Outcome Measures Manual (Adults)

County of Los Angeles

Department of Mental Health

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Prepared by:

Marissa Goode, M.S., Andrew Sarkin, Ph.D., Todd Gilmer, Ph.D., Kimberly Center, M.A., Kyle Choi, M.P.H
Health Services Research Center
University of California, San Diego
http://hsrc.ucsd.edu

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Executive Summary

The purpose of this document is to help inform and guide individuals through the transition from the currently used assessments (DMH Interim Assessment and the ASSIST) to the newly selected recovery focused outcome measures (IMR and Integrated Self-Assessment, see below). We will continue to use the Milestone of Recovery Scale (MORS). The new outcome instruments have been chosen for their clinical usefulness, ease of administration, and minimal staff time burden. Within this document you will find some information regarding each of the new outcome measures, a step-by-step tutorial on how to use these new measures, and sample client recovery report.

Evaluation of Outcome Measures

In order to improve the assessment of health outcomes, the County of Los Angeles Department of Mental Health (DMH) contracted with University of California San Diego's Health Services Research Center (HSRC) to review instruments that would measure clients behavioral and physical health outcomes and recovery.

After having gathered evidence from academic research, professional review of instruments, focus groups with providers, and an ongoing advisory group of measurement experts and county mental health administration staff, several outcome measures have been chosen for implementation. These outcome measures will replace the DMH interim measures.

Implementation Timeline

As part of the Innovation Evaluation, UCSD's HSRC will be assisting providers to implement these measures. Each provider will receive online training via webinars, with follow-up video trainings for new employees or as a refresher for current employees. Additional training and on-site support is available based on individual program needs. Immediately after the training, the provider will switch to the new outcome measurement tools and stop using the DMH interim measures and the temporary assessment packet.

Assessment Schedule

Assessments for clinicians and clients will occur at baseline (intake), quarterly (every 3 months) and semi-annually (every 6 months).

Staff: Clinicians should complete a client's first IMR, MORS and Physical Health Screener **within 30 days of their initial intake assessment**. Because clients recovery and treatment plans should change throughout the program, clinicians will be asked to complete **follow-up IMRs and MORS every 3 months, and the Physical Health Indicators Screener should be completed every 6 months**. Clinicians and staff will also be asked to complete the Innovation Staff Satisfaction Survey every **May and November**.

Client: All new clients should complete the Integrated Self-Assessment at intake (baseline) and Internalized Stigma of Mental Illness (ISMI) Scale. We suggest asking clients to complete this measure **while awaiting their first appointment**, or immediately afterwards, as this time may be most convenient. Program staff should **collect the baseline assessment during the client's first 30 days in the program.** The PROMIS Global Health is the only measure assessed **quarterly** for clients. To evaluate change as a result of the Innovation program, clients will complete the **Integrated Self-Assessment every 6 months.** Clients will also complete **one of the following measures during their semi-annual assessment; the ISMI stigma scale, the Satisfaction Survey or the Post-Outcomes Survey.** [Note: If a client is unable to complete the Integrated Self-Assessment, clinicians should indicate the reason why on the bottom of the Clinician Face Sheet (i.e., Unable, Language, etc.)].

Summary of New Outcome Measures

Client Perception of Behavioral and Physical Health

Integrated Self-Assessment

Client Program Outcomes

Internalized Stigma of Mental Illness (ISMI) Scale **OR**

Satisfaction Survey **OR**

Post-Outcomes Survey

Clinician Perception of Progress

Illness Management and Recovery (IMR) Scale

Milestones of Recovery (MORS) Scale

Physical Health Indicators Screener

Clinician Program Outcomes

Staff Satisfaction Survey

Interim Measures

Clinician Measure	# of Items
MORS	1
ASSIST	72
Health Indicators	6

Client Measure	# of Items
ASSIST	72
Housing/Residential Status	52
Emergency Room Utilization	2
Employment Status	14
Educational Status	5

New Innovation Measures

Clinician Measure	# of Items	Frequency
MORS	1	3 mos.
IMR	18	3 mos.
Physical Health Indicators Screener	Varies	6 mos.
Satisfaction Survey	20	6 mos.

Client Measure	# of Items	Frequency
PROMIS Global Health	10	3 mos.
CHOIS Supplement	19	6 mos.
Health and Behavior Survey	15	6 mos.
Stigma **OR** Satisfaction **OR** Post-Outcomes	10	6 mos.
Alcohol/Substance Use*	12	6 mos.

* Only administered if triggered on Physical Health and Behavior Survey

Description of Outcome Measures

INTEGRATED SELF-ASSESSMENT- To measure clients' perspective of their behavioral and physical health and well-being, clients are asked to complete the Integrated Self-Assessment. Specifically, the self-assessment measures clients' health-related quality of life, physical health behaviors, mental health, positive recovery factors and substance use.

IMR—To measure clinician perception of client recovery, the clinician version of the Illness Management and Recovery (IMR) scale will be used. The IMR has 15 items, each addressing a different aspect of illness management and recovery. Each item could function as a domain for improvement. Clinical staff members will be completing the IMR.

MORS—The Milestones of Recovery Scale (MORS) will be used to assess clinician perception of clients' current degree of recovery. Ratings are determined considering three factors; their level of risk (co-occurring disorders, likelihood of causing harm to self or others, and level of risky/unsafe behaviors), their level of engagement within the mental health system and their level of skills and supports (which is a combination of their abilities and support network and their level of need from support staff). Clinical staff members will be completing the MORS.

PHYSICAL HEALTH INDICATORS– Clients' Diabetes, Obesity, Cardiopulmonary disease, Tuberculosis, Asthma, Emphysema, and STD risk will be identified through appropriate screening and testing, and summarized on the Physical Health Indicators Screener. The screener will be completed by clinical staff members using information from the clients' medical records. The indicators were selected because they should be collected in routine primary care practice and are common chronic conditions within the populations.

SATISFACTION SURVEYS (Client and Staff)—Satisfaction Surveys were developed by HSRC for the Innovation Program to reflect the overall goals of an integrated mental and physical health program. Items on the surveys were developed through targeted focus groups, clinician and patient interviews, and adaptation of existing measures. Client items relate to a variety of aspects of care, including interactions with staff and physicians, cultural competency, access to resources, and the clinic in general. Staff surveys tend to focus on program implementation, clinic capabilities, internal communication, training, and comfort level treating patients with new diagnoses. Client satisfaction will be assessed semi-annually (6 months) using sampling techniques. Staff satisfaction surveys should be completed at baseline and semi-annually (in November and May) so we can measures how providers satisfaction changes as programs become more integrated.

