MHSA Recommendations: MHSA Governance			
MHSA Governance Findings: 1. Various Stakeholders within the County have confusion about their roles of various entities with responsibility for MHSA administration and advisement. 2. Role confusion has contributed to tension between various stakeholders, including reports of contentious meetings when presenting MHSA content. 3. Recent attempts to educate MHSA stakeholders on roles, responsibilities, and program requirements has had a positive impact and served to reduce recent challenges. 4. Despite these attempts, retention of information and understanding by lay persons of the often-complex financial reporting and ever-evolving policies at the state level related to MHSA will likely remain a challenge. This is further exacerbated by the changing membership of the BOS/BHAB (term limits)			
Recommendations	Response	MHSA Divisions/Manager	Notes/Timeline
Provide (or incorporate into existing curriculum) training for the BHAB and BOS members specific to roles (advisory vs. management) and responsibilities as a BHAB/BOS Board member, including an MHSA Overview and conflict of interest training, on recurring basis to assist with ongoing retention of information.	HCA agrees with this recommendation. A comprehensive training and overview of the BHAB roles and responsibilities is provided on, at minimum, an annual basis at the BHAB annual retreat. The MHSA office will provide additional training to BHAB members, as well as stakeholders to include an overview of MHSA, the roles of the Behavioral Health Advisory Board in the Community Planning Process, and the role of stakeholders. Additionally, the MSHA Office has incorporated an MHSA at a glance overview before each community planning meeting in 2022 and 2023 and will continue do so for all presentations to the BHAB. MHSA conducted a full “MHSA 101” at the July MHSA Planning Advisory Committee (PAC) meeting attended by several BHAB Members. The MHSA Office can offer an MHSA 101 training annually as part of the BHAB planning retreat, which all members attend for strategies, objectives and interests for the upcoming calendar year.	Michelle Smith Brad Hutchins	Recommendation has been completed. The training has been incorporated at the BHAB Retreat with everyone in attendance.
Make MHSA Overview training a component of HCA/MHRS new employee onboarding to ensure assimilation of program changes and updates at the state level, as well as general understanding of the role of MHSA has in the broader mission and responsibilities of MHRS.	MHSA Office agrees with this recommendation and will ensure inclusion in New Employee Orientation.	Michelle Smith Brad Hutchins	The recommendation is being implemented and will be completed by March 2024. March 2024 is when the New Employee Orientation process will be updated and implemented.

MHSA Recommendations: Community Planning Process			
1. The County of Orange CPP approach is currently in transition under new MHRS and MHSA leadership. Coming out of COVID-19 pandemic allowed the County to resume in-person engagements and also consider and incorporate lessons learned of how to effectively use virtual setting to expand access to feedback. 2. While a critique of historical approaches included a lack of engagement until much of the planning had already occurred, the current MHRS, MHSA and BHAB leadership have a vision of transforming the planning process to a continuous engagement activity. 3. Stakeholders noted they can see the vision and direction, but it has not yet fully been realized. It is important to note the current MHSA coordinator has been in the position less than one year; much of which was dedicated to the current MHSA Three-Year Program and Expenditure Plan, thus at the point of this review there was insufficient time for these changes to have been fully realized or to fully measure their impact.			
Recommendations	Response	MHSA Divisions/Manager	Notes/Timeline
Continue and expand plans to increase presence at regularly scheduled meetings in locations and times when key stakeholders are already gathering to ensure ongoing opportunities for participation and input into planning.	MHSA Office agrees with this recommendation. The MHSA Community Planning team continues to outreach and work with different members of the community to come to different scheduled meetings. Additionally, in the past year, the MHSA Office has made an emphasis on engaging with the members receiving direct services at the MHRS Clinics and Wellness Centers and has arranged for transportation and support for clients electing to engage in community planning activities. This has resulted in a 400% increase in participation in MHSA CPP meetings. CPP is an ongoing process that is grounded in continuous improvement. MHSA will continue to meet with additional populations, find ways to integrate key stakeholders, and hopes to have more meaningful engagements to further enhance CPP.	Michelle Smith Brad Hutchins	The recommendation has been implemented
Examine communication and outreach process to ensure it effectively reaches stakeholders for whom English is not their primary language.	MHSA agrees with the recommendation to expand outreach to additional interested participants from monolingual populations. The MHSA Office has continued to translate all important documents into threshold languages related to Community Planning (flyers, registrations). MHSA Office staff are working with the Ethnic Services Manager and the Behavioral Health Equity Committee (BHEC) to coordinate efforts and connect with diverse populations for planning efforts.	Michelle Smith Brad Hutchins Deanne Helmy	Recommendation is being implemented.
The presentation of the plan is comprehensive and provides an overview of the County's plans for the year. Consider adapting the presentation, or providing access to MHSA outcomes in other ways, to include a narrative for how the 3-year plan takes into account community needs and program impact. Making specific	MHSA Office agrees with the recommendation and continues to look at different ways to communicate and present outcomes while still adhering to health literacy standards. MHSA office continues to look revamping the HCA MHSA website to be a hub for information regarding program outcomes to help inform the community throughout the year, not just at publishing of MHSA plans. With the recent implementation of the Planning Advisory Committee (PAC), each meeting will focus on a different area of MHSA with a planning/input focus compared to more recent informative style. MHSA is looking to implement templates for how outcomes are presented for the community, the planning	Michelle Smith	Recommendation is being implemented and will be completed by May 2024.

