Innovations Learning Session I

Small Group Discussion Highlights

October 4, 2012

LAC DMH
LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH

On October 4, 2012 Innovations program providers came together with LACDMH staff and the evaluation team to hold the first quarterly learning session. As a part of the overall learning session, providers participated in small group discussions about challenges and successes related to integrated teams, integrated charts and funding integrated service. The goal of the small group discussions was to facilitate cross-model and cross-agency discussions specific to the implementation and provision of integrated services so that through these conversations providers and LACDMH staff could learn from each other's experiences.

Highlights from each discussion topic are summarized below.

Integrated Teams: Innovation model programs are comprised of multi-disciplinary teams staffed with professionals and paraprofessionals providing community-based integrated mental health, health and substance abuse services. Trained peer staff or peer supporters are part of the program design of each Innovation model. The work of each integrated team is expected to be coordinated by one point of supervision and one set of administrative and operational policies and procedures. Below are highlights of the challenges and solutions identified by the small groups focused on Integrated Teams:

+ **Challenges: buy-in, trust, learning to work with non-traditional providers and time available across team**

+ **Solutions: regular integrated team meetings and data sharing; "warm handoffs"**

Integrated Charts, Documentation, & Treatment Planning:

Innovation model programs have created and are utilizing an integrated health record/chart, with the expectation of significantly reduced fragmentation of care planning, delivery, and monitoring. Innovation providers have expressed concern and confusion regarding Medi-Cal documentation as it relates to integrated services. Below are highlights of the challenges and solutions identified by the small groups focused on Integrated Charts:

+ **Challenges: lack of consistent standards for integrated charts; implementation and use challenges including partner technology differences, receiving information in a timely manner, storage and accessibility to team**

+ **Solutions: chart standards, consistent structures, and training; team buy-in, communication, and adherence, work-arounds until EHRs fully implemented**

Funding Integrative Services:
In program design each Innovation model has emphasized leveraging slightly differently. However it is an expectation that Innovation model programs are leveraged with other resources other than MHSA funds to establish sustainable revenue as MHSA Innovation as a funding source is

time limited. Leveraging FQHC, FQHC Look-Alike or Public-Private Partnership funding is expected and benefits establishment is an expectation for IMHT & ICM providers. Innovation programs have also been encouraged to partner with community resources and organizational supports. Below are highlights of the challenges and solutions identified by the small groups focused on Funding Integrative Services:

+ **Challenges: billing, especially for non-traditional services; sustainability of integrative funding; partnerships with FQHC complex; eligibility issues**

+ **Solutions: collaborate and coordinate; formalize collaborations, up front screening by social work to determine eligibility, leveraging health care reform to create sustainable funding**

"Connecting the Dots"
Three preliminary learnings emerged from cross-group, cross-model discussions:

+ Establishing consistent standards and facilitating clear, regular communication among teams are key to success across models, populations and providers.

+ Providers are at different phases of implementation with some well underway and others in the very earliest stages of implementation. Many of the "early" implementers have already experienced significant organizational learning --this suggests readiness for peer learning.

+ This work is truly innovative and new for everyone. This provides a space for experimentation and learning together across providers and LACDMH staff.

Innovation Learning Session II:
How Data Tells a Story

Learning Brief

January 24, 2013

HEALTHSERVICES
RESEARCH CENTER

HOPE WELLNESS RECOVERY
LAC DMH
LOS ANGELES COUNTY
MENTAL HEALTH

harder+company
community research

Background

On January 24, 2013 Innovation program providers came together with LACDMH staff and the Evaluation Team for the second quarterly Learning Session. The theme of the session was *how data tells a story*. Attended by over 95 people, the session included: 1) a data collection and outcomes update, 2) an introduction to, and discussion about, each Innovation Model's Storyboard, and 3) an informal Social Network Analysis (SNA) training. A panel of eight providers representing each model and two LACDMH staff shared highlights from their small group storyboard discussions. Three providers from different models shared reflections with the full group after the SNA activity.

This learning brief includes highlights from the session with an emphasis on the challenges, successes and lessons learned to date in Innovation. It is intended to document the session for attendees and provide information for stakeholders unable to participate.

Data Collection and Outcomes Update

After LACDMH's Debbie Innes-Gomberg opened the session, Marissa Goode from the Evaluation Team provided information about iHOMS and presented findings from baseline data. (Please see Appendix A for the full data presentation.)

+ iHOMS updates were highlighted including new features (for example, assessment status reports and client lookup search feature) and upcoming features (notifications and reports including compliance and outcomes reports).

+ Data collection progress and overall Innovation program baseline data through December 31, 2012 were shared including overall program enrollment, demographics, mean scores for baseline measures, baseline health conditions, homelessness, risk, constructive behaviors, and previous medical care.

+ 1,017 clients have been registered in iHOMS and baseline data is available for 205 clients.

Client Enrollment by Model
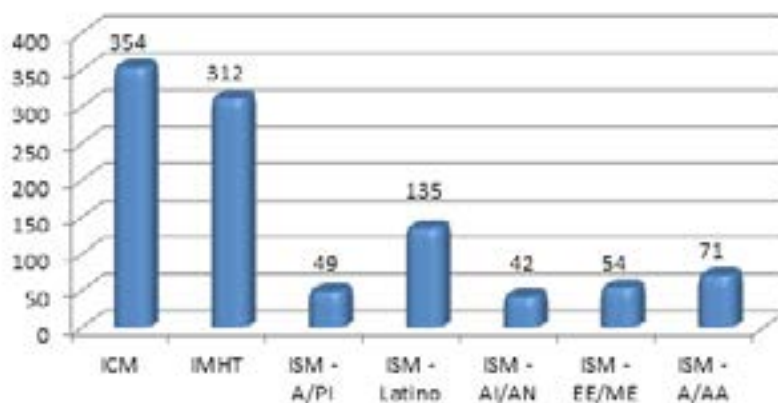
Storyboards

A storyboard is a visual communication tool used to convey information about a program, including purpose, objectives, outcomes, and lessons learned. When updated over time, a storyboard can be used to illustrate change and document learning. During the morning, providers worked together in model-specific groups to learn about storyboarding and to participate in the creation of a storyboard for their model (ICM, IMHT, ISM African/African-American, ISM American Indian/Native Alaskan, ISM Asian/Pacific Islander, ISM Eastern-European/Middle Eastern, ISM Latino, and Peer Run[1]). LACDMH staff members created initial storyboards for each model in advance of the session. Provider groups engaged in discussions focused on staffing, outreach and engagement, and data and outcomes using the LACDMH-created storyboards as starting points. Common themes across multiple models and model-specific discussion highlights are included in this section.
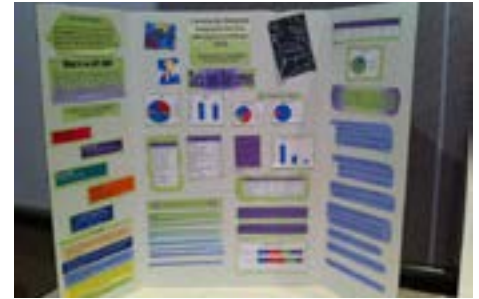
Common Lessons and Challenges

The Evaluation Team analyzed the notes (full notes available in Appendix B) from each small group storyboard discussion to identify common lessons learned and challenges to implementation to date. Common findings are presented by topic (staffing, outreach and engagement, data and outcomes) below. Lessons learned and challenges that were specific to individual models are described later in this brief.

Staffing
Lessons Learned & Strategies

+ Successful staff recruitment strategies included internal recruitment and using internal and external networks to find skilled team members.

+ Regular in-person team meetings are important to successful integrated team communication.

+ Peers are critically important to integrated teams; they play unique roles in engaging and supporting clients. However peers have unique training needs relative to other members of the integrated team (e.g., CPR, establishing boundaries with clients, etc.).

Issues & Challenges

+ Budgeting, finding qualified people, language skills related to available people, and finding and hiring people who are passionate and committed to this work.

Outreach and Engagement
Lessons Learned & Strategies

+ Prior to Innovation, providers' outreach strategies were more informal and less strategic. Now their outreach is more rigorous, focused, and incorporates non-traditional methods which have helped increase recruitment.

+ Initial client engagement is more likely to come through issues related to physical health and wellbeing, housing, and access to resources; engagement around mental health and substance abuse is happening later into treatment.

Issues & Challenges

+ Particularly across the ISMs, there has been continued resistance and stigma toward mental health services.

Data and Outcomes
Lessons Learned & Strategies

+ Providers intend to use outcome data to help inform their outreach efforts.

Issues & Challenges

+ Providers expressed concern about the accuracy of client-report data due to accessibility of measures (currently available only in English), cultural sensitivity/relevance of measures, and client willingness to give honest responses.

+ Providers are interested in understanding how to use outcome measures in their clinical practice but need training to do so later into treatment.

[1]While providers discussed model-specific storyboard, LACDMH staff discussed the global Innovation program.

Model- Specific Discussion Highlights

While the previous section highlighted common themes across models, themes specific to each model are presented below. The Evaluation Team identified these themes using notes from each model's small group discussion as well as the panel discussion. (For more information and the full notes from each model, please see Appendix B.)

ICM

Spokesperson **Veronica Lewis** from *SSG HOPICS* shared that one of the model's main lessons was reminding providers to meet the immediate needs of their clients first in order to then be able to meet their mental and physical health needs. For example, if providers meet clients' housing needs, clients can then better focus on their mental health issues.

ICM providers expressed the need for training around identifying and recruiting clients that meet program criteria.

ICM team members have trained and educated other staff and departments within their organizations about integration and their program.

IMHT

Spokesperson **Michael Marx** from *Step-Up on Second* shared that providers are looking forward to using outcome information and appreciate that evaluation measures are allowing staff to ask questions that they normally would not ask. He also noted that some medical outcome measures have created frustration for staff – for example, clients are averse to providing blood specimens.

IMHT providers have found that office-based services are a draw to clients since they provide internet, food, restrooms, a point of engagement, and safety while also helping to build trust. They noted that mobile services are important but best when paired with office-based services; clients want both.

ISM African/African-American

Spokesperson **Jennifer Schott** from *SSG Weber Community Clinic* noted that providers have learned to be very flexible and have patience in regards to changes in rules and procedures. They have learned that integration requires a lot of meetings and case conferences as well as learning a new language (mental health speak versus physical health speak).

ISM African/African American providers have found it helpful to hold dedicated clinic days for their Innovation clients in the medical clinic. It has been especially important to have staff that represent the community and are "able to speak the language of the population."

ISM American Indian/Native Alaskan

Spokesperson **Ixtlana Lopez** from *United American Indian Involvement, Inc.* shared that non-traditional outreach activities have helped reduce stigma around mental health services. This team would like training for their staff on how to utilize the evaluation measures clinically.

The cultural elements of this ISM have helped reduce client isolation and integrated clients with their community to help provide "empowerment in their own healing process."

ISM Asian/Pacific Islander

Spokesperson **Sam Joo** from *Koreatown Youth & Community Center* noted that providers of this ISM see value in collecting data and conducting evaluation activities that capture changes related to the systems created, partnerships made, and barriers to accessing services. They hope to work with LACDMH and the Evaluation Team to capture these changes.[2] He also shared that due to cultural views of hierarchy, the act of evaluating agency staff can be uncomfortable for their clients. Providers in this ISM would like to find a way to collect data without the use of tablets.

Providers from this ISM have found it particularly difficult to staff their teams with people who have the qualifications, language and cultural knowledge, and broad skills such as experience with clients from a wide age range.

ISM Eastern-European/Middle Eastern

Spokesperson **Arpe Asaturyan** from *IMCES* shared that their model did not have very much data which made them decide that they need to monitor what data is being collected and its accuracy.

This ISM has experienced challenges working with physicians who do not currently understand the program, making communication with them more challenging. Co-location has been an important factor in successful communication.

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[2]The Evaluation Team shared that model-specific measures will be identified in the coming quarter. In addition, collaboration and integration will be evaluated as part of the formal social network analysis and the Case Western Reserve University integration tool. Both evaluation processes will begin spring 2013.

Model- Specific Discussion Highlights (continued)

ISM Latino

Spokesperson **Claudia Rice** from *Alma Family Services* shared that collecting client-reported data has been challenging since measures are not yet translated into Spanish.[3] Currently, clinicians are translating for clients which creates concerns about translation consistency and data quality.

Medical and dental insurance rates reported for this model seemed high and rates of drug/alcohol use and smoking seemed low to providers. This may be due to cultural interpretations of what constitutes problem drinking. Providers hope to use outcome data to see where clients begin and how they change over time.

Providers have experienced success "going to where clients are," (including non-traditional locations like laundromats and Home Depot) to conduct outreach. This has resulted in an unexpected but positive challenge for providers -- outreach has increased the number of male clients so that they do not have enough male providers to match with new clients.

Peer Run

Spokesperson **Libby Hartingan** from *SHARE!* noted that although this model has not yet begun delivering services, there were lessons learned from the planning process. During this time providers learned that they had to step back and see their place in the community and benefited from being open to community needs, opportunities, and new partnerships.

Providers from this model anticipate that the newness of the program could create perceived credibility issues that may make recruitment challenging.

LACDMH Staff

Spokespeople **Nina Tayyib** (*ISM*) and **Mary Kim** (*ICM*) shared that LACDMH staff talked about the importance of taking this opportunity to do things differently related to how they approach agencies and programs. They also reported how it is important to build relationships with providers. They are seeking to learn from providers and not audit them. They are focused on balancing their role as funders and also learning along with providers

Social Network Analysis

Following the panel discussion, the afternoon session consisted of Social Network Analysis (SNA) training led by Joelle Greene from the Evaluation Team. SNA is a technique that can be used to visually map relationships among people, organizations, or other entities. Ultimately the Evaluation Team will use SNA to describe and measure change in the composition of and relationships among integrated teams for Innovation providers. An informal approach to conducting a local SNA was presented so providers could use it as a tool to understand and describe their current IT and partners. During the training, each individual provider identified their Innovation integrated team and partners, scored each partners' level of collaboration, and then created their own informal SNA. (For more information about the SNA activity including the levels of collaboration, please Appendix C.) At the end of the SNA activity three providers reported to the full group about their SNA. Below are highlights of their comments.

- ✚ *ISM* provider **KYCC** reported that the activity helped illustrate that they are early in the integration process. They would like to share their SNA with their medical partners, stakeholders, and LACDMH to help discuss and understand the inner-workings of their integrated team.

- ✚ *Peer-Run* provider **SHARE!** presented their unique SNA which had interconnected and overlapping triangles representing the relationships among clients, the program and the community.

- ✚ *IMHT* provider **St. Joseph's** SNA resulted in a complex map since they have two mental health providers with a myriad of collaborative partners. They felt the SNA could be a helpful tool to show where their team is now and to discuss how the team could achieve higher collaboration rankings and more integrated systems in the future.

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[3]Client-completed evaluation measures are currently in the process of being translated and Spanish translations are expected soon.

Connecting the Dots

Four themes emerged across the learning session activities:

✚ **We are all learning, experimenting and innovating.** Everyon involved with the Innovation program is learning and adapting to best meet program goals.

✚ Within integrated teams, as well as between LACDMH staff and providers, **everyone is focused on building relationships and increasing communication.**

✚ **Stigma about and resistance to receiving mental health services presents a real barrier to engaging clients.** Many providers have innovated diverse outreach and engagement strategies to overcome this barrier. **These strategies could be shared more widely to the benefit of Innovation**.

✚ At this time providers appreciate trainings and tools that support implementation of Innovation. **Providers need additional support in order to use outcome measures as tools in clinical treatment.**

Action Steps:

✚ **Providers:** Each organization will create their own storyboard and share it with their colleagues at the next learning session. Information and instructions will be provided in advance of the session. Providers' informal SNA may be included as part of the storyboard.

✚ **LACDMH Staff:** The next Learning Session is scheduled for April 25, 2013 at St. Anne's. Instructions for how to prepare storyboards will be provided in advance of the session.

✚ **Evaluation Team:** The Evaluation Team will roll out translations of client-completed measures (beginning with Spanish), provide updates and reports for iHOMS, and will begin the process of identifying model-specific measures. Site visits to assess current level of integration (using the Case Western Reserve University Integration Tool) will begin in early April 2013.

Innovation Learning Session III: *Learning Together*

Learning Brief

April 25, 2013

HEALTHSERVICES
RESEARCH CENTER

harder+company
community research

Background

On April 25, 2013 Innovation program providers, LACDMH staff and the Evaluation Team came together for the third quarterly Learning Session. Attended by over 95 people, the session included: 1) an introduction of and presentations by the two new **peer-run providers**, 2) round table discussions around some of the key elements of integration followed by group report outs, 3) a data and outcomes update and 4) a storyboard activity using both model level and individual provider data.

Debbie Innes-Gomberg set the stage for the session by highlighting the importance of using Innovation to learn about integration not only for the benefit of LACDMH and providers, but because it can be used to inform integration efforts that will result from Health Care Reform.

This learning brief includes highlights from the session with an emphasis on the challenges, successes and lessons learned to date in Innovation. It is intended to document the session for attendees and provide information for stakeholders unable to participate.

Getting to Know the Peer-Run Models

Two providers of peer-run services officially joined the Learning Session community on April 25th: Project Return and SHARE! Each project team made a short presentation to the group.

+ Keris Jan Myrick, CEO of **Project Return,** provided an overview of the organization's approach via a real-life example of how the team empowered clients to make a desired trip to Disneyland a reality. Highlights of the process included community engagement, raising awareness of Project Return and the availability of mental health services.

+ Keris also provided a brief overview of **levels of inclusion** and emphasized the need to move clients to full participation and integration into the community as independent and self-sufficient individuals.

+ Team members from **SHARE** provided an overview of services including numerous self-help groups like AA, Recovery International and CODA.

+ SHARE has developed the **Recovery Tracker** to help identify issues that clients are ready and willing to address. They shared the tool with attendees, demonstrated how it might be used to establish rapport between a client and a peer and answered questions about the tool.

> *The Peer-Run models may provide useful resources to other Innovation programs working to incorporate peers with lived experience into their Integrated Teams.*

Learning about Integration

The last part of the morning was spent in small group discussion to further learning about some of the core elements of integration and to learn about ongoing challenges, emerging solutions and promising practices. Participants were asked to join one of four thematic discussions focused on: Integration of care, peers as part of the integrated team, incorporating data into practice and delivering culturally competent services. There were two separate tables for each topic discussed.

Groups facilitated their own discussion and took notes on easel paper. After the lunch break, a spokesperson from each table provided a summary of their table's discussion. The discussion and report out was guided by four key questions: *How does the group define the element of integration? What are the advantages of incorporating this element? What are the challenges? What solutions are working so far or are needed?* Here we highlight themes addressed by each group in the report out.

The appendix contains the full notes from each table group's self-facilitated discussion during this portion of the Learning Session.

Integration of Care
Report out was provided by Wendy Zheng (Asian Pacific Health Care Ventures/Pacific Clinics ISM) and Brooke Mathews (St. Joseph's Center IMHT)

Definition
+ A medical home is where treatment is integrated. Mental and physical health, as well as substance abuse treatment is provided in-house. Other care such as acupuncture and spiritual support are also part of integration.

+ Integration is more than co-location or referrals; it requires constant communication among agencies.

+ Integration is essentially a team effort; the hallmark of integration is how we come together to generate solutions.

Advantages
+ Beneficial to clients; promotes the whole health of the individual.

+ More cost effective to programs

+ Supports learning

Challenges
+ Across the board integrating care means integrating systems. Different organizations and providers speak a different language or modality. Different pay systems also create challenges for integration.

+ Finding and integrating peers effectively into the model, especially teaching staff to work with peers.

+ Educating clients about integration, for example ISM clients are not used to in-home services and want access to multiple providers.

Solutions
+ Using an on-site benefits specialist to coordinate services; implementation of ACA will favor this model of care.

+ Organizations need a strategic plan that specifically addresses integration. Management support is key to success.

+ Integration requires more help; bring in interns, fellows and volunteers to help.

Peers as Part of the Integrated Team
Report out was provided by Jason (Project Return Peer-Run) and Nicole Brown (Step Up on Second IMHT)

Definition
+ A person with lived experience that can connect with clients in a way that is different from other staff.

Advantages
+ Peers teach by example; they model recovery and connect with clients through shared lived experiences.

+ Well suited for outreach and to explain the INN program to potential clients.

Challenges

+ Finding peers with enough recovery experience to serve as appropriate models.

+ Peers prior relationships on the street may limit their ability to work with clients.

+ Determining how to bill for peers.

+ Training peers about boundaries; ensuring peer involvement is appropriate.

Solutions

+ Ensure the organization and all staff understand the value and role of peers.

+ Create a peer job fair to find qualified peers to hire; link with providers from the peer-run models.

+ Work with LACDMH to ensure there are appropriate billing codes for peer-provided services.

Incorporating Data into Practice
Report out was provided by Vilma Haas (Didi Hirsch ISM) and Lezlie Murch (Exodus Recovery, Inc. IMHT)

Definition
+ Using data to inform integration.

+ Need to use data at different levels: client, program, and agency.

Advantages
+ Communicating data back to staff in clear and simple ways will help support data collection.

+ Data is an objective tool that evaluates how a program is doing and measures improvement of services.

Challenges
+ Need to educate clients to understand how to understand outcomes reports.

+ Poor data quality; most programs do not have a person dedicated to data entry and no funding to hire someone to regularly enter data.

+ Agencies still not entirely clear how to best incorporate new reports into practice.

+ Overemphasis on quantitative data without meaningful qualitative data.

Solutions

+ Create a data code for billing; use outcomes assistance to bill.

+ Use iHOMS webinars to train staff.

+ Adjust the measures to reflect the specific target populations and client issues for each organization and/or model.

+ Incorporate the qualitative data that agencies are already collecting apart from the evaluation into evaluation findings.

Delivering Culturally Competent Services
Report out was provided by Diane Kubrin (Los Angeles Gay & Lesbian Center ICM) and D. Davidson (Village Health Foundation)

Definition
+ Serving the client in a culturally sensitive manner while incorporating multiple services.
+ Goes beyond language; many considerations

Advantages
+ The ability to relate to the community that you are serving.
+ Engaging people where they are at.

Challenges
+ Overcoming stigma and misunderstanding about mental health services.
+ Lack of knowledge by the community; helping clients understand what the organization can and cannot do.
+ Serving the uninsured/uninsurable.

Solutions
+ Increase the collaborative conversations among INN partnerships; bring decision makers to the table so changes can be made.
+ Expand the outreach and engagement period – sometimes eight weeks is not enough.
+ Understanding that clients are the most important part of the program.

Data and Outcomes Update

Marissa Goode from the UCSD Health Services Research Center provided an update on iHOMS. This included an overview of data entered, the availability of client measures in several languages (Spanish, Farsi, and Korean) and the launch of both provider and client level outcomes reports.

Physical health data is the most commonly missing data, and INN programs were encouraged to back enter that data if it is available. There are also a lot of missing MORS scores to which INN providers indicated a need for additional training. In response, the Evaluation Team will arrange an additional MORS training opportunity to support future completion of MORS.

> **Organizational Learning: The intentional practice of collecting information, reflecting on it, and sharing the findings to improve the performance of an organization.**
> ~*Stanford Social Innovation Review, Summer 2011*

Outcomes reports will be available in iHOMS beginning April 26th, 2013. Marissa demonstrated how to run reports at the program and client levels and walked through how to interpret the information on reports. The tutorial will be available via iHOMS to view or use in training other staff members.

IT Tool Site Visit Update

Ben Henwood from USC gave a brief presentation about the Integrated Treatment Tool (IT Tool) site visits that are currently being scheduled as part of the INN evaluation. The IT Tool site visits will provide feedback designed to help organizations build on their strengths and move closer to fully integrated care. Team members from the **Tarzana Treatment Center** program (ISM Latino) briefly shared their perceptions of site visit at their clinic. While it took some work to organize the day, overall it was a positive experience and the team looks forward to receiving the feedback.

Storyboard Activity

A storyboard is a visual communication tool used to convey information about a program, including purpose, objectives, outcomes and lessons learned. When updated over time, a storyboard can be used to illustrate change and document learning. Storyboards were first introduced in Learning Session II.

Program teams were provided reports of their INN program's current enrollment and outcomes data as well as their overall model data. Each provider group was asked to consider how their program was contributing to the model's success. Programs will be asked to develop their own storyboard for future learning sessions. It is hoped that programs will use storyboards as a way to communicate their programs' activities, learnings and challenges with their organizations, teams and other providers.

Provider Nominated Activity

Providers in attendance at Learning Session III were asked to nominate an activity for Learning Session IV (***Please see Exhibit 1 on the next page for a complete list of topics nominated***). The Learning Session workgroup will incorporate at least one of these topics/activities into Learning Session IV. The workgroup is also seeking several providers to join LACDMH staff and Evaluation Team members in the Learning Session planning process. Please contact Amber Anderson at LACDMH if you are interested in participating.

Exhibit 1: Provider Nominated Activities/Topics for Learning Session IV

- New agencies need intensive handholding regarding data collection/outcomes, billing for non-traditional services, etc.
- iHOMS staff need to be more responsive to iHOMS-related questions.
- More relevant training (clinical).
- More communication between iHOMS & agencies.
- Billing productivity while not burning out staff
- Teaching staff social skills training for clients w/schizophrenia-best practices
- Break-out groups based solely on model so that each model can collaborate & learn from each other.
- Showcase some cultural integration projects and their lessons learned.
- Improving communication and cooperation between behavioral care and primary care
- The cost benefits of integration
- Presentation – Non-traditional approach – integration…
- Incorporating families/outside support systems into treatment
- Training for substance abuse clients-dealing with addicts/co-occurring disorder
- Grief/Loss for clients, ex: loss of status, death, loss of family, loss of friends/support system
- "Coping with your own death" for clients that are medically compromised.
- Team Care – future training
- Leveraging resources
- Treatment resistant substance abuse/addiction.

- Engaging families & outside support systems into treatment.
- Incorporating nutrition and weight management into integrated care.
- Evidence Based Practices – Illness & Recovery, Family Psycho Education.
- How providers can communicate effectively
- Housing – Access to housing resources, i.e. Vouchers
- Employment – access community resources
- Health Care reform in L.A. County
- Addressing stigma of associated with mental health visits
- Working with disabled and depressed patients who do not have family or support network, ethnic population.
- Combining/integrating electronic health records between mental health and primary care
- What happens to a client's ongoing medical care when mental health treatment ends?
- Fully integrating alternative treatments into client care.
- Challenges with primary (fully) care and mental health needs
- How to motivate clinical team in becoming culturally competent when working with clients.
- Motivation for staff in utilizing the evaluating measurements.
- How to bill innovative ideas (e.g., CM's fiving English classes).
- Maybe a mock video of a client/therapist reviewing data outcomes.

- Effective ways to build trust among local community non-traditional providers to increase collaboration
- Staff burn-out
- How to make programs more outcomes-focused rather than billing-focused.
- Critical time intervention
- Different way to bill for primary health and substance partners.
- How are groups developing or developed teams for care and an integrated client?
- I'd want to see a chart, learn how different levels of privacy were tacked, etc.
- For programs that got started late, please consider extending the enrollment expectation.
- iHOMS should be condensed, too many measures to implement.
- It may be easier to only have one agency as the providers, versus three different agencies, very challenging to complete paperwork in a timely manner.
- Team building techniques
- How to integrate her records (different agencies).
- How can DMH work better with FQHC's
- Can DMH and FQHC's share a common language?
- Substance abuse training for mental health providers.
- Common physical health disorders and meds and how it can affect mental health.
- Share of cost/Medicare and private insurance integrations.
- Increased integration of alternative services in overall care.

Closing

Debbie Innes-Gomberg closed Learning Session III by thanking everyone and reminding them of the intent for these sessions to become more provider-lead.

Appendix

This appendix contains the full text of the notes provided by each self-facilitated discussion group from the morning activity focused on organizational and programmatic learning about integration. Each group presented highlights of their discussions during the afternoon share-out which are captured in the Learning Brief. These notes contain both the shared content and other discussion points that may not have been shared with the entire group. The notes are organized by discussion theme and table as there were two separate discussion tables for each topic.

Element I: Integration of Care

Table # 1

Define Topic/element
+ Co-location is not integration. Collaboration is also not integration.
+ Integration is a continuum.
+ How well does the team communicate?
+ Access to shared info (integrated chart) and shared treatment plan.
+ View person holistically: mental health, physical health, substance abuse—how do they impact well-being?
+ A culture of shared values, goals, and language.
+ A shared treatment approach by the team.
+ Shared resources.
+ Use of data for guidance (for system of care and individual).

Integrating and Incorporating Care
+ Medical home.
+ Information sharing (case consultation).
+ Treat the whole person; holistic approach.
+ Respect for one another.
+ Shared responsibility.
+ Client/patient-centered.
+ Infrastructure (challenge)
+ Daily team meetings (1hr) collocated, field-based services, two operation sites, "huddles."
+ Agreement to share info. Streamline electronic record. Send electronically. Challenge: cost-effectiveness.
+ "Group Me" app.

What are the advantages?
+ Health promotion
+ Greater sense of accountability. Patient/client is held accountable.
+ Less repetition of work.
+ Care coordination. Care informs plan.
+ Collocation may reduce stigmas.
+ Mind-body-spirit recognition—yes!
+ Shared medical records. Dangers in not communicating.
+ COST SAVINGS!

What are the challenges?
+ Institutional barriers/silos. Different languages/ HIPPA. Different approach. Different pay structure.
+ Sharing of records when not co-located.

- Cultural change/organizational change. Agency cultures competing.
- Compliance with DMH vs. being INN.
- Speaking the same language.
- Modalities/ frameworks.
- Buy-in!!!

What are the solutions to the challenges?
- Educating others (i.e. PTT partners).
- In progress.
- Creating a culture of open communication.
- DMH: figure out pay structure.
- Better funding for PTT partners (FQHC).
- Benefits specialists.
- Remember why we are here. KEEP HOPE ALIVE!!
- Look at success; decrease burn-out.
- We are the solutions—working together.
- We want more opportunities to be more innovative.
- Address organizational barriers.
- Cleaning house.
- Buy-in at all levels.
- Address resistance to change; be patient.
- Case managers: trained in medical benefits. Educating (housing, medical, financial).
- Psychosocial vs. Medical

Table #2

Define Topic/element*(No information was provided.)*
Integrating and Incorporating Care
- Mental health agencies—develop program together with FQHC partner.
- Inclusion of full-time medical (PCP)—in all aspects of program, including planning and education.
- Trust—working with known and trusted CBOs.
- Commitment from top-down.
- Continual education and tracking of staff.

What are the advantages?
- Better engagement care, recovery and client experience outcome (mental and physical health, plus substance abuse).
- Maximize limited resources—cost effective.
- Barriers removed—services accessible for the client.
- Staff morale higher—interesting, meaningful, work as part of a team.
- Common goals.
- Integrated education (for both client and staff).
- More continuity and contact.
- Reduced higher intensity treatment (hospitals, ERs, etc.)
- Better quality of life (clients and staff).
- Longer life.

What are the challenges?

- Finding culturally and linguistically competent staff.
- Finding qualified staff in needed disciplines.
- Integration of Peers.
- Choice limitations—can only receive care in their health homes (but will soon be true for everyone).
- ISM has particular challenges due to services not being collocated.
- Billing integration.
- Staff understanding how to be part of an integrated team—meshing of philosophies.
- Financial sustainability for possible future capitalization.
- Team members understanding the others' point of view.
- Integrated chart—privacy issues, requirements.
- Terminology differences for the various disciplines.

What are the solutions to the challenges?
- Recruitment: Hire graduate trainees. Offer internships/training programs (i.e. "grow on your own" through community partners).
- Psychiatrists: use of recruiters. Contract Traditional Behavioral Health. Locum Tenons (temporary psychiatrist).
- Common consent: can share information that's related to treatment.

Element II: Peers as Part of an Integrated Team

Table # 1

Define Topic/element
- Peers connect with clients differently. (Review psycho-social rehab model).

What are the advantages?
- Peers with lived experiences teach skills-empowerment component.
- Defined Peer job description in the organization; treated as a staff member with special skills and defined roles; may require ADA accommodations.
- Agency creates room for expansion of role (case management, independent living skills, continuing education.

What are the challenges?
- Peers may become too invested (boundaries, burn-out).
- Access to clinical records, documentation skills.
- Prior relationships on the street.
- Finding skilled peers (language, training).

What are the solutions to the challenges?
- DON'T BE AFRAID, HIRE PEERS!

Table #2

Define Topic/element
- Person with lived experience.
- Not specific to DMH.

+ Not specific to a job position. Need to understand what standard to use.

What are the advantages?
+ Enhanced connection in a way that non-peer cannot.
+ Ability to understand the context-lens.
+ Credibility in environment.
+ Modeling the recovery journey for other consumers.
+ Economically: gives people more jobs as Peer (employment) that enhances themselves and their own recovery.
+ Innovations models support each other in identifying/hiring peers. **Peer job fairs.
+ Share resources to recruit, train, and retain.
+ Increase participation—walk the path.
+ More comfort asking for help from Peer.

What are the challenges?
+ Idea of "Do not harm." If a person is not ready, needs to be addressed so no set-back in own recovery. Important to deal delicately. At the same time, helpful to address in sheltered environment.
+ A lot of supervision to support Peer.
+ Stigma: being an identified Peer.
+ Conflict of interest; boundaries are different. What looks inappropriate may look different. Favoritism.
+ Potentially foster dependency on Peer.
+ Bias on what is the "right way" of recovery.
+ Issue of documentation and billing that is done by Peer. Audit liability. Grammar/DMH Read/ A lot of training. Charting for Peer by clinician, this takes away from peer dynamic.
+ Question: Can we use new code specific to Peer (replace T1017 #2015)?
+ Assessing what clinical situations would be appropriate/inappropriate for Peer.
+ Impact of relapse of Peer on clients (re-traumatizing).

How are Incorporating/Using Peers?
+ Meet with Peer daily, go out daily, go out in partnership with IMHT.
+ Provide skills training, modeling for clients.
+ Promotoras: cultural variation on how implemented.
+ Self-help support groups that cater to certain cultures.
+ We are part of community even if we do not have lived experience. It is about my community's recovery.
+ Community (geographic, cultural, etc.) context of mental illness and trauma that was experienced; (ISM) is key.
+ Presentation of peer in context of family is key in culture
+ "Encyclopedia" of resources: "knowing what sells."
+ Make connection and trust with the agency. Spread info without stigma.
+ Transform process of receiving/ mental health/ physical health/ resource information/ engaging others.
+ Variety of Peer perspectives (i.e. solutions and options). Recovery is not a "one size fits all." Informs ability to interact more appropriately/effectively.

What are the solutions to the challenges?
+ Hiring choices: being very thoughtful in hiring Peers with variety of skills and experiences.
+ Identify core competency and training for what Peer is—informs the hiring process.
+ Build consistency/standard of how Peer services are billed.
+ Define ways to best recruit Peers. Example: 1 hand experience with 12 self-help support groups.
+ Variety of activities that Peers are engaged in that they don't useful fit present billing codes.

+ IDENTIFY PEER BILLING CODES!

Element III: Incorporating Data into Practice

Table #1

Define Topic/element
+ Data should be useful to track progress.
+ Data should be easy to understand…for general public.
+ More simple, not lengthy.
+ Tool for overall practice.
+ Getting buy-in…understanding significance.
+ Being able to identify a trend in what is working or not.
+ Embracing communication between clinician and data person.

What are the advantages?(No information was provided.)

What are the challenges?
+ Minimized client sessions due to allowed funding.
+ Repetition with forms that need to be filled out by clients.
+ Accuracy on assessments.
+ Confusing questions (clarity).
+ Clear about underline meaning.
+ Danger about being bias. Not having funding for hiring a data person.
+ Missing data before individual becomes client.
+ Having administrative time to complete data.
+ ISM only funds for face-to-face.
+ Lack of time: completing needs to enter data or get patient to be seen by the doctor.

How to Incorporate Element?
+ Hiring a data person or point person.
+ Advocate for funding.
+ Responsiveness by iHoms staff.

What are the solutions to the challenges?
+ Access and use to recorded webinar trainings. iHoms trainings and presentations.
+ Request ISM to provide funding for training time. To provide a greater reach of information about iHoms data training.
+ Improve response time by iHoms staff.
+ Get back to question in a timely fashion.
+ Make information more available to all. Create a brief with most asked questions and make it available online.
+ Announce on website and by email about trainings and resources available online.
+ Use the recorded webinars. Increase the number of trainings for those who enter data or analyze data.

Table # 2

Define Topic/element
+ Looking at outcomes and finding ways to change clinical practice.
+ Sharing data with clients.
+ Using data as self-monitoring tool and engagement tool.

What are the advantages?
+ Able to self-identify (recognize triggers).
+ Objective way to evaluate program.
+ Way to inform clinical practice based on successes/challenges.
+ Helps to know if goals are met.
+ Data informs learning.
+ Holds clinicians accountable.

What are the challenges?
+ Collecting data.
+ Accuracy of data.
+ Baseline data hard to record without rapport.
+ Dealing with other agencies.
+ Duplication data collection (redundant for client).
+ Long term engagement of client.
+ Stigma in communities.
+ Qualitative vs. quantitative.
+ Changing forms of baseline data.
+ Less time to show impact.
+ Difficult to measure as Peers.
+ How to measure hope.
+ Is comparison between models appropriate?
+ Language barrier in sharing data.
+ Educating staff/Peers on health indicators.
+ Getting clinicians to buy-in, to collect and use data.

How to Incorporate Element?
+ Design new method. Drill down data.
+ Sit down as a team to understand data. Have conversation about medication and impact on weight and other metabolic issues.
+ Using data to help make the client informed about care—early and often.
+ Bring client's data into annual care plan.

What are the solutions to the challenges?
+ Developing rapport
+ Education of staff and clients purpose of data to improve quality of treatment.
+ Adjust indicators to reflect target population/cultural issues to capture qualitative data. Need structured format. Incorporate qualitative data into learning collaborative sessions.
+ Develop ways to control duplication.
+ Transfer data between agencies.

Element IV: Delivering Culturally Competent Services

Table #1

Define Topic/element
(No information was provided.)

What are the advantages?

+ Providing services to mental health with no insurance patients. Educate the community. Outreach and engagement.
+ Access to physical health.
+ Offer programs, physically holistic health care.
+ Being with the patient until comfortable.
+ Peer support.
+ PCP suggesting counseling.
+ Pieces of the puzzle are there. We just need to put it together. We are providing mental health to the community.
+ Beyond language, multiple cultures, multiple health issue, meeting clients where they, and finding common ground to build a connection.

What are the challenges?

+ Barrier: the DMH cultural-system itself.
+ Stigma.
+ Languages.
+ Lack of cultural evidence practice.
+ Lack of team meetings.
+ Before DMH, federal being restricted.
+ Health and mental access to care barred on indigent status.
+ Lack of training.

What are the solutions to the challenges?

+ Learning collaborative to exchange ideas and solutions.
+ Common language among providers.
+ Affordable Care Act.
+ Regular team meetings/communication.
+ Co-location of staff.

Table #2

Define Topic/element

+ Serving the client/family the way they are—no assumptions.
+ Try to identify individual circumstances.
+ Not all individuals from the same culture have the same behaviors.
+ Incorporating multiple community resources to reduce stigmas, improve communication.

What are the advantages?

+ Connecting physical health to mental health or the other way around.
+ Engagement, education, building resources.
+ Agencies being able to relate to the community.
+ Agencies learning to be more flexible and develop more skills.

What are the challenges?

+ Overcoming trust issues.
+ Re-victimization: Previous services were reduced or stopped, now they have access but have fear accessing it.
+ People promised to receive feedback but were never followed through.
+ Being transparent with services.
+ Relating to the "customer".
+ Myths about mental health, breaking through the wall. Must have confidentiality.
+ Providing services in multiple locations, rather than being fully integrated (one location).
+ Barriers to enrolling in service due to cultural stigmas and fear of background checks.
+ Redefine terms to make services more accessible.
+ Limitations of 8 week COS, some communities take longer to engage/commit to services.
+ Subgroups within the culture.

