MHSOAC
Mental Health Services
Oversight & Accountability Commission

Written Testimony for the Little Hoover Commission Hearing September 23, 2014

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WRITTEN TESTIMONY FOR THE LITTLE HOOVER COMMISSION

This written testimony is provided as requested in the August 13, 2014 letter from Executive Director, Carole D'Elia, of the Little Hoover Commission. Following are the responses to the questions posed in the letter in order to prepare for the hearing on September 23, 2014.

1. How has the role of the commission changed since the MHSA was enacted and what are the commission's current oversight responsibilities?

The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) was established by Proposition 63 in 2004 and codified in Welfare and Institutions Code (WIC) Section 5845 to oversee the Adult and Older Adult System of Care, the Children's Mental Health Services Act, and MHSA-funded programs. The MHSOAC consists of a group of 16 Commissioners representing the various aspects of society that are impacted by mental illness. To assist with its oversight and accountability role, the Commission has five standing advisory committees, chaired by commissioners and made up of stakeholders. The committees are: Client and Family Leadership, Cultural and Linguistic Competency, Evaluation, Financial Oversight, and Services.

The Commission's role and responsibilities are governed by multiple sections within the MHSA and other sections in the WIC. For a detailed overview of the Commission's statutory responsibilities, including those outside of the MHSA, please see Attachment 1. The following descriptions of the Commission's role focus on those that have been impacted by legislation subsequent to the passage of Proposition 63.

When Proposition 63 was passed in 2004, the Commission was a division within the Department of Mental Health (DMH) and its overarching role included:

(1) Overseeing the Adult and Older Adult System of care; Children's Mental Health Services Act; Human Resources, Education, and Training Programs; Innovation programs (INN); and Prevention and Early Intervention Programs (PEI)
(2) Reviewing and approving county plans for two of the five components, PEI and INN, and reviewing and commenting on the other three components that DMH reviewed and approved
(3) Referring to DMH any critical issue the Commission identified related to county performance

In February 2009, Assembly Bill 5, enacted as Chapter 20, changed the Commission's role by:

(1) Making the Commission independent from DMH
(2) Authorizing the Commission to obtain data and information from DMH and other state and local entities that receive MHSA funds to be used in the Commission's oversight, review, and evaluation capacity regarding projects and programs supported with MHSA funds
(3) Giving the Commission authority to issue guidelines for PEI and INN
(4) Requiring DMH to consult with the Commission when deciding the county allocations of available funds

In March 2011, Assembly Bill 100 enacted as Chapter 5, made the following changes that affected the Commission's role:

(1) Eliminated the Commission's and DMH's review and approval of the county plans for expenditure of MHSA funds
(2) Eliminated the requirement that counties submit the Three-Year Program and Expenditure Plan and Annual Update to the Commission
(3) Provided for MHSA funds to be distributed on a monthly basis to counties

In June 2012, Assembly Bill 1467, enacted as Chapter 23, changed the role of the Commission by:

(1) Reinstituting the Commission's role of approving county plans for INN before the county can expend the funds
(2) Designating the Commission (in collaboration with DHCS and California Mental Health Planning Council and in consultation with California Mental Health Directors Association) to design a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system
(3) Expanding the Commission's technical assistance role to include providing technical assistance to counties to accomplish the purpose of the Adult and Older Adult System of Care and the Children's Mental Health Services Act
(4) Designating the Commission as the state entity to receive the counties' Three-Year Program and Expenditure Plan and Annual Updates
(5) Requiring DHCS to consult with the Commission in developing and administering the instructions for the MHSA Annual Revenue and Expenditure Report (ARER)
(6) Designating the Commission and DHCS to jointly establish the performance outcomes for services under the Adult and Older Adult System of Care and the Children's Mental Health Services Act

In June 2013, Assembly Bill 82, enacted as Chapter 23, made the following changes to the role of the Commission:

(1) For the first time, mandated the Commission to issue regulations for PEI and INN
(2) Codified that the Commission is separate and apart from the California Health and Human Services Agency

1a. Please also briefly describe the commission's oversight role both in terms of ensuring the MHSA funds are spent properly, and ensuring that the funds are supporting programs designed to achieve their intended results.

When the Commission was first established, it focused its oversight role on plan review and approval to ensure MHSA funds were distributed to the counties and used in accordance with the Act. The MHSA was new and innovative, and had a goal of transforming the community mental health system from a "fail-first" to a "help-first" system. In November 2010, the Commission decided to broaden its focus from MHSA implementation to have a greater emphasis on evaluation focusing on outcomes and the appropriate and effective use of MHSA funds. The Commission felt that this was a critical shift to support its oversight and accountability responsibilities.

Based on the Commission's changing statutory role and focus, it has developed and adopted several policy papers to operationalize the Commission's oversight role via evaluation efforts. In November 2010, the MHSOAC adopted a Policy Paper titled, "Accountability through Evaluative Efforts: Focusing on Oversight, Accountability, and Evaluation"[1], which highlights the Commission's focus on evaluation as an oversight and accountability strategy and provides examples of core research questions to focus on (e.g., How has the money been used? What has been the impact of investments in mental health?). In 2011, the MHSOAC adopted a Logic Model[2] that describes a series of oversight and accountability "focus areas" and "strategies". The Logic Model illustrates the relationship between county actions that the MHSOAC should focus on (i.e., planning, choosing, designing, implementing, and evaluating mental health programs, and using evaluation results to improve the quality and outcomes of services) and the strategies that the MHSOAC intends to use to carry out its oversight and accountability role:

- Influencing policy
- Ensuring collection and tracking of data and information
- Ensuring that counties are provided adequate support
- Ensuring MHSA funding and services comply with relevant statutes and regulations
- Evaluating impact of MHSA
- Utilizing evaluation results for quality improvement
- Communicating impact of MHSA

In March 2013, the Commission adopted an Evaluation Master Plan[3] and an associated Implementation Plan[4] to guide its evaluation efforts. The Master Plan incorporates tenets of the Logic Model (e.g., focus on mental health outcomes at the individual/family, system, and community levels). The Commission, at its September 2014 meeting, is scheduled to vote on an update to the 2010 evaluation Policy Paper. The updated Policy Paper, titled "How Evaluation Efforts Can Contribute to MHSOAC-Adopted Oversight and Accountability Strategies: Encouraging Positive Outcomes Across the State", describes a series of policies and procedures for how evaluation efforts can be used to contribute to each of the seven oversight and accountability strategies in the Logic Model.

These documents collectively provide guidance and explicit procedures for how the Commission has and intends to continue to provide oversight and ensure that MHSA funds are being spent properly to support programs, and that those programs are achieving intended results.

[1] The 2011 Policy Paper may be found at:
http://www.mhsoac.ca.gov/meetings/docs/Meetings/2011/Mar/Eval_Tab5_AccountabilityPolicyPaper.pdf
[2] The Logic Model may be found at:
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/July/Eval_071114_Tab4_MHSOAC_LogicModel.pdf
[3] The Evaluation Master Plan may be found at:
http://www.mhsoac.ca.gov/Evaluations/docs/EvaluationMasterPlan_Final_040413.pdf
[4] The Evaluation Implementation Plan may be found at:
http://mhsoac.ca.gov/Meetings/docs/Meetings/2013/OAC_032813_Tab2_EvalImplementPlan.pdf

2. What, if any, challenges make it difficult for the commission to provide oversight of the MHSA funds? Please briefly describe the commission's efforts to address those challenges and, if possible, ideas for further improvement.

The Commission provides oversight of the MHSA funds in two ways: (1) looking at the actual expenditures and (2) evaluating the outcomes of those expenditures. For both of these oversight methods, the key challenge is the lack of timely and accurate data. Challenges related to oversight of expenditures are provided below. Challenges related to evaluating the outcomes of those expenditures are provided within the responses to Questions 3 and 5.

Data Challenges for Oversight of Expenditures

Currently, counties submit fiscal information to the Department of Health Care Services (DHCS) and the MHSOAC via the ARER, which contain details regarding expenditures for each MHSA component. The primary issue with this reporting mechanism is that it does not lend itself to provision of fiscal information that allows for a clear, accurate, and detailed understanding of MHSA allocations, expenditures, and balances of unexpended funds. The instructions to counties for how to complete the ARER were initially provided by DMH and are now provided to the counties by DHCS with consultation by the Commission. Because these instructions have changed yearly they have often led to a lack of clear and uniform definitions. This in turn has led to inconsistent, ineffective, and untimely fiscal data. DHCS is currently in the process of generating instructions for counties on what to submit for FY 2012/13 ARER, which means the most recent fiscal year for which the Commission has data is 2011/12. In addition, not all counties have consistently, accurately, or timely submitted their ARER, despite the instructions.

Another challenge has resulted from the elimination of State approval of MHSA plans by Assembly Bill 100 in 2011. As such, it is difficult to ensure that counties are spending funds as described in county Three-Year Program and Expenditure Plans (Three-Year Plans) and Annual Updates. The Commission compares the Annual Update and Three-Year Plans with the ARER to monitor whether funds were spent on programs as developed in local Community Program Planning (CPP) processes and approved by the local Board of Supervisors. However, because there is a back log on the ARER, this oversight mechanism is not up to date.

As a result of Assembly Bill 100, the MHSA funds are distributed directly to the counties on a monthly basis and there is no incentive for counties to provide timely and accurate data to the State on expenditures or balances. The State no longer has the ability to withhold funds as a consequence for failing to comply with State reporting requirements, such as the ARER.