connections with the data used to inform the program adjustments or additions proposed could help increase a sense of engagement from stakeholders, including consumers and BHAB/BOS members.	recommendations/answers to planning focused questions will be addressed on the MHSA website as well as at the next planning meeting to continuously update community to what is being recommended for program implementations/updates/focus. Members of the BHAB are always invited to and often attend PAC meetings and receive all emails sent out by MHSA.		

MHSA Recommendations: MHSA Contracting and Contract Oversight

1. Strong partnerships exist between the MHRS/MHSA Programs staff and HCA contract and procurement staff to support the MHSA contract management.
2. While partnerships are strong, county workforce shortages have impacted timeliness of procurement and contracting activities, despite recent successful performance improvement initiatives.
3. Implementation of new MHSA funded contracts within desired timeliness is also challenged by the lengthy procurement and contracting steps, and this has added risk to timely contracting and expenditure of MHSA funds.
4. Lack of vendor response to procurements has also increased risk to timely contracting and expenditure of MHSA funds.
5. Tension is created by requirement that the BOS provides approval of all contracts, and most contracts being up for renewal or execution at the same time; this is a tremendous amount of review for BOS members in a short timeframe while managing significant pressure and intent to be thorough in the review.
6. While corrective action plans are an existing tool for MHSA/MHSA contract monitoring, informal approaches through provider meetings are leveraged before formalizing action plans related to performance.

Recommendations	Response	MHSA Divisions/Manager	Notes/Timeline
To support thoughtful review and consumption of contract information, consider ways to spread contract renewals throughout fiscal years, including longer (than one FY) contract terms for established providers and programs; and consideration of thresholds for necessary review by BOS such as reviewing only renewals or amendments with new scopes of work, or above reasonable dollar threshold.	HCA agrees with this recommendation. HCA Procurement and Contract Services in collaboration with the Director's Office, developed a strategic plan for contract renewals and solicitations. Based on the County Contract Policy Manual (County Procurement Policy) which includes an initial 3-year term with an option to renew for an additional 2-year term before conducting another solicitation.	Michelle Smith Juan Corral	The recommendation has been implemented
Conduct a time-study to confirm timeframes associated with various steps in the procurement contracting process, as well as a review of county	HCA agrees with this recommendation. HCA Procurement and Contract Services specific time study conducted yearly. Timeframe is from service request to contract award; current average is 25 weeks. Time study and mapping of the process to be conducted in FY 23/24,	Juan Corral	The recommendation has not been implemented but will be completed by June 30, 2024

polices related to these activities to further identify human resources needed for timely execution,.	will continue to be used to evaluate an improve the procurement and contracting process in collaboration with the County Procurement Office and HCA Executive Leadership.		
Create standardized processes for maintaining a pipeline of potential programs by component area for rapid implementation should unexpected funding occur.	HCA Agrees with this recommendation. HCA Procurement and Contract Services will reach out to local jurisdictions to evaluate their processes in relation to MHSA vendors and determine if these are feasible with County Policy and any applicable government codes. Any deviation from currently Policy would require collaboration with County Counsel and County Procurement Office for review prior to any recommendations made. In addition, PCS has provided staff training on identifying potential co-operative contracting opportunities.	Juan Corral	The recommendation has been implemented. Improvement recommendations to be identified and shared with County Counsel and County Procurement Office by June 30, 2024.
Consider contracting a portion of MHSA funds under Master Agreements, where a preferred list of bidders is pre-approved bidding specific services, reducing the content required for response, as well as review and scoring those responses.	HCA partially agrees with this recommendation. HCA Procurement and Contract Services currently utilizes Master Agreements to increase the number of approved bidders. Will continue to utilize this approach, Master Services Agreements, and co-operative opportunities to help increase the number of approved bidders.	Juan Corral	The recommendation has been implemented
The timeline for this review did not allow for a thorough review of contract monitoring documentation for all programs; consider a review of these processes to further ensure provider accountability and strengthen the ability to respond to inquiries from the BHAB and or BOS. This should include formulizing the triggers and timelines associated with use of corrective action plans with providers to ensure standardization of application of this tool across programs, and inclusion with information share with the BOS during contract renewal periods.	HCA agrees with this recommendation. HCA Procurement & Contract Services has a Corrective Action Plan workflow that delineates triggers and a standardized process for handling issues related to performance. Additionally, HCA Procurement & Contract Services is currently working with HCA Programs to re-evaluate the contracts' performance objectives and formalize monitoring on an additional tab of the "Expenditures and Revenue" report document for monthly review and consideration.	Juan Corral	The recommendation has been implemented

