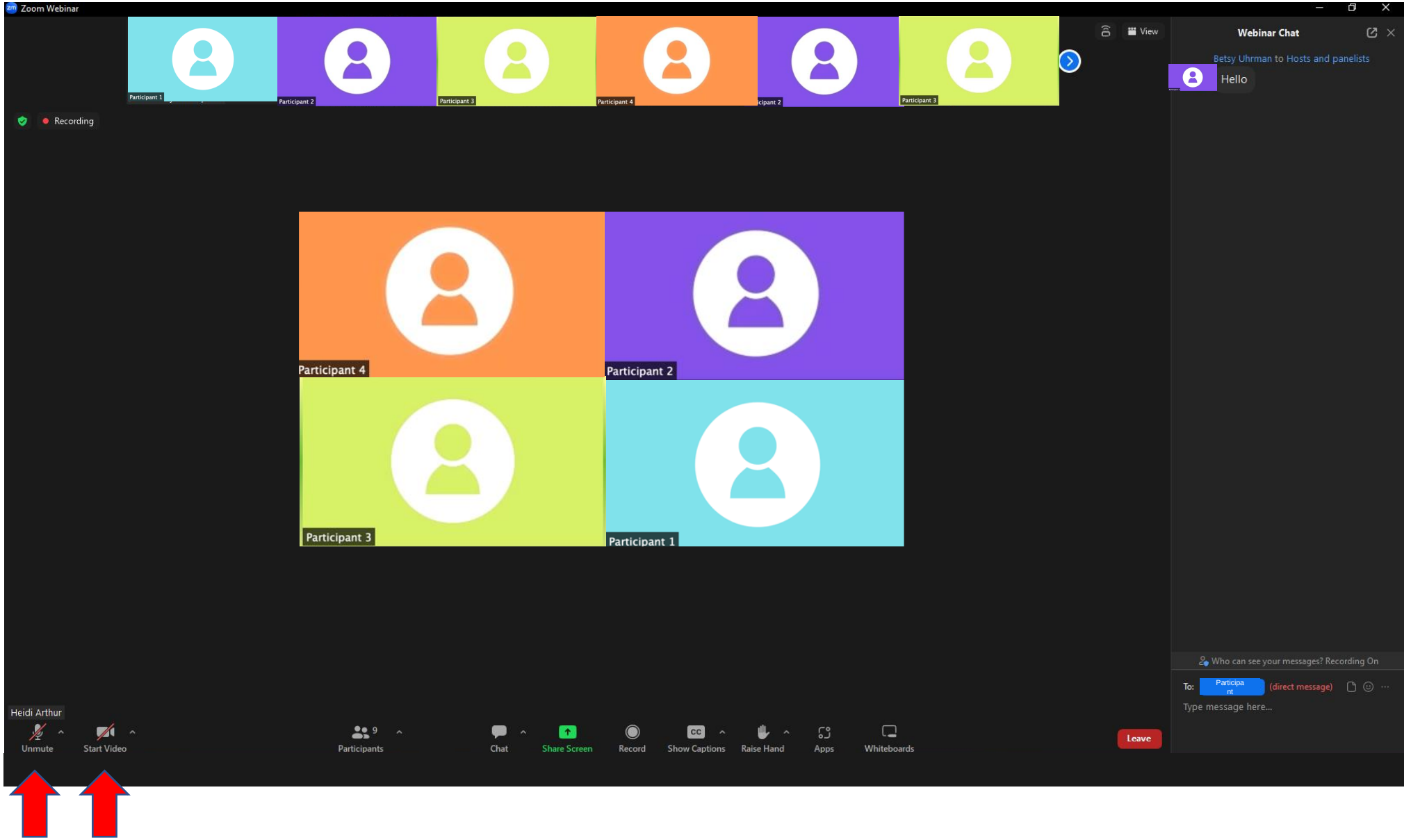
CalHHS

Workgroup 5: Data & Metrics

Meeting 1 of 2
May 17, 2024

Webinar: Panelist View



Webinar View: Attendee

- Workgroup members will be able to utilize the chat function throughout the meeting. Chat messages cannot be seen by non-workgroup members, but they will be captured in the public meeting summary.
- Workgroup members will be asked to use the "raise hand" function when you would like to speak.

Workgroup 5, Meeting 1 Agenda

1. Level Setting on AB988 and the Workgroup Process
2. Workgroup 5 Context
3. Results Based Accountability (RBA) Framework
4. Discussion: Identifying Metrics
5. Preview Meeting 2
6. Public comment

Public Comment Overview

- **All comments—whether written or spoken—will be shared with the Work Group in the meeting minutes.**
- We will take comments in the order in which we receive sign-ups.
- If you would like to make a public comment, please raise your hand at any point throughout the discussion. We will write down your name and call on you to speak during the public comment period.
- Each person will have 2 minute to speak. If you have a condition that may require an accommodation (such as additional speaking time), please notify the project team and we will do our best to provide that accommodation.
- If you would like to make a comment but prefer not to do it in front of a camera or microphone, you may email your written comment to the project email address: AB988Info@chhs.ca.gov.