An additional challenge is to provide oversight of the use of the MHSA administrative fund. The Commission is not currently involved in the decision-making process for approval and distribution of the administrative fund.

Efforts to Address Challenges and Ideas for Further Improvements

The Commission is continuing to work with DHCS on the ARER and the accompanying instructions. As mentioned above, DHCS is currently in the process of preparing the instructions for the FY 2012/13 ARER. The goal of the Commission is that ARER instructions are provided to the counties in advance of the fiscal year being analyzed so that counties can better prepare to

collect (and later report) the information that the State needs for proper fiscal oversight. In this respect, the Commission has included in the proposed regulations for the PEI and INN components specific fiscal reporting requirements for these two components to be included in the ARER. Having the specific fiscal requirements in the regulations provides counties advance and consistent reporting requirements. An idea for improvement is that specific fiscal requirements for all of the MHSA components be in regulations instead of yearly instruction.

Another recent effort implemented by the MHSOAC in 2013 is that the Financial Oversight Committee has begun to invite state entities to present how they are using the MHSA administrative funds. The Committee will then present its findings to the Commission and Department of Finance. The ability to provide input to the Department of Finance before it decides on how to allocate MHSA administrative funds would further allow the MHSOAC to provide oversight of the funds.

3. How does the commission evaluate the use of MHSA funds to ensure they are leading to improvements in mental health services throughout the state? What challenges, if any, have you encountered in terms of evaluating the various fund categories? What strategies, if any, would you recommend to help improve the process?

MHSOAC Processes for Evaluation of MHSA Funds and Associated Outcomes

As mentioned above in response to Question 1a, the MHSOAC adopted a Logic Model[5] and Evaluation Master Plan[6] to further define and set directions for the Commission's long term use of evaluation as an oversight and accountability strategy. The Master Plan describes three primary evaluation-based methods in which the Commission can use evaluation to contribute to its oversight role (i.e., performance monitoring, evaluation studies, and developmental and exploratory studies). The Master Plan lays out a series of evaluation activities to complete over a five year period. The Commission also adopted an associated Implementation Plan[7] that describes how to go implement the activities in the Master Plan. The Commission is currently in year two of this Implementation Plan. Both of these Plans describe an annual prioritization process through which MHSOAC staff work with the Evaluation Committee to prioritize evaluation activities to carry out in the coming fiscal year. Attachment 2 is the MHSOAC Performance Dashboard[8], which lists all current evaluation efforts, their timelines, and major deliverables.

In addition to the Master Plan, the Commission adopted an evaluation Policy Paper[9], as was mentioned above in response to Question 1a. This Paper provides principles for designing and using evaluation efforts so that they can focus on areas of importance (e.g., ensuring funds are

[5] The Logic Model may be found at:
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/July/Eval_071114_Tab4_MHSOAC_LogicModel.pdf
[6] The Evaluation Master Plan may be found at:
http://www.mhsoac.ca.gov/Evaluations/docs/EvaluationMasterPlan_Final_040413.pdf
[7] The Evaluation Implementation Plan may be found at:
http://mhsoac.ca.gov/Meetings/docs/Meetings/2013/OAC_032813_Tab2_EvalImplementPlan.pdf
[8] The August 2014 MHSOAC Performance Dashboard may be found at:
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/August/OAC_1C_PerfDash_082814.pdf
[9] The 2011 Policy Paper may be found at:
http://www.mhsoac.ca.gov/meetings/docs/Meetings/2011/Mar/Eval_Tab5_AccountabilityPolicyPaper.pdf

leading to improvements statewide). The updated Policy Paper, which was presented as a first-read to the Commission on August 28, 2014 and will be presented for adoption at the forthcoming September 30, 2014 meeting, describes specific procedures to actively implement oversight and accountability strategies put forth in the Logic Model.

The MHSOAC is committed to ensuring that its statewide evaluation efforts are used to encourage continuous improvements in the quality of community mental health system, and guide public investments in it. The MHSOAC has carried out several evaluations that speak to the performance of California's public community-based mental health system and the impact of the Act. Evaluation results are presented to the Commission and then referred to the Evaluation Committee for further potential policy development and consideration of how the results can be used for quality improvement efforts. Examples of when this process has been used are described below.

Examples of MHSOAC Evaluations of MHSA Funds and Outcomes

The MHSOAC has assessed costs and activities of each component focused on specific fiscal years for which data was available. For example, the Commission completed a series of reports[10] focused on each of the MHSA components. The reports looked at component allocations, approved funding, and expenditures for four fiscal years (i.e., FY 2006/07 through 2009/10). The Commission intends to continue further fiscal analyses of county expenditures as data becomes available. In addition, the Commission has completed a variety of evaluations focused on assessment of whether programs within various components have achieved their intended results. Examples pertaining to the broad Community Services and Supports (CSS) component, Full Service Partnerships (FSPs), a part of CSS, the PEI component, and the Innovation component are included below.

In July 2014, the Commission released the "Priority Indicators Trends Report"[11]. This report describes 12 indicators of the public community-based mental health system's performance over a series of seven fiscal years (i.e., 2004/05 through 2011/12). The outcomes are based on goals stated within the Act (e.g., reduced homelessness, reduced justice system involvement). For example, the report showed that the percentage of FSP consumers reporting access to a primary care physician increased significantly since passage of the MHSA.

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[10] The series of reports focusing on the cost and activities of MHSA components may be found at:
http://www.mhsoac.ca.gov/Evaluations/docs/Evaluation_Deliverable1A_Briefs_ExecutiveSummary.pdf
http://www.mhsoac.ca.gov/Evaluations/docs/Evaluation_Delievrable1A_Brief1_CSS.pdf
http://www.mhsoac.ca.gov/Evaluations/docs/Evaluation_Deliverable1A_Brief2_FSP.pdf
http://www.mhsoac.ca.gov/Evaluations/docs/Evaluation_Deliverable1A_Brief3_OE.pdf
http://www.mhsoac.ca.gov/Evaluations/docs/Evaluation_Deliverable1A_Brief4_GSD.pdf
http://www.mhsoac.ca.gov/Evaluations/docs/Evaluation_Deliverable1A_Brief5_WET.pdf
http://www.mhsoac.ca.gov/Evaluations/docs/Evaluation_Deliverable1A_Brief6_PEI.pdf
http://www.mhsoac.ca.gov/Evaluations/docs/Evaluation_Deliverable1A_Brief7_INN.pdf
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2013/FinancialOversight_102313_Tab5_UCLAReport_CAInvestmentInPublicMHSystem.pdf

[11] The "Priority Indicators Trends Report" may be found at:
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/July/OAC_072414_4A_PriorityIndicatorsTrendsReport_UCLA.pdf

Additional reports[12] on FSPs have highlighted other positive outcomes associated with these programs. These reports show that clients reaching one year of continuous FSP enrollment experienced 30% fewer substance abuse related emergency events and over 50% of individuals who were homeless at the time of enrollment were no longer homeless, incarcerated, or in an emergency shelter upon discharge. Another MHSOAC-sponsored evaluation[13] showed that, as FSP clients with severe mental illness improve, they are less likely to require ongoing psychiatric care and emergency room visits, or be involved in the criminal justice system, which saves the State money in these areas. This evaluation showed that 81% of FSP program costs were offset by savings in these areas—a savings of $161.5 million over two years.

Another example is the assessment[14] of county implementation of PEI programs using MHSA funds and the impact of those programs. In FY 2011/12, a total of $318 million was committed to PEI programs by counties. Over 365,000 consumers at risk for, or with early onset of, mental illness were directly served by MHSA-funded PEI programs in that year across the state. Benefits[15] (i.e., positive outcomes) were identified for specific types of early intervention programs in a subset of counties.

The MHSOAC is currently in the process of examining county planned and implemented Innovative Programs. Funding for Innovative Programs is designed to allow counties to evaluate novel concepts that may further achievement of MHSA goals and positive outcomes, but for which there is currently no evidence. In essence, Innovative Program funds are to be used to provide evidence of the possible efficacy of these novel previously untested concepts. As of August 2014, at least 48 counties have either planned or implemented an Innovative Program.

These sample evaluation efforts highlight how the MHSOAC has worked to ensure that MHSA funds have been spent properly and are being used to support programs designed to achieve their intended results, including goals stated in the MHSA. During these evaluations, the Commission has encountered several issues with obtaining consistent and accurate data regarding both MHSA funds and outcomes from all counties in a reliable manner. Such challenges diminish the impact and utility of these evaluations. Below is a description of the issues.

Challenges with Oversight and Evaluation of MHSA Funds

As mentioned previously in response to Question 2, the overarching issue associated with the MHSOAC's difficulty with providing oversight and evaluation of MHSA funds is that the current structure that is used for counties to submit their expenditures (i.e., the ARER) does not contain adequate or consistent information from all counties for all years that the Act has been

[12] The Statewide FSP Outcomes Report may be found at:
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/July/OAC_072414_6A_Report.pdf
[13] The FSP Cost/Cost Offset Report may be found at:
http://mhsoac.ca.gov/Meetings/docs/Meetings/2012/Nov/OAC_111512_Tab4_MHSA_CostOffset_Report_FSP.pdf
[14] The assessment of county implementation of PEI Programs may be found at:
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/January/OAC_012314_Tab7_PEIReport.pdf
[15] Reports on specific clusters of early intervention programs may be found at:
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/July/OAC_072414_5A_Cluster1.pdf
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/July/OAC_072414_5A_Cluster2.pdf
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/July/OAC_072414_5A_Cluster3.pdf

implemented. The MHSOAC has attempted to make use of the ARER for several evaluations with fiscal components; each has concluded with results that must be interpreted with caution or assumed to be estimates due to the limitations of this data source.

