

MHSA Outcomes Workgroup Recommendations



MHSA Outcomes Workgroup Overview

The Mental Health Services Act (MHSA) has provided a dedicated source of funding to transform behavioral health systems. Intended goals are defined in the legislation and include access, equity, prevention and quality of life outcomes such as education, employment, housing, justice system involvement, recovery, and mental health. San Mateo County Behavioral Health and Recovery Services (BHRS) is committed to develop ongoing data collection and reporting frameworks for MHSA-funded programs and services. The purpose of this workgroup was to provide insights and recommendations to improve the measurement and reporting of outcomes for direct outpatient treatment and recovery services funded by the MHSA Community Services and Supports (CSS) – General System Development and Outreach and Engagement (O&E) service categories. As BHRS transitions MHSA to Proposition 1 – Behavioral Health Services Act (BHSA), the recommendations of this workgroup will inform overall BHRS data collection and reporting infrastructures, regardless of the funding source.

SMC BHRS in collaboration with the American Institutes of Research (AIR), convened three meetings with the working group with the overall goal of improving process of measuring and reporting on outcomes from these direct treatment programs. Exhibit 1 describes the objectives of this workgroup.

In this document, we first present the updated recommended definitions of all indicators based on input from the workgroup (Exhibit 2). We also discuss recommendations from the workgroup on improving data collection and reporting of the indicators (Exhibit 3).

Indicator Definitions

In this section, we present the recommended definitions of the nine indicators that will be used to assess the impact of the direct treatment programs (Exhibit 2).

Overall, the workgroup suggested a need to focus definitions to holistic, person-centered measures of connection, wellbeing, and resilience, while also recognizing the challenges of data collection and system constraints. The workgroup discussed focusing on strength-based indicators (through social or person-centered approaches) versus deficit-based, crisis-focused indicators (through current medical models). In addition, they recommended looking at the interconnectedness among these indicators as these indicators do not work in isolation, and one or more indicators may influence the outcomes of others (for example, housing may have an impact on criminal justice, or emergency utilization).

Exhibit 1: Objectives of the Workgroup

- *Develop a standardized framework for reporting on the outcomes of direct treatment programs funded by MHSA.*
 - *Identify and define key indicators that capture behavioral health outcomes of clients in a meaningful and accessible manner.*
 - *Discuss strategies for improving both the data collected and reporting of key indicators.*
-

Exhibit 2: Recommended Indicator Definitions Based on Workgroup Input

Indicator	Recommended Definitions (As Relevant to the Program or Services Provided)
Emergency Utilization	The frequency and reasons for clients' use of emergency services, including emergency room care, psychiatric emergency care, and urgent care. This measure will indicate the impact on reducing crisis experiences and promoting overall wellbeing.
Employment	Clients' employment experience, including gaining and retaining, the types of jobs that are fulfilling and improve their well-being. This measure will assess how job readiness is supported by the program and clients' job satisfaction.
Individual Goals Met	The extent to which clients make progress toward their self-identified personal goals, reflecting success in supporting clients' individual aspirations.
Housing	The stability and quality of clients' housing experiences, including access to secure, stable, and adequate housing. This measure reflects how clients are supported in accessing processes and tools (e.g. housing assistance) to reduce the risk of homelessness and how the program improves access to stable, affordable, and adequate housing.
Connection	The strength and quality of clients' social connections and support networks—including engagement in community activities, sense of connectedness with their community, and feelings of belonging to their community—reflecting how meaningful relationships and social inclusion are fostered.
Criminal Justice	Clients' experiences with the criminal justice system—including encounters such as arrests, incarcerations, and legal challenges—reflecting effectiveness in reducing criminal justice system involvement.
Hospitalization	The number and frequency of clients' hospital admissions for physical and mental health care and their experience with care leading to improvement in wellbeing or addressing their unmet needs. This measure will reflect clients' improved ability to manage their health needs and outcomes to promote their overall wellbeing.
Substance Use	The change in clients' utilization (amount and frequency) of substances. This measure assesses effectiveness in supporting recovery and improving the quality of life of clients with substance use disorders to enhance their overall health and wellbeing.
Education	Clients' change in attaining educational achievements based on their goals. This measure would assess progress towards achieving clients' educational goals—including engagement in educational programs—and impact on enhancing educational outcomes and opportunities for clients.

Data Collection and Reporting

In this section, we present recommendations from the workgroup participants on topics of data collection and reporting. We also list the action items and implementation plans based on these recommendations.

