

Riverside University Health Systems– Behavioral Health
Proposition 47 Grant #550-17
Integrated Care Behavioral Health
Full Service Partnership Programs
Local Evaluation Plan
2017

Program Overview

The RUHS-BH Proposition 47 grant will establish two Integrated Care Behavioral Health Full Service Partnership (FSP) programs that will provide integrated mental health treatment, substance abuse treatment and connection to primary care services. The target service population are adult residents of Riverside County with a history of mental health and/or substance abuse disorder that are currently in contact with the criminal justice system and who could benefit and need intensive community based support as an appropriate alternative to incarceration or re-incarceration. They may be homeless or at imminent risk of homelessness. Service locations will be established in the Coachella Valley (Desert Region) and in the area of Perris/Moreno Valley in order to serve the Western and Mid-County regions of Riverside County. Drawing from the model first adopted by the Mental Health Services Act (MHSA), services will be based on the Full Service Partnership model of care that provides intensive treatment, case management, support, and wrap-around services based on the principles of mental health and substance abuse recovery. The Prop 47 funded FSP model will provide integrated behavioral health services by leveraging both Specialty Mental Health and Drug Medi-Cal services. The model will include integrated and closely coordinated physical health care and a recovery-based care plan, using a trauma-informed approach.

Program services will include a comprehensive integrated assessment and the development of a recovery-oriented care plan that will guide services. The Integrated Care FSPs will be providing both mental health and substance abuse services. Treatment services will include evidence-based practices, psychiatric, medication services, and peer-supports. Training to program staff and on-going fidelity monitoring will be utilized to ensure quality program implementation.

Project Goals:

- Divert individuals with serious Mental Illness and/or Substance Abuse disorders seen in Veterans court, Homeless Court, or identified by probation into an Integrated Care FSP program and ensure program enrollees satisfy court requirements.
- Reduce recidivism of program enrollees by providing a comprehensive Integrated care FSP program with a “wrap-around” approach focused on recovery.
- Reduce the likelihood of recidivism by increasing program enrollees success in other life domains such as housing stability and behavioral health stability.

Project Performance

To track changes and implementation over time, RUHS-BH reports will be developed to provide regular data and evaluation on the program implementation; including status of staffing and service delivery, housing utilization, client enrollment and service utilization, and outcomes. Reports will be presented for review to the stakeholder advisory group to provide a regular feedback mechanism. RUHS-BH evaluation unit developed with consultation resources.

- ✓ Regularly measuring the results (outcomes) of services
- ✓ Using this information to increase efficiency and effectiveness in service delivery.
- ✓ Reporting important indicators of program operations and results.

Data Management

Data Sources :

RUHS-BH will be utilizing the RUHS-BH ELMR electronic health record (EHR) to collect and maintain information on a significant portion of the client level data. The electronic health record will contain the treatment episodes, client demographics and service data necessary to determine if the program is serving clients as intended. It is expected that each Integrated Care FSP program will enter the client into the ELMR EHR and create a treatment episode that is specific to the Integrated Care FSP program reporting unit. Once the client is enrolled into the program and electronic health record the client chart documentation is attached to the specific Integrated Care FSP in the EHR. The contractors providing the program will be required to enter all the chart documentation and services records into the ELMR EHR.

