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GREG HORNE: Hello, and welcome to *The Health Pulse,* a podcast exploring how analytics in the health and life sciences industry is growing and its repercussions in all our lives. My name is Greg Horne, and I am your host for this series. And as always, I will be joined by my expert guests to discuss a topical subject.

So on this week's episode, we turn our attention to whole person care with our guest Dr. Dawnté Early. But before we get to that, we've been hearing a lot around the pharmaceutical world and around our health care world on how analytics is used.

And we still have our email address available, which is thehealthpulsepodcast@SAS.com. We've been getting a few questions and suggestions come through there. Please keep those coming through. It helps us to understand a bit more about what people want to hear in the show, other guests we're going to get on and how to keep it relevant to all our listeners. So please keep those emails coming to thehealthpulsepodcast@SAS.com.

So without further ado, let's turn across to our guest today. So Dr. Early, good afternoon. Would you like to come on and introduce yourself, please?

DAWNTÉ EARLY: Hi, Greg. I am so excited to be here. Thank you for having me. As you said, my name is Dr. Dawnté Early. Just call me Dawnté. I am the chief of research and evaluation for the Mental Health Services Oversight and Accountability Commission here in California.

GREG HORNE: Fantastic. And can you just tell me a little bit about how you got to that position and a little bit about what you do day-to-day?

DAWNTÉ EARLY: Yeah. Oh, wow, my journey to this position-- it's been a long road. So my PhD is in human development with a minor in quantitative psychology from UC Davis-- Go Aggies. I jumped into state service fairly early on because I wanted to have a bigger impact and use, what I would say, my data superpower for good to advocate and help communities that are underserved or unserved.

I started with Department of Health Care Services here in California, then moved on to Public Health. Did a lot of work with the California Department of Corrections and Rehabilitation post-ACA, looking at the impact that health insurance has on recidivism.

If you think about it, when you have health care, you can stay healthy. You can keep a job. And the number one predictor of not recidivism is having employment. It's amazing what happens when you can pay your bills, feed your family, and keep a roof over your head. From there, I moved on to where I'm at now, which is the MHSOAC, The Commission for short, and looking at transforming California's mental health system.

GREG HORNE: Fantastic. And one of the other things that we always do on the podcast is get people to tell us something about themselves that we wouldn't know otherwise. So Dawnté, tell me a little bit about what you like to do outside of your role in California?

DAWNTÉ EARLY: So I coach basketball. I have a 19-year-old-- he's almost 20. I coached his football team for many years. And now I have our eight-year-old daughter, and she likes to play all kinds of youth sports. I played college basketball. I started off at Alabama A&M, which is in Huntsville, Alabama, and played basketball there-- Go Bulldogs.

And so my love of sports and just giving back to the community, I think that happens when you play sports, especially at a high level. It's ingrained in you to mentor, to mentor youth, and to pass those skills and those life lessons on. I'm also a Girl Scout troop leader because I also believe in empowering young girls.

GREG HORNE: Fantastic. That's-- wow, a lot of sport and a lot of activity. Fantastic. Dawnté, in your earlier comment there, you talked a bit about The Commission. Can you just tell me a bit more about The Commission, what its role is, and exactly what it is you're looking to achieve?

DAWNTÉ EARLY: Yeah, so Greg, The Commission's work, first of all, comes from Prop 63, which was implemented in 2005. It is the Mental Health Services Act, which is funded by imposing an additional 1% tax on individuals whose income is over $1 million. It's actually a very unique revenue stream that sets California apart from all other states.

It helps to address the shortcomings of driving transformational change in the mental health system. And The Commission is a 16-member commission with individuals from various backgrounds and sectors. Overall, Greg, you heard me touch on the fact The Commission's mission is to transform the mental health system so that everyone who needs care receives high quality and culturally competent care.

And so this means we engage with public agencies, particularly agencies that intersect with the mental health system such as schools, health care, and criminal justice. And then all of these different systems have a stake and a role in reducing and supporting early and effective services and care.

GREG HORNE: Fantastic. And I think what we've seen with some of our recent episodes where we've touched on some of these subjects is the role of social determinants, the impact they have in health care in general. Have you come across social determinants in your work? Talk to me a little bit about the impact of them. And how are you looking to use that kind of data to level the field, as it were?

DAWNTÉ EARLY: So one of the things that we've really begun to, I would say, push on the past couple of years is how do we do a better job of integrating data systems that-- and the systems that touch mental health consumers here in California. And so for us, we started off with connecting mental health consumer data at the individual level to criminal justice data from Department of Justice.