Workgroup 5 Members

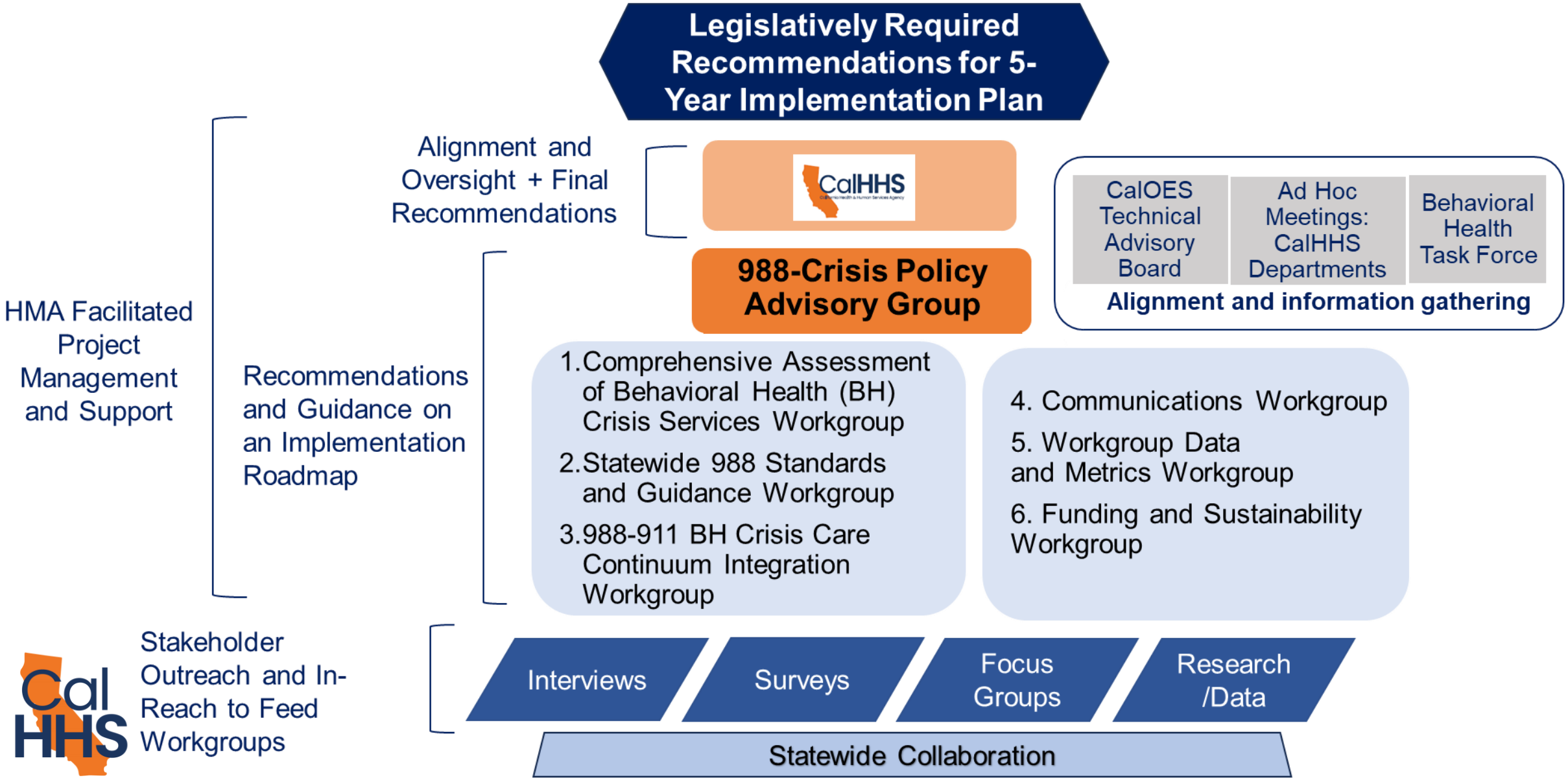
***Co-Chair, Kirsten Barlow**,* CA Hospital Association
***Co-Chair, Robb Layne**,* CAADPE
Alec Smith, DHCS
Ashley Metoyer, UCSD Mobile Crisis
Blanca Gutierrez, Contra Costa Crisis Center
Brenda Grealish, CDCR
Brandon Jacobs, RUHS BH
Casey Heinzen, DHCS
Curt Guillot, CalOES
David Bond, Blue Shield
Elizabeth Manley, University of CT
Erika Cristo, DHCS
Jonah Cox, CDPH
Mark Salazar, Mental Health America SF
Molly Miller, Interagency Council on Homelessness
Paul Troxel, CalOES
Rebecca Bauer-Kahan, CA State Assembly
Sarah Feingold, Youth for Change
Shauna Simon, CDPH
Sheree Lowe, CHA
Tara Gamboa-Eastman, Steinberg Institute
Tony Kildare, Yolo County Health and Human Services
Tracy Lacey, CBHDA

Code of Conduct

- Presume positive intentions
- Ask from a place of inquiry
- Be present and stay engaged
- Be brief and brilliant
- Be respectful and courteous

Note: Meetings of the Work Group are open to the public and are subject to Bagley-Keene Open Meeting Act requirements

AB 988 Organizing Structure



Desired Outcomes of the Future CA Crisis System: PAG and Workgroup Input

The Future State… (Adapted from the CCC-P)	Characterized by…
Consistent statewide access	▪ Increased capacity, affordability, and range of services ▪ Connecting people in crisis to immediate and ongoing care
High quality services	▪ An array of essential crisis services across the continuum ▪ A comprehensive strategy for data measurement and quality of care that is inclusive of all populations and geographies
Coordination across and outside the continuum	▪ Offering the least restrictive responses to crisis ▪ Robust formal and informal community-based partnerships
Serves the needs of *all* Californians	▪ Services that are culturally and linguistically responsive ▪ Services that are person- and family-centered ▪ No Wrong Door: Services are delivered regardless of insurance/payer source, regardless of where a person presents for care