Another challenge in getting accurate component-specific expenditure data is that the funding for the programs or specific services within programs is sometimes blended. In such cases, counties are not able to separate out the funds, for example, expended on Prevention versus Early Intervention efforts. This inability to parse out expenditures is problematic because it prohibits the ability to fully understand what types of services PEI funds are being used for, as well as the impact of specific types of programs and services (including potential cost benefits).

Challenges with Evaluation of Clients, Services, and Outcomes

Even though the MHSOAC has statutory authority to request data from any entity that receives MHSA funds, it has no authority to enforce such requests. This has led to challenges with the Commission's ability to obtain basic data to support its evaluations. Additionally, DHCS is the owner of the primary data collection and reporting systems that provide information regarding CSS clients and services. Of these systems, only the one for FSPs collects actual outcome data.

MHSOAC has identified other significant limitations of these systems as we have worked with them. In November 2012, the MHSOAC drafted a paper ("Gaps and Limitations in California's Mental Health Services Statewide Data Collection and Reporting Systems"), which highlighted the many ongoing problems with these data collection and reporting systems. The issues described in the paper fell within the following overarching categories:

- **Problems with reporting systems/infrastructure.** There are many issues with the physical systems currently in place for counties to report data and information back to the state that limit the quality of the data received.
- **Lack of knowledge/guidance regarding use of reporting systems/infrastructure.** Counties may not have proper knowledge on how to use the current reporting systems; nor is there always guidance available to assist with the reporting process.
- **Problems with data collection/entry systems/infrastructure.** There are problems with the physical IT systems that are currently in place that allow counties to enter and submit data back to the State. The systems are not easy to use and do not always function properly.
- **Lack of knowledge/guidance regarding data collection and entry.** Counties may not have proper knowledge or necessary guidance regarding how to collect meaningful data and accurately use the data entry systems that are currently available.
- **Lack of knowledge/guidance regarding what data to collect.** Counties may not always understand what specific information they could collect that would be beneficial to the State or should collect since it is required by the State.

The Commission is concerned that there is not enough support for these systems. The MHSOAC has invested approximately $3 million of evaluation funds for direct strengthening of the DHCS-owned data systems, including support of the IT infrastructure and support to facilitate accurate use of these systems by counties. While these efforts have proven helpful, they provide small fixes to a large system that is highly dilapidated. Even more important, the current systems

do not provide data on all aspects of the CSS component that need to be regularly assessed (e.g., no outcomes for clients of CSS services beyond FSPs).

DHCS may not be in a position to independently strengthen these systems so that they meet the MHSOAC's needs within a reasonable timeframe. In essence, the MHSOAC's successful ability to adequately evaluate the use of MHSA funds and ensure that they are leading to improvements in mental health services throughout the state depends on receipt of consistent, timely, and meaningful data from all counties and DHCS.

The MHSOAC has faced similar significant challenges with regard to evaluation of PEI services. The Commission's ability to obtain basic information about PEI services from counties (e.g., numbers served, types of programs being implemented, expenditures, etc.) has been erratic and inconsistent. The lack of a standardized set of reporting requirements and a standardized reporting mechanism for PEI data contribute to the counties' inability to provide requested information. Some counties do not report required data at all, some counties report data using completely different measures and methodologies than other counties, and many counties report data for different fiscal years at different times. This diversity in county data reporting makes it extremely challenging for the MHSOAC to conduct meaningful evaluations that include consistent data from all counties.

Potential Strategies to Address Evaluation Challenges

As noted previously, since the ARER is currently the sole data source the State receives to track county-level MHSA expenditures, the Commission will continue to have a limited capacity to provide a detailed, accurate, and current understanding of MHSA expenditures until these problems are adequately addressed. The Commission has actively advocated to DHCS the need to strengthen the fiscal reporting system and continues to work with them on this matter. The Commission has requested that fiscal experts from DHCS, County Behavior Health Directors Association (CBHDA), and the Commission collaborate to find permanent solutions to the fiscal reporting issues.

Similarly, the statewide systems through which CSS data is collected are in need of serious strengthening. MHSOAC staff continues to meet regularly with DHCS staff to focus on this issue and spearhead efforts to fix the DHCS-owned systems so that MHSOAC data needs can be met. The MHSOAC is currently working toward entering into a contract to complete a study on behalf of DHCS to assess the feasibility for the creation of a new statewide data collection system. This system would be comprehensive and include reporting of data for all the community based mental health programs, including all MHSA components and substance use disorders. Such a comprehensive system would support the counties' ability to accurately submit required data in a timely manner, as well as the State's ability to compile data and aggregate it for statewide evaluation purposes. Success of this project will rely on the cooperation of DHCS. In addition, if the feasibility study successfully identifies and recommends methods for addressing these issues, DHCS will have to acquire the resources to implement the study, which could involve development and deployment of an entirely new statewide data collection and reporting system.

In order to facilitate counties' timely and complete responses to MHSOAC PEI data requests, counties should be given ample notice about what types of data to regularly track, how to collect this data, and how to report it in a standardized way that will be consistent with data from other counties and in compliance with the MHSOAC's data reporting requirements. Counties should also be provided with clear, standardized definitions for different types of PEI services so that they may accurately report data separately for these different types of services. The Commission, in its proposed PEI Regulations, addresses these issues and provides clear requirements to guide counties in their data collection and reporting efforts. Overall, the specific data reporting requirements outlined in the proposed PEI Regulations will facilitate standardization of counties' data collection and reporting and improve the MHSOAC's ability to carry out statewide evaluations of PEI services.

An additional strategy to help improve evaluation of PEI programs is the Commission's preliminary plan to implement a new Technical Assistance and Communication Resource Center. This new Resource Center would serve as an interactive, centralized repository of training tools for counties, which would allow counties to implement services in compliance with State requirements and evaluate services using standardized, rigorous evaluation methods that provide meaningful data that can then be used at the statewide level.

4. Has statewide capacity to provide mental health services and supports improved since passage of the MHSA? If so, what evidence do we have?

The MHSA has undoubtedly improved statewide capacity to provide mental health services and supports. MHSA funds have been consistently provided to counties for almost ten years, and those funds have consistently been used to serve severely mentally ill and emotionally disturbed individuals, as well as those at risk for or showing early signs of mental illness or emotional disturbance. Many individual counties have provided evidence that speaks to improvements in local mental health systems and services. Although evidence at the statewide level has been more challenging to provide, there is information that demonstrates how the MHSA has led to: 1) maintenance of the mental health system at times when it would have otherwise been significantly depleted; and 2) improvements in the system that were the direct result of the passage and implementation of the MHSA.

The State and nation faced serious financial crisis shortly after Proposition 63 passed. As such, some facets of the MHSA (e.g., the CSS component) stabilized and maintained services that would have otherwise been eliminated or reduced. Other MHSA components (e.g., PEI) provided entirely new services and programs that were not in existence prior to the MHSA. Below is evidence generated by the MHSOAC that supports this improved capacity.

<u>Evidence of Improved Statewide Capacity</u>
A Commission evaluation completed in late 2012 showed that, from FY 2004/05 to 2009/10, the State allocated $4.1 Billion to counties to plan and implement MHSA programs. Over 63% of those funds ($2.6 Billion) were appropriately allocated to the CSS component. The next largest funding allocation was for PEI, which accounted for 16% of the funds ($684 Million). Ten percent of the funds ($456 Million) were allocated to Capital Facilities and Technological Needs

(CF/TN). The remainder of the funds (totaling less than 10%) were allocated to Innovation, Workforce Education and Training (WET), and the Community Program Planning process. MHSA funds were provided to counties via a gradual "rolling out" of each component. This process was designed to give counties time to develop and implement components before moving on to another, and to enable counties to develop specific programs suited to their local needs. By FY 2006/07, all counties had received CSS and WET funds. By FY 2007/08, all counties had received allocations for PEI and CF/TN. By FY 2008/09, all counties had been allocated Innovation funds. As of FY 2013/14, counties have been allocated a total of approximately $9.5 Billion to support MHSA programs.

At its height in FY 2007/08, the MHSA generated $1.5 Billon to support California's public community-based mental health system, while providing $848.7 Million at its lowest in FY 20011/12. Although a somewhat volatile funding stream that varies each year based on the economy, the MHSA has consistently provided counties with funding to supplement other resources devoted to mental health services and supports (e.g., Medi-Cal, realignment, federal funds). While Medi-Cal dollars remain the primary source of funding, the MHSA is the second highest funding stream devoted to mental health. The majority of funds have been directed toward the CSS component, which has drastically improved services and expanded the statewide system that serves individuals living with serious emotional disturbance or serious mental illness. In addition, a significant percent of the funds have been allocated for the PEI component, which aims to provide an alternative to an otherwise "fail first" system that intervenes during crisis rather than in a preventative or early capacity. Below are examples from each of these two components that illustrate how the MHSA has improved statewide capacity to provide mental health services and supports.

