



Very Rough Notes!
Data and Evaluation Subcommittee
June 28, 2007

Attendees: Steve Woodcock, Devin Raynor, Stan Gilbert, Julie Maher, Jon Collins, Angela Long, Jill Petersen, Kris Anderson, Tony Biglan, Vicki Nishiki, Nancy Koroloff, Margie Rowland, Theresa Rice, Vera Kraynick, Nancy Latini, Jeanne Negley, Marion David, Susan Arbor. By phone: Cynthia Jaeger, Marcia Hille, Maria Duryea, Stephanie Boyer, Becca Sanders and at least one other person.

Comments on the Oregonized SOC principles (I will pass these on to people who are working on these...)

need to include one on use of evidence based practices—But often times there is not a research base around options that families would like to have available and sometimes over emphasis on that takes away things that families want.

Concern is to make sure that effective interventions are available, not to take away.

Concern that outcomes are insufficiently specific—continually monitored at the local and state level for effectiveness

Need to be sustainable—make sure that the policy alignment is there. Much has to happen at the systems level. Financing policy is also sustainable.

On 12, supported by is not strong enough—directed by? Driven? And continually monitored by representatives of different stakeholder groups.

4 should explicitly include at the system level as well.

Anyone who has a specific suggestion will email to Janet.

Looking at the logic models and trying to get to outcomes:

DhS has recently implemented gender-specific services for youth that is now a policy for DHS – would recommend this as a general approach that we should include

AMH is currently using the youth services survey for families—

Is that a tool we want to recommend—it touches on the main issues. A number of states are using it and it is reported for the blocki grant

Possibly convene a stakeholder group to review possible measures for these various things.

Nothing that goes to the access issue—include something about initiation and engagement. Access and availability—need to have enough providers and be able to get in to receive the services in a timely manner.

So can track how many visits within a period of time.

Are services available in a timely way.

And from last time, we need to know how many of potentially eligible are getting services

Also need engagement—lots of services are not family friendly so we need to know if folks are not engaging.

Enough services, timely, and engaging/acceptable

Need quality services

What would the professional outcomes look like—example, teacher or therapist's willingness to be part of a child and family team if they are approached and tracking

Also evidence that these are stressful lines of work—turnover and high stress and now there are interventions to reduce that.

How do provider attitudes look, job satisfaction

There is a fair amount of agreement about what the key service level ones are, what are the core system outcomes may be harder to track?

What are the most sensitive outcomes?

Biggest challenge is allowing us to talk to one another. We can't match between child welfare and mental health. CW and MH may be well organized within each "silo" from local to state, but in other areas, the databases are maintained locally and they can't/don't share data across localities.

From JJ perspective: the most sensitive indicator is did they commit more crimes. Also checking on the fidelity of our EBPs and then looking about if kids are going to those programs are they committing less crimes. Helps us move away from "traditional" approaches that really don't work.

Even if it is not feasible, what would be ideal is to link outcomes from our system and if they are successful does that impact other outcomes—like school engagement, school completion—and ultimately make for better transition?

So is there even a unique identifier—kids do have unique identifier in education but other systems use different ids so can't match on that.

Currently there is no way to track data across systems. So first recommendation is to have a shared unique id.

Another recommendation: Address confidentiality requirements across systems-- some of HIPPA stuff is myths. Most complaints of violations or blocking of services is because people are overdoing HIPPA. It's not intended to block quality improvement. Ask for and get guidance. Get the federal OK on this. Fear has become one of the biggest barriers. We know other states have done it.

There are two different kinds of information—point of service and being able to communicate across agencies that are serving a kid, and then the back end with administrative data—you can share and what comes into play more are the state laws. This is easier to share. State administrative databases

I would not recommend the unique identifier path—I don't think it will ever happen. Look at other ways to match up data.

One possible outcome is that we can share data both at the service level and for evaluation of the system.

IT infrastructure can become a barrier—if we say you need to track this, some places don't have the infrastructure to support that reporting.

