Data Collection and Reporting (DCR) Recommendations Memorandum

October 2021

Executive Summary

As part of the Multi-County Full Service Partnership (FSP) Innovation Project (the "Project"), stakeholders expressed a desire to advocate for meaningful changes to the Data Collection and Reporting (DCR) system to improve the user experience. After engaging with FSP providers and behavioral health agencies, feedback on the system has been compiled into actionable recommendations. These recommendations serve as the basis of this memorandum and are organized into three categories: (i) training and technical assistance, (ii) communication support, and (iii) technical system enhancements. Counties request that the California Department of Health Care Services' (DHCS) prioritize implementing the near-term recommendations.

Section 1: Training and Technical Assistance (TA)

Context	Recommendations
● County and provider staff report receiving limited to no training on the DCR, and counties believe staff would benefit from more formal and centralized training and technical assistance. ● Due to the lack of formal system training, county staff and providers have adopted inconsistent data collection and reporting processes and norms, which can adversely impact data quality and impede tracking FSP consumer outcomes.	**Near-Term:** ● Publicize and build upon the existing DHCS Training Hub to create a comprehensive "one stop shop" for all FSP data needs. Examples of training topics include: ○ Practical use case scenarios to help counties troubleshoot challenges ○ Outcomes data extraction, reporting, and interpretation of results ● Hold regular webinars on these topics with live Q&A sessions. ● Provide a platform for counties to convene and connect with each other to share learnings on how to use data.

Section 2: Communication Support

Context	Recommendations
● County staff often do not know who to contact within DHCS for support services or urgent troubleshooting needs. ● Counties need DHCS to give final approval to authorize DCR user accounts for new behavioral health staff, but it often takes DHCS months to approve authorization, which delays critical reporting. ● County staff experience delayed response times overall from DHCS.	**Near-Term:** ● Establish a public central directory of DHCS staff members who serve as liaisons to clarify who county administrators should contact for different purposes. ● Provide counties with access to more administrative accounts to support various functions across different departments. ● Develop a new county support policy that requires DHCS liaisons to respond to email inquiries within a reasonable timeline.

Section 3: Technical System Enhancements

Context	Recommendations
• DCR users across the state have identified several technical systemic issues with the DCR that have resulted in the system being inflexible, outdated, and duplicative. • DCR users raised concerns about data quality, particularly with the KETs, which do not collect data at a regular interval and rely on information inconsistently self-reported by consumers. • The Comprehensive Behavioral Health Data Systems Project will streamline DCR data entry processes and has the potential to eventually address many of the DCR challenges. However, there are shorter-term recommendations that DHCS can take, separate from the Data Systems Project, to improve user experience. • Perspectives and input from DCR users on system attributes should be taken into consideration before procuring a new data system through the Data Systems Project.	**Near-Term:** • Revise the language on the DCR forms to be more recovery-oriented • Revise DCR forms to include additional text fields and consider the ability to pre-populate certain sections of the state reporting requirements • Revise the online DCR forms to match the re-formatted printed forms (completed by MHDA) which are more user friendly; • Revise the DCR forms to allow users to edit consumers' date of birth, merge duplicate forms, skip questions that are not relevant, and pre-populate basic demographic information. **Longer-Term:** • Reconsider the functions of the KETs and 3Ms, and instead consider one assessment at a regular interval that takes into account the workload burden of providers, but maintains a high standard of data quality. • Consider a new system with advanced API capabilities that could integrate with counties' existing EHR systems. • Implement a new ticketing system that sends automated acknowledgements of receipt of emailed requests to inquiring county administrators. • Continue efforts to collaborate with other state entities to create data sharing agreements in order to collect relevant consumer data to support outcomes reporting. • Collaborate with the Mental Health Oversight and Accountability Commission (MHSOAC) and county behavioral health agencies to form a recurring workgroup to streamline MHSA data reporting requirements for current and future data systems, as well as the reporting requirements for SB-465. • Collaborate with other state agencies to align how demographic fields are collected across different departments.

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Introduction & Overview

In January 2020, a cohort of six California county behavioral health departments in Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura embarked on a 4.5-year Multi-County Full Service Partnership (FSP) Innovation Project (the "Project") to identify data-driven best practices and improve FSP service delivery across California. Catalyzed by similar efforts by the Los Angeles County Department of Mental Health to transform their FSP programs, the Multi-County FSP Innovation Project aims to implement a uniform, data-driven approach that improves counties' capacity to use centralized data to enhance FSP services and outcomes. The Project is supported by numerous stakeholders, including Third Sector as the outcomes-focused technical assistance provider, the Mental Health Services Oversight and Accountability Commission (MHSOAC), California Mental Health Services Authority (CalMHSA) as the fiscal agent, and the RAND Corporation as the Project evaluator. This memorandum was drafted in close partnership with the County Behavioral Health Directors Association of California (CBHDA) and its members.