Exhibit 3: Recommendations for Data Collection and Reporting Based on Workgroup Input

Discussion	Summary of Recommendations	Action Items
<p>Strategies for improving data collection.</p>	<p>Workgroup members suggested developing integrated, accurate, cultural and trauma informed data collection processes that prioritize trust and empowerment of clients in their own care processes. Specific suggestions include:</p> <ul style="list-style-type: none"> • The need for culturally sensitive data collection practices, such as using the phrase “preferred language” rather than “primary language,” to respect clients’ cultural and personal identities. • The importance of empowering clients to have more control over the data collected about them. Workgroup suggested creating systems where clients can easily access and review their information. • The need for feedback loops and regular updates to definitions and data collection processes that evolve in response to changing behavioral health landscape, client needs and input. • The importance of having continuity in providers who serve clients so that they (clients) feel comfortable sharing their story with the same provider (or team of providers). • The need to develop infrastructure and data systems that allow all providers to have access to a 	<ol style="list-style-type: none"> 1. In collaboration with stakeholders (e.g. clients, providers) develop a trauma and culturally informed best practice data collection plan and tools that cover all indicators: <ul style="list-style-type: none"> • Implement strategies to get meaningful feedback from clients, providers and stakeholders throughout the process of data collection, reporting and dissemination. • Develop and implement qualitative data collection tools (e.g., patient surveys, interview and focus group protocols) to capture clients’ experience and engagement with a program. • Provide program staff with tailored implementation and technical assistance support. • Establish feedback loops with clients and program staff to get their input on data collection processes. • Share and disseminate results of data collection with clients and partner agencies. 2. Review the cadence of data collection processes: <ul style="list-style-type: none"> • Identify the optimal intervals for data collection once the baseline has been established.

	<p>client’s complete health history, preventing clients from having to repeatedly share their story. The need for mechanisms to trigger automatic reporting and allow for the collection of data across systems (e.g., transition to Epic) to better track client progress, especially for clients who receive services from multiple providers.</p> <ul style="list-style-type: none"> • The workgroup discussed the importance of capturing what engagement means from the clients’ perspective. The workgroup suggested developing processes to get clients’ perspective on measuring and reporting engagement. <p>The group discussed that the data collection process must remain flexible and adaptable to changing circumstances. Workgroup stressed the importance of continuous feedback loops, allowing for iterative revisions to the data collection methods.</p>	<ul style="list-style-type: none"> • Assess the optimal frequency of data collection and develop a plan for continuous improvement. <p>3. Integrate the County’s <i>“Inclusive Language Guidelines”</i> into data collection processes. Programs can:</p> <ul style="list-style-type: none"> • Incorporate <i>“Inclusive Language Guidelines”</i> into all qualitative data collection tools (e.g. patient surveys, interviews and focus groups). • Check if existing secondary data collection methods include options from the <i>“Inclusive Language Guidelines.”</i> If necessary, consider adding new categories or modifying existing ones to better capture diverse identities.
<p>Strategies for improving reporting of outcomes.</p>	<p>Workgroup members highlighted the need to refine outcome reporting processes, with particular emphasis on ensuring clarity, accurate representation, and flexibility in data management.</p> <ul style="list-style-type: none"> • The need for clarity on the purpose of the reporting; what are “good” outcomes, what are key performance indicators, and how the data should be utilized for continuous improvements. • Instead of simply reporting goal completion rates, the workgroup highlighted the importance of exploring the reasons behind these outcomes. • The group suggested that progress towards goals should be framed in a way that considers 	<p>1. Improve reporting of program outcomes:</p> <ul style="list-style-type: none"> • Include a section in all BHRS reports that provides the purpose of the report and explains how the required performance indicators and goals align with this purpose. • Include narrative insights as well as qualitative data on clients’ perspectives on engagement and program effectiveness. • Provide narrative context with all data tables and charts that include provider and client feedback and the reasons behind the outcomes. <p>2. Report referral data and goal completion data separately.</p>

participants' unique circumstances, ensuring that they are both meaningful and achievable.

- The workgroup recommended analyzing referral data separate from goal completion data for a better insight into how clients are progressing both quantitatively and qualitatively through different stages of engagement and program effectiveness, which would help to identify areas in need of improvement.
- Workgroup emphasized the need for close collaboration with providers to ensure that outcomes are not only correctly understood but also appropriately utilized.

3. Incorporate stakeholder input on interpretation of findings before finalizing the report:

- Ensure appropriate interpretation of the results, develop processes to gather input from providers, clients and other stakeholders on results and conclusions before finalizing the report.

4. Develop best practices around utilization of results for continuous improvement:

- Consider providing technical assistance (e.g., coaching on how to use results of data analysis) to providers based on results of the report.
- Use the results of data analysis to improve client engagement.