Proposal for Multnomah County Mental Health System Analysis
CSS #4000005995

Human Services Research Institute
7690 SW Mohawk Street, Building K
Tualatin, OR 97062

September 11, 2017
September 11, 2017

Tamara Bertell, Contract Specialist
Multnomah County Department of County Management
501 SE Hawthorne Blvd, Suite 200
Portland, Oregon 97214
Email: tamara.bertell@multco.us

Re: CSS #4000005995
Evaluation Strategy Consultant – Mental Health System Review Project

Dear Ms. Bertell,

Human Services Research Institute (HSRI) is pleased to submit this proposal for the above referenced solicitation.

This letter serves as our official proposal binding our organization to the terms, conditions, and provisions included in the solicitation. This proposal is predicated upon all the terms and conditions of the CSS and it is firm for a period of least 120 days from the date of receipt by Multnomah County Department of County Management. I am authorized by the HSRI Board of Directors to sign and negotiate on HSRI’s behalf with the County relating to this solicitation.

We thank you for allowing us the opportunity to bid and look forward to your reply.

Sincerely,

David Hughes, Ph.D.
President
Telephone: (617) 844-2527
Email: dhughes@hsri.org
The Human Services Research Institute (HSRI) is pleased to submit this response to the Multnomah County, Department of County Management, Evaluation and Research Unit for Evaluation Strategy Consultant services. As experts in the assessment of behavioral health systems at the state and county level—including system mapping, gap analyses, and simulation modeling to project future need—we are well-equipped to quickly generate findings and provide actionable information to increase coordination and collaboration, inform development of effective policy and protocols, and support better alignment of behavioral health services in Multnomah County.

HSRI is a nonprofit organization founded in 1976 and headquartered in Tualatin, Oregon and Cambridge, Massachusetts. Our researchers, data scientists, and policy analysts work with government agencies to improve public health services and systems—and to improve the quality of the data for health and human services policy reform. In our 40 years of operation, we’ve applied multidisciplinary expertise to project work with clients at the federal, state, county, and program levels, performing research and consulting projects for 28 federal agencies, 50 states, and over 100 counties and cities. We offer:

- Deep understanding of models and systems across the health and human services sectors
- Experience using claims data to conduct gap analyses and evaluate behavioral health systems
- A strong track record of working with advocates, providers, and other constituents/stakeholders
- A 40-year track record of successful project management

1. Describe your specific experience creating inventories and mapping complicated, multi-jurisdictional, and/or overlapping systems. Please provide examples of this work, if applicable.

HSRI has extensive recent experience conducting analyses of complex systems, like the system described in the CSS solicitation, at the county and state level. In the past five years, we’ve conducted behavioral health system assessments for Pierce County, Washington and Milwaukee County, Wisconsin and for the state of California and state of North Dakota to address issues with access and service delivery. These projects involved a systematic examination of services, supports, and other activities related to the promotion of social and emotional wellness and the prevention and treatment of mental health conditions and substance use disorders. For these projects, we reviewed and comprehensively mapped complex health, social service, educational, and criminal justice systems, sought information and gathered feedback from an array of stakeholders, analyzed claims and service utilization data, and formulated actionable recommendations focused on closing identified gaps. Below, we provide brief descriptions for each project; references are available upon request.

**Pierce County Behavioral Health Needs Assessment (2016).** HSRI, at the request of the Pierce County Council in Washington state, conducted a study of the Pierce County behavioral health system. The purpose of the study was to address three major questions identified by the Council:

1. What is the prevalence of behavioral health issues in the County?
2. What is the extent of prevention and treatment services available to address behavioral health issues in the County?
3. What services, policies, or practices should the County pursue to address gaps in the system that would provide the best return on investment?

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1 Final report is available on the HSRI website and on the County’s website at [https://www.co.pierce.wa.us/DocumentCenter/View/44349](https://www.co.pierce.wa.us/DocumentCenter/View/44349)
The study team synthesized quantitative and qualitative data to produce a comprehensive picture of treatment and prevention needs; available emergency, inpatient and community service resources; utilization; and gaps related to this service array. In addition to analyzing existing data from multiple sources to assess prevalence and utilization, the study team conducted key informant interviews, conducted stakeholder surveys on needed services and reasons for unmet needs, and held community feedback listening sessions. We supplied recommendations related to: investing in prevention, balancing inpatient and outpatient services, developing a universal “Front Door” to connect individuals to services in a timely fashion, developing crisis alternatives such as crisis residential programs and peer respite, expanding the use of remote health interventions, supporting efforts to enhance and integrate provider data systems, and developing system metrics to track progress on key goals.

The Milwaukee County Mental Health System Redesign (ended 2015). This project addressed systemic issues with access and service delivery within the adult mental health system in Milwaukee County, including outpatient service utilization\(^2\) and inpatient bed capacity\(^3\). HSRI used an encompassing empirical approach to examine services needed and received and reasons for differences, access and quality of services, service utilization and outcomes. The project involved working closely with stakeholders in Milwaukee to understand the system relationally. Additionally, HSRI used its system planning simulation model, which has been used in 25 states, to dynamically forecast the impact of delivering different service options. HSRI convened stakeholders, including state administrators, Medicaid representatives, and service user and provider groups to develop a rigorous redesign plan. HSRI also surveyed case managers, providers, and service users on their views on available and needed services. To develop recommendations for system improvements, HSRI made use of: key informant interviews; community input; data from the service planning and evaluation surveys of case managers, providers, and consumers; service utilization and assessment data; and data on national best practices. HSRI made recommendations regarding finance strategies and legislative, policy and regulatory actions that will foster sustainability of the service redesign and achieve system transformation.

North Dakota Behavioral Health Needs Assessment (2017 and ongoing). HSRI is currently conducting a comprehensive needs assessment for the Behavioral Health Division of the North Dakota Department of Human Services. Dr. Croft, who we propose to lead the work for Multnomah County, is the Director of the North Dakota project. As part of the North Dakota project, HSRI is reviewing all prior behavioral health needs assessments, reports, and existing quantitative data for the state; collecting new information from stakeholders involved with public, private, and tribal services through key informant interviews and focus groups (over 50 interviews and focus groups have been conducted); and conducting a comprehensive analysis and mapping of the types, amounts, and locations of behavioral health services using qualitative and quantitative data. By blending stakeholder information with available quantitative data, we can present a thorough accounting of not only system gaps but also perceived root causes, barriers encountered, and possible solutions to those barriers. In carrying out this project, we have collaborated closely with various state staff to obtain existing data and ensure representation by the population of known stakeholders. The project work has also involved working closely with leaders from each of the four sovereign tribal nations in the state to gather information about unique behavioral health-related needs and resources of the Native American populations using culturally responsive methods.


California Health Reform Initiative (2011-2014). The California Health Reform Initiative—funded by the Centers for Medicare and Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the California Endowment—was an examination of how the Affordable Care Act (primarily Medicaid expansion) would impact California’s behavioral health system. HSRI partnered with the Technical Assistance Collaborative to develop decision-support systems that forecast the costs and service utilization the State could expect as health reform took shape. The project team examined administrative claims and eligibility data from Medicaid and Medicare, and from California’s Department of Mental Health and Alcohol and Drug Programs, from a 5-year period to identify trends and simulation modeling strategies to predict future utilization and expenditures, including the federal share and state share for the Medicaid expansion population. The team also employed techniques such as synthetic estimation to link national large-scale databases to state data to examine trends at both the county and state levels.

2. Describe your specific experience with qualitative research, including developing and conducting key informant interviews and/or focus groups.

Three of the four projects referenced above involved state-of-the-art qualitative research methods, and members of the proposed research team have received doctoral-level training in these approaches and published qualitative research results in peer-reviewed journals (see our response to Question 3 as well as resumes in Appendix A for more detail). In these and other HSRI projects, we ensure scientific rigor in all research activities, including interview guide development, sampling, conducting interviews and focus groups, and the use of analytic methods such as grounded theory and content analysis.

