younger than 18 years of age as well as employment indicators among TAY who are 18 and older, adults and older adults.

#### **1.1 Indicator: Average attendance – score per year<sup>15,16</sup> (CMHPC Indicators #2 and #8) Population: Children and TAY**

*Rationale for Inclusion:* The number of days a youth attends school during a school year has been used as an indicator of healthy development during adolescence. School attendance has been associated with academic functioning, subjective well-being, and life satisfaction. Youth who are more vulnerable to negative mental health outcomes such as low self-concept and limited sense of social support have been linked with poor academic success including lower assessments of school importance to achieve goals and limited motivation to self-regulate learning behaviors. Further, mental health distress outside of the school environment has been thought to redirect youths' attentions away from attending school. This indicator will help identify the extent to which MHSA programs bolster youths' school attendance.

*Measure:* Number (increase) of days at school annually

*Data Source(s):* Data Collection and Reporting (DCR) System, Consumer Services and Information (CSI) system, Consumer Satisfaction Surveys – Youth Services Survey for Families (YSS-F) version, **proposed new data collection**

*Stakeholder-informed Challenges and Limitations:* Stakeholders reported that accurate school data was difficult to access and normalize due to the types of schooling in which consumers were enrolled. Alternative education and home schooling would have different attendance requirements, for example. A ratio of school days attended to total school days would address this issue (explored in Deliverables 2C and 2D), however no strategy exists to collect the total number of school days from each school district in the state.

<sup>15</sup> Suldo, S., & Shaffer, E., (2008). Looking beyond psychopathology: The dual-factor model of mental health in youth. *School Psychology Review*, 37, 52-68.

<sup>16</sup> Kearney, C., (2008). School absenteeism and school refusal behavior in youth: A contemporary review. *Clinical Psychology Review*, 28, 451-471.

## **1.2 Indicator: Proportion participating in paid and unpaid employment<sup>17,18</sup> (CMHPC Indicators # 8 and #13)**

**Population: TAY, Adults, and Older Adults**

*Rationale for Inclusion:* Unemployment has been identified as a negative outcome of untreated mental illness. Successful employment has been linked to social networks, life stability, and stamina. Some research has shown that vocational training, in combination with mental health services, has been associated with positive employment outcomes such as higher likelihood of being hired in competitive work and having an opportunity to work full-time. A count of all consumers who engage in employment will help identify the amount of consumers employed over time and account for the effectiveness of employment programs for consumers.

*Measure:* Number (increase) of the consumers participating in paid and unpaid employment

*Data Source(s):* DCR system, CSI system

*Stakeholder-informed Challenges and Limitations:* Stakeholders suggested adding the number of days or period of time during which a consumer was employed. Stakeholders also noted that employment information in the DCR system was very limited unlike the CSI system, which accounts for all types of employment (part-time, volunteer, etc.). The evaluation team would only have a robust understanding of consumer employment for persons who were not enrolled in FSPs – those who are more likely to be employed in part-time and volunteer work. Last, stakeholders offered that employment rates, like the economy, occur in cycles that could be overlooked in analyses if unaccounted for.

## **Domain 2: Homelessness/Housing**

This domain encompasses indicators of homelessness and the variety of housing situations among all consumers (children, TAY, adults, and older adults).

### **2.1 Indicator: Housing Situation/Index – Score<sup>19</sup> (CMHPC Indicators #1, #7, #12, #17)**

**Population: Children, TAY, Adults, and Older Adults**

*Rationale for Inclusion:* Untreated mental illness has been linked to homelessness and the ability to live independently. Supportive housing provided through MHSA programs is designed to give independent living opportunities to “low-income adults, or older adults with serious mental illness, and children with severe emotional disorders and their families who, at the time of assessment for housing services, meet the criteria for MHSA services in their county of residence and are homeless or at risk for homelessness.” Further, housing provisions might curb

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<sup>17</sup> Secker, J. & Membery, H. (2003). Promoting mental health through employment and developing healthy workplaces: The potential of natural supports at work. *Health Education Research, 18*, 207-215.

<sup>18</sup> Cook, J., Lehman, A., Drake, R., McFarlane, W., Gold, P., Leff, H., Blyler, C., Toprac, M., Razzano, L., Burke-Miller, J., Blankertz, L., Shafer, M., Pickett-Schenk, S., & Grey, D. (2005). Integration of psychiatric and vocational services: A multisite randomized, controlled trial of supported employment. *American Journal of Psychiatry, 162*, 1948-1956.

<sup>19</sup> MHSA housing program: Background, and information about the application, commitment, and funding processes. (2001, February 1). Retrieved May 20, 2011 from <http://www.calhfa.ca.gov/multifamily/mhsa/process/MHSABackground.pdf>

homelessness, which will subsequently decrease consumers' vulnerability to justice involvement. Identifying consumers' housing situations will improve understanding of access to housing and the range of living situations currently used.

*Measure(s):* Number (increase) of days that children and TAY live in the family home or a foster home; number (increase) of TAY, adults, within dependent residential statuses; number (increase) of older adults with stable housing

*Data Source(s):* DCR system, CSI system, Consumer Satisfaction Surveys – Youth Services Survey (YSS) version

*Stakeholder-informed Challenges and Limitations:* Stakeholders noted three challenges with data related to the Homelessness/ Housing indicator. 1) Both homelessness and housing can change often among the group, yielding complex data. Stakeholders suggested becoming familiar with this particular data before conducting analyses because of its ever-changing nature. 2) Housing data from the CSI system is not updated as regularly as data from the DCR system, and lag might create inaccuracies in the evaluation. 3) Children who are homeless by way of their parents are not measured by the DCR. That is, a child who is with one or both parents can be categorized as “housed” without any indication or measure of his or her parents' living situation. Thus, housing information in the DCR is not absolutely accurate. Beyond data challenges, stakeholders offered that adding the number of days a consumer is housed would be useful to understand housing stability.