988-Crisis Workgroups

Phase 1: January - April

1. Comprehensive Assessment of BH Crisis Services
2. Statewide 988 Standards and Guidance
3. 988-911 BH-CCC Integration

Phase 2: May - August

4. Communications
5. Data and Metrics
6. Funding and Sustainability

Peers
[Added Apr-24]

May 17
July 31

Workgroup 5: AB988 Required Areas

Today's Focus

AB 988 Required Areas

(10) Quantifiable goals for the provision of statewide and regional behavioral health crisis services, which consider factors such as reported rates of suicide attempts and deaths.

(11) A process for establishing outcome measures, benchmarks, and improvement targets for 988 centers and the behavioral health crisis services system. This may include recommendations regarding how to measure, the feasibility of measuring 988 system performance, including capacity, wait time, and the ability to meet demand for services for 988 State Suicide and Behavioral Health Crisis Services Fund recipients. This may also include recommendations for how to determine and report the amount billed to and reimbursed by Medi-Cal or other public and private health care service plans or insurers related to 988 services.

Input from Previous Discussions: PAG Dec-23 Meeting

- Would like data and metrics to provide accountability and oversight, demonstration of system improvement, key transition points in the system, and the right incentives.
- While not specific to the Data and Metrics Workgroup, participants wanted to see improvement in the timeliness of the system (such as answering all 988 calls) and increased data sharing.
- Raised questions about:
  - the use of technology/AI to better streamline data collections
  - how to classify substance use crises appropriately
  - how to ensure that all health plans are meeting their responsibilities to provide essential behavioral health crisis services.
- Concerns expressed by participants included leveraging sufficient resources, balancing needs for data with clients/customers and the need for privacy/trust, and ensuring that 988 is welcoming in hopes that people return.

Input from Previous Discussions: Workgroups 1-3

- Mechanisms and measures of success related to **identifying and responding to SUD/ Physical Health issues**
  - Pre/post-test of knowledge, awareness, confidence (measured verbally, not just written).
  - Experience of those contacting the line – follow up calls, surveys, etc.
  - Caller satisfaction
  - Established protocols and relationships with local EMS, County BH, etc. to ensure proper referrals
  - Community awareness
- Mechanisms and measures of success related to **delivering culturally responsive, trauma informed care:**
  - Caller feedback
  - Staff surveys
  - Wait times for interpretation/ accommodation services
  - Community awareness of the 988 service
  - Caller demographics as compared with community demographics
- Measures of success for the topic of **smooth transfers:**
  - Established protocols and relationships with local EMS, County BH, etc. to ensure proper referrals
  - Standards for when to warm transfer to dispatch, to warm lines, or other resources
  - Shared directory of resources and numbers to connect callers to that can be accessed by all crisis centers (for out of region callers)

How will we know we are on the right path to building a robust BH Crisis Care System?

Assessing & Communicating Impact of Crisis Services

The Challenge

- Crisis services operate in a complicated ecosystem, with multiple players and partners
- Many factors can contribute to results of crisis services
- Transparency and communication are key

Communicating Impact

- Focus on actionable data to help us learn and deliver the BH-CCCP vision
- Clearly communicate progress on what, how much and when we impact population outcomes.

Results Based Accountability (RBA)

Approach to Metrics

- How much we do,
- How well we do it, and
- Is anyone better off?

Source: https://clearimpact.com/results-based-accountability/

RBA: Population vs. Performance Accountability

Results Based Accountability (RBA)
is made up of two parts:

Population Accountability
about the well-being of
WHOLE POPULATIONS

For Communities – Cities – Counties – States - Nations

Performance Accountability
about the well-being of
CUSTOMER POPULATIONS

For Programs – Agencies – Service Systems

State, County, Communities

Set priorities. direct resources through regulations and payment reform

- Measures demonstrate system efficiencies and population outcomes

County BH Plans, Managed Care Organizations

Manage delivery of evidence-based care

- Measures incentivize high quality care in provider network, demonstrate effective management and outcomes for covered lives

Providers

Deliver timely and effective care

- Measures improve care delivery and demonstrate positive client outcomes

For each level:

1) How much did we do?

2) How well did we do it?