HSRI has detailed processes in place to obtain informed consent, provide confidentiality and anonymity when possible, and minimize research burden on participants. To ensure the conduct of ethical research and the protection of human subjects, all qualitative research activities are reviewed and approved by HSRI’s Institutional Review Board.

3. Describe your specific experience researching health, mental health, or other social service fields. If you do not have this experience, how would you supplement your knowledge?

As an organization, HSRI has conducted research in the areas of mental health and substance use prevention and treatment, and other social service fields, for over 40 years. And the members of our proposed research team have decades of this experience between them. All staff assigned to this project have direct relevant experience and expertise to effectively and efficiently provide the County with findings related to improving the County’s mental health system.

Bevin Croft, PhD – Project Director. Dr. Croft will have full authority and responsibility for performance on this project. With extensive experience as the Project Director of the Pierce County and North Dakota projects, Dr. Croft will lead the project team and monitor technical, budget, and schedule performance. She will also be responsible for assuring the quality of all tasks and deliverables. She will serve as the point of contact for all project-related communication to streamline the process. She will manage project timelines, staffing, meeting agendas and minutes, and data deliverables in close collaboration with the project team. Dr. Croft will be joined by three experienced research staff at HSRI: Linda Newton-Curtis (Senior Research Associate), David Hughes (Senior Advisor), and Rachael Gerber (Data
Each team member has experience in data collection, management, and analysis; evaluations; and gap analysis.

Dr. Croft has a doctorate in social policy from the Brandeis University Heller School of Social Policy and Management. She is a behavioral health researcher at HSRI and uses a mix of qualitative and quantitative approaches to conduct research and program evaluation. In addition to her systems analysis work, she is the project director for the evaluation component of the multi-state *Demonstration and Evaluation of Self-Direction in Behavioral Health*, funded by the Robert Wood Johnson Foundation. She was also the project director of an evaluation of the 2nd Story Peer Respite program in Santa Cruz, California, funded by a SAMHSA Mental Health Transformation Grant and one of the first peer respite programs in the US. Dr. Croft was also involved in SAMHSA-funded evaluations of the HIV/AIDS-Related Mental Health Services in Minority Communities project, the Services in Supportive Housing Program, the Mental Health Transformation State Incentive Grant, and the Minority Fellowship Program.

**David Hughes, PhD – Senior Research Advisor.** Dr. Hughes will advise the project team on relevant national developments with his work on projects with SAMHSA, CMS and the National Association of County Behavioral Health and Developmental Disability Directors. Dr. Hughes is the president of HSRI and a nationally recognized expert in the field of behavioral health services research—with particular expertise in evidence-based practices, outcome and quality measurement, and cost simulation models. Currently, Dr. Hughes is serving as Senior Advisor on the behavioral health needs assessment in North Dakota. He has worked on more than 30 projects for SAMHSA, CMS and the Administration for Community Living related to systems needs assessment and planning. For CMS, he has provided technical assistance to more than 12 state Medicaid agencies (including Oregon) on home and community-based service mechanisms, program design, service delivery systems and self-direction services—and in particular on 1915(i) State Plan Amendments and behavioral health services.

**Linda Newton-Curtis, PhD – Senior Research Associate.** Dr. Newton-Curtis, who is located in HSRI’s Oregon office, will work with Dr. Croft on data gathering activities, including conducting site visits and in-depth interviews and focus groups with key stakeholders in Multnomah County. Her experience includes the use of both qualitative and quantitative data collection methods, and administrative and survey data analysis to investigate and understand gaps in, and the effects of, human services interventions. She has extensive experience in the coordination of interconnected components of multifaceted evaluations and using the data gathered to provide informative feedback for systems improvements. Dr. Newton-Curtis was part of the team evaluating the Multnomah County, Department of County Human Services, Mental Health and Addiction Services/Family Involvement Team as well as a study located in Multnomah County, funded by the Robert Wood Johnson Foundation, designed to explore how child welfare systems, substance use treatment systems, and judicial systems were developing policy and practices to support positive treatment outcomes for parents. She is currently the project director for the evaluation component of a demonstration project in Ohio funded by the Children’s Bureau and involving the coordinated efforts of Child Welfare, Juvenile Court, the Health Department, and the Addictions and Mental Health Board toward the support of child welfare-involved families where substance use has been identified as a contributing issue. Dr. Newton-Curtis holds a doctorate in systems science with an emphasis in psychology from Portland State University.
Rachael Gerber, MPH – Data Analyst. Ms. Gerber will serve as a data analyst on the project. She will assist the project team with identifying and obtaining summary reports and publicly available quantitative data, analyzing qualitative data, and conducting and analyzing key informant interviews and focus groups. She will also assist the team with reporting. Ms. Gerber is a research associate at HSRI with over eight years of experience in behavioral health services research, including the systems assessment studies for Milwaukee County and Pierce County.

4. Provide a brief overview of how you would design this project. What activities would you perform to meet the deliverables? What, if any, variables do you think may affect the delivery of those deliverables?

Goals and Aims

We at HSRI believe the primary goal of assessing the County’s behavioral health systems capacity and gaps should be to support the County in ensuring a 21st century behavioral health system driven by quality and scientific merit, efficient in coordinating service provision across agencies, and focused on outcomes leading to recovery with minimal barriers to access. The project will involve an encompassing empirical approach that examines service availability, utilization, access, and gaps using state-of-the-art qualitative and quantitative methods and mapping techniques. The HSRI team has implemented similar approaches successfully in numerous projects, four of which were described previously.

Specifically, the goal of this proposed project is to provide Multnomah County with a comprehensive, data-driven understanding of the existing system that includes a consideration of the alignment of community needs and existing resources. Key considerations include the culturally specific needs of populations, the way funding flows through the system, and collaboration and coordination between different entities and systems in the County. Proposed research aims are as follows:

Aim 1: Develop a detailed inventory of all services provided by the County and its community-partner contractors that includes service type, populations served and capacity for culturally specific services, and funding source.

Aim 2: Catalog connections (communication mechanisms, collaborations, and “handoffs”) between each of the services identified in Aim 1, and between the Aim 1 services and adjacent systems and services, including hospitals and health systems, nonprofit treatment providers, law enforcement and corrections, community justice systems, homelessness and housing services, school-based services, crisis services, aging and disability systems, public health, and Coordinated Care Organizations.

Aim 3: Provide a detailed picture of how funding and reimbursement mechanisms flow through County systems, with a focus on state and county general revenues and federal Medicaid dollars.

Aim 4: Identify gaps between community need and existing services, including services that are not available at all or not accessible to certain populations because of geography, language, financing, or other barriers.