## Domain 3: Justice Involvement

### 3.1 Indicator: Justice Involvement<sup>20, 21</sup> (CMHPC Indicators #1, #7, #12, #17)

#### Population: Children, TAY, Adults, and Older Adults

*Rationale for Inclusion:* Research has shown that a percentage of former inmates who became mental health service consumers had been arrested previously for behaviors stemming from preexisting disorders. That is, an episode left these consumers vulnerable to arrest and incarceration. Among youth, some studies have found significantly higher occurrence of externalizing behaviors, attention deficit, and defiance among those who had been arrested compared to those who had not. This indicator will follow consumers' interactions with the justice system to explore how participation in MHSA programs shapes number of arrests.

*Measure:* Number (decrease) of consumer arrests or incarcerations

*Data Source(s):* DCR system, CSI system, Consumer Satisfaction Surveys – Youth Services Survey for Families (YSS-F) version, Adult version, and Older Adult version

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<sup>20</sup> Daly, R., (2011, January 7). Study examines relationship of arrests, mental illness. *Psychiatric News*, 46, 9-10.

<sup>21</sup> Center for Behavioral Health Services & Criminal Justice Research. (2009, September). The effects of mental health problems on juvenile arrests (Research Brief). New Brunswick, NJ: Hirschfield, P., Maschi, T., Raskin White, H., & Goldman Traub, L.

*Stakeholder-informed Challenges and Limitations:* Stakeholders described different ways to conceptualize “arrests” to create a more specific indicator definition. Some suggested counting incarcerations instead of arrests given that intercession by FSP teams sometimes prevents incarceration. Others suggested counting new arrests given that consumers might be re-arrested for the same offense due to probation violations. Also, the term “episodes” was contested as it did not account for chronic mental health issues. In sum, further revision of what is meant by Justice Involvement is needed. In addition to clarifying the indicator, stakeholders suggest adding the number of days a consumer is held to create a rate that can be followed over time.

## **Domain 4: Emergency Care**

### **4.1 Indicator: Emergency Intervention for mental health episodes (Proposed Indicator)**

**Population: Children, TAY, Adults, and Older Adults**

*Rationale for Inclusion:* Hospital stays and visits to psychiatric facilities for emergency interventions might indicate poor or lack of mental health management. Mental health services and related supports might curb the need for hospitalization related to mental health episodes. This indicator can account for consumers’ hospitalizations and provide trends of reliance on hospitals for mental health management.

*Measure:* Number (decrease) of consumer visits to the hospital or psychiatric facility for mental health issues annually

*Data Source(s):* DCR system, CSI system

### **4.2 Indicator: Emergency Intervention for Co-occurring Physical Injury (Proposed Indicator)**

**Population: Children, TAY, Adults, and Older Adults**

*Rationale for Inclusion:* Hospital stays and visits for physical injuries that may or may not co-occur with mental health issues. It is a secondary measure of mental health management and can provide more accurate counts of episodes that might be missed by a count of facility visits for mental health issues alone.

*Measure:* Number (decrease) of consumer visits to the hospital for physical injuries or physical health disorders that co-occur with mental health episodes

*Data Source(s):* DCR system, CSI system

*Stakeholder-informed Challenges and Limitations:* Stakeholders suggested that creating an appropriate Emergency Care indicator could be difficult given that 1) visits to the emergency room and hospitalization are distinct in the DCR system, and 2) the CSI is not regularly updated with visits and releases from medical facilities. Among additions to the proposed priority indicator, stakeholders proposed adding the number of days a consumer spends in emergency care given that FSP interventions might yield a shorter psychiatric stay. Stakeholders recommended dividing the types of hospitalizations (mental health episodes from physical health issues), when possible, with the understanding that these might co-occur. Stakeholders requested new data collection to create a measure of co-occurring mental and physical health issues among consumers as well as drug and alcohol use.

## Domain 5: Social Connections

### 5.1 Indicator: Proportion Who Identify Family Support (**Proposed Indicator**)

**Population: Children, TAY, Adults, and Older Adults**

*Rationale for Inclusion:* Social Connections – a priority indicator that emerged from stakeholder feedback – has been included in the service of identifying the family and community supports that exist for consumers. Supports can provide consumers a sense of place, belonging, and security that might have been absent or diminished over time. This priority indicator can be considered both a consumer-level indicator when consumers actively seek and establish positive connections that create a supportive community and system-level indicator when organizations create paths toward support systems on consumers’ behalves.

*Measure:* Number of family members (stable or increase) the consumer identifies as reliable supporters, or persons who are consistently present for the consumer

*Data Source(s):* **Proposed new data collection**

### 5.2 Indicator: Proportion Who Identify Community Support (**Proposed Indicator**)

**Population: Children, TAY, Adults, and Older Adults**

*Rationale for Inclusion:* This indicator assesses the extent of consumers’ social support networks beyond the family. It is a measure of individuals and organizations that provide steadfast support around mental health issues, education, and services.

*Measure:* Number of community (non-family) members (stable or increase) that the consumer identifies as reliable supporters; number (increase) of organizations the consumer identifies as providing quality services when needed

*Data Source(s):* **Proposed new data collection**

*Stakeholder-informed Challenges and Limitations:* The Social Connectedness priority indicator was suggested during the feedback period. It is unclear, at present, if existing data accommodates this indicator.

## Mental Health System-level Outcomes for all Consumers Indicator Detail

### Domain 6: Access

This domain encompasses indicators of consumers' and families' ability to obtain timely and convenient care or service based on needs.

#### Processes

##### **6.1 Indicator: Demographic Profile of Consumers Served (CMHPC Indicator #30<sup>22</sup>)**

*Rationale for Inclusion:* Demographic description of those receiving services (all consumers and FSP) within and across counties will provide a better understanding of who is accessing services. Such information may provide insight into ways to improve service outreach and implementation.

