APS Healthcare

Final Report

CAEQRO Report, FY13-14

Los Angeles

Conducted on

April 28 - May 1, 2014

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❖INTRODUCTION❖

BACKGROUND AND METHODOLOGY

The California Department of Health Care Services (DHCS) is charged with the responsibility of evaluating the quality of specialty mental health services provided to beneficiaries enrolled in the Medi-Cal managed mental health care program.

This report presents the fiscal year 2013-14 (FY13-14) findings of an external quality review of the Los Angeles County mental health plan (MHP) by the California External Quality Review Organization (CAEQRO), a division of APS Healthcare, from April 28 to May 1, 2014.

The CAEQRO review draws upon prior year's findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management – emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for Key Components associated with the four domains: quality, access, timeliness, and outcomes. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups and other stakeholders which inform the evaluation within these domains. Detailed definitions for each of the review criterion can be found on the CAEQRO Website www.caeqro.com
- Analysis of Medi-Cal Approved Claims data
- Two active Performance Improvement Projects (PIPs) – one clinical and one non-clinical
- Four 90-minute focus groups with beneficiaries and family members
- Information Systems Capabilities Assessment (ISCA) V7.3.2

❖FY13-14 REVIEW FINDINGS❖

STATUS OF FY12-13 REVIEW RECOMMENDATIONS

In the FY12-13 site review report, CAEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During this year's FY13-14 site visit, CAEQRO and MHP staff discussed the status of those FY12-13 recommendations, which are summarized below.

ASSIGNMENT OF RATINGS

- Fully addressed – The issue may still require ongoing attention and improvement, but activities may reflect that the MHP has either:
  - resolved the identified issue
  - initiated strategies over the past year that suggest the MHP is nearing resolution or significant improvement
  - accomplished as much as the organization could reasonably do in the last year
- Partially addressed – Though not fully addressed, this rating reflects that the MHP has either:
  - made clear plans and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues
- Not addressed – The MHP performed no meaningful activities to address the recommendation or associated issues.

KEY RECOMMENDATIONS FROM FY12-13

- Examine the feasibility of modifying the Quality Improvement Division (QID)/Program Support Bureau (PSB) structure so that headquartered staff are empowered to facilitate and direct both systemwide and Service Area (SA)-specific Quality Improvement(QI)/ Performance Management (PM) efforts and projects:

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  The MHP reports that the administrative structure of QID/PSB authorizes departmental QI staff to monitor and empower each SA Quality Improvement Committee (QIC) on QI-related activities within their SA, with the QID/PSB providing technical assistance and data support. This includes annual statewide Performance Outcomes and Quality Improvement (POQI) survey administration and reporting, change of provider, beneficiary grievance reports, and Performance Improvement Projects (PIPs).

- A few QI projects have been underway in the SAs in the last year, including a successful timely access project at one of SA7's Directly Operated (DO) clinics, highlighting some successful QI strategies and positive outcomes as a result. Review of the eight SA QIC minutes for last year also revealed consistent discussion of the systemwide test call project, including individual SA involvement expectations, as well as the effective rollout of initial service timeliness and tracking policies from the Office of the Medical Director (OMD).
- Several SA QICs received trainings from the Patients' Rights Office (PRO) on beneficiary grievances, change of provider requests, and Notice of Actions to improve overall provider knowledge and to ensure providers take timely and appropriate actions related to these issues. This has resulted in an increase in the number of providers reporting change of provider requests to the PRO, as required.
- The OMD presented important updates regarding psychiatrist peer review activities, new clinical policies, and revision of departmental medication parameters at a departmental QIC meeting this last year. In 2014, the Office of Family Engagement (OFE) made a presentation highlighting the importance of family inclusion and engagement to improve consumer access, service, and satisfaction. Follow-up discussion included identifying family inclusion and engagement as a potential area for QI activity for all SAs.
- At the November 2013 departmental QIC meeting, all SA QIC Chairs received and discussed information and handouts provided by QID relating to *Quality Assurance (QA) versus QI*, *QI for Mental Health*, *Strategies and Innovations for Successful QI in Behavioral Health*, and The Institute of Healthcare Improvement examples of QI. Additionally, five SA QIC Chairs attended a free training on Continuous Quality Improvement offered by RAND.
- In order to ensure the QI function is more fully connected to the Executive Management Team (EMT) and overall quality management efforts, in January 2014 the QID District Chief began updating the EMT on systemwide QI activities/issues quarterly and as needed at Program Deputies meetings.
- Contract providers reported the MHP requires them to maintain monthly QI/QA plans and send updates on their various monitoring projects to their SA QIC each month. Cited projects included developing methods to track service model fidelity and adapting clinical supervision to a holistic approach.

- Target two or three consumer dissatisfaction areas, as gleaned from data trends and/or recent survey results, to develop targeted SA-specific or systemwide improvement projects:

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

The MHP reported engaging in multiple activities in response to consumer feedback from both consumer focus groups and FY12-13 satisfaction survey reports, including:

- In response to feedback gathered from parents/caregivers of Child Full Service Partnership (FSP) consumers, the Children's System of Care (CSOC) Administration launched the Family Support Services Enhanced Respite Care Pilot Program to provide supportive services to parents/caregivers of child FSP consumers. As of October 2013, 46 families had received respite for an average of 9 hours each month. Currently, eight Child FSP provider sites offer these Enhanced Respite Care services to enrolled families. The MHP is creating a workgroup of CSOC providers and willing parents to discuss growing other respite care options using agencies with respite experience specifically for behaviorally-challenged children.
- To address expressed consumer desire for more family involvement, the OFE offered trainings on *Family Psycho-Education*, a SAMHSA Evidenced-Based Practice (EBP) to staff in all eight SAs, training 200 clinicians. They also provided a 3-hour training on *Engaging Families* to 73 staff and a course on *Family Inclusion in the FSP Outreach to Graduation* training. More training is scheduled throughout 2014.
- A 3-month pilot project was developed for staff at two DO clinics, the American Indian Counseling Center's FSP and the South Bay FSP, offering families additional supportive phone calls, home visits, and case consultation.
- The Older Adult (OA) FSP programs implemented a satisfaction survey. Findings indicated that in general, respondents were highly satisfied with their services and the staff providing these services, yet they experience very real limitations in terms of social support from outside the FSP program. From this, it was surmised that OA FSP programs may benefit from exploring various ways to build and sustain rapport, foster effective communication, and strengthen natural community supports for FSP participants.
- The Empowerment and Advocacy Office (EAO), with technical assistance from the PSB, coordinated a peer survey of eight DO clinics in FY12-13 and FY13-14, one in each SA. Surveys were conducted by pairs of volunteers, both graduates of the Client Leadership Class or members of the Client Congress Advisory Board (CCAB). The goal for each clinic was to complete 30 surveys; 234 completed surveys were returned indicating positive feedback regarding MHP services. Concerns centered on a need for cleaner restrooms, cleaner or new furniture in waiting areas, shorter wait times to psychiatry appointments, better customer service from front desk staff, more security, and the provision of magazines or TVs in waiting areas. For most clinics, restroom cleanliness was the main area of concern. These findings were presented to the EMT which approved funding for clinics to obtain additional cleaning services. Other actions taken included using more telepsychiatry appointments to reduce wait times for psychiatry services, requesting new furniture and having old furniture cleaned, providing customer service training for front desk staff, providing magazines and TVs when possible, and adding security for specific

clinics of concern.

- Develop, implement, and evaluate policies to ensure resources allocation is appropriate and equitable for all consumers and that Medi-Cal beneficiaries have same timely access/quality services provided to Healthy Way LA (HWLA)/other specialty population consumers, such as the pending 30-day initial access policy:
  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - In August 2013, the MHP issued Policy 202.43 that establishes timeframes for all individuals to receive their initial appointment and identifies specific data elements to be documented. This policy clarifies that all consumers, regardless of payee source, must be offered an appointment as "close as possible to the date of original contact." Further, requests for services can be prioritized based on department or program criteria but must not delay initial appointments for any new consumer beyond 30 days. It also requires that any consumer discharged from an acute inpatient facility (including Juvenile Hall) must be seen within 7 days of discharge; that appointment is required to be made with a medical provider when a consumer is requesting medication.
  - A subsequent QA Bulletin describes the procedures behind the use of a Service Request Log which documents all initial requests for services. The MHP is currently in the process of transitioning from a paper-based Service Request Log to an electronic system that will track initial requests for all DO and contract providers systemwide. This web-based application, the Service Request Tracking System (SRTS), was deployed a few weeks prior to CAEQRO's visit, and will capture all data elements required by state and federal regulations surrounding initial access. As of the review, approximately 85% of all DO clinics and Legal Entities (LE) providers, as well as the Access Call Center (totaling some 1,300 users) were registered in SRTS. The data will permit the MHP to compile and report information on initial service access and timeliness countywide. DO providers not already converted to Integrated Behavioral Health Information System (IBHIS) and contract providers unable to submit data elements via electronic data interchange (EDI) transactions are required to use SRTS; however, SRTS will be phased-out when all providers are either using IBHIS or can submit data to it via EDI.

- Investigate the feasibility of replacing the current security token technology with newer security authorization technology that will expedite issuing user security authorizations:
  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - In March 2014, the County Board of Supervisors approved the purchase of a software license from RSA Security LLC (RSA) for a countywide risk-based authentication solution to serve all County departments. The RSA product will

replace the current security hardware tokens being used countywide. The project is being led by the County's Chief Information Office and is in the early stages of purchase and implementation planning. The County's Information Systems Department (ISD) will design the infrastructure and rollout a plan for token replacement across all County departments; the MHP has requested to be an early adopter of the new solution when it becomes available. While security token replacement was not listed as an FY13-14 MHP initiative, it will become one as the RSA product becomes available.

- Commit to multiple mechanisms to monitor the effectiveness of the new Access Center system:

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

Multiple mechanisms were implemented to monitor the ability of the Access Call Center to answer calls promptly which include:

- The Access Call Center's data tracking system was upgraded twice during a 15-month period; the Symposium data tracking system was in place through November 2012 and on November 27, 2012, the Web Center system was installed and operational through October 29, 2013.
- The Virtual Call Center (VCC) system was installed by December 31, 2013, and remains in place, offering significant improvements over Web Center. These improvements include use of a system that is more user-friendly for call center phone agents; for example, when agents logon, they are able to view what skills are assigned to them, to easily view the calls waiting in the queue, or to transfer calls to the language line/other providers. VCC allows supervisors to monitor call flow and phone agent activities more closely and in real time, and reduces system redundancy as it shifts automatically to a backup server when production servers need maintenance. Also, VCC allows supervisors to force user logout if users forget to do so. If agents forget their password, they can request a password reset in VCC. Finally, VCC allows administrators to establish security profiles to grant different permissions to different users.
- Data reports are generated weekly by a number of newly designated data analysts and reviewed by the Access staff workgroup and Emergency Outreach Bureau (EOB) management to manage high call volume, using staff re-assignments and external staffing resources when necessary.
- Additional improvements at the Center include hiring ten new Spanish-speaking phone agents, one supervisor, and one training coordinator. The training coordinator developed systematic training protocols designed to increase call handling efficiency as well as assist Center supervisors in monitoring agent call handling more closely. The standard is to answer 75% of all calls within 1 minute; April 2014 data showed that 70%-82% of calls were answered in under a minute, with an average caller wait

of 40 seconds.

- Wait time measurement for calls to the Center now starts when the caller presents to VCC and ends when the call is answered by an agent or the caller leaves a message.
- The MHP reported the average number of calls received per month by the Center during CY13 was 14,812 agent calls and 19,964 Network Interactive Voice Recording system messages. Data provided regarding Access Center service delivery showed that, in FY12-13, over 112,000 mental health referrals were made and 408 primary care provider referrals were made. Approximately 8% of the total calls required Language Line interpretation services.
- CY13 MHP data revealed the Center's abandoned call rate dropped significantly to an average of 11% (down from 21.6% in CY12), following the automatic phone roll over from DO clinics to the Access Center afterhours which began in November 2012. April 2014 data showed the abandoned call rate had dropped further to 7%. With the new system, callers who reach the clinics afterhours have an option of transferring to the Center's toll free number or leaving a voicemail at the specific clinic. This new process for appropriate routing to the Access Center for immediate help is more efficient than past processes in which all DO clinic calls rolled over to the Access Center, irrespective of caller need. Standard after-hours DO clinic phone message scripts are also in use.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

Changes since the last CAEQRO review, identified as having a significant effect on service provision or management of those services are discussed below. This section emphasizes systemic changes that affect access, timeliness, quality, and outcomes, including those changes that provide context to areas discussed later in this report.

- Los Angeles (LA) County is the most populated county in the United States with a CY12 estimated population of 9,905,351 in 88 legal cities and 4,085 square miles. It is the densest part of the state, with a population density of 2,440 people per square miles versus a statewide density of 244 people per square mile.
- CAEQRO approaches the Los Angeles review by visiting at least two SAs annually as well as focusing on larger MHP programmatic and quality efforts. For the FY13-14 review, the SAs reviewed included SA1 and SA3; their SA-specific information and submissions, along with centralized sessions and submissions, inform this report.
    1. SA1 encompasses the northern most part of the county, covering the Antelope Valley. It is the largest geographic SA and the most remote and dispersed. Over 387,000 people live in SA1 (per the 2010 U.S. Census), of which 44.6% are Hispanic and 35.3% are White. The SA contains two adult DO clinics, one child DO clinic, one adult DO Wellness and Enrichment Center, and two co-located Specialized Foster Care (SFC) offices. The MHP contracts with 15 different

community providers in the region to offer services to consumers of any age; SA1 offers 244 Child, Transition Aged Youth (TAY), Adult and OA FSP slots. This SA has only ten adult inpatient beds available within its borders, but an abundance of foster homes.

2. SA3 encompasses the eastern most part of the county, covering the San Gabriel Valley, and is the second largest geographic SA. Over 1.76 million people reside in SA3 (per the 2010 U.S. Census); while SA 3 is predominantly Hispanic (46.3%), it is also home to a large Asian/Pacific Islander (API) community (28%). The SA offers services at one adult DO clinic, one adult DO Wellness Center, five co-located SFC offices, and 1,010 FSP slots for all four age groups. This SA contracts out all children services to 26 providers, as well as maintains contracts with ten adult/OA community providers. Unlike SA1, this SA offers beds at seven local fee-for-service hospitals and five IMDs within its borders.

- FY12-13 data showed the MHP served over 157,400 Medi-Cal beneficiaries countywide, an increase from more than 4,000 beneficiaries from FY11-12, with an increased regular Medi-Cal budget of over $33 million. SA management reported seeing a recent increase in new consumers, especially children, after an increase of adult consumers when Healthy Way Los Angeles (HWLA) rolled out the year prior.
- During the site review, the MHP received confirmation of a $41M award of Senate Bill (SB) 82 funds to expand consumer access to crisis intervention services and reduce unnecessary hospitalizations. The MHP intends to use these funds to:
  - Develop four additional Urgent Care Centers throughout the county in SAs currently without a facility.
  - Develop 560 additional Crisis Residential beds, in approximately 35 facilities, throughout the County. Currently, there are only 34 beds in three facilities; the new facilities will be strategically placed, accounting for location of existing programs, population, and prevalence of mental illness.
  - Increase existing psychiatric mobile response teams and add staff for new partnerships with local law enforcement agencies.
  - Develop new field-based teams countywide, through population specific programs, including Mobile Triage Teams, Youth Crisis Placement Teams, Forensic Outreach Teams, and Crisis Transition Specialist Teams.
- The County saw significant changes in its Assembly Bill (AB) 109 program, including:
  - Creating an AB109 specific training curriculum in concert with the MHP's Training Bureau which was provided to all system providers to enhance their knowledge and practices relating to engaging and treating mental health consumers with co-occurring disorders and criminal justice backgrounds.
  - Funding jail in-reach activities by MHP providers to establish pre-release

linkages between AB109 consumers and community-based providers to enhance later treatment retention.

- Creating of a Co-Occurring Integrated Care Network Pilot project designed to address the needs of AB109 consumers with co-occurring chronic substance use disorders and severe mental illness.
- Developing a Revocation Court which includes the option of up to 90 days of residential treatment at the Antelope Valley Rehabilitation Center.
- Increasing the number of IMD step-down beds by an additional 60 beds to improve community retention, increase access to health care, improve compliance with treatment, decrease substance-related arrests, and reduce crisis, emergency room, and inpatient service use.
- Increasing staffing to cover services previously provided by non-AB109 staff such as assessment and engagement in jail treatment and referring those with mental health issues to community providers.

- The MHP's Office of the Family Advocate has transformed into the Office of Family Engagement (OFE). This office has two dedicated clinical staff that provides support to family members, trainings for staff, and coordinate with family organizations such as NAMI. Although OFE has been out in the community educating providers about their services and newly developed parameters, many contracted provider clinicians interviewed were unaware of the existence of the MHP's centralized OFE or Empowerment and Advocacy Office (EAO) and the resources they provide. OFE will continue to present and educate in the SAs in FY14-15.
- As a result of the Affordable Care Act (ACA) implementation, the MHP now has a dedicated phone line to expedite the handling of urgent referrals from local Medi-Cal Managed Care Plans (MCP) to the Access Call Center. Collaboration between LA Care, the MHP, County Public Health, Beacon, and Health Net led to the creation of a simple, one-page screening form to be used by a MCP clinician at any point of service to request a complete assessment for specialty mental health and/or substance use disorder treatment. Further, the MHP has required all DO and contracted full-scope Medi-Cal clinics to reserve three to five dedicated intake appointment slots each week for these urgent MCP referrals.

  At the Access Center, an agent reviews the MCP screening tool to confirm that the criteria for an urgent appointment is met and then schedules a face-to-face assessment appointment for the referred member within 7 calendar days. In February and March 2014, the MHP received 63 MCP referrals; each resulted in a MHP appointment within 2 or 3 days.

  In addition, as a result of ACA and the expansion of Medi-Cal, children providers are now able to expand access and availability of mental health services to parents/caregivers of youth currently receiving services.
- The MHP continues to transition about 120 DO sites from their present information

system (Integrated System or IS) to IBHIS. In CY12, DO providers served 50,000 duplicated Medi-Cal beneficiaries and provided about $130 million Medi-Cal approved claim services. The initial provider group went live January 2014 and all DO providers are expected to be converted and fully IBHIS operational by December 2014. Transitioned DO site users will be able to do direct data entry into IBHIS and have IS "look-up" capability.

- The MHP's newest initiative builds upon existing community-based partnerships throughout the County to support creating *Health Neighborhoods* with the goal of better coordination of community resources and improved care access for all. Using a partnership strategy to empower communities to improve consumer health outcomes (based on social determinants of health), mental health, substance abuse, and public health agencies will integrate and join social services, faith based organizations, retail merchants, primary care/health plans, law enforcement, and educational systems partners. The MHP routinely gathers and collects outcome measures for the intervention model (known as the Mental Health Integration Program through an existing application. They are actively working with County Health Services (HS) to exchange data with HS data (i.e., health metrics), as part of the overall integration and care collaboration.
- In response to the 1115b Medicaid State Waiver, which was intended to serve as a bridge to health care reform, the MHP facilitated partnerships between the County's 65 Federally Qualified Health Centers (FQHC), DO clinics, and contract providers to improve timely access to community services. In those communities which had already begun this process, the MHP played a key role in training the agencies to use an evidence-based clinical intervention model designed to better integrate care. The MHP is now working with children's mental health providers to incorporate them into these existing partnerships. Many of the health neighborhoods will be organized less by geography and more by culture, ethnicity and linguistic capabilities as a means to address the County's diversity.
- The LA County jail system has been negatively impacted by the mental health needs of inmates. The collaborative goal between the jail system and the MHP is to offer proper mental health treatment to such inmates in the appropriate facility by designing a new facility to replace the current Men's Central Jail, possibly with a community-based treatment facility. In the past, no substance abuse services were provided to County inmates, and so building a community-based facility would allow for this, better preparing inmates for eventual release. The overarching goal is to release inmates back into established Health Neighborhoods with a network of services to meet all of their needs.
- The Adult System of Care (ASOC) embarked on the Clinic Re-design (CRD) project as an important aspect of ACA implementation. Twenty-one DO adult clinics completed a readiness questionnaire to assess for areas to focus implementation. A pilot was implemented with four DO clinics in Long Beach, San Fernando, Santa Clarita and West Valley in December 2013. Each clinic completed a self-assessment

tool and now meets monthly.

A CRD toolkit was drafted to assist all DO clinics with capacity management. While the project's overarching goals are grounded in Health Care Reform's triple aim, the toolkit is designed to maximize staff resources at all levels using a new team-based approach and bi-directional primary care referrals. The project encourages welcoming and engagement processes, as well as consumer program graduation. The toolkit has four sections: Core Principles, Core Components of Team-Based Approach, Getting Started at a Clinic (i.e., clinic readiness self-assessment, action plan logic model template), and Maintaining Sustainability (i.e., self-monitoring tool, evaluation plan).

Using the model requires a clinic to:

- Ensure 8 am to 5 pm weekday walk-in capacity.
- Identify fixed appointment times for screening urgent primary care/MCP referrals (one slot per 300 open cases).
- Integrate a care clinic into their practice. A pilot project is presently being testing in one SA using a clinician and psychiatric nurse team approach to offer medication support to reduce consumer wait between routine medication appointments.
- Integrate membership services by ensuring from point of initial contact that consumers are supported by staff/volunteers with lived experience throughout treatment.
- Screen all consumers at point of referral/triage so that those who are in need of and/or would benefit from medication support services will be provided with same day medication services.
- Develop Membership Services, Behavioral Health Assessment and Care Clinic teams.

- LA is now a two-plan county for Cal MediConnect consumers – having initially been a five-plan county. The MHP reported all the necessary MOUs, systems and processes are in place between the parties.

Performance & Quality Management Key Components

CAEQRO's overarching principle for review emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management – an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies which support system needs – are discussed below.

Quality

CAEQRO identifies the following components of an organization that is dedicated to the overall quality services. Effective quality improvement activities and data-driven decision making requires strong collaboration among staff, including consumer/family member staff, working in information systems, data analysis, executive management and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Figure 1. Quality

Component		Present	Partial	Not Present	Not Rated
1A	Quality management and performance improvement are organizational priorities	X			
1B	Data is used to inform management and guide decisions	X			
1C	Investment in information technology infrastructure is a priority	X			
1D	Integrity of Medi-Cal claim process, including determination of beneficiary eligibility and timely claims submission	X			
1E	Effective communication from MHP administration	X			
1F	Stakeholder input and involvement in system planning and implementation	X			
1G	Consumers and family members are employed in key roles throughout the system	X			

Issues associated with the components identified above include:

- The MHP evidenced a QI Work Plan for FY14-15 with measurable goals and objectives focused on service delivery, accessibility of services, beneficiary satisfaction, and clinical care. Several of the goals are geared towards monitoring these activities with measurable indicators; some goals focus on maintaining the current rate of success. The MHP produced an extensive and detailed evaluation of its FY12-13 QI goals addressing multiple results of its activities outlined that year's Work Plan. Based on that evaluation, CAEQRO encourages the MHP to consider establishing new goals which push for additional improvement in areas where indicators already reveal achievement. DHCS performed its tri-annual review of the MHP in February/March of 2013, and from the MHP's centralized QIC minutes, it appears that several activities since then respond to the findings from that review.

Data reports are dispersed at the monthly countywide QIC meetings focusing on timeliness, access, service capacity, consumer satisfaction, or other indicators, all tracked for progress. The Departmental QIC has attempted to integrate current departmental plans for improvements throughout the various SAs by:

- planning to implement an on-line incident reporting procedure
- issuing a countywide policy on how to document and track provision of timely first services
- considering the possibility of incorporating a suicide assessment risk tool into assessment documentation
- providing policies/definitions for *Katie A*. services
- creating a weekly update via the QA *Tip of the Week* memo
- updating the QI Handbook/Documentation manual
- incorporating substance use disorders into the MHP's care plan

The QID also tracks and trends the results of Access Call Center test calls. In 2013, 91 daytime test calls were made in 11 languages, a strong improvement from having conducted only ten English calls in 2009, with notable improvement in all areas of concern, including Access agents asking for caller's name, assessing for crisis, and logging the call correctly.

In addition to the departmental QIC monthly meetings, each SA conducts its own QIC meetings, either monthly or bimonthly, which are co-chaired by an MHP representative and a contract provider representative. Review of all SA QIC minutes showed that *consistent* monitoring of key quality issues or the proliferation of SA-specific improvement projects was absent. In many cases, activities focused instead on chart/peer reviews, compliance issues, meeting announcements, and discussion of changes to relevant policies and procedures. In most instances, the dissemination of data occurred centrally, and it appears that each SA QIC must initiate its local interpretation of that data. Review of all SA QIC minutes showed that consistent monitoring of key quality issues in each SA – stemming from systemwide or SA-specific data or the proliferation of SA-specific improvement projects was absent. In many cases, activities focused instead on chart/peer reviews, compliance issues, meeting announcements, and discussion of changes to relevant policies and procedures. In most instances, while the dissemination of relevant data occurred centrally, and it appears that each SA QIC must initiate its local interpretation of that data; this does not consistently occur. Onsite stakeholder discussions revealed SA management will need to increase its involvement in order to make SA QI efforts consistent and data driven; even when departmental QIC data is available, it does not get utilized consistently across the system. Some stakeholders suggested that SA management should more effectively use departmental quality data to inform decisions, and that shared data reports should be followed by a dialog to better understand community needs and vulnerabilities. Finally, each SA formats their QIC

minutes idiosyncratically; the MHP could consider a standardized reporting format to provide consistent information provision as well as ensure true QI activities take place.

In November 2013, all SA QIC Chairs received a survey developed by the QID and the Access Call Center to gather feedback related to referral follow-up from the Center. This identified some problems and lead to the development of protocols to improve timely access to services for referred consumers. One problem was a lack of clarity regarding how providers should address inappropriate referrals to the Center. As a result, the Center designated one in-house contact, a Supervising Psychologist, to deal with such concerns. This has effectively established a feedback loop for providers to provide accurate information to Access as well as ensure consumers' access appropriate care in a timely manner.

- The MHP's overall use of data to inform and guide decisions is exemplary and few other counties come close to matching their level of knowledge and expertise. The Strategies for Total Accountability and Total Success (STATS) program provides a forum for the systemic use of identified performance measures (PMs) to facilitate organizational accountability, improvement and decision-making on a monthly basis for all DO clinics. In the few months prior to CAEQRO's visit, STATS had been on hiatus while IBHIS go-live implementation started. During this time the MHP renovated the process and introduced new PMs surrounding access to care and service timeliness. Monthly STATS meetings are set to resume later in 2014.

  SFC also has its own dashboard used by MHP administration to easily identify the state of services. SFC indicators include consumer expenditures, time lapse to consumer service after a County Department of Child and Family Services (DCFS) referral, consumer distribution by SA and Supervising District, and the distribution of children receiving psychotropic medication authorizations from the Court.

  There is also extensive *Katie A*. class/subclass reporting annually which trends costs, services, eligibles, placements, and use of EBPs. An EMT dashboard also provides executive management with information on demand for performance indicators. Further, discussions with providers have ensued this year focusing on how to use data in clinical decision making and as a start to continuous quality improvement within these services.

  With the onset of multiple data collection activities simultaneously required for state and federal mandates, the MHP will need to evaluate whether it has sufficient resources to both maintain and monitor all reporting activities. This includes *Katie A.* tracking, Health Care Reform mandates associated with MCP tracking, and the Cal MediConnect demonstration initiative.

- The MHP allocated over $20 million from their MHSA Information Technology Plan funds to approximately 128 legal entities (LEs), through the Contract Provider Technological Needs Project (CPTNP) to partially offset LE costs to select and implement EHR systems and support implementation of EDI transactions. Created

in 2009, it took time for LE proposals to coalesce so the number of Technological Needs Funding Agreements (TNFA) approved through FY09-10, FY10-11 and FY11-12 ranged from 15 to 20 per year. However, in FY12-13, 55 TNFAs were approved, most as a result of LE need for increased funds to meet IBHIS standards.

Of the $20 million CPTNP funds allocated, approximately 93% is committed to EHR selection, implementation and support; another 4% to Infrastructure/Security; and about 1% for Consumer/Family Access to Computer Resources. Remaining funds will go to Tele-psychiatry/Other proposals. As of January 2014, 114 TNFAs were executed and 98 TNFA were considered active projects. LEs have been paid over $9 million to date, which represents 41% of CPTNP allocation. A $1 million Reserve Fund was designated to support eight new LEs and any HWLA community partner agencies will transition to being a LE during FY14-15.

- The Contract Providers Transition Team (CPTT) continues, performing a critical role in support of Contract Providers Transition Project (CPTP) for IBHIS rollout, especially since contract providers deliver a notable portion of total system services. During CY12, contract providers served 130,000 duplicated Medi-Cal beneficiaries and provided over $600 million of approved claim services.

  To date, CPTT workgroup meetings were held in January and April 2014; three workgroup meetings were held during 2013 and five were held during 2012. These meetings include announcements, agendas and handouts. Presentations are led by subject matter experts and a Q&A format is used. Handouts are also posted to CPTP website. Meetings can be attended in person and are also available through WebEx.

- The MHP plans to also transition about 128 LEs that represent approximately 600 contracts to IBHIS; small LEs could have one contract and single service site, while large LEs could have ten or more contracts with multiple sites. The high-level IBHIS implementation phases for LEs include provisioning, testing readiness, go-live readiness, and go-live. LE go-live readiness workflow includes 43 unique tasks shared between a LE and the MHP. The original IBHIS rollout schedule urged all LEs to complete IBHIS readiness tasks by June 30, 2014, with go-live date not to extend beyond September 30, 2014. The MHP has since revised IBHIS rollout plans and now favors bringing LEs as they are ready to go-live. With the goal to go-live with all LEs by December 31, 2014, the MHP recognizes that some LEs may not be ready until early 2015.

  All LEs must have their own EHR system to electronically exchange consumer-level transactions from their EHR to IBHIS (and vice versa). All data is processed through computer-to-computer data exchange using HIPAA EDI and XML transactions. No LE user will have direct logon capability to IBHIS. Most LEs selected IS vendors and use the ASP model. Where the IS vendor hosts a LE EHR system, the vendor is responsible for data center operations including network connectivity with IBHIS, and support/maintenance of EHR software. Alternatively, a small number of LEs have elected to use Clearing House to exchange electronic transactions between their

own EHR and IBHIS.

IS Vendors Selected by Legal Entities	
IS Vendor	**Number of Legal Entities**
Askesis	3
Caminar	2
Cerner	1
ClaimTrak	1
Clinivate	13
DeFran	3
Exym	41
Netsmart	3
Tier	1
Welligent	21
Clearing House	6
EHR Unknown	32

Note: The above chart represents IS vendors selected by LEs as of March 2014. The number of *EHR Unknown* is not current.

In March 2014, the County Board of Supervisors authorized an additional 51 full-time MHP positions for the development of a Central Business Office (CBO) to reconfigure internal business operations associated with the ACA and IBHIS. The CBO staff supports contract provider transition to IBHIS by providing practitioner maintenance, provider maintenance, user access, and addressing IBHIS rollout and Integrated System shutdown implications. The MHP is keenly aware it cannot stay in rollout mode indefinitely as it is costly for all involved to manage and support both IBHIS and Integrated System (IS), as well as it complicates the cost report data for FY13-14 and FY14-15. As a result, the MHP has requested to extend the IS contract past December 31, 2014, to complete the Pharmacy Benefits Management RFP process and to execute a contract with the selected vendor. An extension will allow additional time for the MHP to adjudicate void and replacement claim transactions for contract providers that submit to the present system prior to their IBHIS claim go-live dates. The IBHIS cut-over period could span almost more than 1 year and the MHP will rely on both systems to produce Short Doyle/Medi-Cal (SD/MC) claim files and other State-required data reporting for the remainder of 2014. Reducing or redirecting staff too early in this process would complicate IBHIS go-live processes and could impact SD/MC revenue and delay other State reporting.

- The MHP has plans to implement IBHIS at the County Jails and Probation

Department in the future. Although these services will not be billed to SD/MC, it will provide for more complete history of services provided to forensic consumers who have mental health diagnoses.

- Historical claim file submissions for FY12-13 indicated timely submittal during the year. The MHP's Medi-Cal claims denial rate was 2.7% for FY12-13, in comparison to statewide rate of 4.1% for the same period. Please refer to *Appendix D* for monthly summary of SD/MC processed claims for further information.
- Various systemwide effective communication mechanisms were noted as continuing, or beginning, this last year.
  - Since March 2014, WebEx conferencing is now used so that SA staff at various levels can attend committee meetings held at the MHP's administrative offices. Previously, this was a barrier as involved travel/time for such meetings was prohibitive.
  - In each SA, the SA QIC Chairs liaise with the SA District Chief and SA Advisory Committee which is comprised of consumers and family members (C/FMs), providers and staff.
  - Managers in various SAs communicate with MHP administration through emails, memos, monthly meetings and regional meetings in which all service provider have representation.
  - An Outcomes Measures Application (OMA) newsletter is issued quarterly to all FSP and FCCS programs, and other interested parties, by the MHP's MHSA Implementation and Outcomes Division.
  - SA management indicated that focused IBHIS training modules were infused throughout the start-up and post-implementation phases with super-users dedicated to address on-going system issues with staff.
  - Most contract providers acknowledged the Chief Information Office Bureau (CIOB) communication strategy to inform and support IBHIS rollout is extremely effective and generally timely and supportive. Meanwhile, the CBO is very new and at present staffed by only a small number Netsmart subject matter experts who provide operational support to contract providers that no longer use Integrated System; the CBO is experiencing a number of challenges, and so their communication efforts lack the efficiency that CIOB evidences.
  - Contract providers report effective access to and communication with SA District Chiefs, other SA leadership, and contract monitors; MHP representatives are responsive by both email and phone, and follow-up on information when the answers are not readily apparent.
  - C/FMs are kept informed via case managers, groups, flyers and handouts, in both English and Spanish, and through contract providers.
  - An EMT representative participates in monthly Cultural Competency Committee

(CCC) meetings; 12 NAMI affiliates also attend.