And since then, we've gone on to link with quarterly wage data from the Employment Development Department, and we recently got death and birth records from our Public Health, and then we will also be getting education data or school data from the California Department of Education. And all of these different systems that we are linking and connecting, we are digging down into potential social determinants of health.

We're also looking at disparities across these different systems, whether that be racial/ethnic disparities, gender disparities, age-- and so focusing on older adults, but also looking at focusing on youth and transitional age youth, which we call our TAYs. And so you have these different systems in which you are looking at where people live, work, and play.

And so we're getting the quarterly wage data. We are getting the school data. And again, trying to connect these systems so we not only better understand social determinants of health, but we also better understand some of the potential disparities that we are seeing.

GREG HORNE: Fantastic. And without trying to oversimplify this, do you see an overlap in certain groups? So what I'm thinking about here is if you tend to be misrepresented or underrepresented in a certain area, is that translated across all of the services?

DAWNTÉ EARLY: That's a really interesting question. So let's take an example. So we have our criminal justice data, and we know that the criminal justice system disproportionately impacts communities of color. And so we do see a higher representation proportionately of African-Americans and Latinx communities even in our mental health consumer data within the criminal justice system.

And so when you say, do you see overrepresentation in some areas but under representation in others. And then we see our quarterly wage data in which we see other disparities in which potentially some of our preliminary findings, because we just recently got this data, we are seeing less quarterly wage-- less employment for communities of color.

And so where you have in one area, like our criminal justice system, you see overrepresentation proportionately among certain communities. You have in others in which you're not seeing the same proportionality. And so it doesn't necessarily transfer across high in one area, high in all areas, I think to answer your question.

GREG HORNE: And you know, we've seen this. The really highlighted-- like one of the things that coronaviruses done is made us all much more acutely aware of health data in general. So are you able to talk a little bit about the impact of coronavirus on the population and mental health and how those things have come together? Because certainly in my experience, locally we've seen a massive increase in the need for services, and I wonder if that translates to your work as well.

DAWNTÉ EARLY: So anecdotally, we have seen and heard from our providers, especially when COVID first hit, that they were just overwhelmed. Overwhelmed because they were dealing with the own community trauma of going through a pandemic, but then also trying to serve the most vulnerable who needed the most help, and now more than ever.

And so what we heard, not through the data but through stories, through feedback, was this higher need, this increased need. And so we definitely saw that, what I would say, through more qualitative data or stories. The data that we have now received looking back on 2020 is not yet complete.

And it's not yet complete, and I'm sure you understand this, Greg, because what we heard from providers is it was a matter of deciding am I entering this data right now or am I serving this person right now? It really started to come down to where can I put my time.

And so currently we are trying to go back for 2020 and fill in the gaps potentially where data might have just been missed or not uploaded, so that we can get a fuller picture of what happened in 2020.

I would also say for the death records that we received, as well as the birth records, we have not received data yet for 2020. And so I think that we will not be able to fully capture from a quantitative perspective what has happened in 2020 probably for another year, until those data are fully populated and filled in.

GREG HORNE: OK, and how are you using that as a learning experience? How are you using that data now to fine-tune and think about what you can offer services going forward?

DAWNTÉ EARLY: I think that-- and you probably heard this in the SAS Global Forum in which I talked about, we at The Commission have this balance of we use data to help inform questions, decisions, engage with community, but at the heart of what we do and at the heart of, quite honestly, Prop 63 is nothing about us, without us.

And so, so much of what we do is engage with the community and ask communities, whether that be mental health consumers, organizations that serve mental health consumers, family members of mental health consumers, and stakeholders, and policymakers, what do you want to know? What is your experience on the ground?

And based on those questions, we then use that to inform the questions that we ask of the data. And so when we hear about COVID in those anecdotal stories, we are really trying to pull out what we are hearing from the community. And so I'll give you another example.

For us, one of the things that we looked at when we looked at our data of who was part of what we call full-service partnerships here in California, which are-- think of it as a "whatever-it-takes" program, is what full-service partnerships. If you need transportation, this program will give you transportation. If you need housing, it'll give you housing-- whatever it takes to ensure that you don't end up criminal justice involved or in state hospital or institutionalized.

And so what we saw in regards to enrollment and demographics in enrollment was in comparison to other populations, a fairly high enrollment proportionally for African-Americans. And so we presented this data and this is actually-- we have a transparency suite in which we have all of our data dashboards on our website, but we presented this data to one of our committees, our Culturally Linguistic Competency Committee.