No one has the resources to house all database so it would need to have a home of its own.

State data is based on retrospective, not for planning in real time. Is that a problem for planning across agencies.

For system planning it works fine, but for planning for a child, it doesn't help. Need to do administrative type things to share data in local agencies.

So service planning needs to be done at a local level.

Process measure, locally how well are local agencies able to share.

Can that be uniform across localities.

AMH has uniform processes, but that is with providers.

AMH tells providers what outcomes to report and that we can aggregate. Outcomes act as guiding principles.

So some of the different agencies would be collecting the same measures.

The value is only if you can connect it at the individual child and family level. You can't do cost analysis otherwise.

Currently for matching—often use Medicaid id, with jj we match using parts of first and last name gender and date of birth. Software that does a probabilistic match.

Take the list of outcomes—one element of the system is that all agencies are doing the same assessment. JJ activity and stability of housing and the number of times they run away.

So there is AMH outcome measure. Will email

Some times link to Juvenile Justice but that is not the primary way. And it's hard to track though we can track them with their Medicaid id as to what kinds of medical/mh services they get

whatever measures are used there should be a strengths-based component to it. We can recommend that.

Taking it back to the family level, putting together a plan. Some kids will have JJ and some will not, how do you tie into that—what does that look like to measure the outcomes for your child and your plan.

Want to keep it simple.

Need to also measure needs met on a completely individualized measures. Wraparound Milwaukee has each team rate needs met as defined by the team. This is measure performs well.

For some families graduating from school is not their priority—they may define success differently.

This does not preclude measuring other, more typical things. You can be responsive and still look at those other measures.

There are system level outcomes that don't just look at aggregated child and family data—eg workforce, other things we could look at to keep a handle on the systems change. That can give you immediate effect.

So yes you need process and outcome measures at the system level as well.

We need to get more specific with 5-10 outcomes. Then start thinking about how to measure them.

We have no comprehensive way in the state to report comprehensive outcomes on the region, district, probably OYA can look at localities and their success in reducing criminal rate, but there is not single place where someone could look at how things are going in their area.

Federal gov't has the array of services that they recommend or have as mandatory.

This group is recommending a lot more in terms of standardization across the state than is usual for Oregon.

Providers may not really like that and the possible burdens that come along with that

Brainstormed lists of possible outcomes service and system:

System outcomes:

Single plan of care

Single point of access—no barriers, no filling out tons of forms

Proportion of families that need services that get it

Efficient use of funds—integrated system should be more cost effective

Outcomes are assessed for any family that is in contact with the agencies

Management decisions are based on the data

Cultural competence—equal access?

Measure of collaboration—are people from different agencies working together

Sharing information as needed both at local and state level

Integration—eg of mh in schools, CW with mental health and education, etc.

Workforce: people are skilled in evidence-based interventions

Workforce: people feel supported around stress, could measure turnover, extent to which people feel they have the training they need. Openness to new treatments

Education of workforce—cultures of each system, people need to have learning about other systems

Making services seamless across age categories, barriers are addressed—have a lifespan approach

Community readiness—need to measure

Actual services that are being provided: ones families want, ones that have evidence

Certain array of services available in all places across the state, for all kids (not just ones who get publicly funded services)

Stuff needs to be cost effective,
efficient not too much paperwork!

Information moves where it's needed, eg across geographical areas

Common procedures across the state for access

State needs to hold localities responsible for certain of the outcomes, including process outcomes

Standardized intake form

Way to correct records when they are wrong so that errors are not perpetuated—families can get records modified so that the misinformation is taken out. This should not be hard to do.

Families should be able to access their kids' records—copies of records on discharge (you can have a web based system so that the information belongs to the patient)

Better way to quickly address grievances that is not painful to families

Service level

Families feel that services are integrated—is getting services easier-- and getting the outcomes they want

Uniform assessment—make appropriate referrals

Single care plan

Shared monitoring form—plan review is uniform. Including things like which agencies are involved.