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Mental Health Services for Older Adults: Creating a System That Tells the Story

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“Very little data exist to document MHSA-funded public mental health services and to track outcomes in California.”

SUMMARY: In 2004, voters in California approved Proposition 63 for passage of the Mental Health Services Act (MHSA). From that time until 2014, over \$13 billion in the state’s tax revenue was allocated¹ for public mental health services. There is very little information available to answer critical questions such as these: How much of this amount was spent in the interests of older adult mental health? What benefits were gained from services delivered to older adults? This policy brief promotes

recommendations for specific age-relevant indicator utilization and for an expanded system of uniform and transparent data for all types of MHSA-funded programs. These two policy directions are necessary in order to document the older adult mental health care services provided and to track outcomes at the state level for MHSA programs. A third recommendation centers on assuring that the mental health workforce is prepared to utilize and report age-relevant data indicators.

Mental Health Services Act (MHSA) Overview: Transforming Delivery of Public Mental Health Services

Since its passage by California voters in 2004, the Mental Health Services Act (MHSA) has aimed to transform the delivery of public mental health services from a crisis care model to a consumer wellness, recovery, and resilience model. This transformation provided an opportunity for the continued development of an Older Adult System of Care (OASOC) and expansion of older adult mental health services.^{2,3} MHSA revenue — over \$1 billion yearly—represents about one-quarter of the total mental health funding for all California counties. Between the 2004 MHSA passage and 2014, over \$13 billion in tax revenue was moved into MHSA funds¹ for public mental health services. Neither the amount allocated for older adults’ services nor the outcomes of services to older adults are known by the state.¹

“Stakeholders want to measure the performance of the Mental Health Services Act, which was established to transform the public mental health system into a recovery-based, client-driven, culturally competent set of mental health services. Accountability to the vision of transformation requires that performance indicators be developed to measure progress in ameliorating the negative outcomes of mental illness.... However, a complete set of performance indicators has not been articulated so far.”⁴

– California Mental Health Planning Council

“There is a marked lack of mental health services data for older adult age groups.”

MHSA funds are distributed to all counties to provide programs and services within five components:

- (1) Prevention and Early Intervention
- (2) Community Services and Supports
- (3) Innovation
- (4) Capital Facilities and Technological Needs
- (5) Workforce Education and Training

Community Services and Supports (CSS) is the largest segment of MHSA programming, with a revenue of \$1.482 billion in FY 2016-2017, and provides a variety of therapeutic and support services to the seriously mentally ill. CSS funds four service categories: Full Service Partnerships (FSP), General System Development (GSD), Outreach and Engagement (OE), and the MHSA Housing Program.⁵ The FSP is a small, comprehensive program for those most in need and provides “whatever it takes” in services to support mental health recovery and resilience. The FSP has, by far, the most robust reporting requirements. The MHSA also established the Mental Health Services Outcomes and Accountability Commission (MHSOAC) to oversee the implementation and evaluation of services.

An ongoing concern about MHSA performance, in general, is the lack of transparent accountability data for MHSA services implementation. Furthermore, there is a marked lack of data for older adult

age groups.^{1,6,7} In 2016, a new data system sponsored by the MHSOAC was developed for MHSA Clinical Supports and Services (CSS) programs, which include the FSP program. The goal of this new optional CSS Tracking, Monitoring, and Evaluation System Project was to understand how best to track, monitor, and evaluate CSS programs using an outcomes-based approach. It is another resource for counties that wish to collect data systematically through their CSS delivery system, but it does not include data collection for individuals being served through MHSA Prevention and Early Intervention programs (PEI) or Innovation Program services.

In the same time frame, the MHSOAC contracted with the UCLA Center for Health Policy Research to identify a core set of appropriate assessment measures and outcome indicators for older adult mental health services, summarized below.