The ability to input, analyze, and report consumer data accurately and in a timely manner is critical to enhancing decision-making and improving consumer outcomes. Since the inception of the Project, FSP service providers and behavioral health administrators have expressed challenges with the capabilities of the Data Collection and Reporting (DCR) system and articulated a desire for an advocacy initiative to address these challenges. To thoroughly understand the behavioral health administrators' and providers' perspective, the Project counties launched a stakeholder engagement process over the summer of 2021 that involved surveying seventeen counties and convening over eighty FSP providers and program administrators from across the state to discuss their experiences and ideas for enhancing the accuracy and functionality of the DCR. The data collected through those forums has been compiled into actionable system improvement recommendations, which serve as the basis of this memorandum. The recommendations included herein can be organized into three categories: training and technical assistance (TA), communication support, and technical system enhancements.

The Multi-County FSP Innovation Project stakeholders are aware of DHCS's intentions to launch the Comprehensive Behavioral Health Data Systems Project (Data Systems Project) to modernize and streamline data reporting across the state's fourteen existing behavioral health data systems, including the DCR. Project stakeholders support the modernization effort and acknowledge that the Data Systems Project, once completed, may likely address several the systemic challenges identified by counties herein. Additionally, while the scope of this memo is focused on the DCR specifically, some of the recommendations offered are applicable to other data collection efforts currently conducted by DHCS. However, because the Data Systems Project will take several years to complete, this memo encourages DHCS to prioritize addressing the near-term recommendations related to training, technical assistance, and communication to enhance the utility of the DCR in the interim.

Concurrent to the writing of this memo, SB-465 was passed, requiring the MHSOAC to report FSP consumer outcomes to specified legislative committees, including any barriers to receiving the data and recommendations to strengthen California's use of full service partnerships to reduce incarceration, hospitalization, and homelessness. This memo will preview a number of these barriers, including the lack of consistent and accurate data reporting, and provide initial recommendations to begin to overcome them

Training and Technical Assistance

Behavioral health agencies require adequate training to be able to accurately monitor and analyze outcomes. Many counties believe they would benefit from additional training and technical assistance, as providers and clinic administrators shared that they had never been trained to use the DCR. County and provider staff often rely on informal peer coaching and the knowledge of long-time staff to learn the nuances of the DCR. When staff transition to new roles, leave the department, and/or retire, they take the technical knowledge of how to use the DCR with them. As a result, new staff teach themselves how to use the system, which delays data entry and reporting and leads to inconsistent application of the system. These variable processes adversely impact data quality and impede the tracking of FSP consumer outcomes.

DHCS is best positioned to provide counties with centralized training resources and technical assistance to improve users' knowledge and use of the DCR. In addition to more consistent and centralized training opportunities, counties would also benefit from direct and ongoing TA to support reporting outcomes to the state and using data reports to facilitate ongoing outcomes monitoring and continuous improvement. For example, while counties have access to real time data through other tools to make clinical treatment decisions, some still face major barriers to accessing timely outcomes data from the DCR. Furthermore, counties that are able to extract data may not all define and measure outcomes in the same way. This is a pivotal barrier to reporting on outcomes such as incarceration, hospitalization, and homelessness, as required by SB-465. The provision of ongoing training and TA from DHCS would position counties to better and more quickly track and monitor outcomes, thereby strengthening California's behavioral health system-wide capacity to enhance programs and scale positive FSP consumer outcomes.

Near-Term Training & Technical Assistance Recommendations

County staff articulated a desire for more in-person, video recorded, or live online training webinars that can be centrally accessed and shared with new staff as they onboard. Counties also expressed that it would be helpful to go "deep" into specific topics, in addition to trainings that give a broad overview of topics. Centralized training is integral to helping counties maintain consistent data entry, capacity for analyses, and system knowledge, given the high rates of turnover among behavioral health staff. These capabilities are important to address in the near-term, with the understanding that the Data Systems Project could result in the procurement of a new data reporting system in the future.

The Mental Health Data Alliance (MHDA), an external consultancy, has created accessible video training materials that are available on the DHCS Training Hub. DHCS should consider leveraging these training resources by proactively sharing and communicating these resources with counties. County behavioral health agencies ask that DHCS additionally build upon this resource and adopt the recommendations below to increase counties' data entry and reporting capacity before the end of 2022. DHCS should also prioritize the trainings that are critical for dismantling the barriers to collecting and reporting outcomes data.