What are the solutions to the challenges?

+ Being able to continuously send barriers/challenges as well as solutions.
+ Have decision makers available to make changes.
+ Have more collaboration between ISM or other models.
+ Reassess the program guidelines.
+ Look at the requirements of the RFS and identify those that have become barriers.
+ Develop contacts between agencies to improve communication and increase conversation about barriers and advantages.

Innovation Learning Session IV: *Learning from Each Other*

Learning Brief

July 25, 2013

HEALTHSERVICES RESEARCH CENTER

harder+company
community research

LAC DMH
LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH

Background

On July 25, 2013 Innovation program providers, LACDMH staff and the Evaluation Team came together at the Californian Endowment for the fourth quarterly Learning Session. Attended by 97 people, the session included: 1) A discussion focused on **incorporating evaluation tools into clinical practice**, 2) early efforts to **align Innovation service delivery with health care reform**, 3) a provider panel highlighting **promising practices** in integration, 4) model-level discussions focused on **solutions and successes** and 5) a conference style "poster session" featuring **story boards** created by Innovation providers. The session featured the most provider-led learning and sharing of any session to date.

Debbie Innes-Gomberg welcomed participants and framed the session within the context of three important developments that occurred since Learning Session III in April 2013:

- ISM presentation at **MHSA Innovations Summit** in the context of health neighborhoods created a great deal of interest among attendees;
- Participation of **LACDMH leadership** in monthly INN meetings;
- One-year **funding extension** carrying ICM/ISM/IMHT programs through June 2015 and Peer-run models through June 2016

These events illustrate the **importance** of the work INN providers are doing and the **interest in learning** from these efforts, both within and outside of Innovation.

> *The goal of this learning session was for each provider-organization to learn something new and develop an action plan to implement that learning.*

Incorporating Evaluation Tools into Clinical Practice

Dr. Andy Sarkin from *UCSD Health Services Research Center* presented an interactive session designed to facilitate the use of evaluation tools in clinical practice. Andy reviewed items comprising the IMR and MORS and presented three case studies for discussion with the group. The group discussed the importance of consistency across clinicians in the application of ratings. Andy stressed the use of clinical outcomes for both treatment (at the individual level) and program improvement (at the aggregate level). Organizations were provided with iHOMS reports for their programs to review in the context of this activity. Additional training opportunities related to evaluation measures will be offered in August. The full set of slides from this presentation is included in Appendix A of this brief.

Aligning Innovation Service Delivery with Health Care Reform

LACDMH implemented Healthcare Reform Readiness Workgroups designed to prepare DMH programs and services for alignment with standards of care expected to come online in January 2014. Matt Wells of LACDMH focused the discussion on five areas highly relevant to Innovation work, including Health Neighborhoods, Behavioral Health Center of Excellence, Behavioral Health Homes, Hot Spotting, and Outcomes and Evaluation. He then facilitated a panel of providers to share practices and learning related to Hot Spotting, Behavioral Health Homes, and Health Neighborhoods.

Hot Spotting

Kaney Fedovskiy from *Mental Health America of Los Angeles* (IMHT) shared their organization's approach to "Hot Spotting," which was defined as rapid engagement and front loading of services, including access to housing. Key findings included:

✚ **Engagement** is a very individual process and can be a very long process

✚ The selection of an **FQHC partner** is key; finding the right people to do the field work is important

✚ Helping clients **access detox and substance abuse services** has been an ongoing challenge; organization uses programmatic funds to allow clients to access services

✚ **Housing first** has been achieved through the use of hotel vouchers which has been key as the wait for Section 8 can often be very long

> *"Housing first is key…people want to have their own space—not be in shelters."*
> *~Mental Health America of Los Angeles*

Behavioral Health Homes

Lezlie Murch from *Exodus Recovery* (ICM) shared about their team approach to delivering integrated care. Key points included:

✚ **Early engagement of their FQHC partner** was important for success; involvement from the RFP stage ensured both organizations were on the same page from the beginning

✚ Engagement of both administrative and clinical **leadership** from both organizations was also critical to success

✚ **Flexibility to design clinic space** specifically for their needs supports service delivery

✚ **Daily integrated team meetings** ensure good communication and team approaches to care

✚ Use of **community-based referrals** to allow clients to access services beyond those offered in the clinic

Health Neighborhoods

Judith Perrigo and Gloria Sistos from *Tarzana Treatment Centers* (Latino ISM) shared some of their best practices around partnering and engagement:

✚ **Partnering with the right organizations** in the community; they have to be trusted and known by the community you want to serve

✚ It is important to constantly **foster the relationship with community partners;** TTC regularly meets with partners to discuss what's working and to problem-solve

✚ The use of **culturally sensitive language** is important to reducing stigma around receiving mental health services

✚ There is a need for **psycho-education** in these communities to combat stigma and increase willingness to access mental health services

✚ Current clients are an important source of **referrals**

Learning from Each Other: Promising Practices in Integration

This quarter the Evaluation Team conducted the first round of program site visits to better understand the challenges and successes of delivering integrated services this quarter. These visits were conducting using the Integrated Treatment Tool developed by researchers at Case Western Reserve University as a guide. While these early visits highlighted many of the challenges of this service model, they also revealed a number of interesting and innovative practices with potential applicability across models. Three organizations were invited to share innovative practice during this Learning Session. Highlights of each presentation are summarized below.

Creative (and culturally sensitive) outreach at IMCES (*presented by Arpe Asaturyan*)

+ The team at IMCES (Armenian ISM) created innovated outreach programs to effectively engage community members. This includes "Coffee Talk," which are informal discussion sessions held at Armenian coffee shops in the target service area and book club.

+ A key to success was marketing these events well in advance (up to six weeks) and to be patient as attendance built over time.

+ Case managers and therapists attend these events to begin building relationships with potential clients.

Step Up on Second bridges cultural divides across disciplines (*presented by Michael Marx*)

+ Step Up on Second (IMHT) experienced challenges as physical health, mental health and substance abuse professionals learned to work together

+ It was important to recognize that each discipline has a different way of approaching problems and thinking about treatment

+ Engagement of leadership from all organizations was key to moving to a more collaborative approach, institutional commitment helped overcome "ego" issues

Colocation and warm hand-offs build early success for L.A. Child Guidance Center (*presented by Betty Mendoza*)

+ L.A. Child Guidance Center (Latino ISM) built on an existing relationship with South Central Family Health Centers for Innovation

+ ISM was able to secure dedicated space in the clinic for mental health staff which has allowed the relationships between mental and physical health providers to develop

+ Medical staff administers the PHQ-9 and ISM staff are available for warm handoffs when potential clients are identified

Learning from what's Working: Highlights of Model-level Discussions

Learning session participants have overwhelmingly expressed the desire that sessions continue to include time for model-level sharing as a complement to the cross-model learning that takes place throughout the day. In response to this desire, the afternoon included a facilitated session to share successful strategies within models (ICM, IMHT, ISM and PRISM/PRRCH. The goal of the activity was for each organization to identify at least one practice, technique or approach that has been successful for one of their peers to implement this quarter and to work with their team to develop initial action steps to ensure implementation.

This brief includes a synopsis of some of the successful strategies providers shared and is organized by model. Appendix B includes a more detailed presentation of this information at the table level and also includes a summary of strategies that providers intend to implement in the coming quarter.

Solutions from ISM Providers

Focus Area	Solution
Improve relationship/communication with medical providers and other partners	▪ Weekly in-person case conferences ▪ Up-front communication ▪ Improving communication, setting up in-person meetings
Use of flex-funds	▪ Working on guidelines; make it easier
Stigma	▪ Partner with CBOs ▪ Meet in community/go to the client (field based) ▪ Get community together (field trips, different activities) ▪ Alternative treatments offered (acupuncture, pain management, education) ▪ Communicating with Samoan Community leaders and getting their advice/support ▪ Engaged youth to help support O&E
Engagement & Enrollment	▪ Extra COS (DMH context) ▪ Hiring staff that is culturally responsive (Ethiopian) ▪ Outreach to churches ▪ Men's groups
Retention	▪ Follow-up
Wait-listing/Not being able to serve need	▪ Triage for the highest at need
Outreach	▪ Library (neutral setting) ▪ Diversifying O&E, going to churches, talking to pastors, talking to orgs: APOC, APD ▪ More targeted outreach to specific locations and partners (gatekeepers) ▪ Natural network of clients ▪ More community presence – McDonald's ▪ Radio shows: help overcome fear of deportation ▪ Food banks
Cultural activities & billing	▪ Advocating for policy change
Finding non-traditional partners	▪ Trying to be culturally relevant and literate. ▪ Started knitting/crochet class
Length of Engagement period too short	▪ Extending O&E was helpful

Focus Area	Solution
	▪ Conducted more *Platicas* (info sessions)
Limited physical space	▪ Asking for additional help from partner organizations ▪ Renting more space and scheduling more efficiently
Getting referrals	▪ Improved communication
Supporting undocumented clients (no SSI number)	▪ Build knowledge so undocumented clients can be referred to appropriate resources
Education	▪ Use incentives when doing outreach

Solutions from ICM Providers

Focus Area	Solution
Outreach & Engagement	▪ Bringing existing support groups together ▪ Outreach through Rainbow Book ▪ Community resources (schools/churches)
Housing/Interagency communication	▪ Increase transitional housing (MLU) communication with other ICM programs to find better options
Education	▪ Increased education (yoga, nutrition groups)
Peer Support/Client Support	▪ More support and life skills groups
Medication problems	▪ Came up with a list of client needs
Engagement in care	▪ Beefed-up wraparound services and ways to help
Identifying eligible clients	▪ Created tool for financial screening
Access & Transportation	▪ Assessed clients' transportation needs ▪ Assisted with disabled bus passes
Engaging clients in social activities	▪ Implemented monthly activities
Appropriate referrals from primary care providers	▪ Daily communication and education about the ICM program and the criteria ▪ Education about physical illness and mental health ▪ Designate one person to be the intake coordinator
Spacing/lack of housing and shelters	▪ Reach-out to local hotel/motel (MOUs)
Resistance to change	▪ Task force to address change and create a uniform method

Solutions from IMHT Providers

Focus Area	Solution
Spike in relapse rated following permanent housing	▪ Night manager(s) working random shifts. ▪ Increase motivational interviewing
Staff retention	▪ Multiple interviews, team investment in hiring
Client retention problematic following initial engagement/"Money Night"	▪ Longer engagement; use example of money order as demo
Fidelity to integrate model	▪ Modeling and reinforcing
Member identification/bonding with single staff members	▪ Developing treatment plan as a team ▪ Social activities/mixers, like picnics
Need for inpatient/residential treatment for serious mental health and substance abuse issues	▪ Identified resources inside DMH ▪ DMH communicated with DHS
Centralized housing/placements	▪ Staff flexibility ▪ Random checks around the clock ▪ Collaborative meetings: PD, housing development, manager, and servers
Medical chart vs. real treatment goals/Justifying billing via medical necessity.	▪ Restructure billing practices.

Solutions from Peer Providers

| Focus Area	Solution

Stigma: How can people with mental health challenges help me?	▪ Work within what is already established
	▪ Work with each other, convey respect to show PEERS are allies and promote the PEER movement.
	▪ Example: increase opportunity with physician to make sure doctor knows what PEER is doing and why, and to learn the doctor's thought process
	   o Welcome outside position, hear what they have to say
	   o Solidify own voice of PEERs and image.
	   o Promote mutual understanding and figure out how to work together through dialogue

Outreach	▪ It does help that they know if someone "just gets it." ▪ Flyers, phone calls, rainbow dictionary ▪ Service area navigators ▪ Give a solid referral

Staffing	▪ Staffing: finding qualified PEERs.
	▪ "Recovering First"
	▪ Staffing
	   o Lived experience of mental health
	   o Lived experience of addiction
	   o Not typically both

Focus Area	Solution
Billing: How will it work with overnight staff?	▪ PRISM site manager for Downtown ▪ C.O.S. and staffing issues resonate ▪ How to discuss letting people know about services
OASIS as a referral source for PEER staffing	▪ Mental health, homeless ▪ Don't have work experience though, but DO have motivation ▪ Solution: "mentoring relationship" ▪ Break days into small shifts ▪ Pair PEER from OASIS with someone with experience for training and support
Trainings	▪ Linked with MHA for ongoing training ▪ Require all PRRCH and PRISM staff to get training ▪ Advocacy Training: Developing active listing mental health terminology ▪ Intern with SHARE! which transitions into a more permanent staff position.
Partnerships	▪ Working in alliance with medical model; how to work with system to support mission of PEER movement.

Storyboard Activity

A storyboard is a visual communication tool used to convey information about a program, including purpose, objectives, outcomes and lessons learned. When updated over time, a storyboard can be used to illustrate change and document learning. Storyboards were first introduced in Learning Session II and have been further refined at each subsequent Learning Session.

In this Learning Session, each provider organization created a storyboard to share with the group. Storyboards were on display throughout the day in the meeting room and adjacent patio in a conference-style poster session. Time was allotted for attendees to view posters at the end of the session. This session included a "scavenger hunt" activity to encourage everyone to visit and read through all of the posters.

Posters were engaging, diverse and reflected the personalities of the organizations they represented. Photos of some of the posters presented at the Learning Session are included in Appendix C.
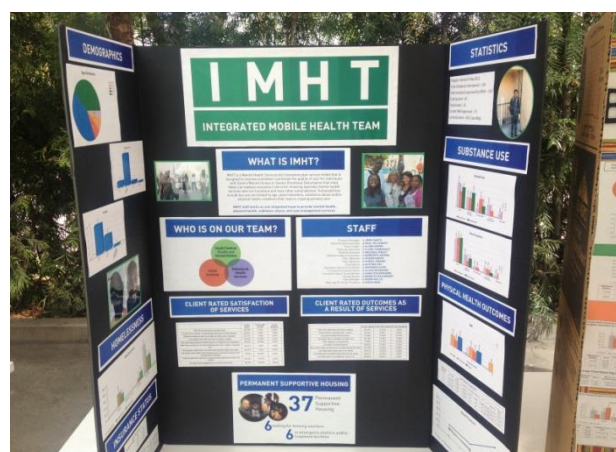
Wrap-up and Take Aways

Debbie Innes-Gomberg wrapped up Learning Session IV by sharing observations of themes and important learning that emerged throughout the day, especially from provider-led presentations.

Learning Session IV Take Aways

✚ **Client Outreach and Engagement:** Develop and share outreach and engagement strategies that make a difference

✚ **Stigma:** In many communities stigma is still a barrier to participation. How can we best utilize the stigma and discrimination reduction campaigns happening at the state and local levels to deal with this barrier?

✚ **Community Visibility**: How do providers become an integral part of their community so that clients, potential clients and other professionals know that you're the place the go for mental healthcare?

✚ **Intentionality:** Intentionality in selecting and engaging partners supports integration. The more you are intentional the more successful you will be.

✚ **Executive Leadership:** Engagement of leadership from mental health, healthcare and substance abuse providers ensures integrated teams are focused on the same goals and can solve problems as they arise.

✚ **Co-location:** When mental health providers have a physical presence within the FQHC it allows for critical warm-handoffs and continuous interaction with medical staff to increase awareness of ISM services.

Learning Session V will be held November 7th, 2013 at The California Endowment.
Please save the date!

Appendix A

This appendix contains slides from the PowerPoint presentation presented by Dr. Andy Sarkin of UCSD Health Services Research Center about the use of evaluation measures in clinical practice.

Incorporating Evaluation Tools Into Clinical Practice : Clinician-Rated Mental Health

Training for Los Angeles County Innovations

Importance of Measurement

Why invest time in program evaluation activities?
- Continuous Program Improvement
  - Identifying training and technical assistance needs
  - Test program changes or new programs
  - Identifying client groups that need attention
- Accountability to Stakeholders, Motivating Staff
  - Staff, Funders, Community, Clients and Families
- Securing Future Funding

How will this help our individual clients?
- Tracking Individual Progress and Treatment Plans
- Promoting an Integrated Recovery Orientation
- Facilitating Recovery and Communication
  - Between people receiving and providing services
  - Between service providers in an integrated system

Types of Program Information

- Needs
  - Programs and staffing
  - Referrals and partnerships
  - Education and training for staff or clients
- Successes
  - Outcomes improvements
  - Enrollment, retention, and graduation
- Challenges
  - Relapses and rehospitalizations
  - Engagement and outreach
- Accountability

Clinician-Rated Mental Health

- MORS – Milestone of Recovery Scale
  - 1 item with 8 possible anchored responses
  - Assesses level of risk, engagement, support needs
  - Requires training to get valid scores
- IMR – Illness Management and Recovery
  - 15 Items, each with 5 anchored responses
  - 3 subscales and total score that measure
    - Management of Illness and Symptom Reduction
    - Recovery-oriented Behaviors and Self-Management
    - Substance Abuse
  - IMR scores are reliable and valid without training, but reliability may be increased by consensus

Using Clinician-Rated Mental Health for Individuals and Programs

- Rating IMR and MORS(only done by clinicians)
- Effectively using the Ratings from Clinicians
  - Needs assessment for
    - Treatment planning
    - Program planning
  - Assessing progress for people and programs
  - Critical indicators such as relapse or gaps in referral
  - Strengths that can aid in recovery and growth
  - Enhancing the therapeutic dialogue to
    - Increase client involvement in treatment, setting goals
    - Increase staff involvement in program planning

Progress Towards Personal Goals

- 1. In the past 3 months, s/he has come up with…
  - No personal goals
  - A personal goal, but has not done anything to finish the goal
  - A personal goal and made it a little way toward finishing it
  - A personal goal and has gotten pretty far in finishing the goal
  - A personal goal and has finished it

1

Knowledge

▸ 2. How much do you feel your client knows about symptoms, treatment, coping strategies (coping methods), and medication?
  ◦ Not very much
  ◦ A little
  ◦ Some
  ◦ Quite a bit
  ◦ A great deal

Involvement of Family and Friends in My Mental Health Treatment

▸ 3. How much are people like family, friends, boyfriends/girlfriends, and other people who are important to your client (outside the mental health agency) involved in his/her mental health treatment?
  ◦ Not at all
  ◦ Only when there is a serious problem
  ◦ Sometimes, like when things are starting to go badly
  ◦ Much of the time
  ◦ A lot of the time and they really help with his/her mental health

Contact with People Outside My Family

▸ 4. In a normal week, how many times does s/he talk to someone outside of his/her family (like a friend, co-worker, classmate, roommate, etc.)?
  ◦ 0 times/week
  ◦ 1–2 times/week
  ◦ 3–4 times/week
  ◦ 6–7 times/week
  ◦ 8 or more times/week

Time in Structured Roles

▸ 5. How much time does s/he spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment? That is, how much time does s/he spend in doing activities for or with another person that are expected of him/her? (This would not include self-care or personal home maintenance.)
  ◦ 2 hours or less/week
  ◦ 3–5 hours/week
  ◦ 6–15 hours/week
  ◦ 16–30 hours/week
  ◦ More than 30 hours/week

Symptom Distress

▸ 6. How much do symptoms bother him/her?
  ◦ Symptoms really bother him/her a lot
  ◦ Symptoms bother him/her quite a bit
  ◦ Symptoms bother him/her somewhat
  ◦ Symptoms bother him/her very little
  ◦ Symptoms don't bother him/her at all

Impairment of functioning

▸ 7. How much do symptoms get in the way of him/her doing things that s/he would like to do or need to do?
  ◦ Symptoms really get in his/her way a lot
  ◦ Symptoms get in his/her way quite a bit
  ◦ Symptoms get in his/her way somewhat
  ◦ Symptoms get in his/her way very little
  ◦ Symptoms don't get in his/her way at all

2

Relapse Prevention Planning

▸ 8. Which of the following would best describe what s/he knows and has done in order not to have a relapse?
  ◦ Doesn't know how to prevent relapses
  ◦ Knows a little, but hasn't made a relapse prevention plan
  ◦ Knows 1 or 2 things to do, but doesn't have a written plan
  ◦ Knows several things to do, but doesn't have a written plan
  ◦ Has a written plan and has shared it with others

Relapse of Symptoms

▸ 9. When was the last time s/he had a relapse of symptoms (that is, when his/her symptoms got a lot worse)?
  ◦ Within the past month
  ◦ In the past 2 to 3 months
  ◦ In the past 4 to 6 months
  ◦ In the past 7 to 12 months
  ◦ Hasn't had a relapse in the past year

Psychiatric Hospitalizations

▸ 10. When is the last time s/he has been hospitalized for mental health or substance abuse reasons?
  ◦ Within the past month
  ◦ In the past 2 to 3 months
  ◦ In the past 4 to 6 months
  ◦ In the past 7 to 12 months
  ◦ No hospitalization in the past year

Coping

▸ 11. How well do you feel your client is coping with his/her mental or emotional illness from day to day?
  ◦ Not well at all
  ◦ Not very well
  ◦ Alright
  ◦ Well
  ◦ Very well

Involvement with Self-Help Activities

▸ 12. How involved is s/he in consumer run services, peer support groups, Alcoholics Anonymous, drop-in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs?
  ◦ Doesn't know about any self-help activities
  ◦ Knows about some self-help activities, but isn't interested
  ◦ Is interested in self-help activities, but hasn't participated in the past year
  ◦ Participates in self-help activities occasionally
  ◦ Participates in self-help activities regularly

Using Medication Effectively

▸ 13. (Don't answer this question if his/her doctor has not prescribed medication) How often does s/he take his/her medication as prescribed?
  ◦ Never
  ◦ Occasionally
  ◦ About half the time
  ◦ Most of the time
  ◦ Every day
  ◦ __ Check here is client is not prescribed psychiatric medication

3

Impairment of Functioning Through Alcohol Use

▸ 14. Drinking can interfere with functioning when it contributes to conflict in relationships, or to financial, housing and legal concerns, to difficulty showing up at appointments or focusing during them, or to increase in symptoms. Over the past 3 months, did alcohol use get in the way of his/her functioning?
- ◦ Alcohol use gets in his/her way a lot
- ◦ Alcohol use gets in his/her way quite a bit
- ◦ Alcohol use gets in his/her way somewhat
- ◦ Alcohol use gets in his/her way very little
- ◦ Alcohol use is not a factor in his/her functioning

Impairment of Functioning Through Drug Use

▸ 15. Using street drugs and misusing prescription over-the-counter medication can interfere with functioning when it contributes to conflict in relationships, or to financial, housing and legal concerns, to difficulty showing up at appointments or focusing during them, or to increase in symptoms. Over the past 3 months, did drug use get in the way of his/her functioning?
- ◦ Drug use gets in his/her way a lot
- ◦ Drug use gets in his/her way quite a bit
- ◦ Drug use gets in his/her way somewhat
- ◦ Drug use gets in his/her way very little
- ◦ Drug use is not a factor in his/her functioning

IMR Management Subscale

▸ Symptom Distress (6)
▸ Impairment of Functioning (7)
▸ Relapse of Symptoms (9)
▸ Coping (11)

IMR Recovery Subscale

▸ Progress Towards Personal Goals(1)
▸ Knowledge (2)
▸ Contact with People Outside of Family (4)
▸ Relapse Prevention Planning (8)
▸ Involvement with Self-Help Activities (12)

IMR Substance Use Subscale

▸ Impairment of Functioning Through Alcohol Use (14)
▸ Impairment of Functioning Through Drug Use (15)
▸ Scale score is the most impaired of these two items, unlike other scales where scales score is the average of the items in the scale

IMR Items not in a subscale are included in the IMR Total Score

▸ Involvement of Family and Friends in my Mental Health Treatment (3)
▸ Time in Structured Roles (5)
▸ Psychiatric Hospitalizations (10)
▸ Using Medication Effectively (13)

4

Using Our Innovations Data

▸ Case Study A – Determining Needs at Intake
▸ Case Study B – Understanding Outcomes
▸ Case Study C – Program-Level Outcomes

Other Important Sources of Data for Program Improvement

▸ Clinician mental health
▸ Physical health indicators (Screening, BMI)
▸ Client-reported outcomes
▸ IS system for service utilization
▸ Outreach, enrollment, and retention
▸ Social network analysis
▸ Integration tool and site visits
▸ Qualitative interviews and focus groups
   ◦ Cultural Competency, Outreach and Engagement

5

Appendix B

This appendix contains the full text of the notes provided by each self-facilitated discussion group from the afternoon activity focused on organizational and programmatic learning about integration. Each group presented highlights of their discussions during the afternoon share-out which are captured in the Learning Brief. These notes contain both the shared content and other discussion points that may not have been shared with the entire group. The notes are organized by model and table as there were multiple tables per model. The Evaluation Team transcribed notes from the chart paper as they were written by providers and made only minor edits to correct spelling or clarify ideas.

ISM Table #1
Organizations present: Tarzana Treatment Center, LA County Department of Mental Health, Institute for Multicultural Counseling & Education Services (IMCES)

Past Challenges & Solutions

Focus Area	Solution
Improving relationship with medical providers	Weekly in-person case conference.
Stigma down	Partners with CBOs around community
Communication amongst partners	Up front communication
Exchange forms/information	Improving communication and setting up in-person meetings
Use of flex-funds	Working on guidelines; make it easier
Stigma around mental health	Meet in community, go to client (field-based) Get community together (field trips, different activities)

In the Pipeline & Key Next Steps

Focus Area	Key Next Steps
Staff development	More clinical training to non-clinical staff
Stigma	Using resources from community organizations
Improving ISM program	Better communication with agencies Out-of-the-box thinking
Improve communication	Communicate more often and to everyone Clarifying Policies and procedures
Outreach & Engagement	Open up funds (i.e. meeting/lunch)
Implementation	Monthly case conference Create support network
Improve integrated care	Build relationships
Managing Promotoras	Use shared calendar Doing visits to actual classes
Wellness classes	Offer more trainings

Organizations present: Didi Hirsch, Kedren Mental Health Center, Jewish Family Services of Los Angeles, United American Indian Involvement, Inc.

Past Challenges & Solutions

Focus Area	Solution
Engagement & Enrollment	Extra COS (DMH context)
Retention	Follow-up
Outreach location	Library (neutral)
Engaging men into treatment	Men's groups
Cultural activities & billing	Advocating for policy change
Engaging/language	Engaging other agencies/partners/DCFS

In the Pipeline & Key Next Steps

Focus Area	Key Next Steps
Eligibility requirements difficult for kids to meet, but need culturally responsive mental health treatment	Talk to DMH; Looking at parent as "identified patient" and including kid in family treatment
Transportation	Food trucks as wellness trucks – education, dispels stigma; Look at voluntary ride sharing
Additional feedback	Getting involved in local service areas Online provider language directories Breaking down cultural barriers
Stigma/Parenting groups didn't take off (stigma)	Media outlets/YouTube channel targeting Armenian community Safe form of outreach Change location? Anonymous call-in show? Seeking more feedback Rebranding "Parenting"
Clients' social connections (community is dispersed)/Difficult to run groups	Get space for activities at FQHC Partnering with Native American community organizations Learning where existing clients go Involving community leaders

Organizations present: SSG – Samoan, Alma Family Services, Barbour & Floyd Medical, LA Child Guidance Clinic, Kedren Mental Health Center, Koreatown Youth & Community Center (KYCC)

Past Challenges & Solutions

Focus Area	Solution
Finding non-traditional partners	Trying to be culturally relevant and literate Opened knitting/crochet class
Outreach & Engagement/getting referrals	Diversifying O&E, going to churches, talking to pastors, talking to orgs: APOC, APD
8 week engagement period too short	Extending O&E was helpful Conducted more Platicas (info sessions)
Limited physical space at Center	Asking for additional help from partner organizations Renting more space and scheduling more efficiently
Mental health as a taboo for Samoan Community	Communicating with Samoan Community leaders and getting their advice/support Engaged youth to help support O&E
Getting referrals	Improved communication
Questions about undocumented clients, no SSI number	Referring undocumented clients to appropriate resources
Engaging African-American community, getting through the door	Hiring staff that is culturally responsive (Ethiopian) Outreach to churches
Stigma	Alternative treatments offered (acupuncture, pain management, education)

In the Pipeline & Key Next Steps

Focus Area	Key Next Steps
Finding approved clients	Continue to reach-out to the community Make non-traditional service be cost-effective
Needs new healthcare partner/Must be able to accommodate more services to be paid	Meeting with new healthcare partner
Find resources in the community that offer resources in Spanish, after discharge	Contacting local agencies and introducing ISM program; offering classes for the elderly
Incentives	Bring food/provide certificate of appreciation
Immigration	Partnering with legal center to provider legal services
Unemployment	Host educational events; connecting clients to additional resources (unemployment)
Flow/communication between mental and physical	To hire OBN

Organizations present: Didi Hirsch, SSG – OAP, UMMA Community Clinic, SSG – Weber Community Center, LA County Department of Mental Health, Korean American Family Service Center (KAFSC), SSG – Asian Pacific Counseling & Treatment Centers (APCTC)

Past Challenges & Solutions

Focus Area	Solution
Support ISMs for structuring in practice	Personal approach, unique solution
Outreach with sick clients	More targeted outreach to specific locations and partners (gatekeepers) Natural network of clients
Wait listing/Staff overburdened not being able to serve need	Triage for the highest at need
Clients to be engaged with their care	Be sensitive to clients' needs, consider what they need One-on-one communication with clients
Talking to other provider/Not seamless between different providers, hard to track clients	Re-gaining trust with medical providers Call two days before and ask about barriers Reminders for specialty providers Training for health neighbors Developing protocols of contact
Admin challenges: reimbursements & service treatment plans	Expanded outreach Bundle rate billing for FQHC Use of food for outreach Mixing groups of enrolled and not enrolled
Outreach/mistrust	Increasing radio advertisements Staffing, careful consideration Attend community events Sensibility to community concerns (not promoting stigma)
Identify clients/outreach	More community presence – McDonald's Radio shows: help overcome fear of deportation Food banks
Outreach: initial interest, but not ready for all services especially mental health	Explain benefits Practice cultural sensitivity Using other funds to provide mental health services

In the Pipeline & Key Next Steps

Focus Area	Key Next Steps
Some questions not culturally relevant	Cultural component now being studied by medical anthropologist
Paperwork	Hire recent graduates/students and train them Have them be patient advocates
Clients refuse services after intake: denial, fear, stigma around treatment, immigration concerns	Longer Outreach & Engagement Discrimination reduction program Peer support: exposure to current clients
Staff burn-out	No tentative solutions
Transportation to services	Classes scheduled after group in the next building is over; more funding
Working with MediCal provider (challenges)/ Turnover with providers	Try to increase visibility with medical providers Meeting with medical providers that require their presence; Co-location Block-out time with medical provider for care conferences every week Need commitment from the top Video conference

ISM Table #5

Organizations present: Asian American Drug Abuse Program (AADAP), Office of Samoan Affairs (OSA), SNNA, SSG – Samoan, St. Joseph Center, Pacific Asian Counseling Services (PACS), Institute for Multicultural Counseling & Education Services (IMCES)

Past Challenges & Solutions

Focus Area	Solution
Stigma/Mental health education	The pantry Culturally sensitive Respectful of beliefs
Collaboration/coordination	SA therapists provide services at mental health agency
Talk therapy	Incorporating of non-traditional services
Partnership with FQHC	Setting up a meeting CSS-collecting physical health info
Education	Use incentives when doing outreach

In the Pipeline & Key Next Steps

Focus Area	Key Next Steps
Relationship with FHQC	Meeting once a month
Stigma	Use different languages "someone to talk to" Incorporation of non-traditional services to help clients identify mental health connection, medical model
Retention	More outreach, screen properly, build trust, peer advocates accompany clients, community leaders' acceptance of mental health services

Focus Area	Key Next Steps
Training	Attend trainings
Approach	Media/radio broadcast exposure

ICM Table #1
Organizations present: JWCH Institute, SSG – HOPICS, Los Angeles Gay & Lesbian Center

Past Challenges & Solutions

Focus Area	Solution
Outreach & Engagement	Bringing existing support groups together
Housing/Interagency communication	Increase transitional housing (MLU) communication with other ICM programs to find better options
Education	Increased education (yoga, nutrition groups)
Peer Support/Client Support	More support and life skills groups

In the Pipeline & Key Next Steps

Focus Area	Key Next Steps
Peer support services (ICM-specific)	Monthly/bimonthly meeting – bringing existing support groups together
Transitional housing	Outreach with other ICM programs to find better options
Self-management	Yoga instructor, nutrition groups
CSS Funds	Budget groups
Engagement	Increase pamphlets and materials
Office Space	Keep community events on activity board up to date
More support for clients	Incentives (food vouchers, gift cards)
Group engagement	More support groups: life skills, organization Peer advocate integration
Outreach and housing	Hunger needs
In-reach	Get love, YMCA potential housing, and hotel
Transgender care	Use of prescreen FQHC
Outreach/Community referrals	Walking group (weekly) Referrals from MDs Immigration reform/concerns Wellness/education/exercise class and groups
Community connections	Relations with vendors…discount rates
Housing	Transitional housing connections, get calls when beds are available Engagement.
Dental	Negotiating/shopping around to get best deal
Diabetes/chronic care referrals to group	Trainer that has nutrition, fitness education

ICM Table #2

Organizations present:

SSG – HOPICS, Exodus Recovery, Inc., The Saban Free Clinic, Los Angeles Gay & Lesbian Center

Past Challenges & Solutions

Focus Area	Solution
Medication problems	Came up with a list of client needs
Finding clients	Outreach through Rainbow Book Community resources (schools/churches)
Engagement in care	Beefed-up wraparound services and ways to help
Identifying clients	Created tool for financial screening
Access & Transportation	Assessed clients' transportation needs and assisted with disabled bus passes
Engaging clients in social activities	Implemented monthly activities

In the Pipeline & Key Next Steps

Focus Area	Key Next Steps
Medication Problems	Create policy against prescribing addictive medications Psycho-education about negative effects of certain medications
Triage patients	Schedule specific intake times
Waitlist problems	Create structured timeframe for course of treatment
As patients increase psych medication adherence, they have increased BMI	Implement fitness and nutrition programs Implement medication support group
Employment challenges	Link to volunteer opportunities
Client education	Money management, GED, career guidance, ESL Increase communication: structured protocol for case conferencing
Client engagement/Meeting contract numbers	Continue implementing groups/classes Sessions with multiple providers Develop protocol for graduation, discharge or reduction in utilization

ICM Table #3

Organizations present: Los Angeles Gay & Lesbian Center, LA County Department of Mental Health

Past Challenges & Solutions

Focus Area	Solution
Communication to primary care providers for appropriate referrals	Daily communication and education about the ICM program and the criteria Education about physical illness and mental health Designate one person to be the intake coordinator
Spacing/lack of housing and shelters	Reach-out to local hotel/motel (MOUs)
Paperwork	Make three copies of everything
Resistance to change	Task force to address change; create a uniformity

In the Pipeline & Key Next Steps

Focus Area	Key Next Steps
Client education: finances, nutrition, chronic disease	Reach-out for money management workshops Self-reliance, engagement CLUB MED Program: gardening, understanding your labs, knitting, medical adherence
Discharging clients and billing issues	Point person managing and reviewing IS for last claimed services
Too many administrative people/ One person with multiple roles	DMH documentation training
Billing, what to claim? When? Electronic case conferencing?	Q&A liaison per service area

IMHT Table #1

Organizations present: JWCH Institute, Step Up On Second, Exodus Recovery, Inc., SCHARP Los Angeles, Mental Health America of Los Angeles

Past Challenges & Solutions

Focus Area	Solution
Spike in relapse rated following permanent housing	Night manager(s) working random shifts Increase motivational interviewing
Staff retention	Multiple interviews, team investment in hiring
Client retention problematic following initial engagement/"Money Night"	Longer engagement Use example of money order as demo
Fidelity to integrate model	Modeling and reinforcing
Member identification/bonding with single staff members	Developing treatment plan as a team Social activities/mixers, like picnics

In the Pipeline & Key Next Steps

Focus Area	Key Next Steps
PH increased outcomes EBP	Team care training.
Substance use	Identify best practices, motivational interview training
Lonely (return to homeless friends)	Social activities; interaction matters Evidence-based practices (EBP)
Housing retention	Housing redevelopment New housing coordinators Establish relationships Streamlining process Master leasing
Lack of access to detox services	BCDC at detox center Look for additional ISM providers
Efficiency of care	Introduce parents to providers/services in geographic location close to them (the nearest providers)
Employment development	Recruitment, engaging agencies with sheltered environments

IMHT Table #2

Organizations present: St. Joseph Center, Step Up on Second, The Saban Free Clinic, Exodus Recovery, Inc., Los Angeles Christian Health Centers (LACHC)

Past Challenges & Solutions

Focus Area	Solution
Chronic medical conditions comprised of a substance or mental illness that can't be managed as an outpatient	Resources inside DMH DMH communicate with DHS
Centralized housing/placements	Staff flexibility Random checks around the clock Collaborative meetings: PD, housing development, manager, and servers
Medical chart vs real treatment goals/Justifying billing via medical necessity	Restructure billing practices

In the Pipeline & Key Next Steps

Focus Area	Key Next Steps
Cross training for all scopes of practice	Making an announcement
Additional medical staff	Hire MA/nurse
Increase the use of the MORS and IMR	Introduce to the team Implement immediately
Time management	Officer of the day/staff rotation
Housing	Locate housing in safer neighborhoods without bugs in a timely manner
Client boredom	Networking in the community for resources PEER training, groups

PEER Table #1

Organizations present: SHARE!, Project Return

Past/Present Challenges & Solutions

Focus Area	Issues/Solution/Key Next Steps
Stigma	✚ How can people with mental health challenges help me? • Work within what is already established • Work with each other, convey respect to show PEER services are allies and promote the PEER movement • Example: increase opportunity with physician to make sure doctor knows what PEER is doing and why, and to learn the doctor's thought process ▪ Welcome outside position, hear what they have to say… ▪ Solidify own voice of PEERs and image ▪ Promote mutual understanding and figure out how to work together through dialogue
Outreach	✚ Stigma, ignorance, lack of understanding

Focus Area	Issues/Solution/Key Next Steps

	✚ People don't understand the role of PEERs
	   • Goal is to be support person
	     ✚ Reaction is that this won't work
	     ✚ No clinical component
	   • ARE YOU A THERAPIST?
	     ▪ But it does help that they know if someone "just gets it"
	     ✚ Flyers, phone calls, rainbow dictionary
	     ✚ Service are navigators
	     ✚ Give a solid referral

Staffing	✚ Staffing: finding qualified PEERs
	✚ Resistance: people say it won't work
	✚ "Recovering First"
	   • Staffing
	     ▪ Lived experience of mental health
	     ▪ Lived experience of addiction
	     ▪ Not typically both

Billing	✚ COS Billing: How will it work with overnight staff?
	✚ PRISM site manager for Downtown
	   • COS and staffing issues resonate
	   • How to discuss letting know people about services

OASIS as a referral source for PEER staffing	✚ Mental health, homeless
	✚ Don't have work experience though!
	✚ But DO have motivation
	✚ Solution: "mentoring relationship"
	   • Break days into small shifts
	   • Pair PEER from OASIS with someone with experience for training and support

Trainings	✚ Linked with MHA for ongoing training • Require all PRRCH and PRISM staff to get training ✚ Advocacy Training: Developing active listing mental health terminology ✚ "Work in Progress" - must be in a place in recovery to help others ✚ Intern with SHARE! which transitions into a more permanent staff position
Partnerships	✚ Working in alliance with medical model • How to work with system to support mission of PEER movement