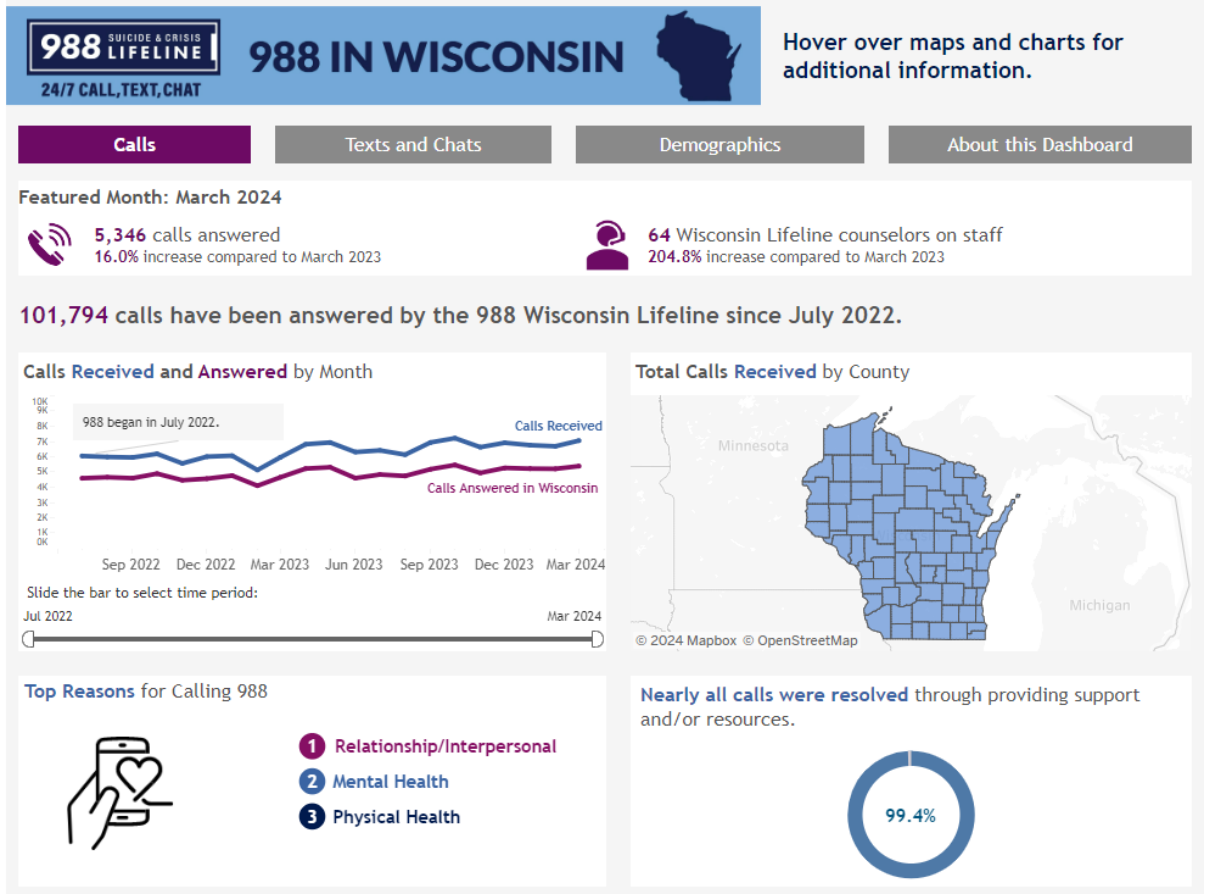
3) Is anyone better off?

Dashboard Examples from Other States

Dashboard Examples: Wisconsin

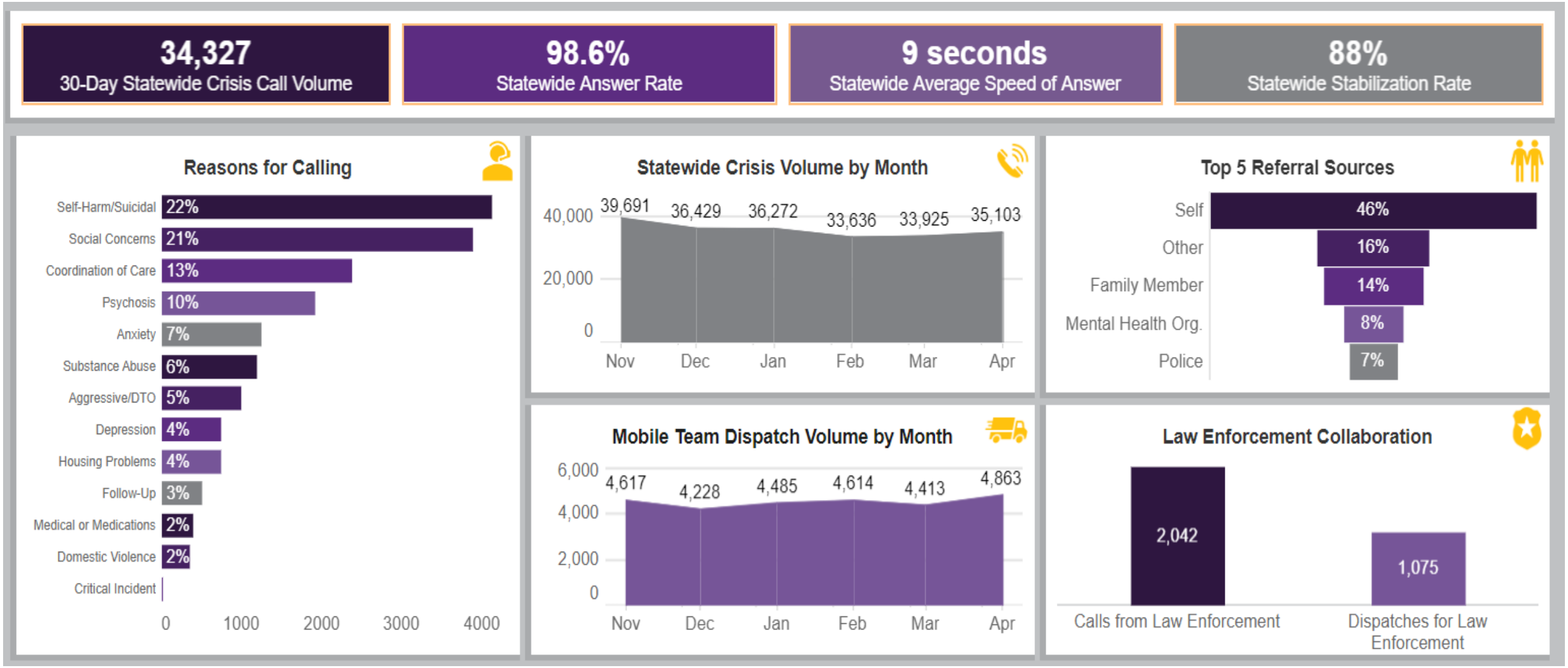
[Crisis Services: 988 Suicide & Crisis Lifeline Data Dashboard | Wisconsin Department of Health Services]