1. Publicize and build upon the MHDA DHCS Training Hub to create an "FSP Playbook" to serve as a comprehensive "one stop shop" for all FSP data needs. This playbook should be made available to all roles that interact with FSP including data, clinical, IT, and administration teams in both XML and online counties.

a. The current DHCS Training Hub includes training on the following topics:
    i. 'FSP DCR User Training' to facilitate an introduction to the system;
    ii. 'EPLD Template Analysis Training' to help counties extract select data;
    iii. FSP 'DCR XML Administrator Training' to support XML counties on how the transfer of FSP data is completed and the accompanying rules surrounding the transfer; and
    iv. FSP 'DCR Administrator Training'
b. The FSP Playbook should add training videos on the topics below:
    i. Data entry and specific data elements, including a document that clarifies the differences between various FSP forms and the purpose behind each of the data elements;
    ii. Data qualification; and
    iii. Creation and interpretation of outcomes data reports
c. The FSP Playbook should include practical use case scenarios to help counties troubleshoot different challenges (e.g. how to look at missing 3Ms or other missing data, cleaning up past due forms, errors and other issues).
d. The FSP Playbook should also add a data dictionary or alternate resource that includes the shared FSP consumer population definitions that the Project counties have created over the course of the Project.

2. In addition to expanding the suite of MHDA training videos, institute quarterly technical assistance webinars on the topics above with opportunities for live question and answer sessions. Training resources should also include supplemental materials to accompany the webinars.
3. Provide a platform for counties to convene and connect with each other to share learnings on how to use data for continuous improvement purposes.

Communication Support

DHCS is the first point of contact for counties when they face challenges with the DCR. However, counties have found it to be increasingly challenging to reach DHCS representatives to request system access and routine support services in a timely manner. Counties have shared that they do not know who to contact any longer within DHCS for support services or urgent troubleshooting needs. One behavioral health staff member shared:

"We have a huge spreadsheet of all the Partnership Assessment Forms (PAF), Key Event Tracking Forms (KET) and the Quarterly Assessments (3M) that have been rejected...I don't even know who to contact to get troubleshooting assistance. It's a lot. It's a lot of work."

Many county staff report that they often do not receive timely responses from DHCS representatives even when they are able to identify a point of contact. For example, several counties described applying to become XML counties and waiting more than six months to receive an update regarding the status of their applications. In addition, county staff report needing DHCS to give final approval to authorize DCR user accounts for new behavioral health departmental staff, but it often takes DHCS months to approve authorization. One county administrator attempted to seek access by filling out the "County Approver Certification Form" in April 2021 and had still not received a response or confirmation of receipt of the request by June 2021. These delays in communicating approvals can create disruptions by hindering onboarding for new staff members and timely data entry and reporting. The consequences for the delay

in DCR access can have ripple effects by creating more reporting burden on providers. For example, when providers and county administrators do not have access to the DCR, they are unable to fill out state-required forms in the time that is required. This puts a greater burden on providers to backfill forms in chronological order once they receive access.

Counties recognize that DHCS has recently begun to create new processes to mitigate these communication challenges and to strengthen relationships with county MHSA coordinators. The Project stakeholders are encouraged by these efforts and are optimistic that DHCS will concretize the new processes and consider the below recommendations in the near future.

Near-Term Communication Support Recommendations

Based on feedback from California county FSP providers, program administrators, and county behavioral health agencies, Project stakeholders ask that DHCS leaders adopt the recommendations below to improve communication between counties and DHCS, and ultimately support more timely data reporting by March 2022.

1. Establish a public central directory of DHCS staff members who serve as county liaisons to clarify who county administrators should contact for specific business functions related to DCR access and functionality. The central directory and DHCS county liaisons should follow the guidelines below;
    a. This directory should address all aspects of DHCS contacts for counties, inclusive of other data reporting systems;
    b. This directory should include the email and phone numbers of liaisons;
    c. County liaisons should host quarterly meetings with their assigned counties to develop a deeper understanding of counties' user experiences and to create a dedicated space to troubleshoot issues; and
    d. County liaisons should have deep systems-level knowledge of the DCR to be best positioned to support their assigned counties. The directory should be updated regularly to reflect any changes in personnel
2. Provide counties with access to more administrative accounts to support functions across IT, research & evaluation, and program supervisors.
3. Develop a new county support policy that requires DHCS liaisons to respond to email inquiries from county administrators within a reasonable timeframe, such as five business days of receipt.