Appendix C: Storyboards

ISM Storyboards

Top Left:
+ IMCES

Top Right:
+ Jewish Family Services

Bottom Left:
+ Asian Pacific Islander

Bottom Center:
+ UMMA/SSG

Bottom Right:
+ Alma Family Services
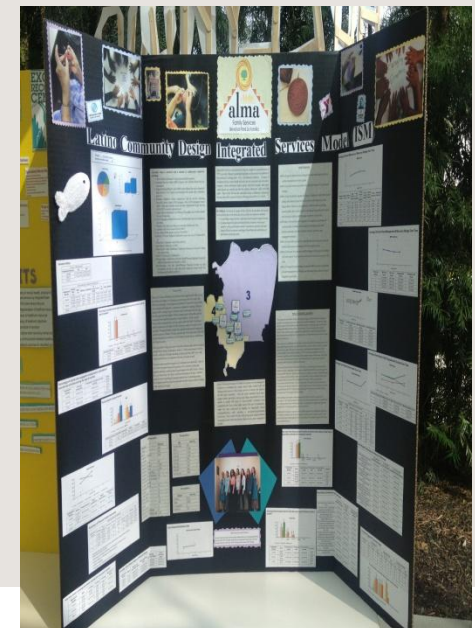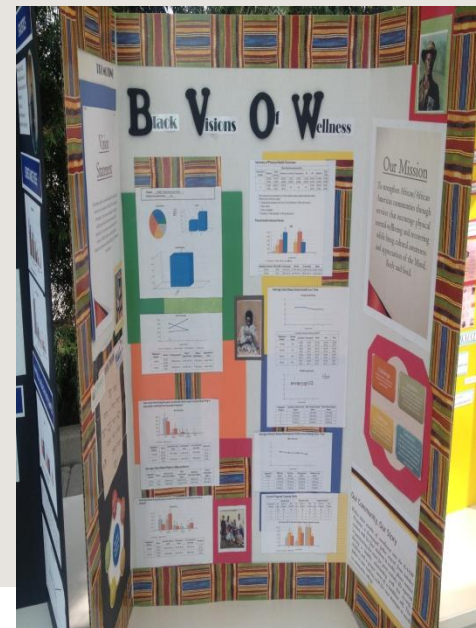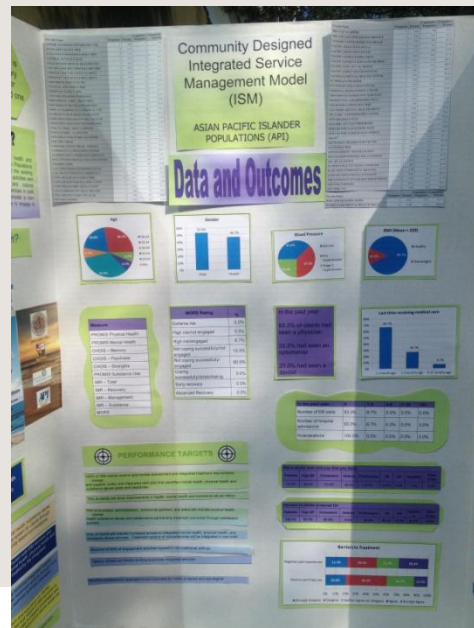
ICM Storyboards

Top Left:
+ L.A. Gay & Lesbian Center

Top Center:
+ SSG – HOPICS

Top Right:
+ JWCH – SCHARP
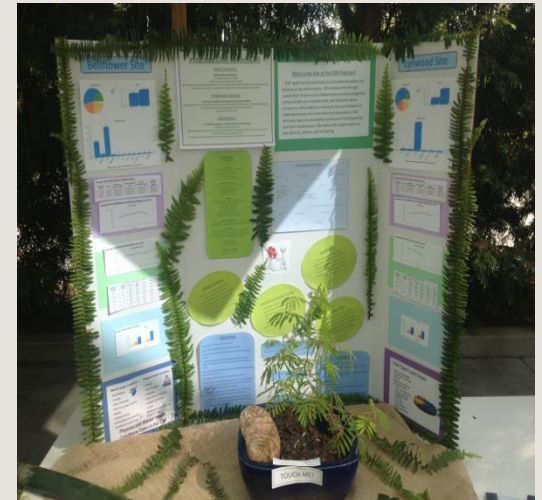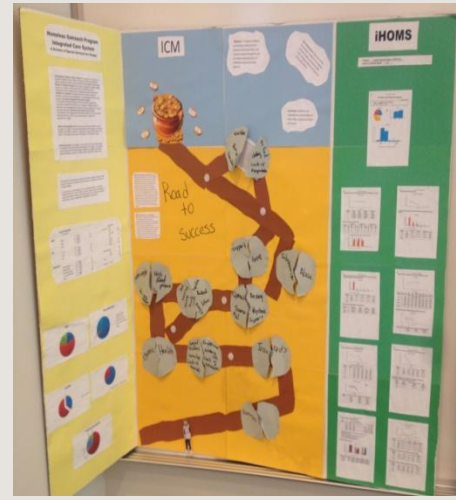
IMHT Storyboards

Center Left:
+ JWCH – SCHARP

Center Right:
+ Exodus Recovery

Bottom Left:
+ Step Up On Second

Bottom Right:
+ St. Joseph Center
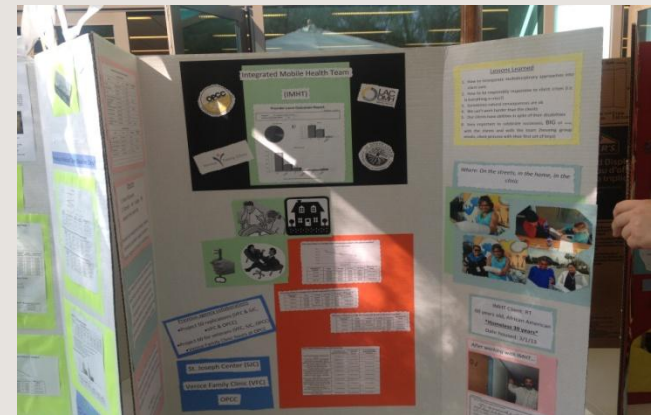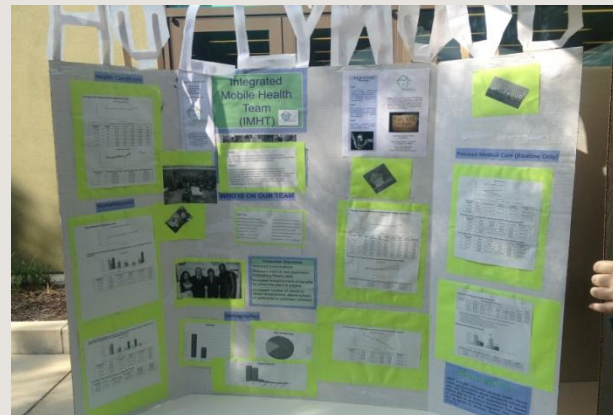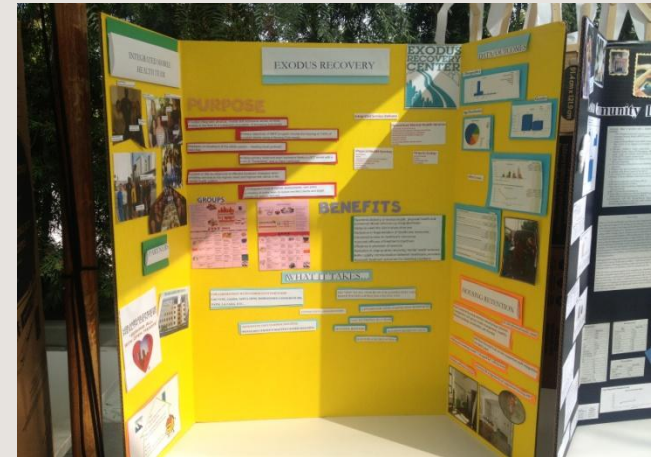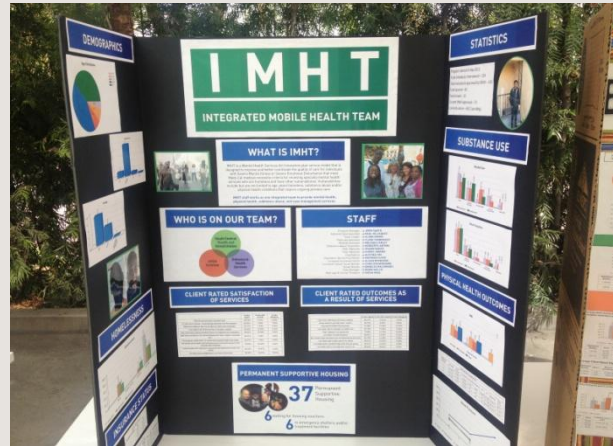
Innovation Learning Session V: Celebrating *One Year of Learning Together*

Learning Brief

November 7, 2013

HEALTHSERVICES
RESEARCH CENTER

harder+company
community research

Background

Los Angeles County Department of Mental Health Innovation providers, staff and Evaluation Team members came together for the fifth quarterly Learning Session on November 7, 2013 at the California Endowment. This Learning Session was attended by 107 people and marked a full year of learning together from the implementation and evaluation of Innovation. Learning Session topics included: 1. A presentation by Dr. Andy Sarkin from UCSD about **Integrating Client Outcome Measures into Clinical Practice**; 2. **Storyboard updates** by several programs; 3. A panel discussion focused on **Enhancing Client Care Coordination in Integrated Settings**; and 4. A panel featuring consumer/provider teams to share **Innovation Success Stories**.

This Learning Brief contains an overview of the first year of Learning Sessions as well as highlights from Learning Session V.

One Year of Learning: Developing a Community of Practice

Learning sessions were designed to support the implementation of Innovation by creating opportunities for providers and LACDMH to identify common challenges and recognize promising and best practices as they develop in **real-time**. In a sense, Learning Sessions were intended to create a community of practice among INN grantees.

> *Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly.*
> *~Wenger-Trayner*

Initial Learning Sessions were more focused on sharing by LACDMH and Evaluation Team members; over time, Learning Sessions have become more interactive and have incorporated more sharing by providers via formal presentation and small group discussion. **Story Boards** were introduced as a tool for sharing program implementation and outcomes data. Typically organizations bring between two and five team members to each session, and include a mix of administrative and clinical staff. While some organizations have opted to bring the same core set of staff members, other alternate attendance at each session, normally with the program director attending consistently and other program staff based on interest in agenda topics and availability.

LAC DMH
LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH

HOPE · WELLNESS · RECOVERY

The graphic timeline below illustrates the timing and highlights key content and/or process information about the first year of Learning Sessions. It provides a record of how Learning Sessions have evolved over time.

Exhibit 1. Graphic Timeline of 2012-13 Innovation Learning Sessions
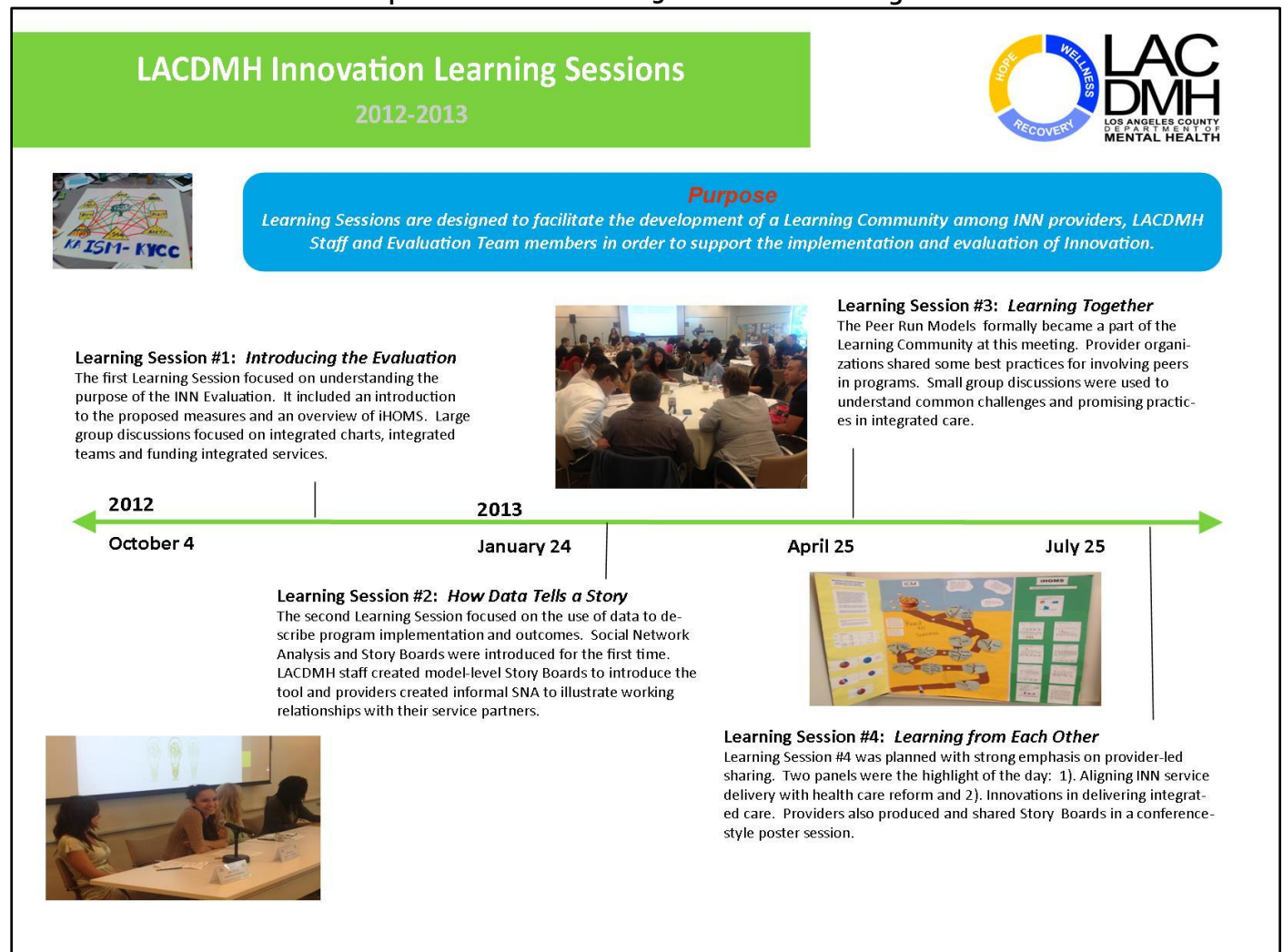
## Integrating Client Outcomes Measures into Clinical Practice

Dr. Andy Sarkin from UCSD Health Services Research Center facilitated an interactive session designed to support INN providers use of client outcomes measures (that are used for evaluation purposes) into clinical practice. Copies of the PowerPoint slides for this presentation can be found in Appendix A. The session highlighted the use of the PROMIS Global Health and Derived Alcohol/Substance Abuse Scales, CHOIS, physical health and behaviors and the ISMI (Internalized Stigma of Mental Illness Scale). Several fictitious client profiles were shared and attendees worked together in small groups to interpret measure scores in light of case history information provided.

Groups also identified ways in which they currently use or could envision their teams using client outcomes measures in clinical practice. A list of ideas captured during share out can be found in Appendix B.

*"One year ago, we talked of the **challenges** of collecting data; now we understand the **value** of using data."*
~Debbie Innes-Gomberg

Story Board Updates

Three provider organizations shared updated story boards with the group. This included: SSG/L.A. Gay & Lesbian Center, Project Return (Hacienda of Hope) and SHARE! (Recovery House).
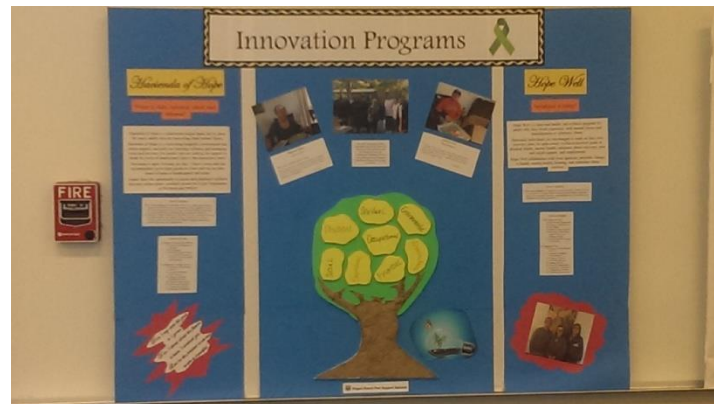
Teams reported that Story Boards have become a helpful tool for communicating about program goals and processes to a variety of audiences, including potential clients and their family members, INN program team members, organizational staff not a part of the INN program and community partners.

Enhancing Client Care Coordination in Integrated Settings

The afternoon session began with a panel discussion focused on client care coordination, with an emphasis on lessons learned for creating successful collaborations with Federally Qualified Health Centers (FQHC). Participants included Hua Wen and Wendy Zhen (APFC/APHCV Health WISE Chinese ISM),

Hillary Marshall and Maria Lopez (JWCH/Sharp IMHT), Stephanie Love, Dora Magana, and Kathy Trujillo (Mental Health America – LA, IMHT)

Challenges of Integration

Providers shared some of the challenges of coordinating care and working together with FQHC/mental health/substance abuse team. Key themes included:

+ Working across organizations with different infrastructure. Lack of shared **Electronic Health Records (EHR)** has been challenging, so is the lack of a **shared calendar** which can make it difficult to schedule team meetings or consultations.

+ Medical and mental health providers speak "different languages." Even seemingly simple issues, such as referring to a client as a "member" versus a patient can slow down communication.

+ There is some lack of clarity around HIPPA issues and the sharing of mental health related information with medical providers; if some team members do not have full access to the information it creates a big challenge to care coordination.

Best Practices

Panelists shared some of the best practices that they have developed over the life of Innovation.

+ **Develop ways to be in constant communication**. In addition to consistent and regular team meetings, being able to access any team member, whether in person, on the phone, via email right in the moment that information is needed has proven invaluable to care coordination.
+ **Thorough charting** also is seen as an important tool for client care coordination; it ensures everyone knows what is going on and is on the same page.
+ **Cross training** to help all providers get comfortable with the basic language and terminology of the other disciplines around the table. In some cases this is formal training, in other cases it looks like team members taking the time to explain what they mean during team meetings.
+ **Warm hand-offs** using health navigators, peers, case managers has been very helpful, especially in cases where providers are not co-located.

Following the panel, small group discussions were used to generate ideas for improving communication and client care coordination. Appendix C contains the notes transcribed from each small group discussion.

Innovation Success Stories: A Celebration of Innovation!

The afternoon session wrapped up with a panel of providers and consumers who shared some early Innovation success stories. Consumer names have been changed to protect confidentiality.

Story one

Consumers: Richard & Ann **INN Program:** IMHT

We never intended to be homeless at any point but it happened, we went from having our own space to searching in trashcans. We call it the dream team (referring to the providers) -- I could not have done it myself. Before meeting them the only sort of recipe we had was to self-medicate and we did; we started drinking alcohol and we were in a survival loop where our day-to-day was surviving. We met Rachel who was helping a friend of ours. I asked her how to get help and from that day on I was inspired to know who that special team was. We came across a lot of medical issues -- we had been stabbed and these people came to us as a team; there were like two or three doctors and they just came to us as a team and me and my wife just started crying. They helped us a lot and the first day they addressed our health issues and mental issues. We were lost, and we were able to get help from the doctors who gave us coping skills and we wanted to better ourselves. One aspect led to another and it is a working combination that it has gotten us where we are today. We used to have problems like finding a place to eat and now we have an apartment with a refrigerator, we even have cable. We got past the depression and our alcoholism and we have clean clothes, plans for the future, and a bright future at that because of these people.

Story two

Consumer: Frank **INN Program:** ICM

I was an amputee and became diabetic. I tried to stabilize my diabetes and saw fliers and all the things that they do. At that time my second toe started to get infected as well. They told me they wanted to help me and asked me to participate. At that time I had no food, no house, no income, and no social security so it was overwhelming. All the people care and touched base with me. I never had to do anything with mental health and I felt that they just took that extra mile on the care, I was so happy I brought 6 other people so they could get help. They are just people that care about you and it is not just their job. Most people go to their job but they really wanted to help me, they did research. I was the perfect poster child of things that do not work in LA County. They went above and beyond the County system. When I went for medical care because of my toe they denied me glasses and told me I had diabetes. The only thing I got was a bill for $1,200 and was hurt from that. But the program connected me and they gave me glasses. I got the eye exam and he looked at my old prescription and said "whoever gave you this prescription didn't care." I see this team as when you go to a restaurant, the receptionist and case worker are in the front, you are served well but behind they are cooking help with housing, transportation, etc. You do not see that behind the scenes. It really is a lot different than just going anywhere. Maybe that is the way it was designed, it is just the human compassion of just checking on people. If you find a good doctor, it is like a good mechanic, you will tell other people and that will keep the doors open.

Story three
Consumer: Mary **INN Program:** Latino ISM

I like the services that they offer me because they do not focus on just giving medicine but they also help us with mental health therapy. They are very important because they have communication and they cannot make any mistakes. I had an experience in the past where when you do not have communication the secondary effects can lead to a disaster. For me it was really important that the Doctor believed in my symptoms, in another clinic the doctor told me they did not think I was crazy. I struggled a lot with depression, I have a son with epilepsy and my mother has depression. I am really happy with the services because I was gaining a lot

of weight and with their help I have lost some weight. My son has brain damage and the part of the brain that controls his behavior and emotion it damaged. He was always referred to the psychiatrist and told him he suffered from autism, psychosis, depression, schizophrenia and they were never on the same page about his diagnosis. My son was always sad and finally we went to another neurologist and he asked him if he wanted to talk to somebody. My son said yes and I told the doctor I did not want him to take any more medicine. He started meeting with the therapist and saw a big change. I also met an Armenian psychiatrist and told me that he only needed therapy and not medication. The therapist not only focused on the patient but on the human being and it was all the difference.

Story four
Consumer: Louise **INN Program:** Peer-Run Respite
(Unfortunately, the evaluation team's notes did not capture the full fourth story. We apologize.)

"Part of what I learned today is how far you can come when you have the partnership that you need to succeed."
~Debbie Innes-Gomberg

Wrap-up and Take-A-Ways

Debbie Innes-Gomberg wrapped up Learning Session V by sharing observations of themes and important learning that emerged throughout the day.

✚ Communication: Communication is essential and we can do it in many ways – Facetime, text, emails – there are a lot of ways to make communication successful.

✚ Partnership: Partnership is more difficult. It takes patience, loyalty, respect, time together and commitment. I heard those things over and over again, so moving forward these are things we all should all be thinking about.

Learning Session VI will be held on January 16, 2014 at St. Anne's
Hope to see you there!

Appendix A

This appendix contains slides from the PowerPoint presentation presented by Dr. Andy Sarkin of UCSD Health Services Research Center about the use of evaluation measures in clinical practice.

12/12/2013

1

PROMIS Global Health

- 10 item client self-reported measure
- Reliable and precise measure of self-reported health status for physical, mental, and social well-being
- Applicable across a wide variety of chronic diseases and conditions and in the general population

PROMIS Global Physical Health items

- In general, how would you rate your physical health?
  - **Answers:** (Excellent, Very Good, Good, Fair, or Poor)
- To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?
  - **Answers:** (Excellent, Very Good, Good, Fair, or Poor)
- How would you rate your fatigue on average?
  - **Answers:** (None, Mild, Moderate, Severe, or Very Severe)
- How would you rate your pain on average?
  - **Scale:** 0 (no pain) – 10 (worst imaginable pain)

2

PROMIS Global Mental Health items

- In general, would you say your quality of life is:
  - **Answers:** (Excellent, Very Good, Good, Fair, or Poor)
- In general, how would you rate your mental health, including your mood and your ability to think?
  - **Answers:** (Excellent, Very Good, Good, Fair, or Poor)
- In general, how would you rate your satisfaction with your social activities and relationships?
  - **Answers:** (Excellent, Very Good, Good, Fair, or Poor)
- How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?
  - **Answers:** (Never, Rarely, Sometimes, Often, or Always)

CHOIS Recovery Supplement

- Developed using focus groups involving mental health clients
- Assesses some common mental health symptoms using familiar language
- Suicidal ideation screening item
- Assesses positive recovery factors
  - These are things that the mental health clients said helped them get better, and/or prevented relapse.

3

Sample CHOIS Symptom Items

- ‣ I had disturbing memories or images of a stressful experience.
- ‣ I had difficulty thinking clearly while doing familiar tasks.
- ‣ I believed people were following or trying to harm me or my family.
- ‣ I had thoughts of ending my life or harming myself.

__Answers__: (Never, Rarely, Sometimes, Often or Always)

Sample CHOIS Recovery Strengths

- ‣ I felt good about myself.
- ‣ I had goals and worked towards achieving them.
- ‣ I felt hopeful about the future.
- ‣ I felt spiritually connected.
- ‣ I had contact with people that care about me.

__Answers__: (Never, Rarely, Sometimes, Often or Always)

4

Physical Health and Behaviors Survey

▶ Designed to address the specific objectives of the Innovation program

▶ Asks clients to report on:
  ◦ Previous experience receiving care for physical and mental health issues
  ◦ Hospital and emergency room visits
  ◦ Barriers to treatment
  ◦ Health behaviors
  ◦ Living conditions

Items only asked at Baseline – Barriers to Care

▶ Resources are not available in my home community

▶ Doctors or healthcare providers are not sensitive to my cultural background (race, religion, language, etc.).

▶ I don't believe doctors or healthcare providers can help me.

▶ I have had negative experiences receiving care in the past.

Answers: (Strongly Disagree, Disagree, Neither Agree or Disagree, Agree, or Strongly Agree)

5

Sample Physical Health items

▸ **Healthcare Utilization**
- In the past 6 months, how many times did you go to an emergency room OR hospital?

▸ **Substance Use**
- During the last 6 months, how often did you have any kind of drink containing alcohol, such as beer, wine, or liquor OR use an illegal drug or use a prescription medication for nonmedical reasons?
- Do you smoke tobacco?

▸ **Physical Activity**
- How many times in a usual week do you do 30 minutes of physical activity that increases your heart rate or makes you breathe harder than normal? (for example, walking or jogging, carrying light loads, bicycling, or playing sports)

▸ **Medication Use**
- In the past month, how often did you take your medications as the doctor prescribed?

PROMIS–Derived Alcohol/Substance Use

- 12 item client self-reported measure
- Applicable for alcohol, illegal substances, and nonmedical use of prescription drugs
- Focuses primarily on negative consequences of alcohol or substance use, rather than the amount or frequency of use
- ONLY completed by client if they indicated that they used alcohol, illegal drugs or prescription medication for nonmedical reasons within the past six months on their Physical Health and Behaviors survey

6

Sample Substance Use items

- I used substances (alcohol, illegal drugs) too much.
- I felt I needed help for my alcohol or substance use
- I took risks when I used alcohol or substances.
- Alcohol or substance use created problems between me and others.
- Others had trouble counting on me when I used alcohol or substances.
- Alcohol or substance use made my physical or mental health symptoms worse.

Answers: (Never, Rarely, Sometimes, Often or Almost Always)

Internalized Stigma of Mental Illness (ISMI)

- 10 item measure that captures several dimensions of mental health stigma:
  - Social Withdrawal
  - Perceived Discrimination
  - Stereotype Endorsement
  - Alienation
  - Stigma Resistance

7

Sample ISMI Stigma Items

- ▸ People with mental illness make important contributions to society.
- ▸ Others think that I can't achieve much in life because I have a mental illness.
- ▸ I stay away from social situations in order to protect family or friends from embarrassment.
- ▸ People ignore me or take me less seriously just because I have a mental illness.
- ▸ I can have a good, fulfilling life, despite my mental illness.

Answers: (Strongly Disagree, Disagree, Agree, or Strongly Agree)

Clinician–Rated Mental Health

- ▸ MORS – Milestone of Recovery Scale
  - ◦ 1 item with 8 possible anchored responses
  - ◦ Assesses level of recovery/risk, engagement in treatment, and support needs
- ▸ IMR – Illness Management and Recovery
  - ◦ 15 Items, each with 5 anchored responses
  - ◦ Total score and 3 subscales that measure:
    - ・ Management of Illness (Symptoms, Functioning)
    - ・ Recovery-oriented Behaviors (Self-Management)
    - ・ Substance Abuse

8

Examples of Using Information

- To better understand the people we are helping
- To comprehensively assess a person's needs
- To aid in treatment planning and goal setting
- To assess recovery progress and outcomes
- Identify critical indicators (relapse or suicidality)
- Identify strengths that can aid in recovery
- Enhancing the therapeutic dialogue to
  - Increase client involvement in treatment planning
  - Set shared goals and monitor recovery together
  - Increase sharing of information in integrated team

Breakout Exercise

9

Integrating Information

- ‣ Some information can be examined from both the clinician and client perspective, giving a more complete picture of the individual.
- ‣ Example: Social Health
  - ◦ PROMIS Global Health
  - ◦ CHOIS Supplement
  - ◦ Illness Management and Recovery Scales
- ‣ Example: Substance Abuse
  - ◦ PROMIS Substance Abuse
  - ◦ Physical Health and Behaviors
  - ◦ Illness Management and Recovery Scales

Using Data – Case Study

10

Appendix B

This appendix contains a list of ideas for using client outcome measures as a part of clinical practice. These ideas were generated during small group discussions following an interactive presentation by Dr. Andy Sarkin on using Client Outcome Measures to Inform Clinical Practice for LACDMH Innovation grantees.

+ Print out individual-level reports and share with clients
+ Use during supervision
+ Use to document client progress at program disenrollment
+ Use by Physician as part of care planning
+ Use at morning team meetings to drive treatment planning
+ Share aggregate results with staff to boost morale, see how far clients have come
+ Justify program changes
+ Identify staff development needs
+ Use during integrated care meetings with partners
+ Share with community partners during weekly team meetings

+ Share with clients to establish accountability and provide empowerment
+ As a way for peers to engage clients with treatment goals (may need coaching to accomplish)
+ Use to develop treatment plans
+ Bring to multidisciplinary team meetings as a way to highlight client perceptions of their own needs (that perspective often gets lost in planning)
+ Use a tool for engaging MFT interns in case conferencing
+ Use to inform outreach efforts
+ View data collection itself as a part of intervention; opportunity to engage clients in discussion about their needs h efforts

Appendix C

This appendix contains a notes transcribed from each small group discussion of practices to improve client care coordination. These notes were transcribed verbatim; the evaluation team only corrected spelling where necessary.

Small group activity Guiding Questions

1. What solutions have been implemented to improved communication and the coordination of consumer care in your programs?

2. What other solutions would you still like to or plan to implement?

Group #1
Participants:
- Megan Rowland (UCSD)
- DMH partners (Erik, Hector (OMD ICM), Lisa, Amy)
- Chautalee (SHARE!)
- Nayon, Charlene (KYCC)

Responses:
- Interdisciplinary weekly meetings (including clinicians, members, psychiatrists, care coordinator), psychiatrist comes to give input for client information but not comprehensive to program
- Peer to peer interaction- importance placed on equal status/role to encourage communication
- Information shared at retreat house but only share what they want to share. Peers share, no staff.
- Peer to work in out with/in themselves
- Ambiguous/ no labels to not create hierarchy and reduce stigma and promote communication.
- SHARE---referral source role
- Promote, not force healthy behaviors (peer-staff level)
- "peer bridgers"- go to house and help bring resources to persons (support group type). Different type of resources given (housing, medical, etc.)
- Due to complicated collaborative structure:
    - Learning how to do business

- Understanding different practices and policies
- To look more uniform, united
- We have had several collaborative retreats
- Relationship building, supporting each other staff from different agencies
- Teleconferences, monthly collaborative meetings
- **OMD**
    - Monitors contracts (PH and SA under one roof). Some agencies under one roof, others separated into multiple agencies
    - Contracts, Proper billing, DF services being delivered (notes unclear)
    - Service of framing __ for PH by psychiatrist. Excited to learn about diagnoses and treatment
    - Became a bridge for PH and SA agencies to unite them and learn a lot about respective PH/SA structures and operation
    - Became more comfortable with integration of PH and SA.

Group #2
Participants:
- Arnali Ray (Saban Community Clinic manager, behavioral health)
- Paul Gore PhD (Saban Community Clinic director, behavioral health)

- David Fallon and Michael Mat (?) (Step Up HOST/IMHT)

Responses:
- Got CEO involved in advocating for communication (IMHT)
- Weekly case conference with medical providers, mental health and substance abuse (FQHC) (ICM)
- Being consistent with communication weekly team meetings and bi-monthly admin meeting (ICM)
- Conference call FQHC members in on meetings (ISM)
- Communicate via text, email (IMHT)
- Sending pics of medical issues to medical staff for updates and concerns (IMHT)
- Transparency with team members (ICM)
- Peer counselor- work with members, keep contact with team (ICM)
- Daily meetings with everyone present, different disciplines
- United American Indian involvement (ISM)

What ideas can we take back?
- Common experience with struggles. We are on target with other agencies
- Can do more cross-trainings learn about different disciplines
- Overcoming time as a barrier. Sometimes relationships among providers helps facilitate communication
- Use of technology versus face to face
- Integrate medical providers more to team to potentially reduce hospitalizations
- Better use of integration of story board
- Learning to better use technology EMR, IHOMS
- Bad communication styles
    - Different EMR programs for mental health and physical health care – better if they were integrated

- Limited access to records from FQHC and subcontractors
- Laws and limits of release of substance abuse treatment information/records

Group #3
Participants:
- Arpe Asaturyan (Armenian ISM-IMCS)
- Noel Noananu and Carol Pele (Samoan ISM, SNNA)
- Ivandora Ugaitafa (OSA Samoan ISM)
- Angela Kang (SSG Samoan ISM)

Responses:
Communication styles that detract
- Language barrier between client and FQHC. Solution: CM acts as an interpreter to better help client express needs
- Case manager is only link between client/FQHC/provider. Solution: Build better relationship.
- Lack of communication with FQHC and provider. Solution: CM accompanies client

Group #4- ICM Exodus IMHT
Participants:
- Hilary Haylock
- Patzi Dvoiatchka
- Patrick Hooks
- Brandy Leos
- Amber Halley
- Cindy Kang
- Lezlie Murch

Responses:
- 1. Early integrated program design
    - Integrated assessments (CCCP)
    - Integrated charts
    - Resulted in a reduction of language communication barriers
- 2. Daily team meetings
- 3. Internal weekly education program.
    - Case studies with multidisciplinary discussion
- 4. Full time co-location and consistency of staff (FQHC)

Group #5-
Participants:
- Torri Toliver-McDonald (Kedren Community Mental Health/ISM)
- Berta Ortiz (Kedren Community Mental Health/ISM)
- Seta Haig (Didi Hirsh- Armunity)
- Claudia Rice (Alma Family services)
- Cynthia Tanniehht (Hacienda of Hope)
- Patrick Thompson (Hope Well)
- Maviko Kahn (PACS)
- Young Boek (AADAP, inc- Korean Cambodian ISM)
- Misook Nierodzik (Korean American Family Services)

Responses:
- Meetings between other agencies
- Meetings with client coordination
- Communication outside scheduled meetings
- Willingness/being cohesive with one another
- Asking for assistance
- Log Book
- Staff respecting clients and other staff
- Making sure to get right partners due to stigma and mental health
- Having bilingual staff
- Having the same vision

Group #6-
Participants:
- Hacienda of Hope and Hope Well- Eunice Contreras, Veronica Vaca, Winston Taw, Daphne Graves
- St Joseph Center- Vanessa Mendoza, Brooke Matthews, Adrianne Angeles
- Jewish Family Services- Carolyn Heier
- Didi Hirsh- Arsineh Ararat

Responses:
- Co-located staff allows easier access to one another's services

- Joint service delivery (case management, psychiatry, therapy, medical treatment simultaneously)
- Peer advocates to triage the gap between services/service providers
- Staff advocate for clients during crises (i.e., same day medical appointments)
- Multidisciplinary team meetings (daily/weekly)
- Integrating charts-hard copies/electronic copies or each other's notes
- Warm hand-off from shift changes (huddle)
- Technology access- Ipads, iphones, texting, email
- Cross-disciplines trainings- help staff understand each other's language

Group #7-
Participants: Not recorded
Responses:
- Education to staff
  - Medical to mental
  - Mental dual training (psychiatrist provide education on mental and medical (primary care)
  - Meetings- fixed, regular. Fixed agenda and open agenda
  - Consultation (constant)
  - Nightly report (non-clinical note)

Group #8-
Participants:
- APHCV/APFC (Chinese ISM)
- MHA/TCC= IMHT)
- JWCH/Lynwood (ICM)
- SHARP/SCH (ICM)

Responses:
  - Productivity standard varies between FQHC and MHC. i.e., 20 minutes/patient vs. 60 minute client
  - Human capital/staffing- right staff to work with clients. Staff attitude interacting with clients

- - Billing policy compels providers to focus on quantity over quality
  - Supporting INN through more flexible fiscal billing
  - Sharing of best practices during INN session every step of the way (forum, conferences, sharing protocols)

Group #9-
Participants:
- Piscay Sok (Pacific Asian Counseling Services)
- Nicole Brown (Step Up on Second)
- LACheisa Bell (Step Up on Second)
- Vanarra Taing (Cambodian Association of America)
- Frances Marion, Grant Courtney, Bryan Patel (LA Gay and Lesbian Center)
- Michi Okano (PACS)

Responses:
- Verifying the scope
- Full integration of EMR
- Multidisciplinary case conference
- Daily meetings
- More collaborative trainings
- Integrating other community resources (faith-based, culturally based)

Group #10-
Participants:
- Betty, Anna, Nina, Mirtala, Marine, Judy, Silvia, Jerri (Providence IMHT-JWCH, Latino ISM- Tarzana and LA Child Guidance Clinic)

Responses:
- Training from lead agency to identify clients that met criteria for mental health services
- Screening tool to screen for MS, SA, to help communicate
- Promotora speaks language and build rapport with clients. Clients becomes involved with wellness classes

- Integrated wellness meetings (SA, medical,MH, client, Case manager)
- To do: quarterly meetings to look at patient outcomes
- Start looking at outcome data regarding clients response to wellness classes

Innovation Learning Session VI:

Tools of the Trade- Learning from the Integrated Treatment Tool and the IBHP Tool Kit to Enhance the Provision of Integrated Care

Learning Brief

January 16, 2014

HEALTHSERVICES
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LAC DMH
Los Angeles County Department of Mental Health

Los Angeles County Department of Mental Health Innovation providers, staff, and evaluation team members came together for the 6th quarterly Learning Session on January 16, 2014. Attended by 92 people, the learning session included in-depth discussion of the Integrated Treatment (IT) Tool, small group exploration of domains within the IT Tool, and an introduction to and discussion of the Integrated Behavioral Health Project resource tool. This Learning Brief describes highlights from the day.

Integrated Treatment Tool Initial Findings and Learning Opportunities

After Debbie Innes-Gomberg's welcome, evaluation team member Dr. Benjamin Henwood (from the USC School of Social Work) presented findings from the Integrated Treatment (IT) Tool site visits.

Background
The evaluation team conducted site visits at 24 Innovation programs between April and October of 2013 in order to document and describe the process of integration. The team used the IT Tool as a guiding framework and index of integration. The tool was developed at Case Western Reserve University (through support from SAMHSA) and incorporates theoretical, empirical, and practice based knowledge about integration of mental health, physical health and substance abuse services. The tool has been used by providers across the country to assess integration and develop action plans to improve the practice of integrated care.

Although there was considerable variability in the implementation of integration across models, the evaluation team identified ten "lessons learned" common across both providers and models. These lessons address both barriers and facilitators of integrated care; many exist at both program- and systems-levels. The lessons are also included in the INN Year One Evaluation Report.

✚ There are **developmental stages** of integration.

✚ Integrated **policies and continuous quality improvement** (CQI) are in early stages of development.

✚ **Peer specialist roles** are evolving.

✚ **Interdisciplinary meetings** work.

✚ Effective care coordination requires **efficient and timely communication**.

✚ Innovation programs continue to face **numerous barriers to maximizing effective communication**.

✚ **Care manager role and duties are typically shared** by more than one person or a full team.

✚ The **CCCP is a perceived barrier** to integrated care planning.

✚ There are **opportunities for training** that can be leveraged.

✚ Programs are **preparing to become data driven**.

The full presentation can be found in Appendix A.

