

# Children's Mental Health Initiative National Evaluation

## Supporting Statement

### B. COLLECTION OF INFORMATION EMPLOYING STATISTICAL METHODS

#### 1. *Respondent Universe and Sampling Methods*

Although most funded CMHI grantees are expected to participate in the Evaluation to some degree, the extent of each grantee's participation will be limited as much as possible. (See Table 1).

**Table 1. Participants: Respondents for each data collection activity by grant cohort, data source, and frequency of data collection**

Data Collection Activity	*Grant Type	Data Sources	Frequency
<b>All eligible grantees</b>			
Key Partner Interview	All grantees	High-level key partners <ul style="list-style-type: none"> <li>• Project director</li> <li>• Heads of child-serving agencies</li> <li>• State-level directors of family and youth organizations</li> <li>• CMHI quality monitors</li> </ul>	Twice for all grants: during the first 12 months and the last 12-18 months of grant funding.
SOCESS	All grantees	Key Partners <ul style="list-style-type: none"> <li>• Project director</li> <li>• Heads of child-serving agencies</li> <li>• State-level directors of family and youth organizations</li> </ul>	Baseline within the grant's first 18 months, then annually through end of grant funding, for all grants.
Network Analysis Survey	All grantees	<ul style="list-style-type: none"> <li>• Project director</li> <li>• Heads of child-serving agencies</li> <li>• State-level directors of family and youth organizations</li> </ul>	Twice: Baseline within the grant's first 18 months of grant with follow up 2-3 years later
Financial Mapping Interview	All grantees	Financial administrators	Twice: Baseline within the grant's first 18 months with follow up 2 years later
Financial Plan Interview	All grantees	Financial Plan Manager	Interviews years 2 , 3 and 4
Child and family outcome instruments	Children and Families receiving grant funded services	<ul style="list-style-type: none"> <li>• Children aged 0 to 5</li> <li>• Youth age 11-17</li> <li>• Young adults age 18-26</li> <li>• Caregivers of clients age 0-17</li> <li>• Administrative and/or clinical records <ul style="list-style-type: none"> <li>• GIS analysis performed on census block data from administrative record</li> </ul> </li> </ul>	Intake, discharge, 6 and 12 months (while receiving SOC services)  GIS: Intake

Data Collection Activity	*Grant Type	Data Sources	Frequency
<b>Convenience Sample</b>			
Benchmark Tool	Volunteer grantees	Data compiled by personnel working with state Medicaid and MH Authority reporting and payment systems	Twice: Baseline for two cohorts within the grant's first 18 months. Follow-up 2 years later for the first cohort.

### Sample Size and Power Analysis for the Child and Family Outcome Component.

For the child and family outcome component, it is important that CMHS draws enough participants from each grantee to ensure the evaluation will be able to detect the impact of the SOC initiative on child and family outcomes. If the number of participants is too small, significant differences of an important magnitude might go undetected. The effect sizes of the phenomena of interest form the basis of determining the minimum number of participants needed through a statistical power analysis.<sup>1</sup> In order to obtain complete follow-up data on 74 participants per grantee, it will be necessary to enroll 90 families into the evaluation for each grantee (based on a 90% retention rate at each follow-up data collection point). If SAMHSA assumes that grantees will serve 45 children for each full year of service delivery, 112 children will be served during the 2.5 years of enrollment period (i.e., the first six months will be start-up and the last year will be follow-up data collection). An initial response rate of 85% will allow the enrollment of 90 families.

CMHS conducted power analyses to determine the appropriate sample size. The overall goals of the Evaluation are twofold. CMHS believes that individual grantees should obtain a sufficient sample to conduct meaningful analyses for their own use. CMHS also needs to obtain sufficient data to conduct cross-site analyses related to the overall evaluation questions. Therefore, CMHS ran separate power analyses for these two separate yet related domains.

For individual grantee power analyses, CMHS uses the G\*Power application to estimate the needed sample size using the following assumptions. CMHS assumes an average of three time points of data to be used in repeated-measures ANOVA. CMHS also assumes a retention rate of approximately 90% at each time point (for an overall baseline to 12 month follow-up retention rate of 81.5%), power of .80, an effect size of .26 or higher, repeated measures correlation of .5 or lower, and level-1 (time) variability of 1.0. Using these assumptions results in an estimated final (complete) sample size of 74 at each individual grantee needed in order to detect between-group differences in change over time in communities for their local analytic purposes.