POST-OUTCOMES SURVEY—The Post-outcomes Survey will be completed by clients semi-annually (every 6 months after enrollment). The survey was developed by HSRC to assess self-reported changes in behavioral and physical health as a result of the Innovation program.

ISMI SCALE– The Internalized Stigma of Mental Illness (ISMI) scale will be used to measure clients' subjective experience with mental illness stigma. The 10-item scale consists of five subscales, which will assess Alienation, Perceived Discrimination, Social Withdrawal, Stereotype Endorsement and Stigma Resistance. It will be administered to all clients at baseline to assess their existing stigma attitudes and experiences before joining the Innovation program. It will also be administered during the semi-annual assessment to a sample of clients to estimate how mental health stigma may change as a result of the Innovation program.

Integrated Self-Assessment

Conceptual Foundation: The Integrated Self-Assessment is a set of self-reported core measures selected to assess the client's perspective of their health-related quality of life, including physical functioning, and quality of well-being, their physical and behavioral health and health care utilization.

Development: The measures included in the Integrated Self-Assessment were selected during meetings with stakeholders, such as program directors, county model leads, local experts and academics, and staff who are delivering services. The selection process involved a review of available measures for their relevance to the goals of the programs, clinical utility, psychometric validity, cultural competence, and cost, copyright, and translation issues. Some measures, such as the satisfaction and post-outcomes surveys and the physical health and behaviors questionnaire, were developed in order to best meet needs of the program while giving preference to validated instruments. The Patient Reported Outcomes Measurement Information System (PROMIS) is a NIH-sponsored system of highly reliable, precise measures of patient-reported health status for physical, mental, and social well-being. The PROMIS Global Health was selected because it is sensitive to change in the general population, and is also applicable for individuals with diverse health conditions. Additionally, the Creating Healthy Outcomes (CHOIS) Supplement was developed as a companion measure of mental health symptoms, including compulsive behaviors, psychosis, memory disturbance and depression. The CHOIS Supplement also assesses positive recovery factors, which can help identify a client's strengths. The PROMIS-derived Substance Use Scale was included to assess the negative consequences of substance use for any clients who report that they have used alcohol, prescription or illegal drugs within the past 6 months.

Items and Domains: The Self-Assessment has 44 Likert-style items, with an additional 12 items that will be completed by clients who respond positively to the substance use screening items.

Populations: The Integrated Self-Assessment is appropriate for TAY (16+) and adults. Testing of the CHOIS Supplement and PROMIS Global Health instruments included an ethnically/racially diverse sample (Asian, Black or African American, White, Hispanic or Latino, American Indian/Alaska native) many of whom had a diagnosis of a chronic health condition or SMI.

Service Settings: The assessment is appropriate for use with TAY (16+) and adults with a wide range of ages and ethnic backgrounds.

Frequency of Administration: The Integrated Self-Assessment should be administered within 30 days of intake (baseline), and follow-up assessments completed every 6 months. The PROMIS Global Health (refer to page 7) should be administered to clients quarterly (3 months).

Translations: The Integrated Self-Assessment is currently available in English, and will be translated in Spanish, Farsi, Eastern Armenian, Korean, Khmer, Cantonese/Simplified, Samoan, Mandarin and Tongan by the end of the year 2012.

PROMIS GLOBAL HEALTH

Please respond to each item by marking one box per row.

	Excellent	Very Good	Good	Fair	Poor
In general, would you say your health is:	○	○	○	○	○
In general, would you say your quality of life is:	○	○	○	○	○
In general, how would you rate your physical health?	○	○	○	○	○
In general, how would you rate your mental health, including your mood and your ability to think?	○	○	○	○	○
In general, how would you rate your satisfaction with your social activities and relationships?	○	○	○	○	○
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	○	○	○	○	○

	Completely	Mostly	Moderately	A little	Not at all
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	○	○	○	○	○

In the past 7 days…	Never	Rarely	Sometimes	Often	Always
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	○	○	○	○	○

In the past 7 days…	None	Mild	Moderate	Severe	Very Severe
How would you rate your fatigue on average?	○	○	○	○	○

In the past 7 days…

How would you rate your pain on average?

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
No Pain										**Worst imaginable Pain**

Please answer the following questions about your PHYSICAL health.

1. Answer YES or NO to the following questions.	Yes	No
a. Before joining this program, did you have a regular doctor or healthcare provider that you saw for PHYSICAL health problems?	○	○
b. In the past year, have you seen or talked to an optometrist, ophthalmologist or eye doctor about your vision?	○	○
c. In the past year, have you seen or talked to a dentist, dental hygienist, orthodontist or oral surgeon?	○	○

2. When was the last time you got medical care for a PHYSICAL health problem?

○ Less than 1 month ago ○ 1-3 months ago ○ 4-12 months ago ○ 1-3 years ago ○ More than 3 years ago

3. In the past 6 months, how easy was it for you to get help for a PHYSICAL health problem?

○ Very Easy ○ Somewhat Easy ○ Somewhat Difficult ○ Very Difficult ○ Haven't tried to get help

4. In the past 6 months, how many times did you see a doctor or healthcare provider for a PHYSICAL health problem?

○ None ○ 1-3 times ○ 4-6 times ○ 7-10 times ○ More than 10 times

5. In the past 6 months, how many times did you go to an emergency room?

○ None ○ 1-3 times ○ 4-6 times ○ 7-10 times ○ More than 10 times

6. In the past 6 months, how many times were you admitted to a hospital?

○ None ○ 1-3 times ○ 4-6 times ○ 7-10 times ○ More than 10 times

7. During the past 6 months, how many times were you sent to jail or prison?

○ None ○ 1-3 times ○ 4-6 times ○ 7-10 times ○ More than 10 times

8. Please rate how much you agree that the following items have prevented you from receiving PHYSICAL HEALTH care.	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
a. Resources are not available in my home community.	○	○	○	○	○
b. Doctors or healthcare providers are not sensitive to my cultural background (race, religion, language, etc.).	○	○	○	○	○
c. I don't believe doctors or healthcare providers can help me.	○	○	○	○	○
d. I have had negative experiences receiving care in the past.	○	○	○	○	○

9. Has a doctor, nurse, or health professional ever told you that you have…	Yes	No
a. Diabetes?	○	○
b. High blood pressure?	○	○
c. High cholesterol?	○	○
d. Emphysema?	○	○
e. Asthma?	○	○
f. Tuberculosis?	○	○
g. HIV / AIDS?	○	○
h. Hepatitis?	○	○
i. Other sexually transmitted disease?	○	○

10. Do you smoke tobacco?

○ Every day ○Some days ○Not at all

11. In the past month, how often did you take your medications as the doctor prescribed?

○ All the time (100%)

○ Nearly all of the time (75%)

○ About half of the time (50%)

○ Less than half of the time (<50%)

○ My doctor hasn't prescribed any medications

12. 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)

○ None	○ 1 time	○ 2 times	○ 3 times	○ 4 or more times

13. During the last 6 months, how often did you have any kind of drink containing alcohol, such as beer, wine, or liquor?