*Potential Measure(s):* Age, gender, race/ethnicity, language spoken of consumer population (overall and FSP)

*Potential Data Source(s):* DCR system, CSI system

*Stakeholder Informed Challenges & Limitations:* Demographic information (i.e., ethnicity, gender) contained in the DCR is imported from the CSI database. Thus, any FSP consumer not registered in the CSI system will have incomplete demographic information in the DCR database.

##### **6.2 Indicator: New Consumers by Demographic Profile (CMHPC Indicator #34<sup>23</sup>)**

*Rationale for Inclusion:* Demographic description of all new consumers (i.e., those not receiving services for prior 6 months) within and across counties, and in comparison to the existing service population, will provide description of how access of services may be changing. Specifically, this indicator may serve as a gauge of the penetration of outreach and engagement services, including what has been done to engage underserved populations.

*Potential Measure(s):* Age, gender, race/ethnicity of new consumer population in comparison to those receiving services for more less than 6 months, 1 year, and more than 1 year

*Potential Data Source(s):* DCR system, CSI system

##### **6.3 Indicator: High Need Consumers Served<sup>24</sup> (Proposed Indicator)**

*Rationale for Inclusion:* Previous studies have indicated a high occurrence of mental illness amongst the homeless, those who are unemployed<sup>25</sup>, and those in poverty. Homeless individuals and those in poverty tend not to seek necessary supportive services. Thus, connecting these

<sup>22</sup>California Mental Health Planning Council's Performance Indicators for Evaluating the Mental Health System, January 2010.

<sup>20</sup>Health Care for the Homeless Clinicians' Network. 2000. "Mental Illness, Chronic Homelessness: An American Disgrace." *Healing Hands* 4:1-6.

<sup>21</sup>Linn, M., Sadifer, R., and Stein, S. (1985). Effects of unemployment on mental and physical health. *American Journal of Public Health*, 75, 502-506.

<sup>22</sup>California Mental Health Planning Council's Performance Indicators for Evaluating the Mental Health System, January 2010.

groups with appropriate services becomes difficult and requires extensive outreach and engagement to do so. Profiling service to these groups will provide greater understanding of access to services among these high need groups, within counties and across the state.

*Potential Measure(s):* Homeless (past 12 days and past 12 months); Unemployment (past 12 days and past 12 months); Consumers with justice involvement; Consumers with multiple psychiatric hospitalizations

*Potential Data Source(s):* DCR system, CSI system

*Stakeholder Informed Challenges & Limitations:* Stakeholders expressed concerns that variables included in the CSI database, such as Living Situation and Employment, may not be updated regularly for non-FSP consumers. If these items are found to be unreliable, high need consumer served through non FSP programs may not be accurately described.

### **Outcomes**

#### **6.4 Indicator: Access to Primary Care Physician<sup>26, 27</sup> (CMHPC Indicator #31<sup>28</sup>)**

*Rationale for Inclusion:* Individuals with mental illness tend to experience poor health, as compared to the general population. The medical needs of those with mental illness are often not met due to poor access to general health care. This indicator will provide indication of the extent to which FSP services have been successful in connecting consumer with regular sources of primary health care.

*Potential Measure(s):* Consumers who have a primary care physician currently/past 12 months

*Potential Data Source(s):* DCR system, CSI system, primary data collection (e.g., surveys, interviews, or focus groups; **proposed additional data collection**)

*Stakeholder Informed Challenges & Limitations:* Stakeholders expressed concerns that CSI data regarding access to a primary care physician may not be reliable. If this information is not reliably reported, access to a physician among all mental health consumers cannot be accurately assessed and comparisons to FSP consumers cannot be made.

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<sup>26</sup>Druss, B.G. and Rosenheck, R.A. (1998). Mental Disorders and Access to Medical Care in the United States. *American Journal of Psychiatry*, 155(12), 1775-1777.

<sup>27</sup> Statutory outcome: Improve health and mental health (WIC 5801(d)(2), WIC 5806(a), WIC 5840(a), WIC 5840(c))

<sup>28</sup>California Mental Health Planning Council's Performance Indicators for Evaluating the Mental Health System, January 2010.

**6.5 Indicator: Consumer / Family Perceptions of Access to Services<sup>29, 30</sup> (Proposed Indicator)**

*Rationale for Inclusion:* Subjective evaluations of services can provide indications that barriers may exist to accessing care or service. Additional qualitative data collection can provide indications of the specific problems that may hinder access to care.

*Potential Measure(s):* Perceived access to services

*Potential Data Source(s):* Consumer Satisfaction Surveys – YSS, YSS-F, Adult, and Older Adult; primary data collection (e.g., surveys, interviews, or focus groups; **proposed data collection**)

## **Domain 7: Performance**

This domain includes indicators of the extent to which county mental health system processes met the values and expectations of consumers and families, communities, providers and the MHSA initiative overall.

### *Processes*

**7.1 Indicator: Consumers Served Annually through CSS<sup>31</sup> (FSP, GSD, Outreach & Engagement; CMHPC Indicator #43<sup>32</sup>)**

*Rationale for Inclusion:* Tracking the number of individuals targeted and served through CSS services will provide a snapshot of system implementation and highlight progress toward achieving service goals.

*Potential Measure(s):* CSS consumers targeted in county plan compared to those who were served.

*Potential Data Source(s):* Quarterly Progress Reports (i.e., CSS Exhibit 6), Annual Updates

*Stakeholder Informed Challenges & Limitations:* Stakeholders expressed concerns that Exhibit 6 is not a reliable source for information regarding consumers targeted or served through CSS programs due to the various ways in which counties define these categories. If data regarding consumers targeted or served is found unreliable across counties, the statewide ratio of target consumers to served consumers cannot be accurately estimated.