Key Indicators

After an extensive literature search and key stakeholder input, we identified 10 key concerns in mental health for older adults (Exhibit 1). For these concerns, we have identified 23 indicators that are either specific for or known to be effective with older adults. The recommended indicators are fully defined and described in the project’s final Indicator Report.⁸

Recommended Key Indicators for Older Adult Mental Health Services

Exhibit 1

Mental Health Concern	Recommended Indicators
Affective Disorders (varies)	Depression Screening ^a Depression Assessment and Management ^{a,b} Anxiety Assessment ^b
Suicide Risk ^{b,d}	Suicide Risk Assessment (Individual) Suicide Risk Assessment (Systems Level)
Medication Review ^{a,b,d}	All Medications Review
Cognitive Health ^{a,d}	Cognitive Assessment
Alcohol Use and Substance Misuse ^{a,b,d}	Alcohol and Substance Misuse Screening, Brief Intervention, and Referral to Treatment (SBIRT)
Independent Living ^{b,d}	Housing Help and Stabilization Independent Living Assessment (Basic and Instrumental Levels)
Social Connections and Social Isolation ^{c,d}	Social Connectedness Engagement in Meaningful Activity
Consumer/Family Satisfaction with Care ^{c,d}	Experience of Care Rating of Care Access to Care by Diverse and Special Populations Culturally and Linguistically Competent Care
Continuity and Integration of Care (varies)	Comprehensive Health Assessment Follow-up Care, Post-MH Hospital/ER Care ^{a,b,d} Comprehensive Coordinated Care ^{b,d} Behavioral Health Care Coordination with Other Services ^{b,d} Diabetes/Cardiovascular Disease Screening for People with Schizophrenia
Health Services Utilization ^{b,d}	Psychiatric Hospitalizations Emergency Room Use for Mental/Behavioral Health Care

a = represented in the meaningful use indicators

b = collected for clients enrolled in MHSA Full Service Partnerships

c = collected through the MHSIP Older Adult Consumer Survey for reporting on National Outcome Measures (NOMs) for recipients of SAMHSA Community Mental Health Services Block Grant

d = proposed collection in new CSS Tracking, Monitoring, and Evaluation System

Currently, almost all of the older adult mental health concerns identified already have some type of required or suggested reporting measure for CSS programs.⁴ Also, several of the indicators are identified by the Centers for Medicare and Medicaid (CMS) as being for “meaningful use,” which provides reimbursement for data collection.⁴ However, *how* these measures are collected and reported varies across counties. Reporting for PEI programs and those housed within Innovation funding are scant. Very few counties are using age-relevant measures for older adults. In the full report, specific measures effective with older adults are defined and linked to national quality standards.

The Benefits and Challenges of Indicator Adoption and Implementation

With the number of older adults in California growing, adopting standardized measures for assessing need, access, efficiency of care, and quality of care for older adults is a priority. There is considerable variation in how counties collect and report currently “required” data. Changing to a standardized data collection and reporting system and incorporating older adult-specific indicators present challenges. However, the new, optional CSS Tracking, Monitoring, and Evaluation System provides a tool for standardizing data collection so that the same information can be collected

“There is considerable variation in how counties collect and report currently ‘required’ data.”

“California must create a standardized minimum data requirement across counties.”

in the same way across all 58 California counties. If all or most counties decide to utilize this new system, it will allow the MHSOAC to aggregate outcome data reports for MHSA services at the state level that are reliable. The new CSS system will also be able to accommodate additional indicators designed for other MHSA programs (such as PEI) and for specific populations (such as the ones we have recommended for older adults). The expansion of value-based care and reimbursement models creates more opportunity for looking at the comprehensive needs of older adults who have chronic physical and mental health conditions. Value-based care holds the promise of increasing quality and reducing costs, but a robust set of data from across the health care network is required in order for it to work effectively.

It is necessary to balance the potential benefits for quality of care with the burden, or perceived burden, of data collection at the county level. Statewide data collection must be purposeful, with clearly articulated goals and plans for data utilization. The state provides reimbursement to counties for collection of mandatory reporting data. Thus far, while there has been piloting of data reporting for children’s mental health services, there has been nothing specific regarding data reporting for older adults with complex and unique mental health service needs.

As a beginning, it is essential for California to systematically determine which data elements counties are currently collecting by MHSA program type and by population group, including older adult services (and among these, services for older adults that may be provided within an Adult System of Care). Creating such a repository would not only help achieve an understanding at the state level of what is being collected, but it would also identify those counties with more robust reporting practices that could be models for other county data-collection expansion. Requiring counties to collect and report on

indicators relating to the Older Adult System of Care is vital to the state’s responsibility for oversight of the MHSA.

Policy Recommendations

Based on this work, we have identified three recommendations for policy change. If implemented uniformly in all California counties, these changes would strengthen county and state data reporting, promote utilization of appropriate mental health screening, and provide monitoring and outcome measures for uniformly assessing the quality of mental health care provided to older adults.