While MHSA program timelines will continue to be a challenge, consider conducting a provider/vendor survey to inform an understanding of other barriers to provider network participation and potential changes to procurement/contract processes (or other barriers) that would allow the county to expand the provider pool.	HCA partially agrees with this recommendation. HCA Procurement & Contract Services has conducted provider/vendor surveys to understand the barriers to applying for and maintaining contracts with HCA to identify possibly efficiencies in the Procurement Process. To address concerns identified in the survey, HCA, in collaboration with the County Procurement Office, conducted two Learning Labs to educate current and potential providers on the Solicitation process. The purpose was to engage new providers and improve solicitation responses to enhance competition for MHSA funds. HCA will continue to identify opportunities to expand the provider pool which includes outreach and communication efforts.	Juan Corral	The recommendation has been implemented

MHSA Recommendations: Fiscal Administration

1. The County of Orange is compliant with current minimum reserve requirement and maximum limits
2. The current reserves represent only a fraction of the current MHSA funding for essential services, however this context is not widely understood be behavioral health advocates
3. The County of Orange MHSA program has not reverted funds back to the state since FY 2010-2011
4. While outside the scope of this review, interviews with stakeholders indicated the county may not be maximizing Medicaid funding for some CSS services provided to Medi-Cal enrollees.

Recommendations	Response	MHSA Divisions/Manager	Notes/Timeline
Conduct an analysis of contract provider applications of funding streams, such as Medi-Cal, to ensure the county is optimizing other available funding streams before applying MHSA funds	HCA partially agrees with this finding. Analysis of Medi-Cal revenue received is done throughout the Fiscal Year, and is reported in the MHSA Annual Revenue and Expense Report (RER). The RER is posted on the County MHSA website within 30 days of submission to the State. Stakeholders are notified of the posting.	Anthony Le	The recommendation has been implemented. Will emphasize Medi-Cal revenue earned and RER being posted when information is available.
Provide recurring education on MHSA funding cycles and history of reversion. Reversion of a County's MHSA funds is a matter of public record, include this historical information when sharing financials to ensure stakeholders have an accurate understanding of reversion history.	HCA partially agrees with this finding. We invite our Consultant for an annual presentation of MHSA to our Advisory Board and community. The presentation provides revenue projections for upcoming years as well as training and information on where MHSA funds come from, guidelines on its use, and explanation of reversion and prudent reserve. This ensures stakeholders have an understanding of these concepts. County of Orange has never had to send the State back reversion dollars nor had we had funds withheld due to reversion.	Anthony Le Julia Rinaldi Michelle Smith	The recommendation has been implemented. Will emphasize reversion information when presenting to advisory board.

Provide continued education on Prudent Reserve funding. HCA clearly outlines the reserve calculation and maximum and available reserves in the 2020-2023 Plan, as it is appropriate for the 5-year cycle. Include this information publicly facing expenditure reports and presentations as a reminder to stakeholders of the current reserve level.	HCA partially agrees with this finding. An HCA Consultant provides in depth annual presentations, which includes education about the Prudent Reserve, and the CEO Finance staff provide quarterly updates, which include information and education about the Prudent Reserve to our Advisory Board and community. The presentation provides revenue projections for upcoming years as well as training and information on where MHSA funds come from, guidelines on its use, and explanation of reversion and prudent reserve requirements. This ensures stakeholders have an understanding of these concepts including Prudent Reserve. In addition, the Prudent Reserve Calculation is included in the attachment section of the publicly posted MHSA Plan.	Anthony Le Julia Rinaldi	The recommendation has been implemented. Will emphasize Prudent Reserve information when presenting to advisory board.
Consider providing reserve information as an overall percentage of MHSA funding to provide context for the need for reserves.	HCA partially agrees with this finding. When we present Prudent Reserve information we will continue to provide education about the parameters of the law and can also identify the overall % as well as the balance amount.	Michelle Smith Anthony Le	The recommendation has been implemented. HCA will continue to include reference to the 33% Prudent Reserve cap as well as the dollar amount in future presentations.