Discussion about IT Tool Results & Focus Areas

After the presentation, learning session attendees participated in small group discussions across models designed to support action planning for program improvement based on the findings of the IT Tool site visits. Participants selected from among five thematic topics:

Discussion Topic	Key Question(s)
Interdisciplinary Communication	Team meetings work, but they can be resource intensive. How important do you see team meetings for your INN program? What alternatives exist?
Holistic Integrated Care Plan	How has your program utilized the CCCP and/or other mechanisms outside of it for your integrated care planning?
Organization-wide training	What future trainings would be most helpful, in what venue (i.e., group training versus on-site technical assistance), and by whom (i.e., programs with internal or partner expertise, DMH, or other external providers?)
Care Manager	What are the advantages of a single person versus multiple people fulfilling the care manager role?
Organizational Policies and procedures	What are important policies and procedures for your INN program to establish?

Summaries of report outs from each of the small group discussions are presented below. Please see Appendix B for full small group discussion notes documented by the participants at each table.

Interdisciplinary Communication

Challenges & Barriers:
- Integrated charts. Electronic medical records and paper charts vary in their ability to share files and support communication.
- Working with two different models -medical and mental health. Communication with medical staff was noted as a specific challenge.
- Accountability of everyone on the team and all partner agencies
- Budgetary and time constraints

Solutions, Alternatives, & Improvements:
- Meet on a consistent basis. For example, meet every morning to discuss case loads.
- Contract with a psychiatrist specific to the program
- Encourage medical schools to train and retrain physicians
- Use alternative communication modes such as email and phone calls
- Some people believe having an integrated chart is vital to interdisciplinary communication; other teams have found that access to records is sufficient.

> *"Team meetings work, but they can be really intensive in terms of resources, so they need to be structured."*
> *~Learning Session Participant*

Holistic Integrated Care Plan

Challenges & Barriers:
- Lack of communication between team members. Goals are written in isolation when they should be written as a team.
- Communication with other agencies about the CCCP.
- There are concerns about if certain aspects related to physical health will be able to be reimbursed if put into the care plan
- It is unclear how to get input from the physical health providers when the focus of the CCCP is mainly mental health

Solutions, Alternatives, & Improvements:
- Implement case conferences so that all interventions are written into the care plan
- Increase the time and frequency of agencies' meetings
- Receive training on CCCP and on other ways to implement care plans
- Have a clear process for how physical health is incorporated into mental health
- Develop a tool to gather information about the different goals.
- Invite someone from Department of Health Services to provide support and guidance
- Train on behavioral change because physical changes (healthy eating) require behavioral change and readiness for change
- Integrate non-traditional services like acupuncture and prayer into care plan
- Change the CCCP. It is cumbersome.

Organization-wide Training

Solutions, Alternatives, & Improvements:

- Provide program wide training at the beginning. Some of the DMH training would have been more helpful if it had been received earlier in their program development.
- Learn from other providers' internal training. For example, Tarzana conducts online training with an exam afterward. Exodus does continuous training through discussion of case studies, multidisciplinary feedback to problem solve, and webinars.
- Peer training is unique since it does not assume specific expertise
- Providers would benefit from trainings on integration, how to work with other departments and agencies (i.e., school districts, probation), and joint training with physical and mental health providers

Care Manager

Challenges & Barriers:

- Advantages of team care management:
  - Potential burnout of an individual care manager. It can be overwhelming for one person.
  - Institutional rapport is built instead of individual rapport
  - More people can outreach to one single person
- Disadvantages of team care management
  - Client can build a better rapport with one individual care manager
  - For cultural reasons it can be better to have one person

Solutions, Alternatives, & Improvements:

- Receive DMH training specifying the roles of care manager
- Go on site visits to other providers to see what is working for them
- Build communication between agencies when they are not co-located (i.e., use a master calendar and other shared electronic systems between providers)
- Allow for daily meetings if co-located and in clinic based settings
- Provide more training across disciplines so behavioral providers feel comfortable working with medical staff and vice versa
- Share resources between agencies so that the other agencies can benefit from each other
- Improve coordination within the team to help prevent burnout of case managers. Give care manager more credit and thanks since they wear so many hats.

> *"Improved coordination within a team can help prevent burnout of case managers."*
> *-Participant*

Organizational Policies and Procedures

Challenges & Barriers:

- Philosophies do not match between partners (mental health, medical, substance abuse)
- With INN funding potentially ending, why invest in developing INN policies? Providers should develop policies and procedures because they can become the model for integrated care and that can be a very valuable end product.
- IMHT has policy and procedures that ISM may not. There are questions about the amount of time providers should spend writing policies and procedures because the programs are constantly changing.

Solutions, Alternatives, & Improvements:

- Identify specific policy and procedures depending on the population
- Establish most important policies first (i.e., policies related to technology and communication)
- Receive technical assistance on how to develop integrated policies
- Empower line staff to help in the development of policies and procedures
- Take funding streams and DMH into account as part of policies

During the second round of small group discussions, this group devoted their time to developing suggestions for how to develop policies and how to deliver technical assistance for it:

- Request that DMH establish a workgroup to develop policies specific to integrated care delivered with FQHCs
- How to best provide technical assistance to help create policies and procedures? Use examples from IMHT. IMHT is already required to integrate with FQHC.
- How to share information about clients? A lot of clients are still using paper so there are legal implications about sharing charts. DMH could help develop a policy about this.
- Establish training at the director level to lead into accreditation programs
- Learn what other agencies have done. Find a way to incorporate those into DMH requirements.

Introducing the Integrated Behavioral Health Tool Kit

The *Partners in Health: Mental Health, Primary Care and Substance Use Interagency Collaboration Tool Kit*, developed by the Integrated Behavioral Health Project (IBHP) and sponsored by CalMHSA, was introduced to Learning Session participants during the afternoon. The IBHP Tool Kit is designed to help primary care clinics and behavioral health agencies improve collaborative relationships and service delivery. Karen Linkins and Barbara Lurie, the creator of the IBHP Toolkit, shared a brief presentation about the CalMHSA Integrated Behavioral Health Project and the specific features of the IBHP Tool Kit. Please see Appendix C for the full presentation. Below is a brief description of the Tool Kit and some images of example sections from the Tool Kit.

IBHP Tool Kit

What is it?

The interactive IBHP Tool Kit was designed to help primary care clinics and behavioral health agencies with all aspects of integrated care. The 354-page Kit is an updated version of the 2009 edition. The Tool Kit focuses on California and contains in-depth material such as:

- Screening instruments and evaluation tools
- Sample agreements and contracts
- Sample job descriptions
- Task checklists
- Client perspectives

Who created it?

California Mental Health Services Authority (CalMHSA) and the Integrated Behavioral Health Project (IBHP).

How do I find it?

The Tool Kit is available for free use on IBHP's website. The Table of Contents for the Tool Kit is interactive.

www.ibhp.org

ADVICE from those who've been there

- The glue [that holds the collaboration together] is psychiatric consultation.
- The primary care system has to be convinced of the financial incentive for treating people with serious mental disorders. Since many of them have Medi-Cal, there's financial revenue maximization for the clinics – more so than treating indigents with no insurance.
- The problem may be that mental health workers in primary care aren't connected to the mental health system, so they often don't get needed clinical supervision. It helps if they report to [county] mental health to get the benefit of that system. It probably works out best if they report administratively to primary care and clinically to county mental health.
- It's good to have a primary care liaison [within the county mental health system] for any problems that bubble up. If a patient is too much for primary care to handle, the liaison can make sure that he or she gets the next level of care.
- It's really important to have cross-training to learn about each other's systems.
- You've got to identify the needs of clients so the system reflects the type and level of need.

BARBARA GARCIA, DEPUTY DIRECTOR OF HEALTH, DIRECTOR OF COMMUNITY PROGRAMS, SAN FRANCISCO DEPARTMENT OF COMMUNITY BEHAVIORAL HEALTH SERVICE AND PRIMARY CARE

- Psychiatric consultation often is important, but primary care providers often won't take advantage of it unless they have a working relationship with, and trust in, the psychiatrist. They're very protective of their patients and want to make sure they're getting the best advice and psychiatric service. So to build up both trust and relationships, it's a good idea to have the psychiatrist come to the clinic in advance to conduct trainings and answer questions.
- Take it slow and develop a relationship. Establish what you're willing to take on and what support you'll need. Cultivate trust and really understand what the other system's internal themes and culture are.
- Training about the ins and outs of each other's systems is absolutely necessary.

JOHN GRESSMAN, PRESIDENT AND CEO, SAN FRANCISCO COMMUNITY CLINIC CONSORTIUM

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Job Descriptions

Sample Job Description for Behavioral Health Consultant in a Primary Care Setting

The following was taken from Cherokee Health Systems in Tennessee

Job Title: Behavioral Health Consultant.
Education/License: Licensed Social Worker (Masters) or a licensed Clinical Psychologist (Doctoral).

Position Requirements:

- Has excellent working knowledge of behavioral medicine and evidence based treatments for medical and mental health conditions.
- Has ability to work through brief client contacts as well as to make quick and accurate clinical assessments of mental and behavioral conditions.
- Is comfortable with the pace of primary care, working with an interdisciplinary team, and has strong communication skills.
- Has good knowledge of psycho-pharmacology.
- Has the ability to design and implement clinical pathways and protocols for treatment of selected chronic conditions.

Role:

- Management of psychosocial aspects of chronic and acute diseases.
- Application of behavioral principles to address lifestyle and health risk issues.
- Consultation and co-management in the treatment of mental disorders and psychosocial issues.

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Sample agreements and contracts

Information Sharing Between Mental Health and Primary Care

INFORMING PATIENTS OF THEIR RIGHTS REGARDING SHARING OF INFORMATION BETWEEN AGENCIES

(taken from the State of California's ehealth Privacy 360)

1. What is a Health Information Organization (HIO)?

An HIO is a third party company that enables the health care provider to transfer or exchange your health information to other health care providers or health-related entities who need your information to be able to treat you. HIOs are used to exchange your health information when the health care provider may not have the technical capability to securely exchange information and HIOs have special software programming that will allow them to transfer your information securely.

2. Do I have access to my medical information that is held or kept by either my health care provider or a HIO?

You are entitled to get copies of your own health information, by law. If you want copies of your health information, ask your health care provider with whom you have a direct care relationship how you would be able to access or to get copies of your information. You may be able to either access and print your health care information online or request hard copies of your information to be provided to you. Since most HIOs do not have a direct relationship with each individual patient, it is unlikely that you will be able to obtain your medical information directly from a HIO. Some HIOs' role is only to transmit the medical information between entities and not to store it; therefore, they would not be able to access it for individuals' requests.

3. How do I give permission or consent to let others such as my doctors to see my medical information through a HIO?

Generally, providers who use HIOs to exchange your health information do ask patients for their consent in order to allow the patients' information to be exchanged through the HIO. The two most common types of consent are: "Opt In" and "Opt Out". If you are asked to give Opt-In consent, you will be asked to sign a written (paper or electronic) form giving your permission for your information to be exchanged through the HIO. If you are given Opt-Out consent, you should be provided with information about the HIO and given a period of time to exercise your opportunity to refuse to let your information be exchanged. In order to opt out, you must usually either send in a form by mail or else click on a certain box on a website to make clear that you do not want your information to be exchanged through the HIO. Some providers in California might have a no-consent policy. A No Consent model is appropriate when the HIO does not have access to any health information.

4. How long does my permission/consent last with a health care provider or HIO?

This will depend on the policies of your health care provider. It also depends on the procedures the participating organizations of a HIO follow. It may last until you revoke your consent or you may be asked to sign a new consent periodically (such as, annually). However, once your health information has been viewed or exchanged through a HIO, it cannot be retracted which means the information already viewed or exchanged cannot be taken back or deleted out of the system. Providers who have relied on this information to make decisions about your health must be able to retain a record. If you revoke your consent, then your health information will not be able to be further viewed or exchanged through the HIO.

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Discussion about IBHP Tool Kit

Following the IBHP Tool Kit presentation, learning session participants were given tablets and laptops to explore a PDF of the Tool Kit. Attendees participated in a small group activity (with people from the same model) to search for resources on specific topic areas (i.e., client engagement, chronic disease self-management) within the Tool Kit and to discuss as a group how they could apply or adapt the information for their program. Discussion questions included:

- What can you take away from the resources to make immediate changes today?
- What resources look promising, but need to be adapted to your program?
- How would the resources need to be adapted? What additional information do you need?

Highlights from the IBHP Tool Kit small group discussions

What can participants take away from the resources to make immediate changes today?
- Procedures for medication reconciliation
- Sample MOUs
- Consumer recommendations
- Job descriptions
- Stigma assessment survey for healthcare providers
- Brochure templates
- Spanish language tools and handouts

How could the resources be adapted? What additional information is needed?
- Cultural competency section
- Client experience section
- Outcome measures for nontraditional services
- Informal ways to develop accountability
- Toolkit search features

Learning Session VII will be held on April 17, 2014 at St. Anne's.
Hope to see you there!

Appendix A

This appendix contains slides from the PowerPoint presentation presented by Dr. Benjamin Henwood of USC School of Social Work regarding initial findings from the IT Tool INN program site visits.

Black box of integrated care

Integrated healthcare → Improved outcomes
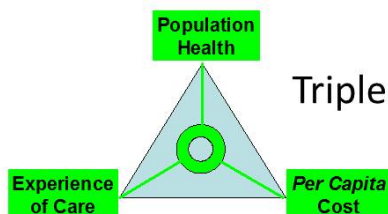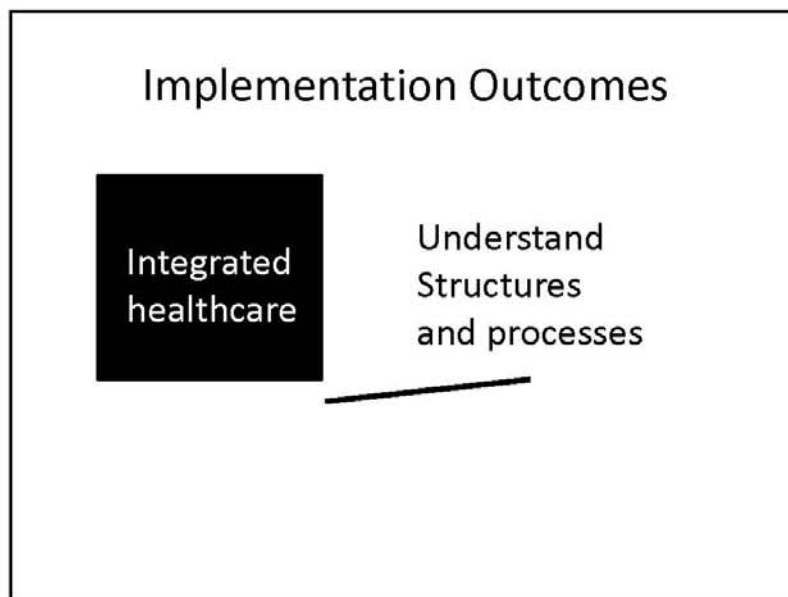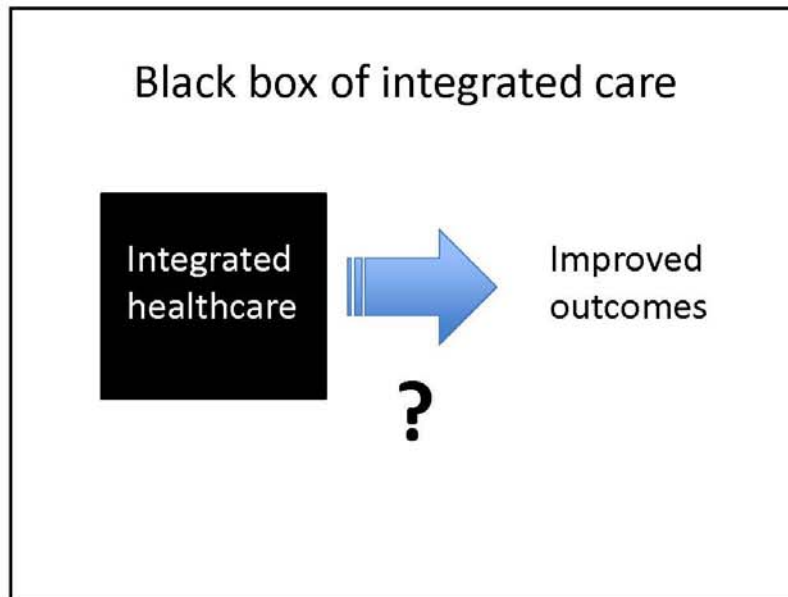
?

Implementation Outcomes

Integrated healthcare

Understand
Structures
and processes

Integrated Treatment Tool "IT"
A Tool to Evaluate the Integration of Primary and Behavioral Health Care

CASE WESTERN RESERVE
UNIVERSITY

Shawnee

- Organizational characteristics
- Treatment characteristics
- Care coordination/management characteristics

Available at: http://www.centerforebp.case.edu/

ITT Site Visit Reports

Integration at an Individual Innovations Program
Year 1 Observations

3

ISM Program Overview

ISM Programs

- Outreach
- Care management
- Multi-disciplinary approach

ICM Program Overview

ICM Programs

- Interdisciplinary communication
- Labs/Test tracking
- CQI

4

IMHT Program Overview

IMHT Programs
- Integrated approach
- Peer support
- Outreach

Top 10 Lessons Learned Across Models

5

#1: There are developmental stages of integration.

- Range of partnership outcomes

- Integration associated with blurring of organizational boundaries.
    - Share expertise and role expansion
    - Agency identification -> Treatment team identification
    - Overlapping policies and procedures
    - Shared resources at organizational level

- Problems faced separately -> shared responsibility

#2: Policies and CQI are in early stages of development.

- Organizational CQI but not INN program CQI

- P&P to sustain programs beyond current staff.

- P&P for accreditation as an integrated program
    - Joint Commission,
    - Council on Accreditation of Rehabilitation Facilities
    - Council on Accreditations
    - National Council on Quality Assurance.

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#3: Peer specialist roles are still evolving.

- What are peer services within integrated services?

- Within communities in which mental illness is highly stigmatizing, would a mental health peer – *defined as having a mental illness* – help reduce stigma or instead alienate the target population?

- Would a peer - *defined as having similar cultural experiences* – be better able understand and connect with the target population?

#4 - Interdisciplinary team meetings work.

- Facilitate interdisciplinary communication and care coordination
- Provide a venue for supervision and case review
- Offer an opportunity for cross disciplinary training

BUT:
➢ What are the costs?
➢ What alternative exist and at what costs?

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#5: Effective care coordination requires efficient and timely communication.
#6: Innovation programs continue to face numerous barriers to maximizing effective communication.

- High- and low-tech ways to improve communication.
  - E.g. Telemedicine, EHR, patient portals.

  Questions:
- Which ones do you/could you use?
- How far does communication extend beyond designated partnerships?
- What are barriers does your program face?

#7 - Care manager role and duties are typically shared by more than one person or a full team.

- *What are the advantages to having a single vs group care manager role?*

8

#8 - The CCCP is a perceived barrier to integrated care planning.

- Weave together mental health goals and physical health or substance abuse goals ("Golden Thread")

- Maintain a focus on mental health goals within the CCCP and either have no or have separate treatment plans for primary care and substance abuse partners.

- Include all relevant goals related to primary care, mental health, and substance use as treatment goals within the CCCP – accepting that some services will not be reimbursed.

#9 - There are opportunities for training.

- Who should/can provide training in integrated settings?

- What is the best venue for staff training?

- What types of training are needed?
  - Cross-discipline communication/language
  - Chronic disease self-management
  - Team building and leadership
  - Others?

9

#10 – Programs are preparing to become data driven.

- *ISM programs* utilize many non-traditional providers – how can programs assess their impact?

- Given high rates of early mortality, particularly among *IMHT* clients, how can programs assess the quality or effectiveness of end-of-life care?

- Given difficulties engaging clients in some *ISM* programs, and high rates of no-shows that are typical of a clinic based (*ICM*) model, how do programs assess the effectiveness of their outreach efforts that include clinical home visits?

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Appendix B

This appendix contains notes transcribed from each IT Tool small group discussion. These notes were transcribed verbatim; the evaluation team only corrected spelling where necessary.

Interdisciplinary Communication

Team meetings work, but they can be resource intensive. How important do you see team meetings for your INN program? What alternatives exist?

Table #1	■ Why chose this topic?
	   ➢ Communication is essential on the ground and on paper
	   ➢ Want to shape best practices
	   ➢ It is a struggle because of different EMR's and being in the field without data is a big problem.
	■ How are we using the integrated chart?
	   ➢ Very individualized based on the program and the program resources
	   ➢ Some programs really use the medical element of the paper chart vs. others would prefer to look it up
	   ➢ Some programs have a clinic at the mental health agency
	   ➢ Texting – looks on phone, careful about sharing PHI
	■ Team Meetings
	   ➢ Challenge to get all providers at the table/full time staff
	   ➢ Struggle with getting time with psychiatrist
	   ➢ IMHT has daily meetings
	   ➢ Dedicated staff makes it easier
	■ Alternatives
	   ➢ Telecommunication with psychiatry
	■ Improvement
	   ➢ Getting part-time psychiatry/medical providers to understand the program goals
	   ➢ Fill gaps in missing staff people
	   ➢ Revisit team approach regularly
	   ➢ Agencies- support staff for medical providers
	   ➢ Breaking down silos between medical and mental health agencies
	   ➢ In-house trainings

Table #2	■ Complicating factors
	   ➢ Time
	   ➢ Cost
	   ➢ IT issues
	   ➢ Productivity
	   ➢ Management issues
	■ Team meetings work but should be structured/phone consultation/emails
	■ Strengths
	   ➢ Medical (LVN) as a bridge between the medical provider and team
	   ➢ New medical partner who provides a NP who is the middle person
	■ Improvement
	   ➢ Meeting daily
	   ➢ providing updated (i.e., medical)

Table #3	- Realistically communication does not include all staff involved in patient care (i.e., FQHC, obtaining client notes, coordinating client care, cancelled appointments) - Team meetings are critical - Alternatives - Phone conferences - Shared electronic record - Case conference notes - Non-traditional provider attendance - Texting as needed - Strengths - Some agencies have electronic shared record (Transworld, Wellagen) - In house communication runs smooth (psychiatrist, clinicians, etc.) - Improvements - Communication between needs improvement via potential trainings for medical providers on mental health issues/agencies.
Table #4	- Communication with medical staff can be problematic - Entitlement/accountability between disciplines is an issue - Unification of records (EMR vs. "traditional" charts) - Budgetary constraints (interdisciplinary/subcontractors have varying budgets and focus) - Different response times by discipline within respective models (appointment settings, response times, internal/external hierarchies) - Contracting with a psychiatrist enhanced communication within ICM - Consistency/frequency crucial to coordination - Field capability (or lack) limits communication - Language/culture of clients vs. providers
Table #5	- Use team building to learn about gaps and improve workflow - Interagency referral form for alcohol & drug services

Holistic Integrated Care Plan

How has your program utilized the CCCP and/or other mechanisms outside of it for your integrated care planning?

Table #1	- How is the integrated care plan currently used? - Each agency does differently. - What goes on the CCCP? - Who does the service? - Therapists - Case managers (sometimes) - Improvement - Training on behavior change regarding physical health - Need structural process to add physical health - Agencies need clarification on physical health on CCCP - Agencies would like a tool to address each goal

Table #2	■ How is the integrated care plan currently used?
	   ➢ Difficulty coordinating time
	   ➢ Lots of good discussion on how to translate on paper
	   ➢ There should be more emphasis on readiness for change
	   ➢ Determining priorities (Medical v. mental health v. other problems)
	■ Mechanisms to utilizing holistic integrated care plan
	   ➢ Using cultural activities as a coping skill or skill building activities
	   ➢ Sitting with team daily to determine what services are being provided
	■ Improvement
	   ➢ Communication regarding CCCP specifically
	   ➢ Clarification regarding holistic care and its value (from county and state DMH). What is reimbursable?
	   ➢ Clarity across disciplines regarding goals

Table #3	■ Focus is on how to avoid getting billing rejected in audit
	■ Barriers to good plans
	   ➢ Lack of communication across team
	   ➢ Goals written by person without access to medical, case management and mental health goals.
	   ➢ Medical staff too busy to participate, especially if not co-located
	■ Strengths
	   ➢ Incorporating non-traditional approaches
	      ❖ Buddhist prayer
	      ❖ Acupuncture
	      ❖ Rosary
	      ❖ "Whatever it takes" which may include teaching people how to take bus, deal with police, etc.
	      ❖ People writing their own goals (peer program)

Table #4	■ Add non-traditional support on CCCP (challenging to integrate non-traditional goals)
	■ More clarity on appropriate goals related to holistic care
	■ Including all disciplines on the CCCP
	■ Weekly case conferencing
	■ Access to EMR within agencies
	■ Shared database
	■ Improvement
	   ➢ Integrate all agencies more frequently during meetings
	   ➢ Increased communication/regular communication
	   ➢ Increase the usage of technology (group text/email)
	   ➢ CCCP training specific to Innovation models

Organization-Wide Training

What future trainings would be most helpful, in what venue (i.e., group training versus on-site technical assistance), and by whom (i.e., programs with internal or partner expertise, DMH, or other external providers?)

Table #1	■ Ensuring staff are adequately trained by providing:
	   ➢ Online training and exams
	   ➢ DMH trainings
	   ➢ Case studies
	   ➢ Trainings during lunch (providing lunch).
	   ➢ Webinars.
	   ➢ CIMH website.
	■ Improvement
	   ➢ Organizational leadership support for direct service staff.
	   ➢ Cross-training (mental health, medical, substance abuse).

Table #2	■
	■ INN Model Program thinks about *training* differently than described in the IT Tool
	    ➢ Peer (completely different) - not assuming expertise.
	■ Training avenues
	    ➢ DMH – only certain number of slots – not enough
	    ➢ In service – will come back and train others
	    ➢ Other agencies
	    ➢ Internal – if they have the expertise
	■ Ensuring interdisciplinary staff are adequately trained
	    ➢ Still working on it
	    ➢ Share ideas with DMH liaison
	■ Future Training Topics
	    ➢ Specific to integration (people who have experience integration)
	    ➢ Population
	        ❖ Youth
	        ❖ Substance Use
	        ❖ Homeless
	    ➢ DCFS involvement
	    ➢ Probation
	    ➢ Schools
	    ➢ Legal issues, subpoenas, testify

Care Manager

What are the advantages of a single person versus multiple people fulfilling the care manager role?

Table #1	■ Some agencies have a single point of contact, some don't (team oriented) or a combination.
	■ Differences in terminology has led to confusion (i.e., Care manager)
	■ Cookie cutter vs. innovations
	■ Agency culture, agency structure, individual client need is tailored to i.e. cultural needs of client
	■ Responsiveness to client needs
	■ Care management improvements
	    ➢ Training for various topics (mental health, medical condition, housing issue, medication issues)
	    ➢ Collaborative resource sharing across agencies
	    ➢ Coordination of care with other providers
	■ Challenges
	    ➢ Risk of being burn out (wearing too many hats)
	    ➢ Extra paperwork.

Table #2	■ Sit with a member and research services together
	  ➢ Make phone calls
	  ➢ Accompany members
	  ➢ Stay with them as a program for an extended time to ensure stability
	■ Single case manager
	  ➢ It may take a while for the single person to get back to individuals
	  ➢ Responsibilities then can end up falling on other team members
	  ➢ Then staff leave (overwhelmed)
	  ➢ Then members leave (needs not met)
	  ➢ Developing positive relationship with one point person
	■ Multiple provider team
	  ➢ Develops more positive relationships with multiple team members
	  ➢ Shared responsibility. More coverage for community
	  ➢ Less overwhelming. More support.
	  ➢ Better knowledge of member/family due to shared information
	  ➢ Splitting may occur
	■ Strengths
	  ➢ Targeting specific populations reduce stigma
	  ➢ Reduces language/cultural barriers
	■ Improvement
	  ➢ Give care managers more credit (multiple hats/responsibilities/expectations)
	  ➢ Better care management terminology
	    ❖ Not clinical
	    ❖ Professional but welcoming
	    ❖ Keeping up with changes and standards
	  ➢ Trainings from DMH
	    ❖ Specific to the role of care manager- understanding clinical information from case manager role
	  ➢ Collaborate or train with other community agencies
	    ❖ One-on-one trainings paired with agencies within Innovation Model
	    ❖ Site visits to other agencies
	    ❖ Interview what is working, where are struggles

Table #3	■ Important factors
	   ➤ Introduction of roles
	   ➤ Orientation packet
	   ➤ Staff roster and pictures
	   ➤ Program criteria at admission
	   ➤ Electronic record to be accessible to all team members
	   ➤ Training is very important for the one person model
	   ➤ Program specific training is very time consuming and costly
	■ Single Person Role
	   ➤ Better rapport and trust with one staff
	   ➤ Potential burn out of one staff and staff attrition
	   ➤ Combined with team approach is important to create "institutional rapport"
	   ➤ Can be combined with team – shared case load integrates the treatment activities
	   ➤ In model when treatment is not fully integrated or not in one site, one care manager helps coordinate among all parties
	   ➤ Co-location helps with access to all team members even with one care manager
	   ➤ Documentation is a challenge with health and mental health records
	   ➤ With specific culture/language needs, one person as care manager may not connect or be limited
	■ No Single Care Manager Model
	   ➤ Caseload volume is overwhelming when assigned to one person
	   ➤ Team approach is introduced to consumers
	   ➤ Provide accessibility throughout week regardless of team members' availability
	   ➤ Clinic-based setting allows for daily team meeting
	   ➤ All team members participate in treatment. No delineation of specific tasks
	   ➤ Use one master calendar
	   ➤ Division of role needs to be determined based on consumer's needs
	   ➤ For specific language/cultural need, single care manager is needed

Organizational Policies and Procedures

What are important policies and procedures for your INN program to establish?

Table #1	■ Integrating clinic policy and procedures with the INN policy and procedures ■ We need housing policies that match with partners and need ■ Philosophies don't match each other for integrated care ■ Identify policy and procedures for client termination ■ Policy and procedures for substance abuse transfer from medical and behavioral health ■ Develop policy and procedures from the ISM, then given policy and procedures from DMH, then had to be revised ■ Why do we have to do this since funding will end? ➤ Need to develop this for a model for future for integrated care ■ IT communication important to share information on the clients rather than verbal and paperwork ■ DMH and partnering agency wants a policy to commit to the integration ■ IMHT model always have written policy and procedures but evolved and need to revise them. ■ Agencies have developed procedures but not written. But investment of time and cost. Some like IMHT have more detailed manual of procedures. ■ Difference between policy and procedure. Many have procedures which change. ■ Can there be a set of policies that govern good integrated care based on what we learned? ■ Some policies were mandated by the funding and there was a struggle to meet those by some programs. ■ Look at the outcomes, target population to figure out what worked ■ Need technical assistance on how to develop integrated policies for integrated care ■ Find a way and empower the line staff on the development of policy and procedures ■ Technical assistance to integrate the Innovation policies into an agency's funding stream and DMH requirements

Table #2	■ How to provide technical assistance?
	   ➢ IMHT is required to integrate policy and procedures with the FQHC
	      ❖ Administrative
	      ❖ Operational
	      ❖ Look at what makes Innovation unique from other funding
	   ➢ How to get policies to reflect that?
	      ❖ Need to work with the FQHC to get this written
	   ➢ IT issue for a shared chart
	      ❖ IMHT and ISM on paper not an EHS
	      ❖ Others can do a shared electronic
	      ❖ Request: DMH should develop policy and procedures for all agencies to use for EHS, i.e. business requirement, OAHC
	      ❖ Request DMH to establish a work group to discuss IT issues/shared chart
	   ➢ Share policy and procedures that are written already, templates being used. Circulate them. Maybe start with DMH requirements, for example ISMs – evolution on what would be accepted as O and E.
	   ➢ Request a workgroup to discuss how to develop policy and guidelines on how to integrate with FQHC
	   ➢ Still need a mechanism that integrates with partners (FQHC, SA and MH)
	   ➢ A workshop at directors' level on the accreditation agencies or certification organizations
	   ➢ How to integrate the data/outcomes into policy and procedures evolutions?
	      ❖ Who and how to share the outcome data
	      ❖ Include staff data somehow
	      ❖ Client satisfaction survey – use them

Appendix C

This appendix contains slides from the PowerPoint presentation presented by Karen Linkins and Barbara Lurie with the CalMHSA Integrated Behavioral Health Project (IBHP). The presentation describes the IBHP's background, lessons learned, and future planning around implementation of integrated healthcare.

1

IN SUPPORT OF THE FIELD:
CalMHSA IBHP GOALS

* Improve behavioral health treatment access and outcomes for all Californians

* Reduce stigma of seeking mental health services

* Improve cultural responsiveness of services and workforce

* Strengthen capacity of Counties to address integrated care needs by developing resources, tools, and trainings

* Strengthen networks & collaboratives among mental health, substance use, primary care, & social services providers, consumers, and systems

BUILDING AND SUPPORTING
CONNECTIONS ACROSS THE FIELD

* Partners: CiMH, CPCA, CASRA, CAMHPRO, MHA CA, National Council, AHRQ/SAMHSA, CalSWEC, etc.

* Build and Support Cross-Sector and Cross-Population Learning Opportunities

* Develop resources to support Policy and Advocacy Work

* Training and Technical Assistance

* Partnerships and Collaborations

2

NEEDS ASSESSMENT LESSONS LEARNED:

Peer Programs:

√ Need to raise awareness within PC & Health Plans re: potential role of peers

√ Peer informed measures & strategies re: "patient experience"

√ Elevate role of peers through certification

√ Incorporate peers into chronic disease self-management efforts

CalMHSA

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Integrated Behavioral Health Project

NEEDS ASSESSMENT LESSONS LEARNED:

Network & Coalition Building:

√ Limited cross-system communication and SU, especially, is not at the table

√ Language and communication across systems needs to be improved and standardized (e.g., peer involvement)

√ Limited championship for integrated care – need to educate and build awareness for state leaders, associations, and health plans

√ Limited awareness of IBH within the "person-centered health home" (Priority in Affordable Care Act)

CalMHSA

IBHP
Integrated Behavioral Health Project

3

NEEDS ASSESSMENT LESSONS LEARNED:

Mental Health and Substance Use Services:

√ Improved tracking of outcome measures, data collection & IT infrastructure, data sharing capacity

√ Education and awareness of clinical aspects of addiction for PCPs, increase knowledge & awareness among SUD providers re: health needs of clients

√ Stronger coordination/integration of MH and SUD services with PC and hospitals

√ Increased awareness of co-occurring disorders in health plans and primary care

CalMHSA
Compassion. Action. Change.

IBHP
Integrated Behavioral Health Project

NEEDS ASSESSMENT LESSONS LEARNED:

Pipeline and Workforce:

√ Understanding workforce competencies for members of integrated care teams

√ Cross-provider stigma/lack of knowledge of different competencies and specialty expertise

√ Need to elevate promising practices of staff recruitment/training to work on integrated teams

√ Front desk and MAs (first in line) identified as target for stigma/discrimination training

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4

NEEDS ASSESSMENT LESSONS LEARNED:

County Mental Health:

√ Leverage and spread CiMH investment in integration

√ Identify and prioritize standard measures for registries and EHRs, and cross system data sharing

√ Bi-directional care – models that work, including staffing and reimbursement

NEEDS ASSESSMENT LESSONS LEARNED:

Health Plans:

√ Strengthen relationships between BH providers and plans; ensure network adequacy

√ Health plans typically haven't recognized IBH as an issue of concern and investment because of the carve out

√ Health plans want their role to be data integration; don't understand their role in promoting access to integrated care, including engagement/responsiveness through member services

5

NEEDS ASSESSMENT LESSONS LEARNED:

Federally Qualified Health Centers & Clinics

√ CPCA BHN has prioritized: outcome measurement, pain management, SBIRT implementation, connection to SUD providers

√ Need to improve relationships and collaboration between SUD providers and primary care and MH

√ Community health centers serve SMI/SUD clients, but they remain unidentified due to stigma and lack of an identified clinical approach, or concern about availability of referral sources

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Opportunities under Health Reform and Medi-Cal Expansion for IBH

The ACA and Medi-Cal Behavioral Health expanded benefits:

— Addresses lack of health care access AND quality of care provided in public & private health systems

— Requires health plans to cover mental health and substance use services, and meet certain standards – care quality, improved efficiencies in delivery, and emphasis on prevention

— Expanded Medi-Cal BH benefit expansion, SBIRT

6

Key IBHP Activities 2014

√ Small and Medium County Summits and tailored technical assistance/coaching

√ SUD Case Studies

√ Tool Kit: Role of Peers in Integrated Behavioral Health (collaboration with CASRA)

√ On-going technical assistance to Counties and other stakeholders on integration and ACA implementation (including expanded Medi-Cal BH benefit for mild to moderate)

CalMHSA
Compassion. Action. Change.

IBHP
Integrated Behavioral Health Project

7

Appendix D

This appendix contains learning session participants' suggestions for future learning session activities or topics.

- Would like to arrange a meeting, specifically for the medical providers to share ideas and to get to know each other and discuss best practice
- More training on health risks of substance dependence
- Training on drug related psychosis
- Expanded Medi-Cal benefits and challenges
- Team Care Trainings
- Model list serve or an online forum to communicate in between meetings
- Focus on clinical intervention with substance abuse especially as an integrated approach, challenges, and successes
- More Motivational Interviewing training for primary care staff
- Health care data/ interactions; how are other agencies doing, and what are they doing to complete on time requested data (health care measures)
- Billing and progress note writing; what and how are others incorporating nontraditional work in their progress notes
- DMH Paperwork training - how to document within integrated models
- How to write CCCPs that meet DMH/ Medi-Cal requirements and reflect all the services (traditional/nontraditional); incorporating behavioral health, substance abuse and primary care goals and interventions

Innovation Learning Session VII

Improving Care: Utilizing Outcome Data to Implement Program Change and Improve Whole Health Outcomes

Learning Brief

April 17, 2014

HEALTHSERVICES
RESEARCH CENTER

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community research

LACDMH
LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH

Los Angeles County Department of Mental Health Innovation providers, staff, and evaluation team members participated in the seventh quarterly Learning Session on April 17, 2014. Attended by 77 people, Learning Session VII focused on the use of outcome data for program improvement. The day included an overview to finding and using data in the Annual Evaluation Report, a provider panel focused on how organizations currently use data for program improvement, and a small group activity focused on the analysis and use of data to identify actionable changes. This Learning Brief describes highlights from the day.

LACDMH's Debbie Innes-Gomberg set the stage for the days' activities by encouraging providers to aim for transparency and to "get curious" about their data. She challenged providers to compare where they are now and where they want to be in the near future and to think about evaluation data as a tool to getting there.

A Year of Outcomes: Understanding Findings from the Innovation Annual Evaluation Report

Evaluation Team member Marissa Goode shared a brief presentation about how to use the first Innovation year-end report (and Quarterly reports) to evaluate program performance related to client outcomes. Two ways of benchmarking data were presented: 1. Program-level client outcomes can be compared to outcomes for the entire model and 2. Change over-time in outcomes can be considered via the use of matched sample (clients for whom there are baseline measures and one or more additional sets of measures). A few highlights about the differences among clients served by IMHT, ICM and ISM services included:

+ At baseline, **IMHT** model clients reported higher levels of substance abuse, as well as poorer mental and physical health than clients from other models. At 12 months, IMHT clients experienced significant reductions in homelessness, cognitive impairment, symptom distress and hospitalization.

+ **ICM** model clients are on average younger and are more likely to be employed than clients served by other models. In addition, clients demonstrated significant improvements in physical and mental health outcomes and were more likely to be covered by insurance after 6 months of program services.

+ On average, **ISM** clients showed a higher level of engagement according to the MORS at baseline than clients from either ICM or IMHT. At six months, ISM clients experienced a statistically significantly reduction in self-reported stigma and blood pressure based on analysis of matched data.

Data from Peer Programs was not included in this report because these programs started later. A frequently asked questions (FAQ) guide to the Annual report was provided to attendees to support independent use of the report. A copy of the PowerPoint presentation can be found in Appendix A and a copy of the FAQ in Appendix B.