For cross-site analyses, CMHS used the Optimal Design application to estimate the Minimum Detectable Effect Size (MDES) using the following assumptions: 69 Grantee Sites, three time points of data, a 3-level longitudinal Multilevel Growth Model testing a quadratic trend, a

<sup>1</sup> NOTE. Briefly, the power of a statistical test is generally defined as the probability of rejecting a false null hypothesis. In other words, power gives an indication of the probability that a statistical test will detect an effect of a given magnitude that, in fact, exists in the population. The power analysis does not indicate that a design will actually produce an effect of a given magnitude. The magnitude of an effect, as represented by the population parameter, exists independent of the component and is dependent on the relationship among the independent and the dependent variables in question. The probability of detecting an effect from the data, on the other hand, depends on several major factors in multi-level or repeated-measures frameworks, some of which include: (1) the level of significance used; (2) the size of the treatment effect in the population; (3) sample size; (4) the intraclass correlation(s), that is, the amount of individual variance accounted for by membership within a group (or nesting), or, similarly, the correlation among repeated measures; (5) the amount of measurement error.

retention rate of approximately 90% at each time point and an overall baseline-to-12 month follow up retention rate of 81.5%, power of .80, residual variability of .3, level-1 (time) variability of 1.0, and 74 people for each grantee. The MDES ranges from .17 (very small effects) for an ICC of .10, .22 for an ICC of .20, and .27 for an ICC of .30.

Each participating grantee will be expected to recruit a sufficient number of children and families to ensure enrollment of 90 children and families in each grantee (or 74 after attrition). Complete data on 74 children and families in each of the 69 Grantee Sites will result in a final sample of 5,106 client families with complete data at the end of the year 2018. This sample size will be large enough to ensure the ability to detect changes in outcomes over time at both the local and national levels.

## ***2. Information Collection Procedures***

SAMHSA has contracted with Westat to conduct the Evaluation. Westat, and its subcontractors and consultants (listed in Section B.5), are referred to throughout this document as the CMHI National Evaluation. Child and family level data will be collected by local service provider agencies. The CMHI National Evaluation will conduct all other data collection activities directly with respondents. The CMHI National Evaluation will provide training and TA regarding child and family outcome instruments added to the CMHI portal and support grantees in the collection of child and family outcome data. The CMHI National Evaluation will receive de-identified client-level data from all grantees. Table 1 shows each data collection activity by respondent and data collection interval.

## **Implementation Assessment**

The evaluation is designed using a strategic framework (adapted from Stroul and Friedman 2011 and Stroul, Dodge, Goldman, Rider and Friedman, 2015) that provides five analytic dimensions: 1) policies, 2) services/supports, 3) financing, 4) training/workforce, and 5) strategic communications). These dimensions cut across the State System, Local System and Service Delivery levels and together link to a range of proximal and distal outcomes. The evaluation will identify and assess the mechanisms and strategies employed to implement and expand systems of care, and explore the impact on system performance and child and family outcomes. Evaluation activities are framed by the five strategic areas to examine whether specific mechanisms and strategies lead to proximal and distal outcomes. System of care principles are woven throughout the framework at both the State and Local levels. The evaluation tools are designed to allow analysis across levels.

***Key Partner Interview.*** The Key Partner Interview organizes qualitative data collection into these five areas and will allow within and across grantee evaluation of the implementation and impact of activities in these areas. The semi-structured interview will be conducted by phone with administrators, youth and family representatives and child agency representatives. This interview will be conducted twice, once at baseline during the first twelve months of grant implementation and once during the final 12-18 months of grant implementation.

***SOCES (System of Care Expansion and Sustainability Survey).*** The SOCES is designed to capture self-report implementation data using the strategic framework adopted by the

2015 National Evaluation that consists of five analytic dimensions: 1) policies, 2) services/supports, 3) financing, 4) training/workforce, and 5) strategic communications) as discussed above. The SOCESS organizes self-report data collection into these five areas and will allow within and across grantee evaluation of the implementation and impact of activities in these areas.

This self-report survey will be administered via the online CMHI portal. Respondents will rate items on a Likert-type scale. Respondents will include representatives from approximately 54 grantee organizations and representatives from family and youth organizations, child-serving sectors, advocacy organizations for diverse populations, provider organizations, and financial officers, among others. Evaluation staff will identify potential respondents through previous evaluation efforts (e.g., document review, Key Partner Interviews) and invite those partners to participate in this component. Grantees will complete this survey in the first 12 to 18 months of funding and annually thereafter through the end of their funding period or June 2018, whichever comes first.