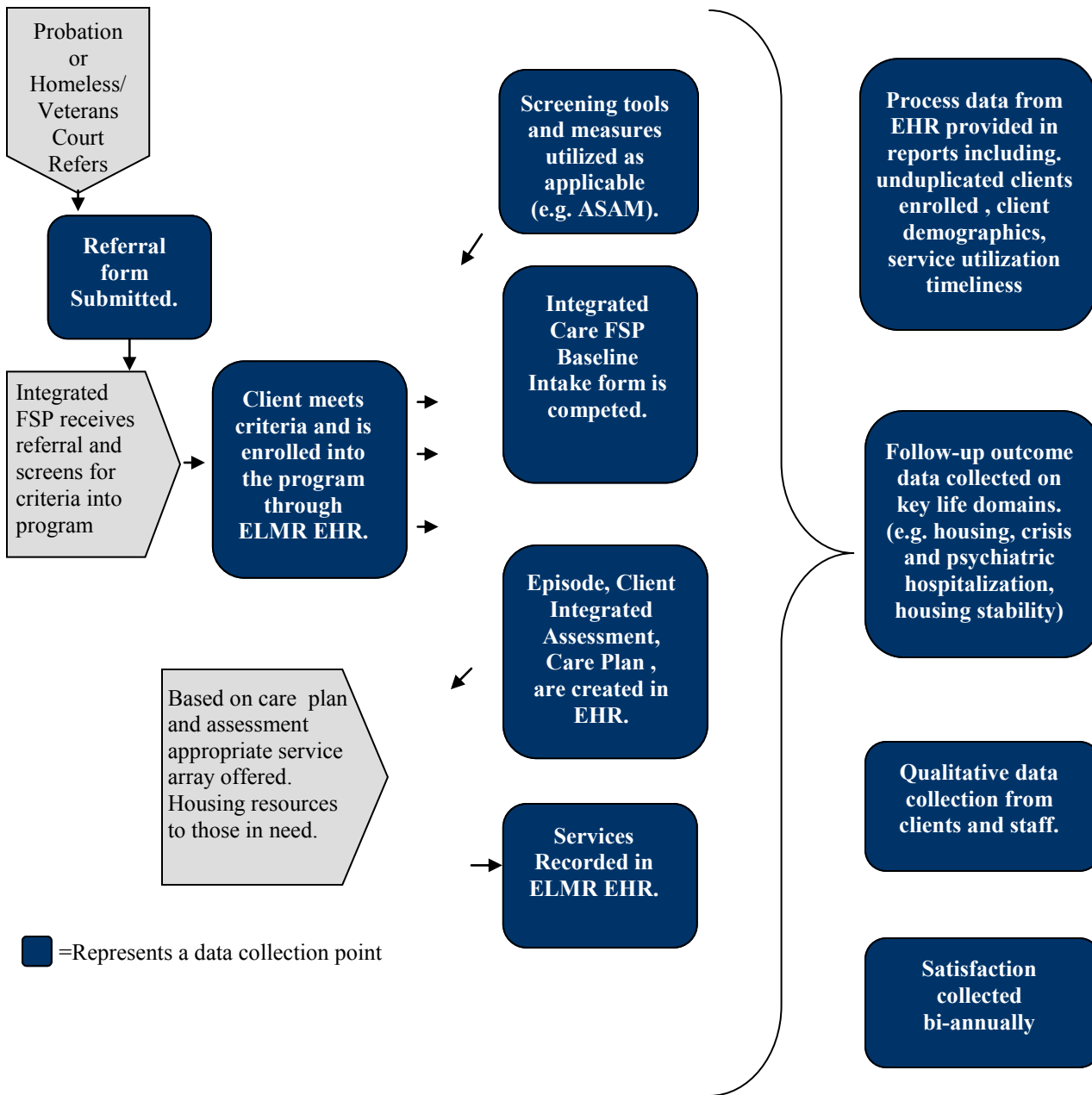
Each individual service provided is recorded in the EHR under the specific Integrated Care FSP program reporting unit. These service records include the date, service code, and duration of service. Length of stay (treatment episode admission to treatment episode discharge) and the various treatment modalities utilized by program participants will also be available in the EHR. The contracted Integrated Care FSP provider will be responsible for entering the enrolled client into the ELMR EHR and maintaining appropriate chart documentation in the EHR including the Assessment, Diagnosis, Care Plan, and progress notes which includes each specific service record. The American Society of Addiction Medicine screening tools is also maintained in the EHR.

A pre to post quasi-experimental design will be utilized to compare program enrollees improvements in key outcome domains. Baseline data will be collected on multiple variables across these domains at intake into the program. Follow-up data will be collected through out the clients program participation with data collected at least quarterly. This outcome data will be collected utilizing a baseline intake form and a quarterly follow-up form for each client. The baseline and follow-up measures are designed to collect the same information so that the data can be used as a pre to post measure on key outcomes . The baseline outcomes data collection form will include information on clients in the year prior to their enrollment in the program, and will include arrests/law enforcement contacts, jail days, probation legal status, housing status, sources of financial support, employment, use of psychiatric emergency room, inpatient psychiatric hospitalizations, and health insurance and other benefits. Follow-up forms cover the same variables as the baseline and are used to track changes in the key domains. Client program closure forms will be used to document the reason a client closed out or left the program (successful completion, new law violation, unable to locate etc...). Satisfaction forms on consumers perceptions will also be utilized.

Qualitative data collection will occur at least twice a year with both clients and staff utilizing a combination of interviews and focus groups. Focus group questions will be developed in conjunction with the local advisory committee. The intent of the focus groups will be to gather information from staff and client's perspective to further examine how the program is working.

It is expected that probation partners will participate in an MOU data sharing agreement to ensure that recidivism data can be collected and analyzed. The intent of the focus groups will be to gather information on the client's perspective of how the program is working; and to identify the extent to which they attribute their success to the programs activities.

Data Workflow



Research Design

The evaluation plan for the RUHS-BH Integrated Care FSP will include both process and outcome measure collected using both quantitative and qualitative methods.