<u>Community Services and Supports (CSS)</u>
By FY 2008/09, all counties and municipalities were expending funds on CSS. Examination of unemployment and foreclosure data over time suggest that, as pressure on the public mental health system has been increasing in recent years, the rate of CSS funding is keeping pace with the increased need for public mental health services. Over 600,000 individuals have consistently been served via the CSS component from 2004/05 through 2011/12, which speaks to the ability of the MHSA to help counties maintain mental health services and supports, even during times of economic downturn, such as the recession that began in 2008.

CSS funds have promoted system wide transformation, despite economic instability and an increased need for services, through the development of recovery-focused programs that provide wrap-around services to individuals. CSS services also provide outreach, crisis, and case management services that were in low supply or unavailable prior to the passage of the MHSA. For example, FSP were a direct outgrowth of the MHSA and have now been implemented in all 58 counties. FSPs are designed to meet the diverse needs of the most severely mentally ill or emotionally disturbed clients. These programs use a "whatever it takes" philosophy, which involves finding the methods and means to engage a client, determining his or her needs for recovery, and creating collaborative services and support to meet those needs. This concept may include innovative approaches to services based on individual needs, as well as progress toward the path to recovery.

As a result of the MHSA, the number of FSP clients served throughout the State has increased dramatically from approximately 300 in FY 2005/06 to over 31,000 in FY 2011/12. The proportion of children/youth, transition-age-youth, and older adults served through FSPs has trended up since passage of the MHSA. This trend suggests that the MHSA is supporting the expansion of services to these previously underserved populations. Recent MHSOAC evaluations of FSP programs underscore their utility and continued potential to improve functioning in severely mentally ill and emotionally disturbed individuals.

Prevention and Early Intervention (PEI)

Prior to the passage of Proposition 63 in 2004, there was no statewide support for individuals at risk for or showing early signs and symptoms of mental illness. Services were limited to people with the most serious mental illnesses, usually after a point of crisis—an approach that critics refer to as "fail first". With the passage of Proposition 63, California became the first state in the nation to make a significant, comprehensive, statewide commitment to prevention and early intervention, with 20% of MHSA funds dedicated to this purpose.

As noted previously, in FY 2011/12, a total of $318 million of MHSA funds were committed to PEI programs/activities by counties. Over 365,000 consumers at risk for, or with early onset of, mental illness were directly served by PEI programs in that year across the state. Over 76% of counties are serving individuals at risk of a serious mental illness (prevention) and almost 69% are serving individuals with early onset of a mental illness (early intervention).

Approximately 71% of counties are offering other PEI activities specified within the MHSA that focus on identifying people with a mental illness (or encouraging them to self-identify) and linking them to treatment. These include outreach to people who can recognize and respond to early signs of potentially disabling mental illness, improving timely access to services for members of underserved populations, increasing access to treatment (beyond early intervention) for individuals across the lifespan who already have a severe mental illness, and reducing stigma and discrimination that discourages individuals from seeking treatment. This 71% does not include local efforts toward achievement of these goals that are embedded into direct PEI services. Local and recent statewide efforts suggest that direct PEI services for individuals at risk of or showing early signs and symptoms of mental illness have resulted in achievement of MHSA goals.

MHSA PEI funds also support three statewide programs, administered by the California Mental Health Services Authority (CalMHSA): suicide prevention, stigma and discrimination reduction, and student mental health. These three projects are developing and testing best practices with potential statewide application. All three projects are being evaluated by the RAND Corporation.

5. How does the commission measure MHSA outcomes? Please briefly describe the types of data and information the commission receives from counties, the commission's recent data quality improvement efforts, as well as any areas for improvement or barriers to improving.

Per the Commission's statutory role to provide oversight of the MHSA and evaluate whether its goals are being achieved, the Commission focuses on the goals outlined in the Act and uses them

to define the primary evaluation outcomes. Those outcomes are currently measured in a variety of ways, depending on currently available data sources. Below is specific information about how the MHSOAC measures outcomes for specific MHSA components.

Outcomes for the Community Services and Supports (CSS) Component

The MHSOAC measures outcomes for the CSS component via a series of performance indicators. The use of performance indicators to assess and monitor central aspects of the publicly funded mental health service delivery system is consistent with national efforts used to support quality improvement and increase accountability. In essence, indicators provide measurements that speak to how well the mental health system is functioning and if stated goals are being achieved.

In 2010, the California Mental Health Planning Council (CMHPC), per their statutory role, approved a set of performance indicators[16] designed to measure outcomes at the individual and system levels in relation to MHSA funded programs and services within the CSS component. Indicators were based on currently available data that speaks to goals identified within the Act (e.g., reduced justice system involvement, improved physical and mental health, reduced homelessness, implement a recovery vision, increased employment and education). From these initial performance indicators, MHSOAC and CMHPC identified a core set of 12 "priority indicators" on which to begin data analysis and reporting. The "Priority Indicators Trends Reports"[17] completed in July of 2014 used these 12 priority indicators to illustrate the performance of MHSA-funded CSS programs over time at the State and county levels. This task was done using currently available data, which, due to the data quality limitations previously mentioned, limits the accuracy, recentness, and statewide-ness of the findings.

Types of Available CSS Data and Challenges with that Data

There are currently three statewide data sources that include specific information about people served through the MHSA and types of services received. Existing data sources include the Client Services Information (CSI) system, the Data Collection and Reporting (DCR) system, and the Consumer Perception Survey (CPS). A description of each of these data sources is provided below and includes the type of data collected and the process for collecting data. This information is followed by a description of DHCS and MHSOAC roles related to these data systems, as well as data limitations, challenges, and on-going opportunities for improvement.

Client Services Information (CSI) system was implemented by DMH in 1998 and designed to collect data on individuals served through the public mental health system in all 58 California counties. Management of the CSI system was transferred from DMH to State Hospitals in 2012 and then to DHCS in January of 2013. The CSI system is updated monthly with client level data for consumers of the CSS component. Counties are required to provide electronic data to DHCS for client demographics (e.g., race/ethnicity) and service characteristics (e.g., enrollment date) within 60 days of each monthly reporting period.

[16] The Performance Indicators proposal may be found at: http://www.dhcs.ca.gov/services/MH/Documents/PerformanceIndicatorProposal.pdf

[17] The Priority Indicators Trends Reports may be found at: http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/July/OAC_072414_4A_PriorityIndicatorsTrendsReport_UCLA.pdf

Data Collection and Reporting (DCR) system was implemented by DMH in 2006 and transferred to DHCS in January 2013. It maintains client level data from each county for all individuals participating in FSPs. Counties are required to collect outcome data for FSP participants at enrollment and throughout service engagement. This data must be submitted electronically to DHCS within 90 days of each monthly reporting period. Required information includes changes in residential status, employment, education, criminal justice system involvement, legal designations, and emergency interventions.

Consumer Perception Survey (CPS) is a semi-annual survey of California mental health consumers designed to gather information regarding access to services, satisfaction with services, individual changes in status, and quality of life measures. County mental health plans and their providers who receive federal block grant funds are required to collect data from a sample of individuals with "serious, persistent mental illness" who have received services for 60 days or more. The sample consists of individuals served in the public mental health system during a specific one week period twice a year. DHCS currently contracts with the California Institute for Behavioral Health Solutions to oversee the administration of this survey in all counties.

Unfortunately, each of these data systems presents significant challenges in the areas of quality, integrity, consistency, and timeliness. As previously mentioned, these data challenges have been documented by the MHSOAC and its evaluation partners in a number of reports[18], including a recent compilation of challenges with each of these systems that limit the Commission's ability to calculate priority indicators and use them for performance monitoring. The MHSOAC continues to work closely with DHCS to address data quality issues that negatively impact the Commission's ability to fully carry out its statutory oversight and accountability role.

Through its evaluation efforts using DHCS-owned data, as well as efforts spearheaded by MHSOAC to improve the DCR and CSI data, MHSOAC has identified several problems with these statewide data collection systems. The Commission's recent efforts (which use data from 2004/05 through 2011/12) have revealed several major issues with the data systems. These issues include: 1) consistency of the data submitted by counties to DHCS (e.g., there is a significant amount of data missing from all three systems, and some counties have not submitted any data for certain periods); 2) accuracy of the data submitted by counties to DHCS (e.g., some counties have been unable to correct data errors due to limitations of the DHCS-maintained infrastructure); 3) receipt of data that is useful for MHSOAC evaluation purposes (e.g., the current data systems do not provide information for all of the MHSA components, such as the PEI component, and do not include outcome data for all CSS clients/services); and 4) reliability of the data extracted and provided to MHSOAC (e.g., the MHSOAC has identified very significant differences between CSI data previously received from DMH and what was supposed to be the same CSI data obtained from DHCS). Until these issues are fully addressed, MHSOAC evaluation efforts that rely upon this data will result in limited, untimely, and non-comprehensive conclusions.

[18]The Data Quality Report may be found at: http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2013/Eval_PriorityIndicatorsWkgp_1209-1313_DataQualityReport.pdf

Outcomes for the Prevention and Early Intervention (PEI) Component

Because of the newness of PEI programs, there are no system-wide performance indicators for this component that have been established and adopted. However, the MHSA describes specific goals for PEI programs. The MHSOAC uses these goals as statewide outcomes that are intended to be achieved via county implementation of PEI efforts. Goals from the MHSA include the following:

- Improve timely access to services for underserved populations [WIC §5840(a)];
- Conduct outreach to families, employers, primary care health care providers, and others to recognize early signs of potentially severe and disabling mental illnesses [§5840(b)(1)];
- Create access and linkage to medically necessary care provided by county mental health programs [§5840(b)(2)];
- Reduce stigma and discrimination associated with being diagnosed or seeking mental health services by delivering PEI services in ways that promote access and acceptance for the diverse people of California who can benefit from them [§5840(b)(3) and (4)].