The WI dashboard has tabs for calls, texts and chats, demographics and a tab describing the technical notes re: data collection, updates, etc.



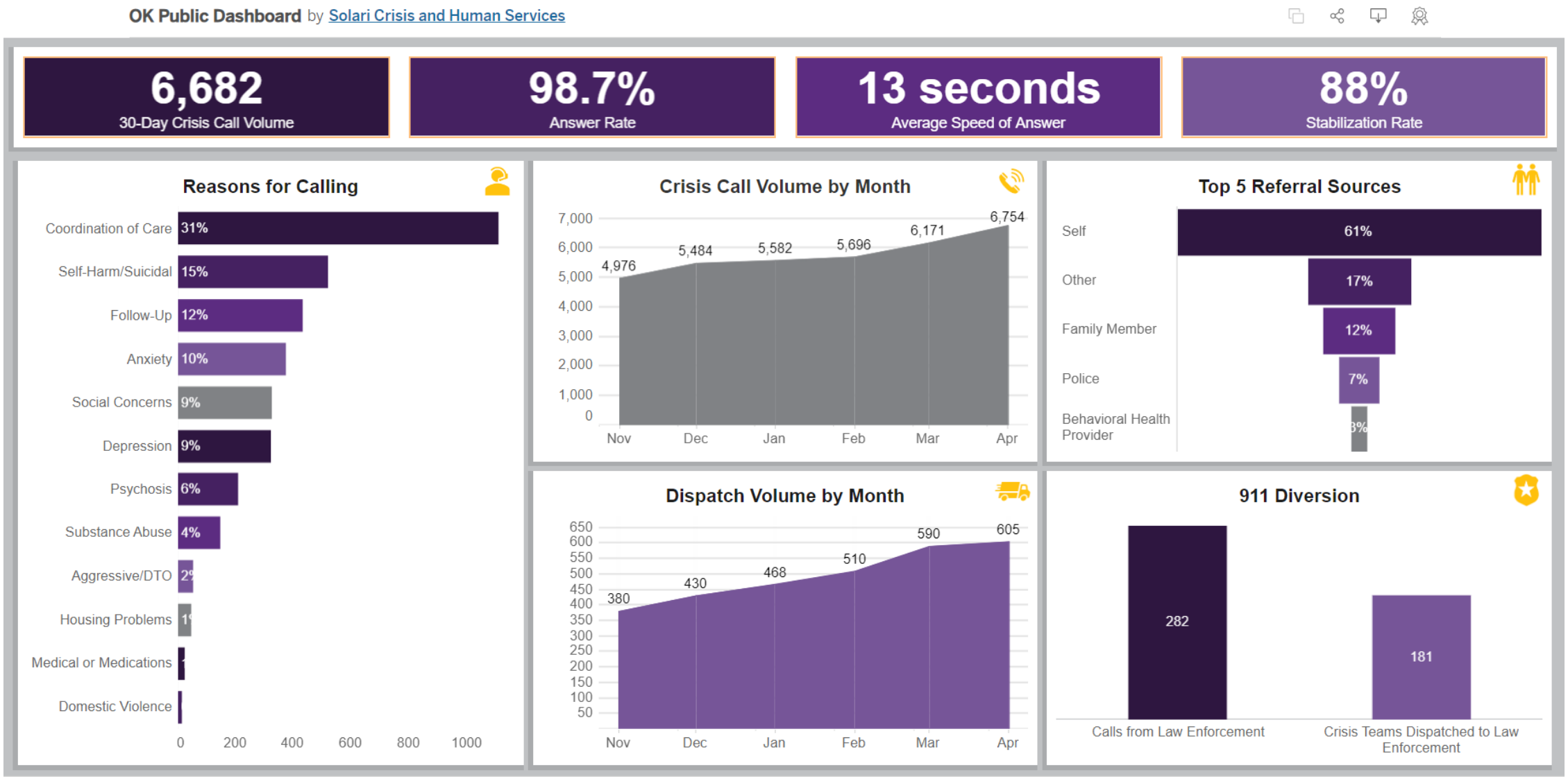
Dashboard Examples: Arizona

[AZ600 Statewide Dashboard | Tableau Public]