1. Process Evaluation:

- Project Development:** As described in the project grant proposal the Integrated Care FSP was developed in collaboration with the Local Advisory Committee (LAC). In developing the program approach the LAC took into account the challenges faced by individuals with serious mental health, substance abuse and/or co-occurring disorders who are frequently cycling through the criminal justice system. An model of service similar to the Full Service Partnerships was developed as it was considered to be the most comprehensive “wrap-around” approach that could be adapted to fit the needs of this population. Qualitative key informant interviews and information flowing through the LAC will be collected to provide a running narrative as the program rolls out.
- Project Implementation:** A Request for Proposals (RFP) was developed to enlist a community based organization (CBO) to provide the Integrated Care FSP program. The RFP outlines the program structure and requirements with regards to the use of mental health and substance abuse evidenced based practices, criteria for service delivery, staffing and documentation of all services and outcomes. Once a provider is selected based on the most competitive response to the RFP then training and program oversight will begin to ensure the program rolls out services as intended. Communication to the LAC on implementation progress will be utilized to keep the program on track to deliver services and to ensure accountability. Qualitative information on the process of program implementation will be maintained and described in reports to the LAC. Evaluation staff will be involved in the LAC and the will attend the program staff meeting regularly to collect and maintain information on program implementation.
- Services and Staffing:** It is expected the Integrated FSP program will utilize court based teams to engage individuals identified by the court for possible referral to the program. The Integrated FSP services will be based on the Full Service Partnership model of care that provides intensive treatment, case management, support, and wrap-around services based on the principles of mental health and substance abuse recovery. Programs will be required to be State certified to provide both Specialty Mental Health Medi-Cal Services and Drug Medi-Cal Services. The CBO providing the Integrated FSP staffing will consist of multi-disciplined teams of licensed/waivered, certified and paraprofessional practitioners that include peer support counselors. All licensed or certified providers shall be dually trained and competent to provide assessment and treatment for mental health and substance abuse disorders as required and as authorized by State regulations. Paraprofessional staff shall include peer counselors consistent with the recovery model of care. Program contract monitoring will be used to ensure staffing is within the guidelines outlined in the RFP and required under the contract that will be established once a provider is selected. Service data will be collected in the RUHS-BH EHR and service utilization reports will be generated from the EHR to closely monitor service delivery. Staffing will also include 2 full time equivalent (FTE) Behavioral Health Specialist and two FTE Peer Support Specialists who will be employed as court based engagement teams to identify and link clients to the Integrated Care FSP.

Research Design

1. Process Evaluation (continued):

The RUHS-BH Integrated Care FSPs are expected to serve 90 clients in two regions of the County for a total of 180 clients served. Using process data the evaluation questions to be addressed and achievements documented include; 1). Is the program serving the intended population?, 2). Is the program serving the number of clients expected?, 3). Is the service array provided appropriate and delivered as expected?, 4). Are clients been referred to community supports?

As described in the previous data management section the majority of the process data collection will be accomplished utilizing the RUHS-BH electronic health record (see data management section and diagram on pg4). The RUHS-BH Research and Technology Evaluations unit has direct access to the electronic health record data and utilizes both crystal reporting and SQL data management and reporting tools. Utilizing these tools it will be possible to track and report on the process data shown in Table 1. Regular reports on process data will be discussed and reviewed in the Local Advisory Committee meetings. Dashboards will be developed and utilized when possible.

Table 1

- ✓ **Total unduplicated clients served within time frames defined by selected parameters, such as monthly, quarterly of FY number served.**
- ✓ **Demographic of clients served (Age, Gender, Race/Ethnicity, Language).**
- ✓ **Diagnostics (Mental Health, Substance Abuse, and Co-Occurring)**
- ✓ **Timeliness of service after engagement and enrollment .**
- ✓ **Service utilization including service type, duration, and frequency.**
- ✓ **Utilization of Peer Services.**
- ✓ **Service retention**
- ✓ **Discharge Reason from treatment episode**

Additional Process Data: Referrals and utilization of resources such as housing or vocational programs. Physical health referrals and utilization. Utilization of residential substance abuse programs, or medication assisted treatment. Specific data will be collected and analyzed on the number and percent referred to housing resources after program enrollment, including timing and utilization of housing services. The Housing Coordinated Entry System will also be utilized.

Research Design

Outcome Evaluation:

Evaluation questions to be addressed include; 1). Can collaboration with the courts and probation result in successful diversions of clients into the program through recruitment by outreach and engagement teams?; 2). Will the Integrated FSP program reduce recidivism for enrolled clients?; 3). Will clients maintain participation in the program?; 4). Will clients mental health or substance abuse issues be stabilized with reductions in crisis or psychiatric hospitalizations?; 5). Will clients housing stability be maintained or improve?

It is expected a pre to post design will be utilized for outcome measures. Key life domains collected at baseline and at follow-up points will provide the data to measure changes over time for clients (see data management section pg 4). Evaluation of outcome objectives is described in the following evaluation matrix.