MHSA Recommendations: Data Collection and Analytics A. Data Systems 1. Due to the challenge with utilization of multiple systems combined with varying levels of provider sophistication, the utility of data for informing MHSA programming priorities is currently limited. 2. MHRS is in the process of updating and consolidating systems to simplify processes for both the county and their contracted providers			
Recommendations	Response	MHSA Divisions/Manager	Notes/Timeline
Consolidate data systems to reduce the number of different places programs and providers need to log into for data collection and reporting.	HCA Agrees with this recommendation. The process of consolidating existing data systems was started by creating and distributing a data system inventorying survey to better understand databases currently utilized by MHRS programs and staff. Information gathered was used to develop a map of existing relational databases and plan for establishing a streamlined and comprehensive data repository that would reduce data entry burdens, decrease data extraction challenges, and improve the analytic capabilities both of their program and the Agency as a whole. As part of the survey, specific needs and requirements were gathered. Qualitative descriptions of the databases uncovered additional nuanced information. Documenting the unique features of each database allowed for more informed decisions when archiving and consolidating certain data systems. The primary systems identified for data collection are IRIS/Cerner (EHR), Chorus and Qualtrics, with the goal of eliminating MS Access databases and, to the greatest extent possible, Excel workbooks.	Sharon Ishikawa	The recommendation has not been fully implemented but will be completed by June 30, 2025. Chorus and Qualtrics, which are both cloud-based are being set up with Single Sign-On and multi-factor authentication to simplify and enhance secure access to these systems. WET programs have benefited from automated aggregation and dashboarding of post-training feedback surveys that are automatically emailed out to key program stakeholders on the first of

			each month. Over the next year, MHRS will work on expanding these efforts across additional programs.
Phase out outdated Microsoft products and migrate contracted providers into secure systems that are interoperable and allows provider to push data from their system to MHRS systems and avoid double entry of data.	HCA Agrees with this recommendation. Prevention and Early Intervention (PEI) and Crisis and Acute Care providers are being migrated out of MS Excel and Access and transitioned into secure cloud-based systems (Chorus, Qualtrics). The Agency is also working towards partnering with a health information exchange (HIE). Once established, the HIE will allow the contract providers to build data exchange interfaces that allow them to send required data to HCA as opposed to double data entry. This will comply with state and federal interoperability requirements that address data, privacy and security.	Sharon Ishikawa Adil Siddiqui	The recommendation has not been fully implemented but will be implemented by December 30, 2024. Currently, data are exported from Chorus into a sFTP and migrated into the County's Azure data lake through weekly jobs scheduled in Databricks. While the HIE is being established, MHRS data analytics and HCA IT staff are exploring setting up a partially manualized ETL process in which MHRS receives data exports from the provider's EHR, loads them into the County's Azure Databricks File Storage, and transforms and joins the provider datafields with HCA's IRIS data to monitor performance outcomes. Testing of this process is anticipated to begin in Q1 of CY 2024.
Consolidate and migrate to a small set of secure data systems to allow for ready audits and monitoring of data quality (both in terms of quantity as well as quality of data submitted).	HCA Agrees with this recommendation. MHRS is in the process of migrating to three main systems for collection of source data: Cerner/IRIS for client electronic health record information, Chorus for management of client referrals, linkages, calls, PEI cases, CARE Act implementation, etc., and Qualtrics for one-time survey data. Where possible, required fields, data validation rules, input masks, drop-down lists, etc. are included in electronic data entry forms to increase data quality. Data entered in and generated by IRIS and Chorus are loaded into Databricks for data handling and analytics and will ultimately be loaded into Tableau dashboards to monitor data quality, quantity and performance outcomes. In-app dashboards provide similar functions within Qualtrics.	Sharon Ishikawa	The recommendation has not been fully implemented but will be implemented by December 30, 2024. To increase the number of PEI program measures completed, outcome forms have been streamlined, having removed duplicative items and items that do not directly tie to program services and goals. Outcomes for CSS programs that bill Medi-Cal are tied to