All the aims will consider previous related work, particularly existing inventories and maps created by the County, the Behavioral Health Collaborative, and the Local Public Safety Coordinating Council, as well as any resources discovered as part of HSRI’s data-gathering process. The proposed team has significant experience working with communities to identify relevant existing resources and incorporate past learnings so that our efforts add value and are not duplicative.
Foundational Assumptions

The following three assumptions are the basis of our proposed approach:

**System Complexity.** Mental health systems today are becoming increasingly complex, presenting new challenges for needs assessment and planning. In past years, mental health services were divided between two relatively distinct sectors: 1) a publicly funded array of inpatient and outpatient services primarily for people with serious, long-term mental health conditions, most of whom were uninsured; and 2) a sector consisting of private providers serving individuals with less severe or more acute conditions, with services funded by insurance. Substance use treatment was similarly divided into public and private sectors, with service users differentiated primarily based on insurance status. Today those boundaries have blurred, and the structures within each sector have become more diffuse. Consequently, assessing the need for services and identifying gaps in a given locale has become much more challenging. The complexity of mental health systems today requires innovative approaches to assessing need for planning purposes. HSRI’s approach considers community needs in relation to specific features of need related to sub-groups, service types, workforce characteristics, etc.—and in the context of system capacity, the potential for adding new resources, reallocating existing resources, and increasing efficiency. This rigorous process involves examining all available data and conducting detailed interviews with a wide range of stakeholders—including agency staff, providers, advocates, and consumers—to identify system strengths, limitations, bottlenecks, and opportunities for improvement. This approach has proven an effective one for not only assessing the capacity of the current health system but also for generating information needed to combat system stressors: The complexity of contemporary health systems means that performance shortcomings, limitations, and gaps in one part of the system may have consequences for elements of the system that are functionally far removed. In an example derived from previous HSRI system evaluations, a case management program may lack policies and procedures for discharging individuals who are no longer in need of that level of service, with the result that access for individuals newly entering the system who would benefit from the service is blocked. As a distal consequence, these underserved individuals may be more likely to experience behavioral health–related crises that result in ED visits and, from there, hospital admissions.

**Measurement Benchmarks.** An important tool that HSRI uses in identifying system gaps is the 2011 paper published by SAMHSA entitled “Description of a Good and Modern Addictions and Mental Health Service System,” authored by a frequent HSRI collaborator, John O’Brien, during his tenure at SAMHSA. As stated in the paper’s introduction, a modern mental health system is “accountable, organized, controls costs and improves quality, is accessible, equitable, and effective.” The good and modern system includes an array of service delivery sources including general hospitals, state mental health hospitals, community mental health centers, psychiatric/psychosocial rehabilitation centers, child guidance centers, private acute inpatient treatment facilities, licensed addiction agencies, opioid treatment providers, individually licensed practitioners, primary care practitioners, as well as recovery and peer organizations. HSRI’s gap analysis and systems mapping projects draw upon this document as a template for a comprehensive continuum of care against which service systems may be measured.

**Identifying Causal Mechanisms.** An important challenge for systems planning is the difficulty of identifying causal relationships among the components of the system. An example is the problem of emergency department boarding for persons in crisis. HSRI has learned that systems issues such as this, which are initially identified as primary problems, often turn out to be a secondary consequence of limitations elsewhere in the system. Identifying these primary causes and the appropriate ways to

4 [https://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf](https://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf)
address them is no simple task, however. Because relationships among the components of behavioral health systems vary so extensively from one locale to another, there is no single formula. Instead, HSRI’s approach is a combination of rigorous and comprehensive data analysis paired with qualitative evaluation methods, especially focused interviews with stakeholders to understand the dynamics of relationships among the components of the system, where these are problematic, and the options for addressing them in ways that promote a system that espouses the principles of resiliency and recovery, evidence-based practices, effectiveness, and efficiency.

Data Collection and Implementation Timeline

To explore the above aims, we propose a mix of qualitative and quantitative methods and a variety of analytic techniques, including content analysis and system mapping. Our proposed research consists of two major types of data collection:

1. We’ll work with the County to identify key stakeholders of interest and conduct key informant interviews and focus groups with these organizations and individuals.

2. We’ll work with county partners and key informants to identify and obtain existing summary reports and additional data sources, including information about populations served and funding sources. We will also gather publicly available quantitative data that will inform work toward the study aims. If possible and as time and resources permit, we are prepared to work with claims data or other administrative data such as county-generated summary tables defined and requested by HSRI.

We anticipate generating information about the services and systems listed in the CSS solicitation, and are open to adding information on services as the County deems appropriate during the project. For efficiency purposes, to minimize the burden of primary data collection and analysis, we will use existing data sources wherever available. The mapping/inventorying of existing services using qualitative and quantitative data sources will provide a comprehensive descriptive overview of behavioral health service gaps, inefficiencies, and opportunities for improvement. Exhibit 1 identifies our planned implementation timeline and demonstrates the completion of all project deliverables within the requested timeframe.

Exhibit 1. Implementation Timeline for Key Components, October 2017 – June 2018

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<th>Key Internal Tasks &amp; Project Steps</th>
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<td><strong>Task 1: Project Management</strong></td>
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<td><strong>Task 3: Conduct multi-disciplinary stakeholder interviews and focus groups</strong></td>
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<td>3a: Identify stakeholders for key informant interviews and focus groups, schedule interviews and focus groups</td>
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<td><strong>Task 4: Analysis and mapping of qualitative and quantitative data</strong></td>
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<td>4a: Analyze quantitative data, request any additional data needed</td>
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At the start of the contract, members of the HSRI team will meet with county officials for a kick-off meeting. This meeting will serve as an opportunity to discuss the goals of the project, review the required deliverables, and develop a meeting schedule to ensure efficient and quick delivery of the proposed tasks and deliverables. During the kick-off meeting HSRI will work with the Department to determine how frequently project meetings are needed. In the first weeks of the project, these meetings will focus on identifying existing data sources and key stakeholders to be interviewed. Regular meetings with the County will be used to track progress toward each task and proactively address any issues that may impact the timeline.

**Brief Description of Potential Approaches to System Mapping**

To be useful for detailed analysis and planning, mapping a system should do more than provide an inventory of available mental health and substance use services in the county. It should be multi-dimensional so that it may be used to address specific queries—for example, “How do Corrections Health mental health services interact with community supports to ensure individuals returning to the community are connected to needed services?” and “How do mental health treatment providers engage with service users and community groups to ensure services are culturally responsive?” Second, to the extent possible in a complex system, it should be dynamic—that is, it should be able to demonstrate the flow of service users through the system, as well as into and out. Third, it should be aligned with a model of an ideal behavioral health system for the county.

As relates to health care, “system mapping” applies to several different approaches, though each is used to visually represent data. Compared to traditional data tables and chartbooks, system mapping makes it easier to see and draw conclusions about patterns and relationships among data elements. Some of these techniques are computer or internet based, using various software programs; these have the benefit of being interactive, allowing the user to submit queries that result in graphical representation of data elements. HSRI proposes two possible approaches to system mapping, to be decided upon in consultation with the County, or both may be used if preferable. The first is Geographic Information System (GIS) mapping that uses any of various software packages available for representing data with reference to geographic location on the earth’s surface. The second is a static version of computer-based GIS mapping, using color-coded maps to represent the distribution of various elements. The pros and cons of each are described below. (Other more technical approaches for similar purposes, such as network analysis and simulation models, are available. Some of these have been used extensively by HSRI but may not be feasible within the timeline of this project.)
GIS: Familiar examples of GIS mapping in Oregon are the Behavioral Health in Oregon Mapping Tool which shows various types of information about the behavioral health system in Oregon, including service locations, prevalence of behavioral health-related needs, and some financing information. The advantage of GIS mapping is that it is interactive, allowing for queries to display various levels of data. The primary disadvantage is that developing GIS maps is resource intensive, and these maps do not easily represent temporal dimensions—for example, for the purposes of projecting trends.

Color-Coded (Static) Maps: Static color-coded maps of various aspects of health status and health system characteristics are relatively straightforward and may be combined to project trends. Nodes or elements in these maps may include systems and services and may represent whether and how resources move throughout the system, or points of coordination and collaboration among services and systems. Also, static maps may more easily incorporate qualitative data and secondary data from existing reports, whereas GIS mapping generally requires analysis and organization of primary data sets. Like GIS maps, these also lend themselves to web-based presentation; however, they are easier to incorporate into PowerPoint-style presentations to stakeholder groups. The major disadvantage compared to GIS mapping is that they do not allow for the same functionality for more complex queries, though they do allow for switching from maps showing one level of data to another. This limitation can be addressed through an accompanying narrative that describes relationships and patterns based on analyses of underlying data.