### **Network Analysis and GIS Component**

***Network Analysis Survey.*** This survey will be administered online to grantees via the CMHI portal described in Section A.3. Respondents will be high-level participants such as project directors, heads of child-serving agencies, and leaders of family and youth organizations. The survey will collect data on agencies and organizations with whom the respondent interacts as part of the SOC implementation and expansion effort. The list of these partner agencies and organizations will be developed based on document review, interviews with key partners, and other data collection efforts. In addition, respondents will have the opportunity to identify additional agencies/organizations with which they interact. For each survey item, respondents will report the extent to which their agency/organization engages in that activity with other agencies. In addition, the CMHI National Evaluation will ask respondents to indicate whether those relationships are formalized (i.e., whether there are written agreements, memoranda of understanding, or contracts). The initial survey will be conducted within the first 18 months of the grant's funding, with the second administration 2 to 3 years later.

***GIS. Child and family.*** For children/youth receiving services and their caregivers, grantee staff members already obtain addresses as part of routine intake procedures. To obscure families' identity, the CMHI National Evaluation will provide grantee staff with software that converts home addresses to census block groups. Site staff will enter census block group data into the CMHI portal (but *not* addresses). This information will be collected at baseline only. Client/ family addresses will not be part of the evaluation dataset or transmitted by the grantees to SAMHSA or its contractors.

Grantees will participate in this Evaluation component in years 2 and 4 of their funding cycles.

### **Financial Mapping and Benchmark Component**

***Financial Mapping.*** The CMHI National Evaluation will make information requests and conduct semi-structured interviews with key grantee administrators and staff. Specifically, data will be collected on children's MH funding sources for all states, counties, and tribes with CMHI

grantees during the first 18 months of the grant and the next to last or last 12 months of the grant funding period. The CMHI National Evaluation will review publicly available information to develop a preliminary list of children's mental health services in the state, county or tribe. This list will be sent to interview respondents at least a week prior to the interview with a request to make any needed corrections. The corrected list will then be incorporated into the interview schedules. The interview schedules will be shared with state and county agencies, and with tribal representatives who can describe Medicaid-funded, MH Authority-funded, and Indian Health Service-funded services in the form of a WebEx. In addition, the CMHI National Evaluation will also speak to representatives from family organizations about their funding sources and provider associations to learn what services are covered by commercial insurance plans. Key information from interviews with Mental Health agencies, Medicaid agencies and tribal authorities will be summarized in a matrix, and sent back to respondents for validation.

***Financing Plan.*** The Team will collect data on grantees' strategic financing planning process through an interview in years 2, 3 and 4. This analysis will include funding sources considered and the reasons for excluding any potential funding sources, agreements achieved to braid or pool funding, and barriers and facilitators to planning. The final interview will be conducted in the fourth year of the grant focusing on how the financial planning process supported or hindered attainment of sustainable financing.

***Benchmark Component.*** Each grantee volunteering to participate in the Benchmark Component will receive preparation support for and begin cost data collection upon OMB approval. Data will be collected during the first 18 months for two cohorts. Data will be collected during the third and beginning of the final year of the grant funding period for the first cohort. Volunteer state or county MH and Medicaid agencies will collect and report a core set of data that will be used to calculate access, utilization, and costs for child MH services. The CMHI National Evaluation will provide states and counties with contact information to reach Evaluation staff if they have any questions about the data request. Evaluation staff has considerable experience in collecting these types of data and can effectively clarify any confusion or help to address limitations or problems that states may encounter when generating the requested information.

## **Child and Family Outcome Component**

We will use SAMHSA's existing data reporting requirements for the SAMHSA National Outcomes Measures (NOMS) system to identify persons for whom data will be collected for The Child and Family Outcome Study. Clients will need to: (1) receive services through a selected local service system within a funded grantee; (2) meet the local system's service program eligibility criteria for SOC services; (3) be between age 0 and 26 years; (4) have a MH diagnosis; (5) not have a sibling already participating in the Evaluation; (6) have a participating caregiver if the client is age 0 to 17 years old; and (7) provide informed consent/assent, as appropriate based on client age. Data collection for this Evaluation component will begin soon after OMB approval.

Child and family data will be collected at intake, 6-months, and 12-months post service entry (as long as the child/youth is still receiving services). Data will also be collected at discharge if the child/youth leaves services before the 6- or 12-month data collection point. Evaluation staff will

collect these follow-up data from caregivers of minor children and adolescents (age 0 to 17) and from youth and young adults age 11 to 26.

### ***3. Methods to Maximize Response Rates***

Several steps will be taken to maximize response rates and reduce non-response bias for all data collection efforts. The CMHI National Evaluation will lead and/or be available to support each data collection process. The CMHI National Evaluation will provide ongoing technical assistance and remain available to grantees and other respondents to respond to questions and provide clarification or guidance whenever needed.