Using Data to Improve Client Outcomes - Provider Panel Discussion

"We are using outcome data so we can really know if we are meeting our stated objectives."
~Exodus Recovery

LACDMH staff Mirtala Parada-Ward, Anna Bruce, and Lise Ruiz facilitated a panel discussion with providers who have begun the process of using data to improve client outcomes. Each panelist provided a brief overview of how their organization or team actually uses the data and what changes have resulted from the use of data. Presentations were followed by a lively question and answer session. Audience members were particularly interested in practical advice and logistical considerations for how to incorporate the use of data in program planning and improvement. Highlights from each organization's presentation are summarized below:

Organization	Summary
Exodus Recovery (IMHT), presented by Lezlie Murch	**What the data told them:** The IMHT team members were surprised that their clients' physical health outcomes were not improving as quickly as they expected. The team worked with their organization's data analyst who designed a simplified outcomes dashboard with specific information, including health outcome measures, from iHOMS. This allowed the team to more regularly monitor change in their client's physical health. They disseminated these dashboards widely -- both internally and externally to their partners. **Action steps:** As a result of this data, Exodus decided to hire an LVN to support clients with health education and medication management. They also hired a benefits specialist to ensure all clients were connected health insurance and other entitlements in a timely manner.
SSG HOPICS (ICM) presented by Stephanie Castillo and John Hilliard	**What the data told them:** The ICM team used their data to verify the perception that they had a high no-show rate for appointments. **Action steps:** They explored possible reasons for the high no-show rate and experimented with a variety of tactics to improve attendance at appointments. For psychiatric visits they had success when they personally called clients to troubleshoot any issues with them, which frequently included transportation and child care. As a result, the program is now in the process of hiring peer specialists to take on the task of providing appointment reminders and will work with clients to identify and alleviate barriers to keeping appointments (such as transportation and childcare).
Didi Hirsch (ISM-Armenian) presented by Arsineh Ararat and Seta Haig	**What the data told them:** The team suspected that female clients were self-isolating and had few opportunities to participate in supportive social interactions. **Action steps:** They created more women's groups to increase social interaction and opportunities to receive social support. They also prioritized using the iHOMS results with clients so they can see their progress and areas for improvement.

Comparing Provider Outcomes with Model Level Outcomes: Getting Curious about the Data
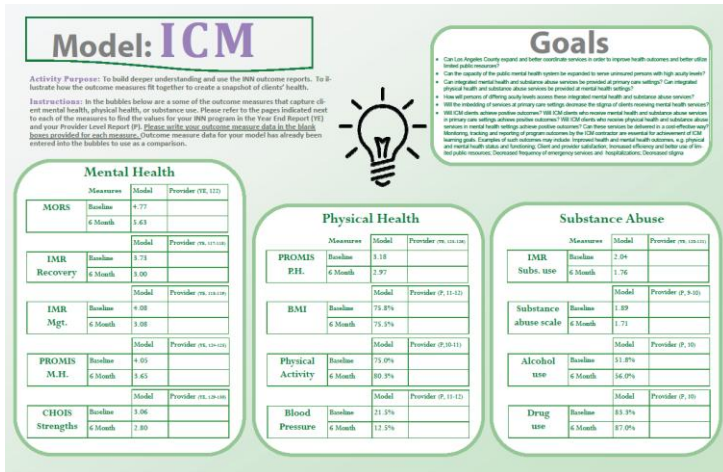
Following the overview from the Evaluation Team and the panel presentation, teams from each program worked together to identify their own data from the INN outcome reports and compare their baseline and outcome data to other programs in the same model. A worksheet was provided to each team to guide the activity (see sample worksheet to the left). These lively discussions involved review and interpretation of data with support from the evaluation team. Discussion questions included: 1) How does your provider-level outcome data compare to your model-level data? What are your strengths that you could further build on? What are areas that could be improved? 2) Is there important context that should be considered when identifying main areas of strength and areas of improvement? How might any of this data have changed since late 2013? Why? 3) Of the areas that could be improved, which are the highest priority areas to improve in the next 3 to 6 months? Why? Following the activity, teams shared their observations with the group. Selected highlights from the teams are presented below.

Selected Highlights

- JWCH/SCHARP (ICM) observed that average physical health scores for one of their sites were lower than the model. Potential strategies they identified to address this include **implementing a balanced living curriculum, utilizing a nutritionist, and hiring a physical trainer**.

"iHOMS data really helps ground clients so they can see strengths and areas where they can make improvements."
~Didi Hirsch

- LA Gay & Lesbian Center (ICM) noted that their client's BMI is, on average, lower than the model average. At first, this seemed like a positive finding, as many clients across INN programs struggle with obesity and metabolic syndrome. Upon closer examination, the team realized that their clients' low BMIs may actually be related to the fact that many are HIV positive, and that crystal meth use is also an issue among their clients, both of which cause weight loss. **They pointed out that low BMI may not necessarily indicate good health status for their clients.** The team suggested **adding physical activity and nutrition into their program** as a response to the findings.

- Pacific Asian Counseling Services (ISM) identified the need for their program to increase physical activity to help impact physical health outcomes. One potential strategy they identified is increasing physical activity through **cycling**. Their client population, the Cambodian population, typically biked as a main form of transportation while living in Cambodia.

These share-outs illustrated the importance of the **context and understanding** that teams bring to the interpretation of the data. While the data itself offers some information about how clients are doing, context is critical in order to appropriately identify areas for improvement and to select strategies to address issues.

Utilizing Outcomes to Set and Implement SMART Goals

Dr. Andy Sarkin from the evaluation team presented about the important role of data in **continuous quality improvement.** While data itself does not drive quality improvement it is one important tool that can be used to bring about change. Data can be an important part of creating goals that ultimately lead to improvement.

Andy reviewed the characteristics of SMART and SMARTER goals:

SMART goals are:	SMARTER goals are also:
■ **Specific**	■ **Evaluated**
■ **Measurable**	■ **Reviewed**
■ **Achievable**	
■ **Relevant**	
■ **Time-bound**	

The difference between **process and outcome measures** of a program's effectiveness, were described, emphasizing the importance of both to SMART continuous quality improvement. Some examples of process measures include satisfaction with services or reasons for discharge. Examples of outcome measures include clinician-rated scales (like the MORS) and health indicators like BMI. The full presentation can be found in Appendix C at the end of this Learning Brief.

Strengths and Priorities: What's Working and What Matters Now?

Strengths:
+ The variety and success of non-traditional supports and services (e.g., knitting, walking, Zumba, nutrition)
+ Recruitment, team work and full program enrollments, many programs now have waiting lists
+ Early improvement in substance abuse, with clients increasingly becoming ready for detox

What matters now?
+ Many providers recognize need to improve clients' physical health
+ Improve collaborations and partnerships with medical clinics and other physical health providers
+ Increase the use and dissemination of data among all team members

After the presentation, providers worked together with others from the same program model to share their reflections from the data they reviewed during the morning break-out session. Organizations were asked to share their strengths and priority goals moving forward. Each small group then identified three high priority areas and developed action steps for those areas. The notes captured by each table can be found at the end of the brief in Appendix D. Some highlights from the report out can be found in the box called Strengths and Priorities: What's Working and What Matters Now?

Building the Will to Improve Care

Debbie Innes-Gomberg introduced the closing activity by sharing highlights from the Institute for Healthcare Improvement High-Impact Leadership report. The report focused on **five behaviors of great leaders** highlighted in the sidebar.

> Over half (58 percent) of all providers identified improving the usage, integration, and sharing of data as a goal or task.

After the presentation, Learning Session attendees once again worked in program teams to identify <u>one</u> goal area that they want to **improve or change** about their program in the next three to six months. The goals did not have to be large-scale, but teams were asked create SMART goals consistent with the presentation on goal setting earlier in the afternoon. The goals and associated tasks were documented on worksheets that the evaluation team scanned and archived.[1] At the July 2014 Learning Session, providers will be invited to provide an update on progress towards these goals

The evaluation team analyzed the goals set by programs during the session and noted the following trends across all INN program models:

- Over half (58%) of programs set goals or identified specific tasks that addressed the **usage, integration, and sharing of client outcomes data**.

- Twenty-five percent (25%) of all programs specifically mentioned the intent to use **client outcomes data and iHOMS reports** to achieve their goals. For example, one provider proposed to bring program data from iHOMS to monthly staff meetings as a first step towards incorporating outcome data into the team's clinical practice.

- Twenty-five percent (25%) of all programs created goals focused on **improving physical health outcomes** among clients. For example, one program proposed to implement a weekly physical exercise group in order to lower the average BMI scores among their clients and improve other physical health outcomes.

High-Impact Leadership Behaviors: *What Leaders Do*

1) **Person-centeredness:** Be consistently person-centered in word and deed

2) **Front line engagement:** Be a regular authentic presence at the front line and a visible champion of improvement

3) **Relentless focus:** Remain focused on the vision and strategy

4) **Transparency:** Require transparency about results, progress, aims and defects

5) **Boundarilessness:** Encourage and practice systems thinking and collaboration across boundaries

Excerpted from: Swensen S, Pugh M, McMullan C, Kabcenell A. (2013). *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs.* Cambridge, Massachusetts: Institute for Healthcare Improvement.

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[1] Copies of worksheets may be obtained from your INN contact person or by emailing nmcgovern@harderco.com .

The evaluation team also noted some trends within INN program model:

ICM

Sixty percent (60%) of ICM providers developed goals or tasks aimed at **improving BMI scores or other physical health outcomes**. Typical activities intended to meet these goals included physical activity (such as yoga classes), walking clubs and low- or no-cost gym memberships. Many programs are also seeking to improve clients' nutrition through nutrition groups and healthy cooking classes.

> Many providers recognize the need to **train partner organizations** on how to understand and interpret their program data in order to meet their goals of improving client outcomes.

IMHT

Eighty percent (80%) of IMHT providers explicitly identified an intent to **use data found in iHOMS to track, inform, and improve their client's health outcomes**. For example, one provider set a specific goal to increase the number of clients with a MORS (*Milestones of Recovery Scale*) score of "six" or greater by ten percent and to decrease the client use of alcohol and drugs by 10 percent. Many IMHT programs articulated the intent to **more carefully monitor change in client MORS scores** as part of their action planning activity.

ISM

Approximately 75% of ISM programs expressed the i**ntent to use the client outcome data found in iHOMS to improve clinical care and practice.** For example, one program team strategized ways to incorporate client outcome data via iHOMS reports into weekly client case conferences. Many ISM providers mentioned incorporating data into their clinical practices as goals or tasks, and this included providing **training for other program staff and staff at partner agencies** on how to interpret the client outcome measures found in iHOMS.

Peer-Run

The Peer-Run Model providers stated the intent to provide and/or improve educational tools and workshops for their staff. One provider seeks to ground their teams in principles of recovery, resilience, and hope. Another provider seeks to increase the number of referrals made from mental health providers to their PRISM program.

How Programs Use Data

Learning Session Participants were asked to use a word or short phrase to answer the question:
How Does Your Organization Use Data?
The word cloud to the right illustrates relative frequency of responses. Words in larger type appeared more frequently in responses than words appearing in smaller type.

We look forward to revisiting these goals and learning about the progress that programs and organizations make towards them at Learning Session VIII on July 17, 2014 at The California Endowment.

Appendix A

Appendix A contains slides from the PowerPoint presentation presented by Marissa Goode of the evaluation team and UC San Diego reflecting an overview of the Innovation Year-End Report.

Annual Innovation Outcome Report

Marissa Goode
mgoode@ucsd.edu

Annual Report

- Data pull was on October 1, 2013
- Data in the report reflects a snapshot and will not be updated
  - As this is the first Annual Report, it is intended to be a learning tool
  - Future annual reports will reflect all of the data available at that time, and will not refer to previous reports
- Additional provider level data can be found in the Provider Reports (currently reflecting data through December 31, 2013)

Interpretation Resources

- Measuring Client Recovery (p. 9)
  - Statistical Significance
  - Matched Samples
  - Clinical Significance (Mean Important Differences)
- Glossary (p. 146)
  - Descriptions of each measure
  - How to interpret each measure
  - Overview of statistical terminology
- FAQ Handout (in Learning Session Packets)

Clients Served – IMHT
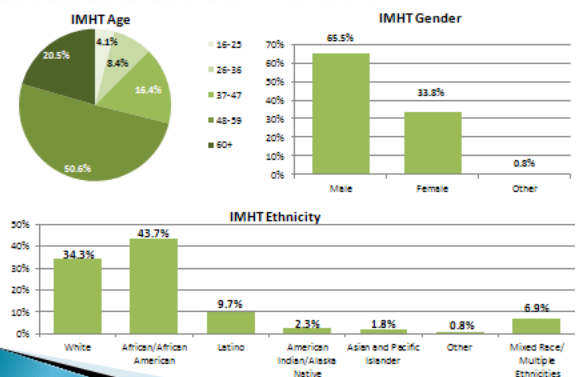
Annual Report p. 34

IMHT Baseline Health

- **90.6%** were homeless at least 4 of the previous 6 months
- **52.7%** of clients reported that they Rarely or Never lived in a home that made them feel safe
- **60.6%** had used alcohol and **43.4%** had used illegal drugs in the past 6 months
- **40.2%** had thoughts of suicide or self-harm in the past week
- **29.1%** reported that they were incarcerated in the previous 6 months
- **69.9%** reported that they went to the emergency room in the previous 6 months
- **48.2%** reported that they were admitted to a hospital in the previous 6 months

IMHT Baseline Health

- Only **3.6%** had paid employment
- **48.7%** were insured
- IMR scores indicate little social support and few coping skills
- **74.6%** were high or extreme risk (MORS: 3.33), but **81.3%** of clients were engaged
- Clients were likely to be bothered quite a bit or a lot by symptoms (IMR), and symptoms got in their way quite a bit or a lot (IMR)
- Clients were likely to have experienced a relapse of symptoms recently (IMR)

IMHT Progress at 12 months

▸ Significant reductions in:
  ▪ Homelessness, with significantly more clients reporting always living in a safe home
  ▪ Hospitalizations for mental health or substance abuse
  ▪ Symptom distress and relapse of symptoms (IMR)
  ▪ Cognitive impairment (CHOIS)
  ▪ Drug use (at 6 months)
▸ Significant improvements in:
  ▪ Insurance coverage
  ▪ Social support and coping skills (IMR)
  ▪ Engagement and progress towards recovery (MORS)
▸ Large, non-significant reduction in thoughts of self-harm (from 50% to 10% reporting any thoughts in previous week)

Clients Served – ICM

Annual Report p. 112
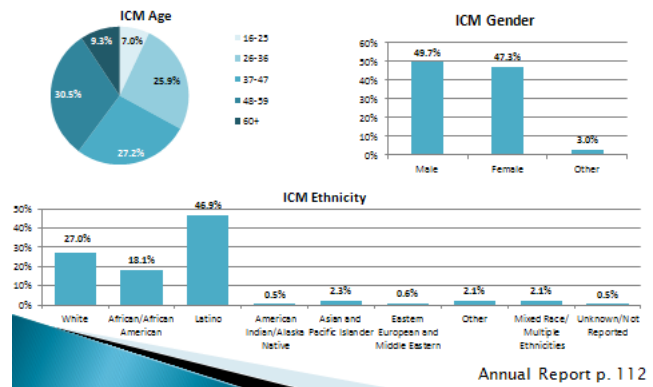
ICM Baseline Health

▸ **19.4%** were insured
▸ **52%** had used alcohol and **19.8%** had used illegal drugs in the past 6 months
▸ **34.1%** had thoughts of suicide or self-harm in the past week
▸ **34.3%** reported that they went to the emergency room in the previous 6 months
▸ **19.3%** reported that they were admitted to a hospital in the previous 6 months

ICM Baseline Health

▸ **26.6%** had paid employment
▸ IMR scores indicate little mental health knowledge and few coping skills
▸ **19.2%** were high or extreme risk (MORS: 4.71), **81.4%** of clients were engaged
▸ Clients were likely to be bothered quite a bit or a lot by symptoms (IMR: 4.22), and symptoms got in their way quite a bit or a lot (IMR: 4.04)
▸ Clients were likely to have experienced a relapse of symptoms recently (IMR: 3.81)
▸ Moderate cognitive impairment (CHOIS: 2.87)
▸ Few strengths/coping skills (CHOIS: 2.97)

ICM Progress at 6 months

▸ Significant reductions in:
  ◦ Hospitalizations
  ◦ Thoughts of self-harm
  ◦ Alcohol and drug use
  ◦ Symptom distress and relapse of symptoms (IMR)
  ◦ Cognitive impairment (CHOIS)
▸ Significant improvements in:
  ◦ Insurance coverage
  ◦ Both physical and mental health (PROMIS)
  ◦ Engagement and progress towards recovery (MORS)
  ◦ Mental health knowledge and coping skills (IMR)

Clients Served – ISM

Annual Report p. 68
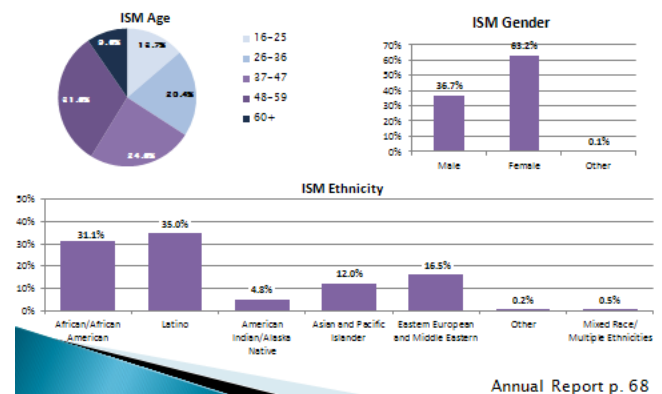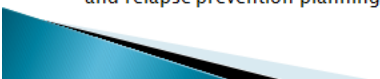
ISM Baseline Health

- **43.7%** had used alcohol and **13.5%** had used illegal drugs in the past 6 months
- **26.6%** had thoughts of suicide or self-harm in the past week
- **32.9%** reported that they went to the emergency room in the previous 6 months
- **16.7%** reported that they were admitted to a hospital in the previous 6 months

ISM Baseline Health

- **27.9%** had paid employment
- IMR scores indicate little mental health knowledge and few coping skills
- **23.8%** were high or extreme risk (MORS: 4.66), **86.9%** of clients were engaged
- Clients were likely to be bothered quite a bit or a lot by symptoms, and symptoms got in their way quite a bit or a lot (IMR: 4.23 , 4.16)
- Clients had poor mental health knowledge and were unlikely to have personal goals or a relapse prevention plan (IMR: 3.99, 3.99, 4.24)
- Moderate cognitive impairment (CHOIS: 2.73)
- Few strengths/coping skills (CHOIS: 2.98)

ISM Progress in 6 months

- Significant reductions in:
  - Blood pressure
  - Drug use
  - Thoughts of self-harm
  - Symptom distress and impairment in functioning (IMR)
  - Mental health stigma (ISMI)
  - Symptoms of psychosis (CHOIS)
- Significant improvements in:
  - Strengths/coping skills (CHOIS, IMR)
  - Both physical and mental health (PROMIS)
  - Engagement and progress towards recovery (MORS)
  - Mental health knowledge, creating/using personal goals, and relapse prevention planning (IMR)

Conclusions

- Data represents a snapshot in time
- Baseline data can be used to guide outreach and engagement to reach target audience
- Outcome data can be used to plan and evaluate changes to program implementation
- Small changes can have a large impact on outcomes
- By comparing data from different time periods, you can determine the impact of any changes

Appendix B

Appendix B includes the Frequently Asked Questions Guide to reading and understanding the Annual Evaluation Report.

Innovation Reports Frequently Asked Questions

If you have questions that aren't listed in this document, please refer to the FAQ document on iHOMS. You can access it by going to ihoms.ucsd.edu, and clicking the (+) next to General Inquiries. You may also email ihomshelp@ucsd.edu.

Analyses

What is statistical significance?

Statistical significance means that there is a greater likelihood that the difference (or change) between two outcomes could be attributed to the benefits of receiving INN services and not chance variation. Paired samples t-tests and chi-square tests were used to examine the statistical significance of changes in scores on the measures over time. For model level analyses, outcomes were considered significant if $p \leq 0.05$, meaning that the likelihood of changes in outcomes being due to chance is less than 5 percent of the time. Since there was a smaller sample size for provider level analyses, their outcomes were considered significant if $p \leq 0.1$.

What are matched samples?

Matched, or paired, sample analyses include every client who completed the measure during each time point being compared. For example, to compare change in PROMIS Global Health ratings across the baseline and six month follow-up assessment, the paired sample would comprise clients who completed the PROMIS measure at both of these time points. These paired comparisons show change for individual clients as they progress through services, which allow changes to be more easily attributed to INN services. While data for all clients provides a more complete picture of the clients being served, it can be biased by clients who were discharged from the program without completing follow-up assessments, or clients who missed the baseline assessment.

What is clinical significance (minimal important differences)?

Clinical significance is determined using the Minimal Important Difference (MID), which represents the smallest improvement in a scale score that would indicate an observable change in client health. MID estimates were calculated separately for each outcome measure using the benchmark distribution method of ½ the standard deviation (the variance between all scores) at baseline. However, the MORS uses a MID of 1, which is the smallest observable change for the scale. Although the MORS is not a linear scale, transitioning into a higher or lower level of recovery was interpreted as a clinically meaningful change.

If the difference between a client's baseline and follow-up scores on a specific outcome measure is greater than the MID, that client is considered to have achieved a clinically meaningful change for that outcome.

The MID estimates used in the Annual report are provided in the table below.

Minimal Important Difference (MID) Estimates	
Scales and Sub-Scales	MID Estimate
Overall IMR	0.3
IMR Recovery	0.4
IMR Management	0.4
IMR Substance Use	0.8
MORS	1.0
Overall PROMIS	0.4
PROMIS Mental Health	0.4
PROMIS Physical Health	0.4
CHOIS Psychosis	0.6
CHOIS Memory and Cognitive Impairment	0.6
CHOIS Strengths	0.4
Internalized Stigma of Mental Illness	0.3
PROMIS-Derived Substance Use	0.6

Why does the Annual Report discuss both statistical and clinical significance?
Statistical significance describes the likelihood that changes were due to chance, but does not demonstrate the magnitude of the change. Statistical significance is also influenced by extraneous factors, such as sample size (the number of completed assessments). When sample sizes are small, statistical analyses of provider-level outcomes and longer assessment period comparisons (e.g. baseline/twelve-months) may not be statistically significant. This does not indicate that the changes in the outcomes were not meaningful to clients' health. Incorporating both statistical and clinical significance in the report enhances our understanding of whether the changes on the outcome measures reflect meaningful changes in individual health. Also, clinical significance is determined by individual client improvement and is therefore less influenced by sample size.

Why are my outcomes non-significant when there was a large change between the data?
Statistical significance is influenced by extraneous factors, such as sample size. If a matched sample is small on a specific measure, statistical analyses may not be statistically significant despite a large change in scores. Since paired comparisons show change for individual clients as they progress through services, it is important that that the outcomes are representative of all of the clients that your program serves. For these reasons, it is especially important to complete measures in iHOMS prior to the data pull at the end of each quarter.

Data Accuracy
Why does the data in the report look different than the data I see in iHOMS?
Reports in iHOMS are generated in real-time, meaning that they include every assessment that has been entered up to the time that the report is opened. Data in the Annual Report was pulled at the end of fiscal quarter one of 2013/2014 (October 1, 2013). Additionally, data in the iHOMS reports include all clients for each time point. The Annual Report only includes data for clients who completed each of the measures at each time point (with matched samples). The graphs in the Annual Report include data for all clients at each time point, which should look more similar to the data that you see in iHOMS.

My program has a lot of clients so why are there so few clients in the analysis?
The data for the Annual Report was pulled on October 1, 2013 so any assessments completed after that date are not included. Additionally, the Annual Report only includes data for clients who completed each of the measures at each time point (with matched samples). If a client was missing a baseline assessment, had not yet completed a follow up assessment, or if the follow-up assessment hadn't been entered into iHOMS before the data pull, that client's data would not be included in the analysis.

Why don't the enrollment and discharge numbers match our program records?
The enrollment and discharge numbers reflect the clients who are registered in iHOMS at the time of the data pull (October 1, 2013). Please register all clients in iHOMS as soon as they are enrolled, and let us know when a client is discharged from the program. You can send a list of discharged clients to ihomshelp@ucsd.edu. Include only there IS number, first and last initial, and a brief reason for discharge. Once a client is discharged from iHOMS, they will no longer show up in the Assessment Status Report or the Assessment Progress Summary.

We have completed all of the measures for our clients, so why are the completion numbers so low?
If you have a lot of clients registered in iHOMS who are no longer involved in your program, they will appear to be incomplete in the Assessment Progress Summary, which affects the completion summary percentages. You can send a list of discharged clients to ihomshelp@ucsd.edu. Include only there IS number, first and last initial, and a brief reason for discharge. Once a client is discharged from iHOMS, they will no longer show up in the Assessment Status Report or the Assessment Progress Summary.
Another potential reason for low completion numbers is that assessments were not entered into iHOMS before the data pull. If you are completing client measures on paper, please be sure to enter them into iHOMS before the data pull, which is the first business day of each fiscal quarter (January 1, April 1, July 1, and October 1).

Interpretation

How do I know how much time has passed between assessments?
The baseline assessment is also referred to as Assessment 1. It is administered when a client first enrolls in the program. After the baseline, shorter quarterly assessments are administered every three months, with more comprehensive semi-annual assessments being completed every six months. Assessment 2 is administered when the client has been in the program for 3 months (the first quarterly assessment), which is followed by the semi-annual assessment, Assessment 3, at 6 months. Assessments continue to advance every three months, even if a client misses one. So, Assessment 4 is always 9 months, Assessment 5 is always 12 months, etc.

What are the implications if my clients are doing very well on a measure at the baseline and they don't have room to significantly improve?
If the score on any measure is very good at the beginning (whether it is substance use or hospitalization, or Overall IMR score), there probably won't be clinically meaningful improvement or statistically significant changes. To give a simple example, we noticed this for several of the ISM programs in homelessness. If fewer than 5% of clients were homeless at baseline and no clients were homeless at the six month assessment, the change often wasn't significant. Obviously, you can't do better than reducing homelessness to 0% so the change is important. We kept the interpretation very simple on the Annual Report, so this may not have been specifically addressed every time it occurred. As the measures were designed to work across all models, we recognize that some providers don't need to help their clients improve in every domain. However, in some cases it may be an indication that the program should work to enroll more clients with greater need.

What if the physical health indicators for my program are getting worse?

We have seen that BMI is generally getting higher for INN clients, which we try to interpret holistically. It may be related to a greater number of clients taking prescription medications that have weight gain as a side effect, or taking their existing medications more regularly. Short term changes in physical health indicators may indicate that a client is taking steps towards recovery, and that they may need secondary interventions to alleviate any side effects. For example, they may have better access to nutritious food, but need help establishing a balanced healthy diet.

Why did my clients' self-reported outcomes get worse?

Due to social desirability or stigma, clients often exaggerate positive health behaviors. One example we noticed across INN models is self-reported exercise frequency. The effects of social desirability are strongest on baseline measures, when a client wants to appear "normal" or may not fully trust the program to maintain confidentiality (in the case of illicit behavior). This could explain the reduction we observed in exercise frequency. These declines can actually be an indication that clients are becoming more comfortable with a provider, or experiences less stigma.

The measure completion rate for my program is lower than other programs in my model, but we are serving more clients. Will we be penalized for lower completion?

Completion rates are too complicated to compare directly between providers. Each provider has an enrollment goal, and they may not all be the same. We understand that it isn't possible to have completed measures for every client at each time point. This is especially true of programs that started serving clients before the outcome measures were available in iHOMS. Our goal for each provider is an 80% completion rate. Providers who are not meeting their enrollment goal, but are meeting the completion goal are less likely to see significant changes in their outcomes. The same is true for providers who are meeting their enrollment goal, but not their completion goal. There are a few things you can do to improve completion rates, including discharging clients from iHOMS when they are no longer in your program, and entering client assessments in iHOMS prior to the data pull deadline at the end of each quarter.

Appendix C

Appendix C contains slides from the PowerPoint presentation presented by Dr. Andy Sarkin (UCSD, HSRC).

Using Evaluation Tools to Drive Continuous Program Improvement

Los Angeles County Innovation Program

Continuous Program Improvement Takes Many Forms – Examples

- Adding a substance abuse counselor to a program that has a high prevalence of addiction problems
- Reducing wait times to improve satisfaction of people getting services
- Increasing outreach to targeted groups who are not using a program as much as expected
- Providing technical training to enhance staff ability to utilize outcomes information for individual treatment

SMART Goals

- Specific
- Measurable
- Achievable
- Relevant
- Time-bound

SMARTER Goals are also:
- Evaluated
- Reviewed

Implement Positive Change

▸ Identify an area for creating a positive change
▸ Set SMART goals for improvement
▸ Create and implement a strategy for change
▸ Monitor the process of change
▸ Measure the impact on program outcomes
▸ Disseminate the results for learning

Outcome Measures Examples

My physical health has improved

- 3.15 — Fiscal year 2011–2012 (N=33)
- 3.72 — Fiscal year 2012–2013 (N=25)

I deal more effectively with daily problems

- 3.40 — Fiscal year 2011–2012 (N=35)
- 3.88 — Fiscal year 2012–2013 (N=25)
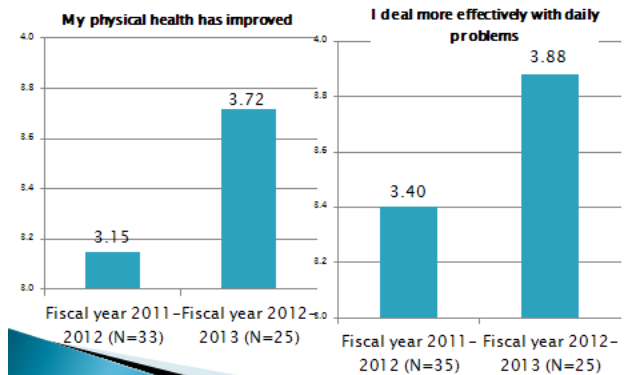
Process Measures Examples

My beliefs were considered as part of the services that I received.

- 4.00 — Fiscal year 2011–2012 (N=26)
- 4.38 — Fiscal year 2012–2013 (N=24)

I felt comfortable asking questions about treatment and medication.

- 4.64 — Fiscal year 2011–2012 (N=22)
- 4.23 — Fiscal year 2012–2013 (N=40)
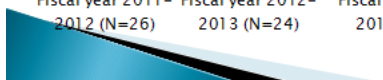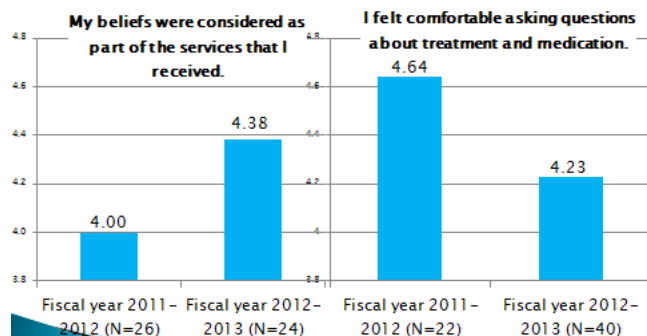
Measure Program Improvement

▸ Process Measures
  ◦ Outreach and engagement with targeted population
  ◦ Discharge reasons and referral patterns
  ◦ Screening practices for physical health
  ◦ Medication and treatment adherence
  ◦ Satisfaction with services
▸ Outcome Measures
  ◦ Health indicators (weight, diabetes)
  ◦ Clinical status as rated by a clinician (MORS, IMR)
  ◦ Self-reported client-centered outcomes
  ◦ Changes in the magnitude of improvement
  ◦ Percentage of people who improve significantly

Appendix D

This appendix contains notes transcribed from small group discussion in the first break-out session of the afternoon. Providers from the same model worked together to reflect on the data reviewed in morning session. Each group of providers then identified three high priority areas to discuss. Action steps were identified for each priority area. These notes were transcribed verbatim; the evaluation team only corrected spelling where necessary.

Table #1 ISM	**Strengths** ➤ Non-traditional services like yoga, acupuncture, energy healing, massage, spirituality ➤ Tele-psychiatry ➤ Integrated /expedited services in various areas; stronger integration and better access to services ➤ MH Outcomes (MORS, IMRS) ➤ Process – O&E and Referral patterns ➤ Largest/ oldest agency for APIs ➤ Word of mouth referrals ➤ Proximity of health partner ➤ Shelter **Areas of Improvement** ➤ PH improvement but BMI worsened ➤ "Drugs never used" percentage increased (although substance use overall went down) ➤ Blood pressure increased slightly ➤ Slow enrollment in ACA, over usage of indigent number **Action Steps/Priorities for next 3-6 months** ➤ Integrated electronic chart for MH/PH/SA ➤ Documentation training by promotores / peer supporters / non-traditional providers ➤ Explore why BMI and health indicators worsened where overall PH outcomes improved ➤ Talks/ workshops on nutrition, MH stigma reduction ➤ Improving integration, especially with physical health services ➤ Focusing on recovery model for clients, including housing, employment, etc.

Table #2 ISM	**Strengths** ➢ Case management: linkages ➢ Non-traditional services: yoga, nutrition, walking, Zumba ➢ Rapport with clinical staff ➢ Outreach and engagement team ➢ Good collaboration with partner agencies ➢ Support received from focus / empowerment groups **Areas of Improvement** ➢ Increase nutrition classes from monthly to weekly ➢ Physical activity **Priority Areas** ➢ More use of outcome data with clinical treatment ➢ Improving physical health ➢ Education / awareness on health/nutrition ➢ Other areas for improvement where there is no data **Action Steps/Priorities for next 3-6 months** ➢ Incorporating healthier diet by also considering cultural foods ➢ Incorporating outcome data into 1-1 clinical sessions as positive reinforcement and integrative meetings ➢ Nutrition specialist to be a part of the treatment team ➢ Assessing client needs (gambling addiction, domestic violence education)
Table #3 ISM	**Strengths** ➢ Synergistic ➢ Combination of alternative services and case management (med) ➢ Enhanced outreach / engagement ➢ Outreach – no problem with recruitment ➢ Support / treatment groups (knitting, ceramics, etc.) ➢ Team work **Priority Areas** ➢ Incorporating data more effectively **Action Steps/Priorities for next 3-6 months** ➢ Hire LVN ➢ Bring data to team regularly ➢ Incorporate and monitor non-iHOMS data ➢ Off-site FQHC coordination ➢ Outreach / engagement support
Table #4 ISM	**Strengths** ➢ Good engagement ➢ Some ISMs had positive physical activity (Zumba, YMCA, health workshops) ➢ Nutritionists, API doctors ➢ Health navigators ➢ Some ISMs have a strong partnership with medical clinic which results in effective treatment for individuals ➢ Partnership is key! **Action Steps/Priorities for next 3-6 months** ➢ Improved partnership (primary clinic) ➢ Continually assess individual to evaluate treatment goals if client is not doing well ➢ DMH fixing current COS billing to reflect diverse culturally competent services and activities being provided

Table #5 IMHT	**Strengths**
	  ➤ Exodus Recovery – clients have higher prevalence of SUD at baseline than model. Significant gains made between 1 and 3 assessment. SUD still a challenge.
	Areas for improvement
	  ➤ Medication treatment of benzos, stimulants, pain class 3. Decrease drug seeking behaviors.
	  ➤ Keep close eye on clients, offer service in harm reduction
	  ➤ Resident rules related to substance abuse / use standards held in place – person may fail. May lose housing.
	  ➤ "We know when they are ready." Detox beds and CSS $.
	  ➤ Less data collection to improve compliance. Some are duplicative.
	  ➤ Increase life skill groups for housed population.
	  ➤ Client self-report scores increased time 1-3 vs staff report scores decreased 1-3.
	  ➤ Question the phrasing of questions and tools
	
	Action Steps/Priorities for next 3-6 months
	  ➤ MORS team meeting, arrive at a consensus.
	  ➤ Staff attend training on MORS.
	  ➤ IMR – same as above.
	  ➤ Substance abuse use: sub spec works graveyard shift random and unannounced in housing
	  ➤ Coordinate with residential staff
	  ➤ Need more MORS training
	  ➤ Possible different agency / partners
	  ➤ Need to standardize the rating scale to promote consistency (interrater reliability)
	  ➤ Substance use – look at reduction versus abstinence (harm reduction)
	  ➤ Focus more on mental health – MORS and IMR scales
	  ➤ Comparing to model as a whole or individual agencies
	  ➤ (don't be too hard on selves, dig deeper in #'s)
	  ➤ Medical improvement in HTN/BP scores; physical activity up
	  ➤ Want primary care linkage to improve and more solid data

Table #6 ICM	**Concerns** ➢ SSG- HOPICS – Numbers have improved, but concerned about the quality of their data ➢ LA CADA / JWCH – Concerned about data on substance abuse ➢ Saban – Difficulty in collecting data subsequent to baseline; increased focus on data, refresher course for staff; discrepancy between program and model data ➢ Exodus – Concerned about baseline data; using dashboard to compile data ➢ LAGLC – Utilizing physical health data to implement increased focus on nutrition and physical exercise ➢ SHARE – limited data to due first year of program; incomplete data sets; difficulty getting consistent outcome measures due to client engagement; Historically, they were an anonymous program so poses problems in outcome measures, asking patients to participate **Action Steps/Priorities for next 3-6 months** ➢ Data indicates need for increased focus on physical health ➢ Interested in data gathered from clients who are engaged in multiple services versus clients who utilize fewer resources ➢ Print individual iHOMS data and add to individual medical record for use in intervention and treatment planning ➢ Increased utilization of iHOMS progress report ➢ Review / revise program goals consistently **Areas of focus: Physical health** ➢ BMI ➢ Nutrition ➢ Utilize health promoter; engage family support ➢ Work with in-patient treatment providers to improve nutritional value of food provided ➢ Cooking groups; lunch and learn programs ➢ Life skills group could focus on shopping for healthy food ➢ Work with nutritionist and trainer ➢ Utilizing client data to motivate engagement ➢ Walking groups ➢ Community Garden – cooking with items from garden; provide healthy recipes ➢ Cal Fresh provides vouchers for buy 1 /get 1 at Farmer's markets

Appendix E

This appendix contains learning session participants' suggestions for future learning session activities or topics.

- Documentation – Integrating behavioral health.

- Substance abuse and primary care goals into the CCCP; addressing medical necessity, etc.

- Documentation of progress & results for provider.

- Data collection & analysis (outcome measurement).

- Client testimony about the changes made through INN services.

- Partnering with medical staff that may not be a part of the INN programs; Example: Children that can benefit from ISM services, but have a strong healthy relationship with their doctor. They should not be required to switch doctors.

- Increasing family involvement & participation.

- Fiscal sustainability beyond the INN contract.

- Retention & Discharge protocols/guidelines.

- The Impact of MCE on the INN requirement of 60% indigent clients. We are finding some 40% indigent clients now qualify. How is DMH going to handle this?

Innovation Learning Session VIII

Applying Learning: Strategies to Incorporate Outcome Data Spreading and Scaling Innovation Learning

Learning Brief

July 17, 2014

Los Angeles County Department of Mental Health Innovation providers, staff, and evaluation team members held the eighth quarterly Learning Session on July17, 2014. Attended by 98 people, this Learning Session included a presentation of a rubric LACDMH is considering to evaluate model effectiveness and learning, a provider panel presentation focused on the use of client outcome data to drive program change, and a presentation about spread of learning within and across organizations.

LACDMH's Debbie Innes-Gomberg framed the day by reminding everyone that Innovation is intended to be a "learning lab" where all stakeholders can try things out, evaluate and adapt practice. She shared that from the early planning phases, Innovation was designed to examine client outcomes, rather than process and a great deal of care and research went into identification of outcome measures. Measurement of outcomes was intended to be ongoing and frequent so that data could be used to assess success, measure progress and make course corrections as needed.