<sup>29</sup>Onken, S., Dumont, J., Ridgeway, P., Dornan, D., and Ralph, R. (2002). Mental Health Recovery: What Helps and What Hinders? NASMHPD and NTAC.

<sup>30</sup> Statutory outcome: Reduce disparities in access (MHSA Section 3(d), WIC 5878.3(b), (WIC 5813.5(d), WIC 5840(a), WIC 5830(a)(1))

<sup>31</sup> Statutory outcome: Implement MHSA county plans (WIC 5847(b))

<sup>32</sup> California Mental Health Planning Council's Performance Indicators for Evaluating the Mental Health System, January 2010.

## **7.2 Indicator: Involuntary Care<sup>33</sup> (CMHPC Indicators #35 & #36<sup>34</sup>)**

*Rationale for Inclusion:* Tracking the number of consumers requiring therapeutic seclusion or restraint, as compared to populations served (e.g., age groups) will provide indication of the extent to which mental health systems employ these therapeutic strategies.

*Potential Measure(s):* Ratio of Involuntary Services to Consumers served and overall Count/State population

*Potential Data Source(s):* Annual Report on Involuntary Detentions, DCR system, CSI system

## **7.3 Indicator: 24-hour Care<sup>35</sup> (Revision of CMHPC Indicators #37-41<sup>36</sup>)**

*Rationale for Inclusion:* The use of Long-Term Strategies for Community Placement and Alternatives to Institutions for Mental Diseases (IMDs) among various populations/groups (e.g., age, race/ethnicity) can provide a picture of how consumers are cared for within county mental health systems and across the state.

*Potential Measure(s):* Utilization of Institutions for Mental Disease (IMD)/Mental Health Rehabilitation Centers (MHRC)/Specialized Nursing Facilities (SNF)/State Hospitals (SH) compared to Child/TAY/Adult/Older-adult populations; Utilization of CTF, RCL 14, MHRC compared to child population; Consumers in IMD/MHRC/SNF/SH by race/ethnicity; Readmission to acute care facility within 30/180 days

*Potential Data Source(s):* DCR system, CSI system

## **7.4 Indicator: Appropriateness of Care<sup>37</sup> (Proposed Indicator; Revision of CMHPC Indicator #24<sup>38</sup>)**

*Rationale for Inclusion:* This indicator will focus on the extent to which care or service is relevant to consumer/family needs. Several factors may provide evidence of the appropriateness of care or service, including: 1) the existence of treatment protocols for co-morbidity, as serious mental illness often co-occurs with substance use disorders; 2) greater length of stay in acute care facilities may indicate inadequate services or supports; 3) consumer/family perceptions of the appropriateness of care they receive, including involvement and a sense of empowerment in the treatment decision making process, will provide a key reflection of services as received.

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<sup>33</sup> Statutory outcome: Implement Recovery Vision (WIC 5813.5(d))

<sup>34</sup> California Mental Health Planning Council's Performance Indicators for Evaluating the Mental Health System, January 2010.

<sup>35</sup> Lutterman, T., Ganju, V., Schacht, L., Shaw, R., Monihan, K. (2003). 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.

<sup>36</sup> California Mental Health Planning Council's Performance Indicators for Evaluating the Mental Health System, January 2010.

<sup>37</sup> McEwan, K., and Goldner, E. (2001). Accountability and performance indicators for mental health services and supports: A resource kit. *Department of Psychiatry, University of British Columbia*. Retrieved March 16, 2011 (<http://www.hc-sc.gc.ca/hppb/mentalhealth/service>)

<sup>38</sup> California Mental Health Planning Council's Performance Indicators for Evaluating the Mental Health System, January 2010.

*Potential Measure(s):* Treatment protocols for co-morbidity; Hospital readmission rate; Average length of stay in acute care; Consumer/family perception of appropriateness of care

*Potential Data Source(s):* DCR system; CSI system; Consumer Satisfaction Surveys – YSS, YSS-F, Adult, and Older Adult; document review and primary data collection (e.g., surveys, interviews; **proposed data collection**)

*Stakeholder Informed Challenges & Limitations:* Assessing treatment protocols for co-morbidity would require extensive document review to establish their existence in each county, and additional data collection (e.g., surveys or interviews) to assess whether they are appropriately applied.

### **7.5 Indicator: Continuity of Care<sup>39</sup> (Proposed Indicator)**

*Rationale for Inclusion:* This indicator will center on the extent to which county mental health systems provide uninterrupted, coordinated care and services across programs, providers, organizations, and levels of care/service.

*Potential Measure(s):* Use of crisis services; Services provided in community settings; Documented discharge plans

*Potential Data Source(s):* DCR system; CSI system; Consumer Satisfaction Surveys – YSS, YSS-F, Adult, and Older Adult; primary data collection (e.g., surveys, interviews, or focus groups; **proposed data collection**)

*Stakeholder Informed Challenges & Limitations:* Comprehensively assessing continuity of care may require extensive document review or additional data collection (e.g., surveys or interviews).

## **Outcomes**

### **7.6 Indicator: Penetration Rate<sup>40</sup> (Revision of CMHPC Indicator #33<sup>41</sup>)**

*Rationale for Inclusion:* The penetration of CSS services among targeted groups (e.g., age, race/ethnicity, individuals in poverty, homeless) will provide an important indication of the extent to which services are reaching those most in need.

*Potential Measure(s):* Ratio of CSS consumers served, compared to eligible for services among targeted populations; Ratio of CSS clients served, as compared to Holzer Targets (i.e., estimates of the prevalence of serious mental illness/serious emotional disturbance)

<sup>39</sup>Hermann, R.C., Mattke, S., Somekh, D., Silfverhielm, H., Goldner, E., Glover, G. Pirkis, J., Mainz, J., Chan, J.A. (2006). Quality indicators for international benchmarking of mental health care. *International Journal for Quality in Health Care*, September 2006, 31-38.