In addition, the Act lists seven negative outcomes associated with untreated mental illness that are intended to be addressed via MHSA: prolonged suffering, suicide, incarcerations, school failure or dropout, unemployment, homelessness, and removal of children from their homes. These outcomes and the MHSA goals listed above are used to define primary PEI outcomes.

Types of PEI Data Received from Counties and Challenges with that Data

The MHSOAC currently receives minimal data on PEI outcomes from counties via Annual Updates. The data that is received is highly variable across counties and fiscal years, and is often provided in narrative form rather than one that is amenable to easy analysis and statewide aggregation. Furthermore, not all counties are actively evaluating all of their PEI programs to assess their efficacy in achieving MHSA goals. The guidelines issued by DMH in 2008 only require the counties to evaluate one PEI program, although counties need to identify target MHSA outcomes for each of their PEI programs. These barriers have created challenges when trying to understand the utility of the PEI component to achieve MHSA goals across the state.

These challenges were highlighted in recent MHSOAC evaluations[19] of three groups or clusters of early intervention programs, which relied upon locally-collected data pertinent to MHSA goals. Limitations noted in this evaluation included inconsistent data collection methods across counties and programs, including variation in use of pre- and post-intervention measures, and variation in measures of consistent MHSA-defined outcomes. Although this evaluation demonstrated that counties appear to have an interest and be invested in using evaluation for quality improvement purposes within PEI programs (despite the lack of/minimal requirements to do so), counties would benefit greatly with guidance aimed at supporting their local evaluations and instilling practices that allow for rolling up of comparable county data to the statewide level.

[19] Reports on specific clusters of early intervention programs may be found at:
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/July/OAC_072414_5A_Cluster1.pdf
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/July/OAC_072414_5A_Cluster2.pdf
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/July/OAC_072414_5A_Cluster3.pdf

Commission's Recent Data Quality Improvement Efforts

The MHSOAC has invested significant resources (approximately $3 million as of 2014) to improve the quality and reliability of information collected by the CSI and DCR systems (e.g., provision of technical assistance to counties, identification of ongoing issues and possible solutions to address those issues, and implementation of fixes to the DCR data infrastructure). Recently, the MHSOAC initiated efforts to identify data needs and requirements within the CSS component and will pilot a system that incorporates all of those needs in 2015. The MHSOAC has also partnered with DHCS to develop and implement a new comprehensive statewide data system that includes mental health, including all MHSA components, and substance use disorders, and intends to provide funds for preliminary planning and development of this system, as well as funds for additional strengthening of the currently available systems, in coming years.

The current priority indicators are limited to measuring the impact of the CSS component and were not designed to assess other components such as PEI, Innovation, and WET. As outlined in the Evaluation Master Plan[20], the MHSOAC is working with the CMHPC and key stakeholders to modify/improve existing performance indicators and identify new indicators designed to provide a broader measure of the impact of MHSA and support quality improvement efforts at the state and local levels. Future performance monitoring will incorporate additional indicators that include community level indicators that assess the potential impact of the MHSA on California as a whole.

The proposed PEI regulations, which the Commission anticipates will be completed by January 2015, delineate specific requirements for measurement of PEI outcomes, data reporting, and evaluation of PEI services, and clearly state the timing of when such data reporting must be completed and submitted to the State. Thus, the proposed PEI Regulations will clarify what data reporting is necessary, and when and how often this data reporting must happen. Once adopted, the proposed PEI Regulations will establish a more standardized process through which the MHSOAC can obtain consistent data from all counties and use this data to evaluate the impact of the PEI component on mental health outcomes statewide. The proposed Regulations will facilitate consistency across counties' data reporting and clarify how specific types of services should be implemented and evaluated. The regulations will also set clear standards for reporting of basic information about PEI services.

With regard to evaluation, counties will be required by the proposed PEI regulations to provide explicit details about their ongoing evaluation methods and findings at least once every three years. In terms of outcomes, the PEI regulations will require that counties measure reduction of prolonged suffering for each PEI program that directly serves individuals. In cases where PEI programs are designed to impact other outcomes beyond prolonged suffering (e.g., suicide, incarcerations, homelessness, and removal of children from their homes), counties will be required to select, define, and measure appropriate indicators for these other outcomes.

By requiring the measurement of specific types of outcomes for each type of PEI program, and by establishing clear standards and timing for required data reporting and evaluation, the proposed PEI regulations will standardize counties' reporting of PEI data and greatly improve

[20] The Evaluation Master Plan may be found at:
http://www.mhsoac.ca.gov/Evaluations/docs/EvaluationMasterPlan_Final_040413.pdf

the MHSOAC's ability to conduct statewide evaluations of the PEI component. However, implementation of a new comprehensive statewide data collection and reporting system that includes PEI (and other MHSA components) and allows for relevant data to be submitted and received electronically would further strengthen this ability and more readily facilitate submission and collection of timely, accurate, and consistent data from all counties.

Barriers to Improvements

The MHSOAC has spearheaded many efforts to strengthen the data that is made available to the Commission,-which is relied upon to perform the Commission's statutory oversight and accountability role. Nonetheless, the Commission faces many challenges that may hinder the success and impact of these efforts. One primary challenge is limited resources for evaluation and data collection/reporting throughout the State. Limited resources exist at the State level to strengthen current data systems, or develop a new statewide data system. In addition, limited resources are available to counties to ensure that they can collect required data and accurately submit it to the State in a timely manner; if the State were to adopt a new system, counties would inevitably need resources to possibly update local systems to enable them to meet new State requirements, as well as resources to connect local systems to the State's new system.

Similarly, limited resources have generally been allocated for evaluation purposes. Although the MHSOAC's evaluation staff and budget have recently grown, these resources are seemingly small compared to the large goal that needs to be accomplished (i.e., completion of enough evaluation of the statewide public community-based mental health system that allows for a full and accurate understanding of the performance of this system and the ability to make changes when necessary to meet the goals of the Act). Counties have consistently shared similar struggles as they've attempted to respond to MHSOAC evaluation and data requests with limited time, money, and staff devoted to doing so. While some counties should be commended for their local evaluation and quality improvement efforts, other counties would likely benefit from support and guidance in these areas, as well as resources devoted to them.

Another primary challenge may stem from a lack of incentive to participate in and actively carry out meaningful evaluation and data collection efforts. It is not yet clear that all entities that make up and engage in the State's public mental health system understand the value of evaluation and how it can and should be used to improve the quality of services and systems. A common complaint is that funds allocated to evaluation may be better spent on actual services. The misunderstanding here is that evaluation can and should be used to identify what services should be funded, or what services should be revised, to better meet goals, including achievement of outcomes identified within the Act (e.g., improved health and recovery). Creating a culture that values evaluation and use of it for quality improvement purposes across the State—as well as provision of adequate resources to support this culture—may help motivate all appropriate entities to more readily engage in and support MHSOAC evaluation and data collection efforts.

Mental Health Services
Oversight & Accountability Commission

Duties/Responsibilities Set Forth in the Mental Health Services Act (MHSA)

(1) Ensure MHSA funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public (Uncodified Section 3(e) of MHSA)

(2) Approve County Innovation programs (WIC §5830(e))

(3) Oversee, review, provide training and technical assistance, accountability and evaluate state and local projects and programs supported by MHSA funds (WIC §5845(d)(6))

(4) Ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures (WIC §5892(d))

(5) Participate in joint state-county decision making process per §4061 for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system (WIC §5845(d)(7))

(6) Develop strategies to overcome stigma and discrimination (WIC §5845(d)(8))

(7) Advise Governor or Legislature regarding actions the state may take to improve care and services for people with mental illness (WIC §5845(d)(9))

(8) Refer to DCHS critical issues related to the performance of a county mental health program (WIC §5845(d)(10))

(9) Assist in providing technical assistance, in collaboration with DHCS and consultation with CMHDA, to accomplish the purposes of the Adult and Older Adult System of Care and Children System of Care (WIC §5845(d)(11))

(10) Work in collaboration with DHCS and CMHPC and in consultation with CMHDA in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including but not limited to the parts specifically listed in the MHSA. Heath and Human Services Agency has lead. (WIC §5845(d)(12))

(11) Adopt regulations for programs and expenditures for INN and PEI. DHCS regulations shall be consistent with the Commission's regulations. (WIC §5846(a),(b))

(12) Provide technical assistance to county mental health plan as needed to address concerns or recommendations of the Commission or when local programs could benefit from technical assistance for improvement of their plans (WIC §5846(c))

(13) Ensure perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations. (WIC §5846(d))

(14) Receive county three-year program and expenditure plan and annual updates adopted by county board of supervisors. (WIC §5847(a))

(15) Jointly with DHCS and in collaboration with CMHDA, establish performance outcomes for services of CSS and PEI (WIC §5848(c))

(16) To be consulted by DHCS in developing regulations (WIC §5898)

(17) To be consulted (along with CMHDA) by DHCS in developing and administering instructions for the Annual MHSA Revenue and Expenditure Report ("ARER") (WIC §5899(a))

(18) Receive ARER the purpose of which is specified in §5899(b) and (c). (WIC §5899(a))

(19) Serve as ex officio members of the CMHPC (WIC §5771.1)