1. At the state level, create an expanded uniform minimum data requirement for all MHSA-funded programs for persons over 60 years of age who use the continuum of older adult mental health services funded by MHSA, to include:
 - a. Assessment and monitoring tools designed and tested for, or known to be effective with, older adults.
 - b. Inclusion of measures specific to older adults within planned state longitudinal tracking systems to regularly collect data for mental health assessment, treatment, and follow-up care; utilization of these data to establish or enhance service quality improvement for older adult mental health services.
2. Utilize the new expanded uniform minimum data (recommendation 1) for all MHSA-funded programs for persons over 60 years of age to prepare and disseminate, on a regular basis, plain language state- and county-level reports, to document (at a minimum):
 - a. Numbers of older adults served by age
 - b. Differences in age categorization and racial/ethnic older adult groups served
 - c. Effectiveness of services, including older adult consumer ratings of care

3. Provide training sponsored by MHSA Workforce, Education, and Training (WET) funds to all county mental health personnel, including clinicians, involved in delivering MHSA mental health care and prevention services to older adults in order for counties to accomplish the above recommendations. Training should be provided once for existing personnel and again upon the hiring of new personnel. Training topics should include general information about older adults and mental illness; age-relevant data collection requirements and recommendations; and the use of age-relevant screening, assessment, and management outcome measures. This recommendation requires immediate action to continue MHSA WET funding, since the original MHSA legislation sunsets WET funding at the end of fiscal year 2017-18.

Conclusions

The indicator development component of our project embraced the spirit of key stakeholder input by utilizing the Project Advisory Committee (PAC) to fully guide this work. We developed a comprehensive Indicator Matrix (available in the full report) that is summarized here. The recommended indicators represent critical areas for mental health services within a comprehensive Older Adult System of Care. The real work ahead is to act on the recommendations to systematically improve the data collection concerning mental health services for older adults across all counties.

Critical action steps are needed at both the state and county levels. California must create a standardized minimum data requirement across counties, and it must also provide resources for data collection and continued workforce development. The state has already moved in this direction by sponsoring the

development of the optional CSS Tracking, Monitoring, and Evaluation System Project. While this is a very important step, it falls short by not requiring standardized reporting for all MHSA programs and not including age-relevant outcome measures.

Counties have a particularly important role in identifying a workflow process that allows for ease of data collection, minimizes burden, and supports quality improvement. If a county does not have an Older Adult Advisory group comprised of older consumers and older adult mental health experts, one should be formed to guide this work. Counties should proceed in a deliberate and perhaps incremental way to assure that there is true system change and that it occurs with adequate stakeholder input.

Mental health stakeholders and older adult advocates also have a critical role in system expansion and quality improvement. In the decade since the MHSA was funded, the pendulum has swung in the direction of county autonomy, which is very important for assuring that local needs are met through service planning. An unintended consequence of this localization of decision making is that 58 different versions of mental health outcome reporting have emerged. The new CSS data system is a building block that can be expanded to include all MHSA program data and age-relevant outcome measures. It is critical that data for all programs sponsored by the MHSA are reported in a standardized and appropriate way for the populations being served.

“Mental health stakeholders and older adult advocates also have a critical role in system expansion and quality improvement.”

Data Sources and Methods

The UCLA research team, which included two consultants who are national mental health and aging specialists, conducted secondary analyses of existing reports. The analyses included the examination of reports related to outcome and performance commissioned by California's Mental Health Services Oversight and Accountability Commission (MHSOAC), state stakeholder organization reports on performance monitoring, California mental health data reporting systems data dictionaries and reports, county-specific assessment tools and resources, and national mental health quality improvement materials. The team identified quality indicator thresholds and appropriate age-specific goals for effective systems of mental health care, as well as approaches to performance monitoring that are adaptable to the changing needs of older diverse populations. Each of the indicators recommended is critically important to older adult mental health, representing highly prevalent or predictive health concerns.¹⁰⁻²⁶ Throughout the study, project activities were guided by the key stakeholder Project Advisory Committee. The full Indicators Report and Appendices are available at <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1559>.

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MHSA Evaluation:

This policy brief is part of a six-county study of public mental health services for older adults funded by the MHSA. For more information on this evaluation, and to see all related publications, please visit: <http://www.healthpolicy.ucla.edu/Older-Adult-Mental-Health>

Endnotes

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