- There are provider meetings once a month for each service stream (CSOC, ASOC, OA) and the various School-Based Collaboratives meets quarterly.
- The SA District Chiefs meet every Wednesday, with a rotation of which Chief will set the agenda and chair the meeting. Each week includes updates from an EMT member. In the SAs, the program heads meet monthly and ASOC/CSOC provider meetings for both DO and contractors occur monthly.
- A countywide Multidisciplinary Assessment Team (MAT) Coordinators meeting occurs monthly, as does countywide age-specific navigator meetings.
- MHP and contracted staff considers communication to be open and bi-directional with their own SA leadership and that urgent information is communicated efficiently by email instead of waiting until the next meeting. However, MHP staff also felt that communication from senior MHP leadership was absent and suggested that the EMT visit the various SAs/clinics to meet with staff directly.
- The API Council participants indicated more outreach and communication is needed to increase community awareness of the services available and how to access them.
- Quarterly the *Minds and Matters* mental health wellness magazine is available on the public MHP website. Pamphlets in different languages are available to the public in numerous locales detailing specialized outreach and law enforcement teams. There are also flyers detailing MHSA Prevention and Early Intervention (PEI) and Innovations programs, as well as the Access Call Center and how to contact them, available in all threshold languages.

- As in past years, the MHP continues to evidence multiple forums and avenues for stakeholders from all groups to be a part of systemwide planning.
- A group of consumers have had active advocacy roles via the ongoing CCAB Forum and the MHP includes CCAB and C/FM representation on its hiring panels for all Deputy Director positions. The CCAB meets quarterly to discuss policy and advocacy issues of importance to C/FMs. Other C/FMs may attend the meeting, but have no voting rights. The CCAB also leads the Planning Committee for the Client Congress Forum that meets annually; in 2013 peers chose the topic of *Career Paths for Peers*.
- The MHP sponsors three annual *Hope and Recovery* consumer conferences in English, Spanish and API languages to better engage them in systemwide change. Consumers determine the theme, agenda, workshops, and speakers while the MHP funds the events and provides staff support and coordination.
- Family members were actively involved in the development of the recently published *Parameters of Family Engagement and Inclusion for Adults* shared in all SAs.

- A Client Leadership Training was offered to 25 consumers per cohort with a goal of developing leadership skills and doing volunteer work. Training consists of 4 day-long sessions over 4 consecutive months.
- Monthly SA provider meetings allow for providers to be an integral component in planning and sharing effective strategies and diverse ways to address gaps in service delivery. Contractors indicated a sense of openness, camaraderie, and inclusion with the MHP; however, secondary to each agency having its own QIC, the MHP QIC activities often conflict with their scheduling or priority needs. Providers are included in the systemwide written and on-line communications regarding QA/QI updates and are part of the trainings delivered by the MHP. Contractors reported being involved in the recent MAT process redesign, as well as taking part in some SWOT analyses and strategic planning efforts.
- Systemwide, providers are included in all surveys conducted by the MHP, include assessing barriers to services, Access Call Center concerns, and *Healthy Minds and Bodies* events. Results, when tabulated, are shared with these providers.
- Ten healthcare reform readiness workgroups were created to prepare for ACA; seven of the ten were open to the community participants and 224 people signed up to participate in the process.
- CCC meetings allow for staff and other stakeholders to participate via web-ex. Clinical staff reported that feedback is welcomed and time is set aside in every meeting for open discussions; following the "chain of command" to provide input is not required.
- Peer employees interviewed were divided in feeling the MHP effectively engages them and C/FMs as a whole as stakeholders. Given the large size of the MHP and numbers of individuals involved, varied impressions are probable.

- Since the January 2014 departure of the Director of the EAO, there has not been active peer representation on the EMT, although the MHP reported recruiting for this position presently, having received 60 applications. CAEQRO noted during the last few annual onsite reviews, the EMT has continued to report *reassessing* having a peer position at the executive level, although no final outcome has been shared.

  In May 2012, County Human Resources (HR) changed the title of the existing Peer Advocate classification to Mental Health Advocate, which lists two qualification options – one for an applicant with lived experience who has "completed a recognized peer, parent, or family advocate training program," and one for those "with paid/volunteer work experience in mental health advocacy." Bifurcating the qualifications in this manner allows applicants without lived experience to qualify for Advocate positions and promotions, potential reducing the presence of those with the lived experience in the applicant pool and positions. This may put consumers and family members at a disadvantage in the hiring and the promotional

process. Various stakeholders reported instances when eligible consumers had been passed over for advancement as a result and of HR-supplied qualified Advocate applicant lists containing only those with work experience/commensurate education and none with lived experience. The MHP should carefully monitor for potentially unintended consequences in the capacity to provide peer services.

The current MHP peer employee career ladder begins with a stipended Wellness Outreach Worker (WOW) volunteer position, progresses to a part-time or full-time Advocate position, then to a Community Worker position, in which promotion to a Senior Community Worker is possible. While only the WOW positions are dedicated to applicants with lived experience, the Advocate position was created to serve as the entry rung of a career ladder for lived experience applicants; the Advocate, Community Worker, Senior Community Worker and Community Services Counselor positions do not require formal education. A Bachelor's degree is not required until the Medical Caseworker position; however, the Director expressed his commitment to investigate with County HR if this educational requirement can be met by a certain number of years of mental health field experience, making it also a viable option for peers. A number of contractors systemwide provide dedicated employment options for those with lived experience and evidenced supervisory peer positions.

In the past year, an additional 100 volunteers with lived experience were trained to a become WOWs; currently about 100 trained WOWs serve in DO clinics, providing peer support to consumers at all levels of care from FSP to Wellness Centers. WOW duties include greeting consumers in the lobby, providing translation, calling consumers for appointment reminders, accompanying consumers on community outings, and running peer support groups. During the past two years, 30 WOWs from six different DO clinics were specifically trained as Clinic Ambassadors, participating in a specialized training to serve as greeters who create a calm, safe, and welcoming environment, reducing the need for a strong presence by armed guards. This year, a 16-session Community Health Care Navigator training for WOW graduates will also be implemented to expand the skills of WOWs into helping consumer navigate health, mental health, and substance abuse systems to obtain effective integrated care. This training began in March 2014 with the goal of training at least 30 WOWs; additional WOW and Clinic Ambassadors trainings are planned for next FY. Further, the MHP was able to add supervisory, clinical and peer positions to their Navigation teams through the award of SB 82 funding; the opportunity for higher stipends for WOW will be created with this funding as well. In the last year, OFE staff have responded to approximately 1,500 calls and trained over 200 staff in effectively engaging families. The Office facilitated the adoption of NAMI affiliates by 18 of 21 DO clinics countywide and is piloting five Family Advisory Boards - in SAs 7 and 8, as well as one countywide group. Nine meetings have already taken place among the Boards in both Spanish and English. Family members and MHP staff will meet to share information and ideas to ensure quality

service.

Access

CAEQRO identifies the following components as representative of a broad service delivery system which provides access to consumers and family members. Examining capacity, penetrations rates, cultural competency, integration and collaboration of services with other providers form the foundation of access to and delivery of quality services.

Figure 2. Access

Component		Present	Partial	Not Present	Not Rated
2A	Service accessibility and availability are reflective of cultural competence principles and practices	X			
2B	Manages and adapts its capacity to meet beneficiary service needs	X			
2C	Penetration Rates are used to monitor and improve access	X			
2D	Integration and/or collaboration with community based services	X			

Issues associated with the components identified above include:

- The MHP has 12 threshold languages: Spanish, Vietnamese, Cantonese, Mandarin, Other Chinese, Armenian, Russian, Tagalog, Korean, Farsi, Arabic, and Cambodian. Consumer language preference information is now collected at point of initial system contact, per a new policy in August 2013, and totals are monitored monthly through the Service Request/Referral Logs maintained in each SA by all providers. Consumer primary language is also tracked systemwide by both inpatient and outpatient service use, by hospital discharge follow-up appointments, and at rehospitalization. Further, the MHP annually tracks and trends the number of Change of Provider requests due to language issues; there were 54 in FY11-12 and 75 in FY12-13.

  Along with preferred language, cultural considerations are also documented for each new consumer at initial contact, and the Log notes which provider a consumer was referred to, and by whom, in order to best meet their language and cultural needs. An annual MHP report tracking service requests for the first 3 months of CY14 showed 2,396 requests for service in one of the 12 threshold languages and 30 requests for other non-threshold languages during that time. During ongoing service provision, the MHP's Client Face Sheet and Care Coordination Plan requires

documentation of a consumer's primary language *and* preferred language, and if the Plan was interpreted for the consumer in their preferred language when created.

While access disparities are not monitored by preferred language, the MHP tracks Language Line use by all clinics, in addition to the Access Center's use. County HR maintains a list of all qualified interpreters for DO clinic use and contractor providers are required to maintain their own current internal interpreter rosters. In CY13, the MHP noted 71 requests for services in a non-threshold language systemwide, with the most being for American Sign Language in SA5. The MHP continues its interpreter training project which offers four levels of progressively more specialized training through eight courses; 146 providers systemwide were trained in FY13-14.

- C/FM navigation staff are used systemwide for children, TAY, and adults to assist new consumers with linkages to provide early engagement with services and to help them avoiding getting lost in system procedures.
- In October 2013, the MHP moved clinical staff into Patriotic Hall to join other veterans' service providers to create a one-stop shop for veterans. The MHP is now serving over 500 veterans at this new service location, as well as having designated veterans' services staff at a number of other co-located sites throughout the County.
- The MHP has become involved with DCFS efforts to reduce the number placements necessary for newly detained foster children who runaway and ultimately becoming child sex trafficking victims prior to receiving any interventions. In the last year, efforts focused on incorporating preventive measures into countywide trainings for any agencies treating TAY and existing grass roots trafficking agencies. A special symposium on the topic was planned for May 2014.
- The MHP noted that over the past few years, the OA consumer population is actually several years younger than in the past, resulting in more complicated co-occurring diagnoses/substance use issues. As a result, the MHP has engaged in more OA staff skill building, training them to use the Screening, Brief Intervention, and Referral to Treatment screening tool, and on common medical conditions seen in this population.
- As an expansion of the previous capacity building project that funded the recruitment, training, and integration of the Promotoras de Salud Project Model (Health Promoters) within the Latino Community, the FY13-14 Latino Under-Represented Ethnic Populations (UREP) Committee proposed to fund a research project to measure the effectiveness of the Promotoras Model as an outreach and engagement strategy aimed at Latinos within the County. The findings will provide the MHP with recommendations focusing on the mental health disparities that significantly impact the Latino community. Furthermore, Latinos continue to be the fastest growing ethnic population in the County, yet they also continue to be underserved within the public mental health system. Approval of this project is in process.

- The American Indian/Alaska Native (AI/AN) Mental Health Conference, an AI/AN UREP Project funded for FY13-14, was held on November 20, 2013. The theme was *Integrating Services to Heal Our Generations* and was attended by 301 participants. It highlighted how the integration of mental health, substances abuse, and physical health services with traditional spiritual/cultural practices can improve outcomes for the AI/AN community. Researchers, clinicians, tribal chiefs, community leaders, veterans, and youth representing both local and national tribes presented an array of information. With remaining funding, the AI/AN UREP Committee is proposing to implement a Community Spirit Wellness Project, using consultants to recruit/train AI/AN community members as Community Spirit Healers – to outreach, engage, and educate their community, as well as to facilitate linkage to mental health services through community trainings and forums. Approval of this project is also in process.
- The African/African American (A/AA) UREP Committee undertook a Resource Mapping Project this last year, designed to identify community resources, service providers, community leaders, and agencies in SA 6 where there is a large A/AA population. The focus was to reduce stigma by funding agencies to provide outreach/engagement, training, education, non-traditional wellness activities, and various technological approaches in this SA to address community mental illness. Each funded agency will target a unique, sub-population within the A/AA community.

  The A/AA UREP Committee is also developing culturally relevant pamphlets to outreach/engage the underserved, inappropriately served, and hard to reach ethnic communities by reducing stigma. The pamphlets serve to educate and inform these ethnically diverse communities about the benefits of mental health services, and to provide referrals and contact information for both MHP and community providers. It will be translated into Amharic, Swahili, Ibo, Yoruba and Somali.

  Finally, the A/AA UREP Committee assisted in the development of an Ethiopian Community Mental Health Training and Education Project, along with the African Communities Public Health Coalition. The project goals are to reduce the stigma of mental illness in the Ethiopian community as well as to facilitate service access especially during crises, setting a precedent of using culturally appropriate mental health education when working with ethnic communities. This 9-month project will provide training to select volunteer community members, referred to as Ethiopian Community Advocates, so that they may become *lay-experts* on mental health issues, crisis intervention, and appropriate mental health resources. Training began in December 2013. Since the implementation of this project, other African groups in the County, specifically the Somalia and the Sierra Leonean, have expressed a strong interest in extending this project to their communities.
- In FY12-13, the Eastern European/Middle Eastern (EE/ME) UREP Committee developed a project to produce culturally relevant promotional materials to outreach/engage the underserved and hard-to-reach families within the Armenian,

Russian, Persian, and Arabic communities. A brochure on mental health issues has been created and translated into Armenian, Russian, Farsi, and Arabic. The project also includes other promotional items such as pens, totes, magnets, and posters. All items include the MHP's 24/7 Access number.

For FY13-14, the EE/ME committee is working on launching a media campaign for the Armenian and Russian communities including 30-second public service announcements (PSAs) for use on traditional media venues. These PSAs will inform viewers about common mental health issues, substance abuse, and domestic violence. For the Persian community, a radio campaign will also be developed, and for the Arabic community, community education efforts will include spiritual-based organizations and schools.

- For FY13-14, the API UREP committee has proposed to hire a consultant to launch their Consumer Employment Training Program, with the goal of increasing the number of culturally competent API Peer/Family Advocates and Health Navigators at community mental health agencies that serve the API community.

  In SA3, an API Consumer Leadership Council, comprised of adult API consumer leaders exists. This last year they undertook extensive community outreach, developed an API Speaker's Bureau, and created an outreach/engagement media campaign, including a Council website and newsletter. Onsite discussion with the Council confirmed they have built a sustainable program that provides ongoing consumer leadership development and recovery principle modeling.

- The MHP has numerous EOB's Field Response Programs, many of which liaise with various levels of law enforcement, other county agencies, and/or community-based services to serve anyone in need. The eight SA Psychiatric Mobile Response Teams (PMRT), nine Law Enforcement Teams (LET), Mental Health Alert Team, and Special Prevention Unit work with either local or multiple enforcement agencies to deal with urgent situations involving mentally ill, high-risk or homeless persons in the community (i.e., an involuntary detention evaluation, mental health expertise during barricaded/hostage instances, threat management). Since FY06-07, the eight PMRTs have conducted between 9,997 to 13,243 field visits annually, evidencing a steadily increasing trend of engagement. The teams triage those of highest need, doing limited targeted case management to ensure service linkage for the individual. FY12-13 data showed that these visits occurred equally between work hours and after-hours. LET field visit data spanning 7 FYs showed an average of 6,936 visits annually. Between the LETs and PMRTs, in FY12-13, a total of 2,156 present or former DCFS-involved children received a crisis response field visit, the majority of which were between 11 and 15 years old; 54% of these visits ended in the hospitalization of the child. Further, PMRT response for involuntary detention evaluations to local hospital Emergency Rooms countywide has skyrocketed 222% since beginning in FY06-07.

  There are also two operations dedicated to engaging and assisting the County's

homeless – Homeless Outreach Mobile Engagement (HOME) and Homeless Outreach Teams. In FY12-13, the seven clinical HOME staff outreached to over 1,200 persons linking them to mental health, substance abuse, medical, dental, financial and/or housing services. Additionally, School Threat Assessment Response Team (START) staff pairs with educational institutions and law enforcement to assess and monitor students, faculty or staff thought to be at risk for school-based violence. The START program has served 4,532 consumers since its inception (64% of which were children) and delivered over 8,000 trainings to students, staff, or parents.

Finally, the Emergency Response Team provides MHP staff from the LETs and PMRTs to offer on-scene critical incident debriefing and crisis intervention to anyone affected by a traumatic community event. This includes a team for each of the three County airports. In FY12-13, a total of 208 staff responded to 70 such events.

- The MHP reported that, as of July 1, 2010, they had been providing telepsychiatry services countywide for consumers aged 18 years and in 25 different languages. Last year they estimated serving 600 adults through this mechanism.
- The MHP has invested in innumerable EBPs to treat anxiety, trauma, crises, depression, emotional dysregulation, disruptive behaviors, conduct disorder, and parenting/family difficulties both in their DO and contracted clinics. To goal is to better meet the specialized needs of consumers as well as track the outcomes of treatment for all types of distress. While the approach is warranted, contract providers reported onsite that the complexity and sheer number of EBPs, with different requirements for each target population, have led to staff loss, turnover and burnout at their agencies. Among the chosen EBPs, they said, are too few that use train-the-trainer models, and provider training and monitoring costs have not been built into contract rates, nor can providers bill for completing any outcome measures. Their stated preference would be that clinicians have the flexibility to decide when use of an EBP was best rather than have it dictated by contract and policy.
- The MHP continues to use U.S. Census Bureau data for population estimates and UCLA's California Health Interview Survey prevalence estimates. They use IS data to identify consumers served and produce penetration rates systemwide as well as for the eight SAs. They further drill-down SA prevalence/penetration rate data by race/ethnicity, age groups, gender, language, and Medi-Cal eligibility. Penetration data of service utilization is analyzed for identified target populations and their demographics to measure disparities and unmet needs of underserved populations. It is also used as a general measure of accessibility and for setting goals/objectives in annual QI Work Plans prioritizing underserved populations. Retention rates are reported using approved outpatient claims and grouping them by number of claims (i.e., one, two, three, four, 5-15, and 16 or more).
- The MHP launched a Clergy Academy in January 2014 to provide faith-based and community leaders with education about various mental health-related and social

issues. Topics include *Mental Health 101, Complementing Caring Congregations, Effective Communication Skills, Self-Care, Navigating the MHP's System, Moral Injury (for Veterans), Domestic Violence, Sexual Abuse, Psychological First Aid, Pornography*, and *Suicide*. Ninety representatives were in attendance at the kick-off event; since then, 20 Latino pastors/chaplains have begun a 10-week training; 100 Korean-speaking Christian pastors have been meeting monthly; 34 representative of the Buddhist Tzu Chi Foundation will start training in June 2014; and 20 clergy in the South Bay area meet/train bimonthly. The 20 trainers are mental health professionals and able to present in English, Korean, Spanish, Cambodian, Tagalog, and Mandarin.

- Health Care Reform strategies are an MHP priority. The MHP collaborated with UCLA for general health training culminating in *Health 101* – a series of three presentations attended by 96% of all DO staff. The MHP also continues collaboration with the UCLA Harbor Medical Center to address co-occurring health issues such as diabetes and heart disease.
- SA3 has collaborated on an initiative to better serve foster children placed in the neighboring San Bernardino County. They contracted with three providers which offer services in both counties and created slots for 75 FSP-like services. The SA also noted a recent increase in detentions/placement of children aged 0 to 5 years, a population for which few placement options exist.
- Implementation of the *Katie A.* settlement agreement looks very different in LA County as it was settled independently years earlier (in 2003) than the statewide lawsuit. As such, their eligible screening, service delivery, and outcome tracking processes are notably more developed than any other California county. Further, the County committed to a Quality Service Review process to examine the utilization of the shared Core Practice Model (CPM) as it applies to their practice. Engagement, Teamwork, and Assessment and Understanding are practice indicators which are measured over the prior 90-days. The passing standard for the Overall Practice and Overall Status indicators is 85% and 70%, respectively. Additional Safety and Permanency indicators were identified to ensure tracking of the progress of children in the child welfare system in the County.

  Initially, to enhance identification of the needs of and expedite services for DCFS-involved children at risk of mental health problems, DCFS and MHP leadership engaged in an interagency collaboration that includes the co-location of staff, development of a mental health screening tool, and data-sharing practices. Today, 18 co-located offices exist throughout the county; the MHP maintains a dedicated *Katie A.* unit, and a Project Leadership team, as well as various implementation teams. Collaboration with the 64 contracted providers occurs as documents and processes are streamlined. Extensive stakeholder input was gathered as the initial planning phase occurred and numerous parent advocates continue to sit on the implementation teams.

  Child and Family Teams (CFTs), in line with the CPM, are in place for any child in

Wraparound, Treatment Foster Care (TFC), or Intensive Field Clinical Capable Services (FCCS) programs systemwide. The MHP plans to extend CFTs to children in FSPs, group home placements, and youth served by the planned SB82 Youth Placement Stabilization Teams. On a monthly basis, both DCFS and the MHP track children identified as subclass eligible; data has shown that about 85% of foster children screened by DCFS staff need a formal MHP mental health assessment. While initially data matching between DCFS and MHP cases was handled by County ISD, it transitioned to the MHP a few years ago, and now has been taken over wholly by DCFS.

To date, about 1,500 youth have been provided service since 2003 and an updated RFP was released earlier in 2014 soliciting new or existing providers which can provide services adjusted to include state-directed CPM tenets and service expectations. Final contract awards to such providers were pending at the time of the review. In FY12-13, 22 CPM trainings were offered to MHP, DCFS, and provider staff. This year's goal is to extend CPM training to all Intensive FCCS, TFC, and Wraparound providers. In the meantime, TFC has also been working to increase their services countywide by adding staff, securing more beds, and getting approval for an increased caregiver stipend. The MHP is also hoping to secure additional EPSDT funding to treatment substance abuse issues in adolescent consumers.

Tri-annual reports, submitted to the County Board of Supervisors, track the time it takes from DCFS screening/case opening to MHP screening, to referral to MHP co-located staff for the assessment of acuity and service need. MHP co-located staff is required to track each DCFS referral from assessment to linkage to an appropriate provider, offering support should there be a waiting period. Each event has an associated time benchmark based on acuity.

Timeliness

CAEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Figure 3. Timeliness

Component		Present	Partial	Not Present	Not Rated
3A	Tracks and trends access data from initial contact to first appointment	X			

Figure 3. Timeliness					
Component		Present	Partial	Not Present	Not Rated
3B	Tracks and trends access data from initial contact to first psychiatric appointment			X	
3C	Tracks and trends access data for timely appointments for urgent conditions	X			
3D	Tracks and trends timely access to follow up appointments after hospitalization.	X			
3E	Tracks and trends No Shows			X	

Issues associated with the components identified above include:

- Currently, timeliness of first appointment from service request data is being collected at the SA level. As discussed above, the new SRTS Tool to track the timeliness indicator is being implemented systemwide. CAEQRO verified the MHP's timeliness data as submitted. The SA1 data representing December 11, 2013 through January 31, 2014 revealed 95.4% of consumers were seen within the systemwide 30 days standard, with the average wait of 5.7 days. SA3 data for the same time period revealed 34.4% of consumers were seen within the 30 days standard, with an average wait being 27 days.

  SA1 reported that most intakes occur within the first week after services are requested, with roughly 250 intakes per month – 150 in Lancaster and 100 in Palmdale. Each of the two DO clinics has five appointment slot allocated each week for Access Center urgent referrals.. SA3 reported onsite that their one adult DO clinic initially employed a walk-in system for intakes, as other SAs do, but tried to switch to an appointment-based system recently. This switch unfortunately led to extended waits for most consumers, well over the 30-day standard, so they switched back to the walk-in model, offering appointments within 1 to 2 weeks from request only to those consumers who desire it. Child contract providers interviewed onsite reported recent wait lists and/or extend delays for initial intakes of referred consumers, requiring MAT staff to follow the family weeks longer than expected to ensure linkage. Wait lists for Spanish-speaking or unique population services of three to four months were also reported. For FY 14-15, MHP administration implemented a tracking log to assist in monitoring the timeliness of linkages and a plan to redesign MAT.

  In FY12-13, a Clinic Peer Survey was undertaken systemwide which queried consumer experience of timeliness to first appointment. Results revealed, of the 218 consumers surveyed, 32% were seen the same day they requested services, 56% were seen within the 30 day standard, and 12% were seen after the 30 days had elapsed.

SA performance varied; the proportion initial service provision that was longer than the 30 day standard ranged from 0 to 36%. The survey also queried consumers on how long they waited at a DO clinic for their appointment once they arrived. The vast majority (84%) indicated a wait of less than 30 minutes.

- The MHP does not yet monitor timeliness from initial contact to first psychiatry appointment nor do they track/trend no shows, but reported they will be able to do both once all providers use IBHIS.

  SA management reported difficultly maintaining adequate psychiatric capacity since the beginning of CY14, which lengthens the wait for initial psychiatric evaluations, especially for child consumers. While the MHP had hoped that the newly graduating class of MDs this spring would lead to the hiring of new providers, this has not occurred. Presently, the wait to be seen by a child psychiatrist extends past 60 days in some SAs; this is further impacted by the initial wait for intake, at which time the child psychiatry referral is made. This has led to severe treatment complications for newly referred children in need of a medication refill. In some SAs, child contractors rely on MHP psychiatric services, and telemedicine is not yet offered consistently.

- All urgent service provision countywide is handled by the eight SA PMRTs. If one PMRT is occupied, a surrounding SA's PMRT, if free, will respond. PMRT timely response data is routinely tracked by the EOB and a one-hour response time standard continues, regardless of county location or time of day. CAEQRO-verified FY12-13 data reported by the EOB, which revealed that for PMRT response during daytime hours (i.e., 8 am to 5 pm), contact was made with 86% of those referred within the one hour standard, another 7% were contacted within 61 to 90 minutes, and 3% waited over 91 minutes to be contacted. These daytime response percentages represented the timeliest daytime response to urgent needs since FY09-10. FY12-13 after-hours data (i.e., 5 pm to 2 am) revealed 70% of the individuals in urgent need were contacted within the one hour standard, another 21% were seen between 61 to 90 minutes, and only 7% has to wait at least 91 minutes. The data also showed that most PMRT field visits in the last 4 FYs have lasted over 4 hours.

- Although no system is currently in place to track/trend appointment scheduling for consumers subsequent to hospitalization, IBHIS is anticipated to have this capability in the near future. However, systemwide timeliness of this indicator is monitored for all DO clinics through the monthly STATS process. FY12-13 MHP data revealed that among total hospital inpatient discharges, 62.5% had a subsequent MHP outpatient service, an improvement from FY11-12 where 60.5% of hospital discharges received an outpatient service. Of those contacts, on average discharged consumers were seen 24.7 days after discharge; despite the MHP's 7 day standard, 35% of consumers were seen within the standard.

  In SA1, there were 778 consumers discharged from hospital in FY12-13, representing about 3.8% of total countywide discharges that year. On average, they were seen within 16 days of discharge, with 60% of consumers being seen within the 7 day

standard. In SA3, there were 1,973 consumers discharged from hospital the same FY, representing about 9.6% of countywide discharges. On average, these consumers were seen within 23 days of discharge, with 80% being seen timely. These SA calculations differs slightly from what the MHP reported pre-review for this specific indicator in both SA1 and SA3; that is, pre-review SA1 was reported as having a longer average wait time of 21 days while SA3 was reported as evidencing shorter average wait time of 18 days. FY12-13 data showed that the typical profile of a consumer discharged from hospital and seen for a follow-up MHP service is an adult, of African-American or Latino background, who speaks English.

The lack of timely follow-up or any follow-up for consumers discharging from hospitals was attributed to delayed data entry by clinicians, indicating service dates and/or the lack of coordinated communication between DO clinics and various hospitals countywide. Anecdotally, it was reported that staff often learned about a consumer's hospitalization post-discharge.

- The MHP reported tracking rehospitalizations. While maintaining a systemwide goal of 30% for this indicator, verified FY12-13 MHP data revealed an overall 31.1% 30-day rehospitalization rate. The same data set revealed a total of 41.5% of discharged consumers were rehospitalized within a year of the first noted hospitalization.

Outcomes

CAEQRO identifies the following components as essential elements of producing measurable outcomes for beneficiaries and the service delivery system. Evidence of consumer run programs, viable performance improvement projects, consumer satisfaction surveys and measuring functional outcomes are methods to evaluate the effectiveness of a service delivery system as well as identifying and promoting necessary improvement activities to increase overall quality and promote recovery for consumers and family members.

Figure 4. Outcomes

Component		Present	Partial	Not Present	Not Rated
4A	Consumer run and or consumer driven programs	X			
4B	Measures clinical and/or functional outcomes of consumers served	X			
4C	One active and ongoing clinical PIP			X	
4D	Clinical PIP shows post-intervention results			X	

Figure 4. Outcomes					
Component		Present	Partial	Not Present	Not Rated
4E	One active and ongoing non-clinical PIP	X			
4F	Non-Clinical PIP shows post-intervention results			X	
4G	Utilizes information from Consumer Satisfaction Surveys	X			

Issues associated with the components identified above include:

- CAEQRO visited two DO Wellness Centers, one in Lancaster and one in Arcadia, as well as two contract provider Wellness Centers, the TAY Drop-In Center run by Pacific Clinics in Irwindale and the Discovery Center run by Mental Health America in Palmdale. The Wellness Center in Lancaster is a consumer centered program serving 200 mental health/substance abuse consumers. It offers psychiatry, group therapy, employment support, outings, individual peer support, and peer-run groups. The Discovery Center located in Palmdale provides a consumer-run peer advocate program, peer run self-help groups, and assists with vocational/educational support activities. Peer advocates are employed in the Palmdale Center and recently, a peer coordinator was appointed at this Center with responsibility for overseeing the daily functioning/scheduling with support from an MHP staff supervisor. Discovery Center training is informal for the on-site functions, consisting of learning on the job or job shadowing of other peers. The formal training that occurs is in regard to documentation so peer advocates can bill for providing Community Outreach Services.

  The Irwindale TAY Drop-In Center is supervised by one clinical staff person but directed by a full-time peer Mental Health worker and two part-time peer staff. It is attached to Pacific Clinics' TAY FSP program. The Center requires users to be goal-oriented rather than "dropping in" or "hanging out." Various activities include peer-run classes and groups; no professional therapeutic services are provided. It has an internal Advisory Board staffed with elected members every 6 months.

  Overall, peer employees indicated that extended hours are needed at some Wellness sites that serve the community, since some consumers require after-hours support. Further, they asserted that knowledge of these Centers comes mostly from word of mouth, but consumers could benefit from the provision of a written pamphlet at intake to inform consumers of the various Centers throughout the County. A Welcome Packet for all new consumers was recently developed and will be presented to the EMT for budget approval in July 2014.

- The MHP continues to use their custom-designed OMA tool to track all outcomes for consumers served in FSP and FCCS systemwide. In addition, another custom-designed application captures pre- and post-outcomes scores for all PEI programs using a variety of published measures, such as the Child Behavior Checklist. They have a contract with CiMH to collect outcomes for some EBPs, including some funded under PEI and SFC, and another contract with UC San Diego to collect data for the MHSA Innovation programs, including level of service integration, health/mental health status improvement, substance use, consumer satisfaction, community satisfaction, and cost effectiveness. Children served in wraparound programs or through *Katie A.* services are tracked with the Child and Adolescent Functional Assessment Scale and the Child and Adolescent Needs and Strengths tool. A consumer self-report measure to track therapeutic alliance, symptoms, general functioning, physical health, substance use, social connectedness, and recovery/wellness orientation is used at all DO Wellness Centers.

  In addition, the MHP has contracted with UC San Diego for a comprehensive evaluation of their Innovation project to testing out models of integrated health, mental health and substance abuse delivery. Each model has begun to demonstrate progress in the areas of physical health, mental health symptom reduction, and reduction in self-stigma.

  EBPs are infused systemwide for both the DO and organizational providers. These practices utilize respective outcome tools and results are reported regularly and distributed at SA QIC meetings. Relevant managers review the results with staff. Consumer outcome reports are distributed at program-related meetings with providers. Outcomes are also communicated through links on the MHP's Reports Website, on User Group SharePoint sites, via email distribution, at formal performance-based management meetings, at STATS meetings, to the Systems Leadership Team, by Electronic File Transfer (EFT), at provider network meetings, during technical assistance site visits with providers, during learning networks, in regional data workgroups, and at general stakeholder meetings.

  Currently, in six MHP-HS co-located sites, the Collaboration Program has been tracking and analyzing data for consumers whose treatment focus is either Anxiety or Depression. The MHP reported results to date reveal an average 48% improvement between pre-/post- screening tool scores for Anxiety and a 53% improvement between pre-/post- screening tool scores for Depression.