○ Never	○ Less than once a week	○ 1-3 times per week	○ 4 or more times per week	○ Every day

14. During the last 6 months, how often did you use an illegal drug or use a prescription medication for non-medical reasons?

○ Never	○ Less than once a week	○ 1-3 times per week	○ 4 or more times per week	○ Every day

15. During the past 6 months, which of the following have you done?	**Yes**	**No**
Have paid employment?	○	○
Participate in volunteer (non-paid) activities?	○	○
Attend school (including high school, technical/vocational school, community college, 4-year college or graduate school)?	○	○

Please respond to each item by marking one box per row. If you have not used any alcohol or illegal drugs in the past six months, please skip these questions and continue the assessment on the next page

In the past 30 days…..	Never	Rarely	Sometimes	Often	Almost Always
I used substances (alcohol, illegal drugs) too much.	○	○	○	○	○
I used alcohol or substances throughout the day	○	○	○	○	○
I had an urge to continue drinking or using substances once I started	○	○	○	○	○
I felt that I should cut down on my alcohol or substance use.	○	○	○	○	○
I felt I needed help for my alcohol or substance use	○	○	○	○	○
I took risks when I used alcohol or substances	○	○	○	○	○
I felt guilty when I used alcohol or substances	○	○	○	○	○
Others complained about my alcohol or substance use	○	○	○	○	○
Alcohol or substance use created problems between me and others	○	○	○	○	○
Others had trouble counting on me when I used alcohol or substances	○	○	○	○	○
I felt dizzy after I used alcohol or substances	○	○	○	○	○
Alcohol or substance use made my physical or mental health symptoms worse	○	○	○	○	○

In the last 7 days…..	Never	Rarely	Sometimes	Often	Always
Thoughts entered my mind that I had trouble getting rid of.	○	○	○	○	○
I did things I couldn't resist or did things more often than I should.	○	○	○	○	○
I had disturbing memories or images of a stressful experience.	○	○	○	○	○
I had memory problems, such as forgetting names or appointments.	○	○	○	○	○
I had difficulty thinking clearly while doing familiar tasks.	○	○	○	○	○
I believed people were following or trying to harm me or my family.	○	○	○	○	○
I heard voices that no one else could hear.	○	○	○	○	○
I had thoughts of ending my life or harming myself.	○	○	○	○	○
My child(ren) had emotional and/or behavioral problems.	○	○	○	○	○
I felt good about myself.	○	○	○	○	○
I had goals and worked towards achieving them.	○	○	○	○	○
I felt hopeful about the future.	○	○	○	○	○
I was able to handle things.	○	○	○	○	○
I felt happy.	○	○	○	○	○
I had energy and was full of life.	○	○	○	○	○
I felt spiritually connected.	○	○	○	○	○
I had contact with people that care about me.	○	○	○	○	○
I lived in a home that made me feel safe.	○	○	○	○	○

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
How difficult have any problems reported here made it for you to do your daily activities, work (including school), take care of things at home, or get along with other people?	○	○	○	○

Illness Management and Recovery (IMR)

Aim: Researchers developed the Illness Management and Recovery (IMR) Scales (Mueser, Gingerich, Salyers, McGuire, Reyes, & Cunningham, 2004) to measure outcomes targeted by the Illness Management and Recovery Program. The IMR program is an evidence-based practice designed to assist individuals with psychiatric disabilities develop personal strategies to manage their mental illness and advance toward their goals.

Conceptual Foundation: The IMR Scales were developed as a measure of illness management, based on the stress-vulnerability model of severe mental illness. According to this model, the severity of a mental illness and likelihood of relapses are determined by the interaction between biological vulnerability and socio-environmental stressors, both of which can be mitigated. Biological vulnerability can be reduced by adherence to prescribed medications and reduction or avoidance of alcohol or drug use. The effects of stress on vulnerability can be reduced by improved coping skills, social support, and involvement in meaningful activities.

Development: Consumer/survivors, family/friends of consumer/survivor, members of racial and ethnic minority groups, providers, researchers, and advocates contributed to the development of the instrument. Items were generated by IMR program practitioners and consumers in order to tap the various content areas targeted by the IMR program with as few items as possible. Feedback was obtained from other clinicians and consumers about item selection and wording, and modifications were made accordingly.

Items and Domains: The IMR includes 15 Likert Scale items, with a 5-point response scale wherein response anchors vary depending upon the item. The scales are not divided into domains. Rather, each item addresses a different aspect of illness, management, and recovery. An additional three items, which measure employment, housing and educational goal planning should be completed when a client has been seen for follow-up treatment planning.

Populations: The IMR Scales are intended to be used to assess adults from diverse ethnic/racial backgrounds who have been diagnosed with a serious mental illness, including those who have a dual diagnosis. Testing of the instrument included an ethnically/racially diverse sample (Asian, Black or African American, White, Hispanic or Latino) of respondents who had a diagnosis of serious mental illness, some of whom had a dual diagnosis.

Service Settings: The IMR Scales are intended for use in an array of service settings including the criminal justice system, inpatient service settings, outpatient service settings, peer-run programs, and residential service settings. Testing was conducted using a sample of respondents drawn from an outpatient service setting.

Frequency of Administration: The IMR should be completed by clinicians within 30 days of their clients' initial intake assessment. All clients should have a follow-up IMR every 3 months.

Translations: Spanish, Hebrew, and 10 other languages.

1. Progress towards personal goals: 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

2. Knowledge: 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

3. Involvement of family and friends in my mental health treatment: 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

4. Contact with people outside of my family: 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

5. Time in Structured Roles: 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/wk

6. Symptom distress: 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

7. Impairment of functioning: 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

8. Relapse Prevention Planning: 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

9. Relapse of Symptoms: When is the last time s/he had a relapse of symptoms (that is, when his/her symptoms have gotten much worse)?