Incorporate modern data tools (e.g. mobile friendly surveys) to facilitate timely and consistent data collection and encourage data collection at the point of care such as client experience of care or client reported outcomes.	HCA Agrees with this recommendation. Using Qualtrics and Chorus, MHRS creates mobile-friendly surveys and makes them available to clients through QR codes and electronic links. Paper versions are also available when the client does not have access to an electronic device or prefers to complete the form on paper.	Sharon Ishikawa Adil Siddiqui	The recommendation has not been fully implemented but will be implemented by December 30, 2024

MHSA Recommendations: Data Collection and Analytics B. Data Governance			
1. Historically, MHRS has lacked working centralized enterprise warehouse to collect and report data, leading to delays in reporting and higher than necessary administrative burden 2. MHRS has not had the necessary allocation of human resources to support a data driven organization or thoughtful approaches to MHSA program evaluation.			
Recommendations	Response	MHSA Divisions/Manager	Notes/Timeline
Develop a governance structure to support coordination and collaboration across MHRS units to optimize SME.	HCA Agrees with this recommendation. MHRS has reorganized into seven functional areas (i.e., Children and Youth Mental Health, Adult Mental Health, Substance Use Disorders, Crisis and Acute Care, Forensics, Quality Management Services and Data Analytics and Evaluation), as well as specialized supports managed through the Director's Office (i.e., MHSA Administration, BH Outreach and Engagement, grants, etc.). To support timely and effective coordination and collaboration, MHRS has established bi-weekly meetings with the Directors and bi-weekly meetings with MHRS Directors and Senior Managers on alternating weeks. All MHRS managers as well as HR, IT and Contracts attend monthly MHRS Operations meetings, and the Behavioral Health Director hosts a monthly townhall with all MHRS to keep lines of communication open across all levels of MHRS. Targeted inter-area meetings occur as needed to advance on specific evaluation and data projects. In addition, the MHSA Program Planning and Administration began hosting regular MHSA Internal Planning meetings. Attendees include representatives from every component of MHSA. A comprehensive timeline for coordination was presented at the inaugural meeting, outlining key milestones and responsible units for completing each milestone. This communication tool is foundation for keeping individuals on track. In	Sharon Ishikawa Michelle Smith	The recommendation has been implemented. This process has been implemented and leadership continually evaluates the effectiveness of the structure, purpose and outcomes of each of these meetings, identifying opportunities for improvement, growth and streamlining.

	addition, the meeting reviews proposed, pending, and current legislation that affects MHSA programs; finance; CPP processes and plan development coordination; and stakeholder feedback.		
Program staff should work together with IT and research to develop solutions (such as working with IT to select data tools and research to identify performance or outcome metrics) that encourage more robust collection of data that are usable for informing program decisions.	HCA Agrees with this recommendation. Key staff and stakeholders from MHRS programs, data analytics, quality management and/or HCA IT have established recurrent meetings focused on advancing specific projects (i.e., External Quality Review Organization Performance Improvement Projects, Behavioral Health Quality Improvement Program projects, contract amendments on performance outcome standards and monitoring, etc.) that include MHSA-funded programs. These project meetings include the identification of strategies that support more robust, complete and accurate data collection, as well as outcomes and metrics that lead to actionable intelligence and insights.	Sharon Ishikawa	The recommendation has been implemented. Since the IT and analytics infrastructure is still be established and stabilized, MHRS is aware that some elements of data pipeline/process may be updated or changed, as needed, in the future.
Expand Workforce Capacity to support an Enterprise-Wide Data System: The aspiration to become a data-driven organization is contingent on having the right capabilities and resources to support the execution of modernization efforts described above. Rapid evolution of technology and data analytic capabilities to use modern data systems to analyze and extract needed data are critical. This means creating up to date job descriptions that can attract and pay adequately for specific technical expertise (IT and data) to support the necessary changes across MHRS.	HCA Agrees with this recommendation. Central Human Resources has identified the need to establish a job classification series for data science, which the County currently does not have. The current classification traditionally used to perform outcomes monitoring and reporting (Research Analyst, RA) does not adequately address the computer science and mathematics background and skillset needed to stay current with the rapid evolution of technology, advanced analytics, AI, machine learning, natural language processing, etc. Moreover, the minimum qualifications for each level of the RA series are dependent on years of experience. This precludes potential candidates graduating with degrees in Data Science from qualifying beyond the RA I or II levels. Not only would young data scientists hired into these positions be working out of scope/class shortly after onboarding, but the pay scale is also not competitive with data science positions from the private and healthcare sectors, leaving the County vulnerable to losing out on critically needed talent.	Sharon Ishikawa Michelle Smith	The recommendation requires further analysis and is currently under review with Central Human Resources. No projected timeline has been communicated.