<sup>40</sup> Statutory outcome: Increase number of individuals receiving public mental health services (MHSA Section 3(d), WIC 5813.5(a), WIC 5830(a)(4))

<sup>41</sup>California Mental Health Planning Council's Performance Indicators for Evaluating the Mental Health System, January 2010.

*Potential Data Source(s):* DCR system, CSS Exhibit 6 Quarterly Reports, California Health Interview Survey (CHIS; **proposed external data source**), Census data (**proposed external data source**)

*Stakeholder Informed Challenges & Limitations:* Stakeholders have expressed concern about the reliability of Exhibit 6 data. If such data proves unreliable, the penetration of CSS services among populations in need cannot accurately be assessed.

### **7.7 Indicator: Consumer Wellbeing<sup>42</sup> (Revision of CMHPC Indicator #33<sup>43</sup>)**

*Rationale for Inclusion:* Perceptions of improvements in functioning, the appropriateness of care they receive, participation in treatment, quality of life, and satisfaction with services among consumer groups (e.g., age, gender, race/ethnicity, individuals in poverty), can provide indications of the quality of service within county mental health systems and across the state.

*Potential Measure(s):* Client/family perception of improvement in functioning (current, over time, among high need groups); Client/family perception of quality of life (current, over time, among high need groups)

*Potential Data Source(s):* Consumer Satisfaction Surveys – YSS, YSS-F, Adult, and Older Adult; Primary data collection (e.g., surveys, interviews, or focus groups; **proposed data collection**)

*Stakeholder Informed Challenges & Limitations:* Different sampling methods for consumer satisfaction survey respondents have been employed over time, which may have implications for analysis and any conclusions drawn. Additional qualitative and quantitative data collection may be needed to create an indicator of wellbeing which is sensitive to county context and the backgrounds of consumers and their families.

### **7.8 Indicator: Consumer Satisfaction (Revision of CMHPC Indicator #25<sup>44</sup>)**

*Rationale for Inclusion:* Consumer/family satisfaction with the care and service they receive will provide an important reflection of the ability of county mental health systems to achieve stated values and goals.

*Potential Measure(s):* Consumer/family satisfaction with the care or service

*Potential Data Source(s):* Consumer Satisfaction Surveys – YSS, YSS-F, Adult, and Older Adult

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<sup>42</sup> Statutory outcome: Improve health and mental health (WIC 5801(d)(2), WIC 5806(a), WIC 5840(a), WIC 5840(c))

<sup>43</sup> California Mental Health Planning Council's Performance Indicators for Evaluating the Mental Health System, January 2010.

<sup>41</sup> *ibid.*

## 8. Domain: System Structure

This domain includes indicators of the mental health system workforce, and the type and quality of programs/services.

### Processes

#### 8.1 Indicator: Workforce Composition (Revision of CMHPC Indicator #45<sup>45</sup>)

*Rationale for Inclusion:* This indicator addresses the extent to which the mental health system workforce is appropriately configured to serve the diverse populations of county mental health systems.

*Potential Measure(s):* Staff to consumer ratio, demographic composition of mental health workforce, consumer/family member employment (i.e., number, FTE, % of workforce)

*Potential Data Source(s):* Cultural competence plans; WET Plans; Primary data collection (e.g., surveys, interviews, or focus groups; **proposed data collection**)

*Stakeholder Informed Challenges & Limitations:* Stakeholders expressed concern about the reliability of workforce data in Cultural Competence Plans and WET Plans over time at the program level. Without a valid source of data regarding workforce makeup, the appropriateness of the workforce for serving the current consumer population cannot be assessed.

#### 8.2 Indicator: Evidence-Based/Best Practice Programs and Services<sup>46</sup> (**Proposed Indicator**)

*Rationale for Inclusion:* Care or services that are implemented based on the best available evidence will lead to improved client outcomes. This indicator will center on whether county/regional/statewide mental health services and supports adhere to best practice criteria established through scientific evidence and/or expert consensus.

*Potential Measure(s):* Use of evidence-based practices; Fidelity of best practices to established models; Receipt of best practices services/supports among consumers/families

*Potential Data Source(s):* CSI system, Primary data collection (e.g., surveys, interviews, or focus groups; **proposed data collection**)

*Stakeholder Informed Challenges & Limitations:* Stakeholders expressed concern that the fidelity with which evidence-based services are implemented is not captured by the relevant CSI item. Thus, it is recommended that additional data collection (e.g., surveys, interviews, or focus groups) be conducted to assess the fidelity of reported evidence-based program implementation.

<sup>45</sup>California Mental Health Planning Council's Performance Indicators for Evaluating the Mental Health System, January 2010.

<sup>46</sup>Anthony, W., Rogers, E., Farkas, M. (2003). Research on evidence-based practices: future directions in an era of recovery. *Community Mental Health Journal*, 39, 101-114

## Outcomes

### 8.3 Indicator: Cultural Appropriateness of Services<sup>47</sup> (CMHPC Indicator #23<sup>48</sup>)

*Rationale for Inclusion:* This indicator addresses the extent to which the care or service is configured to best address the diverse cultures served by county mental health systems.

*Potential Measure(s):* Client and family perceptions of cultural appropriateness

*Potential Data Source(s):* Consumer Satisfaction Surveys – YSS, YSS-F, Adult, and Older Adult

### 8.4 Indicator: Recovery, Wellness, and Resilience Orientation<sup>49,50</sup> (Proposed Indicator)

*Rationale for Inclusion:* Recovery, wellness, and resilience orientation is a core value of the MHSA initiative. The recovery process generally includes learning ways to manage mental illness, but also involves learning attitudes and skills about living, learning, working, having meaningful relationships, a place in the community and connection to the world. This indicator is focused on the extent to which county mental health systems are structured to provide guidance and support to consumers and families in their transition from living with mental illness as the most important part of their lives to being only a part of who they are.