- In planning for the upcoming statewide performance outcomes system for EPSDT youth, the MHP has implemented the Youth Outcome Questionnaire (YOQ) systemwide. The YOQ is administered by clinicians for children age 4 to 17 years, while the YOQ-Self Report is also used for children aged 12 to 18 years. The Outcome Questionnaire, also a self-report tool, is used for EPSDT consumers aged 19 years and older. Results are used both at the consumer and aggregate levels. Each SA does track initial service access for EPSDT consumers; SA1 and SA3 anecdotally noted it occurs on average in one week.

- In August 2013, the MHP undertook the annual required consumer perception survey (POQI) provided by DHCS. August 2012 POQI results were extensively analyzed and shared with each SA and distributed at the departmental QIC. Of the 10,452 surveys completed in 2012, 77% were English, 22% in Spanish, and the remainder was in Chinese or Vietnamese, representing an overall 19.5% response rate. Results showed 95% of respondents agreed when asked "Was written information available to you in the language you prefer?" Comparison of general satisfaction, perceptions of service quality/appropriateness, and perceptions of participating in treatment planning remained high for all age groups from May 2009 to August 2012. Among the 11,237 2013 POQI respondents, 91% agreed that "services were available at time that were good for me," a 3% increase from November 2008 POQI findings.

  Consumer satisfaction surveys focusing on consumer employment and meaningful activities are also undertaken twice a year at the DO Wellness Centers. Results for the latest survey showed a 24.5% employment rate, overall 51% of the Wellness Center consumers indicated meaningful activities were a part of their lives. Retirement was reported by only 4% of the population. As a result of a successful supportive employment pilot in SA 2, the MHP plans to implement a supportive employment pilot this coming FY on a larger scale.

  An OA FSP satisfaction survey in three languages was undertaken in FY12-13; of the 206 consumers identified to participate, 161 responded – a 78% response rate. Findings indicated 94% of those surveyed felt services that were provided to them in the language they are most comfortable with, and 87% were highly satisfied with their FSP services. Additionally, 48% reported relationships with family/peers improved since starting FSP services, and 84% reported being asked by providers to identify their own recovery goals. Eight Child FSP family focus groups were also conducted in FY12-13 throughout the County. Thirty-six consumers and 49 parents/caregivers participated and groups were conducted in English and Spanish. All participants indicated they received services in the language of their preference, 94% felt they have benefited from these services, and 84% felt they were successfully linked to services within their community.

  The MHP reported a commitment this last year in changing the way consumer survey data is collected; as in the past, C/FMs has expressed the desire for more opportunities to be involved. So, when the Clinic Peer Survey was conducted in 2013 at eight DO clinics (one in each SA), paired graduates of the Client Leadership Class and/or members of the CCAB, one who was bilingual in Spanish, were used to engage and survey consumers. Overall, the findings were favorable in regards to consumer service satisfaction, but concerns were expressed that clinics needed cleaner furniture and restrooms. As a result, the MHP spent about $2,200 a month for 4 months for additional cleaning services. New furniture was provided or older furniture was cleaned. Several other improvements were noted as a result of the consumer responses, including adding more trained peer navigators at each clinic to

assist with survey completion and educating MHP reception staff to provide quality/welcoming customer service.

❖CURRENT MEDI-CAL CLAIMS DATA FOR MANAGING SERVICES❖

Information to support the tables and graphs, labeled as Figures 5 through 15, is derived from four source files containing statewide data.[1] A description of the source of data and summary reports of Medi-Cal approved claims data – overall, foster care, and transition age youth – follow as an attachment. The MHP was also referred to the CAEQRO Website at www.caeqro.com for additional claims data useful for comparisons and analyses.

RACE/ETHNICITY OF MEDI-CAL ELIGIBLES AND BENEFICIARIES SERVED

The following figures show the ethnicities of Medi-Cal eligibles compared to those who received services in CY12. Charts which mirror each other would reflect equal access based upon ethnicity, in which the pool of beneficiaries served matches the Medi-Cal community at large.

Figure 5 shows the ethnic breakdown of Medi-Cal eligibles statewide, followed by those who received at least one mental health service in CY12. Figure 6 shows the same information for the MHP's eligibles and beneficiaries served. Similar figures for the foster care and TAY populations are included in Attachment D following the MHP's approved claims worksheets.

[1] Percentages may not add up to 100% in some of the figures due to rounding of decimal points.

Figure 5a. Statewide Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity CY12

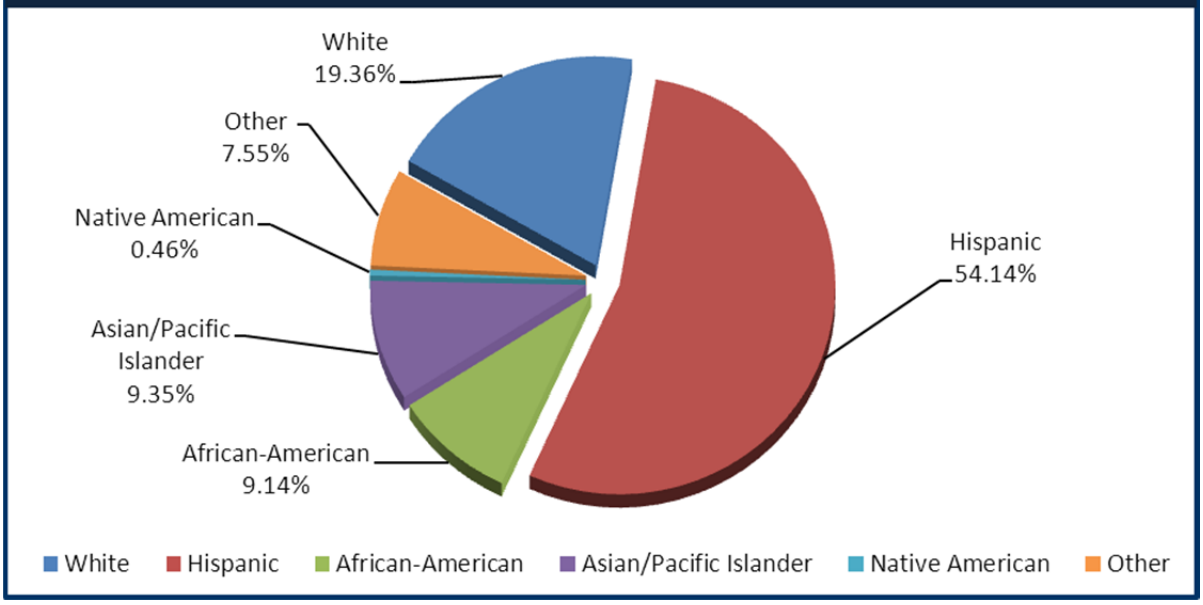


Figure 5b. Statewide Medi-Cal Beneficiaries Served, by Race/Ethnicity CY12

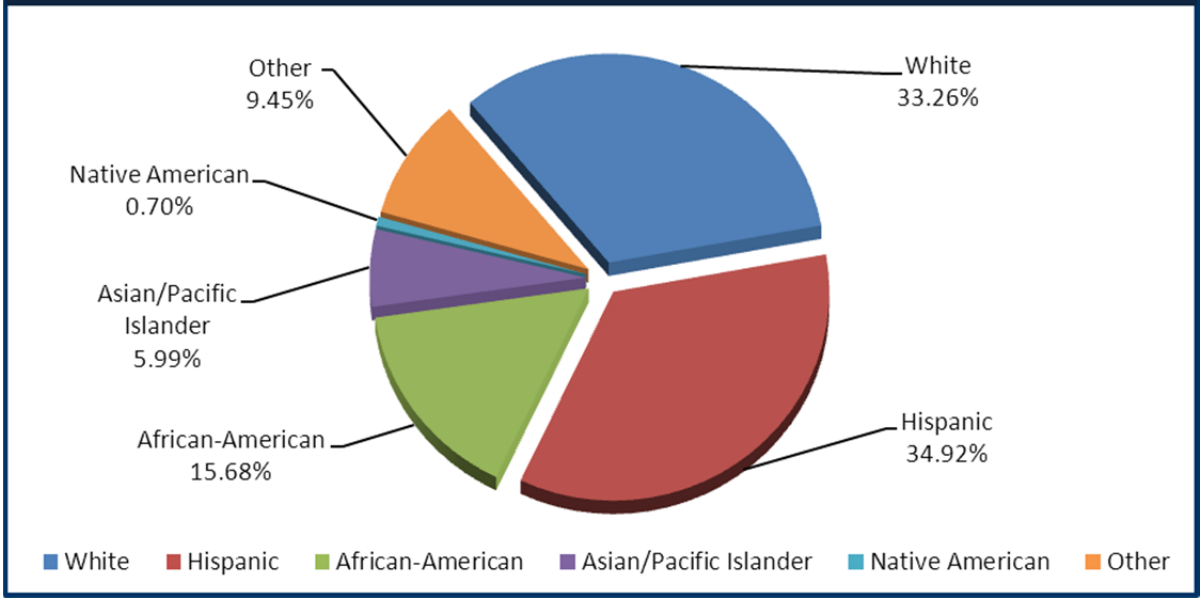


Figure 6a. Los Angeles Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity CY12

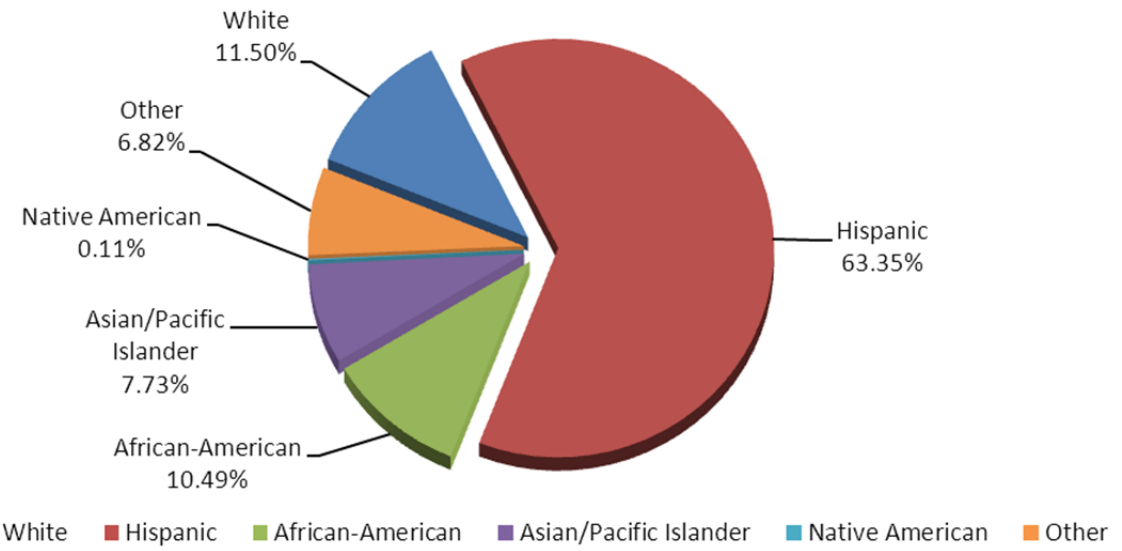
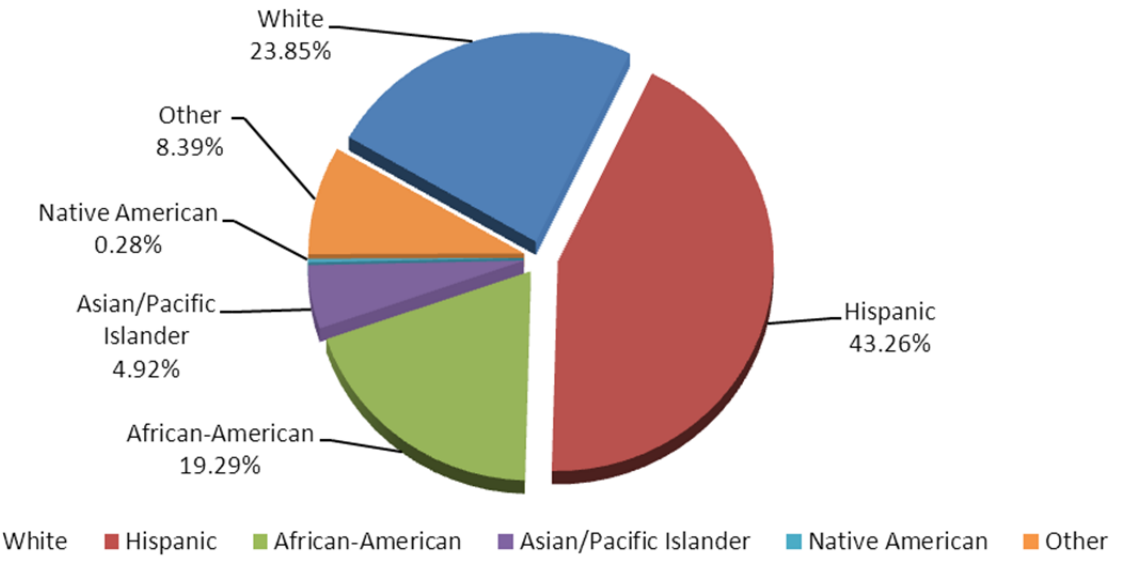


Figure 6b. Los Angeles Medi-Cal Beneficiaries Served, by Race/Ethnicity CY12



Penetration Rates and Approved Claim Dollars per Beneficiary

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average eligible count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Rankings, where included, are based upon 56 MHPs, where number 1 indicates the highest rate or dollar figure and number 56 indicates the lowest rate or dollar figure.

Figure 7 displays key elements from the approved claims reports for the MHP, large MHPs, and the state.

Figure 7. CY12 Medi-Cal Approved Claims Data

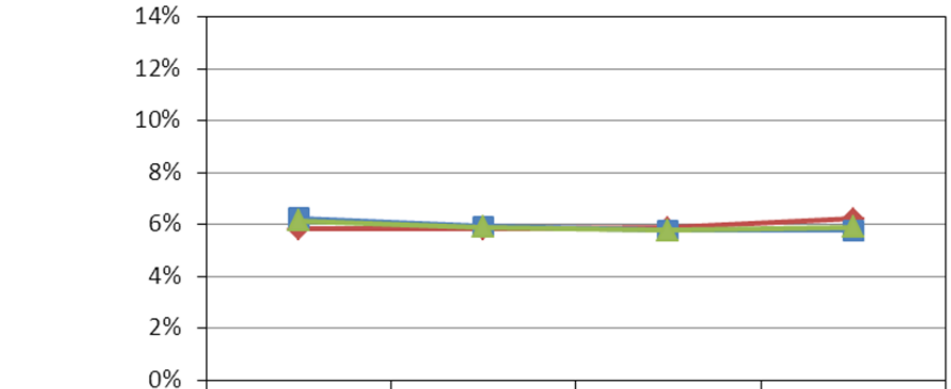
Element	Los Angeles	Rank	Large MHPs	Statewide
Total approved claims	$907,530,896	N/A	$1,011,905,446	$2,400,665,781
Average number of eligibles per month	2,510,108	N/A	3,750,774	7,956,900
Number of beneficiaries served	155,845	N/A	216,335	469,651
Penetration rate	6.21%	33	5.77%	5.90%
Approved claims per beneficiary Served	$5,823	12	$4,677	$5,112
Penetration rate – Foster care	61.97%	12	48.04%	53.34%
Approved claims per beneficiary served – Foster care	$9,108	14	$8,343	$8,485
Penetration rate – TAY	7.39%	33	6.86%	7.03%
Approved claims per beneficiary served – TAY	$7,570	7	$5,753	$6,331
Penetration rate – Hispanic	4.24%	23	3.63%	3.81%
Approved claims per beneficiary served – Hispanic	$5,634	13	$4,417	$4,913
Penetration rate – African-American	11.41%	23	9.65%	10.13%
Approved claims per beneficiary served – African-American	$5,232	23	$5,444	$5,318

Figure 7. CY12 Medi-Cal Approved Claims Data

Element	Los Angeles	Rank	Large MHPs	Statewide
Penetration rate – Asian/Pacific Islander	3.95%	28	3.63%	3.78%
Approved claims per beneficiary served – Asian/Pacific Islander	$4,254	24	$4,008	$4,089
Penetration rate – Other	7.64%	34	7.06%	7.39%
Approved claims per beneficiary served – Other	$5,829	20	$5,415	$5,650
Penetration rate – White	12.88%	9	10.20%	10.14%
Approved claims per beneficiary served – White	$6,959	7	$4,424	$5,245

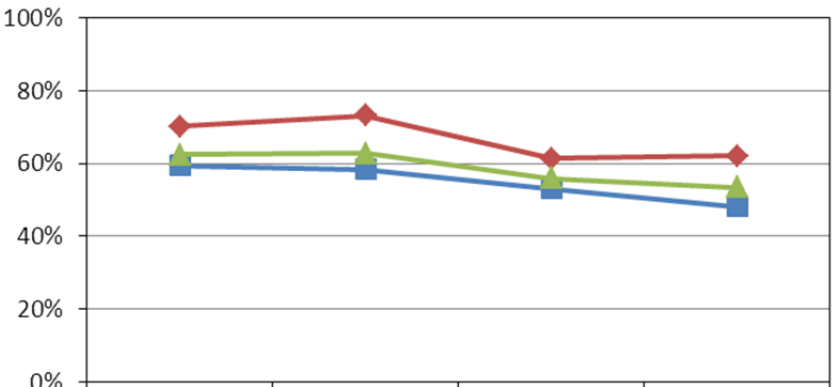
Figures 8 through 11 highlight four year trends for penetration rates and average approved claims.

Figure 8. Overall Penetration Rates CY09-CY12



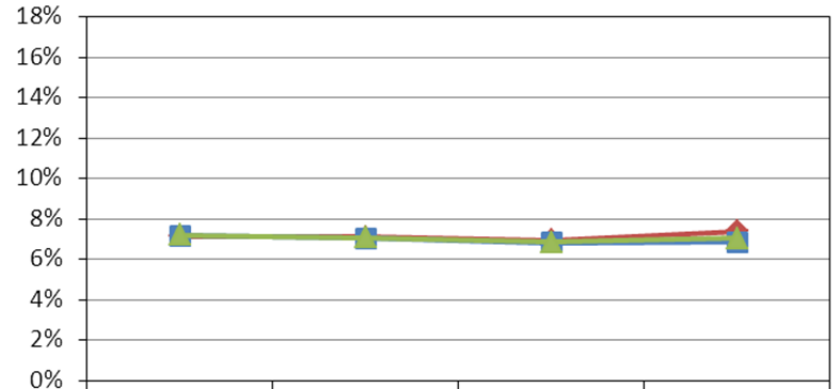
	CY09	CY10	CY11	CY12
Los Angeles	5.82%	5.81%	5.87%	6.21%
Large MHPs	6.25%	5.92%	5.76%	5.77%
Statewide	6.15%	5.89%	5.78%	5.90%

Figure 9. Foster Care Penetration Rates CY09-CY12



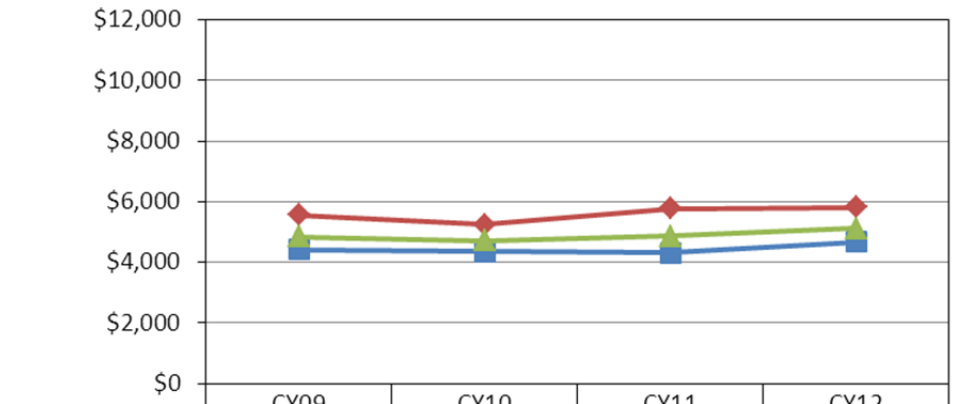
	CY09	CY10	CY11	CY12
Los Angeles	70.07%	73.19%	61.41%	61.97%
Large MHPs	59.43%	58.33%	52.99%	48.04%
Statewide	62.43%	62.67%	55.88%	53.34%

Figure 10. Transition Age Youth Penetration Rates CY09-CY12



	CY09	CY10	CY11	CY12
Los Angeles	7.13%	7.11%	6.94%	7.39%
Large MHPs	7.17%	7.05%	6.83%	6.86%
Statewide	7.21%	7.06%	6.86%	7.03%

Figure 11. Average Approved Claims per Beneficiary Served CY09-CY12



	CY09	CY10	CY11	CY12
Los Angeles	$5,569	$5,242	$5,775	$5,823
Large MHPs	$4,410	$4,351	$4,319	$4,677
Statewide	$4,841	$4,723	$4,872	$5,112

Medi-Cal Approved Claims History

The table below provides trend line information from the MHP's Medi-Cal eligibility and approved claims files from the last five fiscal years. The dollar figures are not adjusted for inflation.

Figure 12. Los Angeles Medi-Cal Eligibility and Claims Trend Line Analysis

Fiscal Year	Average Number of Eligibles per Month	Number of Beneficiaries Served per Year	Penetration Rate		Total Approved Claims	Approved Claims per Beneficiary Served per Year	
			%	Rank		$	Rank
FY12-13	2,588,848	157,459	6.08%	33	$947,477,153	$6,017	14
FY11-12	2,511,125	153,420	6.11%	33	$877,244,266	$5,718	13
FY10-11	2,296,806	138,310	6.02%	36	$760,595,461	$5,499	12
FY09-10	2,459,433	140,916	5.73%	37	$736,164,484	$5,224	15
FY08-09	2,389,943	136,302	5.70%	43	$751,874,313	$5,516	18

Review of Medi-Cal approved claims data, displayed in Figures 5 through 12 reflect the following issues that relate to quality and access to services:

- All LA MHP claims data should be viewed in light of the fact that it comprises 30% of the statewide data upon which it is compared. However, LA data are not included in the "large county" data.
- For CY12, the MHP's overall penetration rate of 6.21% is 7% greater than the large county average (5.77%) and 5% greater than the statewide average (5.90%).
- During CY12, the MHP's approved claims per beneficiary served were $5,823, being 25% greater than the large county average ($4,677) and 14% greater than the statewide average ($5,112).
- The MHP's CY12 foster care penetration rate of 61.97% is 29% greater than the large county average (48.04%) and 16% greater than the statewide average (53.34%). Thus, while overall, the MHP's foster care penetration rate from CY09 to CY12 declined from a high of 73% to 62%, statewide foster care penetration rates also evidenced a downward trend during that same period (62.67% in CY10 to 53.34% in CY 12).
- For CY12, MHP foster care approved claims per beneficiary served was $9,108, being 9% greater than the large county average ($8,343) and 7% greater than the statewide average ($8,485).
- Approved claims per Hispanic beneficiary served at $5,634 were 28% greater than the large county average ($4,417) and 15% greater than the statewide average ($4,913). Further, the MHP's Hispanic penetration rate of 4.24% was 17% greater than the large county average (3.63%) and 11% greater than the statewide average (3.81%). However, Hispanic beneficiaries accounted for 63% of the County's Medi-Cal eligible population.
- Approved claims per White beneficiary served at $6,959 were 57% greater than the large county average ($4,424) and 33% greater than the statewide average ($5,245). Further, the MHP's White beneficiary penetration rate at 12.88% was 26% greater than the large county average (10.20%) and 27% greater than the statewide average (10.14%). White beneficiaries accounted for 23.85% of the County's Medi-Cal eligible population.
- Approved claims per African-American beneficiary served at $5,232 were 4% less than the large county average ($5,444) and 2% less than the statewide average ($5,318). The MHP's African-American penetration rate of 11.41% was 15% greater than the large county average (9.65%) and 11% greater than the statewide average (10.13%). African-American beneficiaries accounted for 10.49% of the County's Medi-Cal eligible population but 19.29% of beneficiaries served.
- Approved claims per API beneficiary served at $4,254 were 6% greater than the large county average ($4,008) and 4% greater than the statewide average ($4,089). The MHP's API penetration rate of 3.95% was 9% greater than the large county average (3.63%) and 4% greater than the statewide average (3.78%). API beneficiaries

accounted for 7.73% of the County's Medi-Cal eligible population and 4.92% of the beneficiaries served.

HIGH-COST BENEFICIARIES

As part of an analysis of service utilization, CAEQRO compiled claims data to identify the number and percentage of beneficiaries within each MHP and the state for whom a disproportionately high dollar amount of services were claimed and approved. A stable pattern over the last five calendar years of data reviewed shows that statewide, roughly 2% of the beneficiaries served accounted for one-quarter of the Medi-Cal expenditures. The percentage of beneficiaries meeting the high cost definition has increased in each of the four years analyzed. For purposes of this analysis, CAEQRO defined "high cost beneficiaries" (HCBs) as those whose services met or exceeded $30,000 in the calendar year examined—this figure represents roughly three standard deviations from the average cost per beneficiary statewide.

Figure 13. High-Cost Beneficiaries (greater than $30,000 per beneficiary)

	Beneficiaries Served			Approved Claims		
	# HCB	# Served	%	Average per HCB	Total Claims for HCB	% of total claims
Statewide CY12	12,479	469,651	2.66%	$50,451	$629,572,276	26.22%
Los Angeles CY12	4,444	155,845	2.85%	$50,210	$223,134,187	24.59%
Los Angeles CY11	4,415	147,713	2.99%	$50,137	$221,355,131	25.95%
Los Angeles CY10	3,393	140,753	2.41%	$50,212	$170,369,727	23.09%
Los Angeles CY09	3,841	141,205	2.72%	$48,564	$186,536,173	23.72%

CAEQRO also analyzed claims data for beneficiaries receiving $20,000 to $30,000 in services per year. Statewide, this population also represents a small percentage of beneficiaries for which a disproportionately high amount of Medi-Cal dollars is claimed. Statewide in CY12, 38.31% of the approved Medi-Cal claims funded 5.20% of the beneficiaries served when this second tier of high cost beneficiaries is included. For the MHP, 36.70% of the approved Medi-Cal claims funded 5.76% of the beneficiaries served. This information is also depicted in pie charts in Attachment D.

- In CY12, HCBs represented 2.85% of all MHP beneficiaries served, which was 7% greater than the statewide average (2.66%). It represented 29 more beneficiaries than in CY11 and a decrease in the percentage of beneficiaries which were considered high cost, as the MHP served over 8,000 more beneficiaries in CY12 than CY11.

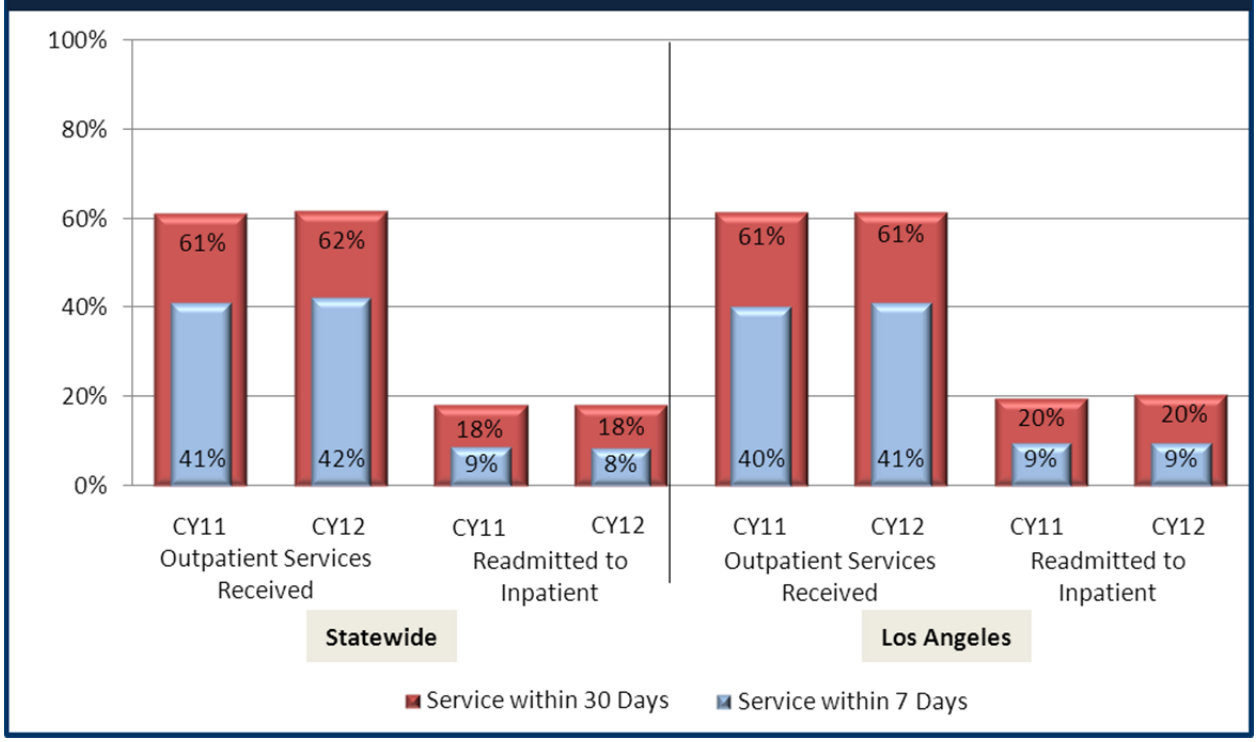
- Total CY12 HCB dollars represented 24.59% of all Medi-Cal claims, which was 6% less than the statewide average (26.22%). The MHP's percentage of total claims attributed to HCBs was *slightly* lower than the statewide percentages for all four years displayed (CY09 to CY12).
- In CY12, the MHP funded the balance of Medi-Cal services (94.24% for 146,866 beneficiaries) with 63.30% of its approved claims dollars. For beneficiaries who received less than $20,000 in approved claims, their average claim per beneficiary was $3,912 and the median was $2,267 – both figures was greater than comparable statewide figures ($3,326 and $1,727, respectively).

Timely Follow-up After Hospital Discharge

CAEQRO reviewed Medi-Cal approved claims to identify what percentage of beneficiaries statewide and within each MHP received a follow-up service after discharge from an inpatient setting - within seven days and 30 days. Similarly, this analysis shows the percentage of beneficiaries who were re-hospitalized during those time frames. It should be noted that when Medi-Cal beneficiaries are admitted to inpatient facilities that do not bill Medi-Cal, those inpatient episodes are not represented in the claims analysis. Also, this data includes only the first inpatient episode in that CY for a given beneficiary, from January through November.

Figure 14. Timely Follow-up: 7 and 30 days After Hospital Discharge

Percentage Receiving Outpatient Service or Readmitted Los Angeles and Statewide, CY11 and CY12



Statewide in CY12, within 7-days of discharge, 42% of beneficiaries received at least one non-inpatient service. Also within that time frame, 8% of beneficiaries were readmitted to an inpatient setting, a decrease over CY11 at 9%. Within a 30-day time frame, 62% of beneficiaries received a non-inpatient service after discharge in CY12, an increase from CY11 at 61%. The statewide inpatient readmission rate held steady at 18%.

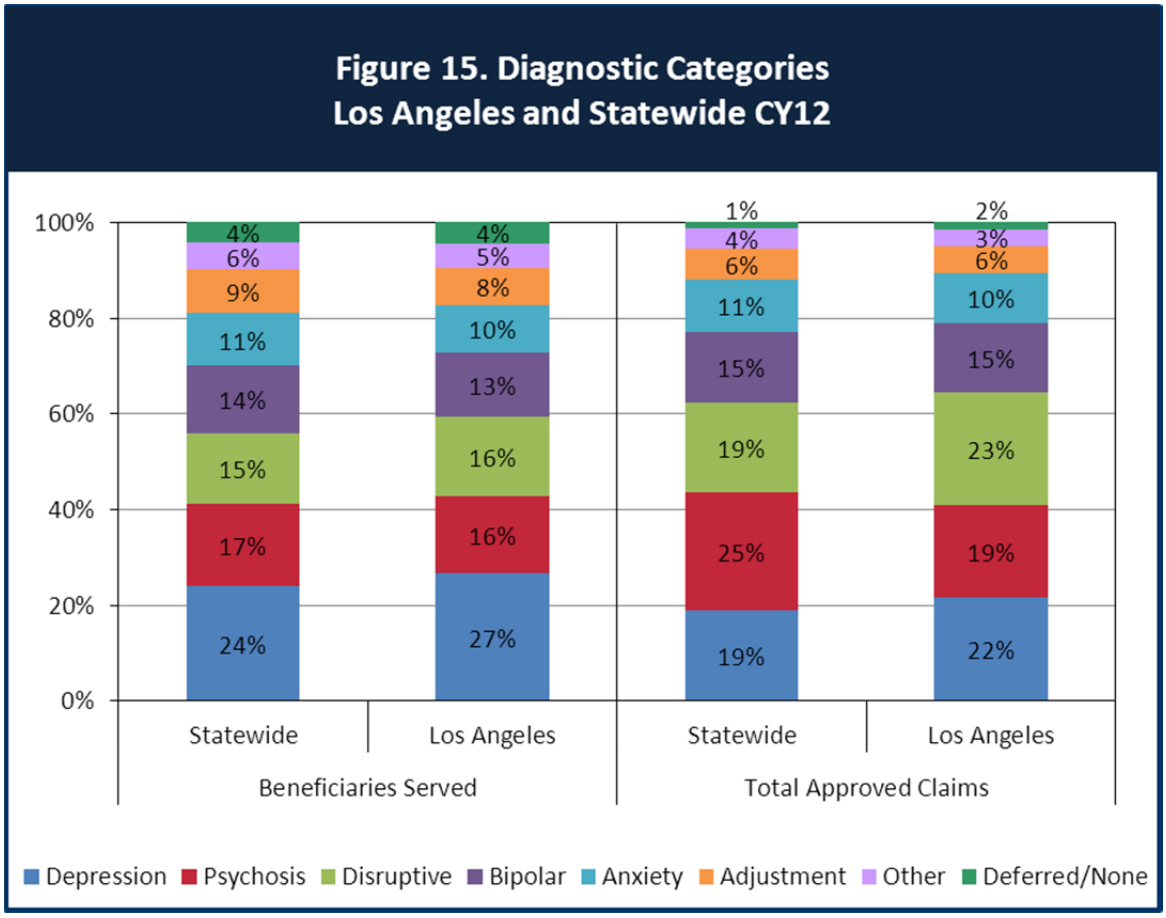
For the MHP, the follow-up and readmission rates reflect the following:

- During CY12, outpatient services were provided to 41% of beneficiaries within 7days following hospital discharge, which was less than the statewide average* (42%). During this 7-day time frame, the MHP's inpatient readmission rate of 9% was greater than statewide average* (8%).
- Also in CY12, outpatient services were provided to 61% of beneficiaries within 30-days following hospital discharge, which was less than the statewide* rate of 62%. The 30-day MHP readmission rate was 20%, thus greater than the statewide average* of 18%.
- The MHP's provision of follow-up services post-hospital discharge at either the 7- or 30-day mark was consistent between CY11 and CY12. So too was the CY11 and CY12 7- and 30-day readmission rates.