Outcome Evaluation	Measurement	Data	Plan
Divert individuals with a history of MH or SA from Conviction or Incarceration with cases in Veterans or Homeless court by enrolling into Integrated Care FSP	Number and percent enrolled in Integrated Care FSP by Source of Referral.	Referral forms and ELMR-EHR	Calculate number and percent of clients referred that enroll in the program. Gather qualitative information on the establishments of collaboration and flow into program from jail.
Reduction in recidivism	Number and percent of enrolled clients with a conviction of a new felony or misdemeanor committed within 3 years of placement on supervision for a previous conviction (PC Sec 6046.2 (d)).	Follow-up Key life domain outcome forms, and arrest/conviction data from courts.	Calculate recidivism each full FY of program implementation. Compare to other recidivism rates available from probation
Program Retention	Number and percent of clients maintaining participation in treatment services.	EHR service utilization data	Analyze service and length of stay data to determine level of participation in program.
Pre to Post comparisons of Key Life domains (reductions in crisis and inpatient psychiatric admissions, decreased jail days, improvements in sources of financial support)	Reductions in the number of crisis or hospital admissions. Outcomes on Key life domains collected on baseline and follow-up forms.	Baseline and follow-up Key life domain outcome forms	Compare clients baseline information with changes documented on follow-up forms
Housing Stability maintained or improved	Number and percent of homeless clients connected to housing. Reductions in days spent homeless. Number and percent in stable housing.	Baseline and follow-up Key life domain forms	Calculate the number obtaining housing and the number maintaining housing stability

Expected Intervention:

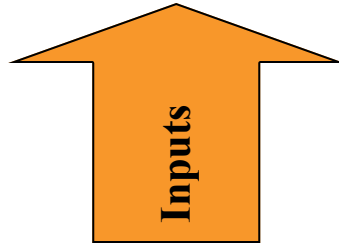
Criteria for entry into the program is as described in the program proposal. The targeted population are adults with misdemeanors and serious mental illness, or substance abuse disorders identified through the Veterans Court, Homeless Court, or from probation

The Integrated Care FSP is a comprehensive approach with a service array that is based on an integrated assessment of all enrolled clients mental health, physical health, and/or substance abuse needs, and the development of a client driven treatment plan to address the physical, mental health and/or substance abuse issues that are impacting the client's overall functioning. As such clients will receive a "wrap around" approach with multiple program elements that are expected to work in concert and compliment each other. Services will be individual, group and family therapies, including evidenced based trauma-informed practices that include education of the consumer regarding his/her mental illness, substance abuse, physical health, the interface between these issues and the effects (including side effects) of prescribed medications. Additionally, interventions will be utilized that assist the consumer to identify the symptoms and their occurrence patterns and development of methods (internal, behavioral and adaptive) to lessen their effects. Services will support life-skill building across the clients life domains, system navigation and access, household management, health and wellness training and support, peer-support, and when possible family counseling. Examples of the interventions include: Motivational Interviewing; CBT/DBT; Illness and Recovery Management; Seeking Safety; peer support groups, targeted case management and linkage, psychiatric evaluation and medication services, including medication, physical health evaluation and linkage to physical health care, indigent medications (e.g. Psychiatric and Medication Assisted Treatment for Substance Abuse disorders).

As described in the data management section on pgs 3 and 4, all clients will be entered into the RUHS-BH electronic health record which will provide data on the demographics, services received, length of stay in the program, and discharge data from the program. The RUHS-BH EHR includes data elements for demographic characteristics (gender, race/ethnicity, age, language, veteran status), episode of treatment (date of entry, discharge date, and discharge reason), and individual client level service records for each individual service provided (service date, service type, service duration). Diagnosis for each client is also recorded in the electronic health record. It is also anticipated that data will be collected on improvements in behavioral health symptoms and for those with a substance abuse issues the reduction of substance use (days sober). The selection of a behavioral health improvement measure will be done with the contracted provider (once selected) and the Local Advisory Committee with input from RUHS-BH Evaluation unit to ensure program buy-in to the measure selected. Process data combined with collecting data on changes in key life domains along with changes in the experience of mental health symptoms, and or the experience of substance use will provide the information necessary to evaluate program outcomes. Information collected from qualitative data collection will provide additional perspectives on program implementation and the clients thoughts on how the program has impacted their lives.

Collaborative Partnerships and Strategic Coordinated Work

Local Advisory Committee



Collaborations with Probation, Veterans and Homeless Courts

Establishment of two regional Integrated Full Service Partnership Treatment programs

Training on Evidenced-based Practice & Trauma Informed Care Leveraging Resources Technical Assistance Fidelity Monitoring