*Potential Measure(s):* Consumer/family member/staff perceptions of recovery orientation of system and services

*Potential Data Source(s):* Recovery Oriented Systems Indicators Measure (ROSI; proposed data collection), Developing Recovery Enhancing Environments Measure (DREEM; proposed data collection)

*Stakeholder Informed Challenges & Limitations:* Any measure of recovery orientation must be sensitive to, and informed by, the unique needs and circumstances of diverse cultural, ethnic, regional, and age groups across the state.

## Potential Implications of Indicators for MHSOAC, Counties, Consumers and Their Families, and Other Stakeholders

Based upon the revised tentative indicator set presented in this report we offer some conversation topics that might be fueled by the indicator set or ways that indicators might be brought into ongoing conversations about MHSA performance, accountability and improvement. In other words, we propose a handful of ways the priority indicators can work for the greater MHSA community, whether in programming, service, or planning efforts. The final set will depend on

<sup>47</sup> Thomas, D. (2002). Evaluating the cultural appropriateness of service delivery in multi-ethnic communities. *Evaluation Journal of Australasia*, 2, 50-56.

<sup>48</sup> California Mental Health Planning Council's Performance Indicators for Evaluating the Mental Health System, January 2010.

<sup>49</sup> Statutory outcome: Implement Recovery Vision (WIC 5813.5(d))

<sup>50</sup> Anthony, W. (2000). A recovery-oriented service system: setting some system level standards. *Psychiatry Rehabilitation*, 24, 159-169.

data availability, quality and reliability. Data integrity will be examined through a comprehensive data review process which will commence upon receipt of relevant data. To the extent existing data (already collected across counties) is complete and appropriate, we expect the indicators detailed in this report will hold several implications for MHSOAC, counties, consumers and their families, and other stakeholders working to improve MHSA services. The questions outlined below, many informed by stakeholders, are by no means exhaustive but rather are examples of those that might be answered using priority indicators.

***Evaluating Mental Health System Processes and Outcomes***

Given the multiple ways that MHSA is designed to shape the mental health system (through improving consumer access, service performance, and system structure), system-level indicators reflect diverse points of MHSA impact. The indicators can offer broad insights into system processes (e.g., appropriateness of care) and relevant outcomes (e.g., consumers’ aggregated experiences). As illustration, indicators regarding mental health system processes or outcomes might address the following points.

Discussion Points	Relevant Indicators
<i>Processes</i>	
<ul style="list-style-type: none"> <li>To what extent have demographic (gender, language, income, age) disparities been addressed among MHSA service consumers?</li> </ul>	6.1, 6.2, 8.1
<ul style="list-style-type: none"> <li>Have rates of hospital visits, involuntary care, and 24-hour care changed since the MHSA was established, and from whom?</li> </ul>	7.2, 7.3, 7.4, 7.5
<ul style="list-style-type: none"> <li>What best practices for consumer care are most prevalent within and across counties?</li> </ul>	8.2
<i>Outcomes</i>	
<ul style="list-style-type: none"> <li>What is the quality of care and services according to consumers and their families?</li> </ul>	7.8
<ul style="list-style-type: none"> <li>How can various cultural groups be most appropriately served?</li> </ul>	8.3
<i>Processes and outcomes</i>	
<ul style="list-style-type: none"> <li>What services and supports do consumers use after a mental health episode or psychiatric hospitalization, and how do they perceive the service experience?</li> </ul>	6.4, 6.5, 7.5, 7.8, 8.3

Questions of mental health system performance can provide necessary context for greater understanding of how system processes are related to consumer outcomes, which will be essential for improvement of monitoring, transparency and effectiveness of MHSA services.

***Improved monitoring, transparency and effectiveness, transparency***

Among consumer outcomes, the indicator set might more fully explain how consumers navigate available mental health interventions, the provisions made for consumers, and service quality.

Such increased understanding will provide the opportunity to address questions of monitoring, transparency and effectiveness at the consumer level, such as those outlined below.

Discussion Points	Relevant Indicators
<ul style="list-style-type: none"> <li>To what extent do consumers have access to independent living or supported living opportunities?</li> </ul>	2.1
<ul style="list-style-type: none"> <li>For children and TAY, what roles do schools play in mental health support?</li> </ul>	1.1

Broader questions that can inform what we know about system monitoring, effectiveness, and transparency at the system level are as follows:

Discussion Points	Relevant Indicators
<ul style="list-style-type: none"> <li>To what extent are mental health services being accessed within and across target consumer populations or county mental health systems?</li> </ul>	6.1, 6.2, 6.3, 6.4
<ul style="list-style-type: none"> <li>To what extent are county mental health systems aligned with the values and expectations of consumers, families, communities, providers and the MHSA initiative overall?</li> </ul>	6.5, 7.4, 7.8, 8.3, 8.4
<ul style="list-style-type: none"> <li>What is the makeup of the mental health system workforce, and the type and quality of programs/services they provide?</li> </ul>	8.1, 8.2

***Reduce burden/cost***

We propose that the indicator set will also add positive perspectives to the ongoing discussion of mental health’s social costs. Some questions are beyond the indicator set, suggesting that indicators evoke peripheral discussions that are important to maintaining MHSA performance and quality. Particularly, the indicators might inform the following questions:

- What is the cost saved/absorbed by hospitals that consumers use for emergency mental health intervention?
- What are the social ramifications of reducing homelessness through mental health intervention?

At the system-level, it is equally important to consider such questions as:

- Are services reaching those most in need?
- Are recovery, wellness, and resilience being promoted?