5. **Describe your specific experience in written and oral presentation. You may provide samples of reports or presentations, if applicable**

HSRI has extensive experience producing high-quality reports with sophisticated graphics in electronic formats. As an important part of this process, we work closely with the client to identify the target audience(s) and to design reports and other products, such as PowerPoint presentations, in formats appropriate to the audience. Members of the project team are seasoned public speakers with significant experience delivering oral presentations in multiple formats to a variety of audiences—including in briefings to federal government officials, county officials, and to general audiences. We have presented the results of our research in academic and professional conferences, live-streamed webinars, public forums, and training and educational settings. For example, findings from the Pierce County Behavioral Health Needs Assessment were delivered in the form of a detailed final report ⁵, an infographic ⁶, and a two-hour presentation ⁷ to the Pierce County Council and over 100 members of the public that was streamed online and broadcast on a local television station ⁸.

6. **Propose a fixed price for the base project as well as an hourly rate that would apply if additional consultation beyond the original scope of the project is needed.**

HSRI’s fixed price for the base project is $60,000 with payment schedule to be negotiated with the County. This price is all inclusive and includes labor costs for all five tasks: project management, identifying and obtaining existing qualitative and quantitative data, conducting multi-disciplinary stakeholder interviews and focus groups, analyzing and mapping the qualitative and quantitative data,

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⁸ [https://online.co.pierce.wa.us/cfapps/council/iview/councilMeeting.cfm?meeting_dt=9/27/2016%203:00%20PM](https://online.co.pierce.wa.us/cfapps/council/iview/councilMeeting.cfm?meeting_dt=9/27/2016%203:00%20PM)
and producing a final report. Should additional consultation be needed, the hourly rate for the work will be $110.

7. **Describe your ability to meet the desired timeline outlined in this document, or, if you feel the timeline is not reasonable, please describe why, and provide a proposed schedule of each deliverable. Please also provide details about items or issues that you think may impact the timelines once the project begins.**

HSRI has a 40-year track record of successfully completing projects for federal, state, and county agencies. Our project management processes have been finely honed. Although the timeframe specified in the CSS solicitation is somewhat compressed, HSRI has extensive experience meeting such expectations, including the recently completed projects referenced previously.

HSRI will develop and utilize standard project management tools that meet the County’s standards (flow charts, labor loading/monitoring schemas, etc.). We will submit a Work Plan within a week after the kick-off meeting that will include agreed upon timelines. HSRI will revise this key document as necessary for initial approval and to reflect changes that may occur as the project progresses. In addition, comprehensive and effective communication is a cornerstone of our approach. The project team will remain in close communication with the Department throughout the project to ensure the relevance and utility of project activities.

8. **Briefly describe other characteristics of yourself, if a sole proprietor, or your firm or organization that you believe specifically qualifies you to engage in the work outlined in this CSS solicitation.**

HSRI has offices in Tualatin, Oregon and Cambridge, Massachusetts with satellite offices throughout the country. HSRI is a 501(c) (3) nonprofit, nonpartisan research institute with over 50 employees. Our team of nationally recognized experts provides high-quality research, evaluation, program implementation, and data and statistical services.

We support federal, state, and county agencies and local communities in their quest to improve the health, well-being, and economic and housing stability of the populations they serve—and to remove obstacles to quality of life. Simply put, our mission is to help improve the systems that improve lives. We achieve this by conducting collaborative, inclusive research and working to identify sustainable solutions to complex health and social challenges. We conduct this work across all fields of health and human services, including population health, behavioral health, intellectual and developmental disabilities, aging and physical disabilities, child and family well-being, and housing and homelessness.

Having been in operation since the mid-1970s, we understand the complexity of the human services landscape, including the interrelated and co-occurring physical, social, and behavioral factors that affect the health and autonomy of individuals and populations. And we specialize in inclusive research, actively engaging project stakeholders—including consumers and people with lived experience—to pursue effective, sustainable solutions; as such, we have extensive experience managing projects that require coordination across stakeholder groups and agencies.

Our scope of work includes:
- Assisting in the development of policies, the analysis of policy alternatives, and the implementation of policy directives at the federal, state, local, and program level
• Analyzing and reporting on the quality of services and systems; developing and maintaining national data collection protocols and databases regarding outcomes
• Applying rigorous standards for data security and integrity, as showcased in recent “big data” projects in population health
• Developing techniques for resource allocation planning and implementation of resource strategies; facilitating dynamic needs assessment planning using simulation models
• Evaluating programs at the system and program level

HSRI’s project experience includes:
• Multi-faceted evaluations
• Identifying and making recommendations for process improvements
• Conducting capacity analysis
• Collecting, analyzing, and reporting on multi-faceted datasets
• Creating geographical system maps
• Organizing, convening, and facilitating focus groups and interviews with a wide-range of stakeholders (i.e., service users and their families, professionals), including the creation of surveys and questionnaires
• Working in collaboration with all levels of department staff—at the federal, state and local level—who have a range of data and evaluation expertise
• Providing policy and funding recommendations based on federal and state regulations

Experience with Diverse Stakeholder Groups
We’re a strong proponent of participatory or citizen science, and our work is designed to be broadly inclusive. We value the perspectives of persons with lived experience and their families when thinking through the various components of policy development and implementation as well as issues related to system design and quality, and we incorporate these viewpoints into our reports and recommendations. We also work to ensure that our products and deliverables are accessible to people with physical, sensory, or cognitive disabilities and are compliant with Section 508 of the Rehabilitation Act.

Empirical and Evidenced-Based Orientation
We maximize the use of the existing knowledge base, as reflected in published and unpublished materials, when considering approaches and conducting projects as well as conducting our own tests to evaluate the empirical foundations for project recommendations and products.

9. Describe in detail your cultural competency and diversity training, and the expectations of recruited staff that will be working with diverse populations to ensure program values and goals are met.

The ethnic and cultural diversity among our staff promotes a high level of sensitivity and support for a culturally informed approach to our work and culturally competent products and services. Our team includes individuals of Hispanic, African American, Asian, and Middle Eastern descent, members of the Cherokee Tribe, and members of the LGBT community—and our board of directors is similarly and purposely diverse. We also have staff who have lived experience of the mental health system or are family members of people with lived experience. Additionally, our organization was founded on a commitment to engaging service users and members from diverse racial, ethnic and cultural groups in significant roles on project planning and implementation (adhering to the principle of “Nothing About Us
Without Us”). This practice enhances our ability to deliver maximally informed and useful analysis, tools, and services.

Moreover, all of our project activities are informed by the Health and Human Services National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards). For example, when translating materials for our projects or preparing for focus groups, we adapt the materials to ensure the content is pertinent to the target culture, engaging native speakers to assist in this regard.

10. **(Responsible Business Practices)** Please describe, in detail, your firm’s, organization’s, or your, as a sole proprietor, commitment to sustainable business practices, which might include, but are not limited to a formal sustainability program or policy; workplace practices that use electronic communication to submit reports and invoices electronically; use of post-consumer recycled materials; use of alternative fuel vehicles and/or route optimization for business travel; recycling and/or waste management measures; energy conservation plans; water conservation policies; and/or use of certified green cleaning products in the office.

HSRI strives to reduce its carbon footprint with sustainable business practices. These practices include providing virtual work environments to reduce travel, printing, and mailing, and to increase electronic communication. HSRI also employs the latest collaboration and meeting software to facilitate interactive online events, such as webinars and virtual meetings, that promote on-screen sharing and, when appropriate, reduce team members’ need for travel.

Additionally, green-friendly practices are part of our workplace culture, thanks in part to HSRI’s Recycling Committee, a staff-led committee that brainstorms and proposes organizational initiatives and policies focused on energy and resource conservation.