○	○	○	○	○
Within the last 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

10. Psychiatric Hospitalizations: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?

○	○	○	○	○
Within the last 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

11. Coping: 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

12. Involvement with self-help activities: 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

13. Using Medication Effectively: (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 if the client is not prescribed psychiatric medications.

14. Impairment of functioning through alcohol use: 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 increases of symptoms. Over the past 3 months, did alcohol use get in the way of his/her functioning?

○	○	○	○	○
Alcohol use really gets 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

15. Impairment of functioning through drug use: Using street drugs, and misusing prescription or 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 increases of symptoms. Over the past 3 months, did drug use get in the way of his/her functioning?

○	○	○	○	○
Drug use really 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

Please complete the following items if the client is being seen for his/her follow-up treatment planning.

	Yes	**No**	**No goal on client's plan**
16. Has the client demonstrated progress towards achieving his/her **employment goal** since the last treatment planning?	○	○	○
17. Has the client demonstrated progress towards achieving his/her **housing goal** since the last treatment planning?	○	○	○
18. Has the client demonstrated progress towards achieving his/her **education goal** since the last treatment planning?	○	○	○

Milestones of Recovery Scale (MORS)

Aim: The Milestones of Recovery Scale (MORS) was developed by Dave Pilon, Ph.D and Mark Ragins, M.D., in collaboration with California Association of Recovery Rehabilitation Agencies (CASRA) to provide mental health agencies with a tool to assess the objective and observable behavioral correlates ("milestones") of recovery.

Conceptual Foundation: Mental health recovery is a concept that is evolving through greater understanding of the lived experience of resilience and rebound among people with serious psychiatric disabilities. This focus on recovery has significant implications for the types of mental health services offered, the manner in which they are delivered, as well as the way in which the effectiveness of mental health programs are evaluated.

Development: The three underlying dimensions of the MORS were developed based upon feedback from a workgroup of 50 administrators, clinicians and consumers in the mental health field. The MORS assesses a client's/consumer's (a) level of risk, which is comprised of their likelihood of physically harming oneself or others, their level of participation in risky or unsafe behaviors, and their level of co-occurring disorders; (b) level of engagement within the mental health system; and (c) level of skills and supports, which is a measure of the client's/consumer's abilities and support network, and their level of need from support staff. The MORS was psychometrically tested using staff at The Village, a multi-service organization serving the homeless mentally ill in Long Beach, CA, and Vinfen Corporation, a large provider of housing service to mentally ill persons in Boston, MA. (Fisher, et al., 2009).

Items and Domains: Clients are given one of eight ratings; extreme risk, high risk/not engaged, high risk/engaged, poorly coping/not engaged, poorly coping/engaged, coping/rehabilitating, early recovery, or advanced recovery.

Populations: The MORS is intended for use with adults from diverse ethnic/racial backgrounds who have been diagnosed with a serious mental illness or who have a dual diagnosis. Individuals from several ethnic/racial groups were included in the sample during testing at The Village: Black or African American, White, Hispanic or Latino (limited testing), Asian (limited testing) and limited testing with members from other minority groups. Individuals from several ethnic/racial groups were also included in the sample during testing at Vinfen Corporation.

Service Settings: The MORS is intended for use with individuals who receive services in outpatient service settings, peer-run programs, residential service settings, and comprehensive community support programs. Testing of the instrument included data gathered from individuals receiving services in many of the above mentioned settings.

Frequency of Administration: The MORS should be completed for all clients within 30 days of their initial intake assessment by a clinician who has received training from a licensed MORS trainer. Clinicians should complete a follow-up MORS every 3 months.

Translations: No known translations.

Milestones of Recovery Scale (MORS)

Please circle the number that best describes the current (typical for the last two weeks) milestone of recovery for the member listed above. If you have not had any contact (face-to-face or phone) with the member in the last two weeks, please check here □ and do not attempt to rate the member. Instead, simply return the form along with your completed assessments.

1. **"Extreme risk"** – These individuals are frequently and recurrently dangerous to themselves or others for prolonged periods. They are frequently taken to hospitals and/or jails or are institutionalized in the state hospital or an IMD. They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely that they can be served safely in the community.

2. **"High risk/not engaged"-** These individuals often are disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability which they are not actively managing. They often engage in high-risk behaviors (e.g., unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing, etc.). They may not believe they have a mental illness and tend to refuse psychiatric medications. They experience great difficulty making their way in the world and are not self-supportive in any way. They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.

3. **"High risk/engaged"** – These individuals differ from group 2 only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low functioning and not self-supportive in any way.

4. **"Poorly coping/not engaged"** – These individuals are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They may have deficits in several activities of daily living and need a great deal of support. They are not participating voluntarily in ongoing mental health treatment and/or are very uncooperative toward mental health providers.

5. **"Poorly coping/engaged"** – These individuals differ from group 4 only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support.

6. **"Coping/rehabilitating"** – These individuals are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication. They are actively setting and pursuing some quality of life goals and have begun the process of establishing "non-disabled" roles. <u>They often need substantial support and guidance but they aren't necessarily compliant with mental health providers.</u> They may be productive in some meaningful roles, but they are not necessarily working or going to school. They may be "testing the employment or education waters," but this group also includes individuals who have "retired." That is, currently they express little desire to take on (and may actively resist) the increased responsibilities of work or school, but they are more or less content and satisfied with their lives.

7. **"Early Recovery"** – These individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. <u>With minimal support from staff</u>, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.

8. **"Advanced Recovery"** – These individuals differ from group 7 in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits or health insurance because their employer does not provide health insurance. While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their non-disabled neighbor.

Physical Health Indicators

Aim: The Physical Health Indicators Screener was designed for the Innovation Evaluation program to summarize the quality of medical care delivered to clients, and create an integrated record for all health care providers.

Development: Physical health indicators were selected by Dr. Ted Ganiats, an internationally known expert in the measurement of health outcomes.

Items and Domains: The Physical Health Indicators Screener assesses screening and care for Diabetes, Obesity, Cardiopulmonary disease, Tuberculosis, Asthma, Emphysema, and STD risk. All of the information needed to complete the form should be found in the clients' chart.

Populations: The Physical Health Indicators screener is intended for use with adults from diverse ethnic/racial backgrounds and health conditions.

Service Settings: The Physical Health Indicators form can be used with individuals who receive services in outpatient clinic settings, peer-run programs, and comprehensive community support programs.