*The CY12 MHP's hospital discharges and readmissions were included in the CY12 statewide totals, representing just over 30% of those totals.

DIAGNOSTIC CATEGORIES

CAEQRO reviewed approved claims to analyze the frequency of primary diagnoses throughout the state and each MHP. Similarly, this analysis examined the dispersal of approved claims by diagnostic category. For a complete list of the diagnoses within each diagnostic category, please refer to the CAEQRO Website at www.caeqro.com. The diagnoses reflect the primary diagnosis as reported on the Medi-Cal approved claims.



Statewide in CY12, Depressive disorders are most frequent at 24%. This is followed by Psychotic disorders at 17%, Disruptive disorders at 15%, and Bipolar disorders at 14%. When examining approved claims, there are proportionately more funds expended on Psychotic disorders (25%) and Disruptive disorders (19%) and proportionately fewer funds expended on Depressive disorders (19%) and Adjustment disorders (6%). Statewide, 4% of diagnoses are deferred/none, though they represent only 1% of claims. Statewide, there is little change in the diagnostic data compared to CY11 patterns.

For the MHP, diagnostic categories show the following notable differences:

- CY12 MHP data revealed the MHP assigned a greater percentage of Depressive Disorder diagnoses (27%) to beneficiaries compared to the statewide* trend (24%); this diagnostic category similarly comprised a greater percentage of MHP approved claims (22% versus statewide 19%).
- Conversely, the MHP assigned a smaller percentage of Psychotic Disorder diagnoses (16%) to consumers compared to the statewide trend (17%), with a significantly smaller percentage of MHP approved claims dollars attributable to this diagnostic category than seen statewide (19% versus statewide 25%). This disparity suggests that the MHP would benefit from determining if individuals with psychotic

disorders are receiving appropriate levels of service.

- The MHP assigned a slightly greater percentage of Disruptive Disorder diagnoses (16%) to consumers compared to the statewide trend (15%). This diagnostic category comprised a greater percentage of approved claims dollars at the MHP (23% versus statewide 19%).

*The CY12 MHP's diagnostic information was included in the statewide CY12 totals, representing just over 30% of these totals.

❖PERFORMANCE MEASUREMENT❖

Each year CAEQRO is required to work in consultation with DHCS to identify a PM which will apply to all MHPs – submitted to DHCS within the annual report due on August 31, 2014. These measures will be identified in consultation with DHCS for inclusion in this year's annual report.

❖CONSUMER AND FAMILY MEMBER FOCUS GROUPS❖

FOCUS GROUPS SPECIFIC TO THE MHP

CAEQRO scheduled four 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CAEQRO requested focus groups as follows:

1. A group of Latino/Hispanic adult Medi-Cal beneficiaries receiving specialty mental health services – one group each in SAs 1 and 3.

2. A culturally diverse group of parents/caregivers of youth receiving *Katie A.* services – one group each in SAs 1 and 3.

Of the focus groups requested, the following did not occur as planned:

- In SA 3, only one Latino/Hispanic adult consumer showed for the focus group, so no group took place. The individual was thanked for their effort and provided a gift certificate.

The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to services, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CAEQRO provided gift certificates to thank the consumers and family members for their participation.

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

This 90 minute focus group was conducted with seven adult consumers who receive services and was held at the Antelope Valley Wellness Center in SA 1 in Palmdale, CA. Provisions were made by the MHP for a Spanish-speaking interpreter for this group.

Group participants received a variety of services including individual therapy, group therapy and medication support. Group participants received services ranging from the last one year to over three years. All group participants indicated services were available in Spanish if preferred.

The majority of group participants indicated that each was primarily served by both a psychiatrist and a clinician. It was mentioned by some of the group that if a psychiatrist resigned then appointments would be rescheduled. The concern was that these appointments were at times rescheduled after a medication supply had run out and getting timely refills was experienced as difficult. It was strongly expressed that for the continuity of care, participants felt it would be valuable to reschedule appointments within a reasonable time.

Those served by psychiatrists were seen on a regular basis with appointments ranging from biweekly to every three months, depending on treatment plans. The exceptions were mentioned above in regard to the cancelled appointments. Consumers had a sense of how to obtain care in the event of a crisis and had utilized the crisis center, an emergency room, warm line or, if needed, contacted 911.

The majority of consumers expressed how responsive service providers had been at the facility and their initial appointments were made immediately. Focus group participants overall felt a sense of hopefulness from providers. The consensus was that each felt they had been helped at the MHP and could continue to improve.

This particular group of consumers had initially entered services through either voluntary or involuntary hospitalization, or were referred by the Mental Health America, an unemployment office or a community agency. Consumers who used MHA services were appreciative and indicated these were available when they were most in need.

The group participants had limited knowledge of venues for participation beyond the Wellness Center and none of the members had been extended an invitation to serve on any committees. Additionally, none were aware of available consumer volunteer opportunities. Overall, this group felt the system's strengths were its responsiveness and the support from staff.

Recommendations arising from this group include:

- Increase education for family and community members regarding mental health recovery.

- Provide opportunities to give back through volunteering, re-entry job options, and socialization activities.
- Provide peers to assist with getting other services such as food, housing, jobs, and healthcare benefits.

Participants from the group provided the following demographic information:

Figure 16. Consumer/Family Member Focus Group 1

Number/Type of Participants	
Consumer Only	5
Consumer and Family Member	2
Family Member of Adult	
Family Member of Child	
Family Member of Adult & Child	
Total Participants	7

Ages of Participants	
Under 18	
Young Adult (18-24)	
Adult (25-59)	6
Older Adult (60 and older)	1

Preferred Languages	
English	5
Spanish	2

Race/Ethnicity	
Latino/Hispanic	7

Gender	
Male	6
Female	1

Interpreter used for focus group 1: ☐ No ☒ Yes Language: Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

This 90 minute focus group of parents and foster parents of children receiving services was held at the administrative offices of SA 1 in Lancaster, CA. The group consisted of nine participants representing seventeen youth, all of whom are involved with DCFS.

Services for youth had been initiated from the past year to over four years ago. Initial access to services was difficult for those with foster children, as group members indicated the referral was required to come from the CWS social worker, so access was then dependent that worker's responsiveness. They felt that unless the correct "buzz words" were used, delays occurred due to this process. With the delays in referrals, parents experienced frustration as treatment needs were not meet timely for this vulnerable population.

The youth were receiving a broad representation of services including wraparound, therapeutic behavioral services (TBS), medication support, and individual counseling. Many were involved in team decision-making as part of the wraparound services though. Much of the group was experienced foster parents who were cognizant of both the DCFS and MHP systems.

Each of the group participants knew how to access crisis services should the youth need this and had done so, if necessary. One of the most useful services noted was TBS which was said to help tremendously with behavior concerns. Conversely, some of the group indicated that the wraparound approach seemed to create conflicting and opposing goals between the supplemental provisions through the program, such as enrollment into enrichment activities, and the care providers' opinion that this activity can feel like a "reward" which undermines the caregivers' disciplinary procedures. Additionally, exiting from wraparound services often occurred abruptly, contributing to unplanned changes for youth.

Support and appreciation was expressed by those families which worked with the parent partner. Respite services were only known to families who were working with a foster family agency. Group participants indicated that the youth showed progress and that the individual providers were supportive, encouraging, and instilled hope that improvement could occur.

Recommendations arising from this group include:

- Provide written material outlining all available mental health services.
- Offer parent education classes in dealing with behavior problems.
- Offer transition sessions from wraparound to other services.
- Revise the referral process requiring DCFS workers' to initiate the process in a more timely manner.

Participants from the group provided the following demographic information:

Figure 17. Consumer/Family Member Focus Group 2

Number/Type of Participants	
Consumer Only	
Consumer and Family Member	
Family Member of Adult	
Family Member of Child	9
Family Member of Adult & Child	
Total Participants	9

Ages of Participants	
Under 18	
Young Adult (18-24)	
Adult (25-59)	9
Older Adult (60 and older)	

Preferred Languages	
English	9

Race/Ethnicity	
Caucasian/White	5
African American/Black	2
Latino/Hispanic	1
Native American	1

Gender	
Male	2
Female	7

Interpreter used for focus group 2: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

This focus group of parents/caregivers of youth receiving *Katie A.* services in SA3 was held at Enki Behavioral Health's Administrative offices and included four participants. Participants' children receiving services included two sons, two daughters and one foster child. All evidenced service lengths of at least four years.

Participants reported initial service was timely, occurring the same day in two instances. One attendee reported waiting six months for Enki services, but then called Bienvenidos and was served immediately; this contractor access disparity continues, per interviewed clinicians. Routine appointments usually occur twice a month, or even once to twice a week, based on need. All knew of various options for crisis assistance, such as afterhours clinic/staff phone numbers, a local hospital, or calling a clinic during the workday.

The group reported interpreters are available for doctor appointments. Enki was reported as very open to having an advocate or any other person connected to the family's life in sessions with consumers. No one reported receiving a physical health referral from the MHP and that "physical health and mental health care are very separate." The group noted staff reductions or caseload switching in the last year was a notable system change that has negatively impacted them. Families had not been notified in advance of these changes and had no opportunity to say good bye to clinicians.

Two participants reported communication comes to them by way of monthly meetings (if at Enki) or from other consumers. The other two attendees reported no routine venues to receive information and rely on their case managers instead. Enki staff was also endorsed as very open to receiving consumer feedback. Only half the group had heard of the local Wellness Centers; one attends regularly. All had heard of various respite programs, parent advocates, and parent partners. They said support groups are available and they thought that recovery for their children is possible.

Recommendations arising for the group included:

- Improve the community information flow and outreach efforts to make people aware of issues. Promote information about clinics and services available.
- Join school health fairs to make mental health issues more mainstream, as school bullying is an issue for children receiving mental health services at the school.

Participants from the group provided the following demographic information:

Figure 18. Consumer/Family Member Focus Group 3

Number/Type of Participants	
Consumer Only	
Consumer and Family Member	1
Family Member of Adult	
Family Member of Child	3
Family Member of Adult & Child	
Total Participants	4

Ages of Participants	
Under 18	
Young Adult (18-24)	
Adult (25-59)	4
Older Adult (60 and older)	

Preferred Languages	
English	4

Race/Ethnicity	
Latino/Hispanic	3
Caucasian/White	1

Gender	
Male	
Female	4

Interpreter used for focus group 3: ☒ No ☐ Yes

❖PERFORMANCE IMPROVEMENT PROJECT VALIDATION❖

CLINICAL PIP

Status of PIP:

- ☐ Active and ongoing
- ☐ Completed
- ☐ Inactive, developed in a prior year
- ☐ Concept only, not yet active
- ☒ No PIP submitted - the MHP submitted a project which does not quality as a PIP (see explanation below)

Based on the submitted roadmap and onsite discussion, the MHP's submitted project evaluates 524 homeless consumers who happen to be enrolled in the MHSA Innovations Integrated Mobile Health Team (IMHT) program. The evaluation of possible positive change on a number of consumer variables is already being done annually by a contracted party. Further, as there is no clinically, data-driven reason for the selection of these *particular* 524 consumers other than they happened to be those enrolled in IMHT by the five participating agencies and accepted services, this project does not qualify as a PIP. A qualifying PIP does not simply evaluate the effectiveness of a given program, such as the IMHT program and its various EBPs; this is instead a program evaluation. Consumers specifically receiving a qualifying PIP intervention(s) need to be directly related to the identified problem, upon which various interventions (and *not* just program services) can be tested and applied to create improvement. This project, as designed, does not effectively do that.

CAEQRO applied the PIP validation tool, which follows in Attachment E, to all PIPs – rating each of the 44 individual elements as either "met," "partial," "not met," or "not applicable." Because the MHP does not have an active clinical PIP, all items are rated as "not met" for purposes of analysis. Thirteen of the 44 criteria are identified as "key elements" indicating areas that are critical to the success of a PIP. These items are noted in grey shading in the PIP Validation Tool included as Attachment E. The results for these thirteen items are listed in the table below.

Figure 19. Clinical PIP Validation Review—Summary of Key Elements

Step	Key Elements	Present	Partial	Not Met
1	The study topic has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X
2	The study question identifies the problem targeted for improvement			X

Figure 19. Clinical PIP Validation Review—Summary of Key Elements				
Step	Key Elements	Present	Partial	Not Met
3	The study question is answerable/demonstrable			X
4	The indicators are clearly defined, objective, and measurable			X
5	The indicators are designed to answer the study question			X
6	The indicators are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X
7	The indicators each have accessible data that can be collected			X
8	The study population is accurately and completely defined			X
9	The data methodology outlines a defined and systematic process			X
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes			X
11	The analyses and study results are conducted according to the data analyses plan in the study design			X
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion			X
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement			X
Totals for 13 key criteria				**13**

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve other PIPs.

NON-CLINICAL PIP

The MHP presented its study question for the non-clinical PIP as follows:

> "Can the use of an electronic web based tool improve providers' access to information so as to provide accurate referrals pertaining to availability of: 1) Programs slots related to consumer's preferred language request, 2) Program slots related to consumer's request

for convenient location of services, 3) Program slots related to specific mental health services?"

Year PIP began: July 1, 2014.

Status of PIP:

- ☒ Active and ongoing
- ☐ Completed
- ☐ Inactive, developed in a prior year
- ☐ Concept only, not yet active
- ☐ No PIP submitted

The MHP noted that as many new services have become available to consumers, it has been a challenge to keep providers informed of available spots and services. As a result, the goal was to create a web-based application that would assist all providers to better manage consumer flow through the entire system of care and save consumers valuable time when calling programs looking for a vacancy/immediate availability.

The PIP committee surveyed SA4 providers in early 2014 to assess their ability to refer consumers to appropriate services based on up-to-date knowledge of available slots, slots in the consumer's preferred language, slots in a convenient location based on consumer preference, and slots for a specific service, pre-web application. Informed by these results, the MHP developed the Vacancy Adjustment Notification System/Vacancy Referral Reporting System (VANS) which allows providers to update their slot information (and what services and languages they provide), as well as search for vacancies at surrounding providers prior to making a consumer referral. The system also allows provider staff to add programs, services, and slots as they become available and search for a potential referral source within a specific mile radius, locale, language capacity, or need.

While the MHP's developed PIP question and five PIP indicators address the identified issue surrounding assisting providers to make more appropriate referrals, both fail to adequately acknowledge and, ultimately, assess if by making consumer referrals using VANS information will improve consumer service linkage and result in less wait time/effort on the consumer's part. These two issues need to be incorporated into the PIP question in some way as does the MHP need to add at least one consumer-relevant indicator (e.g., assessing effective linkage) to make this project fully meet PIP criteria next FY. Onsite discussion clarified these necessary adaptations, and the MHP reported discussions post-site with various providers about possible ways to track effective consumer linkage post-referral. Once a mechanism has been establish to do so, the MHP can proceed with its detailed data analysis plan of both weekly and monthly tracking using data collected in a SQL database.

CAEQRO applied the PIP validation tool, which follows in Attachment E, to all PIPs – rating each of the 44 individual elements as either "met," "partial," "not met," or "not applicable." Relevant details of these issues and recommendations are included within the comments of the PIP validation tool.

Thirteen of the 44 criteria are identified as "key elements" indicating areas that are critical to the success of a PIP. These items are noted in grey shading in the PIP Validation Tool included as Attachment E. The results for these thirteen items are listed in the table below.

Figure 20. Non-Clinical PIP Validation Review—Summary of Key Elements

Step	Key Elements	Present	Partial	Not Met
1	The study topic has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X		
2	The study question identifies the problem targeted for improvement		X	
3	The study question is answerable/demonstrable	X		
4	The indicators are clearly defined, objective, and measurable	X		
5	The indicators are designed to answer the study question	X		
6	The indicators are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same		X	
7	The indicators each have accessible data that can be collected		X	
8	The study population is accurately and completely defined	X		
9	The data methodology outlines a defined and systematic process that consistently and accurately collects baseline and remeasurement data	X		
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes	X		
11	The analyses and study results are conducted according to the data analyses plan in the study design			X
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion			X
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement			X
Totals for 13 key criteria		**7**	**3**	**3**

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve this or other PIPs. The PIP, as submitted by the MHP, is included in an attachment to this report.

❖INFORMATION SYSTEMS REVIEW❖

Knowledge of the capabilities of an MHP's information system is essential to evaluate the MHP's capacity to manage the health care of its beneficiaries. CAEQRO used the written response to standard questions posed in the California-specific ISCA Version 7.3.2, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

MHP Information Systems Overview

Key ISCA Information Provided by the MHP

The information below is self-reported by the MHP in the ISCA and/or the site review:

- Of the total number of services provided, what percentage is provided by:

Type of Provider	Distribution
County-operated/staffed clinics	23%
Contract providers	74%
Network providers	3%
	100%

- Normal cycle for submitting current fiscal year Medi-Cal claim files:

☐ Monthly ☐ More than 1x month ☒ Weekly ☐ More than 1x weekly

- Reported percentage of consumers served with co-occurring (substance abuse and mental health) diagnoses:

21%

- Reported average monthly percentage of missed appointments:

N/A

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒ Yes ☐ No

The following should be noted with regard to the above information:

- The MHP submits weekly claim files for current FY13-14 services. Services for FY12-13 are claimed separately so claim files are submitted as needed.
- The MHP reported co-occurring diagnosis data is not easily captured in the present EHR as it is not a mandatory field clinicians must complete. Thus, the percentage reported above underrepresents the actual occurrence.
- The MHP's present EHR (Integrated System) does not have the capability to track missed or no show appointments for DO providers; however, IBHIS has the capability to track all initial requests for services for both DO and contract providers and will be used to do so.

CURRENT OPERATIONS

- The delay in the planned shutdown of Integrated System is due to the extended lead time needed to develop and roll-out Client Web Services for contract providers, as well as other issues noted below.
- The MHP continues to rely on Integrated System as its primary system to support practice management, billing activities, and other State reporting requirements. Over 90% of outpatient services provided by DO and contract providers continue to be entered into and billed from this system.
- As part of the Integrated System shutdown contingency planning process, the MHP plans to request a contract extension for Sierra Systems Group to support the system beyond December 31, 2014 in order to:
  - Allow time to complete the Pharmacy Benefits Management RFP process and execute a contract with the selected vendor.
  - Allow time to adjudicate void and replacement transactions for contract provider claims submitted to Integrated System prior to their particular IBHIS go-live date.
- The IBHIS implementation cutover phase began January 2014 when 10 DO providers went live. By February 2014, LEs in Group 1 completed IBHIS provisioning and testing phases and began the go-live implementation phase. As of April 2014, a number of Group 1 LEs had services posted to IBHIS and the MHP submitted SD/MC claim files to DHCS which were successfully approved for payment.

- The Integrated System to IBHIS cut over is a complex, change management project and will require the remainder of 2014 to complete. The CIOB and CBO will need to transition over about 120 DO providers, 128 LEs (representing approximately 600 contracts), and network providers.
- In addition to primary systems identified in Figure 22, the CIOB also supports about 60 other systems and applications that range from legacy systems to mission-critical systems that that support IBHIS.
- During the past year, the CIOB hired 14 technology staff members, while six retired, transferred, or terminated employment. As of March 2014, the CIOB had 13 unfilled positions. The number of authorized CIOB positions remains at 191 to support both DO and contract provider operations.
- With the improvement of the state economy, it was noted by CIOB EMT that it is now more challenging to hire and retain technology staff. It was noted that other health agencies will need to implement ACA technology changes, which could result in the CIOB losing experienced staff.

Major Changes Since Last Year

- The IBHIS project is a huge multi-year effort with a significant number of sub-projects. Below is a list of the critical initiatives and activities that began or were completed in the past year:
  - Implemented the MHP BizTalk Integration environment that automates exchange of data with business partners.
  - Designed, tested, and implemented Client Web Services that enables the MHP to exchange data electronically with contract providers.
  - Implemented the MHP's production of an EFT environment and structured contract provider folders to enable EDI file drops.
  - Implemented MHP Medical Chart Scanning and Indexing.
  - Completed site readiness and roll-out support for some DO providers to convert to IBHIS.
  - Completed the move of consumer and diagnoses data from Integrated System to IBHIS.
  - Implemented IBHIS Pilot 1 reports.
  - Cutover IBHIS to production use.
  - Completed the Avatar security policy.
- One hundred and seventeen contracts funded through the CPTNP have been completed, totaling over $9 million in funding so far.

- Meaningful Use (MU) Incentive Program Stage 1 has moved forward as the MHP had providers execute agreements that assign MU funds to the MHP.
- Telepsychiatry services were expanded.
- More field-based work was supported with technological assistance/advancements.
- Significant desktop hardware and software refreshes were completed, that is:
  - 400 to 500 personal computers and 120 laptops were replaced.
  - XP & Office 2010 operating systems were upgraded to Window 7 & Office 2013 on 1,762 personal computers and 120 laptops.
- Hi-Trust Policy Maps and Gap analysis were completed.

PRIORITIES FOR THE COMING YEAR

- Top IBHIS implementation priorities presently include:
  - Providing site readiness and roll-out support to the remaining DO providers to adopt IBHIS.
  - Transitioning remaining providers who previously used Integrated System direct data entry to EDI transactions through the CPTP.
  - Ensuring contract provider integration with digital key provisioning to ready them for Trading Partner Agreements and authentication, X12 EDI transactions to IBHIS, XML transactions to exchange consumer data through Client Web Services to IBHIS, and XML transactions to exchange Community Outreach Services to IBHIS.
  - Further developing integration expertise and resources.
  - IBHIS system acceptance and sign-off by the MHP.
- Redesigning the MHP's Data Warehouse in response to Health Care Reform and IBHIS implementation.
- Moving forward with MU user compliance – Stages 1 and 2.
- Redesigning the CIOB organization structure to a new support structure.
- Implementing Managed Print Services, in same order as the IBHIS rollout.
- Continuing to support data exchange with the County Social Services and Health Services Departments related to Healthcare Reform and consumer eligibility.
- Replacing hardware security tokens use with RSA adaptive authentication.
- Supporting the possible transition from Blackberry to Smartphone/Bring-Your-Own device use.

- Completing the RFP process to obtain a Pharmacy Benefits Management system to support an e-prescribing solution.
- Improving automated support for IS staff at the various co-located sites.
- Planning for Disaster Recovery.
- Continuing to support the CPTNP so that provider technology initiatives can move forward.
- Renewing infrastructure including:
  - End Point devices (with new mobile systems for IBHIS).
  - Exchange 2010 upgrades.
  - Network and Data Center technologies.
  - Window 7 and Office 2013 upgrades.
- Collaborating with County ISD and migrating to County centralized e-mail services.
- Completing a Hi-Trust Common Security Framework.

OTHER SIGNIFICANT ISSUES

- Historically, contract providers have been reimbursed based on direct services entered into Integrated System. With the IBHIS implementation, providers are concerned that monthly contract payments may be delayed or not paid timely, impacting some providers' ability to pay expenses.
- As the County selected a RSA adaptive authentication product as replacement for the current security hardware tokens, the MHP has requested to be an early adopter of the new solution when it becomes available. Until the new security product is available, the MHP still needs to closely monitor wait times to issuing new security tokens as delays affect staff training and impact staff productivity.
- As of March 2014, approximately 30 LEs had yet to select or implement their local EHR system.
- With the state delay in implementing 5010 HIPAA 270/721 transactions, the MHP continues to rely on staff to logon to MEDS to clear Share-of-Cost transactions one beneficiary at a time. Until it is implemented, the EDI solution for file submission is not yet operational.
- Hiring qualified technology staff and retaining experienced staff is more difficult as the economy improves. Retaining experienced technology staff is especially critical for support of IBHIS during the cut over phase.

The table below lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide EHR functionality, produce SD/MC and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Figure 21. Current Systems/Applications

System/ Application	Function	Vendor/Supplier	Years Used	Operated By
Integrated Systems	Practice Management, Billing	Sierra Systems Group	9	Vendor IS/CIOB
IBHIS	CalPM, CWS, MSO, Billing, Order Connect, Provider Connect	Netsmart Technologies	<1	Vendor IS/CIOB
DMH Data Warehouse	Data Cubes for Reporting Purposes	Sierra Systems Group	9	CIOB
BizTalk Integration System	Data Integration	Microsoft	2	CIOB
ACCESS Center	Call Center Support	Verizon	<1	Vendor IS/CIOB
PATS	Medication Tracking, e-Prescribing	County ISD	20	County ISD

Plans for Information Systems Change

The MHP continues to implement Netsmart's Avatar system to support EHR functionality for all DO providers through IBHIS. Contract providers are required to implement their own EHR systems and use a variety of electronic transactions to exchange consumer-level data between their local EHR systems and IBHIS.

- There are approximately 120 DO provider sites that will implement IBHIS. In January 2014, ten of these providers were selected to go-live; current plans are to have all DO providers go-live on IBHIS by December 2014.
- There are approximately 128 LEs representing approximately 600 contract provider programs that use local EHR systems to exchange electronic transactions with IBHIS. In February 2014, LEs assigned to Readiness Group 1 began the go-live implementation, but there are still three additional LE Readiness Groups that will participate in a phased-in go-live implementation. The current goal is to have most LEs ready to claim by December 2014.
- As of May 2014, the IBHIS project remains in go-live implementation stage that is projected to be mostly completed by December 2014 for Medi-Cal services. IBHIS project Operations and Maintenance and Disposition stages are currently projected to be completed sometime during 2015.

Electronic Health Record Status

See the table below for a listing of EHR functionality currently in widespread use at the MHP.

Figure 22. Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	Avatar		X		
Clinical Decision Support	Avatar		X		
Document imaging	Avatar		X		
Electronic signature – client	Avatar		X		
Electronic signature – provider	Avatar		X		
Laboratory results (eLab)	Order Connect		X		
Outcomes	Avatar/OMA		X		
Prescriptions (eRx)	Order Connect		X		
Progress notes	Avatar		X		
Treatment plans	Avatar		X		
Contract Providers	Provider Connect/EDI/Web Services/ COS		X		

Progress and issues associated with implementing an EHR over the past year are discussed below:

- The original current IBHIS rollout schedule urged all LEs to complete IBHIS readiness tasks by June 30, 2014, with a go-date of September 30, 2014. The MHP has since revised IBHIS rollout plans and now favors bringing LEs on in a flow basis as they are ready to go-live, recognizing that some LEs may not be ready until early 2015.
- LEs are required to implement their own EHR systems and use a variety of electronic transactions to exchange consumer-level data between their EHR system and IBHIS. The first web services go-live phase for providers began February 2014.

❖SITE REVIEW PROCESS BARRIERS❖

The following conditions significantly affected CAEQRO's ability to prepare for and/or conduct a comprehensive review:

- There were no barriers affecting the preparation or the activities of this review.

❖CONCLUSIONS❖

During the FY13-14 annual review, CAEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CAEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access and timeliness of services and improving the quality of care.