HSRI’s standard practice is to send reports, invoices and products electronically, when approved by contracting officers; this includes the use of electronic signatures. HSRI understands printing is occasionally necessary and as such, has committed to using 100% recycled paper and other office supplies that are recycled and certified green. The printing networks at HSRI are securely linked to staff computers and a unique code is required to print, for security purposes, and to allow HSRI management to track printing use to ensure printing is kept to a minimum. HSRI also promotes recycling management through weekly recycling pickup and specifically encourages staff recycling efforts to decrease waste.
Appendix A: Resumes
Bevin Croft
Research Associate

Profile

Bevin Croft has over ten years’ experience with behavioral health services provision, management, quality improvement, workforce development, and research. Dr. Croft has been conducting research on self-direction since 2009, with a special focus on how to adapt the model to meet the needs of persons with behavioral health conditions.

Selected Project Experience

Project Manager, North Dakota Behavioral Health Needs Assessment
Funder: ND Department of Human Services Behavioral Health Division | Dates: 2017
Contribution: HSRI has been contracted to conduct an in-depth review of North Dakota’s behavioral health system and to produce recommendations and strategies for implementing changes to address the needs of the community. Dr. Croft is assisting the project director in carrying out all aspects of the study, including recruiting key informants for interviews, conducting interviews, and analyzing interview and service utilization data.

Project Director, Comprehensive Behavioral Health System Analysis and Study for Pierce County
Funder: Pierce County Washington | Dates: 2016
Contribution: HSRI conducted a comprehensive analysis to identify and understand gaps in service access. The study identified the prevalence of behavioral health issues, extent of services available to address behavioral health-related needs, and provided recommendations for services, policies, and practices the county should pursue to address system gaps. Ms. Croft oversaw all aspects of the study, including recruiting key informants for interviews, conducting interviews, and analyzing interview data. Dr. Croft also oversaw data analysis of publicly available datasets for the study.

Research Assistant, Milwaukee County Mental Health System Redesign
Contribution: HSRI received a subcontract through the Public Policy Forum to assist Milwaukee County in addressing systemic issues with access to service delivery within the adult mental health system. Dr. Croft assisted with analyzing service utilization and assessment data, and national best practices to develop and draft recommendations for system improvements.

Project Director, Developing the Framework for a Large-Scale National Demonstration of Self-Direction in Behavioral Health
Funder: Boston College | Dates: 2013 - Present
Contribution: HSRI received a subcontract through Boston College to continue the efforts of the Robert Wood Johnson Foundation-funded Environmental Scan of Self-Direction in Behavioral Health Services and Supports, this project involves further developing parameters for program design and plans for a large-scale demonstration and evaluation of self-direction in behavioral health. In addition to refining the demonstration and evaluation parameters, the project involved convening the National Self-Direction Practice Advisory Coalition, a group composed of peers and other practitioners with firsthand experience implementing self-directed behavioral health programs. The project is a joint effort of researchers from the National Center for Participant-Directed Services, University of Maryland, and DMA Health Strategies. Dr. Croft was responsible for overseeing and conducting key informant interviews and was the primary

Education

Ph.D.
Brandeis University Heller School of Social Policy and Management
Waltham, MA
(Social Policy)

M.A.
Brandeis University Heller School of Social Policy and Management
Waltham, MA
(Behavioral Health Policy)

M.P.P.
Brandeis University Heller School of Social Policy and Management
Waltham, MA
(Behavioral Health Policy)

B.A.
Brandeis University
Waltham, MA
(English and American Literature and European Culture Studies)

Professional Experience

Research Associate
(2014 – Present)
Policy Analyst
(2013 – 2014)
Research Assistant
(2009 – 2013)

Human Services Research Institute
Cambridge, MA

Quality Coordinator,
Human Rights
(2007 - 2009)
Program Supervisor
(2005-2007)
Cascap, Inc.
Cambridge, MA
Policy Analyst, *Environmental Scan of Self-Direction in Behavioral Health Services and Supports*
Contribution: Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. This environmental scan was designed to 1) understand barriers and facilitators to self-direction in the mental health and substance use fields; 2) ascertain interest among stakeholders; 3) adapt the model and outcome measures to better fit the needs of behavioral health consumers; and 4) develop recommendations to inform next steps. The scan was a joint effort of researchers from the National Center for Participant-Directed Services, HSRI, and others. Dr. Croft was the primary author of the in-depth literature review, one of the key project deliverables. She also participated in conducting key informant interviews and focus groups, lead the data analysis, and was the primary author of the final report.

Evaluation Specialist, *Project LAUNCH (Linking Actions for Unmet Needs of Children’s Health)*
Funder: SAMHSA-ACF | Dates: 2013 - Present
Contribution: HSRI received a subcontract through NORC at the University of Chicago to evaluate and provide technical assistance to 35 grantees implementing interventions to improve community health for children and families through the implementation of evidence-based practices and the integration of behavioral health and primary care. Dr. Croft is currently involved in providing evaluation related technical assistance to grantees.

Policy Analyst, *Evaluation of the Santa Cruz Peer Respite*
Funder: SAMHSA | Dates: 2010 - 2015
Contribution: The 2nd Story program is a peer-staffed crisis residential program that is an alternative to existing emergency psychiatric services. The program was funded by a five-year SAMHSA Mental Health Transformation Grant. The evaluation examined both process and outcome questions related to the program objectives, including issues related to the program’s implementation. The goal of the peer respite is to provide recovery-oriented, trauma-informed peer support in a crisis respite using the Intentional Peer Support model. Bevin served as the local evaluator for this SAMHSA grantee.

Research Assistant, *Mental Health Transformation State Incentive Grant (MHT-SIG) Evaluation*
Contribution: HSRI received a subcontract through MANILA Consulting to evaluate the overall effectiveness of the SAMSHA-funded MHT-SIG program. The objectives of the cross-site evaluation centered around determining the extent to which the mental health systems became recovery focused, how these transformations impacted mental health consumer recovery, how the transformations resulted in changes in client outcomes (measured using SAMHSA’s NOMs), and to identify factors that contributed to successful transformation of the systems and difficulties encountered along the way. Dr. Croft assisted with data analysis and report-writing for this project.

Honors and Awards

- Provost’s Dissertation Support Award (2014)
- Heller Fund Dissertation Support Award (2013)
- Wyatt Jones Fund Dissertation Fellowship (2013)
- National Institutes on Alcohol Abuse and Alcoholism (NIAAA) Traineeship (2010 – 2013)
- Brandeis University Heller School MPP Program Leadership Award (2010)
- Brandeis University National Committee Scholar (2008 – 2010)

Selected Publications and Presentations


Profile

Dr. Hughes is a nationally recognized expert in behavioral health services research, needs assessments, multi-site evaluations, self-direction, evidence-based practices, permanent supported housing, quality measurement, behavioral health and health cost simulation models and the intersection of the behavioral health and criminal justice systems. He has directed and served in senior roles on dozens of HHS-sponsored projects and has worked on more than 15 projects for ASPE, SAMHSA, ACL, and ACF. He received the SAMHSA Leadership Award for his work on the behavioral health managed care multi-site study.

Selected Project Experience

Project Director, North Dakota Behavioral Health Needs Assessment
Funder: ND Department of Human Services Behavioral Health Division | Dates: 2017
Contribution: HSRI has been contracted to conduct an in-depth review of North Dakota’s behavioral health system and to produce recommendations and strategies for implementing changes to address the needs of the community. Dr. Hughes is responsible for carrying out all aspects of the study, including recruiting key informants for interviews, conducting interviews, and analyzing interview and service utilization data.

Project Director, Comprehensive Behavioral Health System Analysis and Study for Pierce County
Contribution: HSRI conducted a comprehensive analysis to identify and understand gaps in service access. The study identified the prevalence of behavioral health issues, extent of services available to address behavioral health-related needs, and provided recommendations for services, policies, and practices the county should pursue to address system gaps. Ms. Croft oversaw all aspects of the study, including recruiting key informants for interviews, conducting interviews, and analyzing interview data. Dr. Hughes was responsible for overseeing the and the final report which included key recommendations to ensure a comprehensive, cost-effective, and recovery-oriented behavioral health treatment system that meets the needs of the Pierce County community.