(20) Assist in establishing a more effective means of ensuring that county performance complies with the MHSA (Uncodified Section 1(b) of AB 100)

Duties/Responsibilities Set Forth in non-MHSA statutes

(1) Investment in Mental Health Wellness Act of 2013: MHSOAC is to develop criteria, award, and administer Triage Personnel Grants (WIC §5848.5(e))

(2) EPSDT: DHCS in consultation with MHSOAC is to create a plan for a performance outcome system for EPSDT mental health services (WIC §14707.5)

(3) County reporting requirements: DHCS, in consultation with MHSOAC and CMHPC, is to develop reporting requirements for county mental health system which shall be uniform and simplified. These requirements shall provide comparability between counties in the reports (WIC § 5610(a))

(4) Information system: DHCS, in consultation with the Performance Outcome Committee, CMHPC, MHSOAC, and Health and Human Services Agency, shall develop uniform definitions and formats for a statewide nonduplicative client-based information system that includes all information necessary to meet federal mental health grant requirements and state and federal Medicaid reporting requirements as well as any other state requirements established by law. (WIC §5610(b))

(5) County Performance Contracts: County mental health systems shall provide reports and data to meet the information needs of the state. The 2012 amendment to this section added, that the county's action was to be "in consultation with CMHDA, DHCS, MHSOAC, CMHPC, and Health and Human Services Agency". (WIC §5664)

(6) Grants under Adult and Older Adult Mental Health System of Care: MHSOAC is a member of an advisory committee established by DHCS to identify specific performance measures for evaluating effectiveness of grants given under Adult and Older Adult Mental Health System of Care Act. (§5814) (Note: Even though this section was amended in 2012 to replace DMH with DHCS it is in conflict with WIC §5845(a) which states that the MHSOAC replaced this advisory committee.)

Performance Dashboard (updated 8/13/14)

August 2014

Mental Health Services
Oversight & Accountability Commission

Current MHSOAC Evaluation Contracts and Deliverables:

University Enterprises Inc. for California State University, Sacramento

DCR Data Quality and Corrections Plan

MHSOAC Staff: Keith Erselius

Active Dates: June 27, 2011 – October 31, 2014

Objective: Assess the quality of Full Service Partnership (FSP) data available via the Data Collections and Reporting (DCR) system and make recommendations for how to overcome problems and limitations. Information regarding the DCR obtained via interviews with State, county, provider, vendor, and stakeholder groups. Summarize issues and recommend potential solutions and best practices**.** Implement solutions as possible (e.g. webinars, onsite and regional trainings).

Status: To date, counties have been provided with user manuals, training opportunities, webinars, and data dictionaries, as well as tools to analyze data from the DCR. County specific reports and statewide DCR quality reports are still pending. Counties have verbally expressed their gratitude for this contact as it has had a profound impact on the way counties can access and analyze their DCR data.

Deliverable	Due Date*	Deliverable Cost	Status
#1.1 Data Dictionary: Draft	August 15, 2011	$27,711.00	Completed
#1.2 Data Dictionary: Final	October 17, 2011	$27,711.00	Completed
#2.1 User Manual Draft Chapters 1-4	October 17, 2011	$14,983.00	Completed
#2.2 User Manual Draft Chapters 5-8	November 21, 2011	$14,983.00	Completed
#2.3 User Manual Revised draft all Chapters	December 19, 2011	$14,983.00	Completed
#2.4 User Manual Final (digital due 1/17/12)	February 13, 2012	$14,983.00	Completed
#3.1 DCR Training Curriculum: Draft	February 13, 2012	$21,894.00	Completed
#3.2 DCR Training Curriculum: Final	April 2, 2012	$21,894.00	Completed

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

Performance Dashboard (updated 8/13/14)

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#4.1 DCR Training: Region 1	June 29, 2012	$8,500.00	Completed
#4.2 DCR Training: Region 2	June 29, 2012	$8,500.00	Completed
#4.3 DCR Training: Region 3	June 29, 2012	$8,500.00	Completed
#4.4 DCR Training: Region 4	June 29, 2012	$8,500.00	Completed
#5.1 Application Notes: Draft 1 & 2	March 5, 2012	$14,443.00	Completed
#5.2 Application Notes Final 1 &2 (digital due 4/5/12)	May 7, 2012	$14,443.00	Completed
#6.1 Data Quality Reports: County Level Draft	November 7, 2011	$20,771.00	Completed
#6.2 Data Quality Reports: County Level Draft	January 9, 2012	$20,771.00	Completed
#7.1 Report Template: Client Level Draft	December 19, 2011	$12,877.00	Completed
#7.2 Report Template: Client Level Final (digital 4/20/12)	May 21, 2012	$17,954.00	Completed
#8.1 Data Analysis Training Curriculum: Draft	March 20, 2012	$17,954.00	Completed
#8.2 Data Analysis Training Curriculum: Final	May 21, 2012	$17,954.00	Completed
#9.1 Data Analysis Training: Region1	June 29, 2012	$8,500.00	Completed
#9.2 Data Analysis Training: Region 2	June 29, 2012	$8,500.00	Completed
#9.3 Data Analysis Training: Region 3	June 29, 2012	$8,500.00	Completed
#9.4 Data Analysis Training: Region 4	June 29, 2012	$8,500.00	Completed
#10.1 e-Learning: Digital video of DCR Training	June 29, 2012	$500.00	Completed
#10.2 e-Learning: Digital Video of Data Analysis Training	June 29, 2012	$500.00	Completed
#11.1 Statewide Data Quality Improvement Webinar and FAQ's	May 15, 2012	$17,567	Completed

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

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#11.2 Statewide Data Quality Improvement Webinar and FAQ's	December 17, 2012	$17,566	Completed
#11.3 Statewide Data Quality Improvement Webinar and FAQ's	February 18, 2013	$17,566	Completed
#11.4 Statewide Data Quality Improvement Webinar and FAQ's	April 15, 2013	$17,566	Completed
#11.5 Statewide Data Quality Improvement Webinar and FAQ's	June 17, 2013	$17,566	Completed
#12 Statewide Data Quality Correction Plan for County Reporting Types	December 17, 2012	$75,400	Completed
#13 Statewide FSP Data Measures Training	September 16, 2013	$69,900	Completed
#14 County-Level DCR Data Quality Reports	December 16, 2013	$62,627	Completed
#15.1 Statewide DCR Data Quality Report: Draft	January 30,2014	$62,890	Completed
#15.2 Statewide DCR Data Quality Report: Final	March 15, 2014	$25,210	Completed
#16 State Data Correction and Cleaning Assistance to Counties for Improved DCR Data Quality	June 30, 2013	$186,388	Completed
#17 Provide a county-level FSP provider and program outcomes report for each county	March 31, 2014	$54,000	Completed
#18 Provide a statewide FSP program outcomes report	June 30, 2014	$49,000	Completed
#19 Program-, provider-, and partnership service coordinator-level report templates	October 15, 2014	$83,000	Pending
Total Contract Amount		$1,121,555	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

Performance Dashboard (updated 8/13/14)

August 2014

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, University of California, Davis			
Reducing Disparities in Access			
MHSOAC Staff: Ashley Mills **Active Dates**: June 25, 2012 – July 31, 2014 **Objective**: Using quantitative and qualitative approaches, evaluate the impact of the MHSA as well as state and local policies and practices on the disparities in access to, quality of, and outcomes of the public mental health system; focus on disparities based on age, gender, race, ethnicity and primary language. **Status**: All deliverables have been completed and the contract has ended.			
Deliverable	**Due Date***	**Deliverable Cost**	**Status**
#1 In Depth Quantitative Data Analysis of Trends in Priority Indicator(s) that Assess the Impact of the MHSA on Disparities			
#1ai Description of Analytic Plan for #1aii	**December 31, 2012**	**$36,716**	**Completed**
#1aii In-depth analysis of data	**December 31, 2013**	**$73,435**	**Completed**
#1b Summary of MHSA impact on reduction of disparities obtained through county-submitted information	**December 31, 2013**	**$55,075**	**Completed**
#1c Report on data sources, limitations and recommendations	**March 31, 2014**	**$18,358**	**Completed**
#2 Qualitative Analysis of Client and Family Member Perspectives Regarding the Impact of the MHSA on Disparities			
#2a Description of research design	**December 31, 2012**	**$37,950**	**Completed**
#2b Draft Analysis of findings for Stakeholder Input	**December 31, 2013**	**$94,875**	**Completed**
#2c Final Analysis of findings using participatory research	**March 31, 2014**	**$56,925**	**Completed**
#3 Final Report	**March 31, 2014**	**$26,666**	**Completed**
Total Contract Amount		**$400,000**	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

Performance Dashboard (updated 8/13/14)

August 2014

Mental Health Services
Oversight & Accountability Commission

Resource Development Associates (RDA)

Community Program Planning (CPP) Process Evaluation

MHSOAC Staff: Ashley Mills

Active Dates: April 1, 2013 – September 30, 2014

Objective: Evaluate the impact of county-level community program planning processes on MHSA outcomes using participatory research methods, and identify promising practices that can be incorporated into a curriculum and associated training and technical assistance. Work with a group of client stakeholders to design and carry out research methods, as well as develop the curriculum.