STRENGTHS

1. The MHP's QI Work Plan demonstrated the MHP's capabilities and commitment to using data to assess the cultural, ethnic, and language needs of the community.
   [Access, Quality]

2. The numerous and growing Emergency Outreach Bureau programs, covering every SA, are designed to meet the urgent and emergent needs of beneficiaries as well as better the health of communities.
   [Access, Quality]

3. The CPTNP allocated over $20 million to more than 120 legal entities to partially offset provider costs to implement their own EHR systems and support EDI transactions. As of January 2014, 114 agreements have been executed, with 98 active projects; invoices paid total over $9 million.
   [Information Systems]

4. The MHP's Clinic Redesign Toolkit provides directly operated clinics with a model to help them maximize resources, create bi-directional primary care referrals, use a team-based approach, and grow welcoming and engagement efforts.
   [Access, Quality]

5. The MHP actively embraces Health Care Reform's triple aim principles and shows a

commitment to be a part of the Healthy Neighborhoods movement, working to bring FQHCs, community, and DO providers together.
[Access, Quality]

6. The MHP's penetration rate has increased each year during the past four years from 5.82% in CY09 to 6.21% in CY12. The number of Medi-Cal beneficiaries served increased from 141,200 in CY09 to 155,800 in CY12.
[Access]

Opportunities for Improvement

1. The present County Mental Health Advocate classification, which is used for MHP peer employment, does not prioritize lived experience; it minimizes peer options for work and advancement.
[Quality, Other: Consumer employment]

2. Some contract providers' monthly SD/MC revenue could be impacted if their IBHIS Legal Entity "claims go-live" is delayed.
[Information Systems, Other: Contractors]

3. SA QICs evidence inconsistent use of quality indicator data to direct QI or other improvement efforts, lack ongoing SA-specific QI activities, as well as lack a clear format to document monthly activities within both DO and contractor provider clinics.
[Quality]

4. As of March, approximately 30 Legal Entities had yet to select or implement their local EHR system.
[Information Systems]

5. The system evidences lack of capacity in numerous SAs to serve child consumers in a timely manner; protracted initial and routine service waits, referred agency wait lists, and diminishing medication support services were reported.
[Access, Timeliness]

6. Wait times for issuing new users' security tokens delays staff training and impacts staff productivity; this requires close monitoring. LA County approved the purchase of RSA adoptive authentication product, but it could be more than one year before implementation.
[Information Systems]

Recommendations

The following recommendations are in response to the opportunities for improvement identified during the review process, identified as an issue of access, timeliness, outcomes,

quality, information systems, or others that apply:

1. Working with County HR, re-evaluate how existing Mental Health Advocate qualifications, unintentionally, create barriers to peer employment and possibly advancement. Include input from the EAO, the OFE, Wellness Center peer employees/supervisors, and WOWs.
   [Quality, Other: Consumer employment]

2. Investigate the ability to reimburse contract providers for SD/MC services to prevent delays in provider monthly revenue flow during the LE IBHIS claims go-live process. Communicate with providers to ensure they are fully aware of what they need to complete for timely reimbursement during the process.
   [Information Systems, Other: Contractor communications]

3. Within the QID and departmental QIC, develop clear guidelines/expectations regarding consistent SA quality indicator/data review and use and SA-specific routine QI efforts and improvement projects. Consider creating a standardized systemwide QIC minutes format to demonstrate such activities occur routinely, as expected.
   [Quality]

4. Monitor and engage the approximately 30 legal entities that have yet to select or implement a local EHR system. Provide technical assistance and EHR project management guidance, where appropriate.
   [Information Systems]

5. At the SA-level, with centralized support, assess what capacity challenges are most pressing for children's services. Consider the expansion of telepsychiatry for children as well as fortifying Specialized Foster Care and Multidisciplinary Assessment Team resources that follow newly-referred children for longer periods than planned prior to linkage.
   [Access, Timeliness]

6. Create a process to monitor user security tokens issuance to identify when significant delays occur, informing the County CIO if this happens, to create a temporary solution while the RSA adoptive authentication product is implemented.
   [Information Systems]

❖ATTACHMENTS❖

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: Data Provided to the MHP

Attachment E: CAEQRO PIP Validation Tools

Attachment F: MHP PIP Summaries Submitted

A. Attachment—Review Agenda

Time	Monday April 28, 2014 – Day 1 Activities – Centralized Review Sessions *All sessions will occur at 695 S. Vermont Avenue*			
9:30-10:00	**CAEQRO Team Gathers**			
10:00-12:30	**Performance Management** **Access, Timeliness, Outcomes, and Quality** • **Introductions and CAEQRO Overview of Review Intent** • **MHP Strategic Initiatives and Significant Changes over the Past Year** • **CAEQRO FY12-13 Report Recommendations** • **Data Sharing by CAEQRO** Participants – Those in authority to identify relevant issues, conduct performance improvement activities, and implement solutions –including but not limited to: • MHP Director, senior management team, and other managers/senior staff in: Fiscal, Program, IS, Medical, QI, Research • Involved consumer and family member representatives and Patients' Rights Advocate ***15th Floor Glass Conference Room***			
1:30 – 2:45	**Service Area District Chiefs** • System-wide challenges and strategies • Capacity management • Interface with Access Center ***15th Floor Glass Conference Room***	**Katie A. Implementation** • Include staff involved in the implementation and monitoring of Katie A. and at least one Child Welfare Partner • Discussions of implementation readiness, strategies, and activities and outcomes ***15th Floor Small Conference Room***	**Consumer Empowerment/ Peer Inclusion** System-wide peer inclusion efforts ***5th Floor Conference Room***	**IBHIS Project Team** • Project Team staff change since 4/2013 • Communications • Integration testing • Custom software development • Go live pilots • Training • Vendor support • Implementation • County-operated • Contractors • Accurate & complete data from providers ***7th Floor Conf. Rm. 713***
3:00 – 4:30	**Emergency Outreach Bureau** • Bureau scope • Significant activities ***15th Floor Small Conference Room***	**Disparities in Access** • LAC-DMH overview • Penetration/Retention • Strategies, projects, and evaluation of efforts to address disparities and expand capacity ***15th Floor Glass Conference Room***	**Office of Family Engagement** System-wide family member inclusion efforts ***5th Floor Conference Room***	**Contract Providers – IBHIS/IBHIS Team Integration, Transition, Training Subject Experts** (*CIOB to identify up to 3 Legal Entity participants in the Go Live Pilot*) • Communications & collaboration • Companion Guides • Training & support • Data exchange accurate & complete • Lessons learned ***6th Floor Conf. Rm. 603***

<table>
<tr><th>Time</th><th colspan="3">Tuesday April 29, 2014 – Day 2 Activities – Service Area 1 Sessions</th></tr>
<tr><td rowspan="3">10:00-12:00</td><td colspan="3"><u>Introductory Meeting</u>

SA 1 Overview: Demographics, New Programs, Unique Challenges

Quality, Access, Timeliness, and Outcomes</td></tr>
<tr><td colspan="2">• Overview of review intent
• Performance improvement measurements utilized to assess and improve access, timeliness, outcomes, and quality</td><td>• Significant SA 3 changes in past year
• Examples of reports used for to manage performance and decisions</td></tr>
<tr><td colspan="3">Participants – Those in authority to identify relevant issues, conduct performance improvement activities, and implement solutions –including but not limited to:

• SA 1 District Chief, SA 1 leadership, and other SA 1 managers/senior staff and Involved consumer and family member representatives

Service Area 1 Administration
2323 A E. Palmdale Blvd., Palmdale, CA</td></tr>
<tr><td>1:00 – 3:00</td><td><u>Consumer/Family Member Focus Group –as specified</u>

8-10 participants:

Latino/Hispanic adult Medi-Cal beneficiaries receiving specialty mental health services

AV Wellness Center
251-H East Ave K-6
Lancaster</td><td><u>Outcomes/Timeliness</u>

• MHP examples of data used to measure timeliness, functional outcomes and satisfaction
• Timely access for non-English speakers
• Review of activities to address Service Area capacity issues

2323 A E. Palmdale Blvd.
Palmdale, CA</td><td><u>Contract Provider Group Interview</u>

Group interview with clinical and program administrators from # identified contract providers, representing children's and adult services
• Access & timeliness to services
• Managing capacity
• EHR operational issues
• Staff recruitment & training
• Integration with primary care

2323 A E. Palmdale Blvd.
Palmdale, CA</td></tr>
</table>

Time	Tuesday April 29, 2014 – Day 2 Activities – Service Area 3 Sessions *Unless otherwise noted, all sessions will occur at:* *Enki Health and Research Systems, Inc - El Monte Administrative Offices* *3208 Rosemead Blvd, 2nd Floor, El Monte*	
10:00-12:00	**Introductory Meeting** **SA 3 Overview: Demographics, New Programs, Unique Challenges** **Quality, Access, Timeliness, and Outcomes**	
	• Overview of review intent • Performance improvement measurements utilized to assess and improve access, timeliness, outcomes, and quality	• Significant SA 3 changes in past year • Examples of reports used for to manage performance and decisions
	Participants – Those in authority to identify relevant issues, conduct performance improvement activities, and implement solutions –including but not limited to: • SA 3 District Chief, SA 3 leadership, and other SA 3 managers/senior staff in: fiscal, program, IS, medical, QI, research, patients' rights advocate • Involved consumer and family member representatives	
1:00-2:30	**Consumer/Family Member Focus Group –as specified** 8-10 participants: A culturally diverse group of parents/caregivers of children/youth receiving *Katie A* services	**MHP and Contract Provider Clinical Line Staff Group Interview – Adult Services** 6-8 clinical line staff (all peers) representing various programs and geographical areas, including EOB Crisis and Homeless
2:30-4:00	**2:30 – 3:00 Travel to Wellness Center**	**MHP and Contract Provider Clinical Line Staff Group Interview – Children Services** 6-8 clinical line staff (all peers) representing various programs and geographical areas, including Specialized FC programs,
	3:00 – 4:00 **Consumer Employee Group Interview** 6-8 MHP or contract employees who are consumers, such as Peer Advocates, Peer Support Specialist, or Consumer Liaisons. ***Arcadia Wellness Center*** ***330 East Live Oak Avenue*** ***Arcadia, CA***	

Time	Wednesday April 30, 2014 – Day 3 Activities – Service Area 1 Sessions	
9:00 – 10:30	**Consumer/Family Member Focus Group –as specified** 8-10 participants: A culturally diverse group of parents/caregivers of children/youth receiving *Katie A* services ***2323 A E. Palmdale Blvd. Palmdale, CA***	**MHP and Contract Provider Clinical Line Staff Group Interview – Adult'sServices** 6-8 clinical line staff (all peers) representing various programs and geographical areas, including EOB Crisis and Homeless ***AV Wellness Center – 251-H East Ave K-6, Lancaster***
10:30 – 12:00	**Quality Improvement Activities** Discussion with Quality Improvement Committee Members • Review of QI activities utilized to improve access, timeliness, outcomes, and quality • QIC accomplishments • Stakeholder involvement and input ***2323 A E. Palmdale Blvd. Palmdale, CA***	**Disparities in Service Access, Retention, Quality, or Outcomes** • Review of MHP data or CAEQRO approved claims data to examine penetration rates and utilization patterns by age, ethnicity, or gender • Review of Cultural Competency strategies to improve access/engagement and improve health equity • Review of activities to address overall capacity • Evidence based or best practices for diverse or high risk populations • Katie A. Implementation ***AV Wellness Center – 251-H East Ave K-6, Lancaster***
1:00-3:00	**Consumer Employee Group Interview** Held at Discovery Center 6-8 MHP or contract employees who are consumers, such as Peer Advocates, Peer Support Specialist, or Consumer Liaisons. ***Discovery Center - 1609 East Palmdale Blvd., Palmdale, #G***	

Time	Wednesday April 30, 2014 – Day 3 Activities – Service Area 3 Sessions *Unless otherwise noted, all sessions will occur at:* *Enki Health and Research Systems, Inc - El Monte Administrative Offices* *3208 Rosemead Blvd, 2nd Floor, El Monte*	
10:00 – 12:00	**Outcomes/Timeliness** • MHP examples of data used to measure timeliness, functional outcomes and satisfaction • Timely access for non-English speakers • Review of activities to address Service Area capacity issues	**Contract Provider Group Interview** Group interview with clinical and program administrators from 6-8 identified contract providers, representing children's and adult services • Access & timeliness to services • Managing capacity • EHR operational issues • Staff recruitment & training • Integration with primary care
1:00-3:00	**Consumer/Family Member Focus Group –as specified** 8-10 participants: Latino/Hispanic adult Medi-Cal beneficiaries receiving specialty mental health services **2:30 – 3:00 Travel to Drop-In Center**	**Disparities in Service Access, Retention, Quality, or Outcomes - Service Area 3 Advisory Committee on API communities** • Review of strategies to improve access/engagement and improve health equity • Evidence based or best practices for diverse or high risk populations
3:00 – 4:00	**TAY Drop-In Center Site Visit – Irwindale** Informal discussion with members and staff Discussion with consumer leaders and steering committee ***Pacific Clinic*** ***13001 Ramona Blvd, Suite H*** ***Irwindale, CA 91706*** ***(Parking along the side of the bldg.)***	**Contract Provider Group Interview** **IS Managers & Billing Managers** **Group interview with IS and/or Billing subject matter staff from # identified contract providers who use various IS systems** • EHR system • EDI transactions • Claims submission to LACDMH • Denied claims reprocessing

Time	Thursday May 1, 2014, - Day 4 Activities – Centralized Review Sessions *Unless otherwise noted, all sessions will occur at 695 S. Vermont Avenue*			
10:00 – 12:00	**Timeliness/ Capacity** • Rio Hondo – Dedicated Triage Team • Long Beach – CARE clinic • Clinic Redesign *5th Floor Conference Room*	**Performance Improvement Projects** • Discussion includes topic and study question selection, baseline data, barrier analysis, intervention selection, methodology, results, and plans *15th Floor Small Conference Room*	**SA QIC Chairs and Co-Chairs** • Review of data and goals for quality measures • Quality improvement initiatives, activities and projects *15th Floor Glass Conference Room*	**Contract Providers** Open to all providers either in-person or can call-in • Communications • CPTT / IBHIS workgroups • Trading Partner Agreement • Readiness Groups • Web Services companion guide • Medi-Cal eligibility • SDMC claims • Accurate & complete data from LACDMH • New user account security tokens • CPTNP • DDE providers & EHR selection • EHR certifications *600 Commonwealth 2nd Floor Conf. Rm.*
1:00-2:30	**System-wide Outcomes** • MHP examples of data used to measure timeliness, functional outcomes and satisfaction • EPSDT Performance Outcomes System • FSP outcomes • Innovations outcomes report • Integrated care outcomes *15th Floor Glass Conference Room*	**System-wide Timeliness and Satisfaction Surveys** • Timeliness Self-Assessment • Timely access for non-English speakers • Consumer satisfaction surveys *5th Floor Conference Room*	**Contract Provider Group Interview** Group interview with clinical and business administrators from up to 10 identified contract providers from SAs 4, 5, 6 *15th Floor Small Conference Room*	**CIOB Management and IS Managers** • FY12-13 Recommendations • Staff resources • Security • SharePoint & Communications • Technology support of IS & IBHIS • Access Call Center • IBHIS county clinics • CPTT & IBHIS contract providers • CPTNP • Meaningful Use • Affordable Care Act • Tele-psychiatry • Consumer portal *6th Floor Conf. Rm. 603.*
3:00 – 4:00	**Final Questions Session** MHP Director, QI Director, Senior leadership, and APS staff only • Clarification discussion on any outstanding review elements • MHP opportunity to provide additional evidence of performance • CAEQRO Next steps after the review *15th Floor Glass Conference Room*			

B. Attachment—Review Participants

CAEQRO Reviewers

Samantha Fusselman, LCSW, CPHQ, Senior Lead Reviewer
Mila Green, PhD, CPHQ, Lead Reviewer
Bill Ullom, Senior Analyst, Information Systems Reviewer
Jovonne Price, MFT, CPHQ, Reviewer
Saumitra SenGupta, PhD, Director of Information Systems, Reviewer
Marilyn Hillerman, Consumer/Family Member Consultant
Debbie Strong, Consumer/Family Member Consultant
Michael Reiter, Pharm D., Executive Director

Additional CAEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-site and the post-site meetings and, ultimately, in the recommendations within this report.

Sites of MHP Review

CAEQRO staff visited the locations of the following county-operated and contract providers:

County provider sites

Los Angeles County Department of Mental Health (LACDMH) Administrative Office
695 S. Vermont Avenue
Los Angeles, CA

LACDMH Service Area 1 Administrative Office
2323 A E. Palmdale Blvd.
Palmdale, CA

Antelope Valley Wellness & Enrichment Center
251-H East Ave K-6
Lancaster, CA

Arcadia Wellness Center
330 East Live Oak Avenue
Arcadia, CA

LAC Offices
600 Commonwealth Avenue
Los Angeles, CA

Contract provider organizations

Enki Health and Research Systems, Inc.
El Monte Administrative Offices
3208 Rosemead Blvd
El Monte, CA

Discovery Center
1609 East Palmdale Blvd., Suite #G
Palmdale, CA

Pacific Clinic- TAY Drop-in Center
13001 Ramona Blvd, Suite H
Irwindale, CA

PARTICIPANTS REPRESENTING THE MHP

Adissa Johg, Alafia Mental Health Institute
Adriana Bugarin, Assistant Clinical Director, D'Veal Family & Youth Services
Agnieszka Medina, QI Director, Child & Family Guidance Center
Alesia Ping-DiFiore, Director, Tarzana Treatment Centers
Alfredo Larios, SA3 District Chief
Alice Chin, FSP Psychiatric Social Worker, Arcadia Mental Health Clinic
Allegra Klacsmann, Children's System/Child Welfare, Clinical Psychologist
Allison Foster, Children's Health Program Analyst
Alyssa Bray, SA4 QIC Chair, Optimist Youth Homes
Ana Suarez, SA7 District Chief
Anahid Assatourian, SA4 QIC Co-Chair/Liaison
Andy Vigil, QA Coordinator, Drew Child Development Center
Angel Baker, PSB Division Chief
Angel Towler, Therapist, D'Veal Family & Youth Services
Angela Boyd, EMR Project Manager/QI Director, Bienvenidos Children's Center
Angela Coleman, FSP Adult Navigator/Impact Coordinator
Angela O'Sullivan, Peer Advocate, Mental Health America Los Angeles
Angelle Hill-Seetal, Child Welfare, Clinical Psychologist
Ann Isbell, Didi Hirsch
Anna Yaralyan, EE/ME Liaison, QID Innovations ISM
Anthony Ramirez, PSB/GIS Research Analyst/Statistician
Aprill Baker, SA6 Training Coordinator
Barbara Bloom, Step Up On Second
Barbara Paradise, Program Director/QIC SA1 Co-Chair, Providence Community Services
Beatriz Trippy, Administrative Lead, Community Family Guidance Center
Berta Ortiz, Chief Operating Officer of Program, Planning, Development Monitoring, Kedren Community Mental Health Center

Bertrand Levesque, SA3 Administration
Bibianca Jaurequi, Intercommunity Child Guidance Center
Bill Sinko, Outpatient Services Manager, Community Family Guidance Center
Brenda Gordon, Peer Advocate/Health Navigator, Pacific Clinics Wellness Center
Brenda Coon, Psychiatric Social Worker, Antelope Valley Clinic
Bruce Boardman, Senior Director of Treatment Services, Social Model Recovery Systems
Carlotta Childs Seagle, Older Adult Deputy Director
Cathy Fisher, 1736 Family Crisis Center
Cathy Warner, Adult System Deputy Director
Chris Luce, Director, Hathaway Sycamores Child & Family Services
Chris Howard, IT Manager, Foothill Family Services
Chris Carlson, SAAC SA3 Chair/Arcadia Wellness Center Case Manager
Cindy Chau, Counselor, Social Model Recovery Systems
Cindy Ferguson, SA1 Administration Senior Registered Nurse
Cindy Padilla, Psychiatric Social Worker, Specialized Foster Care
Claudia Fierro, SA3 Program Administration
Corina Sontimatico, Harbor View Community Services Center
Cynthia Weis, Optimist Youth
Daniel Navasartian, Prototypes
Dave Pilon, CEO, Mental Health America Los Angeles
David Tavlin, Step Up On Second
David Zableckis, Clinical Director, Center for Integrated Family and Health Services
David Gaffield, Mental Health Finance Director, San Gabriel Children's Center
Debbie Innes-Gomberg, MHSA Implementation Clinical District Chief
Debi Berzon Leitett, Specialized Foster Care Training Coordinator
Deborah Devine, Program Manager, Children's Bureau/All4Kids
Debra Mahoney, QI Liaison Children's Countywide
Denise Greenspan, Hillview Mental Health Center
Dennis Murata, PSB Deputy Director
Derek Kleier, Billing Manager, Center for Integrated Family and Health Services
Derek Hsieh, EOB PMRT SA1-4 Clinical Program Head
Dexter Jefferson, California Hispanic Commission
Diana Del Carlo, Arcadia Mental Health Clinic Supervising Psychiatrist
Donald Parrington, Director, Ettie Lee Youth & Family Services
Douglas Corrigan, Program Coordinator, Masada Homes
Dustin Schiada, Clinical Director, VIP Community Mental Health Center
Earleen Parson, QI/Innovations Training Coordinator
Edward Vidaurri, SA4 District Chief
Elaine Louras, Director, Pasadena Unified School District
Eligio White, Saban Community Clinic
Elika Ramirez, Contracts/Billing Director, Hathaway Sycamores Child & Family Services
Elizabeth Marsh, Antelope Valley Wellness Center Clinical Supervisor
Elizabeth Gross, Arcadia Mental Health Clinic Program Head

Elizabeth Hartigan, Program Manager, SHARE
Elizabeth Owens, SA3 Co-Chair, Tri-City Mental Health Services
Ella Granston, Health Planning Analyst, PSB/QI
Emilia Ramos, Long Beach Center Clinical Program Head
Emily Truong, Advocate, Asian Coalition of DMH & NAMI-San Gabriel Valley
Ericka Hermon, Clinic Manager, Bienvenidos Children's Center
Eva Carrera, SA2 Clinical District Chief
G. Kaliah Salas, Child Welfare, Supervising Psychologist
Gabriela Villasenor Rodes, QA Supervisor, McKinley Children's Center
Gail Myers, Mental Health Director, Eisner Pediatric & Family Medical Center
Gassia Ekizian, SA3 Co-Chair, Foothill Family Services
Geanna Thomas, Peer Advocate, Mental Health America Los Angeles
Gene Gray, Counselor, Wellness Center
Genoveva Escobosa, Substance Abuse Case Manager, Prototypes
Gerard Torres, Consumer Services Unit Supervisor, East LA Regional Center
Gina Peck-Sobolenski, Director of Clinical Services, Maryvale
Glenn Masuda, Clinical Psychologist, Pacific Clinics
Gloria Sheppard, HCC Program Head
Gordon Bunch, Project Manager, CIOB
Greg Lecklitner, Child Welfare, District Chief
Helena Ditko, Family Advocate, Office of Family Engagement
Iris Casco, VIP Community Mental Health Center
Irma Valdez, SA1 Administration Health Program Analyst
Isabel Mendez, Adult System WOW Coordinator
Jackie Gonzales, Billing Supervisor, David & Margaret
Jackie Cox, SA6 Clinical Program Head
Jacquelyn Wilcoxen, SA5 District Chief
James Cohen, Peer Advocate, Mental Health America Los Angeles
Janell Eberly, Director of Clinical Services, McKinley Children’s Center
Janet Yang, Clinical Director, Heritage Clinic
Janis Roman, SPSW, Long Beach Center
Jay Patel, ITM, CIOB
Jean Watkins, Quality Services Report/Child Welfare, Supervising Psychologist,
Jeff Aguilar, DISO, CIOB
Jeff Schroder, Senior Billing Specialist, Five Acres
Jen Hallman, Quality Assurance
Jennifer Lane, Director, Penny Lane Centers
Jeremy Stear, Mental Health Worker, TAY Drop in Center/Pacific Clinics
Jessica Ahearn, SA7 Clinical Supervisor
Jessica Chavez Ramirez, Program Assistant, St. Anne's
Jessica Wilkins, SA5 QIC Co-Chair, Alcott Center
Jim Wallace, Star View Adolescent Center
Jim Sperlings, CIOB

JoEllen Perkins, SA1 District Chief
John Ortega, Division Chief CIOB
John Glover, Team Leader, Mental Health America Los Angeles
Jose Vazquez, Billing/Contracts Director, Hillsides
Joseph Hall, Community Worker, Arcadia Wellness Center
Juan Fermin, Integration Lead, Solutions Development, CIOB
Julian Pijuan, Specialized Foster Care Program Head
Julie Valdez, EOB Access Clinical Program Head
Kari Thompson, SA7 QIC Co-Chair, Providence Community Services
Kanchana Tate, Children's Psychiatric Social Worker
Kara Taguchi, MHSA Implementation/Outcomes Clinical Program Head
Karen Marshall, Telecare Corporation
Karen Ferguson, Specialized Foster Care Clinical Supervisor
Karen Van Sant, Technology Services Division Chief, CIOB
Kathleen Kerrigan, Integrated Care Clinical District Chief
Kathy Reyes, Associate Division Director, Pacific Clinics
Kathy Shoemaker, Senior VP Clinical Services, Exodus Recovery
Kelli Courson, Program Director, TAY FSP/Drop in Center-Pacific Clinics
Kenneth Moon, The Help Group Child and Family Center
Kim Farnham, QM Director, Aviva Center
Kim Sasaki, SA8 Program Manager
Kim Blackman, MIS Director, D'Veal Family & Youth Services
Kimber Salvaggio, SA2 Adult Administrative/QIC Chair
Kimia Ghassemy, Clinical Psychologist, Specialized Foster Care
Kumar Menon, Health Program Analyst
Larry Williams, Telecare Corporation
Laura Hernandez, Program Liaison, Tessie Cleveland Community Services
Lauren Dodge, QI Supervisor, Penny Lane Centers
Lawrence A. Hurst, SA4 Clinical Program Manager
Leslie Fuentes, Therapist, Almansor Clinical Services
Leticia Ximenez, CCC Co-Chair
Levana Adato, QA Coordinator, Child & Family Guidance Center
Lezlie Murch, Senior VP, Exodus Recovery
Linda Boyd, EOB START Clinical Program Head
Lisa Harvey, Countywide QIC Co-Chair, EMQ Families First
Lisa Thompson, Director, Child & Family Guidance Center
Lisa Wicker, PSB Clinical District Chief
Lisa Wong, SA2 Adults District Chief
Lise Ruiz, CHEERD Program Head
Lizett Gaona, Therapist, Pacific Clinics
Lorraine Romero, Mental Health Administrative Director, Rosemary Children's Services
Louis Suncin Jr., Rio Hondo Clinic Clinical Program Head
Lourdes Duran, Billing Manager, Foothill Family Services

Luis Montes, Director of Programs, Mental Health America Los Angeles
Lupe Navarro, MAT Therapist, Bienvenidos Children's Center
Lupe Ayala, SA7 Chair
Makesha Jones-Chambers, Antelope Valley Wellness Center Program Head
Man-ching Launen Cheung, Supervising Psychiatric Social Worker, Antelope Valley Clinic
Manuel Rosas, SA3 Children's Clinical Program Head
Margo Morales, Administrative Deputy
Maria Funk, CHEERD District Chief
Mariko Kahn, Executive Director, Pacific Asian Counseling Services
Mark Miller, Assistant Division Chief High Risk Services, Department of Children and Family Services
Mark Parra, Health Program Analyst
Mark Cheng, ITM, CIOB
Marlene Chavez, Psychiatric Social Worker, Palmdale Clinic
Marta Alquijay, LGBTQ Workgroup Co-Chair
Martin Jones, Older Adult District Chief
Martin Zuniga, Service Coordinator, Housing
Martin Hernandez, Supervising QA Patient's Rights
Marvin Southard, Department Director
Mary Marx, CRM Clinical District Chief
Mary Camacho-Fuentes, Palmdale Clinic Clinical Program Manager
Mary Crosby, QID Registered Nurse
Mary Kim, Innovations ICM Services Coordinator
Mastaneh Moghadam, Iranian Outreach Coordinator, Jewish Family Services
Matt Wells, Innovations Training Coordinator
Michael Miller, COO, David & Margaret
Michael Kennedy, Core Revenue Director/Data Systems, Pacific Clinics
Michael Strawn, Director of IT, Five Acres
Michael Tredinnick, EOB Access, Supervising Psychologist
Michele Munde, Director Quality & Compliance, Star View/SA8 QIC Co-chair
Michelle Valencia, Mental Health Lead Biller, Maryvale
Michelle Binoya, Peer Advocate, Mental Health America Los Angeles
Michelle Rittel, SA2 Children's QIC Chair
Minala Parada Ward, PSB Clinical Program Head
Miriam Brown, EOB PMRT LET Clinical District Chief
Misty Aronoff, QI & Compliance Manager, Alma Family Services/SA QIC Co-chair
Monica Cervantes, Mental Health Worker, Pacific Clinics
Monika Johnson, SA5 QIC Chair
Moses Adegbola, PSB/GIS Chief Research Analyst
Naga Kasarabada, QID Clinical District Chief
Nancy Fernandez, California Hispanic Commission
Nancy Ramos, Director, Optimist Mental Health
Nancy Butram, Revenue Management Chief

Nancy Tallerino, Senior VP Outpatient Services, Vista Del Mar
Natasha Desai, Alafia Mental Health Institute
Natasha Bryson, Wrap Coordinator, Intensive Services Child Guidance Center
Neelofer Tayyib, Clinical Psychologist, QID INN ISM
Nellie Garcia-Zuniga, Administrative Supervisor, Community Family Guidance Center
Nicole Rodriguez, MH Billing Specialist, Rosemary Children's Services
Pablo Vargas, Mental Health Administrative Coordinator, Pasadena Unified School District
Paco Retana, Clinical Supervisor, Green Dot Public School
Pansy Washington, Managed Care District Chief
Patrick Jeffries, Peer Partner, Pacific Clinics Wellness Center
Paul Arns, Clinical Informatics Chief
Paul Sacco, EOB LET Clinical Program head
Paula Rande, Mental Health Services Director, David & Margaret
Perla Pelayo, Assistant Clinical Social Worker, KEYS/SPIRITT
Porfirio Rincon, COO, San Gabriel Children's Center
Presley Becerra, IT Specialist, CIOB
Racheal Burgess, IBHIS, CIOB
Rachel McClements, Five Acres
Rachel Riphagen, Therapist, CIFHS - The Family Center
Rakdy Khlok, EOB DSU Senior Disaster Services Analyst
Rani Mammen, Clinical Director, Hillsides
Rashied Jibri, Supervising Patients' Rights Advocate
Rejeana Jones, Social Model Recovery Systems
Reyne Brown, Counselor, Innovations
Robert Greenless, CIO
Robert Levine, Health Program Analyst, DHS Collaboration Program
Robert Rivera, Solutions Development Manager, CIOB
Rocio Cabrales, Operations Manager, Child & Family Guidance Center
Romalis Taylor, AAA UREP Co-Chair
Rosario Samatoa, DMH Billing Supervisor, Five Acres
Rosemary Barragan, Peer Advocate, Mental Health America Los Angeles
Ruby Quintana, QID ISM Latino Liaison Services Coordinator
Ruchi Sukhija, Integration Manager, CIOB
Ruth Canas, Outpatient Director, St. John's Child & Family Development Center
Ruth Manzanares, Parent Advocate, Wraparound
Ruth Burgher-Glane, Program Manager, Drew Child Development Center
Sabrina Ullah, Tessie Cleveland Community Services
Sally Mansour, Community Based Division Director, Five Acres
Sandhya Panguluri, Supervising Psychiatrist, Rio Hondo Clinic
Sandra Rivas, Harbor View Community Services Center
Sandra Ponce, Palmdale Program Manager, Heritage Clinic
Sandra Chin, Research Analyst, QID
Sandra Chang Ptasinski, QIC Supervising Psychologist

Sara Jimenez McSweyn, Clinical Director, El Centro Del Pueblo
Scott Hanada, Adult System Program Head
Senart Admassu, Community Member, African Community Center
Sharon Carlson, Associate CIO/Division Chief, CIOB
Sharon Tan, Clinical Psychologist
Shelvey Tajii, Palmdale Clinic Clinical Supervisor
Sonia Hicks, SA1 Administration Outreach & Engagement
Stella Tam, Clinical Psychologist, Heritage Clinic
Steve Ambrose, Senior VP Programs, Children's Initiative
Steve Stoltz, Utilization Manager, Children's Bureau/All4Kids
Sue Page, Executive Director, CCAV
Suhasini Shah, PIS, CIOB
Sylvia Liu, Principal IS Analyst, CIOB
Tami Miller, Clinical Services Associate Chief, Foothill Family Services
Tanya Mendez, VIP Community Mental Health Center
Terri Boykins, Acting TAY System Deputy Director
Tim Ryder, Executive Director, Amanecer Community Counseling Services
Tim Beyer, QID Psychologist
Tina Mata, SA3 Administration Parent Advocate
Tonya Nowakonski, Executive Vice President, Hathaway Sycamores Child & Family Services
Trang Hoang, Social Worker, SSG Alliance
Treva Blackwell, PSB/Employee Advocate Training Coordinator
Trisha Rich Thurm, Clinical Director, Children's Center of Antelope Valley
Tsu Yen, EOB Clincial Psychologist
Valerie Curtis, Innovations Outcomes/Implementation Training Coordinator
Vandana Joshi, PSB Program Head
Vanessa Marsor, Mental Health Director, Bienvenidos Children's Center
Vatche Kelartinian, CEO, Heritage Clinic
Velia Lopez, Psychiatric Social Worker, Specialized Foster Care
Vernell Carrol, Peer Advocate, Mental Health America Los Angeles
Veronica Arteago, Program Director, St. Anne's
Viola Bernal, Social Model Recovery Systems
Wendi Tovey, Adult System District Chief
Windy Luna Perez, QA Business Manager, Ettie Lee Homes
Winnie Hsieh, Clinical Psychologist, Pacific Clinics
Yvonne Lopez, Alafia Mental Health Institute
Zena Jacobi, ITM, CIOB

C. Attachment—Approved Claims Source Data

APS Healthcare

Medi-Cal Approved Claims Code Definitions and Data Sources	
Last Modified by: Rachel Phillips, February 2014	Source: Medi-Cal Aid Code Chart Master dated – October 28,2013
Source: Data in Figures 5 through 15 and Attachment D are derived from three statewide source files.	
Short-Doyle/Medi-Cal approved and denied claims (SD/MC) from the Department of Health Care Services (DHCS)	
Inpatient Consolidation approved claims (IPC) from DHCS	
Monthly MEDS Extract Files (MMEF) from DHCS	
Selection Criteria:	
Medi-Cal beneficiaries for whom the MHP is the "County of Fiscal Responsibility" are included, even when the beneficiary was served by another MHP	
Medi-Cal beneficiaries with aid codes eligible for SD/MC program funding are included	
Process Date: The date DHCS processes files for CAEQRO. The files include claims for the service period indicated, calendar year (CY) or fiscal year (FY), processed through the preceding month. For example, the CY2008 file with a DHCS process date of April 28, 2009 includes claims with service dates between January 1 and December 31, 2008 processed by DHCS through March 2009. Process dates are in parenthesis.	
CY2012 includes SD/MC (November 2013), IPC (December 2013) and MMEF (March 2013) approved claims	
CY2011 includes SD/MC (December 2012), IPC (March 2013) and MMEF (April 2012) approved claims	
CY2010 includes SD/MC (June 2012), IPC (November 2012) and MMEF (April 2011)approved claims	
CY2009 includes SD/MC (February 2011), IPC (October 2010) and MMEF (April 2010) approved claims	
FY12-13 includes SD/MC (November 2013), IPC (December 2013) and MMEF (March 2013) approved claims	
FY11-12 includes SD/MC (November 2013), IPC (December 2013) and MMEF (March 2013) approved claims	
FY10-11 includes SD/MC (June 2012), IPC (March 2013) and MMEF (October 2011) approved claims	
FY09-10 includes SD/MC (February 2011), IPC (October 2010) and MMEF (October 2010) approved claims	
FY08-09 includes SD/MC (December 2009), IPC (December 2009) and MMEF (October 2009) approved claims	
FY12-13 denials include SD/MC claims (not IPC claims) with process date November 2013	
Most recent MMEF includes Medi-Cal eligibility for April (CY) or October (FY) and 15 prior months	
Service Activity: Defined by Service Modes and Functions	
Inpatient Services	Local Hospital Inpatient, Hospital Administrative Days, Psychiatric Health Facility, and Professional Inpatient Visit
Residential Services	Adult Crisis Residential and Adult Residential
Crisis Stabilization	Crisis Stabilization
Day Treatment	Day Intensive Treatment and Day Rehabilitative
Case Management	Case Management/Brokerage
Mental Health Services	Mental Health Services
Medication Support	Medication Support
Crisis Intervention	Crisis Intervention
TBS	Therapeutic Behavioral Services
Outpatient Services (applicable only to inpatient follow-up services)	Residential, Crisis Stabilization, Day Treatment, Case Management, Mental Health, Medication Support, Crisis Intervention, TBS Services

APS Healthcare

Medi-Cal Approved Claims Code Definitions and Data Sources

Last Modified by: Rachel Phillips, February 2014 Source: Medi-Cal Aid Code Chart Master dated – October 28,2013