Frequency of Administration: The Physical Health Indicators Screener should be completed for clients within 30 days of their initial intake assessment. Clinical staff should complete the form every 6 months. However, we do not expect that all screening tests on the Physical Health Indictors form will be completed every 6 months. Clients should be screened according to clinical need and based on recommendations established by the medical director. So the form can be of clinical use, staff will have the option to list the results and date for any tests completed within the previous 6 months, but can also indicate that no tests were completed.

Physical Health Indicators (Adult)

What is the client's current weight (lbs)? _____ What is the client's height (inches)? _____
BMI-Body Mass Index (kg/m^2) _____ [BMI = (weight (lbs) ÷ height (inches)^2) × 703]

Blood pressure (systolic/diastolic) _____/_____

Is the client insured? □ Yes □ No
If yes, what type of insurance do they have? _____

During the past 6 months, how many days was your client homeless (including living in his/her car)? _____

When was the client last screened or tested for the following medical conditions?
If screening or testing were not completed, please check the appropriate box and move on to the next item. You do not need to fill out the test results section if testing was not completed. Clients should be screened according to clinical need and based on recommendations established by the medical director. Please wait to complete this form until all test results are available.

Diabetes
□ No Tests Completed □ Screening Completed

Fasting blood glucose (mg/dL)_____ Date _____	A1c level (mg/dL)_____ Date _____

High Blood Pressure
□ No Tests Completed □ Screening Completed

Results _____	Date _____

High Cholesterol
□ No Tests Completed □ Screening Completed

HDL level _____ Date _____	LDL level _____ Date _____

Asthma
□ No Tests Completed □ Screening Completed

Results _____	Date _____

Emphysema
□ No Tests Completed □ Screening Completed

Results _____	Date _____

Tuberculosis
□ No Tests Completed □ Screening Completed

Results _____	Date _____

HIV/AIDS
□ No Tests Completed □ Screening Completed

Results _____	Date _____

Hepatitis
□ No Tests Completed □ Screening Completed

Results _____	Date _____

Other STDs
□ No Tests Completed □ Screening Completed

□ Chlamydia Results _____	Date _____
□ Gonorrhea Results _____	Date _____
□ Herpes Results _____	Date _____
□ Human Papillomavirus (HPV) Results _____	Date _____
□ Syphilis Results _____	Date _____

Semi-annual Assessment

The following measures will be administered to clients every six months after their enrollment in the Innovation Program. Adults client will the complete the Integrated Self-Assessment, and either the ISMI stigma measure OR the Satisfaction Survey OR the Post-Outcomes Survey during their semi-annual assessment. By using sampling techniques, we are able to administer several surveys without burdening the client, and still be able to estimate change over time. The iHOMS system has been programed to alert you when an assessment is due for a client, with a link to the appropriate forms. While it is always preferable to have clients complete their assessments on a tablet or computer, if your client needs to complete the assessment on paper, the iHOMS system can provide you with printable PDF forms. For some programs, such as IMHT, it may be more convenient to have several packets of paper forms on hand. The client assessment packets can be printed from the Documents tab on the iHOMS website, and have been clearly labeled to ensure that the client is given the proper semi-annual outcomes measure. Clients whose IDs end with 1, 4, or 7 should receive the Integrated Self-Assessment and the Post-Outcomes Measure. Clients whose IDs end with 2, 5, or 8 should receive the Integrated Self-Assessment and the Satisfaction Survey. Clients whose IDs end with 0, 3, 6, or 9 should receive the Integrated Self-Assessment and the ISMI Stigma Survey.

Clinicians should complete an updated IMR, MORS and Physical Health Indicators form for each client semi-annually. Clinicians and staff at every level of the organization will also be asked to complete a satisfaction survey every May and November. The staff satisfaction survey was developed using targeted focus groups and interviews, and focuses on program implementation, clinic capabilities, communication, training and comfort treating clients with different diagnoses. Individual responses will be kept confidential to promote honest feedback, which will be used to improve the system, training and support. DMH and program staff will only have access to aggregate satisfaction responses.

Internalized Stigma of Mental Illness (ISMI)

Aim: The Internalized Stigma of Mental Illness (ISMI) scale was selected to assess the subjective experience of mental illness stigma. Mental illness stigma has been identified as a significant barrier to mental health care, and is also linked to early termination of treatment. Clients' perceptions of stigma may impede their recovery and their satisfaction with Innovation programs.

Development: The original 29- item instrument was developed by Dr. Jennifer Boyd in collaboration with input from focus groups of mental health clients within the Department of Veterans Affairs (VA) and members of a consumer organization dedicated to fighting the stigma of mental illness. It is a reliable and valid measure of mental illness stigma.

Items and Domains: The brief 10-item survey contains five subscales that will capture client's subjective experience of being "less than a full member of society" (Alienation), their perceptions of how they are treated by others because of their mental illness (Perceived Discrimination), social withdrawal behaviors (Social Withdrawal), common stereotypes about individual with mental illness (Stereotype Endorsement), as well as their ability to resist or be unaffected by internalized stigma (Stigma Resistance).

Service Settings: The ISMI scale is appropriate for use with adults who receive services in outpatient clinic settings, peer-run programs, residential service settings, and comprehensive community support programs.

Frequency of Administration: The ISMI stigma survey should be administered to all clients at baseline, and will be administered to a sample of clients during their Semi-annual assessment.

Translations: The Internalized Stigma of Mental Illness scale has been translated in 60 languages, including Spanish (Spain), Farsi, Korean, Simplified Chinese (Shanghai), Traditional Chinese (Taiwan) and Russian.

Internalized Stigma of Mental Illness (ISMI Scale)

We are going to use the term "mental illness" in the rest of this assessment, but please think of it as whatever you feel is the best term for it.

		Strongly Disagree	Disagree	Agree	Strongly Agree
1.	Mentally ill people tend to be violent.	○	○	○	○
2.	People with mental illness make important contributions to society.	○	○	○	○
3.	I don't socialize as much as I used to because my mental illness might make me look or behave "weird".	○	○	○	○
4.	Having a mental illness has spoiled my life.	○	○	○	○
5.	I stay away from social situations in order to protect my family or friends from embarrassment.	○	○	○	○
6.	People without mental illness could not possibly understand me.	○	○	○	○
7.	People ignore me or take me less seriously just because I have a mental illness.	○	○	○	○
8.	I can't contribute anything to society because I have a mental illness.	○	○	○	○
9.	I can have a good, fulfilling life, despite my mental illness.	○	○	○	○
10.	Others think that I can't achieve much in life because I have a mental illness.	○	○	○	○

Post-Outcomes Survey

Please mark the response that best describes your opinion.