Status: Deliverable 5 (data analysis) consists of two documents; (1) a technical report and (2) a stakeholder report. Both documents have been received and are under the review of MHSOAC staff. The draft of Deliverable 6 (Final Report of Promising CPP Process Practices) has been received and the Contractor has received feedback from staff. The final document was submitted by the Contractor on July 31, 2014. The contract is scheduled to end on September 30, 2014.

Deliverable	Due Date*	Deliverable Cost	Status
#1 Report of Research Design and Data Collection Training Plan	July 31, 2013	$46,600	Completed
#2 Data Analytic Plan	September 30, 2013	$34,950	Completed
#3 Summary of Consultation Provided to Client Contractors re: CPP Process Inventory	March 31, 2014	$11,650	Completed
#4 Report of Other Public Community Planning Processes	November 30, 2013	$34,950	Completed
#5 Summary Report of Results from Data Analysis/Evaluation	May 31, 2014	$46,600	Under Review
#6 Final Report of Promising CPP Process Practices	July 31, 2014	$46,600	Under Review
#7 Summary of Consultation Provided to Client Contractors re: CPP Process	September 30, 2014	$11,650	Pending
Total Contract Amount		$233,000	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

Performance Dashboard (updated 8/13/14)

August 2014

Mental Health Services
Oversight & Accountability Commission

California Institute for Mental Health (CiMH)

Innovative Program Evaluations - Inventory, Evaluation, and Training/Technical Assistance

MHSOAC Staff: Celeste Doerr

Active Dates: June 2013 – May 31, 2016

Objectives: Perform an inventory and meta-level evaluation of the Innovative program evaluation activities that have been planned or carried out by counties. Based on information gleaned from this process, identify promising Innovation evaluation practices and needs for technical assistance at the county level. Develop and provide tools, training, and technical assistance to strengthen county ability to plan and conduct high quality Innovation evaluations. Identify policy recommendations related to the Innovation component. A contract amendment extended due dates, added funding, and revised deliverables to enable more extensive tools, training and technical assistance to counties.

Status: Based on the completed, approved research design (Deliverable 1), CiMH distributed to counties a Universe Verification Data Request, which is being used to identify Innovation programs and collect limited information about them. Responses to the Universe Verification Data Request were due August 8, 2014. All counties but one responded on time. Data will be accepted until August 15, 2014. Information from the Universe Verification Data request will be used in the Inventory of County-level Innovation Evaluations (Deliverable 2). A second data request will solicit more information about each program to be used in the Report of Evaluation Results and Promising Practices (Deliverable 3). A draft of the second data request is currently under review.

Deliverable	Due Date*	Deliverable Cost	Status
#1 Report of Proposed Inventory Method and Research/Evaluation Design	January 21, 2014	$29,631	Completed
#2 Inventory of County-level Innovation Evaluations	October 31, 2014	$98,771	Pending
#3 Report of Evaluation Results and Promising Practices	December 31, 2014	$19,754	Pending
#4 Report of Technical Assistance to Counties	April 30, 2016	$10,000	Pending

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

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#5 Report of Innovation Evaluation Policy Recommendations	February 28, 2015	$19,754	Pending
#6 Develop and Disseminate Tools and Resources to Counties	January 31, 2015	$19,631	Pending
#7 Develop and Deliver a Modular Training Curriculum to Counties	April 30, 2016	$50,000	Pending
Total Contract Amount		**$247,541**	

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Mental Health Data Alliance (MHDA)

CSI Data Quality Improvement Effort

MHSOAC Staff: Keith Erselius

Active Dates: June 15, 2013 – December 31, 2014

Objective: To provide counties with increased access to accurate and timely data though strengthening of the Client and Service Information (CSI) system, which collects data on all clients served via the Community Services and Support (CSS) component of the MHSA. Highlights of this contract include the following:

- Develop county-level CSI data quality reports and disseminate those reports to the counties
- Create statewide CSI data quality report that includes best collection/reporting practices
- Develop, and disseminate to counties, a tool to help counties independently analyze their own CSI data
- Create an information sharing link between CSI and DCR systems

Status: MHDA submitted Deliverable 4 on time. This contract has been amended to run through June 2015.

Deliverable	Due Date*	Deliverable Cost	Status
#1 Statewide data quality best practices plan	January 3, 2014	$58,000	Completed
#2 County-level data quality reports with basic CSI client information	February 28, 2014	$82,250	Completed
#3 CSI data submission file analysis tool	May 16, 2014	$46,000	Completed
#4 Statewide CSI data quality report	August 1, 2014	$76,250	Under Review
#5 Create a link between the DCR and CSI in order to provide diagnosis, GAF scores, and service types for DCR clients served (including final reports)	December 15, 2014	$88,000	Pending
#6 Provide reports on the effects of full service partnership programs on emergency mental health services for youth.	April 30, 2015	$0	Pending

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#7 CSI Submission File Analysis (SFA) Tool Enhancements	March 30, 2015	$64,000	Pending
#8 FSP EPLD Templates Enhancements to Support CSI Tool	March 30, 2015	$17,500	Pending
#9 Regional Trainings and Technical Assistance	June 30, 2015	$68,500	Pending
Total Contract Amount		$550,500	

The Regents of the University of California, University of California, San Diego (IA)

Evaluation of Methods for Engaging and Serving Transition Age Youth (TAY)

MHSOAC Staff: Sheridan Merritt

Active Dates: May 1, 2014 to June 30, 2016

Objective: Identify, describe, and assess outreach/engagement strategies and services that have been or are being offered for TAY throughout the State, and promote continued identification and adoption of effective support (i.e., services, strategies, programs, systems) that promotes positive outcomes in transition-age youth (TAY) with mental health needs, including recovery and resilience.

Status: The report of proposed research design was submitted and approved in June 2014. The evaluators are currently making revisions to the proposed data collection instruments based on stakeholder feedback and will begin data collection later this Summer.

Deliverable	Due Date*	Deliverable Cost	Status
#1 Report of Proposed Research Design	June 1, 2014	$100,000	Completed
#2 Report of Research Findings	March 1, 2015	$150,000	Pending
#3 Report of Recommended Evaluation and Quality Improvement Methods	May 1, 2015	$50,000	Pending
#4 Identify, Develop, and Provide Technical Assistance to Counties			

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#4a Report Describing Proposed Methods to Complete Work Outlined in Exhibit A Section 3.C.vi	May 1, 2015	$50,000	Pending
#4b Report Describing Completion of Work Outlined in Exhibit A Section 3.C.vi	March 1, 2016	$100,000	Pending
#5 Report of TAY Policy Recommendations	April 1, 2016	$50,000	Pending
Total Contract Amount		$500,000	

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The Regents of the University of California, University of California, San Diego
Community Services and Supports (CSS) Tracking, Monitoring, and Evaluation System

MHSOAC Staff: Keith Erselius

Active Dates: ~May 15, 2014 – June 30, 2016

Objective: Development and implementation of a tracking, monitoring, and evaluation system for adults receiving services via CSS that allows for evaluation of those clients and services. The ultimate goal of this project will be to contribute to our ability to understand and improve upon the quality of services offered via the CSS component and the statewide system that supports these services.

- Pilot data and outcomes system with select counties and providers to evaluate the feasibility of expanding the system statewide
- Inform policy and practices regarding a data collection system that could potentially expand to all MHSA components

Status: The MHSOAC has entered into a contract with The Regents of the University of California, University of California, San Diego to complete this work. Currently the contractor is working towards the completion of the first two deliverables and has begun meeting with an Evaluation Advisory Group.

Deliverable	Due Date*	Deliverable Cost	Status
#1 Report of Proposed Tracking, Monitoring, and Evaluation System for Adults Receiving Services within the CSS Component	**January 19, 2015**	**$144,639**	**Pending**
#2 Report of Proposed Implementation Plan to Pilot the Tracking, Monitoring, and Evaluation System in a Sample of Providers/Counties	**January 19, 2015**	**$104,458**	**Pending**
#3 Report of Proposed Research Design and Analytic Plan to Evaluate the Efficacy of CSS Services for Clients in Less Comprehensive Services than Full Service Partnerships	**April 6, 2015**	**$104,458**	**Pending**
#4 Report of Evaluation Results	**March 4, 2016**	**$203,554**	**Pending**

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#5 Report of Policy and Practice Recommendations for How to Improve Upon Current CSS Services, Evaluations, and Systems	**March 4, 2016**	**$139,277**	**Pending**
Total Contract Amount		**$696,386**	

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Ongoing MHSOAC Internal Evaluation Projects:

MHSOAC Evaluation Unit		
Tracking and Monitoring of MHSA Programs and Activities via Plans, Updates, and Expenditure Reports		
MHSOAC Staff: Celeste Doerr, Keith Erselius **Active Dates**: December 2013 – December 2014 **Objectives**: Develop and implement a system for extracting and utilizing information of interest for tracking and monitoring MHSA program activities and outcomes for FY 2011/12 and 2012/13 from Annual Updates, Three-Year Plans, and Annual Revenue and Expenditure Reports. Consider what additional information may be useful to capture via the reporting process. **Status**: A Database has been created in which Annual Update, Three-Year Plan, and Annual Revenue and Expenditure Report information is being entered.		
Work Effort or Product	**Due Date**	**Status**
#1 Determine State needs for information that is currently provided within reports	**March 31, 2014**	**Completed**
#2 Develop system for extracting and cataloging State's data needs	**April 30, 2014**	**Completed**
#3 List of recommended data elements	**June 16, 2014**	**Completed**
#4 Complete construction of tables	**August 15, 2014**	**Completed**
#5 Test database functionality	**August 22, 2014**	**Pending**
# 6 Complete construction of quires and forms	**October 31, 2014**	**Pending**
#7 Use system to extract and catalog data needed by State for FY 2012/13	**October 31, 2014**	**Pending**
#8 Data quality check	**October 31, 2014**	**Pending**

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MHSOAC Evaluation Unit
Community Forums

MHSOAC Staff: Celeste Doerr, Brian Geary

Active Dates: December 2013 – December 2014

Objectives: Strengthen current data collection methods used to summarize what is learned at the Community Forums.