Debbie also outlined the timeline and process being developed for decision-making around recommendations for future program funding which was discussed in greater depth in an afternoon session on rubrics.

The PowerPoint presentation of Debbie's opening remarks can be found in Appendix A of this learning brief.

Panelists share their experiences implementing program changes.

Implementing Change to Improve Care - Provider Panel Discussion

"We were trying to make outcomes data a win-win for everyone."

~UMMA

One of the goals of Learning Sessions has been to foster the use of outcome data in program planning and clinical treatment. During Learning Session VII (April 2014), organizations received data reports that contrasted their clients' outcomes to those of other programs within the same model. This information was used to identify areas for growth and to develop an action plan that was implemented between April and July 2014. Evaluation team member Nicole McGovern facilitated a panel discussion with providers from each model to hear about some of the efforts that were implemented as a result of this process. The panel was followed by questions from the audience. Providers in the audience were particularly interested in talking about how the Peer-Run respite houses might measure self-sufficiency longer term, issues around validity of measures, and how the community can affect outcome measures.

Model/Provider	Implementing Change to Improve Care
UMMA Community Clinic (ISM), presented by Kendra Wilkins and Shawnie Dockery	**What changed:** The team incorporated iHOMS (Health Outcomes Management System) data into weekly case conferences so that all providers, including non-traditional providers, were aware of outcomes data. UMMA also asked for outcomes data from all community partners delivering services to ISM clients. **Challenges:** The team had to alter a case conference structure that had been in place for a long time. It took the team some time to identify exactly which data were most relevant and appropriate to consider. **Next steps:** The team will continue to refine the process of incorporating the results of outcomes measures into case conferences.
JWCH/Scharp (IMHT) presented by Alana Ramos	**What changed:** Include iHOMS data in the morning meeting. All providers – not just clinicians – are seeing the clinician forms now. The IMR is now being completed together. This allows everyone to be involved and see what needs to be worked on. **Challenges:** Some clients refuse to complete self-assessments. Also higher-functioning clients may respond negatively on measures, and lower-functioning clients pretend as if everything is fine with them.
Project Return (Peer-Run), presented by Janet Backes	**What changed**: The team has focused on improving the relationships among peer staff which they hope will lead to more positive outcomes. They have been focusing on the concepts of resilience, hope and recovery. As a result of these efforts, the conversations among staff have improved and become more focused around outcomes. Teams feel more confident and they have a longer term perspective. **Challenges:** Staff does not always see the value in the outcomes measured and tracked in iHOMS. **Next steps:** Increase understanding of and ownership in the iHOMS data so staff can encourage guests to complete measures and see the potential uses of the data to improve outcomes.
Los Angeles Gay and Lesbian Center (ICM), presented by Grant Courtney	**What changed:** In response to their client's BMI data, the team created a four week nutrition class. **Challenges:** Interpretations of the data are not always straightforward and need to be done in context of the program. **Next steps:** The team will be using iHOMS data to track BMI over a six month period. The team also developed an instrument to assess changes in pre- and post-class nutrition knowledge.

Learning Spread: *How do we use what has been learned?*

Matt Wells, Program Staff with LACDMH, presented the concept of "Learning Spread". Spread is the process of **taking local improvement and disseminating it widely** (e.g., within an agency, city or country). The overall aim of the presentation was to have providers consider how they are applying Innovation learning in their programs and throughout their organizations. Key takeaways from his presentation included:

✚ Spread often starts with small-scale testing and moves along to greater implementation

✚ Failure is helpful to see what works and what does not

✚ Leadership buy-in is key to spreading learning

✚ Some change is spread easier than others. Characteristics that encourage spread include:
- Perceived benefit: Do others feel the change is important?
- Compatibility: Does it align with values, beliefs, history and current needs of an organization?
- Simplicity: Is it simple?
- Trial-ability: Are you able to test it on a small scale without large-scale implementation?
- Observability: Can "potential adopters" watch the change and adopt it themselves?

✚ Spreading change is a team effort; the appropriate staff need to be involved

✚ Be clear about what it is you are trying to expand upon /spread and include outcome data to tailor spread

Matt's PowerPoint presentation can be found in Appendix B of this Learning Brief.

After Matt's presentation, providers were asked to go into model-specific small groups and reflect upon the goals they had set during the last Learning Session. Providers were asked to consider what change they had recently tested in their program. How that change was introduced and what steps were taken were also asked of providers. Finally, providers were asked to consider next steps to spread that change. *The full notes from this group activity can be found in Appendix C of this Learning Brief.*

> *"We encourage staff to take the data back and share it with their clients so they can visibly see progress or lack thereof."*
> *~Alana Ramos, JWCH IMHT*

Innovation providers spreading change

Selected highlights from Learning Session VIII:

- Several ISM providers now bring medical record information or other data to weekly meetings with clients.
- It is important for clinicians' to "own" the data. Ownership promotes accurate data collection and facilitates the use of data.
- IMHT providers are incorporating team-building activities to promote buy-in and more self-care.
- ICM providers are also trying to bring more clients into discussion around the data.
- Peer providers have implemented open house events in an attempt to promote more outreach and enrollment.

An Overview of Rubrics

Dr. Joelle Greene from the Evaluation Team and Harder+Company presented the concept and purpose of a rubric in order to set the stage for consideration of the Innovation-specific draft rubric later in the Learning Session. Rubrics are tools for assessing complex performance that involve consideration of multiple characteristics, and data sources. *Joelle's Powerpoint presentation can be found in Appendix D of this Learning Brief.*

The Innovation Rubric: Under Construction

After lunch, Debbie Innes-Gomberg introduced a break-out session **around analyzing the draft rubric currently under consideration at LACDMH**. Debbie's introduction reminded people that this is the *first* attempt at a rubric to capture the important work of

What is a rubric?

+ A tool to measure performance along complex dimensions
+ Combines evidence from multiple sources
+ Considers process and quality
+ Ultimately helps to improve performance

Innovation. The purpose of the rubric is to systematically identify models that are successfully achieving client outcomes. The goal of sharing the rubric at the Learning Session was to get perspectives from providers about the developing rubric.

Debbie provided an overview to the domains of the rubric and shared an overview of the process that has been used to develop the rubric thus far. *The draft rubric can be found at the end of Appendix D of this Learning Brief.* Providers spent the afternoon reviewing model-specific rubrics and discussing three key issues: 1. How should rubric elements be weighted? 2. Are there any domains/subdomains missing? 3. Are there specific domains or sub-domains that are more or less relevant to each models? Providers engaged in group discussions with other providers from their same model and shared their thoughts and concerns back with the larger group. Highlights from each presentation are summarized here.

Rubric Weighting: Domains that should be highly weighted

ICM	1. All domains within Quality of Life (Client-Level)
	2. Access to Care (Program-Level)
	3. Cost (Program-Level)
ISM	1. Mental Health Outcomes (Client-Level)
	2. Client Satisfaction (Client-Level)
	3. Outreach and Engagement (Program-Level)
IMHT	1. Mental Health Outcomes (Client-Level)
	2. Housing
	3. Integration (Program-Level)
Peer-Run	1. Quality of Care (Client-Level)
	2. Emergency service use (Client-Level)

Weighting: Domains that should be less highly weighted

ICM	1. Insurance status (Client-Level)
	2. Income and benefits (Program-Level)
ISM	1. Client flow (Client-Level)
	2. Physical health (Client-Level)
	3. Service location (Program-Level)
IMHT	1. Employment / Volunteer / School (Client-Level)
	2. Insurance Status (Client-Level)
Peer-Run	1. Cultural Competency (Client-Level)

Providers were also asked to consider additional domains/sub-doamins. Suggested data sources, when provided, are in parentheses after the suggested domain/subdomain.

Additional domains/sub-domains

ICM	1. Legal issues and involvement – Client Level (Citizenship, involvement in homeless court, number of expungements)
	2. In-patient hospitalization – Client Level (EHR)
	3. Community engagement and partnerships – Program Level (IT Tool, lists of referrals used)
ISM	1. Environmental stressors – Client Level (Agency documentation)
	2. Cultural competency – Program Level (Client satisfaction / perception of cultural competency)
	3. Non-traditional services offered – Program Level *Some tables thought this should be its own domain (Description of services offered, CSS Invoice, Data from focus groups held by Evaluation team)
IMHT	1. Housing – Client Level (Type of voucher / address)
	2. Pre-post Housing outcomes (iHOMS)
	3. *There was not a third
Peer-Run	1. Peer to peer relationship – Client Level (Survey)
	2. Physical health service use – Client level (Self-report)
	3. Elements unique to the peer model

Next steps: Provider Goals

Providers closed out the day by working in program teams to identify one goal area **to improve or change** about their program over the next 3 to 6 months. Providers were encouraged to create SMART goals (**Specific, Measurable, Attainable, Relevant and Time-based)** and to share them with their program teams. Goals and associated tasks were documented on worksheets that the evaluation team scanned and archived.[1]

After the Learning Session, the evaluation team reviewed a total of 23 completed worksheets and identified themes and trends in goals set for each Innovation model.

ISM

ISM providers had two goals occurring with equal frequency across providers. The first goal (identified by five ISM providers) was **to offer more non-traditional services to clients**. Three of these five providers plan to implement nutrition classes and related services for clients. Other non-traditional services mentioned included employment and art. Notably, most of these providers included measurement goals as part of this implementation. The other most frequently documented goal (also found in five providers worksheets) **was to better incorporate iHOMS data** into program activities and operations. Two providers want to incorporate iHOMS data into client discussions and another provider wanted to improve compliance among staff around completion of outcomes measures found in iHOMS.

ICM

ICM providers created goals designed to **improve physical health outcomes** for their clients and to **improve iHOMS data compliance**. To improve data compliance, tasks included better monitoring and increased training of staff (including peer advocates and new hires).

IMHT

Four of the five IMHT providers identified **client-level goals** as areas to work on. This included goals designed to increase the number of clients housed, increased access to education and vocational resources and improve family-support mechanisms. Two of the five IMHT providers identified **staff development goals** as part of program improvement. For instance, one provider identified staff self-care and team building as a goal. One provider created a goal to **use iHOMS data to inform practice** by incorporating it into the morning case conference meetings.

Peer-Run

Both peer providers set goals around implementing robust and structured outreach and engagement strategies to increase program enrollment and referrals.

> Learning Session IX will be held on October 30, 2014 at The California Endowment.
> *Hope to see you there!*

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[1] A copy of your provider worksheet may be obtained from your INN contact person or by emailing nmcgovern@harderco.com.

Appendix A

Appendix A contains slides from the PowerPoint presentation presented by LACDMH's Debbie Innes-Gomberg about data-informed decision-making.

Innovation Learning Session VIII
Data Informed Decision-Making

Debbie Innes-Gomberg, Ph.D.
District Chief
Los Angeles County-Department of Mental Health
Program Support Bureau
MHSA Implementation and Outcomes Divisions
July 17, 2014

A Brief Review Of How We Got Here

- Measurement elements identified by reviewing the service integration literature and national standards
- Intentional focus on outcome measures vs. process measures
- Measures follow from program design and program expectations
- Interim measures collected

A Brief Review Of How We Got Here

- Evaluation RFS drafted. UC San Diego selected.
- UC San Diego conducted focus groups to obtain feedback on measures to select
- Measures selected, iHOMS data fields developed
- Training on measures and iHOMS use
- Data quality and outcome reports developed and distributed

DMH and Provider Use of Outcome Data for Decision-Making

- Continual assessment to articulate learning
- Systemically, using data to inform and infuse services
- Understanding the role of the Innovation component as an informational feeder for CSS and PEI
  - Innovation as a learning lab
  - Need to create an expectation that successful projects will be continued, intentionally dedicating funding in CSS and PEI each year
  - Innovation is primarily about **learning**

DMH and Provider Use of Outcome Data for Decision-Making

- The morning will be focused on provider small scale tests and using that information to guide services and decision-making within your agency
- The afternoon will be focused on a presentation of a draft evaluation rubric, with small group discussions to following to gather your feedback about how DMH might best use the outcome data to make decisions about:
  - Model success and continuation
  - What measures/indicators have the greatest impact on integrated care
  - Best practice strategies to infuse into service system
  - Qualitative data by model not captured in the evaluation that will contribute to learning about the model and will round out the evaluation

Time Line and Process for Decision-Making

- July 2014: Provider feedback
- July-August 2014: Discuss with EMT the methodology for decision-making and recommendation for increased funding for successful models
- September 2014: Presentation to SLT on INN projects, methodology for evaluation, preliminary INN results
- Final Outcome report-December 2014/January2015
- Recommendations to EMT-January 2015

Appendix B

Appendix B contains slides from the PowerPoint presentation presented by LACDMH's Matt Wells about the concept of Learning Spread.

The Sequence of Improvement & Spread

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Testing, Implementation & Spread

- **Testing-** Trying and adapting existing knowledge on a small scale. Learning what works in your system. *Change is not permanent, Failure is expected, Smaller number impacted than during implementation.*
- **Implementation-** Making this change a part of day-to-day operation of the system. *Don't expect failure here, more people impacted than during testing, increased resistance, Requires more time to roll out.*
- **Spread-** Adapting changes to areas, programs, or populations other than your pilot population.

A Framework for Spread
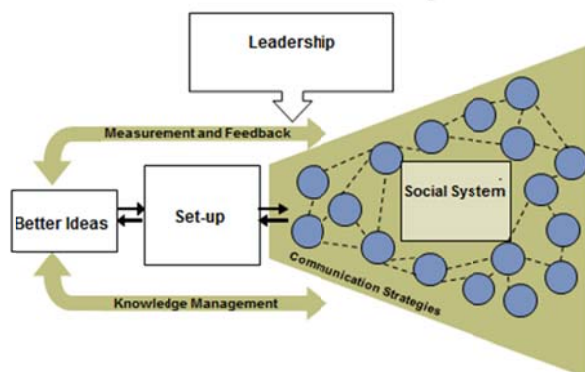
Langley GJ, Nolan KM, Nolan TW, Norman CL, Provost LP. San Francisco: Jossey-Bass; 2009

Leadership is Key:
Are We Ready for Spread?

- Topic is a Key Strategic Initiative
- Goals and incentives are aligned
- Executive sponsor is assigned
- Day-to-Day Managers are Identified
- A spread team has been put in place
- Successful Sites are Identified

Identify the Ease of Spread for your "Better Ideas"

- **Perceived Benefit:** Do others feel that the selected change can help? *Perception is very important.*

- **Compatibility:** Alignment with the values, beliefs, history, and current needs of your organization.

- **Simplicity:** Simple Changes Spread faster than complicated ones.

- **Trialability:** Ability to test the change on a small scale without implementing it everywhere first.

- **Observability:** The ease with which potential adopters can watch others try the change first.
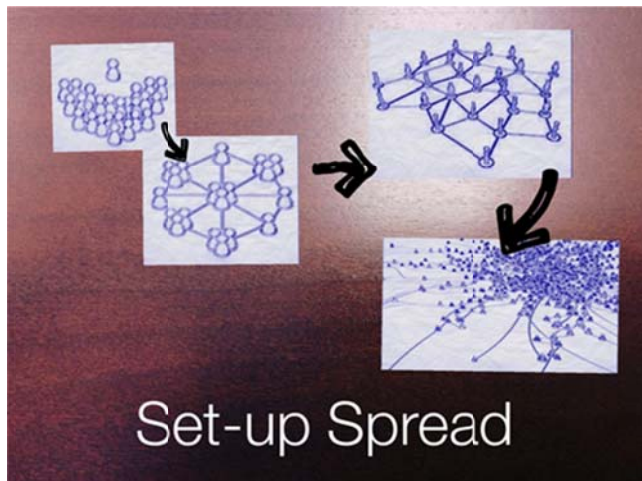
Set-up for Spread

- **Establish an Aim for Spread:** Clearly what is being spread (successful changes)? *Target goals, target populations, timeframe, approach to spread.*

- **Develop an Initial Plan for Spread:** What are you spreading? Who will be the audience for the spread? Which are your successful "sites"? What is needed (tools, skills, staff)? Who are your key partners (Opinion Leaders, Champions, Early Adopters)?

Communication & Knowledge Transfer

- Identify and engage the appropriate members of the Social System. Include champions, those with experience who can mentor, those with formal and informal influence, the preexisting networks or 'communities" of practice that already exist.

- Consider the ways that the social system exchanges information: Training, Morning Meetings or Team Huddles. Do you need to create a learning network?

Communication Plan

- Know your audience: Who is your target audience for the interventions or changes your are spreading? What are the messages that would be most effective for each audience?

- Know your communication channels and methods for spread. Build awareness. What are all the ways you can get the word out? Meeting, email, videos, brochures, paystub stuffers, written material, web-based learning, conference calls

Measurement & Feedback

- Two types of measures needed:
    1.) Measures that demonstrate the extent of spread
    2.) Measures that demonstrate the outcome of changes being spread.

- How will information regarding these measurements be shared with key leadership and through out to those invested in the change effort?

How to Apply Innovation Learning

1.) Consider piloting change in a small setting first. This can help to identify and learn to overcome implementation barriers. The opinions of frontline staff are crucial in understanding what worked and didn't in the process.

2.) Spreading change is a team effort that requires infrastructure support to sustain change. Consider who from your Agency needs to be part of the team? Executive Leadership? Management? Staff? Consider what supports are required to sustain the change? Staff support? Training and mentoring? Regular team meetings?

3.) Outcomes data helps tailor successful spread. How frequently is your team looking at data? What is the feedback loop for using data?

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Appendix C

DMH Learning Session, Morning break-out sessions by model

This appendix contains notes transcribed from providers' small group morning discussion. Providers from the same model reflected on what they had implemented since the last Learning Session where goals were identified. Providers were asked to identify what changes they tested in their programs, what they learned and the next action steps. These notes are transcribed verbatim; the evaluation team only corrected spelling where necessary.

Table #1 ISM	**What change was implemented?** *Change* ➢ Getting FQHCS more involved ➢ Obtaining participation data from partners ➢ Improving communication with partners/FCQHCS. Bringing needed medical record information to weekly meetings with patients ➢ Substance abuse counselor doing outreach to potential patients ➢ Invite to "platica" workshop *Introduction of Change* ➢ Discuss with staff small increments of change ➢ Involve staff in the development of policies and procedures for a program that can be replicated ➢ Identify other partners that can be receptive to working together ➢ Discussing in staff meetings outcomes of Learning Collaborative **Action Steps/Priorities for next 3-6 months** ➢ Getting better at using the iHOMS data/partner data to identify better outcomes ➢ Be more aware of what is going to happen with innovation programs to be able to make decisions for the future ➢ Get medical providers for substance abuse and use/alcohol use and provide a warm hand-off to the substance abuse counselor

Table #2 ISM	**What change was implemented?**
	➢ Using iHOMS to see if the data from iHOMS matched what clients were reporting
	➢ Looking for consistency (and if not, why?)
	➢ As clients increased understanding of data collection, some increase in accurate reporting
	➢ Strategy: Staff discussed discrepancies
	    ○ Staff was asked to discuss discrepancies with clients to obtain additional information
	    ○ Change was successful

Table #3 ISM	**What change was implemented?**
	➢ Similar to Alma's experience
	➢ Accuracy of reporting vs iHOMS data
	➢ Strategy was presented at the TX team meeting
	    o Staff discussed discrepancies with clients
	    o Still evaluation effectiveness
	➢ Integrating client data into treatment (sharing data with clients and implementing that with other DMH programs

Table #4 ISM	**What change was implemented?**
	➢ Utilizing data in txt meetings
	    o Analyzed data to develop/improve client curriculum
	    o Educate/assist staff to value importance of data
	➢ How do you know if successful?
	    o Used pre/post tests
	    o High compliance with data collection due to relationship with clinical
	
	Action Steps/Priorities for next 3-6 months
	➢ Educated staff on the importance of data
	➢ Share results with clients
	    o Motivator: visible results
	➢ Question: is it possible to get more graphical results?

Table #5 ISM	**What change was implemented?**
	➢ What we learned?
	    o Improve compliance with physical health screenings
	    o Attendance to initial screening
	    o Attendance to subsequent screenings
	➢ Consequences: disenrollment from ISM
	
	Action Steps/Priorities for next 3-6 months
	➢ Continued collaboration between providers:
	    o Mental health
	    o Physical health
	    o Substance abuse
	    o Traditional healers
	➢ Brief intervention scripts
	    o Motivational interviewing

Table #6 ISM	**Action Steps/Priorities for next 3-6 months** ➢ Goal: Collect iHOMS data in a more systematic way. Emphasize the clinical utility of outcome measures. ➢ Outcome: a higher percentage of clinicians and clients are completing the outcome measures. Incorporate the data within the group supervision ➢ Planning: having open discussions about how the change would affect the treatment process.
Table #7 ISM	**Action Steps/Priorities for next 3-6 months** ➢ Goal: To develop a nutrition class to reduce BMI ➢ Outcome: Still in planning phase (already identified resources) ➢ Note: An analysis of client medication regimen found 22% of the clients are on psychotropic meds that may cause weight gain, potentially affecting the increased BMI score.

Table #6 ISM	**What change was implemented?**
	➢ Asked clinicians to use iHOMS outcomes in tx
	    ➢ Use data more
	    ➢ We expected some difficulty. Clinicians' ownership/benefit to clients.
	    ➢ iHOMS completion process beneficial to tx.
	➢ Created "worksheet"
	    ➢ Presented on how to interpret iHOMS data at collaboration meeting.
	    ➢ Asked to implement and followed up at collaboration meeting
	➢ Lessons learned:
	    ➢ Too formal
	    ➢ Overwhelming
	    ➢ Pick/choose
	    ➢ New layer: use in consultation

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	➤ Lessons learned:
	   ➤ Too formal
	   ➤ Overwhelming
	   ➤ Pick/choose
	   ➤ New layer: use in consultation

	General ISM questions: ➤ What's going to happen to the current clients that are now enrolling in ACA? ➤ At the end of the ISM, what happens to those individuals that are indigent and in need of culturally competent services? ➤ If the future of ISM is based on iHOMS measures, the data collected is not necessarily culturally sensitive (i.e. it doesn't make sense in Farsi or Armenian).

Table # 7 Peer	**What change was implemented?**
	➤ Tried to increased referrals (10 in 3months); achieved 7 (PRISM)
	   o Educated district chiefs on program; ongoing education at providers
	   o Success = more referrals
	➤ Talking to district chiefs- and asked them to advocate to agencies, and at SLT as well as teams doing outreach/ed
	   o More hands on approach; working with impact meeting with potential referrals at their home/facility meeting people where they were (physically)
	   o Problem in capturing some successes in iHOMS for people who are receiving services but not at SHARE location, (still successful linkages) changes in person before they begin in iHOMS
	
	Action Steps/Priorities for next 3-6 months
	➤ Need to spread strategy to other agencies
	➤ Want to also use word of mouth of past service recipients

	What change was implemented?
Table # 8 Peer	*Outcomes*
	➢ More robust outreach, intentional and with defined outcomes
	➢ Open house events at house
	➢ Going to agency staff meetings, building community relationships
	Trainings
	➢ Staff are relating to guests in a different way
	○ Emphasizing self-help, difference in nature and tone of interactions
	○ When receiving a referral for another agency, SHARE emphasizes helping the person develop a unique relationship with the agency (more trust) and setting it apart from their experience with other MH agencies
	Action Steps/Priorities for next 3-6 months
	➢ Continuing with attendance at SAC meetings with MH navigator and District Chief relationships with use DMH template for tracking referrals
	○ Also created a referral form internally

	What change was implemented?

Table #7 IMHT	➢ What have we learned?
	    o ETOH use going up
	    o Once housed increasing
	        ▪ How to prevent use from going up?
	    o Pro-active rather than reactive
	    o Promoting self-care within Team
	        ▪ Check-in beginning of morning meeting
	        ▪ Positive thinking focus
	        ▪ Team building creates feelings of safety for staff
	    o How to use data more effectively?
	        ▪ Staff need to know how it is useful
	        ▪ Make doing data fun!
	        ▪ How to use time smarter
	    o Death and dying is major part of any IMHT program
	    o More clients into lower level of care using IMR MORS
	    o Creating team/making fun
	➢ Using what we learned
	    o Focused on the MORS and making sure it gets done
	        ▪ The iHOMS were completed
	        ▪ Reduction in incomplete data
	    o iHOMS alerts has caused an awareness to client behaviors that are not self-reported to staff
	        ▪ Collaborative discussions
	        ▪ Pulled the PM into the loop
	    o introduced the change in the morning meeting to use data alerts to notify the team of client self-reports in assessments
	        ▪ Cut and paste alerts to the team: discussions in the morning meeting
	        ▪ Invited UC San Diego to present iHOMS
	    o Started doing print outs to show how valuable the data is. Seeing the data made them feel more involved
	    o Owning it, finding value to spread beyond our program. Have a specific staff member to focus on the process

Table # 8 ICM	**What change was implemented?**
	➢ Increase physical health outcomes
	➢ Walking group- CM
	➢ S.M.A,R.T. goals for physical health (modified)
	➢ Training for staff regarding connecting MH symptoms and physical health
	➢ Encourage staff to have physical health goals
	➢ Engage more with physical health appointments to incorporate information
	➢ Summary:
	    o Changes in agency-wide staffing to improve program outcomes
	    o Increase incorporating mental health symptoms-physical health outcomes
	        ▪ Using social aspect/network
	            • Walking groups
	            • Nutrition groups (LAGBTC)
	            • YMCA memberships (with CSS funds)
	            • Increase review of iHOMS

Table #9 ICM	**What change was implemented?**
	➢ Increase enrollment by hiring staff
	    o 50% of goal met
	    o Some increase in enrollment
	    o Changed recruiting strategies
	    o Agency-wide change to influence retention- improve program goals

Table #10 ICM	**What change was implemented?**
	➢ Improve IMR compliance
	    o Re-education on the data
	    o Restructure system
	        ▪ Take screenshots and share with staff
	    o Retraining
	        ▪ 70%- June
	        ▪ Hired QA/QI to focus on iHOMS

Table #11 ICM	**What change was implemented?**
	➢ Introduce physical health and partner with YMCA
	    o Challenges: YMCA not returning calls
	    o Use CSS funds new YMCA in East LA
	        ▪ YMCA will provide monthly reports
	    o Client interests were inconsistent
	        ▪ Focus on a smaller amount of clients
	        ▪ Independent living skills group
	        ▪ 3 month memberships, monitor physical health indicators (BMI, weight)
	            • Peer staff

Appendix D

Appendix D contains slides from the PowerPoint presentation presented by Dr. Joelle Greene of the evaluation team and Harder+Company. The slides are about the concept and use of a Rubric.

Evaluative Rubrics

What they are, how they're created and what you can do with them

LACDMH INN Learning Session
July 17, 2014

Building a boat

Example of a Task Specific - Boat design

Novice Boat Builder	Apprentice Boat Builder	Master Boat Builder	Mentor Boat Builder
My boat lost its shape or sank as soon as I put it in water.	My boat floated for a while and then started to leak before the end of the time trial.	My boat floated, moved, and was air tight for at least 5 minutes.	My boat floated, moved, and stayed airtight long past the end of the time trial.
Before I let go, I was pretty sure it wasn't going to work like I planned. It doesn't look like my schematics (or if it does, it's because I changed them after I built my boat.)	Before I let go, it looked like the design but was missing some parts or I added new parts before the test without updating the schematics.	Before I let go, it looked exactly like the final schematics and moved just about how I expected. I can tell you about the evolution of my design.	Before I let go, it looked exactly like the final version of the schematics. I can show how my design improved based on schematics from test runs.

Rubric characteristics

+ Systematic and transparent

+ Interpretative guides for evidence

+ Build shared understanding

+ Provide "evidence pictures/scenarios"

Where do rubrics come from?

+ Tool for assessing quality of student performance

+ First published references in early 1980's

+ Adopted as a broader approach to evaluation in last 10 years or so

Sample Evaluative Rubrics

How Do You Create a Rubric?

Recalibrate → Identify criteria → Distinguish performance levels → Create boundaries → Seek input → (cycle)
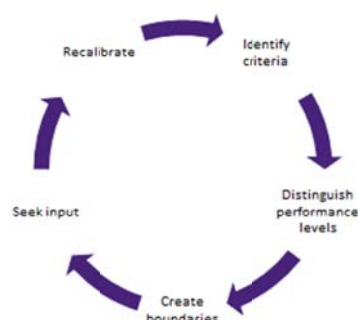
Rubrics may be very criterion-specific

Rating	Description
Highly Effective	• Parents/whānau are extremely well-informed, confident and highly engaged in their children's education in ways that maximize the children's potential. • Parent and whānau knowledge and perspectives are well respected, highly valued and fully integrated in ways that benefit the children's education. • Māori content and language are clearly evident and infused in ways that are appropriate for local whānau
Minimally Effective	• Levels of parent/whānau/caregiver engagement are just sufficient to support children's education, although there is significant room for improvement • The school demonstrates understanding of Māori, Pasifika and other cultures, including the concepts of whānau, co-parenting and other family structures.
Poor or Detrimental	Any one or more of the following: • Levels of whānau engagement are extremely low or are deteriorating – to an extent that adversely impacts children's education • Whānau report being talked "at" or down to, made to feel unwelcome or stupid, or that their perspectives are disrespected or sidelined • Information is either withheld or presented in ways that prevent meaningful whānau involvement

Source: MOE Projects

Rubrics can be generic, to be applied across a range of questions/criteria

Performance Rating	Performance Descriptors for Answering Key Evaluation Questions
Excellent	Performance is clearly very strong or exemplary in relation to the question. Any gaps or weaknesses are not significant and are managed effectively.
Good	Performance is generally strong in relation to the question. No significant gaps or weaknesses, and less significant gaps or weaknesses are mostly managed effectively.
Adequate	Performance is inconsistent in relation to the question. Some gaps or weaknesses. Meets minimum expectations' requirements as far as can be determined.
Poor	Performance is unacceptably weak in relation to the question. Does not meet minimum expectations/requirements.
Insufficient Evidence	Evidence unavailable or of insufficient quality to determine performance.

Source: NZQA's External Evaluation & Review Framework

Rubrics can combine quantitative and qualitative data

Rating	Quantitative Data	Qualitative Data
Excellent (Always)	90% or more agree with statement	Clear example of exemplary performance or best practice in this domain; no weaknesses
Very Good (Almost Always)	80% - 90% agree with statement	Very good to excellent performance on virtually all aspects; strong overall but not exemplary; no weaknesses of any real consequence
Good (Mostly, with some exception)	60% - 80% agree with statement and no more than 15% disagree	Reasonably good performance overall; might have a few slight weaknesses but nothing serious.
Adequate (Sometimes, with quite a few exceptions)	40% – 60% agree with and no more than 15% disagree	Fair performance, some serious, but non fatal weaknesses on a few aspects
Poor (Never, or occasionally with clear weaknesses evident)	Less than 40% or more agree with statement	Clear evidence of unsatisfactory functioning; serious weaknesses across the board on crucial aspects

Rubrics can combine evidence from multiple data sources

Dimensions and Sub-Dimensions of Evaluation	Advanced	Established	Emerging	Data Sources
Overall Portfolio Rating 1. The portfolio of regional family support strategies are designed to meet the needs of children and families in the region.	At least four dimensions scored as Advanced and no dimensions scored as Emerging At least three sub-dimensions scored as Advanced	At least two dimensions scored as Advanced and fewer than three dimensions scored as Emerging At least two sub-dimensions scored as Advanced	Fewer than two dimensions scored as Advanced or three or more dimensions scored as Emerging Fewer than two sub-dimensions scored as Advanced	2012 Regional Needs and Assets Reports
The strategy portfolio includes programs that:				
1.1 Are a good fit with local conditions and family need for support services.	Strong, clear connection between local conditions and rationale for local strategies	Weaker connection between local conditions and rationale for local strategies	Little/no connection between local conditions and rationale for local strategies	RSL Strategic Framework and Logic Models
1.2 Are designed to be consistent with core "system of care" values (i.e. family centered, child centered, strengths and needs of child and family determine type/mix of services provided, culturally and linguistically competent, community-based, with adaptive infrastructure).	Strong, clear connection between most/all system of care values and selection of local strategies	Connection between some system of care values and selection of local strategies	No connection between system of care values and selection of local strategies	Regional Funding Plans Interviews with First Things First (FTF) Senior Directors, Regional Council
1.3 Are a composite set of programs, address identified service gaps.	Regional strategies address all of identified gaps	Regional strategies only address some of identified gaps	Regional strategies not address identified gaps	Directors and Regional Partnership Council Members
1.4 Aligned with FTF Family Support Strategic Framework and Family Support Conceptual Model (e.g. goals/purposes specified in the FTF family support logic model).	Strategies selected from FTF Family Support Strategic Framework	N/A	Strategies are not selected from FTF Family Support Strategic Framework	

How are quality rubrics different from other tools?

Quality rubrics:

+ Consider process as well as outcome

+ Are developmental in nature

+ Help improve performance

Questions and comments?

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MHSA Innovation Rubric

ICM & IMHT only, ICM only, ISM only

Level	Domain	Sub-domain	Potential Data source
Client Level			
	Quality of Care	Mental Health Outcomes	iHOMS - IMR, CHOIS, PROMIS Mental Health, MORS
		Physical Health Outcomes	iHOMS – Physical Health Indicators, PROMIS Physical Health
		Substance Abuse Outcomes	iHOMS - Reported alcohol/substance use, PROMIS Substance Use scale
		Physical Health Labs (screening)	iHOMS - Physical Health Indicators
		Cultural Competency	iHOMS - satisfaction item
	Quality of Life	Incarcerations	iHOMS - client report
		Emergency Services	iHOMS - client report, IMR
		Employment/Volunteer/School	iHOMS - client report
		Housing (% Homeless)	iHOMS
		Housing Retention	iHOMS – one year
		Income/Benefits	IS
		Insurance Status	IS
		Stigma	iHOMS - ISM
	Client Satisfaction	Client Satisfaction	iHOMS - MHSIP
Program Level			
	Data Compliance	Data Compliance	iHOMS
	Access to Care	Clients served relative to target	iHOMS, IS – demographics, diagnosis, location
		Client flow	iHOMS - discharge data
		Cultural Competency	IS – staff languages; iHOMS - client languages
		Clients receive desired care	iHOMS - client satisfaction
		Service Location	IS, provider report
		Office Visits & Service Use	IS, EHR
	Staffing	Staff Satisfaction	iHOMS - staff satisfaction
		Staff Development	ITTool
		Peer involvement	ITTool, staff satisfaction survey
		Leverage of Funding	CSS
	Cost	Cost	IS
	Integration	Integration Efforts	ITTool Report, SNA, iHOMS - client satisfaction and staff satisfaction
	Outreach & Engagement	Client Engagement	iHOMS - MORS score, client satisfaction
		Success in reaching target population	iHOMS demographics, Outreach survey

Appendix E

This appendix item contains learning session participants' suggestions for future learning session activities or topics.

- Incorporating client input on programmatic level.

- How to talk to clients about their iHOMS reports?

- Discussing more clinical items rather than data solely

- UMM/SSG (Weber) would like to present our policy/procedure manual and discuss the process of creating and developing it. Discuss ways to use it. Can be replicated in other AAA communities.

- Discuss how UMMA & Weber collaborate on many other project(s) that originated from ISM partnerships, ex. Pathways, etc.

- Review examples of forms created by different agencies to track effectiveness (or lack of) non-traditional services.

- Community connectedness strategies

- Effective outreach strategies

- Inviting primary care collaborative corporations to be part of the discussion.

- Non-traditional service outreach & sustainability to collaboration.

- Time to discuss INN questions/concerns, examples:
  - iHOMS – culturally sensitive
  - iHOMS reports for individual clients that can be given to them
  - Easier ways to discharge clients from iHOMS (can iHOMS talk to IS system)
  - Plan for undocumented patients post June 2015

Innovation Learning Session IX

Learning from Innovation Model Program Successes

Learning Brief

October 30, 2014

Los Angeles County Department of Mental Health Innovation providers, staff, and evaluation team members held the ninth quarterly Learning Session on October 30, 2014 at the California Endowment. Attended by 105 people, this Learning Session included updates about the INN rubric, a provider panel focused on promising practices, preliminary findings from the Integrate Treatment (IT) Tool follow-up interviews, an activity to help identify and implement learning spread, and a presentation about strategies for using qualitative data as part of evaluation.

LACDMH's Debbie Innes-Gomberg welcomed participants and opened the session. In her opening remarks, she acknowledged the tenth anniversary of Proposition 63, the *Mental Health Services Act*, which made the Innovation program (INN) possible. The time-limited nature of Innovation, coupled with a focus on evaluation and data, has proven useful for testing new models of service delivery so that the mental health services community can learn. As this implementation of INN in Los Angeles County moves into its final months, Debbie emphasized the importance of the learning that has taken place and indicated that LACDMH is striving to incorporate what was learned in this effort into all programs.

Debbie and members of the evaluation team (*Marisse Goode, UCSD, and Nicole McGovern, Harder+Company*) provided a brief overview of the final weightings for each domain of the decision-making rubric. The rubric was developed as a way to quantify program performance considering a variety of data.

Panelists share promising practices from INN programs.

Innovation Promising Practices – A Provider Panel Discussion

Providers from each model were invited to share promising practices that have emerged as a result of learning during Innovation. Evaluation team member Nicole McGovern facilitated a panel discussion with providers from each model to learn more about what each organization has learned, changed and will spread as a result of their experiences in the INN program. Presentations were organized around the following questions:

> "Incorporating any type of mindfulness is really beneficial with staff and clients. We did a good job with integration, but this program really helped tie things together."
>
> ~Saban Community Clinic

+ What is your promising practice?
+ Why do you consider it "promising"?
+ How has this practice impacted clients?
+ How can other programs use what you've learned?

Table 1 incudes a summary of practices and program impact for others who may be interested in implementing similar activities in their programs.

Table 1. Summary of Promising Practices	
Model/Provider	**Practice and Impact**
Saban Community Clinic (ICM), presented by Paul Gore	**Practice:** Developed and implemented a "mindfulness" program. Mindfulness was initially one in a series of topics covered in a ten week sleep class. Clients expressed a great deal of interest in mindfulness as a topic, so it was developed into a mindfulness group. **Impact:** The mindfulness group has proven effective in helping clients with anxiety manage their tension levels. The Saban staff developed a tool to measure changes in tension as a result of the program. They found an average decrease of 30% in tension scores after the ten week class.
St. Joseph Center (IMHT), presented by Erin McGinnis	**Practice:** Increased motivational interviewing, DVT, critical time intervention, and a team approach to identifying and developing treatment plans focused on reducing alcohol abuse. IHOMS data indicated to the team that clients were underreporting substance use so the team developed an approach to improve assessment. **Impact:** The team shared a case of a client who was initially so severely intoxicated that he could not keep appointments. They team worked together to develop a treatment plan which focused on linking the client back to his social support system. The client ended up moving back home and has shown a significant decrease in alcohol use.
The LA LGBT Center (ICM), presented by Amy Kane	**Practice:** Developed a Yoga class as part of a total wellness approach. The class was designed to help people improve mobility and to relieve stress. The team has developed a questionnaire to assess stress at the beginning and end of the class series. They used a nurse who was also certified to teach Yoga as the instructor for the course. Since the nurse was aware of clients' health issues, she could tailor the poses and stretches specifically to their individual issues. **Impact:** The Center shared a story about a client who entered the program with very restricted mobility and as a result is now able to walk 2 miles. An unintended consequence of the class was that it provided clients who were

	socially isolated to connect with other for social support. The team reported that some class members have gone out for coffee and are taking other classes together at another site. They have also seen preliminary reductions on the stress questionnaire they developed for the class.
SHARE! (Peer-run), presented by Stephanie Jones and Patrick Chavez	**Practice:** Linking clients to peers and the community to build trust and help clients take ownership of their own recovery. SHARE! has started to receive referrals from other providers and Peers have been effective at building trust among clients and the team at Scharp, which happen to be co-located but are not formal partners in the program. **Impact:** Helping clients build trust with the team at Scharp is important to ensure clients receive needed medical services. Linkages to the community have helped clients establish relationships with one another. The team shared a story of a client who experienced a great deal of anxiety over the loss of her mother. She organized a Mother's Day celebration with her peers; the event was entirely peer-led and great success.
PACS (ISM), presented by Mariko Kahn	**Practice:** Instituted a traditional Buddhist Blessing Ceremony as part of the program. Historically, there have been strong religious ties in the Cambodian community and monks were seen as important sources of information and education. The team learned a great deal from their initial outreach efforts, which failed to depict a Cambodian style Buddha. **Impact:** To date PACS has conducted five Blessing Ceremonies with 62 client participants and far more staff, family members and friends. According to staff, Blessing Ceremonies have helped clients feel connected to and more integrated into their community. The ceremonies are seen as empowering clients, since the ceremony itself does not differentiate between clients, staff, family and friends. The Blessing Ceremony has helped the staff understand the importance of food, which has led to the development of a new intergenerational cooking program where older and younger clients will work together to prepare food to feed the monks in their community. Feeding the monks is seen as an important "good deed" in the Cambodian culture.