As a direct result of the services I received....

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1.	I deal more effectively with daily problems.	○	○	○	○	○
2.	I know where to get help when I need it.	○	○	○	○	○
3.	My physical health has improved.	○	○	○	○	○
4.	I am better able to manage my health care.	○	○	○	○	○
5.	I feel I belong in my community.	○	○	○	○	○
6.	I do better in social situations.	○	○	○	○	○
7.	My mental health symptoms are not bothering me as much.	○	○	○	○	○
8.	I am better able to take care of my needs.	○	○	○	○	○
9.	I am better able to handle things when they go wrong.	○	○	○	○	○
10.	I am better able to do things that I want to do.	○	○	○	○	○

Client Satisfaction with Services

Please mark the response that best describes your opinion.

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1.	I like the services that I received here.	○	○	○	○	○
2.	If I had other choices, I would still get services from this program.	○	○	○	○	○
3.	Staff were willing to see me as often as I felt it was necessary.	○	○	○	○	○
4.	I was able to get all the services I thought I needed.	○	○	○	○	○
5.	I felt comfortable asking questions about my treatment and medication.	○	○	○	○	○
6.	Staff were sensitive to my cultural background (race, religion, language, etc.).	○	○	○	○	○
7.	This program meets both my mental and physical health care needs.	○	○	○	○	○
8.	My beliefs about health and well-being were considered as part of the services that I re-	○	○	○	○	○
9.	I was provided with referrals to resources that assisted me and/or my family.	○	○	○	○	○
10.	The resources available are in my home community.	○	○	○	○	○

Innovation Provider Outcomes Survey

INSTRUCTIONS: Thank you for your help with this program! Please remember to always include the date and staff identification number. Staff ID is collected for data matching purposes only. All responses will be kept confidential, so please do not include names on any pages. We would like to know about your current experience in meeting clients' behavioral health care needs, so we can focus on ways to make it better. Your input is greatly appreciated.

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1.	I am satisfied with my ability to address the needs of clients with mental health disorders, addictions, and/or psychosocial issues.	○	○	○	○	○
2.	I am satisfied with my clinic's ability to address the needs of clients with mental health disorders, addictions, and/or psychosocial issues.	○	○	○	○	○
3.	I am effective at addressing the needs of clients with mental health disorders, addictions, and/or psychosocial issues.	○	○	○	○	○
4.	My clinic is effective at addressing the needs of clients with mental health disorders, addictions, and/or psychosocial issues.	○	○	○	○	○
5.	I am comfortable being the first line of defense for people with mental health disorders, addictions, and/or other psychosocial issues.	○	○	○	○	○
6.	I am satisfied with my ability to address the needs of clients with medical issues.	○	○	○	○	○
7.	I am satisfied with my clinic's ability to address the needs of clients with medical issues.	○	○	○	○	○
8.	I am effective at addressing the needs of clients with medical issues.	○	○	○	○	○
9.	My clinic is effective at addressing the needs of clients with medical issues.	○	○	○	○	○
10	I am comfortable being the "first line of defense" for people with medical issues.	○	○	○	○	○
11.	In my experience, I am generally satisfied with communication between medical and behavioral health providers.	○	○	○	○	○
12.	I am able to provide or arrange the kinds of services I want for my clients at this clinic.	○	○	○	○	○
13.	My clinic is able to provide or arrange the kinds of services I want for my clients at this clinic.	○	○	○	○	○
14.	Having behavioral health services and medical services integrated will be helpful to clients at this clinic.	○	○	○	○	○

	The following should be priorities as we begin to implement your clinic's integrated behavioral health (BH) program:	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
15.	Elimination/reduction of stigma with receiving behavioral health care.	○	○	○	○	○
16.	Minimal time between PC referral and BH services.	○	○	○	○	○
17.	Co-location or close proximity of PC and BH care.	○	○	○	○	○
18.	BH expertise within PC setting.	○	○	○	○	○
19.	Communication between PC and BH providers.	○	○	○	○	○
	For Medical Staff Only	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
20.	Additional training in mental health diagnosis and treatment would be beneficial for me.	○	○	○	○	○
	For Behavioral Health Staff Only	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
21.	Additional training in medical diagnosis and treatment would be beneficial for me.	○	○	○	○	○

Outcome Measures Tutorial

Objective: Learn the steps to help client's complete the Integrated Self-Assessment and to correctly use the Clinician Assessment Measures [Illness Management and Recovery (IMR), Milestones of Recovery Scale (MORS) and Physical Health Indicators]. Also learn more about the clinical usefulness of these measures and how to incorporate them into treatment planning.

Background: The Department of Mental Health is interested in evaluating behavioral and physical health outcomes and recovery from both the client's and clinician's perspectives. The IMR will be used to assess personal recovery of the client from the perspective of the clinician, and the MORS will be used to assess recovery risk level from the clinician/agency perspective. Behavioral and physical health and well-being will be assessed from the client's perspective using the Integrated Self-Assessment. The quality of physical health care for chronic conditions and screening behaviors will be provided by clinicians' completion of the Physical Health Indicators form. Client and staff satisfaction and stigma reduction, which are also important goals of the Innovation program, will be assessed semi-annually.

Who should complete the IMR, MORS and Physical Health Indicators Screener? Who completes the Integrated Self-Assessment?

Staff: Clinicians will be asked to complete an IMR and MORS for each client as a measure of client recovery. In cases wherein clients see several different program staff at intake and throughout their involvement in the treatment program, the **clinical staff member who works most closely** with the client throughout the therapeutic process should complete the IMR. This can be any staff member who has received training in the delivery of health services, such as a team leader, case manager, clinician, etc. Peer support staff should not complete the IMR. The MORS should be completed by a clinician who has received training from a licensed MORS trainer. Clinicians or staff members will also be asked to complete the Physical Health Indicators form using information found in the client's medical records.

Client: All clients should complete the Integrated Self-Assessment.

What languages will the forms for clients be available in? When will translated forms be available? What if my client is monolingual or illiterate?

The client assessments are currently undergoing translation by Pals for Health, which is a sister organization to SSG (Special Services for Groups). The Integrated Self-Assessment will be available in Spanish, Farsi, Eastern Armenian, Korean, Khmer, Cantonese/Simplified, Samoan, Mandarin and Tongan by the end of the beginning of 2013. Until the translated measures are available in iHOMS, program staff can help clients complete their Integrated self-assessment through interviews.