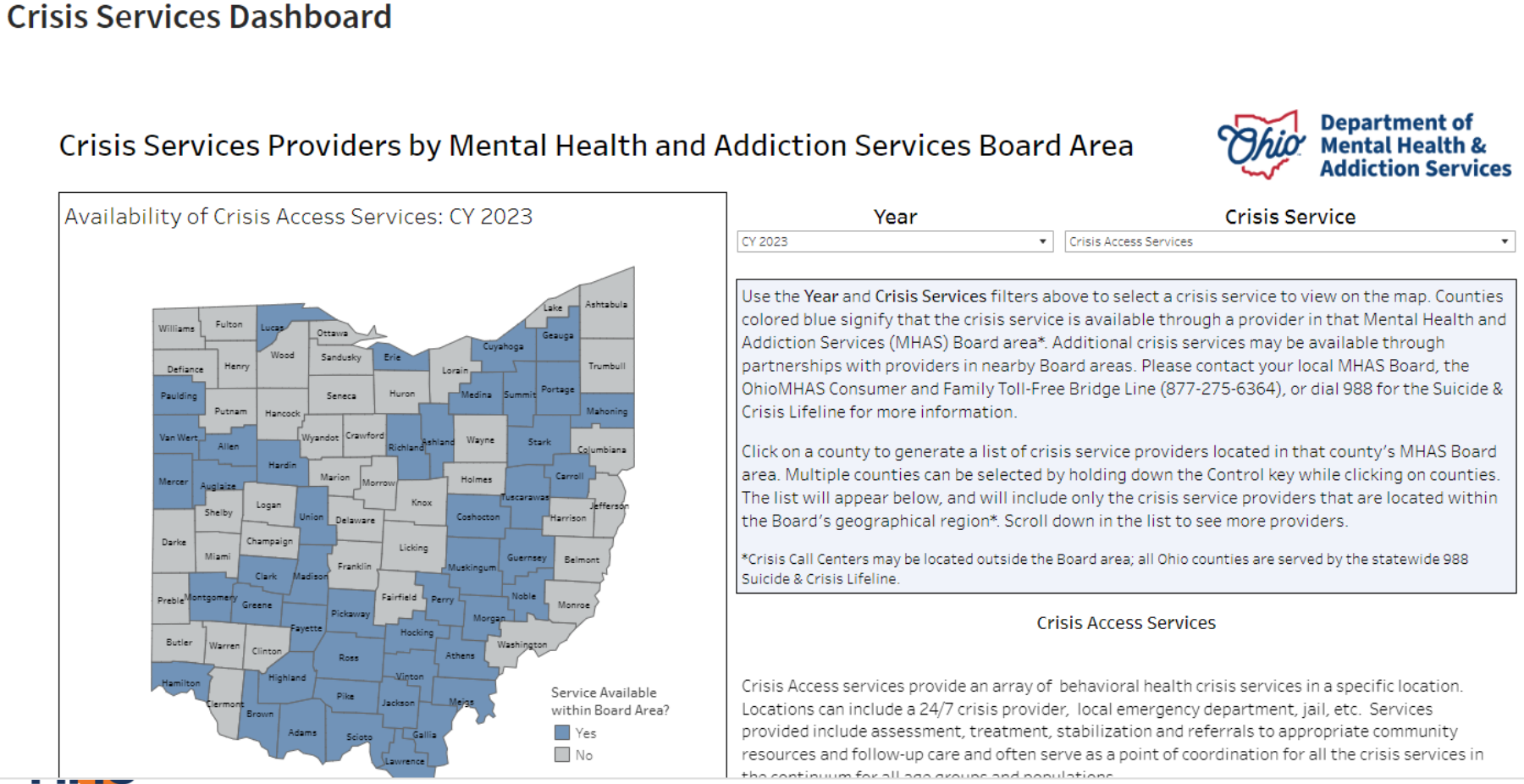
Dashboard Examples: Oklahoma

[OK Public Dashboard | Tableau Public]



Dashboard Examples: Ohio

[Crisis Services Dashboard | Department of Mental Health and Addiction Services (ohio.gov)]



Ohio's dashboard shows the state as a whole and allows users to hover over counties to see the providers for each service type in that county

Dashboard Examples: South Dakota

988 Data Dashboard - Helpline Center

988 SUICIDE & CRISIS LIFELINE

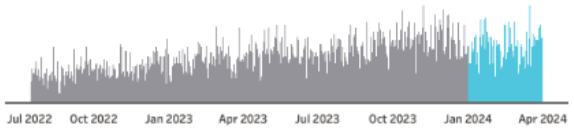
The 988 line launched on July 16th, 2022 nationwide. When South Dakotans call, text or chat 988, they are connected to 988 counselors at the Helpline Center. They listen, assess, provide support and connect to additional resources as needed. The Helpline Center also answers crisis calls that are transferred from local 911 centers in SD.

Step 1: Pick a start date 1/1/2024

Step 2: Pick an end date 3/31/2024

The selected time period is colored TEAL in the graph of daily contacts below.

January 1, 2024 - March 31, 2024
Total Contacts: 2,946
Total Calls: 2,619
Total Texts: 195
Total Chats: 132



Overview | Demographics | Crisis | Geographies | Map

Crisis Contacts

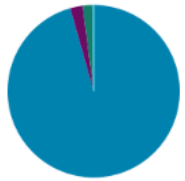
Select a geography for more detail. (All Locations)

The 988 counselor partners with individuals to de-escalate their crisis and develop safety plans.

97.08% of the crisis calls were stabilized by the end of the call and did not require further action, thus requiring fewer interventions by law enforcement.