Technical System Enhancements

Behavioral health providers and administrators across the state identified several technical systemic issues with the DCR that have resulted in the system being inflexible, outdated, and duplicative. Many of these issues, such as the inability to edit dates of birth, or skip irrelevant questions, cause complications later in the process that require significant time to correct. These technical challenges, as well as the timing of the various data collection forms, result in a significant time burden on providers and county administrators.

Additionally, there are concerns about data quality within the current data collection process. These concerns stem from KETs, the form that collects information on major events in consumers' lives, such as changes in their housing status, involvement in the criminal legal system, or admissions into psychiatric hospitals. Since the KETs are not collected at a regular interval, the quality of the data relies on consumers to self-report that the event occurred. When a KET is absent from the system, it is impossible for providers to tell if there was no major event or if the consumer did not share the information. The use of the KETs, without validation from external data sources (e.g., hospitals, other government departments, etc.) is a major barrier to collecting accurate consumer data, particularly on psychiatric admissions. The KETs can also become burdensome on providers if there are multiple major events in one month, or if those events coincide with when the 3Ms are due. A streamlined and consistent data collection process would improve data quality and reduce the duplicativeness of the DCR forms. Additionally, efforts made at the state level to support validation with data available from other state entities such as those charged with housing and justice-involvement initiatives could significantly improve data quality.

The Comprehensive Behavioral Health Data Systems Project presents an ideal opportunity to address many of these challenges and partner with county behavioral health agencies to reimagine what a successful data collection and reporting system could entail. County FSP providers are on the front lines of DCR system utilization and have the deepest knowledge of which characteristics of the system are the most challenging, and conversely, which characteristics will be most conducive to their data reporting needs. In addition to the technical systemic challenges, throughout the various stakeholder convenings, counties expressed a desire for more collaboration and partnership with DHCS.

Near-Term Technical System Enhancement Recommendations

In the interim period before a new, enhanced data system is procured, DHCS should consider making several key technical enhancements to the DCR to immediately improve the system's functionality. Additionally, DHCS should also prioritize the system enhancements that will remove the barriers to sharing outcomes data with the state to satisfy the requirements of SB-465.

Project stakeholders urge DHCS to consider making the following enhancements to the DCR forms before the end of 2022:

1. Revise the language on the DCR forms to be more recovery-oriented. For example:
    a. Using strength-based rather than deficit-based language can help reduce stigma and build more trusting and honest relationships between consumers and providers;
    b. Consumers may benefit from more options in certain sections, such as questions about disability status, to cover a broader array of experiences and life circumstances;
2. Revise DCR forms to include additional text fields. Particularly when asking about consumers' place of residence, the ability to add text to clarify information would be important to understand the nuance of housing status;
3. Consider the ability to pre-populate certain sections of the state reporting requirements that are generally consistent across forms;
4. Revise the online DCR forms to match the re-formatted printed forms (completed by MHDA) which are more user friendly;
5. Revise the DCR forms to allow users greater flexibility to:
    a. Edit a consumer's date of birth;
    b. Merge duplicate forms into one existing form;

c. Allow persons entering data to be able to change dates after the form has been submitted, without re-entering or creating new forms or ID numbers;
d. Allow persons entering data to skip questions that are not relevant or have no changes from the last report entry, without generating the Validation reports;
e. Create fields that can pre-populate basic demographic information that doesn't change regularly (e.g., name, identification number, FSP program) and can transfer information across different forms;
f. Remove certain data elements that have become obsolete. (e.g. the data elements that ask whether a consumer participates in the AB2034 program, which was defunded many years ago); and
g. Remove DCR reporting in the EPLD templates that list missing 3Ms for dates after a consumer is closed or when they have a break in service.

Longer-Term Technical Enhancement Recommendations:

Counties and CBHDA recommend gathering feedback from a broad coalition of stakeholders, including providers, on which systemic features would be optimal to include in an upgraded system, regardless of which system is ultimately chosen.