Data Definitions: Selected elements displayed in many figures within this report are defined below.	
Penetration rate	The number of Medi-Cal beneficiaries served per year divided by the average number of Medi-Cal eligibles per month. The denominator is the monthly average of Medi-Cal eligibles over a 12-month period.
Approved claims per beneficiary served per year	The annual dollar amount of approved claims divided by the unduplicated number of Medi-Cal beneficiaries served per year
Age Group	A beneficiary's age group is determined by beneficiary's age on July 1 of the reporting calendar year.
Eligibility Categories	Medi-Cal aid codes used for approved claims reporting by eligibility category. **Bolded/Blue Aid Codes** indicate EPSDT status with enhanced FFP funding for beneficiaries whose age is less than 21 years on date of service.
Claims Codes	
Disabled	**2H, 36, 60, 63, 64, 66, 67, 6C, 6E, 6G, 6H, 6N, 6P,** 6R, 6U, **6V, 6W, 6X, 6Y,** C3, C4, C7, C8, D4, D5, D6, D7
Foster Care	**40, 42, 43, 46, 49, 4F, 4G, 4H, 4L, 4N, 4S, 4T, 4W, 5K**
Other Child	Beneficiary age is less than 18 AND has one of the following aid codes: **0A, 0M, 0N, 0P, 0W, 01,** 1U, **02, 03, 04, 06, 07, 08, 2A, 2E, 20, 23, 24, 26, 27, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3D, 3E, 3G,** 3F, **3H, 3L, 3M, 3N, 3P, 3R,** 3T, **3U,** 3V, **3W,** 44, **45, 47,** 48, **4A, 4E, 4M, 4P, 4R, 54,** 55, 58, **59, 5C, 5D, 5E,** 5F, 5J, 5R, 5T, 5W, 69, **6A,** 6J, 6K, 6M, **72,** 74, 76, **7A,** 7C, **7J,** 7K, **7X, 82, 83,** 86, 87, **8E, 8G,** 8N, **8P, 8R,** 8T, **8U, 8V, 8W, 8X,** C1, C2, C5, C6, C9, D1, E1, **E2,** E4, **E5, E7,** G0, G1, G2, G5, G6, G7, G8, G9, **H0, H1, H2, H3, H4, H5, H6, H7, H8, H9,** J1, J2, J3, J4, J5, J6, J7, J8, K1, M0, M3, M4, **M5,** M6, M7, M8, P0, **P1,** P2, P3, P4, **P5,** P6, **P7,** P8, **P9,** T0, **T1, T2, T3, T4, T5,** T6, T7, T8, T9.
Family Adult	Beneficiary age is greater than or equal to 18 AND has one of the following aid codes: 0A, 0W, 0M, 0N, 0P, 01, 1U, 02, 03, 04, 06, 07, 08, 2A, 2E, 20, 23, 24, 26, 27, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3D, 3E, 3G, 3F, 3H, 3L, 3M, 3N, 3P, 3R, 3T, 3U, 3V, 3W, 44, 45, 47, 48, 4A, 4E, 4M, 4P, 4R, 54, 55, 58, 59, 5C, 5D, 5E, 5F, 5J, 5R, 5T, 5W, 69, 6A, 6J, 6K, 6M, 72, 74, 76, 7A, 7C, 7J, 7K, 7X, 82, 83, 8E, 8G, 8N, 8P, 8R, 8T, 8U, 8V, 8W, 8X, C1, C2, C5, C6, C9, D1, E1, E2, E4, E5, E7, G2, G6, G8, G9, H0, H1, H2, H3, H4, H5, H6, H7, H8, H9, J3, J4, J6, J8, M0, M4, M5, M6, M8, P1, P4, P5, P6, P7, P8, P9, T0, T1, T2, T3, T4, T5, T6, T7, T8, T9.
Other Adult	Beneficiary age is greater than 19 AND has one of the following SD/MC program aid codes: 0U, 0V, 1E, 1H, 1X, 1Y, 10, 13, 14, 16, 17, 6J, 80, 86, 87, D2, D3, D8, D9, E1, L1, M1, M2, N0, N5, N6, N7, N8, N9, P2, P3.
EPSDT Eligible Aid Codes	Beneficiary age is less than 21 AND has one of the following aid codes: **0A, 0M, 0N, 0P, 0W, 01, 02, 2A, 2E, 2H, 03, 04, 06, 07, 08, 20, 23, 24, 26, 27, 30, 32, 33, 34, 35, 36, 37, 38, 39, 3A, 3C, 3D, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 40, 42, 43, 45, 46, 47, 49, 4A, 4E, 4F, 4G, 4H, 4L, 4M, 4N, 4P, 4R, 4S, 4T, 4W, 54, 59, 5C, 5D, 5E, 5K, 60, 63, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6N, 6P, 6V, 6W, 6X, 6Y, 72, 7A, 7J, 7X, 82, 83, 8E, 8G, 8P, 8R, 8U, 8V, 8W, 8X, E2, E5, E7, H0, H1, H2, H3, H4, H5, H6, H7, H8, H9, M5, P1, P5, P7, P9, T1, T2, T3, T4, T5.**
Aid codes excluded for claims reporting purposes - as they are not SD/MC funded aid codes	0, 00, 0R, 0T, 09, 18, 28, 2G, 31, 3J, 3K, 3X, 3Y, 41, 43, 4C, 4K, 50, 51, 53, 56, 5X, 5Y, 61, 62, 65, 68, 6D, 6F, 6T, 78, 7M, 7N, 7P, 7R, 81, 84, 85, 88, 89, 8A, 8F, 8H, 8Y, 9A, 9C, 9E, 9F, 9G. 9H, 9J, 9K, 9M, 9N, 9R, 9S, 9X, FX, IE, R1, RR.

APS Healthcare

Medi-Cal Approved Claims Code Definitions and Data Sources

Last Modified by: Rachel Phillips, February 2014 Source: Medi-Cal Aid Code Chart Master dated – October 28,2013

MEDS Race/Ethnicity Codes			
1 = White	2 = Hispanic	3 = Black	4 = Asian/Pacific Islander
5 = Alaska native or American Indian	7 = Filipino	8 = No valid data reported	9 = Decline to state
A = Amerasian	C = Chinese	H = Cambodian	J = Japanese
K = Korean	M = Samoan	N = Asian Indian	P = Hawaiian
R = Guamanian	T = Laotian	V = Vietnamese	Z = Other

Race/Ethnicity Group	MEDS Code
White	1
Hispanic	2
African-American	3
Asian/Pacific Islander	4 & 7 + A thru V
Native American	5
Other	8 & 9 + Z

01 = Alameda	02 = Alpine	03 = Amador	04 = Butte
05 = Calaveras	06 = Colusa	07 = Contra Costa	08 = Del Norte
09 = El Dorado	10 = Fresno	11 = Glenn	12 = Humboldt
13 = Imperial	14 = Inyo	15 = Kern	16 = Kings
17 = Lake	18 = Lassen	19 = Los Angeles	20 = Madera
21 = Marin	22 = Mariposa	23 = Mendocino	24 = Merced
25 = Modoc	26 = Mono	27 = Monterey	28 = Napa
29 = Nevada	30 = Orange	31 = Placer/Sierra	32 = Plumas
33 = Riverside	34 = Sacramento	35 = San Benito	36 = San Bernardino
37 = San Diego	38 = San Francisco	39 = San Joaquin	40 = San Luis Obispo
41 = San Mateo	42 = Santa Barbara	43 = Santa Clara	44 = Santa Cruz
45 = Shasta	47 = Siskiyou	48 = Solano	49 = Sonoma
50 = Stanislaus	51 = Sutter/Yuba	52 = Tehama	53 = Trinity
54 = Tulare	55 = Tuolumne	56 = Ventura	57 = Yolo

Counties by DHCS Regions	
Bay Area	01,07,21,27,28,35,38,41,43,44,48,49
Central	02,03,05,09,10,16,20,22,24,26,31,34,39,50,51,54,55,57
Los Angeles	19
Southern	13,15,30,33,36,37,40,42,56
Superior	04,06,08,11,12,14,17,18,23,25,29,32,45,47,52,53

Counties by DHCS County Sizes	
Large	01,07,10,15,30,33,34,36,37,38,43,56
Medium	04,21,24,27,31,39,40,41,42,44,48,49,50,54,57
Small	09,12,13,16,17,20,23,28,29,35,45,51,52,55
Small-Rural	02,03,05,06,08,11,14,18,22,25,26,32,47,53
Very Large	19

APS Healthcare

Medi-Cal Approved Claims Code Definitions and Data Sources

Last Modified by: Rachel Phillips, February 2014 Source: Medi-Cal Aid Code Chart Master dated – October 28,2013

Diagnosis Category	Diagnosis Codes Found in CY12 SD/MC II Approved Claims Files
Depressive Disorders	296.20 - 296.26, 296.83, 296.30 – 296.36, 300.4, 311.
Psychotic Disorders	293.81, 295.10 – 295.90, 297.1, 297.3, 298.8.
Disruptive Disorders	312.81 - 312.89, 312.9, 313.81, 314.00, 314.01, 314.9.
Bipolar Disorders	296.01 – 296.06, 296.40 - 296.76, 296.80, 296.89, 301.13.
Anxiety Disorders	293.84, 300.00 – 300.03, 300.21 - 300.23, 300.29, 308.3, 309.81.
Adjustment Disorders	309.0 – 309.9.
Other Disorders	Substance-Related disorders: 291.0 - 291.2, 291.3, 291.5, 291.89, 291.9, 292.0, 292.11, 292.12, 292.81 - 292.84, 292.89, 292.9, 303.00, 303.90, 304.00 - 304.90, 305.00, 305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90. Childhood disorders: 315.00, 315.1-315.4, 317, 318.0 – 318.2, 319, 299.00, 299.10, 299.80, 307.0, 307.52, 307.59, 307.20 - 307.23, 307.6, 307.7, 307.9, 313.82, 313.23, 313.89, 787.6. Amnesic/Cognitive /Movement disorders: 294.0, 290.10-290.13, 290.20-290.21, 290.40 - 290.43, 293.0, 294.8 - 294.11, 300.6, 300.9, 307.3, 307.89, 333.1, 333.82, 333.90, 780.09, 995.81. Personality disorders: 301.0, 301.22, 301.4, 301.50, 301.6, 301.7, 301.81 - 301.83, 301.9. Sexual/Impulse-Control disorders: 302.72, 302.75, 302.2, 302.3, 302.4, 302.6, 302.81, 302.84, 302.85, 302.89, 302.9, 312.31- 312.34, 312.39, 607.84. Sleep/Eating/Body/Other: 293.9, 300.7300.11, 300.18, 300.81, 300.82, 300.16, 300.19, 306.51, 307.42, 307.1, 307.45 - 307.47, 347, 307.50, 307.51, 307.80, 310.1, 310.20, 780.52, 780.54, 780.59. Relational Problems/Clinical Conditions: V15.81, V61.10, V61.12, V61.20, V61.21, V61.8, V61.9, V62.2, V62.3, V62.4, V62.81, V62.82, V62.89, V65.2, V71.01, V71.02. Other Conditions – 316, 332.1
Deferred and No Diagnoses	799.9, V71.09.

D. Attachment— Medi-Cal Approved Claims Worksheets and Additional Tables

Medi-Cal Approved Claims Data for LOS ANGELES County MHP Calendar Year 12

Date Prepared:	01/24/2014, Version 1.3
Prepared by:	Rachel Phillips, APS Healthcare / CAEQRO
Data Sources:	DHCS Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	11/22/2013, 12/26/2013, and 03/27/2013 - Note (3)

	LOS ANGELES						LARGE			STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL											
	2,510,108	155,845	$907,530,896	6.21%	$5,823		5.77%	$4,677		5.90%	$5,112
AGE GROUP											
0-5	430,615	11,546	$48,786,133	2.68%	$4,225		1.56%	$4,361		1.88%	$4,150
6-17	713,700	62,726	$499,097,253	8.79%	$7,957		7.29%	$5,719		7.80%	$6,472
18-59	949,167	67,189	$315,096,396	7.08%	$4,690		7.68%	$4,181		7.37%	$4,455
60+	416,627	14,384	$44,551,114	3.45%	$3,097		3.33%	$3,398		3.45%	$3,529
GENDER											
Female	1,416,420	76,736	$405,943,411	5.42%	$5,290		5.25%	$4,154		5.31%	$4,593
Male	1,093,689	79,109	$501,587,485	7.23%	$6,340		6.44%	$5,224		6.66%	$5,640
RACE/ETHNICITY											
White	288,554	37,164	$258,613,258	12.88%	$6,959		10.20%	$4,424		10.14%	$5,245
Hispanic	1,590,121	67,417	$379,846,291	4.24%	$5,634		3.63%	$4,417		3.81%	$4,913
African-American	263,413	30,067	$157,323,091	11.41%	$5,232		9.65%	$5,444		10.13%	$5,318

	LOS ANGELES						LARGE			STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year
Asian/Pacific Islander	194,080	7,673	$32,642,845	3.95%	$4,254		3.63%	$4,008		3.78%	$4,089
Native American	2,790	443	$2,857,031	15.88%	$6,449		10.19%	$5,469		9.09%	$5,548
Other	171,152	13,081	$76,248,379	7.64%	$5,829		7.06%	$5,415		7.39%	$5,650
ELIGIBILITY CATEGORIES											
Disabled	347,585	68,313	$345,804,374	19.65%	$5,062		17.26%	$4,904		17.60%	$5,109
Foster Care	21,923	13,586	$123,734,814	61.97%	$9,108		48.04%	$8,343		53.34%	$8,485
Other Child	1,083,266	60,562	$362,691,163	5.59%	$5,989		4.21%	$4,388		4.65%	$4,950
Family Adult	490,622	17,332	$58,769,886	3.53%	$3,391		4.19%	$2,229		3.96%	$2,604
Other Adult	572,698	4,837	$16,530,659	0.84%	$3,418		1.01%	$3,545		1.00%	$3,535
SERVICE CATEGORIES											
Inpatient Services	2,510,108	12,577	$98,618,191	0.50%	$7,841		0.44%	$7,835		0.45%	$7,723
Residential Services	2,510,108	369	$3,156,957	0.01%	$8,555		0.08%	$7,525		0.06%	$7,775
Crisis Stabilization	2,510,108	8,065	$10,903,686	0.32%	$1,352		0.49%	$2,176		0.38%	$1,948
Day Treatment	2,510,108	1,026	$14,127,895	0.04%	$13,770		0.10%	$11,381		0.06%	$12,207
Case Management	2,510,108	65,378	$44,376,496	2.60%	$679		2.19%	$1,041		2.41%	$899
Mental Health Serv.	2,510,108	136,273	$577,293,590	5.43%	$4,236		4.52%	$2,996		4.82%	$3,478
Medication Support	2,510,108	74,720	$102,286,217	2.98%	$1,369		2.97%	$1,153		2.94%	$1,332
Crisis Intervention	2,510,108	14,075	$21,079,798	0.56%	$1,498		0.47%	$814		0.59%	$1,046
TBS	2,510,108	2,474	$35,688,066	0.10%	$14,425		0.11%	$10,644		0.10%	$12,091

Footnotes:

1 - Includes approved claims data on DHCS eligible beneficiaries who were served by other MHPs, based on Medi-Cal recipient's "County of Fiscal Responsibility"

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent data processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DHCS for the reported calendar year

4 - County total number of yearly unduplicated Medi-Cal eligibles is 2,984,424

LOS ANGELES County MHP Medi-Cal Services Retention Rates CY12

	LOS ANGELES			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	11,609	7.45	7.45	9.38	9.38	4.90	18.87
2 services	8,174	5.24	12.69	6.29	15.67	0.00	12.84
3 services	7,107	4.56	17.25	5.38	21.06	2.94	11.11
4 services	6,991	4.49	21.74	4.93	25.98	1.93	9.40
5 - 15 services	48,905	31.38	53.12	32.38	58.36	21.24	40.93
> 15 services	73,059	46.88	100.00	41.64	100.00	23.68	60.46

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 11/22/2013; Inpatient Consolidation approved claims as of 12/26/2013

Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

Medi-Cal Approved Claims Data for LOS ANGELES County MHP Calendar Year CY12

Foster Care

Date Prepared:	01/24/2014, Version 1.2
Prepared by:	Rachel Phillips, APS Healthcare / CAEQRO
Data Sources:	DHCS Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	11/22/2013, 12/26/2013, and 03/27/2013 - Note (3)

	LOS ANGELES						LARGE			STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL											
	21,923	13,586	$123,734,814	61.97%	$9,108		48.04%	$8,343		53.34%	$8,485
AGE GROUP											
0-5	5,708	2,874	$10,476,843	50.35%	$3,645		28.63%	$4,165		36.10%	$3,952
6+	16,216	10,712	$113,257,970	66.06%	$10,573		55.72%	$9,193		60.04%	$9,544
GENDER											
Female	10,675	6,463	$57,464,377	60.54%	$8,891		47.16%	$8,077		52.55%	$8,240
Male	11,248	7,123	$66,270,436	63.33%	$9,304		48.86%	$8,584		54.09%	$8,707
RACE/ETHNICITY											
White	18,026	10,610	$108,245,744	58.86%	$10,202		51.72%	$7,476		56.34%	$9,153
Hispanic	2,475	2,034	$10,156,908	82.18%	$4,994		45.66%	$7,690		51.29%	$6,995
African-American	1,100	730	$4,412,127	66.36%	$6,044		48.89%	$9,687		50.68%	$8,767
Asian/Pacific Islander	56	63	$254,932	112.50%	$4,047		50.99%	$8,868		53.73%	$8,121

	LOS ANGELES						LARGE			STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year
Native American	8	10	$25,724	125.00%	$2,572		50.28%	$6,375		45.17%	$6,902
Other	261	139	$639,379	53.26%	$4,600		39.00%	$12,941		41.80%	$10,199
SERVICE CATEGORIES											
Inpatient Services	21,923	650	$5,112,309	2.96%	$7,865		1.72%	$6,922		2.09%	$7,484
Residential Services	21,923	4	$44,095	0.02%	$11,024		0.01%	$6,987		0.01%	$9,294
Crisis Stabilization	21,923	253	$344,546	1.15%	$1,362		1.34%	$1,580		1.16%	$1,547
Day Treatment	21,923	388	$4,410,161	1.77%	$11,366		3.07%	$13,670		2.31%	$13,509
Case Management	21,923	5,466	$3,303,111	24.93%	$604		19.66%	$1,530		23.26%	$1,128
Mental Health Serv.	21,923	13,225	$88,335,050	60.32%	$6,679		44.78%	$5,545		50.68%	$5,890
Medication Support	21,923	4,503	$8,902,415	20.54%	$1,977		14.99%	$1,414		16.68%	$1,710
Crisis Intervention	21,923	1,050	$2,328,958	4.79%	$2,218		2.61%	$1,072		3.40%	$1,587
TBS	21,923	908	$11,093,971	4.14%	$12,218		3.49%	$10,248		3.57%	$11,250

Footnotes:

1 - Includes approved claims data on DHCS eligible beneficiaries who were served by other MHPs, based on Medi-Cal recipient's "County of Fiscal Responsibility"

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent data processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DHCS for the reported calendar year

4 - County total number of yearly unduplicated Medi-Cal eligibles is 31,476

LOS ANGELES County MHP Medi-Cal Services Retention Rates CY12

Foster Care

	LOS ANGELES			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	628	4.62	4.62	6.08	6.08	0.00	50.00
2 services	558	4.11	8.73	4.91	11.00	0.00	17.65
3 services	412	3.03	11.76	4.25	15.24	0.00	19.35
4 services	410	3.02	14.78	3.34	18.58	0.00	33.33
5 - 15 services	3,345	24.62	39.40	25.11	43.69	0.00	100.00
> 15 services	8,233	60.60	100.00	56.31	100.00	0.00	77.78

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 11/22/2013; Inpatient Consolidation approved claims as of 12/26/2013

Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

Medi-Cal Approved Claims Data for LOS ANGELES County MHP Calendar Year 12

Transition Age Youth (Age 16-25)

Date Prepared:	01/24/2014, Version 1.1
Prepared by:	Rachel Phillips, APS Healthcare / CAEQRO
Data Sources:	DHCS Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	11/22/2013, 12/26/2013, and 03/27/2013 - Note (3)

	LOS ANGELES						LARGE			STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL											
	364,364	26,923	$203,816,641	7.39%	$7,570		6.86%	$5,753		7.03%	$6,331
AGE GROUP											
16-17	116,709	12,228	$110,146,670	10.48%	$9,008		9.37%	$6,651		9.89%	$7,412
18-21	166,846	10,839	$72,509,210	6.50%	$6,690		6.25%	$5,351		6.35%	$5,747
22-25	80,810	3,856	$21,160,761	4.77%	$5,488		4.95%	$4,637		4.82%	$5,039
GENDER											
Female	211,438	13,189	$97,779,643	6.24%	$7,414		5.79%	$5,441		5.94%	$6,055
Male	152,927	13,734	$106,036,998	8.98%	$7,721		8.41%	$6,065		8.58%	$6,603
RACE/ETHNICITY											
White	30,662	5,825	$60,643,842	19.00%	$10,411		10.90%	$5,309		11.62%	$6,681
Hispanic	251,689	13,946	$93,496,559	5.54%	$6,704		4.86%	$5,130		5.09%	$5,777
African-American	41,338	4,644	$30,807,057	11.23%	$6,634		10.80%	$6,657		10.78%	$6,545
Asian/Pacfic Islander	18,392	751	$5,054,849	4.08%	$6,731		3.36%	$6,527		3.50%	$6,494

	LOS ANGELES						LARGE			STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year
Native American	375	42	$306,684	11.20%	$7,302		10.05%	$6,961		9.47%	$6,893
Other	21,910	1,715	$13,507,650	7.83%	$7,876		10.44%	$7,213		10.08%	$7,408
ELIGIBILITY CATEGORIES											
Disabled	29,882	7,216	$53,946,806	24.15%	$7,476		19.73%	$6,644		20.83%	$7,046
Foster Care	5,228	3,968	$39,786,182	75.90%	$10,027		59.17%	$9,663		65.95%	$9,649
Other Child	107,923	9,613	$66,390,496	8.91%	$6,906		7.74%	$5,007		8.30%	$5,665
Family Adult	177,665	7,863	$37,316,573	4.43%	$4,746		4.07%	$3,319		4.22%	$3,791
Other Adult	45,320	1,128	$6,376,582	2.49%	$5,653		3.63%	$4,321		3.29%	$4,587
SERVICE CATEGORIES											
Inpatient Services	364,364	3,435	$22,380,166	0.94%	$6,515		0.82%	$7,186		0.83%	$6,922
Residential Services	364,364	57	$715,251	0.02%	$12,548		0.07%	$6,878		0.06%	$8,030
Crisis Stabilization	364,364	1,978	$2,690,232	0.54%	$1,360		0.78%	$1,727		0.62%	$1,661
Day Treatment	364,364	472	$6,526,737	0.13%	$13,828		0.21%	$12,669		0.16%	$13,319
Case Management	364,364	11,581	$8,724,965	3.18%	$753		2.73%	$1,207		2.99%	$1,001
Mental Health Serv.	364,364	24,133	$131,670,690	6.62%	$5,456		5.61%	$3,536		5.93%	$4,260
Medication Support	364,364	12,153	$18,906,214	3.34%	$1,556		3.16%	$1,147		3.14%	$1,351
Crisis Intervention	364,364	3,416	$5,395,816	0.94%	$1,580		0.77%	$862		0.97%	$1,090
TBS	364,364	694	$6,806,570	0.19%	$9,808		0.16%	$10,245		0.16%	$10,312

Footnotes:

1 - Includes approved claims data on DHCS eligible beneficiaries who were served by other MHPs, based on Medi-Cal recipient's "County of Fiscal Responsibility"

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent data processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DHCS for the reported calendar year

4 - County total number of yearly unduplicated Medi-Cal eligibles is 506,829

LOS ANGELES County MHP Medi-Cal Services Retention Rates CY12

Transition Age Youth (Age 16-25)

	LOS ANGELES			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	1,794	6.66	6.66	9.96	9.96	0.00	21.54
2 services	1,259	4.68	11.34	6.31	16.27	0.00	18.00
3 services	1,073	3.99	15.33	5.29	21.56	0.00	21.43
4 services	997	3.70	19.03	4.59	26.15	0.00	33.33
5 - 15 services	7,229	26.85	45.88	28.93	55.08	15.91	40.98
> 15 services	14,571	54.12	100.00	44.92	100.00	21.05	65.91

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 11/22/2013; Inpatient Consolidation approved claims as of 12/26/2013

Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

SD/MC Claims Processing Summary

The following table provides a summary of the MHP's SD/MC claims processed for services claimed during FY12-13. The data presents claims processed by the State as of November 2013 and may not yet include all original or replacement claim transactions for FY12-13. To meet timely processing rules, MHPs have 12 months from the service month to submit original claim transactions and 15 months from the service month to submit replacement claim transactions.

Figure D-1. Monthly Summary of SD/MC Claims – FY12-13
Claims Processed as of November 2013

Service Month	Gross Dollars Billed by MHP	Denied Dollars	Denial Rate	Number Denied Claims	Claims Adjudicated	Claim Adjustments	Approved Dollars	% Approved	Number Approved Claims	Replaced Claim Dollars	Number Replaced Claims
JUL12	$74,370,591	$2,511,860	3.4%	10,812	$71,858,731	$349,572	$71,509,159	99.5%	379,381	$30,339	90
AUG12	$80,210,164	$2,411,256	3.0%	10,737	$77,798,908	$348,178	$77,450,730	99.6%	407,055	$62,886	189
SEP12	$71,242,421	$1,931,292	2.7%	8,067	$69,311,129	$201,977	$69,109,152	99.7%	365,002	$25,683	86
OCT12	$85,897,881	$2,418,110	2.8%	10,343	$83,479,771	$229,116	$83,250,654	99.7%	435,868	$31,118	96
NOV12	$74,288,106	$2,144,455	2.9%	9,244	$72,143,651	$306,225	$71,837,426	99.6%	380,365	$2,303	6
DEC12	$64,778,211	$1,965,563	3.0%	8,568	$62,812,648	$213,069	$62,599,578	99.7%	332,327	$0	0
JAN13	$80,590,688	$2,224,632	2.8%	10,277	$78,366,056	$122,697	$78,243,359	99.8%	412,697	$0	0
FEB13	$75,533,697	$2,023,069	2.7%	9,406	$73,510,628	$154,971	$73,355,656	99.8%	385,004	$0	0
MAR13	$78,478,822	$1,971,406	2.5%	8,607	$76,507,416	$179,931	$76,327,485	99.8%	397,252	$0	0
APR13	$81,922,810	$1,846,782	2.3%	7,817	$80,076,028	$182,074	$79,893,954	99.8%	416,631	$0	0
MAY13	$78,631,710	$1,586,994	2.0%	7,018	$77,044,716	$186,773	$76,857,943	99.8%	405,143	$0	0
JUN13	$57,708,017	$1,181,072	2.0%	5,529	$56,526,945	$92,140	$56,434,805	99.8%	317,027	$0	0
FY12-13	**$903,653,119**	**$24,216,492**	**2.7%**	**106,425**	**$879,436,627**	**$2,566,724**	**$876,869,903**	**99.7%**	**4,633,752**	**$152,328**	**467**
Statewide	**$2,567,475,896**	**$104,321,260**	**4.1%**	**425,147**	**$2,463,154,636**	**$129,763,039**	**$2,333,391,598**	**94.7%**	**11,907,471**	**$240,828**	**789**

DENIED CLAIMS

The following tables provide a summary of SD/MC denied claims processed during FY12-13. The data presents claims processed by the State as of November 2013 and may not yet include all original or replacement claim transactions for FY12-13. MHPs have 15 months from the service month for replacement claim transactions to correct and convert denied claims to approved claims.

Figure D-2. Denied Claims by Reason – Statewide Top 10 (FY12-13)
Claims Processed as of November 2013

Denial Code Description	Denial Code	Number Claims	Gross Dollars Denied	% Denied
Other health coverage must be billed before the submission of this claim.	CO 22	86,004	$18,657,343	17.9%
Medicare must be billed prior to the submission of this claim.	CO 22 N192	85,464	$18,505,933	17.7%
Beneficiary not eligible. Aid code invalid for DHCS.	CO 177,CO 31	39,732	$9,196,747	8.8%
Emergency Services Indicator must be "Y" or Pregnancy Indicator must be "Y" for this aid code.	CO 204 N30	28,935	$6,313,852	6.1%
Service line is a duplicate and a repeat service procedure modifier is not present.	CO 18 M86	35,150	$5,496,524	5.3%
Invalid procedure code and modifier combination. Service Facility Location provider NPI is not eligible to provide this service.	CO 109 M51,CO B7 N65	22,839	$5,448,775	5.2%
Aid code invalid for DHCS.	CO 31	15,721	$4,713,495	4.5%
Beneficiary not eligible. TBS valid only with Full Scope Aid Code and an EPSDT Aid Code. Aid code invalid for DHCS.	CO 177,CO 204,CO 31	22,762	$4,551,006	4.4%
Service Facility Location provider NPI is not eligible to provide this service within the submitting county.	CO B7	15,411	$3,855,122	3.7%
Only SED services are valid for Healthy Families aid code.	CO 185	16,441	$3,566,065	3.4%

Figure D-3. Denied Claims by Reason – Los Angeles Top 5 (FY12-13)
Claims Processed as of November 2013

Denial Code Description	Denial Code	Number Claims	Gross Dollars Denied	% Denied
Other health coverage must be billed before the submission of this claim.	CO 22	31,660	$6,547,298	27.0%
Medicare must be billed prior to the submission of this claim.	CO 22 N192	25,979	$5,519,437	22.8%
Beneficiary not eligible. Aid code invalid for DHCS.	CO 177, CO 31	12,971	$2,606,884	10.8%
Emergency Services Indicator must be "Y" or Pregnancy Indicator must be "Y" for this aid code.	CO 204 N30	11,666	$2,337,197	9.7%
Only SED services are valid for Healthy Families aid code.	CO 185	7,369	$1,440,667	5.9%

Retention Rates

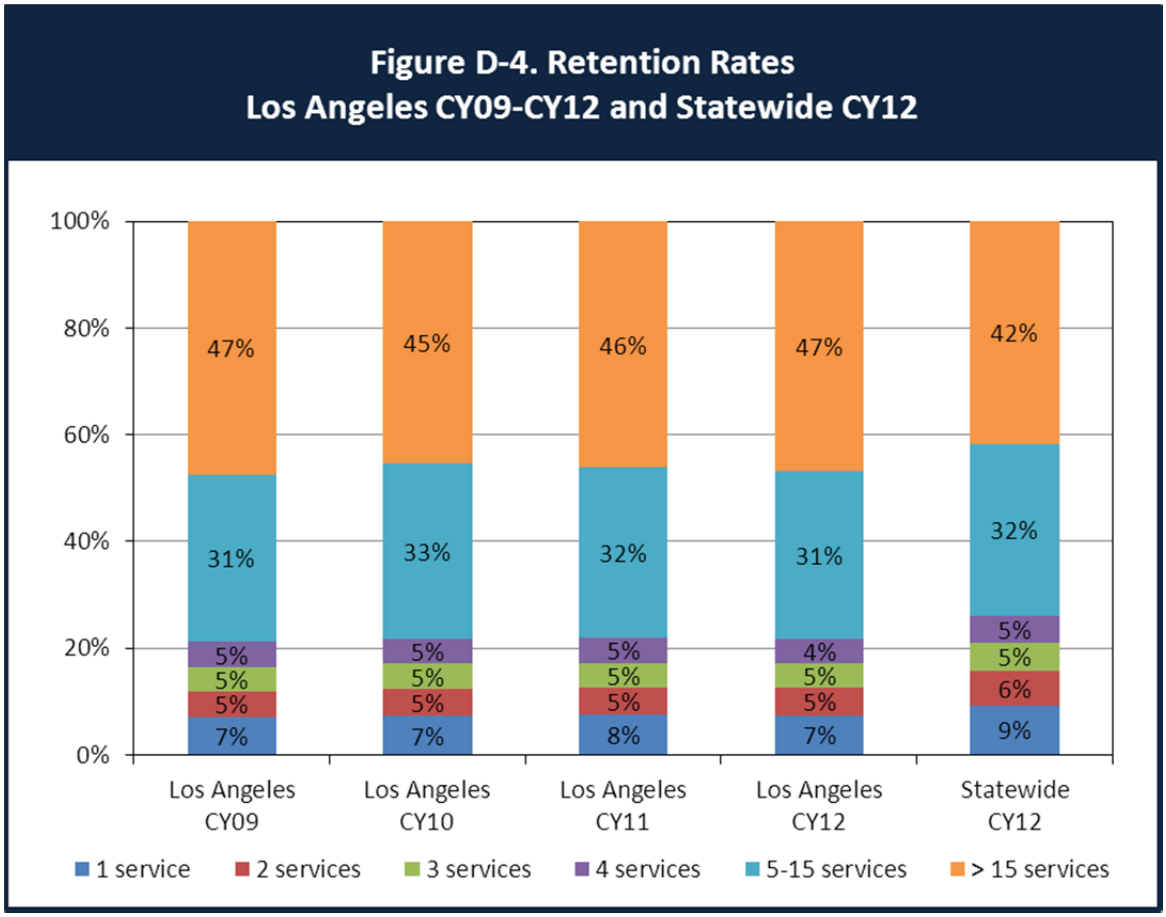


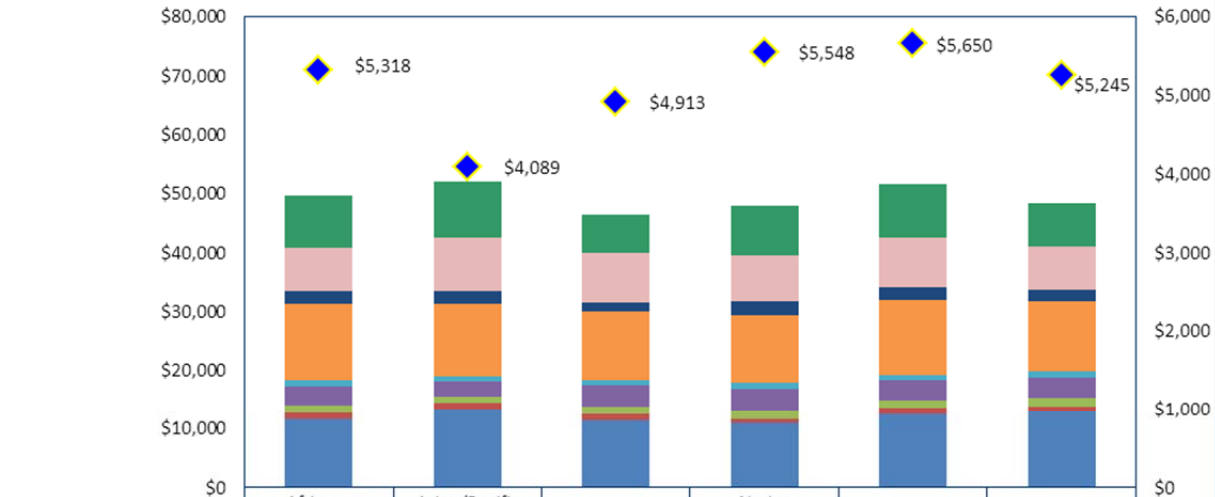
Figure D-5. CY12 Retention Rates with Average Approved Claims per Category

Number of Services Approved per Beneficiary Served	Los Angeles Number of beneficiaries served	Los Angeles $ per beneficiary served	Statewide $ per beneficiary served
1 service	11,609	$337	$338
2 services	8,174	$547	$520
3 services	7,107	$740	$675
4 services	6,991	$882	$815
5 – 15 services	48,905	$1,769	$1,672
> 15 services	73,059	$10,967	$10,637

SERVICE TYPE BY ETHNICITY - STATEWIDE

The following stacked bar charts show the average claims by service modality and ethnicity. It should be noted that these elements are not additive (i.e., the height of the bar has no meaning), and the main use for comparison is the differential use of particular services across various ethnicities. The blue diamond shows the average approved claims by ethnicity for all service modalities. Again, there is no direct relationship between the height of the bar (claims per service modality) and the average claims for that ethnicity.