MHSA Recommendations: Data Collection and Analytics
C. Performance Measures
1. MHRS is utilizing a variety of metric including utilization, process and outcome measures.

2. MHRS/MHSA programs such as INN, appropriately rely on external, independent evaluators when formal assessment is inherent to the spirit of the component-such as demonstrating a promising practice without current evidence.			
Recommendations	Response	MHSA Divisions/Manager	Notes/Timeline
Need for development of meaningful standardized metrics that go beyond outputs to process and outcome measures	HCA Agrees with this recommendation. Historically, the evaluation of Prevention & Early Intervention Services (PEI) was primarily tailored to each program or population served. Each program had an evaluation plan that outlined performance objectives, program-specific outcome measures and data collection procedures. This model created few opportunities to create a cohesive narrative about effectiveness and had an unintended consequence of burdening participants with lengthy outcome forms. To address this, MHRS redesigned the evaluation plan for PEI programs. The goal has been to create a more efficient system of collecting and managing data, as well as a standardized set of outcome tools that will enable MHRS to determine the effectiveness of services while decreasing the burden on providers and participants served. (Please see responses below for additional descriptions.) Over the past year, MHRS has also revamped how it analyzes and presents outcomes for FSPs, which represent the single largest MHSA program category. The new approach shifted away from traditional pre-post or percent change reports, which are subject to issues in normality of data distribution and/or sample size, to whether programs met an established target rate (i.e., at least 80% of clients served in an FSP avoided experiencing a psychiatric hospitalization, incarceration, arrest or unsheltered homelessness).	Sharon Ishikawa	The majority of the recommendation has been implemented. The PEI project took approximately six months between January and June of 2023 to complete. Implementation of the new survey and data collection forms began in July 2023. Data collection was largely conducted using paper & pencil forms. As Chorus and Qualtrics forms were built and deployed, providers were trained and began entering their data electronically. This occurred between July and Dec 2023. As of Dec 2023, all but one surveys/forms were implemented in one of the digital platforms. The last form should be ready to deploy in Q1 of CY 2024.
Create bundles of metrics that allow a fuller understating of program effectiveness. For example, bundles of metrics could be used to collectively track program capacity to meet community needs, provide **high quality care,** and demonstrate impact through **meaningful outcomes**. As appropriate program effectiveness, could also be monitored for	HCA Agrees with this recommendation. Over the course of the last year, MHRS reviewed the program goals, contract scopes of work and outcome measures for each PEI program, along with state measures used in the Mental Health and Substance Use Disorder systems to determine the best approach for evaluating PEI effectiveness. A standardized set of forms and surveys was established and implemented across three primary groups of PEI services: Prevention, Training & Education, and Early Intervention.	Sharon Ishikawa	This recommendation has been implemented. Provider staff have been trained to use the paper and digital forms. See above for timeline.

community impact through surveillance efforts.	Prevention: The primary measure for the Prevention programs is the Mental Health Awareness Survey, which measures mental health knowledge, stigma and help-seeking behavior. These programs also use a Workshop/Presentation Feedback Form, a shorter version of the Mental Health Awareness Survey that does not include items related to stigma reduction but does include a measure of participant satisfaction. Training & Education: These programs use the Workshop/Presentation Feedback Form along with measures to assess learning related to specific content and/or age group. Early Intervention: MHRS used the Mental Health System's DHCS Client Perception Survey, a parenting skills survey and the UCLA Loneliness Scale as the basis for developing the Perceived Impact outcome measures for this service type. There are items on the Client Perception Survey that assess service impact on areas of life functioning that are applicable to services focusing on early intervention counseling and support. • General Perceived Impact: This is a 7-item survey used with adults and youth. It measures relationships with family and friends, school/work performance, community belonging, managing daily life, and help-seeking behaviors. • Older Adult Perceived Impact: This is a 7-item survey used in the Early Intervention Services for Older Adult programs. It measures relationships with family and friends, participation in meaningful activity, community belonging, managing daily life, and help-seeking behaviors. • Parenting Perceived Impact: This is a 6-item survey used in programs that focus on improving parenting skills. It measures parenting skills related to setting limits, proactive parenting strategies and supporting good behavior. • The UCLA Loneliness Scale is a 3-item measure of relational connectedness, social connectedness and self-perceived isolation. This measure is used in the Older Adult program, as well as the supportive component of the Prevention Services & Supports for Families programs.		