Project Director, Milwaukee County Mental Health System Redesign
Contribution: HSRI received a subcontract through the Public Policy Forum to assist Milwaukee County in addressing systemic issues with access to service delivery within the adult mental health system. Dr. Hughes worked closely with stakeholder to design a rigorous redesign plan. Dr. Hughes was responsible for conducting informant interviews, analyzing service utilization and assessment data, and national best practices to develop and draft recommendations for system improvements.

Project Director, California 1115 Mental Health and Substance Use Services Needs Assessment and Service Plan Project
Funder: California Department of Health Care Services | Dates: 2011 – 2014
Contribution: HSRI partnered with TAC to examine how the federal health reform initiative would impact the behavioral health system in California. Dr. Hughes oversaw the examination of 5 years’ worth of Medicaid data to develop cost and beneficiary utilization projections.

Education
PhD
Brandeis University
Waltham, MA
(Social Policy)

MA
Brandeis University
Waltham, MA
(Social Policy)

MA
University of Massachusetts
Boston, MA
(Applied Sociology)

BA
Trent University
Ontario, Canada
(Honors Sociology)

Professional Experience
President
(2017 – Present)

Executive Vice President

Vice President

Senior Research Specialist

Project Director
(1997 – 2007)

Project Manager
(1996 – 1997)

Research Analyst

Research Assistant

Human Services Research Institute
Cambridge, MA
also provided policy assistance regarding the types of benefits and delivery systems needed to serve the Medicaid expansion population.

Project Director, Home and Community Based Services (HCBS) Technical Assistance  
Funder: CMS | Dates: 2015 - Present  
Contribution: HSRI received a subcontract from New Editions to assist them in providing technical assistance to over a half dozen states in response to individual TA requests as well as through the development and presentation of issue papers and webinars. Dr. Hughes is responsible for drafting TA plans, cost estimates and working with states regarding Self-Direction and HCBS research.

Senior Research Specialist, Evaluation of Cooperative Agreements to Benefit Homeless Individuals for States and Communities (CABHI-States and Communities)  
Funder: SAMHSA-CMHS-CSAT | Dates: 2016 - Present  
Contribution: HSRI received a subcontract through RTI International to evaluate two programs: The Cooperative Agreements to Benefit Homeless Individuals (CABHI) and the Programs for Assistance in Transition from Homelessness (PATH). HSRI has the lead for the multi-site evaluation of the PATH program, which is a task under the cross-site CABHI evaluation. Dr. Hughes is involved with the developing the evaluation plan, data collection and data reporting.

Senior Research Specialist, Project LAUNCH (Linking Actions for Unmet Needs of Children’s Health)  
Funder: SAMHSA-ACF | Dates: 2013 - Present  
Contribution: HSRI received a subcontract through NORC at the University of Chicago to evaluate and provide technical assistance to 35 grantees implementing interventions to improve community health for children and families through the implementation of evidence-based practices and the integration of behavioral health and primary care. Dr. Hughes is responsible for developing mechanisms for the delivery of TA, monitoring TA accomplishments, and coordinating TA for both local site evaluations and the project’s multi-site evaluation.

Project Director, Training Materials for Aging and Disability Resource Centers (ADRC) on Mental Health Promotion and Suicide Prevention  
Funder: SAMHSA-ACL | Dates: 2015 - Present  
Contribution: HSRI received a subcontract through Mission Analytics to develop training materials on behavioral health promotion and suicide prevention for the eight states with Aging and Disability Resource Center (ADRC) Part A: Enhanced Options Counseling grants. Dr. Hughes is overseeing the needs assessment which includes interviews, an environmental scan and an online survey. Dr. Hughes is responsible to using these results to develop training webinar and resource guide designed to be adapted as needed for the diverse workforce of those who perform access functions for ADRCs.

Senior Advisor, Developing the Framework for a Large-Scale National Demonstration of Self-Direction in Behavioral Health  
Funder: Boston College | Dates: 2013 - Present  
Contribution: HSRI received a subcontract through Boston College to continue the efforts of the Robert Wood Johnson Foundation-funded Environmental Scan of Self-Direction in Behavioral Health Services and Supports, this project involves further developing parameters for program design and plans for a large-scale demonstration and evaluation of self-direction in behavioral health. In addition to refining the demonstration and evaluation parameters, the project involved convening the National Self-Direction Practice Advisory Coalition, a group composed of peers and other practitioners with firsthand experience implementing self-directed behavioral health programs. The project is a joint effort of researchers from the National Center for Participant-Directed Services, University of Maryland, and DMA Health Strategies. Dr. Hughes is responsible for developing the evaluation plan and design.

Project Director, Evaluation of Programs That Provide Services to Persons Who Are Homeless with Mental and/or Substance Use Disorder  
Contribution: HSRI received a subcontract through RTI International to evaluate four programs: CABHI, the Grants for the Benefit of Homeless Individuals (GBHI), Services in Supportive Housing (SSH), and PATH. HSRI had the lead for the multi-site evaluation of the PATH program. Dr. Hughes was responsible for overseeing HSRI’s work on this project and working with RTI
and SAMHSA staff to coordinate the multiple tasks included in this evaluation. Dr. Hughes was involved with developing the evaluation plan, data collection and data reporting.

**Project Director, Study of the Cost Efficiency of the Mental Health Block Grant Program**  
Funder: SAMHSA | Dates: 2008 - 2010  
Contribution: This project studied the cost-efficiency of implementing evidence-based practices in three states (Arizona, Oregon and West Virginia). Dr. Hughes coordinated all efforts of data collection, including the development of a data layout plan for administrative data and all pertinent cross-walk designs. He also directed efforts at integrating SAMHSA URS (Uniform Reporting System) and NOM measures into the data analytic design and oversee all response to requests by senior SAMHSA Block Grant program staff.

**Mental Health Technical Assistance Provider, National Quality Enterprise**  
Funder: CMS | Dates: 2001 - 2013  
Contribution: For over 10 years HSRI provided technical assistance to state waiver program staff as part of the National Quality Contractor and as part of the National Quality Enterprise. The TA included working with operating agencies and Medicaid agencies to collaborate on the development of performance indicators. Dr. Hughes assisted states with waiver renewals, development of evidence packages, preparation of performance measures, and monographs on topics such as sampling and risk management.

**Project Director, Minnesota Preferred Integrated Network (PIN) Evaluation**  
Contribution: HSRI conducted an evaluation of the Minnesota PIN, an initiative that integrates physical and mental health services in a prepaid health plan and coordinates these with social services. Dr. Hughes oversaw the evaluation in order to address access, quality, accountability, and cost issues associated with integrating physical and behavioral health for the target population of adults with serious mental illness and children with serious emotional disturbance.

**Project Director, Implementing Permanent Supportive Housing for People with Disabilities in Louisiana**  
Contribution: HSRI received a contract to evaluate permanent supported housing programs based in Louisiana. As project Director, Dr. Hughes designed the evaluation component, engaged all stakeholders, and supervised data collection efforts, including data already collected at the state level. Dr. Hughes also developed a management plan for multisite database, including data security and confidentiality and prepared site specific IRB submission. He also directed efforts at responding to a variety of requests for information with quick turn-around time on issues surrounding housing and homelessness.

**Project Lead, Coordinating Center for Managed Care and Vulnerable Populations Project**  
Funder: SAMHSA | Dates: 1997 - 2004  
Contribution: This project facilitated common data collection approaches and analyses across 21 managed care evaluation sites. Dr. Hughes oversaw the development of a multisite dataset and managed all aspects of data collection from documentation to ensure timeliness of data submission. Dr. Hughes conducted multivariate statistical analyses and qualitative data documenting the nature of managed care provided by each site.