Contact Outcomes**
(All Locations)
1/1/2024 — 3/31/2024

Stabilized	1883
911 Wellness Check	36
911 Collaborative Rescue	46
Police Report - Not suicide related	<5



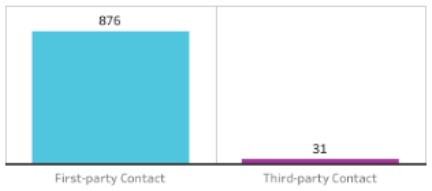
** To preserve anonymity, any category with fewer than 5 responses is reported as <5.

Types of Suicide Contacts

Suicide Related Contacts**

First-Party Contact- The call is related to the caller themselves

Third-Pary Contact- The call is from a family member or friend concerned about a loved one.



Download the PDF

The Helpline Center is South Dakota's leader in suicide prevention and response. If you or someone you know is having suicidal thoughts please call, text or chat 988 anytime, day or night. All South Dakotans have access to the crisis line all day, every day. The service is free and confidential.

For more information please go to https://www.helplinecenter.org/9-8-8/

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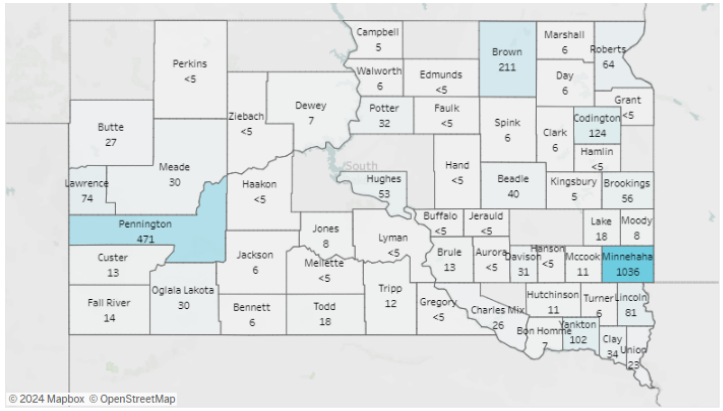
SDSP SOUTH DAKOTA SUICIDE PREVENTION

helpline center

South Dakota's dashboard has tabs and a map that shows the top Counties, Cities and Zip Codes that contact the 988 line.



Top Counties		Top Cities		Top Zip Codes	
Minnehaha	1036	Sioux Falls	1002	57101	371
Pennington	471	Rapid City	443	57701	348
Brown	211	Aberdeen	206	57401	203
Codington	124	Yankton	123	57103	172
Yankton	102	Watertown	119	57105	155
Lincoln	81	Sisseton	56	57078	123
Lawrence	74	Brookings	54	57201	122
Roberts	64	Pierre	45	57104	121
Brookings	56	Spearfish	36	57106	95
Hughes	53	Huron	35	57702	84

Counties with a greater number of contacts are shaded darker.

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SDSP

helpline center

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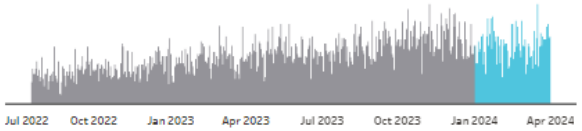
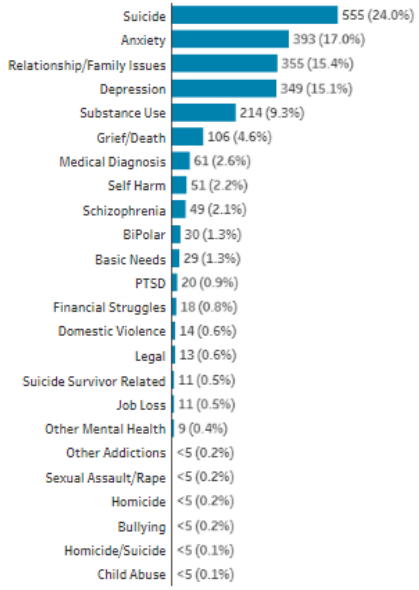


Overview | Demographics | Crisis | Geographies | Map

Presenting Concerns

The primary issue that the contact is identified as having by our 988 counselors.



Contact Method

988 Calls	2527
988 Text	195
988 Chat	132
Transferred from 911	92
Transferred from 211	52

Contact Type

The categorization of the contact by our trained crisis workers. One contact type is identified per contact.

Listening and Support	1064
Crisis	916
Information	841
Referral	87
Admin	29
Advocacy	9

** To preserve anonymity, any category with fewer than 5 responses is reported as <5.

Download the PDF

SDSP SOUTH DAKOTA SUICIDE PREVENTION

helpline center

Discussion: What should we monitor at the state level?

Prioritizing Metrics: Results Based Accountability

Rate (High, Medium, or Low) on the following:

Communication Power	Proxy Power	Data Power
Ability of the metrics to effectively **communicate progress and impact** *Does this indicator communicate to a broad range of audiences?* *Would those who pay attention to your work understand what this measure means (e.g., legislators, funders, public)?*	Ability of measures to **predict the achievement of desired outcomes** and goals. *Does this indicator correlate with the desired result?*	Quality, reliability, and accuracy of the data used to measure outcomes and track progress *Will we be able to effectively disaggregate the data to examine equity?* *Is there consistent and reliable data available on a timely basis for this indicator?*

Source: https://clearimpact.com/wp-content/uploads/2022/05/RBA-Ebook-Updated-FINAL.pdf

Discussion 1: Identifying Metrics: Is Anyone Better Off? (1

BH-CCCP Vision: Consistent and equitable access to high quality, coordinated crisis services for all