And one of the questions that our stakeholders asked us were, OK, so you have these individuals and they are enrolled, but are you sure that they're receiving services? What are the quality of those services? How much are they really, truly mental-- these mental health consumers from communities of color and BIPOC communities engaged?

And so we went back and we looked at the data to figure out what are some proxies for what engagement looks like? What are some proxies for quality of services? And we're still digging into that, but it's those kinds of questions that are coming out of COVID to ensure that we really are looking to make sure that communities and BIPOC communities are receiving culturally competent care. In order to do that, you have to ask the right questions.

GREG HORNE: And how do you-- so you've inspired me in a couple of questions here. The first I'm going to touch on is stigma, because how do you overcome stigma? Because you can have all the quality, you have all the process in the world, but if people feel stigmatized to come to you, that that's a big problem. So let's start with that one actually-- stigma.

DAWNTÉ EARLY: And so in regard to stigma, are you-- stigma in being a mental health consumer? Stigma and receiving--

GREG HORNE: Yeah.

DAWNTÉ EARLY: And so I think having conversations, quite honestly, like this, I think normalizing and contextualizing these conversations. Normalizing that we all have mental health needs in some way or have families that have mental health needs, and that it is not something that we need to, hide but in fact, something that we can receive support for and receive services for, I think that's so important for reducing stigma.

And so again, normalizing these conversations I think is a huge step. One of the things we also try to, what I would say, is be conscious of is even in the language that we use for our policy reports, for our data results, for our transparency dashboard, we try to use humanizing, human-centered language. And so that we are not a part of the problem of stigma, but are part of the solution in breaking that down.

And so in regards to our community engagement, that's actually one of the things that we want to hear is the language that we're using, the words that we're using. Are we using strength-based language? And so, so much of the work that we do is also trying to break down stigma.

GREG HORNE: That's very interesting. And the other point that was in that piece just now was this idea of needs-based outcomes. And that is something that has been looked at in health care a lot. This idea that people stay in hospital because they don't have a hand rail at home, for example, and that applies equally to the mental health world.

We have examples I've worked on, where we've seen that by providing certain support, certain housing, access to food, you can really change an outcome for a patient. But often that is a funding issue, that there's-- the funding is not there to support some of these other activities. How have you managed to get over that hurdle? And how are you using the data to help you drive those results?

DAWNTÉ EARLY: Well, I think that actually points to one of, I would say, our first findings. And one of the reasons why we took the first project that we did that I talked about, which was that linkage work that we did with Department of Justice data, looking at the impact of full-service partnerships, that whatever-it-takes services on reducing criminal justice involvement.

For so long, we knew anecdotally that it was having an impact. And then within the data that we were collecting within the program, we had again respondent data, participant data of what they were seeing their criminal justice involvement was pre, post, and during programming.

But by being able to link it to statewide administrative data, to link it to this, we were able to show a reduction of 67% from pre to post for those who had three or more arrests a year before participating. That was huge. And so when you talk about how do you ensure the funding, first I think it's so important that you show the impact.

One of the key central reasons for full-service partnerships is to reduce criminal justice involvement. We have shown that it's reducing criminal justice involvement. And so it's a lot easier to get funding for programs that you show work.

And so one of the things that we did there is, OK, so if you can provide people individual services within the community, like full-service partnerships, then they don't even make it to the criminal justice system. You are going more upstream so that you save money, both in human capital as well as from a state perspective on our criminal justice system.

You now have individuals who are with their family, being able to participate in the community, and getting the services that they need. And again, having a mental health need is not a crime, and therefore shouldn't be treated like a crime. And so, if we can get individuals the services that they need in the community, then we're all better.

And so I think from that work, we then, again, began to get data from the Employment Development Department to begin to show that mental health services increase employment opportunities. We are also going to show that receiving mental health services-- and we're going to test this.

We don't know, but we're going to get California Department of Education data. It should reduce school failure, but even more importantly, increase student success. And that's what we're wanting to talk about is the success and the strength model.

But what I would honestly say so much of the work that we do does inform policy. And so what we try to use data-- and I think we actually are getting better at it. And I think it is something that every organization really works at, which is using data to answer questions, engaging with the community on those questions, coming back to the community, did we ask the right questions, and then creating policy recommendations around that.