If the client is not literate in their preferred language, you can enter this information on the registration page. Doing so will activate an icon during participant mode, which will read each question and answer responses to the client aloud in their preferred language so they are able to complete the self-assessment on their own. Text-to-speech capabilities will be supported in many, but not all threshold languages by early 2013.

What should I do if a client would like help completing their Integrated Self-Assessment?

All new clients and clients with treatment planning update/follow-up, should be asked to complete the measures on their own. If clients require assistance with their assessment forms, staff can help them complete the assessments as an interview. Ideally, this could be done by a peer or volunteer but any staff could assist. Assisting persons should keep in mind that responses should reflect the *client's* perception of their behavioral and physical health and recovery. If the assessment is completed as an interview, please check the box on the bottom of the Clinician Assessment cover page.

What is the iHOMS website (https://ihoms.ucsd.edu.)?

The Innovation Health Outcomes Management System (iHOMS) website is a secured database developed by HSRC as an electronic health record, wherein the client integrated self-assessments and IMR/MORS/Physical Health Indicator outcomes measures can be entered, paper versions of the questionnaires can be printed, and recovery outcome reports can be generated by designated staff.

A detailed iHOMS tutorial will be provided during the webinar training. Additional information can be found via the 'Help' tab and webpage footer on the iHOMS website. Specific questions about how to use iHOMS can be addressed to Alfonso Martin with Harder+Co. iHOMS support can be contacted by phone at 213-891-1113, or by email **ihomshelp@ucsd.edu.**

How do I register to use iHOMS?

Due to the confidential nature of client information, iHOMS will only be accessible through a secure log-in system. First time iHOMS users will need to register at: **https://ihoms.ucsd.edu/Registration.aspx** At the registration page, you will need to fill in your username, password, name, and email address. Your username should be your first and last name all lower case and all one word. You will also identify your access level and administrator, who will grant staff members access to this log-in system. Specifically, when staff members register to obtain access, this program supervisor will receive email notifications. The program administrator must then log-in to the website and approve access for pending staff members. Once your access have been approved by your administrator, you will be able to login at **https://iHOMS.ucsd.edu**, and review client information and assessment schedule or enter data. If your access has not been approved by your administrator within a week, please contact the iHOMS support staff.

How does my client complete the Integrated Self-Assessment and Semi-annual Measures? How do I complete the Clinician Assessment?

Integrated Self-Assessments and Clinician Assessments (IMR, MORS, Physical Health Indicators Screener) are online questionnaires. The assessments were programmed into iHOMS as smart forms to minimize redundancy and respondent burden. We suggest that clinicians complete IMRs, MORs and Physical Health Indicators Screener directly online, and have clients complete the Integrated Self-Assessment on the tablets supplied by HSRC.

Staff: The iHOMS system has been programmed to track when clients are due for assessment so clinicians and staff do not need to. Clinicians can find a list of all clients registered in their program that are due for an assessment in the Status Report, which can be found on the Aggregate Reports tab. Selecting a Client ID from this report will open the Client Information Page with the assessment forms for that client. Program staff should complete their assessments online by filling in their responses on the IMR and MORS. Information needed to complete the Physical Health Indicators Screener can be obtained from the client's medical records.

Client: All clinics will be provided with a tablet to allow clients to complete their assessments directly into the iHOMS system, which will be used to manage and summarize your clients' health outcomes. Clients need to be registered by a staff member in iHOMS before they can complete their assessments. Staff can follow the "Register New Client" link on the home page to register their clients. You will be asked to provide the client's first and last name, date of birth, preferred language, gender, ethnicity/race, model/program and enrollment date. You will also need their client ID, which is their IS number. Once a client is registered in the system, you will be able to search for the client's information on the Client Data tab. When you select the Client ID, it will open the Client Information Page with a list of the available forms for that client. By selecting the Integrated Self-Assessment, iHOMS will start participant mode, and the client can complete their assessment. While in participant mode, a client is unable to access any other client information or assessments on iHOMS system. Clinicians and clients will have one week to complete their assessments forms after they have been started.

What if my client needs to complete their assessments on paper?

Clinicians can download and print out paper forms for each client due for an assessment from the website: **http://ihoms.ucsd.edu/reports/aggregate/AssessmentStatusReport.aspx** Before having the client complete their self-assessment, please write their Client ID number at the top of each page, and the Clinic ID number and date at the top of the face page. Once the client has finished the assessment, please check each page to ensure all of the questions have been completed, and help the client with any questions as needed. Assessments completed on paper will need to be entered into iHOMS electronic system through Back Entry Mode to ensure that the assessment data is associated with the correct assessment period.

What if I don't know the Client's ID?

A Client ID is their IS number. There is a searchable Client Lookup on the iHOMS website for clients registered in your program. It can be found in the Client Data tab. You will be able to search for clients using their first and last name.

What if a client is unavailable (for example, in jail), when they are due for an assessment?

The Assessment Status Repot, which is available from the Aggregated Reports tab in iHOMS has been programed to alert you when assessments are due for your clients, with a link to the appropriate forms. Assessments will be available in iHOMS up to two weeks before the due date, and for 1 month after the due date. Overdue assessments can be completed up to two months after the due date, however, assessment data completed on-time is more comparable to other programs. If your client is unavailable during an assessment period, iHOMS will record it as a missed assessment, and it will be replaced with the next scheduled assessment in the client status report. Your client does not need to "make up" missed assessments.

Can a clinician complete retrospective or "make up" assessments for clients?

Clinicians have the option to recreate assessments from memory or using medical records for currently enrolled clients (IMR, MORS and Physical Health Indicators Screener). Retrospective assessments allow us to track progress for clients who are already receiving services. Even completing only the Physical Health Indicators screener, which can be accurately recreated using the clients' chart, improves our ability to detect change for clients. Retrospective assessments are not mandatory, and should ONLY be completed by clinicians. There will be a retrospective data entry method programmed into iHOMS to allow you to enter the assessments. Retrospective data is different than the temporary assessment packets that were completed on paper. A separate edit mode will be programmed into iHOMS to edit existing forms, or enter assessments completed on paper.

Can we get reports of client data?

HSRC will combine clients' Integrated self-assessments with their IMR, MORS and Physical Health Indicators data. Reports summarizing client recovery are designed to be of clinical use for treatment planning, and will be available to program staff in real time at the iHOMS website. These reporting features should be available by the end of the year. An example of the Client Recovery Report can be seen on page 31.

Specific cultural questions are not being addressed by any of the core measures. Will additional measures be available?