Integrated Treatment Tool: One Year Later

Evaluation team member Ben Henwood (USC) presented an update about the team's efforts to follow up with providers in order to understand how integration has changed for each model since the year one Integrated Treatment Tool site visits. Key areas that were revisited during follow up calls included:

- Policies and procedures
- Peer support
- Medication reconciliation
- Assessing effectiveness

- Interdisciplinary communication
- Integrated HIT
- Organizational wide training
- Care coordination (ISM only)

Ben also presented a model for thinking about programs' experience of INN along two dimensions, implementation challenges and attitude. This four quadrant model may prove valuable for considering whether programs continue to pursue an integrated care approach after the INN program has ended. *The PowerPoint presentation can be found in Appendix A of this Learning Brief.*

Spreading the Learning: Setting Goals for the Last Quarter of INN

After the lunch break, Matt Wells (LACDMH) introduced the afternoon's first activity, which was designed to help providers identify goals for spreading learning from INN to other programs in their organization. Each participant was provided with a goal-setting worksheet and set of questions to guide discussion. Participants were encouraged to work with other from their own organization and their partner organizations to create goals.

Providers shared some key highlights of their discussions and plans for spreading what they have learned from INN. This included a diverse array of plan, such as creating a white paper to share strategies for outreach and engagement, implementing a "health topic" of the month for mental health providers and increased community building via social activities for clients.

The evaluation team analyzed 24 action plans created by providers during Learning Session IX. Overall more than half of providers (58%) set goals focused on increasing collaboration and integration between and across programs and/or agencies. Thirty-three percent of providers planned to transfer specific learning from INN to another program within their same agency. Nearly 30 percent of providers specifically mentioned an intention to use iHOMS data within a goal, task, or progress measure. Trends by program model are presented below.

ISM

+ **46%** of ISM providers intend to **share successes and lessons learned** with others in their home organization and with other agencies.
+ Proposed methods for sharing information include creating a formal **whitepaper, workshops, and presentations at staff meetings**.

ICM

+ **100%** of ICM programs set goals focused on **increasing the level of integration** among services and between departments. Specific approaches to increasing integration included training physical health staff on trauma-informed services and increasing awareness of physical health in FSP (Full Service Partnership) and Wellness programs.

ISM providers discuss goals for spreading what they have learned from INN.

+ **80%** of programs seek to **increase the capacity of staff** to deliver integrated services via training, presentations, and attendance at professional conferences.

IMHT

+ **50%** of IMHT programs set specific goals to **share what they have learned from INN with other programs** within their home agency.

+ Other goals included team building, presenting iHOMS results to clients, introducing integrated care plans in other programs, and implementing more programs in collaboration with partner organizations.

Peer-Run

+ Peer-run model providers plan to increase the number of assessments completed by their clients and to increase the number of referrals the program receives from other mental health provider organization.
+ One agency intends to develop an action plan to ensure all peer staff members receive training related to administering client assessments in a timely fashion.

Strategies for Using Qualitative Data

Dr. Joelle Greene from the evaluation team (*Harder+Company*) presented strategies for collection qualitative data to round out presentations of a programs' impact and outcomes. She emphasized the need to balance important quantitative outcomes, such as improvement in physical health or recovery, with stories that help stakeholders connect with the experiences of clients. *The PowerPoint presentation from this session can be found in Appendix B.* The topics addressed in the presentation included:

- Story circles, focus groups
- Photo voice/Video voice
- Interviews
- Case studies.

Learning session participants were given the opportunity to experience a simulated Photo voice data elicitation session. Providers were asked to join a table where they selected a photo that was meaningful to them from a group of photos provided by the evaluation team. Each participant was invited to share why they found the photo meaningful with others at their table. Participants were also given the opportunity to read two case studies to get a feel for how this technique might be used to tell the story of their INN program clients. After these two activities, providers were asked to work with others from their program to discuss which of these techniques would be useful for implementation in their program and to determine preliminary plans for using these approaches. In general there was a great deal of excitement around the use of Photo voice and Video voice projects within INN programs, as well as case studies. The detailed notes created by each group are available in Appendix C.

The evaluation team closed this activity by asking each program to submit a photo of their own that speaks to the question: *How has your innovation program impacted your clients or your community?* Providers were asked to submit photos by November 21, 2014 in order to be included in a special project that will be shared at the January 2015 learning session.

Matt Wells closed the session by thanking everyone for their participation and reminding providers that they are welcome to participate in the planning process for Learning Session X by contacting Amber Anderson.

> Learning Session X will be held on January 15, 2015 at
> The California Endowment.
> *Hope to see you there!*

Appendix A

Appendix A contains slides from the PowerPoint presentation presented by Dr. Ben Henwood of the evaluation team (*University of Southern California*) reflecting an overview of the Integrated Treatment (IT) Tool and efforts to assess changes in integration approximately one year later.

Integrated Treatment Tool Follow-Up

Presented by:

*LACDMH Innovation
Learning Session
October 30, 2014*

Benjamin Henwood, PhD, MSW
USC School of Social Work

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ITT Site Visit Reports

Integration at an Individual Innovations Program
Year 1 Observations

CASE WESTERN RESERVE UNIVERSITY

Shawnee

Integrated Treatment Tool "IT"

A Tool to Evaluate the Integration of Primary and Behavioral Health Care

- Organizational characteristics
- Treatment characteristics
- Care coordination/management characteristics

Available at: http://www.centerforebp.case.edu/

Baseline ITT ratings by model

	IMHT	ICM	ISM
Organizational characteristics	3.17	3.33	2.38
Treatment characteristics	3.56	3.18	2.23
Care coordination characteristics	3.54	3.06	2.13
Overall ITT	3.37	3.22	2.28

Follow up calls

- More teams are using data
- Turnover
- Challenges of integrated records ongoing
- New partnerships still occurring
- Most describe huge learning curve

Specific questions we asked about:

- Policies and procedures
- Peer support
- Medication reconciliation
- Assessing effectiveness
- Interdisciplinary communication
- Integrated HIT
- Organizational wide training
- Care coordination activities (ISM only)

Policies and procedures

- Program has integrated care program specific written policies.

- Program has a mechanism/method for updating these policies.

- Program uses these policies to orient new staff.

Peer support

- Program has a peer provider/role.

- Peer support personnel are members of the multi-disciplinary health care team
  (i.e., participate in treatment team meetings, included in interdisciplinary communications, participate in treatment plan development and support, document their interactions in the integrated health record).

Medication reconciliation

- Prescribers communicate with one another or are updated about prescribing decisions made by another prescriber in real time.

- Program has a method for medication reconciliation.

- Reconciliation occurs on a regular basis.

Assessing effectiveness

- Data is shared with clients during treatment.

- Data is reviewed by individual clinicians for treatment.

- Data is reviewed during interdisciplinary team meetings.

- Data is reviewed by program staff to guide program development.

Interdisciplinary communication

- There is 1 central medical record (either electronically or paper).

- Staff have access to all medical records (even if there are separate systems).

- Medical records (whether electronic, multiple systems, or paper) are utilized during team meetings.

Integrated HIT

- Program uses *integrated* (not multiple) HIT medical records.

- All clinical staff has access to information contained with electronic records (even if multiple systems) in real time.

- Electronic records (even if multiple) are used to generate clinical registries to manage population health/program development.

Organizational trainings

- Trainings include mental health, substance use, other health conditions, and interactions amongst them all.

- All staff are trained on integrated care as part of orientation.

- Organization tracks/monitors integrated care trainings.

Care coordination activities

1. Lab and test tracking

2. Referral tracking

3. Medication reconciliation

4. Reminder system

5. Transitions between levels of care

Appendix B

Appendix B contains slides from the PowerPoint presentation presented by Dr. Joelle Greene of the evaluation team (*Harder+Company Community Research*) about using storytelling in evaluation.

Storytelling in Evaluation: Moving Beyond the Numbers
LACDMH Innovation Learning Session
October 30, 2014

There is no greater agony than bearing an untold story inside you."
— Maya Angelou, *I Know Why the Caged Bird Sings*

Evaluation seeks a balance

Qualitative Rich Depth

Quantitative Systematic Aggregate

How storytelling enhances evaluation
o Storytelling values and respects **diverse ways of knowing and learning**
o Stories can be used effectively **alongside statistics**
o Stories speak to a **broad audience**

Collecting stories
o Be systematic
o Good facilitation is key
o Choose a method of facilitation that best fits your community

"Everyone has a story to tell, but many people need help to get their story out." ~The California Endowment

Ways to gather stories
o Story circle
o Storytelling interviews
o Use of photos or video
o Case studies

Story Circle

- Group storytelling
- Participants can build off of each others stories
- Sometimes helps reluctant storytellers
- May offer a good fit with cultural practice

Storytelling Interviews

- Oral histories – can be used to contrast someone's life before and after participation in services
- Institutional memory – staff and participants can help document the history of the organization through stories

Photovoice/Videovoice

- Use of cameras or videos to capture experiences
- Important to frame the task
- Participants interpret and add meaning to their photos/videos

Case studies

- Opportunity to focus on a small number of stories in a great deal of depth
- Can include
  - Biographical information
  - Reason for being involved in your program
  - Experiences in program
  - Challenges, successes and ways lives have changed

Best practice for gathering and organizing stories

- Be consistent and systematic
- Choose facilitators/story collectors carefully
- Record stories as you collect them
- Choose stories strategically
- Consider the ethical implications of sharing stories

Caution

- Stories are most useful when paired with data
- Provide multiple forms of data
- Include a range of perspectives

How can you use the stories you collect?

- Evaluation
- Fundraising
- Public relations
- Policy advocacy

Questions/comments?

Thank you!

For more information:
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Harder+Company Community Research
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Appendix C

This appendix contains notes transcribed from afternoon small group discussion by model. The providers discussed how PhotoVoice and Case Studies could be helpful to their programs. These notes were transcribed verbatim; the evaluation team only corrected spelling where necessary. Highlights from share outs are captured in the body of the learning brief.

<table>
<tr>
<td rowspan="2" style="writing-mode: vertical">Table #1 ISM: JFS; Didi Hirsch; UMMA; Kedren</td>
<td>

Photo Voice Discussion

What does the photo say to you? Why did you choose it?
- Photo of geese:
  - Sense of peace and freedom. I liked it/chose it because I thought it was a beautiful photo. Signifies freedom, movement, independence, nature, outdoors
- Photo of hands in a circle
  - Chose because it shows multicultural unity. Together they form a star with their fingers. Symbol of synergy.
- Photo of woman showing her muscles
  - Says accomplishment, self-worth, independence, confidence
- Photo of couch outside
  - Reminds me of S. LA where I work and spend most of my time. Lots of homeless around. Reminds me of guys who would hang out outside our building. We would say hi- share our food.
- Photo of woman and boy close together
  - Reminds me of work we do as therapists. We try to support that family connection- connection between mother and child. Support families.
- Photo of red stop light
  - Indicates busy lifestyle. Have to take time out, relax, refocus to our priorities. To stop be aware of the area- this is not an environment that you want to be in. It just stood out to me.

How would you implement? What would be some questions you have?
- Hesitant to use photos because of confidentiality
  - People may feel like they have to say yes
- We would have a difficult time with video
  - Our clients speak Farsi
- We would not be allowed
- We think for a fairly new program there could be issues of trust

Case Study Discussion

What was compelling about each case study? Why? What was not compelling? Why? How could each be improved?
- The one about the child with asthma is more compelling—it's more interesting, a human story
- The other one is more academic, research oriented
- Too many figures, too complicated
- Many acronyms, boring

Were these case studies different than what you thought of a case study? If yes, how? What would you do differently if creating a case study for your program?
- Make it such that people can relate to it
- Less academic for the client's words

How could your INN program potentially use case studies? How could your agency use case studies for other parts of your work?
- Funders
- Brochures
- Make it "before" and "after", relatable

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Table #2 ISM: TTC Latino ISM; APFC/APHC Chinese ISM

Photo Voice Discussion

How would you implement? What would be some questions you have?

➢ Sharing about program with others (within agency)
➢ Therapy
➢ Team building
➢ Demonstrate integration
➢ A) What does ISM mean to you? (Agency, staff, clients, non-traditional service providers, family and friends, etc.)
  o Stigma/mental health/wellness
➢ B) Whoever involves e.g. clinicians, clients, family members, etc.
➢ C) ISM Team, agency, community, SAAC meetings
  o Exhibit, youtube, company websites, etc.
➢ D) Outside funding, supplemental quantitative data, encourage staff

Case Study Discussion

What was compelling about each case study? Why? What was not compelling? Why? How could each be improved?

➢ Individual case is more compelling because it is more relatable
➢ How to improve?
  o Attach contact info (asthma)
  o Citing quotes from people benefit from program (San Diego County)
  o Make it more visual (San Diego)
➢ SD case study shows impact of program and drives to connect communities

Were these case studies different than what you thought of a case study? If yes, how? What would you do differently if creating a case study for your program?

➢ We used to think case study mainly focuses at the individual level
➢ Program/ agent/Issue itself can also be topic of a case study
➢ We would make it shorter, easier to digest and more visual

How could your INN program potentially use case studies? How could your agency use case studies for other parts of your work?

➢ To build clinician skills
  o DMH and DHS, communities (Education and Outreach)
  o Cultural competency training for schools and communities
  o Fundraising
  o Website, annual reports
  o Community outreach

Table #3 ICM: SSG Hopics; Saban Clinic	**Photo Voice Discussion**
	How would you implement? What would be some questions you have?
	 ➤ Be mindful of the audience
	 ➤ There is no right/wrong interpretation/narration
	 ➤ Lead organically and unstructured in the beginning
	 ➤ Create safes pace
	 ➤ Struggle with who/how to share
	 ➤ It's an investigative tool for reaching client
	 ➤ Non-linear approach
	 ➤ Other forms to tell a story
	   o Ex) using pictures from magazine to depict/share a story
	 ➤ Using different social medias to present the project
	 ➤ Choose right kind of questions without giving guidance
	
	Case Study Discussion
	General Feedback
	 ➤ One article was more personal, less structured. The other article was more structured, linear, and more data driven
	 ➤ Improvements:
	   o One needs picture, other needs personal story
	 ➤ Thoughts of a case study as "breathing a sigh of relief"
	 ➤ Using an article like "Breathing a sigh of Relief" to help promote our program and improve client engagement
	 ➤ Share caste studies in larger settings to boost morale
	 ➤ Share it through social media and health promotion/outreach

Table #4: UAII; Alma, Didi Hirsch

Photo Voice Discussion

How would you implement? What would be some questions you have?
- ➢ Use with integrated team
    - o 10 photos in wk
    - o Dr. Chiro, Art Ther. Nurse, psych, yoga instruct/self def instructor
    - o Quest Armunity Exper.
    - o Once everybody takes photo email to facilitator. Will print and discuss
- ➢ Team approach
    - o Shed light on individual personalities, strengths, commonalities
- ➢ Showcase non-traditionals
- ➢ Use as org.
    - o How make program unique from other programs
    - o Community project, voice of community
    - o Capturing how you are taking care of self as provider

Case study Discussion

Individual Case Study
- ➢ To the point (not wordy)
- ➢ Health education as preventative measure
- ➢ Integration of providers
- ➢ Easy to read
- ➢ Raise awareness on an individual level
- ➢ We liked it!

Community Case Study
- ➢ Showed how community came together
- ➢ Raise awareness on community level
- ➢ Administration, policy
- ➢ Research based
- ➢ Too many numbers and acronyms
- ➢ More difficult to read

General feedback
- ➢ Can transcend across programs
- ➢ Can document things not shown in data, collaborative work, cultural work, non-traditional activities
- ➢ Share it with staff, funders, community partners
- ➢ Share it on website, email, conference material
- ➢ Increasing knowledge, raising awareness

<div style="text-align: center">**Photo Voice Discussion**</div>

How would you implement? What would be some questions you have?
- ➢ To help advocate for clients
- ➢ Capture experiences of clients, both positive and negative
- ➢ Empowering clients to have a voice
- ➢ Valuable tool to reduce stigma through client testimonies
- ➢ Souvenir
- ➢ Visual measure of progress
  - o Presentations
  - o Fundraising
  - o Outreach to reduce stigma
  - o Intervention tool

What could be your main question or topic area?
- ➢ What was your life like before?
- ➢ How do you feel the services helped you?
- ➢ What would you say to someone else about services?

Who should take the photo?
- ➢ Clients
- ➢ Family members (with client consent)
- ➢ Case manager

Who/how would you share the results?
- ➢ At agency website
- ➢ Facebook and social media
- ➢ FHQC Lobby
- ➢ Blessing ceremony and non-traditional service locations

How could the results be impactful?
- ➢ Reduce stigma
- ➢ Powerful and inspiring messages
- ➢ More welcoming and real accessible

<div style="text-align: center">**Case Study Discussion**</div>

What was compelling about each case study? Why? What was not compelling? Why? How could each be improved?
- ➢ More compelling
  - o Asthma case study because more personable
  - o Integrative treatment
  - o Detailed action plan
  - o Connected more with story
- ➢ Less Compelling
  - o SD case study because disconnected

Were these case studies different than what you thought of a case study? If yes, how? What would you do differently if creating a case study for your program?
- ➢ Yes- more narrative
- ➢ More relatable

How could your INN program potentially use case studies? How could your agency use case studies for other parts of your work?
- ➢ Funders, marketing website, journals/publications, CBO's location
- ➢ Awareness, motivate community, balance of qual and quant data

Table #5: no provider names noted

Table #6 ISM: Korean and Samoan ISM	**Photo Voice Discussion**
	How would you implement? What would be some questions you have?
	➢ Already using photos and video program in outreach (culture)
	Who should take the photo?
	➢ Use clinically- current emotional state (staff and clients)
	Who/how would you share the results?
	➢ Agency- present client work. Share with other clients
	➢ Community newsletter/magazines
	➢ Display client artwork at outreach booth
	How could the results be impactful?
	➢ Impact: Client empowerment, belonging, normalization
	Case Study Discussion
	General Feedback
	➢ White paper/tool for learning/acquire funding/community
	➢ Annual report/newsletter
	➢ Identify solutions present to funders
	➢ Engage community members

Table #7 PRRCH/PRISM: SHARE!; Project Return Peer Support Network	**Photo Voice Discussion**
	
	What does the photo say to you? Why did you choose it?
	➢ Photo of Boy with Woman:
	    o Love, safety, 2 people have a special connection and I'm not a part of
	➢ Photo of couch
	    o Shelter, artistic, hangout, lonely and cold
	➢ Photo of birds flying
	    o Freedom, home, child memory, soaring in recovery
	➢ Photo of star
	    o Connection, out of different pieces you create something bigger, unity, so much I can't do by myself, togetherness
	➢ Photo of stoplight with one way sign
	    o Reminds me of a past I don't want to be. I don't like being directed to only one way. Do I want to commit to that one way.
	What could be your main question or topic area?
	➢ Anyone can benefit from this environment, mothers, father students, executives, we all have issues and all can recover
	Who should take the photo?
	➢ Residents, providers
	Who/how would you share the results?
	➢ Other providers, other residents
	How could the results be impactful?
	➢ Could increase referrals,
	➢ Reduce stigma
	➢ Help people understand peer services
	➢ Influence policy
	➢ Someone could feel uncomfortable might be perceived as a violation of anonymity, reinforce a negative self-identity
	
	Case Study Discussion
	
	Asthma Story
	➢ Uses personal accounts- more personal
	➢ Told a story from case worker and parents' perspective "experiences, strengths, hope"
	➢ Includes education- what to do
	➢ Caseworker saw how the parents were working hard to help. Showed parents' love- touching
	Latino Story
	➢ Hard to engage. Felt sterile, factual, difficult language/concepts
	    o "2300 pounds of toxic chemicals"
	    o GIS Mapping
	➢ No visual words
	    o Photo
	    o Didn't match the title
	    o Include a personal story
	    o Do a neighborhood photovoice story

Table #8 ICM: Exodus, LAGLC, JWCH/SCHARP	**Photo Voice Discussion** **Clients Taking Photos:** ➢ Use in termination: what do you know about yourself and your life for sure? ➢ With older adults or SA group: before and after photos ➢ Give control to clients, to be creative ➢ Use photovoice in cross-trainings with medical staff, use clients' own words/voice ➢ Scrapbook or poster board on success stories ➢ Give clients a camera and give them instructions to take 5 pics of what their life is like, goals for future ➢ Pictures of what homelessness/addiction/mental illness feels like **Staff Taking Photos:** ➢ What staff sees a client as? Strengths? How is different than clients' perceptions of themselves ➢ Assess staff satisfaction, challenges, and learning as a part of integration ➢ Team building activities ➢ Client interviewing staff to show new clients/new staff what program is about ➢ Community partnerships ➢ Funding opportunities ➢ Documenting milestones in clients' lives **Case Study Discussion** **General Feedback** ➢ Showed both community level and individual level-> ➢ Took pieces of whole story from different perspectives ➢ Something wasn't working- problem presented in a compelling way—use of personal experience, quotes, data interspersed ➢ Used as advocacy for change ➢ Environmental—too technical, too much info, boring- wanted to get to the point, realistic, need to have for policy change ➢ Individual view of mom, human component was better ➢ Lack of evidence to show its working- need more data ➢ Importance of balance! (personal and data) ➢ Use simple data- outcome data, importance of outcome data but not typical in mental health work ➢ Who is target audience? Direct focus to audience ➢ How could we do a case study with client participation and outcome data with photovoice to tell our story? ➢ Need to pick 1 outcome-> can be multi-media ➢ Importance of different perspectives ➢ Does MH intervention improve overall physical health ➢ Use to make the case for ongoing funding, use of awards

Table #9 IMHT	**Photo Voice Discussion** **Main Question/Topic**
	   ➢ Where are you going?
	   ➢ What excites you?
	   ➢ What is your story?
	   ➢ Where is your favorite areas? (place, home, space, etc.)
	Who should take photos?
	   ➢ Clients
	   ➢ S.O.'s (family and "family")
	Who should you share it with?
	   ➢ Client groups
	   ➢ Funders
	   ➢ DMH!
	   ➢ Administrators
	Impact/Usefulness
	   ➢ Potential funding
	   ➢ Affirming, encouraging, inspiring to staff/clients alike
	   ➢ Tangible records of hopes, progress, dreams
	   ➢ Brings goals into focus for clients/staff

Table #10IMHT: SUOS; Exodus; St. Joseph's Center	**PhotoVoice Discussion** **Main Question/Topic**
	   ➢ What have IMHT Services meant to you?
	   ➢ How is your life different today than before?
	   ➢ What does housing mean to you?
	   ➢ What does wellness mean to you? (health, recovery)
	Who should take the photos?
	   ➢ Clients could take photos
	   ➢ Staff could share photos they've taken of clients
	Who to share results with?
	   ➢ Photo exhibit- builds more involvement, build confidence
	Impact/Usefulness
	   ➢ Skill building, reduction in isolation, fosters sense of community sense of pride; to document change; DATA
	
	 Case Study Discussion **What was compelling about each case study? Why? What was not compelling? Why? How could each be improved?**
	   ➢ Breathing- no pictures-> would make it more compelling
	   ➢ Reclaiming Latino Neighborhood- a lot of data- might have been presented differently
	Were these case studies different than what you thought of a case study? If yes, how? What would you do differently if creating a case study for your program?
	   ➢ Add picture, personal stories, emotion
	   ➢ Keep succinct
	How could your INN program potentially use case studies? How could your agency use case studies for other parts of your work?
	   ➢ Programs have used individual case studies to share experiences throughout organizations
	   ➢ Case study of clients of programs
	   ➢ Share on social media, website
	   ➢ Spreads the word

Innovation Learning Session X

Our Journey Together: The Impact of MHSA Innovation

Learning Brief

January 15, 2015

Los Angeles County Department of Mental Health (LACDMH) Innovation providers, staff, and evaluation team members came together for the tenth quarterly Learning Session on January 15, 2015 at the California Endowment ; it was attended by 90 people. The session was organized around the theme, "Our Journey together: The Impact of MHSA Innovation." The day included an overview of the rubric used to make funding recommendations, discussions around learning from Innovation (INN), a panel focused on consumer experiences with the program, and a closing ceremony to celebrate the work and learning that occurred during INN.

LACDMH's Debbie Innes-Gomberg opened the session by reminding attendees that the goal of INN was to create a learning culture (Reinelt et al., 2010). Research suggests that learning cultures require at least five foundational conditions:

+ a supportive environment;
+ trusting relationships;
+ a clear purpose;
+ focus on outcomes and results;
+ and synergistic learning.

This approach supported the development of effective service models and led to positive outcomes for clients. There was also a real shift in the way providers work with LACDMH and each other. This can be evidenced in the interactions in panel discussions among providers and LACDMH staff at learning sessions, especially around outcomes data. The model has been effective, and now the goal is to see how we can continue to foster learning to the rest of the department.

Revisiting the Rubric: A Data Overview

The session transitioned into a discussion of the data being used to inform the rubric that LACDMH developed and will use to guide programmatic funding recommendations. Overall, despite the difference in populations, all three models (IMHT, ICM, and ISM) were successful at improving client's physical health, mental health, and substance use symptoms.

The rubric includes data that were benchmarked both against statistical significance and minimal important difference (MID), a measure that identifies change that may not achieve statistical significance but represents meaningful change in client symptoms. (A copy of the day's presentation, including data tables, can be found in Appendix A.)

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Model-level Data Highlights

While all models were successful at improving physical health, mental health, and substance abuse symptoms, models also had unique strengths based on the population served and treatment approach. Highlights shared during the Learning Session are summarized in Exhibit 1. More detailed findings are available for each model in the presentation found in Appendix A of this brief. The Year 2 INN Annual Report should also be available shortly from LAC DMH. The report contains detailed model-level analyses.

Exhibit 1. Outcome Highlights by INN Model	
Integrated Clinic Model (ICM)	**1,408** clients **39.9%** of clients had clinically meaningful improvement in physical health scores 12 months after enrolling in services **71%** of clients showed clinically meaningful improvements in a clinician-rated measure of mental health (IMR) within 6 months of program enrollment. **73.8%** of clients had a clinically meaningful improvement in a measure of recovery (MORS) ratings 18 months after enrolling in services
Integrated Mobile Health Team (IMHT)	**581** clients **32.5%** of clients had a clinically meaningful reduction in alcohol consumption 12 months after enrolling in services **52.7%** of clients had clinically meaningful improvement in physical health scores 6 months after enrolling in services **72.9%** of clients had a clinically meaningful improvement in a measure of recovery (MORS) ratings 12 months after enrolling in services
Community-Designed Integrated Service Model (ISM)	**1,776** clients **38.3%** of clients had clinically meaningful improvement in physical health scores 12 months after enrolling in services **76.2%** of clients showed clinically meaningful improvements in a clinician-rated measure of mental health (IMR) within 12 months of program enrollment. **88.6%** of clients felt that Innovation staff respected their cultural background 6 to 12 months following program enrollment

Spreading the Learning

We have learned a great deal from the process of implementing Innovation. Three highlights include:

- **Creating a learning culture:** Deliberately coming together for the purpose of learning about what we are doing - learning from one another. Giving ourselves permission to experiment and also to fail in order to learn and improve.
- **Collection and use of outcomes:** The importance of collecting outcomes and using them to improve practice. Sharing the data at learning sessions and setting specific goals around the data was key.

- **Successful practices or approaches to integrated care:** Through the Integrated Treatment Tool and sharing about best practices at Learning Sessions, we learned a great deal about how to deliver integrated care.

Organizations shared how INN practice or learning has spread within their own organizations. Lezlie Murch (ICM/IMHT, Exodus Recovery) shared that the positive experience their program has had using LVN's in the case management role has spread throughout their organization. LVN's were particularly helpful because they could help clients manage and learn to manage their own medications and help focus everyone on physical health care along with mental health. Staff from Tarzana Treatment Center (ISM) shared that their organization has implemented teleconferences to provide information and training to staff about various physical health conditions (such as diabetes) throughout the organization and that everyone is being asked to integrate physical health into service planning.

Debbie Innes-Gomberg also challenged INN providers to share what they have learned via other more geographically centered groups, such as SAACs, provider meetings, ACHSA, CCCMHA, or other organizations.

Operationalizing Learning about Integrated Care

Some providers shared with everyone what their organization had learned about integrated care. Learnings were focused on domains that overlapped with the Integrated Treatment Tool (IT Tool) which has been central to the assessment and development of integrated approaches to care throughout INN. These domains included: Care Coordination, Team Meetings and Communication, Using Outcome Data for Program Development, Staffing/hiring, Outreach and Engagement, Non Traditional Services, and Program-level integration. A summary of each organizations key discussion points can be found in Appendix B.

Providers then broke into small groups (by model) to share additional learning, insights, and lessons with one another. Appendix C contains the notes provided by each group (transcribed verbatim from chart paper). An overview of the key themes across those share outs is provided in Exhibit 2.

Exhibit 2.
Key learning and strategies
+ **Use strategies to promote integrated care.** ICM and IMHT providers shared their efforts to promote integrated systems of care through messaging and practicing integrated care, sharing resources and information between departments, and getting executive level director and managers to invest in integrated services. **+** **Use data to improve case management and service delivery.** Providers talked about how they have used secondary data (i.e. from community partners) and iHOMS data to monitor progress and improve case management, incorporating user-friendly and visual representations of data to share with clients. Some providers noted that data does not currently capture clients' stories or the improvement they have shown. **+** **Implement unique outreach and community engagement techniques.** Nearly all providers shared that they have implemented improved or unique outreach and engagement strategies, allowing them to target specific populations or connect to more community members. For example, PRRCH/PRISM providers created social groups to engage and connect clients with one another and with staff.
Spreading Learning
+ **Increase collaboration and integration between departments and organizational partners.** All providers shared the importance of breaking barriers between partners and departments. Strategies to promote integration included sharing program successes with staff, other departments and agencies, setting up interdisciplinary meetings, identifying ideal partner organizations, sharing best practices with other organizations, integrating traditional and non-traditional partners, and sharing data amongst departments. **+** **Increase connections between consumers, community, and providers.** Several providers discussed ways they plan to increase connections between service providers and the community. For example, PRRCH/PRISM providers shared their plans to break down barriers between staff and consumers by hiring staff with lived experience and connecting consumers to resources with a personal relationship to foster trust and comfort. ISM providers shared that they would like to have a system navigator that works directly in the community.

Sharing our Stories: Consumer and Provider Panel

The afternoon panel included collaborative presentations by consumers and providers. Consumers shared their stories and described the impact of INN programs on the lives of themselves and their family members. Here we share brief excerpts from each client's story.

Valerie, SSG-Hopics ISM.
> *"When I met John he didn't immediately say that I needed medication. He felt that I could just be treated with therapy and that made very comfortable because I had experience with attempted overdose. Everyone (program staff) had knowledge of my health issues and that made me feel more comfortable. They also offered me*

psychiatric services. Hopics is like a family, they made me feel very comfortable…They have been instrumental in my healing process. They have helped me get back in school. I went to Cerritos for a Mental Health Certificate. I have made a lot of progress. It's like a family. Everyone I have come in contact with has made me feel comfortable."

Heidi, Hacienda Hope/Project Return Peer Support Network

"When I got to California, I was extremely hooked on drugs, lost and homeless. I went to a treatment center then had nowhere to go. I heard about Hacienda House through an old navy base that serves veterans…when I got there I was a complete mess. I was sober but mentally I was all over the place. Being at Hacienda House, the peer support there is incredible because they have been through similar situations. That really helped me. They offered me hope. They supported me with my sobriety, keep me on track. When I went there I was always judging myself by my intentions and everyone else there was judging me by my actions. I learned that you have to show people and do the things that you want to do for people to judge you by what you are doing. There was a lot of support and friendliness…Whenever I have a problem or just want to talk I come back. Paula is a great mentor she supports me. Now I have gotten a job and my own house. I am sober. I am going in the right direction. My hope for the future, is because of what I've been through, is hoping to take a peer counseling class and help people that were in my situation."

John, Saban Clinic, ICM

"I have been homeless for about 30 years. I was living with my girlfriend. Sometimes we wouldn't sleep for days. We didn't realize the physical and mental damage we were inflicting upon ourselves. We picked up cigarettes off the ground. We were approached by a group of folks from the Saban Clinic. They were very professional and we decided to take up the opportunity. From the first meeting our lives changed. They made us feel comfortable. We received IDs and Social Security cards, then shortly after that I received an apartment. That was a relief -- with air conditioning! No more alleys. All of my family members are back in my life. I plan on also going back to the places I used to be to reach out to others."

Sam, SHARE, Peer-run/PRRCH

"I was first introduced to SHARE back in October of 2013. I was born here in Los Angeles and in 2001 I was diagnosed as HIV positive. My main way of dealing with that was self-medication and suffered depression for a long time which led me to abuse a lot of drugs. At first I was doing well, I was a lawyer. I ended up turning to meth and cocaine. When you mix meth with HIV medication there is potency with that. I suffered a mental breakdown and ended up homeless…went to county jail and then decided to move in with my father in LA. For a long time I was looking for some support for my substance abuse. I read about Recovery Training and they had a meeting at SHARE and that was how I found out about SHARE. They were friendly right away and I really felt comfortable there. I had heard about another program they ran called PRRCH. For me, it worked great. They take you to a meeting every night. That started to open me up to other programs. Employment has been a goal of mine, so I decided to apply for a volunteer program…It helps me feel less isolated. SHARE provides a great space for anybody come in at any time of day…There is always someone to listen. It gave me a sense that I'm not alone. Going to SHARE helps me feel productive. I feel less isolated and more confident."

Marcy, United American Indian Involvement, ISM

"I'm part Apache and Cherokee. I have learned so much there. I walked in there just for a DV class not knowing I was going to receive all this treatment. I got therapy and then a doctor. I had no idea there were also cultural classes there. I went in because I had a case with DV. Going through that class gave me a voice to get out there and share my story. Talking to the women and empowering one another. It has changed a lot in me. What I plan to do is get out there and

do DART- a community program for DV. My therapy has been amazing… I have learned so much about myself which is very mentally healing. UAII has been spiritually healing because of all the cultural classes they offer. I love the beading class that we take. I have taken sage home and prayed with it. I have also shared what I have learned with my family. I've learned about the historical trauma of Native Americans; I also want to share that with my family…I'm hoping to help women with DV cases. I take care of myself a lot better than I have before."

The panel concluded with a brief question and answer session with the audience.

Closing: A Celebration of Innovation

INTEGRATION INNOVATOR 2012-2015

Los Angeles County Department of Mental Health MHSA Innovation Program

Debbie Innes-Gomberg and Dennis Murata offered closing remarks about the success of INN. They thanked and congratulated all providers, DMH staff and evaluation team members for their part in making the initiative a success. In commemoration of their participation, each provider organization was presented with a framed poster of the INN Photo Voice project, an image of which can be seen to the left. Digital copies of the poster, and of the digital storybook that includes all photos and accompanying captions for each image on the poster can be obtained by contacting Nicole McGovern at nmcgovern@harderco.com.

The Evaluation Team from the Health Services Research Center/UCSD, Harder+Company Community Research, and USC School of Social Work extend their sincerest thanks to all INN participants for making the evaluation and these Learning Sessions possible. We were honored to work with you and look forward to your future endeavors!

Appendix A

Appendix A contains slides from the PowerPoint created by LAC DMH and used throughout the day. It includes data for each INN model, an overview of the weighting for Rubric Domains, and highlights of provider share-outs.

1/15/2015
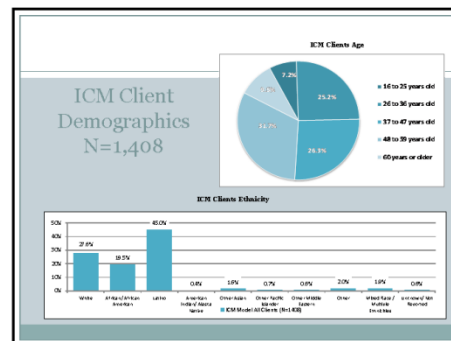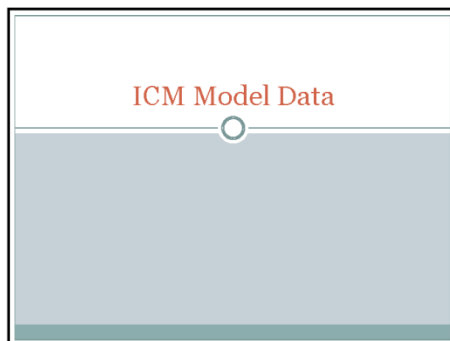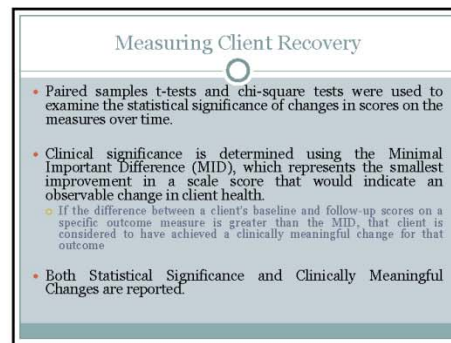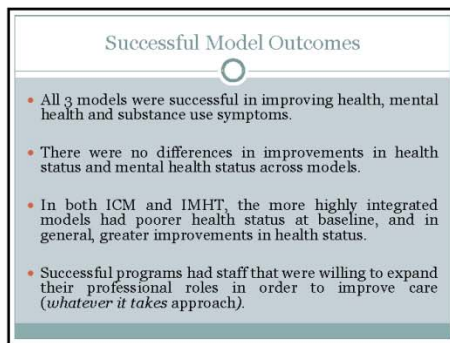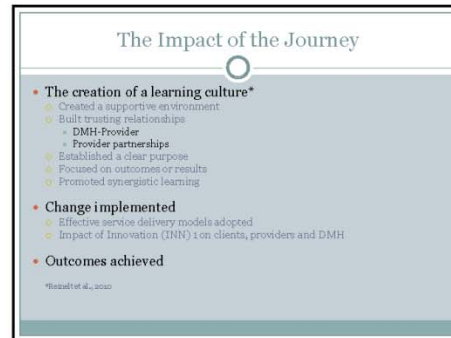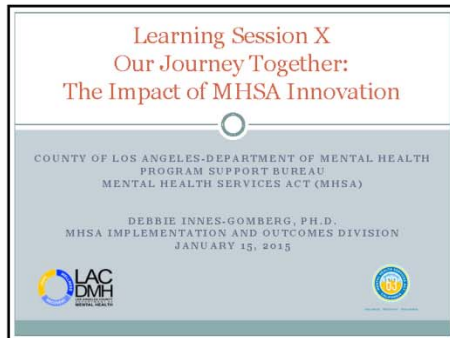
ICM Mental Health Outcomes
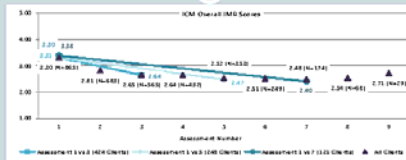
- There were significant improvements on the IMR, a clinician-rated mental health measure, 6, 12 and 18 months after enrollment in INN services, compared to ratings at baseline.
- The majority of ICM clients had clinically meaningful improvement in Overall IMR scores 6 months (71.0%), 12 months (79.4%) and 18 months (81.8%) after enrolling in services.