**Developer, Mental Health Jail Diversion Resource Allocation and Planning Model**  
Funder: SAMHSA | Dates: 2006 - 2009  
Contribution: This project was funded by SAMHSA to develop a computerized budget simulation and resource allocation model for projecting the costs and potential cost offsets of implementing jail or prison diversion programs for offenders with mental illness. Dr. Hughes oversaw all relevant aspects of model implementation, including convening expert panels that included consumers as well as providers and administrators and federal SAMHSA policymakers and drafting data collection plan. He also supervised all analysis involving the model and designed several implementations targeting at trauma-informed care for mental health consumers involved in the criminal justice system.

**Mental Health Technical Assistance Provider, Money Follows the Person (MFP)**  
Funder: CMS | Dates: 2007 - 2012
Contribution: HSRI received a subcontract through the Ascellon Corporation to assist the Centers for Medicaid and State Operations (CMSO) in providing technical assistance to MFP Grantees. Dr. Hughes provided technical assistance regarding quality assurance, improvement strategies, interventions, and data collection strategies as mandated by the MPP statute.

**Project Director, 2004 Real Choice Systems Change Mental Health Transformation Grantee Technical Assistance**

Funder: CMS | Dates: 2005 - 2009  
Contribution: HSRI partnered with Independent Living Research Utilization (ILRU) to provide technical assistance to the 2004 Real Choice grantees funded by CMS. Dr. Hughes provided ongoing technical assistance and training opportunities to 10 states awarded grants in the mental health area, including veterans and military families. They include designing intervention for supported employment and housing. Mr. Hughes also managed technical assistance efforts focused on the implementation of peer provided services, evidence-based practices, policy briefs to help with local implementation, and regional trainings on implementation, workforce and self-determination. He also prepared rapid turnaround response to request by CMS on various aspects of the technical assistance.

**Senior Research Specialist, Mental Health Transformation State Incentive Grant (MHT-SIG) Evaluation**

Funder: SAMHSA-CMHS | Dates: 2005 - 2011  
Contribution: HSRI received a subcontract through MANILA Consulting to evaluate the overall effectiveness of the SAMSHA-funded MHT-SIG program. The objectives of the cross-site evaluation centered around determining the extent to which the mental health systems became recovery focused, how these transformations impacted mental health consumer recovery, how the transformations resulted in changes in client outcomes (measured using SAMHSA’s NOMs), and to identify factors that contributed to successful transformation of the systems and difficulties encountered along the way. Dr. Hughes was involved in designing the evaluation, data collection, and data reporting.

**Selected Publications and Presentations**


Leff, H.S., Hughes, D., Fisher, W., & Warren, R. Consumer comparisons of hospital and community care resulting from Department of Mental Health facility consolidation: Results of a follow-up of Danvers State Hospital consumes transferred to Tewksbury State Hospital. Proceedings of the Fourth Annual Conference on State Mental Health Agency Services Research (pp. 22-23.). Alexandria: National Association of State Mental Health Program Directors Research Institute, 1993.


Profile

Linda Newton-Curtis is a senior research associate at HSRI. She has been involved in the evaluation of human services interventions for well over a decade with areas of focus that include child welfare, substance use and drug courts, and education. She has extensive experience in the coordination of interconnected components of complex evaluations and using the data gathered to help inform practice. She is currently the project director for two studies involving systems collaboration to enhance outcomes for children and families involved in child welfare. Linda holds a Ph.D. in systems science/developmental psychology in which she used systems concepts to explore the socialization effects of peer networks on academic engagement during childhood. Prior to transitioning to research, she was trained as a physical education teacher and taught PE in London, England, and later taught PE to elementary school children in a multinational/multicultural school in Jeddah, Saudi Arabia.

Selected Project Experience

Project Director, Summit County Collaborative on Trauma, Alcohol & Other Drug, & Resiliency (STARS)

Funder: Summit County Ohio Children’s Services | Dates: 2012 - Present
Contribution: HSRI was contracted to conduct the evaluation of a five-year Regional Partnership Grant designed to assess the impact of enhancements to the collaboration between county human service agencies on drug or alcohol affected child welfare involved families. As project director Linda plans, directs and oversees all aspects of the study working closely with the multiple community agencies to assure that data coming from disparate administrative systems as well as that entered into HSRI’s web-based data system can be merged into analytic files. She provides oversight to staff working on the study, and collaborates and coordinates with stakeholders to ensure study goals are being met, providing regular feedback to county staff.

Senior Research Associate, Oregon Independent Living

Funder: Oregon Department of Human Services | Dates: 2010-2011; 2017 - Present
Contribution: HSRI was contracted to conduct program reviews of the 18 Independent Living Programs in Oregon. The goal of the program reviews is to document what each program is doing well, to provide recommendations about how each program could be improved, and to conduct a case audit to explore contract compliance. As senior research associate Linda leads a team of reviewers at selected sites, including ILP peer reviewers and youth reviewers, in conducting the reviews and writing up a final program review report. HSRI provides DHS with a summative report on the program review process and key findings across all 18 programs.

Project Director, Family Reunification through Recovery Court (FRRC)

Funder: Summit County Juvenile Court | Dates: 2013 – current
Contribution: FRRC is designed to impact court-involved child welfare families to address substance use and other family challenges to create healthy, stable home environments that allow families to permanently reunify. The evaluation involves a quasi-experimental, mixed methods approach to examine program implementation and participant outcomes. Propensity scores are used to adjust for differences between intervention and comparison groups. As
project director Linda plans, directs and oversees all aspects of the study, leading the evaluation design, data collection, analyses, and dissemination activities. Linda provides oversight to study team staff working on the study, and collaborates and coordinates with local stakeholders to ensure study goals are met within relevant timelines and to assure any challenges are addressed as they arise.

Senior Research Associate, Evaluation of Ohio’s Title IV-E Waiver Demonstration Project

Funder: State of Ohio | Dates: 2009 - Present
Contribution: HSRI is the independent evaluator for Ohio’s Title IV-E Waiver (a national child welfare demonstration project) in 16 participating Ohio counties. Linda is responsible for the collaboration on the design and execution of the participant outcomes and cost study components of the program. She works with state representatives to understand data elements within SACWIS and delivery of SACWIS files, coordinates with, and oversees sub-contractors’ work to produce analytic files and collaborates with sub-contractors around methodological approaches. She is also responsible for propensity score modeling, intervention outcomes analyses and contributing to report writing and dissemination activities.

Research Associate, Six Ohio Alternative Response (SOAR)

Funder: U.S. Children’s Bureau | Dates: 2010 - 2013
Contribution: HSRI was contracted to conduct the evaluation of a three-year evaluation of Differential Response (DR) Initiative in six Ohio counties, a best-practices approach to serving families reported for child abuse or neglect, using a randomized control design to examine the impact of DR on child welfare outcomes. As research associate on this project Linda’s responsibilities included the collaboration with county leads to develop a standardized protocol for family eligibility into the study and then randomization to intervention or ‘business as usual;’ coordinating with county leads to conduct evaluation training activities with staff; collaboration with the cross-site evaluation team and ‘local’ evaluation teams working in other states to develop comparable surveys for families and staff as well as comparable site visit protocols; coordination with state SACWIS staff to obtain SACWIS data. Other responsibilities included quantitative data manipulation and all quantitative outcomes analyses, report writing and presentations.