Our Commission will normally either adopt those policies, or sometimes we will work with legislatures to create bills, if for whatever reason, the policies or the supports that have come out of the work that we've done don't exist.

GREG HORNE: OK, so one last question. I want to pick up with you now about what the future holds. So where do you see the work of The Commission going next? And what do you think is going to be the role of your Commission, of the work you're doing, into the future? What would you like to see as a future development?

DAWNTÉ EARLY: I think we haven't touched on a lot of the policy work that we also do here at The Commission. It's actually housed within the Research and Evaluation division. And I think that is so important, because I think in addition to the data piece that we talked about, the policy piece is the environmental scan. It is the community engagement. It is the translational piece of data.

Where I imagine that we will continue to go and continue to get better at is connecting data to policy, to community, to outcomes, all to transform the mental health system. Right now we are working on SB 1004, and that is a prevention and early intervention bill to do strategic planning, create measures and outcomes around prevention and early intervention at a state level.

And we've been working on that and we'll have our policy report out soon, but again connecting data to going more upstream. How can we, instead of treating downstream the mental health needs of the community, how do we go more upstream to prevent it from happening in the first place or to intervene earlier so the severity of mental health-- of a mental health illness doesn't impact families as hard.

GREG HORNE: So I do want to ask you another question based on that, because we did some work a while ago where we were going as upstream as you could get, looking at social media and understanding how communities are responding to a mental health crisis through a correlation of tweets and understanding what people are putting out there.

What's your opinion on the harvesting of social media for this kind of work? And how do you think it might either benefit or hinder the work that you're doing?

DAWNTÉ EARLY: I would love to get my hands on social media data. Now we should be clear, I am a bit of a data junkie and I acknowledge that. But what I love about human-centered data and social media is at the heart of it, it's people and data. It's a representation of people and their behavior.

But getting a measurement on how people think, which is what you see on social media, and how people think in their homes, behind their computers, I feel like you get more at the internal psyche of individuals from social media data.

And so I would be curious to link and harvest that, to actual outcomes as well. So you have how people think and then connecting that to outcomes. I mean, I think that would be very interesting.

GREG HORNE: Well, the work we were doing was not looking at individuals. It was looking at the that general consensus in a population. So we would then look at maybe a reservation or a university or around a certain workplace.

And look for whether or not there was a change in the overall feeling to allow an early intervention to a population, not necessarily on an individual basis, which is getting about as upstream as you get. Is that something that you have either thought about doing yourself or how could you see that idea playing out in California?

DAWNTÉ EARLY: Well, it's interesting that you say that. One of the other things that we are responsible for is workplace mental health. We got a bill a couple of years ago that we are writing our policy report on now. But what you just brought up is really interesting around, like you just said, prevention and going really, really upstream in regards to the workplace. And so how do you change mental health within a workplace using something like this? I think it would be fascinating.

GREG HORNE: So Dawnté, just thinking about the future. What does the next maybe four to six months hold for you as a program?

DAWNTÉ EARLY: Well, so Greg, you-- as we already talked about, we recently have really started getting all of this different data. And so what I'm seeing in the future is starting to be able to tell a fuller, richer picture of, for instance, what does the school-to-prison pipeline look like, and how do we truly prevent and intervene in there?

And then what does it look like when you provide children with the services that they need? Do we see better employment outcomes? Because remember we have that quarterly wage data, but even more importantly, I want to follow-- again, my PhD is in human development. I want to follow people across the lifespan. I want to go from school all the way to death and birth.

And we are also getting death and birth records. So what does it look like for a mental health consumer to have a longer life? We know that mental health consumers have shorter lifespans, higher mortality rates, and so how do we intervene? How do we truly go, like we talked about, upstream? With all of this different data that touch all of these different systems, we will now be able to look at that full picture.

So what we talked about earlier was social determinants of health. And so I'm hoping in six months I'm going to be able to tell you at a high level, how do we begin to intervene and what do those patterns look like.

GREG HORNE: Fantastic. Maybe we get you back in six months and hear some more about it.

DAWNTÉ EARLY: I would love that.

GREG HORNE: Dawnté, thank you very much for taking the time today and coming on to speak to us. I think the listeners are going to really enjoy this conversation. And I want to say to our listeners, thank you very much for listening to the episode.

If you have questions, comments, or other suggestions, please remember to send them to thehealthpulsepodcast@SAS.com. We will be back in two weeks with another episode. Thank you very much once again. I've been your host Greg Horne, and this has been *The Health Pulse.*