	• Participants enrolled in services complete the 6-item Anonymous Participant Feedback Form. This is a brief measure of satisfaction with services received. Previously, PEI programs collected satisfaction data on paper twice a year during a catchment period of two weeks. This method was burdensome and not all participants had the opportunity to provide feedback. Now, all participants are asked to complete the survey at discharge or program transition. Prior to the change in evaluation methodology, outcome measures were mostly pre- and post-measures. As stated above, some of the outcome measures were lengthy and created a burden on participants. Therefore, the standardized evaluation forms use a post-only method, which means clients complete assessments at discharge or transition to another type of service. If the program uses additional measures that are tailored to the service type of population served, such as the PHQ-9, Protective Factors Survey or Grief Experience Questionnaire, the administration will be conducted as prescribed by the measure developer. In addition to the measure redesign, MHRS adopted the digital platforms Chorus (for participant-identified data) and Qualtrics (for anonymous data) for data collection, analysis, dashboards and reporting. These systems allow for direct data entry by participants using their own device or one supplied by the provider. This significantly reduces the need for paper forms, which decreases the provider's burden of managing the paper and entering data into another system. Participants experience a simplified, more user-friendly process for completing outcome measures. The process for adjusting the surveys and forms in these platforms has been streamlined for MHRS. Chorus and Qualtrics provide MHRS with the ability to develop dashboards for providers, as well as more real-time and frequent reports for stakeholders.		
Allow flexibility around measuring additional outcomes tied to program objectives to help address concerns around a slate of metrics that better tells the full story of program effectiveness.	HCA Agrees with this recommendation. Some PEI programs have retained population- or diagnosis-specific outcome measure, in addition to the appropriate PEI outcome form bundle. For example, Early Intervention Services for Older Adults will continue to use the PHQ-9 and GAD 7. Performance goals related to depression and anxiety reduction are included in the contracts. Similarly, the OC	Sharon Ishikawa	The recommendation has been implemented. The process of reducing the number of program-specific PEI measures is complete. See timeline above. For programs that kept their

	CREW program, which targets individuals experiencing early onset or first episode psychosis, will continue to use the Brief Psychiatric Rating Scale to assess progress on treating psychosis and other symptoms. Programs with individualized outcome measures have performance objectives related to the measures in the contracts.		program-specific outcome measures, the data are collected on paper and submitted in Excel format via a secure process. The medium- to long-term goal is to build the forms in Chorus.
Require continuous improvement initiatives tied to metrics to monitor continuous improvement efforts to optimize use of effective, evidence-based strategies and abandonment of ineffective strategies or identification of external challenges that may limit program effectiveness.	HCA Agrees with this recommendation. 1. Optimize use of effective evidence-based strategies: MHRS has implemented several evidence-based strategies throughout the department. The MHRS research team is conducting a review of the evidence-based strategies that have been implemented in MHRS programs. The goal of this effort is to develop a framework for implementing such strategies with fidelity and identifying methods for assessing fidelity to evidence-based strategies to achieve optimal client outcomes. 2. Abandonment of ineffective strategies or identification of external challenges that may limit program effectiveness: After the research effort is complete, recommendations will be made to the MHSA, mental health and substance use disorder programs regarding implementation and monitoring fidelity. Programs that have strategies in place may need to address areas where fidelity to the model has not been achieved. This will be a continuous project of assessing fidelity, making program adjustments, reviewing client outcomes, and determining effectiveness of the strategy. Another effort within MHRS is related to CANS/PSC-35 administration and outcome monitoring. Although these measures are not evidence-based strategies and are primarily used in the Mental Health Plan programs, the measures are a DHCS requirement and there are Community Services & Supports-funded programs that administer the CANS/PSC-35 to clients meeting the age requirements. The department cannot abandon the CANS/PSC-35, but MHRS can develop administration monitoring tools for clinicians to improve data quality for outcome analysis, as well as DHCS data submission & acceptance rates. MHRS has been monitoring the outcomes from these measures since implementation in 2018. Over time, it became clear that the department needed to address the low administration rates and correct completion timeliness challenges. One step in this process was to sunset use of the Outcome Questionnaire in the Children's System	Sharon Ishikawa	The recommendation has not been fully implemented. The processes are ongoing. HCA IT is working on connecting the data warehouses to Databricks, and Databricks to Tableau. The latter is anticipated to be completed in 2024. The former timeline will be determined after Cerner has been effectively transitioned to RHO and other IT infrastructure has been implemented.