Research Associate, Multnomah County, Department of County Human Services, Mental Health and Addiction Services/Family Involvement Team (FIT)

Funder: Funding Organization | Dates: 2007 - 2009
Contribution: Through Regional Partnership Grant funding the partners sought to expand and enhance the family drug court, known as the Family Involvement Team (FIT), with the goal of connecting parents with appropriate alcohol and drug treatment as expeditiously as possible and supporting them with appropriate services and staff so families could stay together or be reunited sooner. Responsibilities included coordinating with state staff to obtain state child welfare data and state drug and alcohol treatment data, data management, manipulation, merging and preliminary analyses; the development of family surveys, coordinating with families to conduct family interviews and qualitative analyses.

Research Assistant, Developing Effective Policies for Substance-Abusing Parents Involved with Child Welfare

Funder: Robert Wood Johnson Foundation | Dates: 2002 - 2004
Contribution: Funded by the Robert Wood Johnson Foundation, the purpose of this research project was to explore how child welfare systems, substance abuse treatment systems, and judicial systems were developing policy and practices to support positive treatment outcomes and reunification for parents in response to the Adoption and Safe Families Act. This research was developed in collaboration with local policymakers from each of these systems in Oregon. There were two components to the study; the first component was designed to understand the experiences and outcomes for 16 specific families who were impacted by the legislation. The second component was designed to understand the implications of the legislation from the perspective of attorneys, judges, drug and alcohol counselors, and child welfare workers. As research assistant, my responsibilities included collaborating with the principal investigator and study team to develop qualitative research protocols for both components; arranging interviews with parents whose children had been placed in out of home care and tracking and interviewing parents every three months thereafter for 18 months, or until parental rights were terminated, or until children were returned to the home – whichever occurred first. Permission was also obtained from parents to interview their respective child welfare caseworkers, drug and alcohol treatment providers and attorneys at the same intervals. Collaborated with the study team around qualitative analysis and assisted with dissemination activities.
Selected Publications and Presentations

**Selected Peer-Reviewed Publications**


**Selected Presentations and Posters**


**Reports**


Profile
Ms. Gerber has over eight years of experience in behavioral health research and evaluation, including projects at the federal, state, and community levels. She has developed evaluation and data collection plans, designed data collection tools and validation for online instruments, managed, cleaned, and analyzed complex datasets, and provided technical assistance to grant recipients and government agency staff. She is experienced in quantitative and qualitative methods and has contributed to manuscripts, reports, policy briefs, presentations and guidance documents.

Selected Project Experience

Analyst, Comprehensive Behavioral Health System Analysis and Study for Pierce County
Contribution: HSRI conducted a comprehensive analysis to identify and understand gaps in service access in Pierce County, Washington. Rachael was responsible for identifying sources of behavioral health prevalence and service utilization data, developing and analyzing results of an online survey for case managers and service users on the adequacy of services to meet consumers’ needs, and analyzing behavioral health claims data from Washington’s Comprehensive Hospital Abstract Reporting Systems (CHARS).

Analyst, Milwaukee County Mental Health System Redesign
Contribution: HSRI received a subcontract through the Public Policy Forum to assist Milwaukee County in addressing systemic issues with access to service delivery within the adult mental health system. This included a comprehensive analysis of inpatient and outpatient behavioral health service capacity and utilization. Rachael was responsible for managing large and complex datasets, developing data collection methods, designing data validation and cleaning rules, and analyzing results for reports and dissemination materials.

Lead Analyst, Program Evaluation for Prevention Contract (PEP-C)
Funder: SAMHSA-CSAP | Dates: 2013 - Present
Contribution: In partnership with RTI, HSRI is conducting a national cross-site evaluation of CSAP’s Minority AIDS Initiative (MAI), which awards grants to community-based organizations and minority-serving academic institutions to prevent substance abuse and the spread of HIV and other STDs in high-risk minority communities. Ms. Gerber is responsible for managing large and complex datasets, developing data collection methods, and analyzing process- and participant-level outcomes, producing data for Government Performance and Results Act (GPRA) measures, writing reports and dissemination materials, and creating materials for training and technical assistance to grantees and federal staff.

Senior Analyst, Training Materials for Aging and Disability Resource Centers (ADRC) on Mental Health Promotion and Suicide Prevention
Contribution: HSRI received a subcontract through Mission Analytics to develop training materials on behavioral health promotion and suicide prevention for the eight states.

Education

MPH
Yale School of Public Health
New Haven, CT
(Social and Behavioral Science)

BA
Boston University
Boston, MA
(History)

Professional Experience

Research Associate
Human Services Research Institute
Cambridge, MA
(2013 – Present)

Sr. Research Associate
New England Research Institutes, Inc.
Watertown, MA
(2012 - 2013)

Research Analyst
HSRI
Cambridge, MA
(2009-2012)

Research Assistant
Center for Interdisciplinary Research on AIDS
New Haven, CT
(2007 – 2009)
with Aging and Disability Resource Center (ADRC) Part A: Enhanced Options Counseling grants. Ms. Gerber was responsible for coordinating and participating in key informant interviews with state agency directors, drafting a needs assessment report, developing an online survey for person-centered counseling professionals and analyzing results, and collaborating in the development of a training webinar and resource guide.

**Analyst, Evaluation of Cooperative Agreements to Benefit Homeless Individuals for States and Communities (CABHI-States and Communities)**

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<thead>
<tr>
<th>Funder: SAMHSA-CMHS-CSAT</th>
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<td>Contribution: HSRI received a subcontract through RTI International to evaluate two programs: The Cooperative Agreements to Benefit Homeless Individuals (CABHI) and the Programs for Assistance in Transition from Homelessness (PATH). HSRI has the lead for the multi-site evaluation of the PATH program, which is a task under the cross-site CABHI evaluation. Rachael is involved in data management and analysis of program data.</td>
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**Project Manager/Data Analyst, New Hampshire State Youth Treatment-Planning (SYT-P)**

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<td>Contribution: The NH Department of Health and Human Services contracted HSRI to evaluate its SAMHSA-funded State Youth Treatment-Planning (SYT-P) initiative, an effort to improve access to evidence-based screening, assessment, treatment, and recovery services and supports for adolescents and transition aged youth with substance use and/or co-occurring mental health and substance use disorder. As the Project Manager, Ms. Gerber is responsible for development and management of the project workplan, timeline, deliverables, and communications with designated DHHS staff. She contributes to designing the Evaluation Plan, interviews with State agency stakeholders, and collecting and analyzing data for performance evaluation of the planning initiative.</td>
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**Project Manager/Data Analyst, Bridging the Gaps: The Rochester Community Coalition for Alcohol and Drug Prevention**

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<thead>
<tr>
<th>Funder: City of Rochester, NH</th>
<th>Dates: 2016</th>
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<td>Contribution: HSRI received a contract to provide evaluation services to Bridging the Gaps, the Drug and Alcohol Prevention Coalition of Rochester, New Hampshire in support of its Drug Free Communities (DCF) grant. The DFC grant is administered by the Office of National Drug Control Policy (ONDCP) and supported by SAMHSA to build community coalitions to prevention substance use among youth. In addition to project management responsibilities, Rachael contributed to the development of the evaluation design, created and disseminated an online survey, analyzed trend data on youth substance use in New Hampshire, and contributed to writing the final evaluation report.</td>
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**Research Analyst, Data Analysis Coordination and Consolidation Center (DACCC)**

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<td>Contribution: CSAP funded the DACCC as a means to centralize and elevate its data collection and analysis efforts, producing data that would help it provide appropriate guidance to grantees and to the prevention field in general. Ms. Gerber was responsible for managing, cleaning and analyzing data across programs including the Minority AIDS Initiative (MAI), the Strategic Prevention Framework-State Incentive Grant (SPF SIG), and the Substance Abuse Prevention and Treatment 20% Set-Aside Block Grant. She contributed to technical reports, policy briefs and guidance documents, led trainings and technical assistance during in-person and webinar trainings to grantees and federal Project Officers, and presented findings at professional conferences.</td>
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**Selected Publications**

**Articles**


**Technical Reports**


**Presentations**