*What are quantifiable goals that would demonstrate system efficiencies and **population outcomes**?*

Rate (High, Medium, or Low)

Measure Concepts for Population Accountability	Communication Power *(Impact)*	Proxy Power *(Predict desired outcomes)*
↓ Suicide attempts		
↓ Suicide deaths (within set timeframe post call)		
↓ Overdose deaths		
↓ BH-related Incarceration (disaggregated by pop- e.g., foster youth, unhoused…)		
↑ Individuals with improved functional status		
Population-specific outcomes: e.g., youth: school attendance, grad rates, child welfare involvement		
Health adjusted life expectancy		

Discussion 1: Identifying Metrics: Is Anyone Better Off? (2

BH-CCCP Vision: Consistent and equitable access to high quality, coordinated crisis services for all

*What are quantifiable goals that would demonstrate system efficiencies and **population outcomes**?*

Rate (High, Medium, or Low)

Measure Concepts for Population Accountability	Communication Power *(Impact)*	Proxy Power *(Predict desired outcomes)*
↓ Suicide attempts		
↓ Suicide deaths (within set timeframe post call)		
↓ Overdose deaths		
↓ BH-related Incarceration (disaggregated by pop- e.g., foster youth, unhoused…)		
↑ Individuals with improved functional status		
Changes in population usage of 988 (special populations)		
Reduction in ER Utilization and readmission		
Improved access to and utilization of follow up services after emergency intervention		
Changes in social determinants (e.g., housing)		
Population-specific outcomes: e.g., youth: school attendance, grad rates, child welfare involvement		
Interventions prior to self-harm (as indicators or increased awareness)		
Health adjusted life expectancy		

Discussion 2: Identifying Metrics: How much? How well?

Across Services: Collect data on client profile/demographics and type of crisis

How much did we do
How well did we do it
Work Group additions

Preventing Crisis	Responding to Crisis	Stabilizing Crisis
Peer-Based Warm Lines • # of warmlines • Call volume • Types of calls • Transfer rates/volume between warm lines and 988 [reduced need for transfer] • Links to social services (e.g., housing)	**Hotlines** • Call Volume (repeat callers), Talk Time/Call Length • Call Answer Rates, Time to Answer, Abandonment Rate • Referrals/resources (linked) • Referral utilization and follow up post crisis call • Post caller experience/satisfaction – Net Promoter Scores (NPS) • Ability to respond in caller's preferred language • Reduced levels of distress immediately following the call • 5150 rates	**Crisis Receiving and Stabilization Services** • Number of facilities per county/region • % referrals accepted • Time to access/distance from population base • Reduced hospitalizations and readmissions • Reduced Emergency Department Visits

Community-Based Behavioral Health Services
• % people connected to outpatient services following discharge from hospital or ED for MH/SUD
 	
Digital Apothecary
• E.g. CYBHI digital platform
• # web visits, downloads of digital tools
 	
Other Social Indicators
• E.g., Social Connectedness
	Mobile Crisis
	• Types of mobile crisis teams
	• Number of mobile crisis teams by county, ratio to population
	• Dispatch protocols and rates
	• Average in-person response times
	• Referrals (linked)
		Other Stabilization Services
		• Definitions, operations, availability (time to access, distance from population base)
		  ○ Peer respite
		  ○ In-home crisis stabilization
		  ○ Crisis residential treatment services
		  ○ Sobering centers
		  ○ Post-crisis step-down services, e.g. partial hospitalization, supportive housing

Source: Adapted from the CCC-P with input from the PAG

Plan for Meeting 2

AB988 Area 11:

A **process** for establishing **outcome measures, benchmarks, and improvement targets for 988 centers and the behavioral health crisis services system**.

This may include recommendations regarding how to measure, the feasibility of measuring **988 system performance**, including capacity, wait time, and the ability to meet demand for services for 988 State Suicide and Behavioral Health Crisis Services Fund recipients.

This may also include recommendations for **how to determine and report the amount billed to and reimbursed by Medi-Cal or other public and private health care service plans or insurers related to 988 services**.

Where We Go From Here

- Feedback gathered from this Workgroup will be shared with CalHHS, who will in turn engage their state partners in review.
- Feedback gathered will also be shared with the Policy Advisory Group for further review and input. The Workgroup Co-Chairs will support this effort.
- The outcome of the state and Policy Advisory Group review processes will be a set of recommendations that will inform the development of the Five-Year Implementation Plan.
- **Additional, final meeting on July 31, 1-3PM**

Public Comment Period

Public Comment Guidelines

- **All comments—whether written or spoken—will be shared with the Workgroup in the meeting minutes.**
- If you prefer, you may email your written comment to the project email address: AB988Info@chhs.ca.gov
- Each speaker is allocated 2 minutes to speak unless adjusted by the meeting facilitator.
- A speaker may not share or relinquish any remaining time they have not used to another speaker.
- Speakers may share one time during the public comment period.
- If time in the agenda remains after all individuals who signed up to speak have been called, the facilitator may invite other members of the public to raise their hand to speak. The facilitator will call individuals in the order they raise their hand.
- Speakers shall be civil and courteous in their language and presentation. Insults, profanity, use of vulgar language, or gestures or other inappropriate behavior are not allowed.
- Speakers should not ask questions of Workgroup members or ask Work Group members to respond to their comments directly.

Public Comment Sign-Ups

1. Name

Adjourn

Additional slides (internal use)