	of Care to limit the administration burden on clients and clinicians. A second quality improvement step being explored is the implementation of automated reminders and prompts in the electronic health record, so that clinical staff can monitor administration rates and timelines. A third area for improvement has been creating the ability to analyze and report outcomes on a more frequent basis and in a way that is most useful to clinical staff. As a result of migrating to the Databricks platform, MHRS has been able to analyze and report out on data/performance metrics several times a year as opposed to annually. MHRS is working with HCA IT to allow loading of cleansed, processed data from Databricks into Tableau dashboards so that staff will be able to access essential metrics on-demand.		
Opportunities exist to partner with the state to align metric and reduce provider burden, county staff should remain active in these efforts.	HCA Agrees with this recommendation. The new PEI outcome measures related to the perceived impact of services on participants were drawn from the DHCS Client Perception Survey. This was done to standardize items across the Mental Health System and MHSA programs and allow for a more system-wide evaluation of service impact. Additionally, MHRS will be able to use the historical Client Perception Survey data as a benchmark for the PEI programs. A future effort is planned to implement the PEI Perceived Impact Survey in the mental health and substance use programs that already administer the Client Perception Survey. The goal will be to have more frequent assessment of the impact of services on life functioning. Additionally, it will be designed so that the data are collected from all clients on a periodic basis, rather than only clients that receive services during the annual one-week data collection period of the Client Perception Survey.	Sharon Ishikawa	The recommendation has not been fully implemented. During the process of redesigning the evaluation of PEI programs, MHRS reviewed the Client Perception survey items and historical results for MHRS programs to understand the trends over time on specific items. MHRS selected items from the Client Perception Survey that measure service impact on life functioning such as family/friend relationships, work/school, ability to handle problems or a crisis, and engaging in meaningful activity. This process is complete. Over time, as data are collected, MHRS will be able to compare the PEI results with the benchmark data for all mental health programs in MHRS that administer the DHCS Client Perception Survey. In addition, PEI outcome forms have been removed duplicative items and

			items that do not directly tie to program services and goals in order to reduce burden. Outcomes for CSS programs that bill Medi-Cal have shifted to using state-required functional assessment forms. Once the technical infrastructure has been implemented, MHRS data analytics staff will develop dashboarding tools and automated reports that programs can use for QA/QI on data quantity and quality.
Consider strengthening contractual requirements that incentivize the reporting of key performance metrics in areas where consensus exists and withhold payment for failing to submit data for a target threshold or institute corrective action plans.	HCA partially agrees with this recommendation. Currently, compliance with reporting requirements is reviewed and evaluated on a regular basis. Reporting shortfalls are included as findings and required as part of corrective action reports. In addition, MHSA office is working with programs to determine minimum reporting thresholds specifically for contracted PEI programs that have reported the most difficulty in obtaining appropriate data due to the “light touch” services often provided.	Michelle Smith	This recommendation requires further analysis. HCA must review the legal parameters of withholding payments for services rendered, along with the development of objectives tools to determine the criteria for withholding payment in exchange for data.
As providers become more accustomed and equipped to report data consistently, the county could shift from paying for reporting to paying for performance; over time the county could adjust performance metrics and benchmarks to encourage quality improvements as part of a more robust accountability framework.	HCA partially agrees with this recommendation. Counties are in the process of implementing the CalAIM Initiative. A key component of CalAIM is payment reform. The initiative moves counties from a cost reimbursement system (through Medicaid certified public expenditures) to a value-based reimbursement structure that incentivizes better care and aligns with how physical healthcare is reimbursed. This is a new process that will take time to evaluate and adjust to implement the most effective process. As the changes continue to be implemented, MHRS can evaluate the most appropriate methodologies to align with quality improvement incentives, as legally allowable by DHCS.	Michelle Smith	This recommendation requires further analysis to determine the limits established by our multiple funding sources, as MHSA is frequently utilized as a match or as part of a braided funding model.
Create methods for data sharing and promoting transparency in key quality indicators to facilitate aligned efforts toward improving care access and quality, working towards public reporting as data	HCA Agrees with this recommendation. Due to security issues, providers and staff are not presently able to log into Qualtrics and view program survey dashboards. Instead, updated data dashboards of post-training WET feedback surveys are automatically PDF’s and emailed to key program stakeholders on the first of each month. This is a fully automated process and does not require staff time to	Sharon Ishikawa	This recommendation has not yet been implemented but will be implemented by December 2025.

reporting becomes more consistent, complete and accurate.	execute, other than to update email recipients as needed. Over the next year MHRS will work on expanding these efforts to additional programs. MHRS Data Analytics and Evaluation staff have completed intensive Tableau training to support the deployment of interactive, public-facing dashboards once data reporting becomes more consistent, complete and accurate. The new FSP outcomes described above in response C1 are visualized through infographics, making it easy to read and interpret by the audience. This approach will be adapted and systematically applied to additional program outcomes over the next few years.		