Status: Evaluation staff developed a new questionnaire, facilitator's guide, and scribes' guide. Staff recommended a scribes' reference sheet to be used in the meetings. Draft questionnaire was submitted to Community Forum Workgroup for feedback on June 16, 2014. Changes were made based on Workgroup feedback. Pilot testing is scheduled for August 20, 2014.

Work Effort or Product	Due Date	Status
# 1 Identify Program Unit goals	December 12, 2013	Completed
# 2 Develop plan to strengthen data, meet data-related goals, and preserve process-related value	December 20, 2013	Completed
# 3 Revise questionnaire, Scribes' Guide, Facilitators' Guide	March 30, 2014	Completed
# 4 Present to Commissioners Wooton and Nelson for feedback	April 15, 2014	Completed
# 5 Finalize second-round revisions to materials	May 30, 2014	Completed
# 6 Present to Community Forum Workgroup for feedback	June 19, 2014	Completed
# 7 Pilot test questionnaire	August 21, 2014	Pending

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MHSOAC Evaluation Unit
MHSA Performance Monitoring

MHSOAC Staff: Sheridan Merritt

Active Dates: On-Going

Objective: Implement a process and system for monitoring and reporting on individual- and system-level indicators designed to measure the impact of MHSA funded programs at the State and county level.

Status: The MHSA statewide evaluation recently completed by UCLA provided the foundation for a system of ongoing performance monitoring. In future years, this work will be performed internally by MHSOAC staff. The MHSOAC is currently in the process of expanding its internal data management capacity to support this effort.

Work Effort or Product	Due Date	Status
#1 Secure HIPAA compliance for MHSOAC staff and information systems to allow for the secure storage and analysis of client-level data	**October 1, 2014**	**Pending**
#2 Develop process for adding additional client-, system- and community-level indicators (Step 2)	**December 31, 2014**	**Pending**
#3 Yearly report of Mental Health System Performance for FY 12/13	**June 30, 2015**	**Pending**
#4 Incorporate items from other workgroups in performance monitoring (Step 3)	**June 30, 2015**	**Pending**
#5 Incorporate specific indicators for MHSA components beyond CSS (i.e. PEI, INN, TN WET) (Step 4)	**TBD**	**Pending**
#6 Incorporate community-level indicators in performance monitoring (Step 5)	**TBD**	**Pending**

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#7 Incorporate additional general indicators (Step 6)	**TBD**	**Pending**
#8 Add indicators that measure change over time for individual consumers (Step 7)	**TBD**	**Pending**

MHSOAC Evaluation Unit

Collect, Summarize, and Publicize Outcomes From County Evaluations of the CSS Component

MHSOAC Staff: Celeste Doerr, Carrie Masten

Active Dates: January 2014 – October 2014

Objectives: Collect, summarize, and publicize evaluations that counties have completed on the CSS component. Focus on fiscal years 2011/12 and 2012/13.

Status: MHSOAC Staff developed a method to obtain information from counties about completed CSS evaluations. Staff solicited and incorporated input from counties on the survey methodology. Individualized data requests were disseminated to counties February 14, 2014. All completed surveys and reports of local evaluations were returned to the MHSOAC by June 30, 2014. Information from the surveys and reports is currently being compiled for analysis.

Work Effort or Product	Due Date	Status
#1 Develop methodology to collect information from counties on completed evaluations of the CSS component	**February 15, 2014**	**Completed**
#2 Collect data/information from counties	**June 30, 2014**	**Completed**
#3 Conduct review of data and documents received from counties and extract relevant information as needed	**August 30, 2014**	**Pending**
#4 Written report that summarizes and synthesizes county evaluations of the CSS component completed in FY 2011/12 and 2012/13	**October 31, 2014**	**Pending**

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MHSOAC Evaluation Unit

PEI evaluation strengthening; collect, summarize, and publicize completed PEI evaluations

MHSOAC Staff: Ashley Mills, Carrie Masten

Active Dates: January 2014 – December 2014

Objectives:

- Determine status of county efforts to evaluate one PEI project; make recommendations as needed to ensure adequate evaluations. Focus on fiscal year 2012/13.
- Collect, summarize, and publicize PEI evaluations that counties have completed. Focus on fiscal year 2012/13.

The developed survey instruments were disseminated to the counties (Mental Health Directors and MHSA Coordinators) on February 14, 2014. All completed survey instruments and local evaluation reports were returned to the MHSOAC by June 30, 2014. Information is currently being complied for analysis.

Work Effort or Product	Due Date	Status
#1 Develop methodology to collect information from counties on completed evaluations of the PEI component and evaluation methods used	**February 15, 2014**	**Completed**
#2 Collect data/information from counties on completed PEI evaluations and evaluation methods	**June 30, 2014**	**Completed**
#3 Conduct review of data and documents received from counties and extract relevant information as needed	**August 30, 2014**	**Pending**
#4 Written report that summarizes and synthesizes county evaluations of the PEI component completed in FY 2012/13	**October 31, 2014**	**Pending**
#5 Written report that provides recommendations for how to help strengthen county PEI evaluations and implementation plan	**November 30, 2014**	**Pending**

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Forthcoming MHSOAC Evaluation Contracts:

The Regents of the University of California, University of California, Davis
Early Psychosis Evaluation
MHSOAC Staff: Ashley Mills **Active Dates**: ~September 1, 2014 - Not to exceed June 30, 2017 **Objective**: To determine the costs and cost benefits to providing early psychosis programs. This evaluation will use the data from the Early Diagnosis and Preventative Treatment of Psychosis Illness (SacEDAPT) program in Sacramento County to pilot a method to calculate the costs and cost benefits associated with providing the SacEDAPT program. The evaluation will also develop and implement a method for identifying and describing all early psychosis programs throughout the State, to include specifically, for example, the data elements that are collected by these programs and the various ways in which they are collected (i.e., via Electronic Health Records or EHRs); data elements will be used to provide insight regarding capacity to assess costs and cost benefits for early psychosis programs statewide, as well as methods to use during the Sacramento County pilot. Ultimately, this project will build the foundation for a forthcoming statewide evaluation that aims to demonstrate the benefits associated with providing treatment to individuals experiencing signs and symptoms of early psychosis, including benefits experienced by clients (e.g., improving quality of life) and society at large (e.g., cost savings). **Status**: MHSOAC staff is working with the contractors to develop a scope of work, budget, and deliverables for this contract. The contract is scheduled to be executed on September 1, 2014.

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Contractor TBD via RFP

Recovery Orientation Evaluation (RFP currently released; Proposal due September 5, 2014

MHSOAC Staff: Ashley Mills

Active Dates: ~November 1, 2014 – Not to exceed June 30, 2017

Objectives:

1. To identify, describe, and assess existing measures and methods of evaluating the recovery orientation of programs and services with the goal of providing recommendations and resources to providers, counties, and the State regarding the most optimal measures and methods to use for evaluating recovery orientation;

2. To conduct an evaluation of the recovery orientation of direct and indirect services/programs provided within the CSS component (focused on the adult system of care) that will achieve the following:

    a. Describe the extent to which CSS component programs/services are using recovery orientated approaches and attaining the MHSA value of offering recovery oriented programs/services;

    b. Identify predictors (e.g., types and characteristics of training, staff, programs, services) that promote and encourage recovery orientation; and

    c. Identify client-level outcomes (e.g., individual mental health status and recovery, individual functioning) that result from program/service recovery orientation or predictors of recovery orientation;

3. To use results from the evaluation to provide recommendations to providers, counties, and the State for achievement/promotion of recovery orientation in programs/services, as well as recovery and wellness of the clients that are served via these programs/services.

Status: The Request for Proposal (RFP) was posted for bid on June 30, 2014, and proposals are due September 5, 2014. An external contractor will be selected in the Fall of 2014 through a competitive bidding process with an anticipated contract start date of November 1, 2014.

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Contractor TBD
Full Service Partnership (FSP) Classification Project
MHSOAC Staff: Keith Erselius **Active Dates**: October 2014 – Not to exceed June 30, 2017 **Objective**: Explore the feasibility of classifying FSP programs in a meaningful and useful fashion. **Status**: Evaluation planning will begin in the Fall of 2014.

Contractor TBD via Request for Proposals (RFP)
Determine Effectiveness of Selected MHSA Programs for Older Adults (RFP to be Released in Fall of 2014)
MHSOAC Staff: Sheridan Merritt **Active Dates: ~January 2015 to June 30, 2017** **Objective:** Through this effort, MHSOAC will evaluate the effectiveness of county-led programs to improve outcomes for older adults with mental health needs, support quality improvement efforts for existing programs, and identify best practices and promising programs for expansion to underserved communities. **Status:** Evaluation planning began in early 2014. The scope of work and associated deliverables will be developed along with the RFP. An external contractor will be selected in the Fall of 2014 through a competitive bidding process with an anticipated contract start date of January 1, 2015.

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