### ***Decision making and feedback loop for continuous improvement***

Priority indicator findings will drive important decisions made about the MHSA, its consumers, and its systems. At the consumer level, priority indicators can help make the case for more, fewer, or different types of programs in particular domains, for example. At the system-level, the MHSA administration might use findings formatively, meaning to shape existing practices in the mental health system based on what information priority indicators provide. This could be achieved by redistributing funds to areas that require more support, facilitating the revision of programs and supports that fail to meet expected performance levels, or modifying models to capitalize on a set of best practices that have been shown to consistently produce desired results. At both levels, any information gained from priority indicators is an ongoing assessment of the state of mental health and related services to maintain the highest quality of life possible for consumers and sound system performance.

This report and its companion “Compiling Data to Produce All Priority Indicators” (deliverable 2D) are concrete examples of this continuous feedback loop for quality improvement. Outlined in the next section, feedback from experts and stakeholders has ensured that the resulting proposed indicator set is comprehensive and appropriate for monitoring MHSA consumer outcomes and mental health system processes.

### **Types of Stakeholder Feedback and Corresponding Revisions**

Through the feedback process detailed earlier in this report, stakeholders across the state provided unique and well informed perspectives, thoughtful reaction and insight regarding the initial indicator set and the methods and data sources proposed to compose priority indicators. Stakeholders’ specific concerns regarding limitations or challenges of individual indicators can be found in the *Mental Health Outcomes Indicator Detail* section above. For a table of categorized stakeholder feedback, see Appendix E. Feedback regarding the indicator template presented to stakeholders in the initial draft of this report fell largely into the two domains below:

- *Comprehensive and appropriate indicators.* While many stakeholders expressed a perspective of the proposed set of indicators as largely comprehensive and appropriate for monitoring consumer outcomes and mental health system processes, they also provided feedback regarding a limited number of alternative indicators. For example, many stakeholders expressed the importance of considering Consumer Wellbeing as a consumer level priority indicator, although this indicator was proposed under the performance domain of the system level indicators.
  - *Corresponding revisions.* Based upon feedback regarding alternatives, some indicators proposed in this report reflect revisions to ensure they are most appropriate for monitoring their respective element of the MHSA system or consumer experience. One such revision was reconceptualizing Wellbeing as a consumer level indicator, rather than a system outcome. Many such revisions to incorporate stakeholder feedback regarding alternative indicators have been integrated throughout this report.
- *Data source availability and quality.* Possibly the most common feedback theme was centered on the availability and accurate and reliable data to inform the proposed indicators.

While many stakeholder concerns in this regard will be verified by a thorough review of existing data, the unique insights and historical knowledge of data integrity within specific counties and throughout the state was central to our revisions of the proposed sources of data to be used to compose priority indicators. As an example, stakeholders expressed concern that many indicators could require additional primary data collection to comprehensively capture factors such as Workforce Composition, as they noted that existing sources were incomplete or unreliable with regard to some indicators.

- *Corresponding revisions.* Based upon feedback regarding data concerns several indicators were revised to include alternative existing data sources, potential external data sources (e.g., census data) or proposals for additional primary data collection. Additionally, a data quality review process outlined in a companion report (i.e., “Compiling Data to Produce All Priority Indicators”; deliverable 2D) will provide more detailed knowledge of where the holes are among existing data sources and present logical and practical possibilities for filling them.

### ***Next Steps***

The priority indicators proposed in this report have been elaborated down to the item level, along with more comprehensive proposals for composing or calculating each indicator, in a subsequent report entitled “Compiling Data to Produce All Priority Indicators” (deliverable 2D). Stakeholder feedback was central to revising this companion document to ensure the calculation of each indicator is appropriate and accurate for monitoring MHSA consumer outcomes and mental health system processes.

This report and its companion will be the foundation for forthcoming report 2E, which includes results for all priority indicators at the statewide level, for the most recent one-year period. This report will then be followed by three county level reports on all priority indicators, submitted on a quarterly basis.

Appendix A

## Matrix of California's Public Mental Health System Prioritized Performance Indicators

To Begin Implementation of California Mental Health Planning Council's Approved Performance Indicators

Type of Indicator	DOMAIN			
	Age Group	Education/Employment	Homelessness/Housing	Justice Involvement
<b>Individual Client Outcomes* (for Full Service Partnerships)</b>	Children	Indicator #2: Average Attendance—Score per year	Indicator #1: Housing Situation/Index--Score	Indicator #1: Number of Arrests
	TAY	Indicator # 8: Under 18 years—Average Attendance--Score per year 18+ --Proportion participating in paid and unpaid employment*	Indicator #7: Housing Situation/Index--Score	Indicator #7: Number of Arrests
	Adults	Indicator #13: Proportion participating in paid and unpaid employment*	Indicator #12: Housing Situation/Index--Score	Indicator #12: Number of Arrests
	Older Adults	Indicator #13: Proportion participating in paid and unpaid employment* (Explore feasibility of Indicator #20--Instrumental Activities of Daily Living)	Indicator #17: Housing Situation/Index--Score	Indicator #17: Number of Arrests
<b>County Mental Health System Performance</b>	Indicators #5, 6, 11, 16, 21: Family/Youth/Client Perception of Well-Being Indicator # 30: Age, Gender, Race/Ethnicity of entire FSP population Indicator # 31: Access of FSPs to Primary Care Physician Indicator # 33: Penetration Rate → 03/04 and 06/07 data already provided from CSI Indicator # 34: New Clients by county by age, gender, race ethnicity for FY 04/05 and FY 07/08 from CSI. (New clients are those without service for prior 6 months.) Indicator # 35 or # 37: Involuntary Care—3 day and 14 day commitments Indicator # 43: Annual Numbers Served through CSS from Exhibit 6 of FSPs, General System Development and Outreach/Engagement. Workforce Indicators #s 45 & 46: To Be Requested for the Development of Five-Year Plan			
<b>Community Indicators</b>	None At This Time			

Frequency of Data Request: Individual: Baseline and Annual Data (Y1, Y2, etc.); System: Annually Beginning 04/05; Begin with statewide and regional reports; then produce county specific reports.