For most data collection activities, the CMHI National Evaluation will collect data from participants involved in the planning, implementation, and expansion of SOC. Efforts to maximize response rates are presented here by type of data collection method, as these apply across evaluation components.

- *Requesting documents.* Document requests will be combined across other Evaluation components to minimize the number of requests and to avoid duplicate requests..
- *Identifying respondents among participants.* The CMHI National Evaluation will work with the grantee's project director to identify the appropriate people to interview. All respondents will be partners in the planning, implementation, and expansion of systems of care and will participate in the evaluation as part of the performance of their roles.
- *Scheduling interviews.* The CMHI National Evaluation will be flexible in scheduling interviews, provide a copy of the interview schedule ahead of time, and respect the specified time limits. To make the best use of informants' time, the CMHI National Evaluation will review available documents and perform web searches to collect publicly available information prior to the interview. To keep logistics and costs manageable, interviews will be conducted with individual informants by telephone, Skype, or video-conferencing.
- *Site liaison model.* Individual CMHI National Evaluation staff will serve as a site liaison to each participating grantee to facilitate communication in ways that the CMHI National Evaluation anticipates will enhance response rates, data quality, and grantee motivation. In addition, the site liaison model will enable the CMHI National Evaluation to understand the grantees more comprehensively, which will be of value when interpreting findings.

The CMHI National Evaluation anticipates that grantees and other participants will be particularly motivated to participate in several data collection efforts of the Evaluation. Examples relevant to specific Evaluation components are as follows:

- *Financial Mapping.* The CMHI National Evaluation anticipates that most informants will be interested in finding ways to financially sustain their SOC and will be motivated to participate in the Financial Mapping component. The CMHI National Evaluation will follow up with the people interviewed to share the draft financial map to confirm the

CMHI National Evaluation's understanding of the state's use of funds, which the CMHI National Evaluation anticipate will further enhance motivation to participate

- *Benchmark Component.* In the past, the CMHI National Evaluation has successfully collected similar data from over 31 state and county MH authorities and/or Medicaid agencies, who also participated on a voluntary basis. Grantees that elect to participate will be able to benchmark their state's use of children's MH resources against other participating states. The CMHI National Evaluation believes that states with well-developed information systems that can readily compile the needed data will be interested in the rare opportunity to compare how they use inpatient and residential care to other states. States in the cohort that will be benchmarked twice will also have the opportunity to document how expansion of their SOC may have changed their service use pattern and expenditure rates. This information may be valuable in demonstrating the business case for SOC to legislators and other participants.

#### **4. Tests of Procedures**

The selection of data collection activities was based on a review of those used during the earlier National CMHI Evaluation (OMB Nos. 0930-0192, 0930-0209, 0930-0257, 0930-0280, and 0930-0349) in consultation with individuals involved in both evaluations; an assessment of measurement quality as reported in the literature; and decisions about data collection activities were made in conjunction with expert reviewers, consumers, and family members. These consultants are listed in Section B5. In addition most data collection activities proposed by this request have been thoroughly tested previously to minimize burden and refine the current collection of information. Testing consisted of pilot testing interviews and review of protocols by experts on systems of care. The extensive previous testing makes use of any further pre-testing unnecessary. Feedback from the previous testing was used to clarify individual questions, including re-wording items and adding definitions of terms, and additional information was added to instructions and introductory sections of the tools to provide additional clarity. Grantee participants also provided feedback on the presentation and display of the data collection tools (particularly those displayed online) to make the administration more user-friendly. For example, grantees indicated that it was helpful to display the Key Partner interview questions on the computer through WebEx so that they could read the questions at the same time the interviewer asked them.

#### **5. Statistical Consultants**

The CMHI National Evaluation has full responsibility for the development of the overall statistical design, and assumes oversight responsibility for data collection and analysis for this Evaluation. Training, TA, and monitoring of data collection will be provided by the CMHI National Evaluation. The individual responsible for overseeing the entire evaluation, including all aspects of the design, data collection and analysis, and who had some involvement in the prior CMHI Evaluation, is the Principal Investigator:

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## **List of Attachments**

- 1. Evaluation Logic Model**
- 2. Semi-Structured Key Partner Interviews**
- 3. SOCESS**
- 4. Network Analysis Survey**
- 5. Financing Plan Survey/Interviews**
- 6. Financial Mapping Interview Protocol**
- 7. Financial Benchmarking Tool**
- 8. Child and Family Level Data Tool**