The satisfaction surveys, which are administered semi-annually, were developed to assess programs cultural competency and involvement in the community, which are important goals of the Innovation Program. We plan to make more population and model-specific measures and optional forms available in iHOMS in the future.

How can we enter previous assessments and paper forms into iHOMS? How do we determine which data entry mode to use?

The four data entry modes can be accessed from the Previous Assessments tab in iHOMS. Each mode option is accompanied by a brief description to help you select the correct data entry mode for your needs. Below are descriptions of the four previous assessment modes. Further information is available from the iHOMS Help tab.

- **Review Mode:** Review Mode allows clinicians/staff to view both client and clinician assessment information that has been entered into iHOMS.

- **Edit Mode:** Edit Mode allows clinicians/staff to edit or add information to an existing, submitted assessment form in iHOMS. Information that may need to be edited in an assessment may include data entry errors. You can also use Edit Mode to add information to an existing assessment that was not previously available, including pending labs results.

- **Back Entry Mode:** Back Enter Mode allows clinicians/staff to enter paper forms directly into iHOMS. This feature should only be used to directly transcribe paper forms into iHOMS and not to record retrospective data (covered in the following section). Back enter mode will be available for both current and past due assessments.

- **Retrospective Mode:** Some clinics may wish to record retrospective data into iHOMS, which can be done using Retrospective Mode. This feature is primarily geared toward clinics that have clients who were enrolled in the LA Innovations program before formal assessments began, who as consequence, have missing past due assessments. While entering past due assessments retrospectively is not required, it may benefit programs with clients who have been enrolled in the INN program before formal assessments began to see a more accurate change over time.

What's in this for me and my clients?

Client Recovery: LA County Mental Health strives towards an integrated recovery oriented system. To ensure we are reaching this goal, it is crucial to assess whether or not clients are recovering. Using these assessments will help measure clients' progress towards recovery. The assessments can also help facilitate recovery by encouraging communication between people receiving and providing services.

Clinical Usefulness: These measures were chosen to be clinically useful in addition to measuring outcomes. Completing these measures will not only help further inform the clinical team, but may also enhance the therapeutic process and communication with the client. Responses on the recovery measures can reveal important information for the clinician. The measures can also be used to identify strengths that the client can use in their recovery. Administering the self-reported measures communicates to the client that we see them as a whole person, and are interested in many aspects of their health and quality of life, not just their psychiatric symptoms. For peer specialists or student interns, assisting the client to complete the self-report measures can provide a meaningful structured activity that is very likely to inspire therapeutic dialogue on important recovery issues.

Balanced Workload: As soon as your organization begins to use the Integrated Self-Assessment and Clinician Assessment (IMR, MORS and Physical Health Indicators), you will be able to balance staff workload by eliminating the DMH Interim Baseline Measures and the ASSIST. Both the process of completing the Clinician Assessment and Client Integrated Self-Assessment and the information gleaned from them can be incorporated into clinical practice, and thus ensuring that integrated services are being provided.

Who can I contact about the Outcomes Measures if I have questions later?

Please contact Marissa Goode or Andrew Sarkin at HSRC if you have any questions about the outcome measures. Their contact information is as follows:

E-mail: Marissa Goode, **mgoode@ucsd.edu**; Andrew Sarkin, **asarkin@ucsd.edu**
Telephone: (310) 591-8025 (Health Services Research Center)
Address: UCSD HSRC
5440 Morehouse Drive, #3500
San Diego, CA 92121
Att: Kimberly Center

For concerns about the new tools, you can also contact Matt Wells in the LA County Department of Mental Health. He can be reached by email: **MWells@dmh.lacounty.gov**

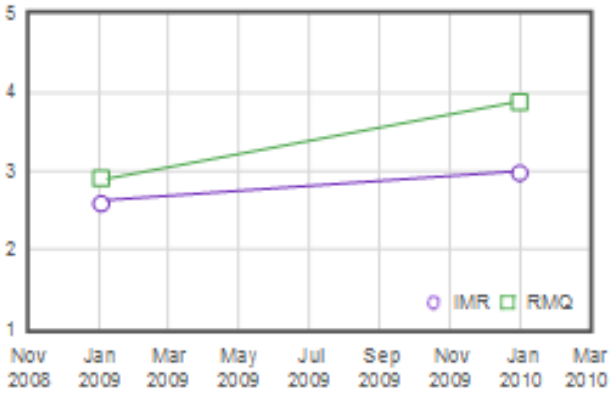
Client Recovery Report

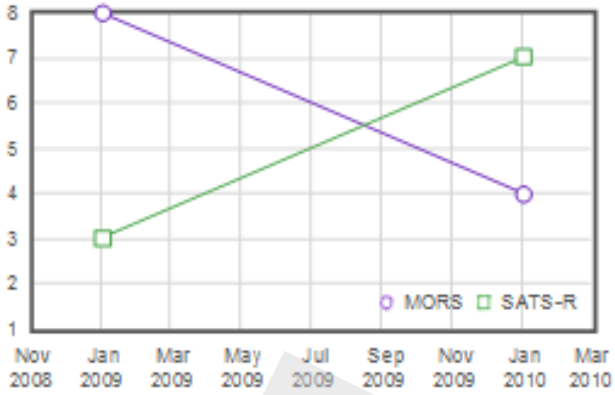
Client Number: 777 **Unit:** 777 - TEST UNIT

Current Recovery Ratings:

IMR: 3.0 **RMQ:** 3.9 **SATS-R:** 7 **MORS:** 4 **LOCUS:** 3

Average Recovery Rating Over Time:





Clinician Rated Recovery (IMR)

Current: 1/1/2010
Previous: 1/1/2009

Knowledge: How much do you feel your client knows about symptoms, treatment, coping strategies (coping methods), and medication?

Current: (3) Knew some
Previous: (1) Did not know very much

Time in Structured Roles: 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?

Current: (1) Spends 2 hours or less/week
Previous: (2) Spends 3-5 hours/week

Impairment of functioning: How much do symptoms get in the way of him/her doing things that s/he would like to do or need to do?

Current: (4) Symptoms get in his/her way very little
Previous: (4) Symptoms get in his/her way very little

Relapse of Symptoms: When is the last time s/he had a relapse of symptoms (that is, when his/her symptoms have gotten much worse)?

Current: (1) Has relapsed within the last month
Previous: (4) Has relapsed in the past 7 to 12 months

- *Higher ratings on IMR, RMQ, SATS-R and MORS indicate greater recovery.*
- *Lower ratings on LOCUS indicate greater recovery.*