Figure D-6. Statewide Approved Claims per Beneficiary CY12 - Race/Ethnicity by Service Type



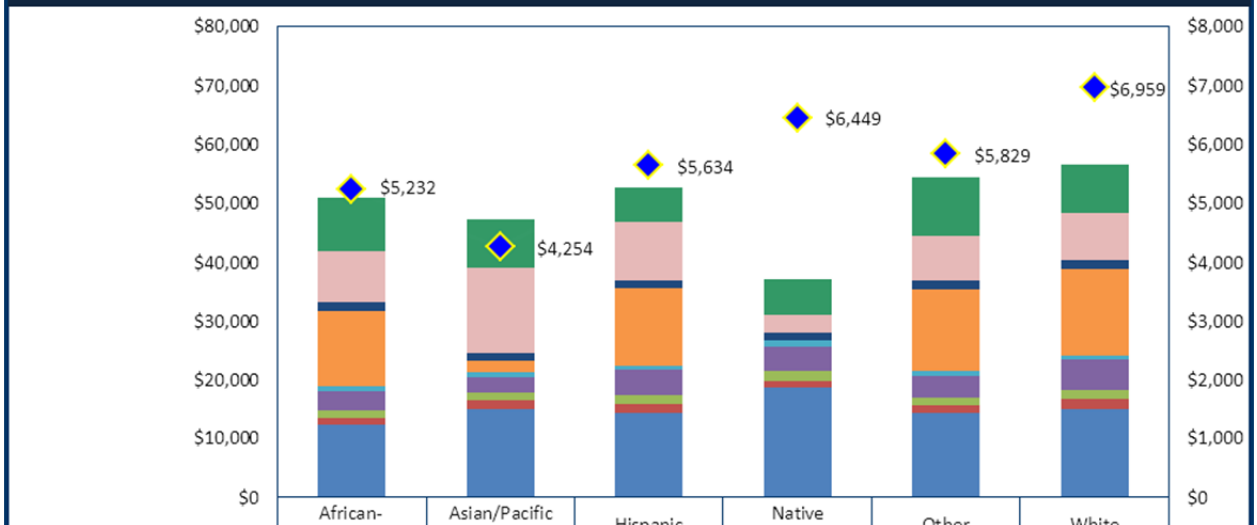
	African-American	Asian/Pacific Islander	Hispanic	Native American	Other	White
Inpatient Services	$8,795	$9,603	$6,433	$8,523	$9,151	$7,497
Residential Services	$7,524	$8,976	$8,355	$7,783	$8,450	$7,349
Crisis Stabilization	$2,108	$2,115	$1,602	$2,299	$2,169	$1,986
Day Treatment	$13,033	$12,263	$11,646	$11,585	$12,640	$11,868
Case Management	$879	$886	$806	$1,098	$992	$973
Mental Health Serv.	$3,440	$2,671	$3,648	$3,531	$3,369	$3,466
Medication Support	$1,216	$1,153	$1,309	$1,482	$1,336	$1,435
Crisis Intervention	$1,067	$1,019	$1,069	$820	$1,029	$1,035
TBS	$11,600	$13,315	$11,435	$10,861	$12,473	$12,823
Overall ACB	$5,318	$4,089	$4,913	$5,548	$5,650	$5,245

Note: The left axis refers to the columns, and the right refers to the diamonds (overall ACB for each category)

Figure D-7. Statewide Number of Beneficiaries Served CY12 - Race/Ethnicity by Service Type						
	African-American	Asian/Pacific Islander	Hispanic	Native American	Other	White
All	73,641	28,112	164,001	3,299	44,391	156,207
Inpatient Services	6,324	1,713	10,405	293	4,274	12,891
Residential Services	871	221	691	47	831	2,370
Crisis Stabilization	6,991	1,412	7,700	265	3,709	10,543
Day Treatment	1,304	185	1,301	43	594	1,740
Case Management	31,017	11,332	64,914	1,497	19,193	63,856
Mental Health Serv.	58,075	21,451	143,412	2,650	34,236	123,718
Medication Support	39,280	17,653	63,114	1,621	26,677	85,861
Crisis Intervention	7,547	1,731	13,210	451	4,839	19,288
TBS	1,229	121	2,792	55	798	2,795

SERVICE TYPE BY ETHNICITY - MHP

Figure D-8. Los Angeles Approved Claims per Beneficiary CY12 - Race/Ethnicity by Service Type



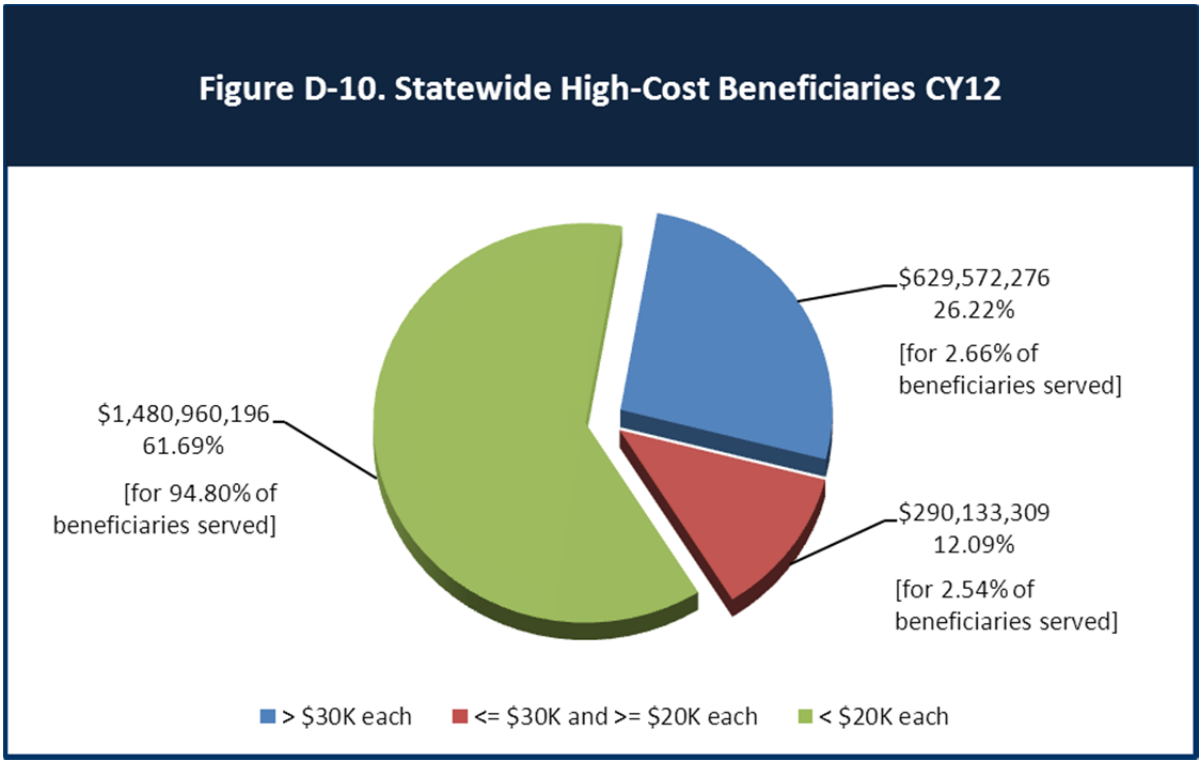
	African-American	Asian/Pacific Islander	Hispanic	Native American	Other	White
Inpatient Services	$9,164	$8,328	$6,034	$5,975	$9,847	$8,244
Residential Services	$8,740	$14,341	$9,851	$3,144	$7,649	$7,974
Crisis Stabilization	$1,413	$1,371	$1,188	$1,141	$1,383	$1,512
Day Treatment	$12,815	$1,979	$13,354	$0	$13,954	$14,695
Case Management	$704	$768	$612	$1,137	$765	$719
Mental Health Serv.	$3,413	$2,704	$4,388	$4,203	$3,603	$5,121
Medication Support	$1,228	$1,263	$1,381	$1,686	$1,315	$1,516
Crisis Intervention	$1,354	$1,551	$1,460	$1,130	$1,338	$1,722
TBS	$12,173	$15,013	$14,486	$18,659	$14,426	$15,097
Overall ACB	$5,232	$4,254	$5,634	$6,449	$5,829	$6,959

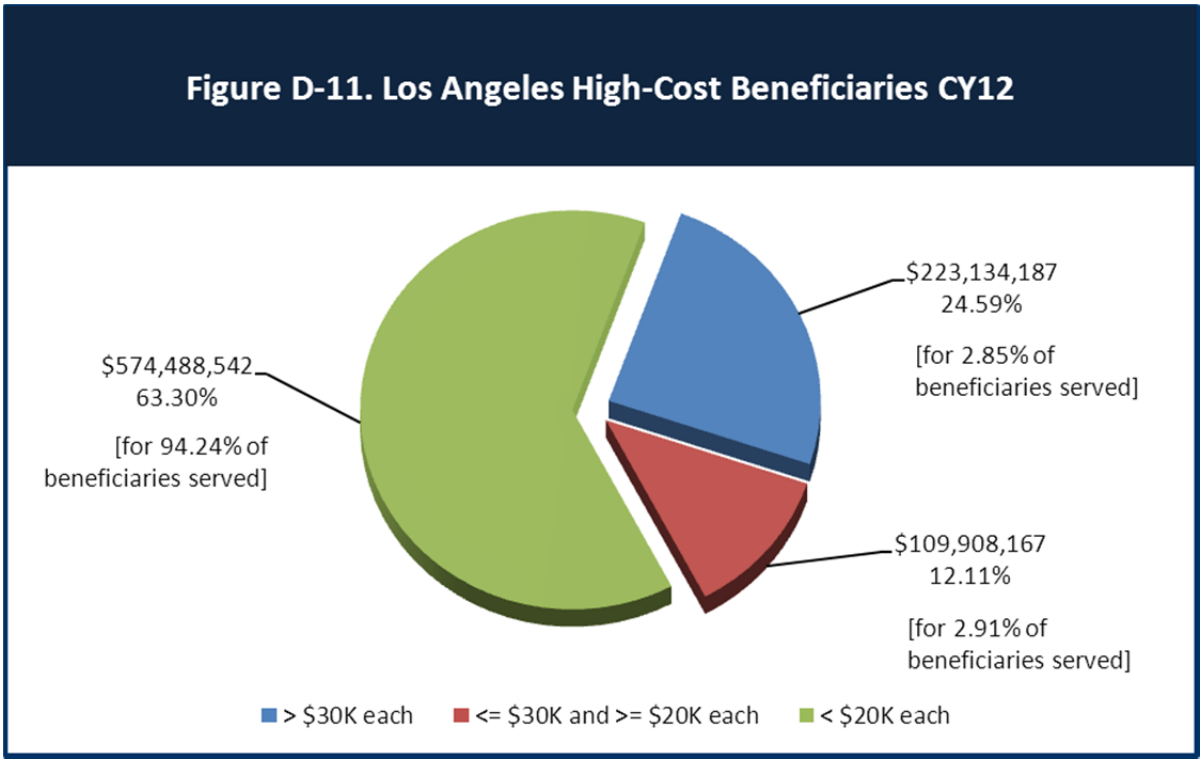
Note: The left axis refers to the columns, and the right refers to the diamonds (overall ACB for each category)

Figure D-9. Los Angeles Number of Beneficiaries Served CY12 - Race/Ethnicity by Service Type

	African-American	Asian/Pacific Islander	Hispanic	Native American	Other	White
All	30,067	7,673	67,417	443	13,081	37,164
Inpatient Services	2,890	511	4,512	57	1,455	3,152
Residential Services	120	6	69	5	64	105
Crisis Stabilization	2,333	255	2,737	34	960	1,746
Day Treatment	209	n<5	365	0	39	410
Case Management	13,569	2,901	27,489	236	5,853	15,330
Mental Health Serv.	24,481	6,994	61,548	379	10,765	32,106
Medication Support	17,145	4,507	25,250	279	7,726	19,813
Crisis Intervention	3,238	501	4,937	62	1,431	3,906
TBS	343	14	909	n<5	169	1,036

HIGH COST BENEFICIARIES





EXAMINATION OF DISPARITIES

Statewide disparities remain for Hispanic and female beneficiaries:

- Approved claims for Hispanic beneficiaries are now at parity with White beneficiaries. While the relative penetration rate disparity has decreased significantly, due to both a decrease in White penetration rate and an increase in Hispanic penetration rate, there remains a continued notable disparity in access.
- The relative access and the average approved claims for female beneficiaries are lower than for males. These disparities have remained relatively stable over the last five years.

For each variable (Hispanic/White and female/male), two ratios are calculated to depict relative access and relative approved claims. The first figure compares approved claims data and penetration rates between Hispanic and White beneficiaries. This penetration rate ratio is calculated by dividing the Hispanic penetration rate by the White penetration rate, resulting in a ratio that depicts the relative access for Hispanics when compared to Whites. The approved claims ratio is calculated by dividing the average approved claims for Hispanics by the average approved claims for Whites. Similar calculations follow in the second figure for female to male beneficiaries.

For all elements, ratios depict the following:

- 1.0 = parity between the two elements compared
- Less than 1.0 = disparity for Hispanics or females
- Greater than 1.0 = no disparity for Hispanics or females. A ratio of greater than one indicates higher penetration or approved claims for Hispanics when compared to Whites or for females when compared to males.

Figure D-12. Examination of Disparities—Hispanic versus White								
Calendar Year	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Hispanic versus White for	
	Hispanic		White		Hispanic	White	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
Statewide CY12	164,001	3.81%	156,207	10.14%	$4,913	$5,245	.38	.94
Los Angeles CY12	67,417	4.24%	37,164	12.88%	$5,634	$6,959	.33	.81
Los Angeles CY11	66,434	4.14%	34,647	11.82%	$5,795	$6,123	.35	.95
Los Angeles CY10	59,372	3.79%	35,581	12.45%	$5,078	$5,642	.30	.90
Los Angeles CY09	55,952	3.61%	38,641	13.25%	$5,398	$6,219	.27	.87

Figure D-13. Examination of Disparities—Female versus Male								
Calendar Year	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Female versus Male for	
	Female		Male		Female	Male	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
Statewide CY12	237,195	5.31%	232,456	6.66%	$4,593	$5,640	.80	.81
Los Angeles CY12	76,736	5.42%	79,109	7.23%	$5,290	$6,340	.75	.83
Los Angeles CY11	73,229	5.15%	74,484	6.80%	$5,244	$6,297	.76	.83
Los Angeles CY10	69,850	5.11%	70,903	6.73%	$4,778	$5,699	.76	.84
Los Angeles CY09	70,434	5.12%	70,771	6.73%	$4,977	$6,158	.76	.81

ELIGIBLES VERSUS BENEFICIARIES SERVED - FOSTER CARE

Figure D-14. Los Angeles Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity - Foster Care CY12

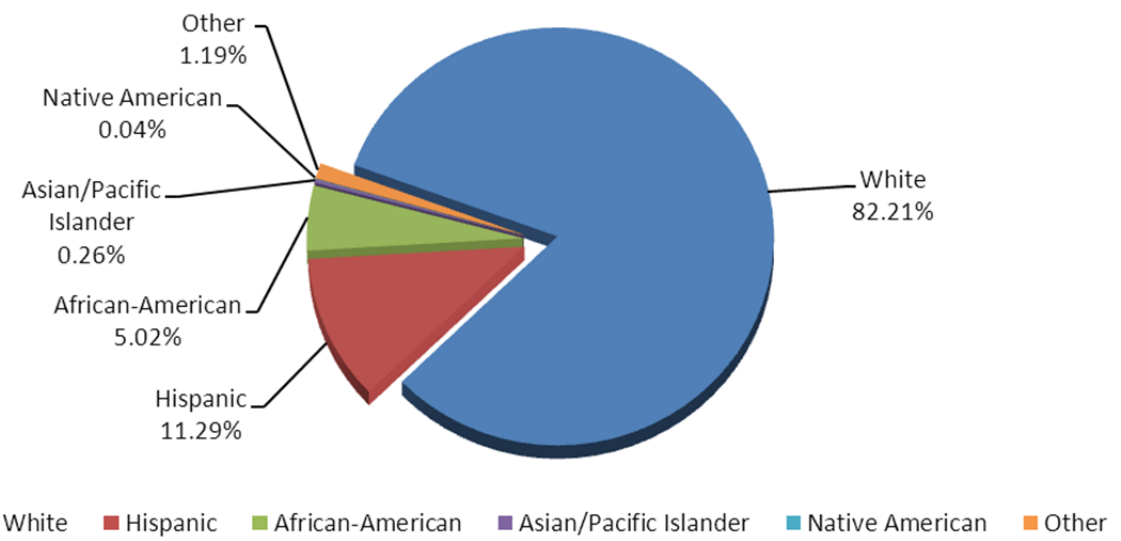
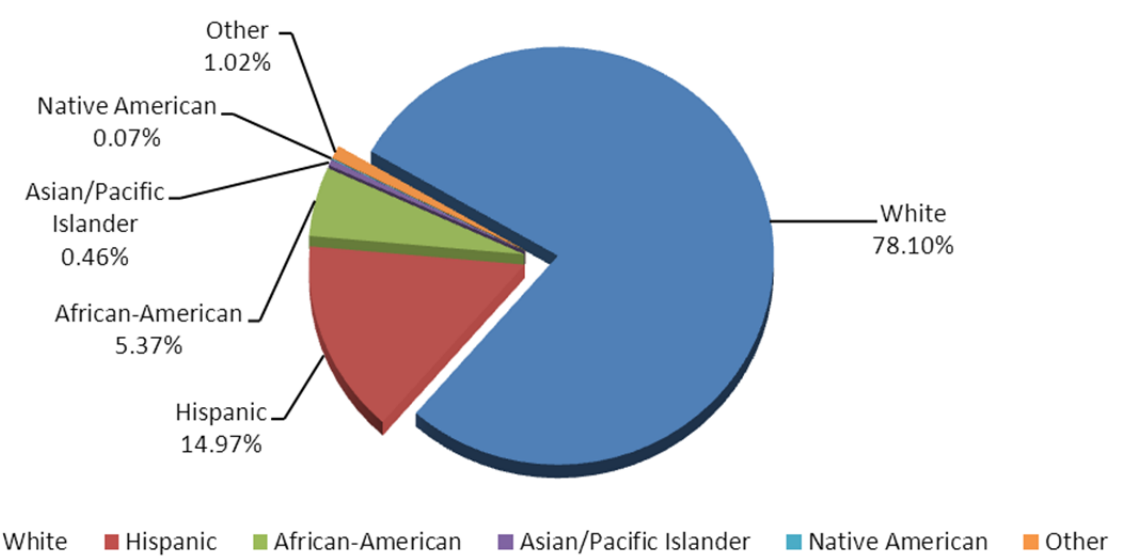


Figure D-15. Los Angeles Medi-Cal Beneficiaries Served, by Race/Ethnicity - Foster Care CY12



Eligibles versus Beneficiaries Served - Transition Age Youth

Figure D-16. Los Angeles Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity - Transition Age Youth CY12

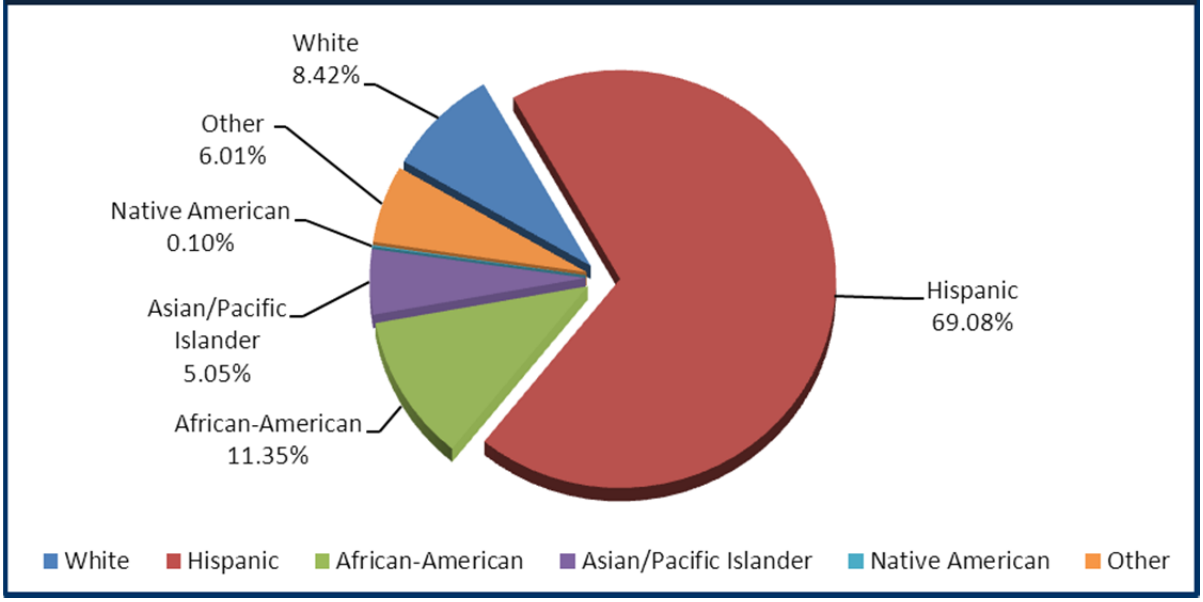
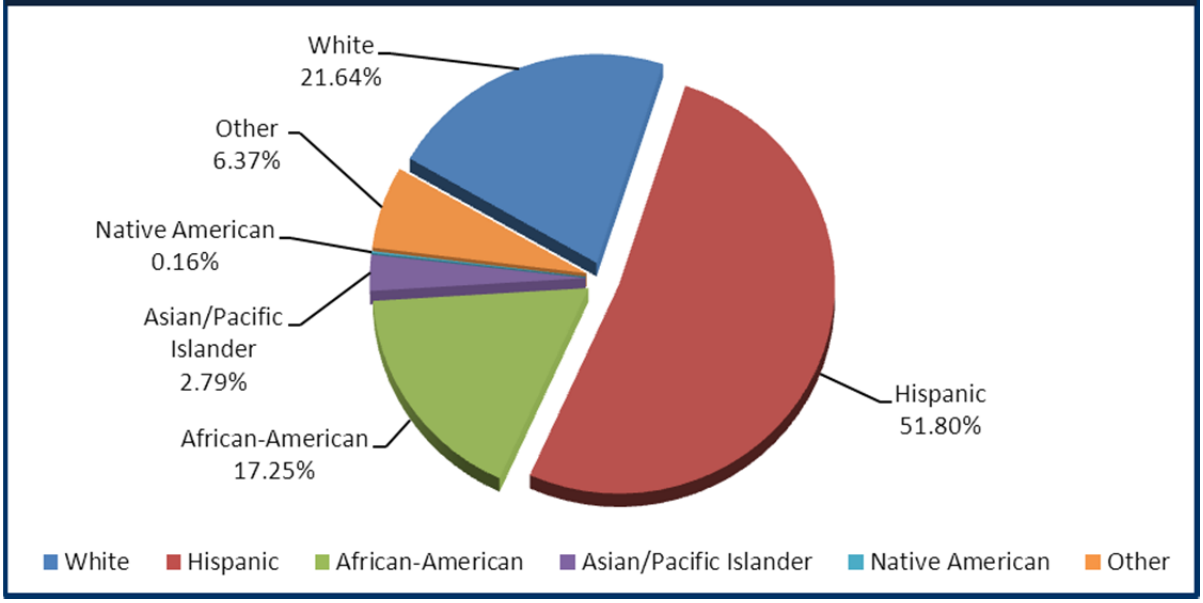


Figure D-17. Los Angeles Medi-Cal Beneficiaries Served, by Race/Ethnicity - Transition Age Youth CY12



E. Attachment—PIP Validation Tool

FY13-14 Review of: Los Angeles ☒ Clinical ☐ Non-Clinical

PIP Title: Integrated Mobile Health Team (IMHT) program

Date PIP Began: July 1, 2013

PIP Category: ☐Access ☐Timeliness ☐Quality ☒Outcomes ☐Other

Descriptive Category: improved diagnosis or treatment processes

Target Population: Other- homeless SMI adults with other vulnerabilities

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
1	**Study topic**					
1.1	Focuses on an identified problem that reflects high volume, high risk conditions, or underserved populations			X		
1.2	Was selected following data collection and analysis of data that supports the identified problem			X		
1.3	Addresses key aspects of care and services			X		
1.4	Includes all eligible populations that meet the study criteria, and does not exclude consumers with special needs			X		
1.5	Has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X		
Totals for Step 1:				**4**		
2	**Study Question Definition**					
2.1	Identifies the problem targeted for improvement			X		
2.2	Includes the specific population to be addressed			X		
2.3	Includes a general approach to interventions			X		
2.4	Is answerable/demonstrable			X		
2.5	Is within the MHP's scope of influence			X		

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
Totals for Step 2:				**5**		
3	**Clearly Defined Study Indicators**					
3.1	Are clearly defined, objective, and measurable			X		
3.2	Are designed to answer the study question			X		
3.3	Are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same			X		
3.4	Have accessible data that can be collected for each indicator			X		
3.5	Utilize existing baseline data that demonstrate the current status for each indicator			X		
3.6	Identify relevant benchmarks for each indicator			X		
3.7	Identify a specific, measurable goal(s) for each indicator			X		
Totals for Step 3:				**7**		
4	**Correctly Identified Study Population**					
4.1	Is accurately and completely defined			X		
4.2	Included a data collection approach that captures all consumers for whom the study question applies			X		
Totals for Step 4:				**2**		
5	**Use of Valid Sampling Techniques**					
5.1	Consider the true or estimated frequency of occurrence in the population			X		
5.2	Identify the sample size			X		
5.3	Specify the confidence interval to be used			X		
5.4	Specify the acceptable margin of error			X		
5.5	Ensure a representative and unbiased sample of the eligible population that allows for generalization of the results to the study			X		

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	population					
Totals for Step 5:				**5**		
6	**Accurate/Complete Data Collection**					
6.1	Identify the data elements to be collected			X		
6.2	Specify the sources of data			X		
6.3	Outline a defined and systematic process that consistently and accurately collects baseline and remeasurement data			X		
6.4	Provides a timeline for the collection of baseline and remeasurement data			X		
6.5	Identify qualified personnel to collect the data			X		
Totals for Step 6:				**5**		
7	**Appropriate Intervention and Improvement Strategies**					
7.1	Are related to causes/barriers identified through data analyses and QI processes			X		
7.2	Have the potential to be applied system wide to induce significant change			X		
7.3	Are tied to a contingency plan for revision if the original intervention(s) is not successful			X		
7.4	Are standardized and monitored when an intervention is successful			X		
Totals for Step 7:				**4**		
8	**Analyses of Data and Interpretation of Study Results**					
8.1	Are conducted according to the data analyses plan in the study design			X		
8.2	Identify factors that may threaten internal or external validity			X		
8.3	Are presented in an accurate, clear, and easily understood fashion			X		
8.4	Identify initial measurement and remeasurement of study indicators			X		
8.5	Identify statistical differences between initial			X		

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	measurement and remeasurement					
8.6	Include the interpretation of findings and the extent to which the study was successful			x		
Totals for Step 8:				**6**		
9	**Improvement Achieved**					
9.1	A consistent baseline and remeasurement methodology			X		
9.2	Documented quantitative improvement in processes or outcomes of care			X		
9.3	Improvement appearing to be the result of the planned interventions(s)			X		
9.4	Statistical evidence for improvement			X		
Totals for Step 9:				**4**		
10	**Sustained Improvement Achieved**					
	Repeated measurements over comparable time periods that demonstrate sustained improvement, or that any decline in improvement is not statistically significant			X		
Totals for Step 10:				**1**		

FY13-14 Review of: Los Angeles ☐ Clinical ☒ Non-Clinical

PIP Title: Vacancy Referral and Notification Project

Date PIP Began: July 1, 2013

PIP Category: ☒Access ☐Timeliness ☐Quality ☐Outcomes ☐Other

Descriptive Category: Improved diagnosis or treatment processes

Target Population: all consumers

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
1	**Study topic** create a web-based application to assist mental health service providers manage client flow throughout the system of care.					
1.1	Focuses on an identified problem that reflects high volume, high risk conditions, or underserved populations	X				Challenge for the system to keep providers informed of available services and slots for services for consumers not only at their service location but at other service provider locations to provide appropriate referral when needed.
1.2	Was selected following data collection and analysis of data that supports the identified problem	X				Baseline SA4 provider survey results showed a substantial need among providers to have access to information related to knowledge of immediate availability of program slots.
1.3	Addresses key aspects of care and services	X				Appropriate service provision/timely referrals
1.4	Includes all eligible populations that meet the study criteria, and does not exclude consumers with special needs	X				All consumers and providers receiving services in SA 4 – both Medi-Cal and Indigent population receiving mental health services.
1.5	Has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X				Vacancy Referral Reporting System (VANS) will allow providers to update information on vacancy for services on web based tool, allowing other providers access. System will facilitate consumers being enrolled in programs/ensure they receive appropriate services in timely/efficient way. Providers will be able to search for services within a certain mile radius and/or by language capacity thereby providing more appropriate and culturally sensitive referrals for consumers.

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
Totals for Step 1:		**5**				
2	**Study Question Definition** Can the use of an electronic web based tool (VANS) improve providers' access to information so as to provide accurate referrals pertaining to availability of: 1) Programs slots related to consumer's preferred language request, 2) Program slots related to consumer's request for convenient location of services, 3) Program slots related to specific mental health services?					
2.1	Identifies the problem targeted for improvement		X			Question lacks the theoretical leap to how it will improve the consumer experience; needs to be included. Could add a phrase such as "thereby make consumer referral linkage more effective and timely."
2.2	Includes the specific population to be addressed		X			As written population appears to be contract providers, and not the relevant consumers.
2.3	Includes a general approach to interventions	X				
2.4	Is answerable/demonstrable	X				
2.5	Is within the MHP's scope of influence	X				
Totals for Step 2:		**3**	**2**			
3	**Clearly Defined Study Indicators** How often do providers make referrals based on: 1) Availability of slots related to specific mental health services such as, FSP, FCCS & EBPs. 2) Availability of slots related to consumer's request for preferred language for services. 3) Availability of slots related to consumer's request for convenient location of services. 4) Availability of slots by funding source: Medi-Cal versus Indigent. 5) Number of calls made by providers for each referral.					
3.1	Are clearly defined, objective, and measurable	X				
3.2	Are designed to answer the study question	X				
3.3	Are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same		X			Discussion onsite about MHP adding consumer indicator to qualify as a PIP i.e. evidence of successful linkage using VANS. Post-review per MHP: All have agreed to definition of a "successful linkage" as when a provider calling on behalf of a client whom this provider cannot serve at present is able to contact another provider and set up a date and time for an intake appointment for the client as an acceptable appointment by the client."