\* Participation in Education not available.

*This Matrix contains selected indicators from the "California Mental Health Planning Council's Performance Indicator Proposal for the Mental Health Services Act, September 2009"*

## Appendix B

### Glossary

#### *Criteria*

A set of standards on which decisions are made

#### *Domain*

An overarching category within which related items are grouped

#### *Indicator*

A gauge or measure of a particular trend or condition

#### *Outcome*

Change brought about by a guiding course of action

#### *Process*

The breadth of actions taken to achieve an outcome or set of outcomes

## Appendix C

### **Data Sources Reviewed**

#### Data Collection & Reporting System for FSP (DCR)

- Key Event Tracking (KET)
- Partnership Assessment Form (PAF)
- Quarterly Assessment Forms (3M)

#### Performance Outcomes & Quality Improvement (POQI)

- Youth Services Survey (YSS)
- Youth Services Survey for Families (YSS-F)
- Adult Survey
- Older Adult Survey

#### Client Services and Information System (CSI)

#### County Reports

- Revenue and Expenditure Reports (R&E)
- Annual Updates
- Quarterly Progress Goals and Report (includes CSS Exhibit 6)

#### Annual Report on Involuntary Detentions

#### Cultural Competence Plans

## Appendix D

### **Participating Organizations and Agencies** (In Alphabetical Order)

Individuals and groups from the following entities responded to an e-mail announcing the availability of MHSA Evaluation Team contract deliverables 2A and 2C (early versions of 2B and 2D). It is possible that more persons than are listed received the call through message forwarding. The following list was created to the best of the team's knowledge and e-mail verification.

- APS Healthcare
- Association of Community Human Services Agencies
- Bonita House
- California Association of Social Rehabilitation Agencies
- California Community Colleges Chancellor's Office
- California Department of Aging
- California Department of Mental Health
- California Institute for Mental Health
- California Mental Health Director's Association
- California Mental Health Planning Council
- California Network of Mental Health Clients
- Contra Costa County Health Services Department
- California Council of Community Mental Health Agencies
- EMQ Families First
- Humboldt County
- California Mental Health Directors Association Indicators, Data, Evaluation Accountability (IDEA) Committee
- Los Angeles County Department of Mental Health
- Mental Health America of California
- Mental Health America of Los Angeles
- MHSA Partners
- Mental Health Services Oversight and Accountability Commission
- Monterey County
- National Alliance on Mental Illness – California
- Nevada County
- Orange County Behavioral Health Services
- San Bernardino County Department of Behavioral Health
- San Diego County
- San Francisco Department of Public Health
- San Joaquin County Mental Health Board
- Seeds of Hope
- Shasta County Health and Human Services
- Turning Point Community Programs
- United Advocates for Children and Families

Appendix E

Table 1: Types of Stakeholder Feedback Received (Summary)

Domain	Alternative domain/measures suggested	Alternative data sources suggested	Challenges with associated data noted	Domains incomplete (changes suggested)	Domains incomplete (additions suggested)	Request for clarification
1. Employment/ Education			●	●	●	●
2. Homelessness/ Housing Situation			●		●	●
3. Justice Involvement			●	●	●	
4. Emergency Care			●		●	
5. Access			●			●
6. Performance			●			
7. Structure	●	●	●	●	●	●

*Additional domains suggested:*

Alcohol and Other Drug Use (AOD)  
 Co-occurring physical health disorders  
 Social connections

*Additional data sources:*

Claiming process  
 Recovery Oriented Systems Indicators Measure (ROSI) / Developing  
 Recovery Enhancing Environments Measure (DREEM)

Table 2: Types of Stakeholder Feedback Received (Detailed)

Indicator	Alternative domain/measures suggested	Alternative data sources suggested	Challenges with associated data noted	Indicator incomplete (changes suggested)	Indicator incomplete (additions suggested)	Request for clarification
1. Employment/ Education						●
<i>1.1 Education</i>			●	●		
<i>1.2 Employment</i>			●	●	●	
2. Homelessness/ Housing Situation			●		●	●
3. Justice Involvement				●	●	
4. Emergency Care			●	●	●	
5. Access						
<i>5.1 Demographic Profile</i>			●			
<i>5.2 New Consumers by Demographic Profile</i>			●		●	

Table 2: Types of Stakeholder Feedback Received (Detailed)

Indicator	Alternative domain/measures suggested	Alternative data sources suggested	Challenges with associated data noted	Indicator incomplete (changes suggested)	Indicator incomplete (additions suggested)	Request for clarification
<i>5.3 High Needs Consumers Served</i>			●	●		●
<i>5.4 Access to Primary Care Physicians</i>	●		●			●
<i>5.5 Consumer/ Family Perceptions of Access to Services</i>						
6. Performance						
<i>6.1 Consumers Served Annually Through CSS</i>			●			
<i>6.2 Involuntary Care</i>						
<i>6.3 24-Hour Care</i>						
<i>6.4 Appropriateness of Care</i>			●	●		
<i>6.5 Continuity of Care</i>			●	●		

Table 2: Types of Stakeholder Feedback Received (Detailed)

Indicator	Alternative domain/measures suggested	Alternative data sources suggested	Challenges with associated data noted	Indicator incomplete (changes suggested)	Indicator incomplete (additions suggested)	Request for clarification
<i>6.6 Penetration Rate</i>			●	●		
<i>6.7 Consumer Wellbeing</i>			●			
<i>6.8 Satisfaction</i>						
7. Structure						
<i>7.1 Workforce Composition</i>	●		●			●
<i>7.2 Evidence Based/Best Practice Programs and Services</i>	●		●	●		
<i>7.3 Cultural Appropriateness of Services</i>		●	●			●
<i>7.4 Recovery, Wellness, and Resilience Orientation</i>			●		●	