ICM PROMIS Physical Health
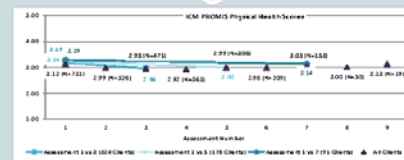
- There were significant improvements in client-rated physical health outcomes 6, 12 and 18 months after enrollment in INN services, compared to ratings at baseline.
- Close to half of ICM clients had clinically meaningful improvement in PROMIS Physical Health scores 6 months (.40.7%) and one year (39.9%) after enrolling in services, compared to baseline.

ICM Milestones of Recovery (MORS)

- Clinicians rated significantly more clients in higher stages of recovery 6, 12 and 18 months after enrollment in INN services, compared to ratings at baseline.
- Approximately 65% of ICM clients had clinically meaningful improvement in MORS ratings 6 and 12 months after enrolling in services, compared to baseline.
- 73.8% of ICM clients had a clinically meaningful improvement in MORS ratings 18 months after enrolling in services, compared to baseline.

ICM Alcohol Use

- Clients reported drinking alcohol significantly less 6 months after enrollment in ICM, compared to ratings at baseline.
- 44.6% of ICM clients reported that they did not use alcohol at baseline and 6 months after enrollment.
- 20.1% of ICM clients had a clinically meaningful reduction in alcohol consumption 6 months after enrolling in services.
- Half (50.9%) of ICM clients reported that they did not use alcohol both at baseline and one year after enrollment.
- 19.9% of ICM clients had a clinically meaningful reduction in alcohol consumption 12 months after enrolling in services. These results were comparable 18 months after enrollment.

ICM Substance Use

- Clients reported using illegal drugs significantly less often 6 months after enrollment in ICM, compared to ratings at baseline.
- The majority (76.0%) of ICM clients reported that they did not use drugs both at baseline and 6 months after enrollment.
- 10.0% of ICM clients had a clinically meaningful reduction in drug use 6 months after enrolling in services.
- Most (80.5%) of ICM clients reported that they did not use drugs both at baseline and one year after enrollment.
- 10.3% of ICM clients had a clinically meaningful reduction in drug use 12 months after enrolling in ICM.
- More ICM clients (90.7%) reported that they had not used illegal drugs within the previous 6 months at the 18 month assessment compared to the baseline.

ICM Use of Emergency Service

There was a significant decrease in use of emergency services 6, 12 and 18 months after enrollment in INN services, compared to baseline.
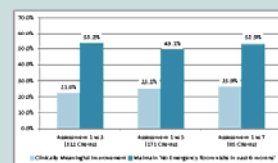
Of those clients that reported visiting the emergency room prior to receiving Innovation services, 25% of these clients reported fewer visits at the 18 month assessment.

2

ICM Cultural Competency and Satisfaction

- Most clients felt that they received all of the services that they needed when assessed at their six and twelve months follow-up visits (83.6%).

- Almost all clients assessed both six and twelve months after enrollment felt that Innovation staff respected their cultural background (87.0%) and beliefs (81.5%).

- The majority of ICM clients (79.2%) reported being satisfied with the integration of their physical and mental health services at their six and twelve month follow-up visits.

ICM Stigma
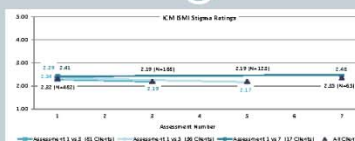
- Compared to baseline, there was a statistically significant reduction in experienced mental health stigma 6 months after enrollment in INN services.

- Many ICM clients reported experiencing less stigma both 6 months (35.8%) and 12 months (44.4%) after receiving services, compared to baseline.

IMHT Model Data

IMHT Client Demographics N=581
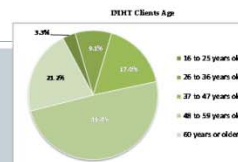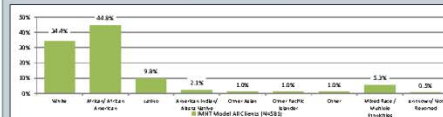
IMHT Mental Health Outcomes
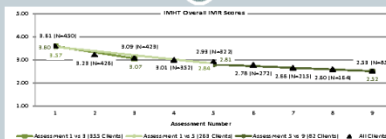
- IMHT clients had significant improvements on the IMR, a clinician-rated mental health measure, 6 and 12 months after enrollment in INN services, compared to ratings at baseline. Clients continued to significantly improve between 12 and 24 months after first receiving INN services.

- The majority of IMHT clients had clinically meaningful improvement in Overall IMR scores 6 months (65.4%) and 12 months (74.9%) after enrollment.

IMHT Milestones of Recovery (MORS)

- Significantly more clients were rated in higher stages of recovery 6 and 12 months after enrollment in INN services, compared to clinician ratings at baseline. IMHT clients' recovery continued to improve significantly during their second year of services, when compared to MORS ratings at 12 months.

- The majority of IMHT clients had clinically meaningful improvement in MORS ratings 6 months (60.1%) and one year (72.9%) after enrolling in services, compared to baseline.

- 45.6% of IMHT clients had a clinically meaningful improvement in MORS ratings 24 months after enrolling in services, compared to ratings at 12 months.

3

IMHT PROMIS Physical Health
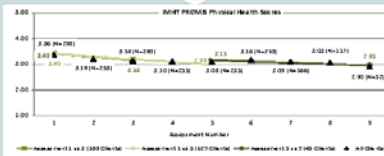
- There was a significant improvement in client-rated physical health 6 and 12 months after enrollment in INN services, compared to ratings at baseline.
- 52.7% of IMHT clients had clinically meaningful improvement in PROMIS Physical Health scores 6 months after enrolling in services, and over half of clients (52.7%) had clinically meaningful improvements 12 months after enrollment when compared to baseline.

IMHT Alcohol Use

- IMHT clients reported drinking alcohol significantly less one year after enrollment in INN services, compared to ratings at baseline.
- 23.3% of IMHT clients reported that they did not use alcohol at both baseline and 6 months after enrollment.
- 26.1% of IMHT clients had a clinically meaningful reduction in alcohol consumption 6 months after enrolling in services.
- 26.2% of IMHT clients reported that they did not use alcohol at both baseline and one year after enrollment.
- 32.5% of IMHT clients had a clinically meaningful reduction in alcohol consumption 12 months after enrolling in services.

IMHT Substance Use

- Many (38.3%) IMHT clients reported that they did not use drugs at both the baseline and 6 months after enrollment.
- 25.1% of clients had a clinically meaningful reduction in drug use 6 months after enrolling in services.
- 40.3% of IMHT clients reported that they did not use drugs at both the baseline and one year after enrollment.
- 28.2% of IMHT clients had a clinically meaningful reduction in drug use 12 months after enrolling in services.

IMHT Incarcerations
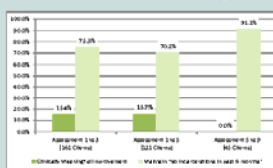
There was a significant decrease in incarcerations 6 months after enrollment in INN services, compared to baseline. There was also a significant decrease during the second year of INN services.

The majority of IMHT clients reported that they had not been incarcerated at baseline, and the 6 and 12 months assessments. Almost all clients (91.1%) reported they were not incarcerated between 12 and 24 months.

IMHT Use of Emergency Service

There was a significant decrease in use of emergency services 6 and 12 months after enrollment in INN services, compared to baseline.

Of clients who had visited the emergency room prior to receiving Innovation services, the percentage of clients with fewer ER visits increased during each subsequent assessment period during the first year.
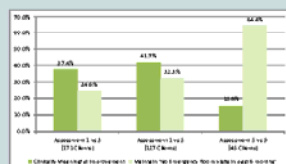

IMHT Homelessness
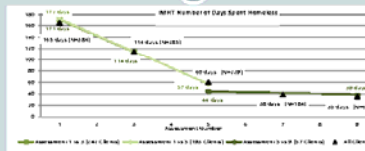
- Compared to baseline, IMHT clients spent significantly fewer days homeless 6 and 12 months after enrollment in INN services.
- Many IMHT clients (40.1%) reported a clinically meaningful reduction in the number of days spent homeless 6 months after enrolling in services, when compared to baseline.
- More IMHT clients (69.9%) experienced a clinically meaningful reduction one year after enrollment in IMHT.

4

IMHT Cultural Competency and Satisfaction

- Most IMHT clients felt that they received all of the services that they needed when assessed at their six and twelve months follow-up visits (85.3%).

- Almost all clients assessed both six and twelve months after enrollment felt that Innovation staff respected their cultural background (81.8%) and beliefs (88.2%).

- The majority of IMHT clients (84.8%) reported being satisfied with the integration of their physical and mental health services at their six and twelve month follow-up visits.

IMHT Stigma Reduction
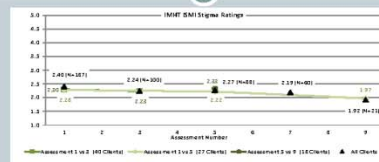
- While there were no significant changes in experienced stigma between baseline and 12 months, there was a significant reduction in stigma during the second year of services for IMHT clients.
- Many IMHT clients reported experiencing less stigma both 6 months (25.0%) and 12 months (25.9%) after receiving services, compared to their experiences at baseline.

ISM Model Data

ISM Client Demographics N=1,776
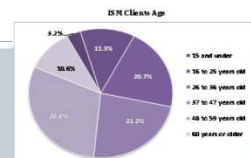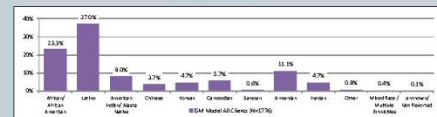
ISM Mental Health Outcomes
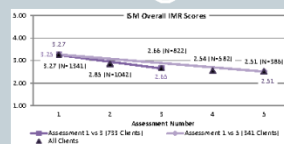
- ISM clients had significant improvements on the IMR, a clinician-rated mental health measure, 6 and 12 after enrollment in INN services, compared to ratings at baseline.
- The majority of ISM clients had clinically meaningful improvement in Overall IMR scores 6 months (73.1%) and one year (76.2%) after enrolling in services.

ISM Milestones of Recovery (MORS)

- Clinicians rated significantly more clients in higher stages of recovery 6 and 12 months after enrollment in INN services, compared to ratings at baseline.
- Half (53.5%) of ISM clients had a clinically meaningful improvement in MORS ratings 6 months after enrolling in services, compared to baseline.
- 62.1% of ISM clients had a clinically meaningful improvement in MORS ratings 12 months after enrolling in services, compared to baseline.

5

ISM PROMIS Physical Health
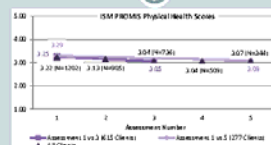
- ISM clients reported significantly better physical health outcomes 6 and12 months after enrollment in INN services, compared to ratings at baseline.
- Many ISM clients had clinically meaningful improvement in PROMIS Physical Health scores 6 months (33.8%) and 12 months (38.3%) after enrolling in services, compared to baseline.

ISM Alcohol Use

- Clients reported consuming significantly less alcohol 6 and 12 months after enrollment in INN services, compared to ratings at baseline.
- 57.3% of ISM clients reported that they did not use alcohol at both baseline and 6 months after enrollment.
- 14.4% of ISM clients had a clinically meaningful reduction in alcohol consumption 6 months after enrolling in services.
- More than half (57.8%) of ISM clients reported that they did not use alcohol at both baseline and one year after enrollment.
- 19.0% of ISM clients had a clinically meaningful reduction in alcohol consumption 12 months after enrolling in services.

ISM Substance Use

- Clients reported using substances significantly less often 6 and 12 months after enrollment in INN services, compared to ratings at baseline.
- The majority (86.0%) of ISM clients reported that they did not use drugs at both baseline and 6 months after enrollment.
- 7.2% of ISM clients had a clinically meaningful reduction in drug use 6 months after enrolling in services.
- Most (83.6%) of ISM clients reported that they did not use drugs at both baseline and 12 months after enrollment.
- 8.9% of ISM clients had a clinically meaningful reduction in drug use12 months after enrolling in services.

ISM Constructive Activities

ISM clients reported a significant increase in paid employment 6 and 12 months after enrollment in INN services. 23.7% of ISM clients reported that they maintained paid employment for the first year of services; 10.7% of ISM clients gained employment within the first year of services.

Significantly more ISM clients reported attending school 6 months after enrollment, compared to baseline. 11.1% of ISM clients reported that they maintained engagement in school for the first 6 months of services; 7.9% of ISM clients began attending school within 6 months after enrollment.

ISM Cultural Competency and Satisfaction

- Most ISM clients felt that they received all of the services that they needed when assessed at their six and twelve months follow-up visits (82.2%).
- Almost all clients assessed both six and twelve months after enrollment felt that Innovation staff respected their cultural background (88.6%) and beliefs (86.1%).
- The majority of ISM clients (86.3%) reported being satisfied with the integration of their physical and mental health services at their six and twelve month follow-up visits.

ISM Stigma Reduction
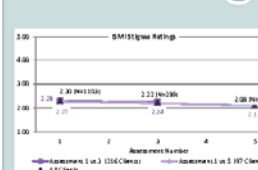
Compared to baseline, there was a statistically significant reduction in experienced mental health stigma 12 months after enrollment in INN services.

Many ISM clients reported experiencing less stigma both 6 months (25.9%) and 12 months (39.2%) after receiving services, compared to baseline.

6

Spreading Successful Approaches

- Innovation process
  - Creation of a learning culture
  - Collection and use of outcomes
  - Permission or expectation to experiment
- Successful practices or approaches to integrated care
- Spreading process and practices:
  - Within your organization
  - Geographically (via SAACs, provider meetings, ACHSA, CCCMHA or other organizations)

The Evaluation Rubric By Model

Client Level (60%)	IHHT	ICM	ISM
Quality of Care	59%	59%	40%
Quality of Life	34%	34%	40%
Client Satisfaction	7%	7%	20%
Program Level (40%)			
Data Compliance	15%	10%	11%
Access to Care	30%	25%	26%
Staffing	16%	12%	6%
Cost	0%	24%	0%
Integration	22%	17%	26%
Outreach and Engagement	17%	12%	31%

ISM Evaluation Rubric

Client Level – Quality of Care	**40%**
Mental Health Outcomes	29%
Physical Health Outcomes	20%
Physical Health Labs (% screened)	8%
Substance Use Outcomes	15%
Cultural competency (client satisfaction)	28%
Client Level – Quality of Life	**40%**
Employment/volunteer/School	10%
Housing	10%
Stigma	45%
Social Support	35%
Client Level – Satisfaction	**20%**

ISM Evaluation Rubric

Program Level – Data Compliance	**11%**
Program Level – Access to Care	**26%**
% of clients discharged due to improvement	20%
% of clients who report receiving desired care	80%
Program Level – Staff satisfaction	**6%**
Program Level – Integration	**26%**
Client experience of integration	25%
Integrated Treatment Tool	75%
Program Level – Outreach & Engagement	**31%**
Client engagement (MORS score + client satisfaction)	50%
Success in reaching target population	50%

ICM Evaluation Rubric

Client Level – Quality of Care	**59%**
Mental Health Outcomes	20%
Physical Health Outcomes	30%
Physical Health Labs (% screened)	30%
Substance Use Outcomes	15%
Cultural competency (client satisfaction)	5%
Client Level – Quality of Life	**34%**
Incarcerations	21%
Emergency Service Utilization	31%
Employment/volunteer/School	11%
Housing	15%
Stigma	11%
Social Support	11%
Client Level – Satisfaction	**7%**

ICM Evaluation Rubric

Program Level – Data Compliance	**10%**
Program Level – Access to Care	**25%**
Clients served relative to target	50%
% of clients discharged due to improvement	30%
% of clients who report receiving desired care	20%
Program Level – Staffing	**12%**
Staff Satisfaction	30%
Staff development (IT Tool)	25%
Peer Involvement (IT Tool)	45%
Program Level – Cost	**24%**
Program Level – Integration	**17%**
Client experience of integration	25%
Integrated Treatment Tool	75%
Program Level – Outreach & Engagement	**12%**
Client engagement (MORS score + client satisfaction)	100%

7

IMHT Evaluation Rubric

Client Level – Quality of Care	**59%**
Mental Health Outcomes	30%
Physical Health Outcomes	30%
Physical Health Labs (% screened)	5%
Substance Use Outcomes	30%
Cultural competency (client satisfaction)	5%
Client Level – Quality of Life	**34%**
Incarcerations	10%
Emergency Service Utilization	10%
Employment/volunteer/School	5%
Housing	30%
Housing retention	20%
Stigma	5%
Income/Benefits	20%
Client Level – Satisfaction	**7%**

IMHT Evaluation Rubric

Program Level – Data Compliance	**15%**
Program Level – Access to Care	**30%**
% of clients who report receiving desired care	30%
% of clients served in the field	70%
Program Level – Staffing	**16%**
Staff Satisfaction	30%
Staff development (IT Tool)	25%
Peer Involvement (IT Tool)	45%
Program Level – Integration	**22%**
Client experience of integration	25%
Organization integration (IT Tool)	75%
Program Level – Outreach & Engagement	**17%**
Client engagement (MORS score + client satisfaction)	100%

Use of the Rubric

- SLT recommendation to continue successful INN models with any available MHSA Community Services and Supports funding.
- Next steps
  - DMH review and decision on SLT recommendation
  - Individual model meetings to review provider level rubric results
  - Provider transition plan for clients
  - Spread of learning on best practices to the mental health community

Operationalizing Integrated Care Learning

Quality of Care-Care Coordination

- In order ensure consistent communication and appropriate linkage to care, programs with High Quality of Care Outcomes established written policies that clearly defined protocols for communication between mental health, substance abuse and primary care providers.

Specific Program Practice

- Exposing clients to a collaborative partnerships added consumers trust and willingness to participate in integrated care.

8

Quality of Care-Care Coordination

- To ensure consistent communication and ensure linkage to appropriate integrated care programs with High Quality of Care Outcomes implemented regular, if not daily, interdisciplinary teams meetings attended by treating team members. The meetings allowed for case conference and cross training.

Specific Program Practice

- Daily Team meetings with a clearly defined purpose and agenda.

- One day a week dedicated to Outcomes & Data.

- One day a week dedicated to Interdisciplinary Cross-Training.

Quality of Care-Care Coordination

- To ensure linkage to appropriate care and constantly improve quality of care being provided programs with High Quality of Care Outcomes utilized outcomes data such IMR, MORS and PROMIS scales to make clinical decisions.

Specific Program Practice

- Utilizing clinical outcomes as a tool to work with consumers toward meeting treatment goals.

Data Compliance-Incorporating Clinical Outcomes Into Program Decision Making

- To ensure interdisciplinary staff understanding and value of Outcome Measures and ability to educate Consumers of on the value of the measures programs with High Data Compliance Outcomes emphasized and utilized outcomes data in team meetings to make clinical and programmatic decisions.

Specific Program Practice

- "Data Dashboard" developed with outcomes data for each team meeting to assist with clinical and administrative decision making.

- Used clinical outcomes to identify and fill in gaps in services. Recognizing physical health outcomes were low program hired LVN.

9

Staffing-Hiring Staff

- Staffing across Innovation Models varied greatly. Successful Programs were able identify staff who were flexible and willing to work as part of a team. Mutual respect between partnering Agencies and Staff was essential.

Staffing-Hiring Staff

- Developing a strong relationship with integrated partners by participating in team building activates and making time to build rapport with each other.

- Peer staff hired to build report, important to consumer engagement. Facilitate Wellness Recovery Action Plan (WRAP) group.

Outreach & Engagement
Integration of Non-Traditional Services

- In order to address stigma and successfully engage consumers in on-going integrated services, programs with High Outcomes in Outreach and Engagement, focused on consumer goals, while building report. Often mental health and substance abuse goals where focused on only after strong report was established.

Specific Program Practice

- Use of culturally relevant activities to decrease social isolation and address trauma.

Outreach & Engagement
Integration of Non-Traditional Services

- In order to address stigma in specific cultural and ethnic communities and successfully engage consumers in on-going integrated services, programs with High Outcomes in Outreach and Engagement, needed to cultivate a relationship with the community.

Specific Program Practice

- Hiring staff who not only speak the language but have an understanding of cultural norms and differences.

10

Program level-Integration

- Successful Innovation programs learned that there are organizational and planning considerations that impact delivery of Integrated Services and have aided in Integrated Service delivery.

Specific Program Practice

- Partnering with an organization that has a similar mission and values as yours.

- The physical design of the clinic can reinforce integrated care and improve care.

St. Joseph Center

- http://www.youtube.com/watch?v=xz0ppP_Q9Zg

Los Angeles Child Guidance Clinic

In addition to providing mental health services, the ISM program engages adults by providing no-cost informational workshops, called "Platicas". The Platicas provide a non-threatening environment and they are designed to encourage healthy living, empower clients to seek and maintain mental health and physical health services. Since July 2012, the ISM program has hosted nearly 202 platicas, serving over 473 participants. Platica topics include: Depression, Anxiety, Nutrition/exercise, motivation, Substance abuse, Domestic Violence, Stress and Relaxation, Chronic medical conditions and the impact on mental health.
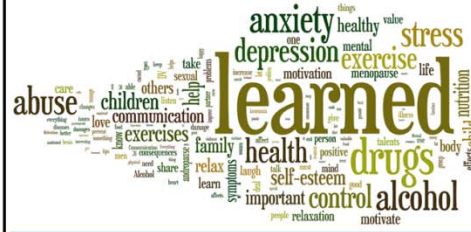
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Los Angeles Child Guidance Clinic

One thing I learned from this presentation was:
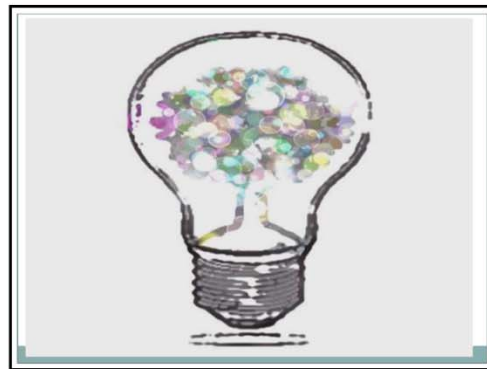

Los Angeles Child Guidance Clinic

The most important thing I learned from this presentation was:

Los Angeles Child Guidance Clinic

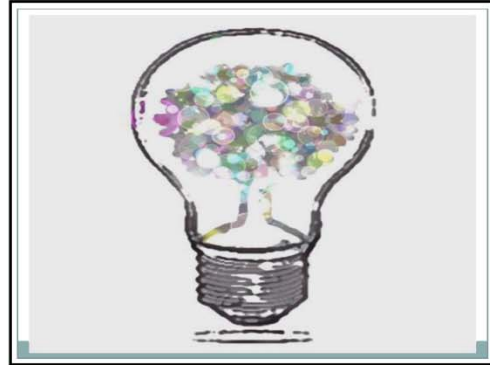Something I think should be changed in this presentation is

MODEL LEVEL BREAKOUT GROUP

1. After hearing the morning presentations, are there any other key learning or strategies from your INN program that have not been shared so far? If so, what have you learned and how did you operationalize that learning? What was the benefit to your program or consumers when you applied this learning?

2. What learning or strategies are important for you to spread? What specific action steps can you take in the next six months to spread INN learning?

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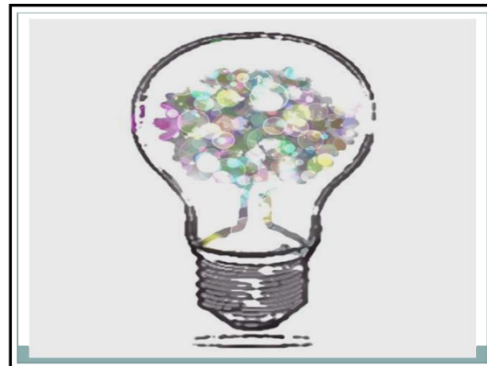
Pacific Asian Counseling Services (PACS)

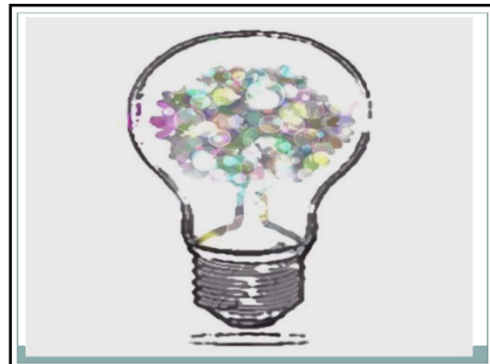link to PACS/ INC's video
http://www.youtube.com/watch?v=mJQl9c7VKqg

Mental Health America of Los Angeles (MHALA) - HIP

- http://youtu.be/rPL3zBm9Mqc

St. Joseph Center ISM

- https://www.youtube.com/watch?v=F-qfFSpzLIU

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Appendix B

Appendix B contains a summary of the main points from the Morning Provider Sharing about what their organization learned about integrated care.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - MHSA IMPLEMENTATION AND OUTCOMES DIVISION

MHSA Innovation Learning Session X
Morning Presentation Provider's
Operationalizing Integrated Care Learning

Concept of Integrated Care	Inn Model	Agency	Contact Person	Discussion Points
Quality of Care - Care Coordination Overall Relationship Slide 48	ICM	SSG	John Heylar	ICM provider shared their learning around engaging consumers in integrated care. ICM providers introduce the consumer to the different care providers assisted in established trust with consumers. Consumers who witnessed the collaboration between care providers were more engaged in services.
	ISM-AAA	SSG Webber/UMMA	Jennifer Schott	A/AA ISM developed policies and procedures as a foundation for integrated care.
	ISM-API	KYCC	Grace Park	The Korean ISM has multiple traditional and non-traditional partners in their collaborative. The Korean ISM found success in appointing one key care coordination, in a supervisorial role, who is responsible for maintaining communication with all partnering agencies.
Quality of Care - Care Coordination Team Meeting/Communication Slide 50	IMHT	MHALA-HIP	Tara Reed	IMHT provider utilizes a mobile group messaging app called GroupMe to maintain communication with their team, including their partnering FQHC. The provider used technology for psychiatrist to video communicate with consumers who were difficult to engage.
	IMHT	St. Joseph Center	Erin McGinnis	IMHT provider developed a structure for integrated care team meetings that incorporated multiple aspects of integrated care, including client coordination, team building actives and cross disciplinal trainings by different team members. For example, on Tuesdays the team would focus the meeting on outcome measures, on Wednesday a staff member would conduct cross discipline training, on Thursdays they would focus on team building activities.

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COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - MHSA IMPLEMENTATION AND OUTCOMES DIVISION

MHSA Innovation Learning Session X
Morning Presentation Provider's
Operationalizing Integrated Care Learning

Concept of Integrated Care	Inn Model	Agency	Contact Person	Discussion Points
Quality of Care - Care Coordination Outcome Data in Program Development Slide 52	ISM	Alma	Claudia Rice	Latino ISM utilized outcome measures as a clinical treatment tool to engage consumers in their recovery. Utilizing outcome measures allowed consumers and clinicians to discuss clients progress or lack of progress in treatment. Latino ISM consumers appreciated seeing the results of their outcomes.
	ISM	Didi Hirsch	Arpe Asaturyan	EE/ME ISM utilized iHOMS data in their weekly case consultation meetings as a treatment planning tool.
Data Compliance- Incorporating Clinical Outcomes Into Program Decision Making Slide 54	ICM/ IMHT	Exodus	Lezlie Murch	1) ICM and IMHT provider outcome data showed low completion rates for physical health indicators. The ICM and IMHT hired a Licensed Vocational Nurse (LVN) to increase the completion rate of physical health indicators on iHOMS. Hiring a LVN was beneficial to both models. 2) ICM and IMHT developed an iHOMS Data Dashboard to review outcome data during team meetings.
Staffing-Hiring Slide 56	ICM	Saban	Arnali Ray	1) ICM providers discuss steps to developing a integrated partnership is creating a common set of values and principles. Mutual respect for partnering agencies and consciously taking the time to nurture and develop a collaborative relationship are key for developing integrated service partnership. 2) ICM providers hired a peer who was the security guard for their agency. The ICM peer was able to engage consumers through his relationship he built as the security guard and through self disclosure and personal experience. Having a peer provider was beneficial for engagement with consumers and assisting consumers navigate the health care system.
	ISM	Alma	Claudia Rice	Latino ISM highlights the importance of hiring staff who not only speak the native language but have an understanding of the cultural norms and differences and the level of acculturation within the community they serve.

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MHSA Innovation Learning Session X
Morning Presentation Provider's
Operationalizing Integrated Care Learning

Concept of Integrated Care	Inn Model	Agency	Contact Person	Discussion Points
Outreach and Engagement Integration of Non-Traditional Services Specific culturally relevant activities Slide 58	ISM	UAII	Dr. Carrie Johnson	AI/NA ISM illustrated the use of non-traditional services as a way to over come historical trauma experienced by NA/AN population. By participating in culturally relevant actives (dance circles, bow wow's and beading classes) reduced social isolation and engaged clients in integrated care.
	ISM	Didi Hirsch	Arpe Asaturyan	EE/ME ISM providers engaged consumers by exploring non traditional services. Many ISM clients were isolated and ambivalent about treatment. Non traditional actives (yoga, coffee circles, soccer, rekey) build rapport and engage consumers in mental health services. The use of non-traditional partnerships reduced consumers social isolation.
	IMHT	MHALA	Tara Reed	Due to the stigma surrounding mental health services, IMHT providers utilized housing and/or physical health services to engage consumers in IMHT services.
	ISM-API	KYCC	Grace Park	ISM providers used non traditional services to engage clients in mental health services and reduce stigma around receiving services. Non traditional services included activities like yoga and acupuncture.
	ISM-A/AA	UMMA	Kendra Wilkins	A/AA ISM provider partnered with the local YMCA to provide outreach and engagement actives in the community.

3

MHSA Innovation Learning Session X
Morning Presentation Provider's
Operationalizing Integrated Care Learning

Concept of Integrated Care	Inn Model	Agency	Contact Person	Discussion Points
Outreach and Engagement Integration of Non-Traditional Services Hiring Staff	ISM	APHCV	Aki Leung	ISM providers highlighted the importance of hiring a peer to provide outreach and engagement. Having a person with lived experience brought value to the team. The peer utilized self exposure to engage clients.
Program Level Integration Slide 62	ICM	Exodus	Lezlie Murch	ICM and IMHT provider partnered with an FQHC with similar mission and/or values as your agency. By sharing similar mission statements the agencies found common ground to develop an integrated partnership. ICM designed the physical space of their office to reinforce integrated care.
	ISM	UAII	Dr. Carrie Johnson	AI/NA ISM held weekly integrated team meetings with physical health and substance abuse partners present. Staff were resistant at first, but now find value in having a integrated team meeting.
	ISM	APHCV	Aki Leung	API ISM's FQHC provider appointed one dedicated staff from the FQHC to coordinate services, that staff person was responsible for conducting and once a week collaborative team meeting, and e-mail and phone call communication with all providers involved in the ISM.

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Appendix C

This appendix contains notes transcribed from small group discussions (by model). These discussions centered on organizational learning from INN and plans to spread what was learned in the next six months. These notes were transcribed verbatim; the evaluation team only corrected spelling where necessary. Themes from share outs are captured in the body of the learning brief.

Question 1: After, hearing the morning presentations, is there any other key learning or strategies from your INN program that have not been shared so far? If so, what have you learned and how did you operationalize that learning? What was the benefit to your program or consumers when you applied this learning?	
ICM: ▪ Saban ▪ SSG ▪ LA LGBT Center ▪ Scharp ▪ Exodus	▪ Importance of technology in integrating care (partners sharing HER, etc.) ▪ Utilizing data from community partners (i.e. gyms) ▪ Training on ACA and payer source changes ▪ Culture/mindset of flexibility ▪ Messaging/practice of integrated care ▪ Strategies for improved engagement ▪ Capturing client service hours
IMHT: ▪ OPCC ▪ St. Joseph's Center ▪ JWCH/Scharp	▪ Data results fail to capture "the story", particularly rewarding interactions and how improved mental health "looks" ▪ We should translate data into emotional experiences underlying processes like team building client engagement, supervision, etc. ▪ Numbers don't reflect severity of client impairment at baseline (i.e. gangrenous limbs, crack abuser declines ambulance despite cut throat) ▪ When homeless clients are houses, initial phase involves struggle with self-esteem; they often bring streets with them

ISM:
 	
▪ Kedren
▪ African American ISM
▪ IMCES Armenian ISM
	▪ Using IHOMS during team meetings:
	  o Use baseline to develop and monitor treatment plan
	▪ Non-traditional
	  o Using activities to create a sense of cohesiveness
	▪ Strong supportive case management approach
	  o Accompanying clients to various appointments (i.e. housing, legal matters, employment, etc…)
	▪ C/C planning as initial goal to empower consumer to improve quality of life in the areas of treatment goals

ISM:
 	
▪ JFS
▪ St. Joseph's
	▪ Outreach and engagement
	  o Unique outreach activities targeting specific cultures
	  o Radio use to promote services
	  o Cos initially prior to treatment services
	▪ Workshops with specific themes

ISM
 	
▪ SSG- Samoan ISM
▪ Did Hirsch- Armenian ISM
▪ Alma Family Services- Latino ISM
▪ UAII- Native American ISM
	▪ Developing partner ships within community (Armenian)
	  o Educating at SVS available, connecting to more people in community
	  o Psychoed (psychology education?)
	  o Misconceptions addressed
	  o Build foundation (ethnic providers, linkage resources) within community then provide svs outreach
	▪ Cultural work to engage community
	  o Decrease stigma
	  o Provide support

	- o Awareness - o Education - o Hope - o Identify resources and services - o Changing language to fit the community/engage - o Introducing "mental health" to cultures where is never suggested

IMHT
 	
    ▪ MHS/CC
    ▪ St. Joseph's/OPCC
    ▪ VFC
    ▪ SWS/Saban
    ▪ Exodus/LACHC
	▪ How to spread MH learnings to physical health providers in other departments in FQHC re: to MH?
	    o Emphasis in FGHC mtgs med providers seems focused on productivity vs. pt care and outcomes
	    o Those enrolled in MH services (IMHT) show up more consistently
	    o Some FQHC staff go out in field to see what works n MH services
	    o Higher ups must be invested in integrated services
	▪ Learning +++ from sub provider to manage physical health. Harm reduction- open conversations
	▪ Team → vs 1:1 staff/client structure embracing ACT= building team morale, self-care-> closer to each other
	▪ Team structure
	    o Smaller sub teams-> census #
	▪ Housing first:
	    o Money mgmt. payee
	    o Sub harmed
	    o Medical
	▪ Celebrations- integrated into meetings routine
	▪ Strengthen based perspective in case conf. vs problems
	▪ Dealing with death- debriefs, memorials gatherings create community
	▪ Substance support separate from Mental Health: harm reduction vs recovery

PRRCH/PRISM
 	
    ▪ Share!
    ▪ Project Return
	▪ Creating social groups without specific focus
	    o Helps with client engagement
	    o Clients leave happier/feeling less isolated
	    o Form relationships between clients
	    o Allows for flexibility to suit clients
	    o All inclusive
	▪ Using iHOMS to incorporate into conversations with clients/residents in the homes
	    o Gives providers the opportunity to look at outcomes they hadn't considered before
	▪ PRRCH Recovery Retreat
	    o Eliminate barriers between staff and consumers
	    o Fosters a sense of safety among residents and allow them to be vulnerable to open up about what's really going on in their lives

▪ UMMA ▪ Weber ▪ Tarzana Treatment Centers ▪ Children's Guidance Clinic	▪ IHOMS compliance rates ▪ using IHOMS visual charts or simplified data user friendly to share with clients ▪ mental health/physical health trainings for non-traditional partners and traditional partners to understand patient flow and service delivery

ISM
 	
▪ Cambodian
▪ Chinese
▪ Korean
	▪ Integrating spiritual and cultural practices with "passion for cooking" classes
	   o Bridge intergenerational gap
	   o Client-led. Empowerment
	   o Learned the importance of letting clients be the experts
	   o Educating clients on healthy nutrition and how it can impact physical and mental health
	▪ Provide O&E during benefits enrollment
	   o Key person to conduct O&E
	   o Seamless referral process
	▪ Find ways for clients to integrate back into the community
	   o Attend cultural/community events
	   o Link clients to resources

Question 2: What learnings or strategies are important for you to spread? What specific action steps can you take in the next six months to spread INN learning?	
ICM: ▪ Saban ▪ SSG ▪ LA LGBT Center ▪ Scharp ▪ Exodus	▪ Importance of positive spin on initiatives ▪ Sharing overall program success with direct service staff ▪ Importance of team feedback for programmatic decisions ▪ Importance of messaging the feedback received from clients ▪ There's always room for more integration ▪ Importance of educating staff on impact of each discipline on patients' overall outcomes ▪ Finding the right team for the job ▪ Understanding limitations of model/available services

IMHT:
 	
▪ OPCC
▪ St. Joseph's Center
▪ JWCH/Scharp
	▪ Operationalization:
	   o Increase home visits
	   o Increase provider education re: mission goals
	   o Increase focus on staff safety protocol
	   o Increase focus on staff retention
	   o Increase recognition of roles; defining duties and safeguards specific to them
	▪ As funding increase for INN populations, we should identify key issues for new providers; what are the "10 commandments of INN?"
	▪ Interdisciplinary meetings are critical to process, as it consistent attendance
	▪ Team building, team building, team building!!!!
	▪ Address limits/boundaries with team members

ISM:
 	
▪ Kedren
▪ African American ISM
▪ IMCES Armenian ISM
	▪ Implementing integration throughout organizations
	   o Out-patient programs, In-patient programs at level of adult and children
	▪ Have health fairs
	▪ Have a system navigator who works out in the community
	▪ Collab. Contacts with various agencies
	▪ Have a newsletter for compliance issues and information regarding INN process
	▪ Have community announcements
	   o Kedren sits advantageously in the midst of the mega Afro-American churches, where we disseminate information regarding AAA/ISM services

ISM:
 	
▪ JFS
▪ St. Joseph's
	▪ Allowing trial and error
	▪ Cultural competence
	▪ Ideal partners
	   o Common values
	   o Proximity
	▪ Organization
	▪ Conveying ISM success to board members, consumers

ISM ▪ SSG- Samoan ISM ▪ Did Hirsch-Armenian ISM	▪ Could have put more focus in beginning on O&E, engagement community work before starting service providing push (enrolling clients) ▪ Sustainability could be addressed earlier what do we do with our clients and the community now?

▪ Alma Family Services- Latino ISM ▪ UAII- Native American ISM	

PRRCH/PRISM
 	
▪ Share!
▪ Project Return
	▪ Breaking down the barrier between staff and consumers
	  o Hiring staff with "lived experience"
	  o Connect consumer to resources with a personal relationship so that the consumer feels more comfortable
	▪ Trust between staff and consumer
	▪ Getting to know clients, so that they feel they are being heard
	  o Show results and experiences to other organizations
	▪ Be an example of truly "peer run" programs
	▪ Use these learnings in trainings to spread to others
	  o How to hire and maintain people with lived experience
	▪ Help organizations move beyond where they've been
	▪ Facilitating a sense of family/community
	  o Through retreats/social activities/trainings

▪ UMMA ▪ Weber ▪ Tarzana Treatment Centers ▪ Children's Guidance Clinic	▪ Full integration of non-traditional partners: data accountability, trainings to be equipped to provide appropriate care, etc. ▪ Have traditional partners/providers experience non-traditional services ▪ Present at conference to share outcomes/experiences o Community meetings ▪ Applying model to other programs within agencies ▪ Email blast of final program report to agency email list serve ▪ Posting on website ▪ Host a social with clients, partners, community ▪ Write a white paper for publication
ISM ▪ Cambodian ▪ Chinese ▪ Korean	▪ Use Excel spreadsheets to share data with other departments ▪ Developing ways to use technology to spread learning and outreach ▪ More photovoice data