1. Reconsider the functions of the KETs and 3Ms, and instead consider one assessment at a regular interval that considers the workload burden of providers, but maintains a high standard of data quality not reliant on consumers' memories;
2. Consider a new system with advanced API capabilities that could smoothly integrate with counties' existing EHR systems. This will streamline the data collection and reporting process and ensure that the two systems do not ask for the same information at different points in time;
3. Implement a new help-ticketing system that sends automated acknowledgements of receipt of emailed requests to inquiring county administrators to field technical issues, and improve communication;
4. Prioritize a new system that requires that reports include the Client Identification Number (CIN) with each record, rather than a separate global unique identifier ID (GUID). This will allow providers and counties to easily identify consumers within the KET and PAFs without running separate report queries;
5. As part of the Data Exchange Framework, DHCS should continue efforts to collaborate with other state and health care entities, such as public hospitals, emergency departments, jails, and housing authorities to create data sharing agreements in order to share relevant consumer data to support outcomes reporting across systems. Currently, the lack of comprehensive integrated data from outside systems hinders providers' and counties' ability to have a comprehensive picture of consumer's interactions with other entities, which is a major barrier to understanding and ultimately improving consumer outcomes;
6. DHCS and the MHSOAC, in collaboration with county behavioral health agencies, should form a recurring workgroup to streamline MHSA data reporting requirements for current and future data systems, particularly when forms are asking for similar information. For example, racial and ethnic categories should be the same for each reporting requirement and should be requested in a similar format.
7. DHCS and the MHSOAC, in coordination with county behavioral health agencies, should collaborate on the reporting requirements of SB-465 and consider a new data system that assesses the degree to which people who are most in need are accessing services/maintaining participation in FSP and incorporates information on consumers who have left FSP; and

8. DHCS should collaborate with other state agencies to align how demographic fields are collected across different departments, without losing any nuance from agencies with more robust demographic fields. For example, counties described the MHSA population data as containing sufficient nuance and detail to adequately describe consumers' gender identity, as well as adequate options to express cultural and ethnic identity. There are a few options for how to approach aligning demographic fields:
    a. DHCS could enhance the Client Services Information (CSI) system to match or roll up from the MHSA population data options; and/or
    b. Future data collection forms should match or roll up from the MHSA population data options.

Data Systems Project Pre-Procurement Process Recommendations:

Prior to the Multi-County FSP Innovation Project, counties were unable to compare data across jurisdictions, as each county defined and tracked consumer populations and outcomes differently. To address this challenge, Project counties collectively developed a consistent set of outcome measures to understand which services individuals enrolled in FSP are receiving and the success of those services. These measures were developed through a collaborative stakeholder engagement process which included over one hundred consumer interviews, a provider survey, monthly work group meetings with Project representatives, and input on evidence-based practices from a third party evaluator. Feedback from all stakeholders led to development of measures in five areas: (i) frequency and location of services, (ii) increased stable housing, (iii) decreased justice involvement, (iv) decreased psychiatric utilization, and (v) increased social connectedness. To accompany the outcome measures, Project counties also developed consistent definitions for individuals in six focal FSP populations: individuals experiencing and at risk of experiencing homelessness, individuals who are justice-involved and at risk of justice involvement, individuals who are high utilizers and at risk of utilizing psychiatric services. Consistent outcomes measurement and population definitions will be a crucial foundation to evaluate California's use of FSP to reduce incarceration, hospitalization, and homelessness statewide, as required by SB-465. More information on the Multi-County FSP Innovation Project can be found on Third Sector's website.

Building off the Project, stakeholders recommend the following approaches to gather feedback and recommendations on desired attributes of a successful future data system. The goal for this engagement is to elevate perspectives from the field and to consider such feedback when pursuing opportunities to enhance the DCR and when designing and/or procuring a new data system in the future.

1. Convene a recurring, bi-monthly workgroup with county representatives across the state to reimagine the role of an FSP data system, including re-designing the data collection forms and improving data reporting timelines and analysis functionality. This group should play a direct role in ensuring data collection and reporting processes in the new system are conducive to their needs and should work closely with DHCS to create accountability to push the recommendations forward.
2. Launch a survey and/or host a Learning Community Convening with FSP providers and behavioral health administrators from all 58 counties to solicit feedback on which technical features a successful data system should include in the future. Feedback from this survey should be incorporated into the DHCS's Data Systems Project efforts and into future pilot projects that focus on FSP data.
3. Build off the efforts of the Project counties to define consistent FSP population definitions and outcome measures as described above.

Conclusion

The Multi-County FSP Innovation Project counties appreciate the opportunity to partner with DHCS and reimagine a DCR system that can streamline data management processes and enable counties to improve FSP service delivery for California's highest-need consumers. The Project stakeholders hope to align these recommendations with the Data Systems Project, particularly with regards to the technical system enhancements recommendations. Additionally, Project stakeholders hope this memo will provide initial context and recommendations for reporting mandated by SB-465. This memorandum is endorsed by CBHDA and County Behavioral Health Departments across the state of California. The Multi-County FSP Project participants, CBHDA, and its represented partners hope executive leaders at DHCS strongly consider adopting the near-term recommendations over the next year, in addition to executing the Data Systems Project. Specifically, represented partners recommend prioritizing the communication and training and TA recommendations, while engaging with stakeholders and co-designing a successful future DCR system for the long-term. Project stakeholders look forward to the opportunity to collaborate with DHCS staff members and CBHDA over the coming months.

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