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
3.4	Have accessible data that can be collected for each indicator		X			Capture evidence of successful consumer linkage once VANS helps referring agency determine slot available to meet needs, or build field into VANS that notes consumer appt date with agency referred to. Post-review per MHP: MHP met with ISD on 5/13/14 to discuss feasibility/cost of enhancing VANS with a feature that allows providers to track successful linkages within the VANS application.
3.5	Utilize existing baseline data that demonstrate the current status for each indicator	X				
3.6	Identify relevant benchmarks for each indicator			X		
3.7	Identify a specific, measurable goal(s) for each indicator	X				
Totals for Step 3:		**4**	**1**	**2**		
4	**Correctly Identified Study Population** *The method for identifying the study population:*					
4.1	Is accurately and completely defined	X				
4.2	Included a data collection approach that captures all consumers for whom the study question applies	X				
Totals for Step 4:		**2**				
5	**Use of Valid Sampling Techniques** All consumers receiving services in SD/MC clinics in SA 4 are included in the study.					
5.1	Consider the true or estimated frequency of occurrence in the population				X	
5.2	Identify the sample size				X	
5.3	Specify the confidence interval to be used				X	
5.4	Specify the acceptable margin of error				X	
5.5	Ensure a representative and unbiased sample of the eligible population that allows for generalization of the results to the study population				X	

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
Totals for Step 5:					**5**	
6	**Accurate/Complete Data Collection** Data collected in the SQL database now used to build weekly and monthly reports. These reports will be disseminated to agencies and management for feedback and monitoring purposes (*in discussion of how this will occur now*) to examine if available slots are being filled and how many providers are reporting vacancies- plan is for MHP contract providers to provide monthly feedback to SA4 providers regarding VANS success, usage, challenges, etc.					
6.1	Identify the data elements to be collected	**X**				1) Weekly reports of available slots per provider. 2) Weekly reports of available slots by language capacity of providers. 3) Weekly reports of available slots by funding source (Medi-Cal versus Indigent) 4) Weekly reports of providers using the application to update the available slot information for their agency 5) Weekly reports of frequency of updating slots by providers.
6.2	Specify the sources of data	**X**				
6.3	Outline a defined and systematic process that consistently and accurately collects baseline and remeasurement data	**X**				
6.4	Provides a timeline for the collection of baseline and remeasurement data	**X**				
6.5	Identify qualified personnel to collect the data	**X**				
Totals for Step 6:		**5**				
7	**Appropriate Intervention and Improvement Strategies**					
7.1	Are related to causes/barriers identified through data analyses and QI processes	**X**				VANS
7.2	Have the potential to be applied system wide to induce significant change	**X**				
7.3	Are tied to a contingency plan for revision if the original intervention(s) is not successful			**X**		
7.4	Are standardized and monitored when an intervention is successful			**X**		
Totals for Step 7:		**2**		**2**		

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
8	**Analyses of Data and Interpretation of Study Results** *The data analyses and study results:*					
8.1	Are conducted according to the data analyses plan in the study design			X		The PIP does not yet have post-intervention findings.
8.2	Identify factors that may threaten internal or external validity			X		
8.3	Are presented in an accurate, clear, and easily understood fashion			X		
8.4	Identify initial measurement and remeasurement of study indicators			X		
8.5	Identify statistical differences between initial measurement and remeasurement			X		
8.6	Include the interpretation of findings and the extent to which the study was successful			X		
Totals for Step 8:				**6**		
9	**Improvement Achieved** *There is evidence for true improvement based on:*					
9.1	A consistent baseline and remeasurement methodology			X		
9.2	Documented quantitative improvement in processes or outcomes of care			X		
9.3	Improvement appearing to be the result of the planned interventions(s)			X		
9.4	Statistical evidence for improvement			X		
Totals for Step 9:				**6**		
10	**Sustained Improvement Achieved** *There is evidence for sustained improvement based on:*					
	Repeated measurements over comparable time periods that demonstrate sustained improvement, or that any decline in improvement is not statistically significant			X		
Totals for Step 10:				**1**		

F. Attachment—MHP PIPs Submitted

APS Healthcare

California EQRO

Feb 2013 – Updates to document noted in blue.

- This outline is a compilation of the "Road Map to a PIP" and the PIP Validation Tool that CAEQRO uses in evaluating PIPs. The use of this format for PIP submission will assure that the MHP addresses all of the required elements of a PIP. The MHP is not limited to using this format and may submit evidence of the PIP in other formats which address the required elements.
    - PDSA Cycles can be submitted as separate documents or outlined as part of #3 barrier analysis (understanding causes), #10 interventions (testing change ideas), as well as #15 data analysis and triggering changes. Conducting PDSA cycles is for purposes of learning and testing; many PDSA cycles in themselves do not complete a PIP.
- Your PIP should focus on a consumer-related problem (access, timeliness, outcomes) which is measured (indicators), for which interventions will be applied to create improvement. Simply setting up a monitoring system for some facet of care is not a PIP unless it is focused on improving an indicator.
- Do not set up a PIP to evaluate the effectiveness of a given program; this is a program evaluation. The individuals receiving the intervention need to be related to the identified problem, upon which various interventions (not just a program's services) can be tested and applied to create improvement.
- You are not limited to the space in this document. It will expand, so feel free to use more room than appears to be provided, and include relevant attachments.
- Emphasize the work completed over the past year, if this is a multi-year PIP. A PIP that has not been active and was developed in a prior year may not receive "credit."
- PIPs generally should not last longer than roughly two years. An MHP is advised to consult with CAEQRO before continuing a PIP into a third year.

CAEQRO PIP Outline via Road Map

MHP: County of Los Angeles Department of Mental Health
Date PIP Began: July 1, 2013

Title of PIP: Vacancy Referral and Notification Project
Clinical or Non-Clinical: Non-Clinical

Assemble multi-functional team

1. Describe the stakeholders who are involved in developing and implementing this PIP.

LAC-DMH MHP:

- Chris Chapman – Enterprise Architecture
- DMH-CIOB
- Edward Vidaurri – Project Lead
- Ella Granston – SA 4 Project Manager
- Junior Togelang – Database Administrator
- Naga Kasarabada – Project Lead
- Nathalie Blume – Data Expert
- Tim Beyer – QI Expert
- SA 4 Providers
- Statewide PIP consulting staff (Including xxx, CIMH)
- Vandana Joshi – Data Lead and Project Sponsor/Champion

"Is there really a problem?"

2. Define the problem. Describe the data reviewed and relevant benchmarks that validate the problem exists. Explain why this is a problem priority for the MHP, how it is within the MHP's scope of influence, and what specific consumer population it affects.

The County of Los Angeles Department of Mental Health (LACDMH) is looking to create a web-based application to assist mental health service providers manage client flow throughout the system of care. Given the recent expansion in services with MHSA funds and realignment many new services have become available to consumers. Service providers have been given additional funding or have been asked to transform their services to meet the needs of consumers. While consumers with a need for high levels of care are being directed to more intensive services, the purpose of additional funding and realignment is to move clients through appropriate levels of care as they receive services and ultimately graduate successfully from programs.

This has created a challenge for the system to keep providers informed of available services and slots for services for consumers not only at their service location but at other service provider locations to provide appropriate referral when needed. Service providers that need to give consumers a referral to another program need to know where there are immediate openings and which programs are filled to capacity. This information will ensure that consumers are provided with the best referral information available and help fill program and service vacancies more efficiently. This service will save consumers valuable time from calling programs that do not have immediate availability.

A baseline survey was designed by the PIP workgroup members to assess the current ability of providers in SA 4 to make referrals to consumers based on their knowledge of immediate availability of program slots. Survey questions evaluating the ability of providers to make referrals based on knowledge of immediate availability of 1) overall program slots, 2) program slots related to consumer's preferred language request, 3) program slots related to consumer's request for convenient location of services, and 4) program slots related to specific mental health services were pilot tested with a sample of providers in SA 4. In addition questions related to number of calls made by providers to other provider agencies regarding the availability of slots, for each referral made by them to a consumer and providers receiving calls from other agencies when their program slots were full to capacity were also field tested. The final baseline survey with 9 survey questions was programmed in a web-based survey tool (VOVICI). The survey was launched on February 28th, 2014 and remained open for 10 calendar days through March 10th, 2014. The survey was sent to all SA 4 provider locations to approximately 103 clinicians and supervisors who make referrals to consumers. These represented all 25 Providers and or Legal Entities who fall under SA 4 Administration jurisdiction. The response rate to

the survey was more than 90% for all unique providers and Legal Entities and 37.8% (39/103) for all clinicians and supervisors responding to the survey.

Providers need a tool to update the number of available vacancies or openings in their program that will make the information available to other providers facilitating appropriate and timely referrals.

The Vacancy Referral Reporting System (VANS) will allow providers to update information on vacancy for services on a web based tool and allow other providers to have access to this essential information. The system will facilitate consumers being enrolled in programs and ensure that they receive appropriate services in a more timely and efficient way.

The VANS will include administrative features that will allow clinic staff to add new programs and services as they become available. Providers will be able to search for services within a certain mile radius and/or by language capacity thereby providing more appropriate and culturally sensitive referrals for consumers.

Team Brainstorming: "Why is this happening?"
Root cause analysis to identify challenges/barriers

3. a) What are the likely causes of the problem? Describe the data and other information gathered and analyzed to understand the barriers/causes of the problem that affects the mental health status, functional status, or satisfaction. How did you use the data and information to understand the problem?

Providers generally do not have easy access to available slots for services at other provider locations. A provider can find the availability of another's provider's treatment services only by calling that other provider and asking. Available slot in a program changes over the course of time, even within a day or less, as new clients are admitted and existing clients complete treatment and exit the program. Thus, one provider must call other providers day after day if it is going to refer people it cannot serve to another provider that can. The process of calling other providers is time consuming, and provider typically do not have the staff time to make multiple phone calls to other providers day after day to find an available program for potential clients.

In reality, providers who are at capacity and unable to accept a new client are more likely to give people in need of services the name and phone numbers of several providers, instructing the client to search for themselves until they find one, or they may offer to place a client on a waiting list until they have an opening. This may lead to a client not receiving services in a timely fashion, and to the client having to make multiple phone calls until he / she can find a provider who has available services. In addition, for providers which have waiting lists there is the added time consuming task of having to go through that list whenever they have new space in a program to take in a new client.

For a mental health provider trying to help connect a person in need of treatment to a provider with an available slot, the process can be time consuming because of no adequate current resource to identify open capacity in mental health treatment programs.

The Baseline Survey results showed that there was a substantial need among providers to have access to information related to their knowledge of immediate availability of program slots. Specifically the results showed that among providers in SA 4:

1) 45% had limited or no knowledge of immediate availability of slots.
2) 45% had limited or no knowledge of immediate availability of slots related to consumer's preferred language request
3) 37% had limited or no knowledge of immediate availability of slots related to consumer's request for convenient location of services
4) 26% had limited or no knowledge of immediate availability of slots related to specific mental health services
5) 58% made 3 or more calls to other provider agencies for each referral provided to a consumer.
6) 37% received referrals from other agencies when they did not have immediate availability of slots.
7) 30% received referrals from other agencies when they did not have immediate availability of slots related to consumer's preferred language request.
8) 14% received complaints from consumers regarding lack of immediate availability of slots.

b) What are barriers/causes identified that require intervention? <u>Use Table A, and attach any charts, graphs, or tables to display the data.</u>

Lack of suitable communication protocols between providers has prevented providers from giving consumers timely and appropriate referrals to other providers when they themselves are unable to enroll them in their own programs for services.

Table A – List of Validated Causes/Barriers

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Providers are unaware of openings in another provider's treatment programs	Information gathered at Service Area provider meetings. Baseline Survey Results assessing the need among providers to have access to information related to immediate availability of slots in other provider agencies. See survey results (Attachment 4)
Lack of an up-to-date list of available treatment services in service area	Information gathered at Service Area provider meetings.

Formulate the study question

4. State the study question. This should be a single question in 1-2 sentences which specifically identifies the problem for improvement, the general intervention, and the desired outcome.

Can the use of an electronic web based tool (VANS) improve providers' access to information so as to provide accurate referrals pertaining to availability of: 1) Programs slots related to consumer's preferred language request, 2) Program slots related to consumer's request for convenient location of services, 3) Program slots related to specific mental health services?

Does this PIP include all beneficiaries for whom the study question applies? If not, please explain. (Remember that all PIPs must include Medi-Cal beneficiaries)

This PIP will include all consumers and providers receiving services in SA 4 – i.e., both Medi-Cal and Indigent population receiving mental health services.

5. Describe the population to be included in the PIP, including the number of beneficiaries.

SA 4 has 6 Directly Operated clinics and wellness centers, and 75 contract provider sites, serving approximately 44,000 consumers annually. Nearly 25% are African Americans, 6% Asians, 51% Latinos, 0.7% Native Americans and 17% White. Majority of the consumers (72%) are English speaking, 21% Spanish speaking and the remaining 7% speak other threshold languages. The PIP will evaluate referral to appropriate services to all consumers receiving services in SA 4.

6. Describe how the population is being identified for the collection of data.

All consumers receiving services in SD/MC clinics in SA 4 are included in the study.

7. a) If a sampling technique was used, how did the MHP ensure that the sample was selected without bias?

NA

b) How many beneficiaries are in the sample? Is the sample size large enough to render a fair interpretation?

NA

"How can we try to address the broken elements/barriers?"
Planned interventions

Specify the performance indicators in Table B and the Interventions in Table C.

8. What indicators were selected to measure improvement?

1) Availability of slots related to specific mental health services such as, FSP, FCCS, EBPs.

2) Availability of slots related to consumer's request for preferred language for services.

3) Availability of slots related to consumer's request for convenient location of services.

4) Availability of slots by funding source: Medi-Cal versus Indigent.

5) Number of calls made by providers for each referral.

a) Why were these performance indicators selected?

These indicators are critical for tracking Service Delivery Capacity and Access to Care.

b) How do these performance indicators measure changes in mental health status, functional status, beneficiary satisfaction, or process of care with strong associations for improved outcomes?

Remember the difference between *percentage* changed and *percentage points* changed – a very common error in reporting the goal and also in the re-measurement process.
(Need to consult during conf. call)

Table B – List of Performance Indicators, Baselines, and Goals

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator (number)	Goal (number)
1	How often do providers make referrals (Always, Often or Sometimes) based upon immediate knowledge of available slots or openings?	Frequency of referrals based upon knowledge of availability of slots.	All Referrals	55.2%	85% of providers will make referrals based upon immediate knowledge of

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator (number)	Goal (number)
					available slots
2	How often do providers make referrals (Always, Often, Sometimes) based upon knowledge of availability of slots related to the consumer's preferred language request?	Frequency of referrals based upon knowledge of availability of slots related to consumer's preferred language.	All Referrals	55.3%	85% of providers will make referrals based upon immediate knowledge of availability of slots related to consumer's preferred language requested
3	How often do providers make referrals (Always, Often, Sometimes) based upon knowledge of availability of slots related to the consumer's preferred location of services?	Frequency of referrals based upon knowledge of availability of slots related to consumer's preferred location of services.	All Referrals	63.2%	85% of providers will make referrals based upon immediate knowledge of available of slots related to consumer's preferred location of services
4	Decrease Number of calls made to other providers for each referral.	Three or more calls for each referral	NA	57.9%	40% of providers will make 3 or more calls for each referral

9. <u>Use Table C to summarize interventions</u>.

a) In column 2, describe each intervention.
b) In column 3, identify the barriers/causes each intervention is designed to address.
c) In column 4, identify the corresponding indicator which will measure the performance of each intervention.
d) Do not cluster different interventions together.

Table C - Interventions

1) Number of Intervention	2) List each specific intervention	3) Barrier(s)/causes each specific intervention is designed to target	4) Corresponding Indicator	5) Dates Applied
1				
2				
3				
4				
5				
6				
7				

Apply Interventions: "What do we see?"

Data analysis: apply intervention, measure, interpret

10. Describe the data to be collected.

Process Measures to measure the Utility of VANS Application

1) Weekly reports of available slots per provider.
2) Weekly reports of available slots by language capacity of providers.
3) Weekly reports of available slots by funding source (Medi-Cal versus Indigent)
4) Weekly reports of providers using the application to update the available slot information for their agency
5) Weekly reports of frequency of updating slots by providers.

Outcome Measures: Follow Up to the Baseline Survey completed by providers using VANS to gather information on the 4 Performance Indicators outlined in 8 b.

11. Describe method of the data collection and the sources of the data to be collected. Did you use existing data from your Information System? If not, please explain why.

Data from the web application will be downloaded into a SQL database to build reports mentioned above in 10).

12. Describe the plan for data analysis. Include contingencies for untoward results.

Data collected in the SQL database will be used to build weekly and monthly reports. These reports will be disseminated to agencies and management for feedback and monitoring purposes to examine if available slots are being filled and how many providers are reporting vacancies.

13. Identify the staff that will be collecting data as well as their qualifications, including contractual, temporary, or consultative personnel.

Staff from ISD and LACDMH Data-GIS Unit staff will prepare and run these reports on a weekly and monthly basis.

14. Describe the data analysis process. Did it occur as planned? Did results trigger modifications to the project or its interventions? Did analysis trigger other QI projects?

15. **Present objective data results for each performance indicator. <u>Use Table D and attach supporting data as tables, charts, or graphs.</u> Include the raw numbers that serve as numerator and denominator!**

Table D - Table of Results for Each Performance Indicator and Each Measurement Period

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/ denominator)	% improvement achieved
THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS							

"Was the PIP successful?" What are the outcomes?

16. **Describe issues associated with data analysis:**

    a. **Data cycles clearly identify when measurements occur. Provide explanation for any analysis occurring less frequently than quarterly. Some activities and outcomes benefit from or require close, routine monitoring.**

    b. **Statistical significance**

    c. **Are there any factors that influence comparability of the initial and repeat measures?**

    d. **Are there any factors that threaten the internal or the external validity?**

17. **To what extent was the PIP successful? Describe any follow-up activities and their success.**

18. **Describe how the methodology used at baseline measurement was the same methodology used when the measurement was repeated. Were there any modifications based upon the results?**

19. **Does data analysis demonstrate an improvement in processes or client outcomes?**

20. Describe the "face validity" – how the improvement appears to be the result of the PIP intervention(s).

21. Describe statistical evidence that supports that the improvement is true improvement.

22. Was the improvement sustained over repeated measurements over comparable time periods? Or, what is the plan for monitoring and sustaining improvement?

Vacancy Adjustment and Notification System (VANS) Survey Report

1: (1. In the last two weeks how many total referrals did you provide to consumers?)
(Respondents were limited to **brief** text responses)

Response	Chart	Frequency	Count
0		**12.8%**	**5**
1		7.7%	3
2		7.7%	3
3		7.7%	3
5		10.3%	4
10		10.3%	4
25		7.7%	3
50		5.1%	2
Other Responses		30.8%	12
		Valid Responses	**39**
		Total Responses	**39**

Question 1 shows the range in the number of referrals from none to 50. While 12.8% (N = 5) of respondents made no referrals, nearly 33.4% reported providing 5 or more referrals in the past two weeks.

2. Of those referrals, how often were they based upon your knowledge of immediate availability of slots?
(Respondents could only choose a **single** response)

Response	Chart	Frequency	Count
(100%) Always		15.8%	6
(80%-99%) Often		10.5%	4
(40%-79%) Sometimes		**28.9%**	**11**
(1%-39%) Rarely		23.7%	9
(0%) Never		21.1%	8
		Valid Responses	**38**
		Total Responses	**38**

Only 55.2% of providers had some knowledge of immediate availability of slots when providing referrals. 15.8% (N = 6) "Always", 10.5% (N = 4) "Often" and 28.9% (N = 11) "Sometimes" made referrals based upon knowledge of immediate availability of slots.

Approximately 44.8% had limited or no knowledge of immediate availability of slots. Nearly a quarter, 23.7% (N = 9) "Rarely" and 21.1% (N = 8) "Never" had any knowledge of availability of slots.

3. In the last two weeks how often did you provide referrals based upon your knowledge of immediate availability of slots related to a Consumer's preferred language request?
(Respondents could only choose a **single** response)

Response	Chart	Frequency	Count
(100%) Always		13.2%	5
(80%-99%) Often		**31.6%**	**12**
(40%-79%) Sometimes		10.5%	4
(1%-39%) Rarely		21.1%	8
(0%) Never		23.7%	9
		Valid Responses	**38**
		Total Responses	**38**

Only 55.3% of the respondents had some or frequent knowledge of immediate availability of slots related to consumer's preferred language request, with 13.2% (N = 5) reporting "Always", 31.6% (N = 12) reporting "Often" and 10.5% (N = 4) reporting "Sometimes" providing referrals.

The remaining 44.7% had limited or no knowledge of immediate availability of slots related to consumer's preferred language request, with 21.1% (N = 8) reporting that they "Rarely" and 23.7% (N = 9) reporting that they "Never" provided any referrals based upon consumer's preferred language request.

4. In the last two weeks how often did you provide referrals based upon your knowledge of immediate availability of slots related to a consumer's request for convenient location of services?
(Respondents could only choose a **single** response)

Response	Chart	Frequency	Count
(100%) Always		**26.3%**	**10**
(80%-99%) Often		21.1%	8
(40%-79%) Sometimes		15.8%	6
(1%-39%) Rarely		21.1%	8
(0%) Never		15.8%	6
		Valid Responses	**38**
		Total Responses	**38**

Approximately 63.2% of the providers had some or frequent knowledge of immediate availability of slots related to consumer's request for convenient location of services, with 26.3% (N = 10) reporting "Always", 21.1% (N = 8) reporting "Often" and 15.8% (N = 6) reporting that they "Sometimes" provided referrals.

The remaining 36.8% respondents had limited or no knowledge of immediate availability of slots with 21.1% (N = 8) reporting that they "Rarely" and 15.8% (N = 6) reporting that they "Never" provided any referrals based upon consumer's request for convenient location of services.

5. In the last two weeks how often did you provide referrals based upon your knowledge of immediate availability of slots related to specific mental health service?
(Respondents could only choose a **single** response)

Response	Chart	Frequency	Count
(100%) Always		18.4%	7
(80%-99%) Often		**34.2%**	**13**
(40%-79%) Sometimes		21.1%	8
(1%-39%) Rarely		13.2%	5
(0%) Never		13.2%	5
		Valid Responses	**38**
		Total Responses	**38**

Approximately 73.7% of the providers had some or frequent knowledge of immediate availability of slots related to specific mental health services with 18.4% (N = 7) reporting "Always", 34.2% (N = 13) reporting "Often" and 21.1% (N = 8) reporting that they "Sometimes" provided referrals.

The remaining 26.3% respondents had limited or no knowledge of immediate availability of slots with 13.2% (N = 5) reporting that they "Rarely" and 13.2% (N = 5) reporting that they "Never" provided any referrals based upon their knowledge of availability of slots related to specific mental health services.

6: (6. In the last two weeks how many calls did you make to other providers for each referral given out to a consumer? (Example: On average I called two providers for each referral given).)
(Respondents were limited to **brief** text responses)

Response	Chart	Frequency	Count
0		13.2%	5
1		**18.4%**	**7**
2		10.5%	4
3		10.5%	4
4		15.8%	6
5		5.3%	2
6		10.5%	4
10		5.3%	2
Other Responses		10.5%	4
		Valid Responses	**38**
		Total Responses	**38**

Approximately 42.1% of providers made 2 or less calls to other providers when making a referral. A small percent (13.2%) of providers did not make any phone calls, 18.4% (N = 7) made one call and 10.5% (N = 4) made only 2 calls to other providers when providing referrals.

The remaining 57.9% of the providers reported making 3 or more calls to other provider agencies for each referral provided to a consumer.

7. In the last two weeks how often did you receive referrals from another agency when you did not have immediate availability of slots for the requested service?
(Respondents could only choose a **single** response)

Response	Chart	Frequency	Count
(100%) Always		2.6%	1
(80%-99%) Often		13.2%	5
(40%-79%) Sometimes		21.1%	8
(1%-39%) Rarely		26.3%	10
(0%) Never		**36.8%**	**14**
		Valid Responses	**38**
		Total Responses	**38**

Approximately 36.9% of the providers received referrals from another agency when they did not have immediate availability of slots, with 2.6% (N = 1) reporting "Always", 13.2% (N = 5) reporting "Often" and 21.1% (N = 8) reporting that they "Sometimes" received referrals from other agencies.

The remaining 63.1% providers reported they did not receive referrals, with 26.3% reporting "Rarely" and 36.8% reporting that they "Never" received referrals from other agencies when they did not have immediate availability of slots.

8. In the last two weeks how often did you receive referrals from another agency when you did not have immediate availability of slots for the preferred language request?
(Respondents could only choose a **single** response)

Response	Chart	Frequency	Count
(100%) Always		2.7%	1
(80%-99%) Often		8.1%	3
(40%-79%) Sometimes		18.9%	7
(1%-39%) Rarely		21.6%	8
(0%) Never		**48.6%**	**18**
		Valid Responses	**37**
		Total Responses	**37**

Approximately 29.7% of the providers received referrals from another agency when they did not have immediate availability of slots for a consumer's preferred language request, with 2.7% (N = 1) reporting "Always", 8.1% (N = 3) reporting "Often" and 18.9% (N = 7) reporting that they "Sometimes" received referrals from other agencies.

The remaining 70.2% providers did not receive referrals, with 21.6% reporting "Rarely" and 48.6% reporting that they "Never" received referrals from other agencies when they did not have immediate availability of slots for a consumer's preferred language request.

9. In the last two weeks how often did you receive a complaint from a Consumer regarding the lack of immediate availability of slots at the agency to which you referred the consumer?
(Respondents could only choose a **single** response)

Response	Chart	Frequency	Count
(100%) Always		0.0%	0
(80%-99%) Often		5.6%	2
(40%-79%) Sometimes		8.3%	3
(1%-39%) Rarely		16.7%	6
(0%) Never		**69.4%**	**25**
		Valid Responses	**36**
		Total Responses	**36**

Approximately 13.9% of the providers received some complaints from a consumer regarding lack of immediate availability of slots at their agency, with 5.6% (N = 2) reporting "Often" and 8.3% (N = 3) reporting "Sometimes" (8.3%).

The remaining 86.1% providers reported that they "Rarely" (16.7%) and 69.4% reported that they "Never" received complaints from a consumer.

Vacancy Adjustment & Notification System (VANS) – Administrative PIP
Progress Report

November 26, 2013

Organizational Notes
QI person in charge of VANS: Tim Beyer
Data Person in charge of Clinical PIP: Sandra Chin
Data Person in charge of Administrative PIP (which is limited to SA 4): Nathalie Blume
ISD Person in charge of website design: Chris Chapman, together with Junior Togelang
Ed Vidaurri and Ella Granston run the pilot out of SA 4.

Request for Data
- Number of slots available by each provider for each service (please include dates so we can build weekly reports)
- Time stamp for provider updates. We need to find out the frequency of when providers are updating their information.
- Number of "active" userids for the application. How many provider userids have actually been used at least once to use the website?

Data received
- Chris Chapman: "I have attached an excel files of the Service History table, the User table and the Programs table." (See attached)

Data still or now needed
- List of providers in SA 4 (both those that were and those that were not provided with an ID)
- List of languages BY providers.

Planned Analyses
- # providers in SA4,
- # (%) with user ids,
- # active slots announced as available with breakdown by provider and by program.
- Have a metric of rate at which slots are filled.

Agenda

Vandana
- Vandana to Chris & Ella: "When Ed returns from jury duty we can set up a meeting to go over the details of building specific data reports."
- Vandana to ask Tim to obtain a list of providers (with ID) in SA4, and cross reference this with Chris' list of Users in order to determine which providers have been issued user IDs. Please send to Nathalie an Excel list of Providers with a column showing whether or not they have a user ID. (More detail is welcome, eg number of IDs, names/id of users given IDs)
- Vandana to let Chris know Nathalie will be his contact on the data side.

Nathalie
- Nathalie to follow up with Junior/Chris to get logon access to the front end of the website, and settle back end access to the usage data.
- Nathalie to send request to Chris and/or Ella for a list of the languages offered, BY Provider_ID
- Nathalie to ask Chris to launch the new application.
- Nathalie to create SQL tables on Program Support Bureau server from data received from Tim, Ella and/or Chris.
- Nathalie to draw up a draft of a weekly report of planned analyses

Other
- In future, maybe do a PDSA ("plan do study act") on whether we should get data on which slots are offered in which language.

VANS Program

Program_ID	Program	Funding_ID	status
1	ART (Aggression Replacement Training)	M	A
3	CAPPS	M	A
4	CBT for Major Depression	M	A
5	CBITS	M	A
7	Caring for Our Families child	M	A
9	Crisis Oriented Recovery Services (CORS)	M	A
10	EDIPP	M	A
12	Functional Family Therapy (FFT)	M	A
13	Gatekeeper Case Finding Model	M	A
14	Group CBT for Major Depression	M	A
15	Interpersonal Psychotherapy (IPT)	M	A
16	Incredible Years	M	A
17	Integrated Treatment OPUS	M	A
19	LIFE Program	M	A
20	Live Well, Live Long	M	A
21	M HIP	M	A
22	Maternal Wellness	M	A
23	Multidimensional Family Therapy	M	A
25	Nurse Family Partnership	M	A
26	PEARLS	M	A
27	Parent-Child Interaction Therapy (PCIT)	M	A
28	Prolonged EXposure Therapy for PTSD	M	A
29	Seeking Safety	I	A
30	Trauma Focused CBT	I	A
31	Positive Parenting Program (PPP)	M	A
34	MAP	M	A
38	Wraparound	M	A
39	DCFS Medical Hubs	M	A
41	Full Service Partnerships (FSP)	I	A
42	Enhanced Mental Health Services	I	A
44	Field Capable Clinical Services (FCCS)	M	A
45	Wellness/Client-Run Centers	M	A
46	Family Preservation	M	A
47	Cal Works	M	A
48	Clinic Outpatient	M	A
52	Innovation Run Model	M	A
53	Therapeutic Behavioral Services	M	A
54	Multi-Disciplinary Assess Team (MAT)	M	A
55	Integrated Services Management Model (ISM)	M	A
56	Integrated Clinical Model (ICM)	M	A
57	Integrated Model Health Team (IMHT)	M	A
58	Child Parent Psychotherapy	M	A
59	Depression Treatment Quality Improvement Intervention (DTQI)	M	A
60	Multisystemic Therapy (MST)	M	A
61	Families and Schools Together	M	A
62	CBT for Late Life Depression	M	A
63	Reflecting Parenting Program (RPP)	M	A
66	Seeking Safety	M	A
67	Trauma Focused CBT	M	A
68	Integrated Services Management Model (ISM)	I	A
2	BRC	M	U
6	CPT for Anxiety	M	U
8	Child Parent Psychology (CPP)	M	U
11	F.A.S.T.	M	U
18	Late Life Depression	M	U
24	MST	M	U
32	Specialities	M	U
33	Bedding	M	U
35	Enhanced Mental Health Services	M	U
36	MAT	I	U
37	MAT	M	U
40	Full Service Partnership (FSP)	M	U
43	MAT	I	U
49	IMHT	M	U
50	ISM	M	U
51	ICM	M	U
64	Bedding	M	U

VANS Users

TBL_ID	User_ID	User_Name	Email	Provider_ID	status	firstName	surName	Title_ID
12	bmorana	Brett Morana	bmorana@apla.org	7061	A	Brett	Morana	NULL
13	asanchez	Amanda Sanchez	asanchez@didihirsch.org	7359	A	Amanda	Sanchez	NULL
16	lclifton	Lisa Clifton	LClifton@stannes.org	7538	A			NULL
17	mopenano	Maria Openano	mopenano@starsinc.com	1557A	A			NULL
22	rzaragoza	Rafael Zaragoza	rzaragoza@ecdpla.org	7581	A			NULL
23	gmorquecho	Gilbert Morquecho	gmorquecho@didihirsh.org	7359	A			NULL
24	lleach	Lorne Leach	lleach@avivacenter.org	7268	A			NULL
25	jstadler	Judi Stadler	jstadler@emqff.org	7749	A			NULL
26	dfarah	Diane Farah	dfarah@emqff.org	7749	A			NULL
35	bryanj	Bryan C Jones	bryanj@fasgi.org	7147	A	Bryan C	Jones	NULL
37	eshaw	Emma Shaw	eshaw@ehrs.com	7472	A			NULL
38	jblack	J Blackburn	jblackburn@jfsla.org	7723	A			NULL
39	tjones	Tiffany Jones	tjones@ehrs.com	7255	A			NULL
40	tsteidl	Tufia Steidl	tsteidl@ehrs.com	7255	A			NULL
42	nkang	Nayon Kang	nkang@kyccla.org	7103	A			NULL
46	Nancyo	Nancy S. Obiacoro	nancyo@fasgi.org	7147	A			NULL
47	glo	Gwen Lo	glo@amanecerla.org	7104	A			NULL
48	marechiga	Martha Arechiga	marechiga@telecarecorp.com	7262	A			NULL
50	lynettagore	LyNetta Gore	lynettagore@imces.org	7312	A			NULL
52	lfernandez	Larry Fernandez	lfernandez@chcada.org	7519A	A			NULL
53	mlinsangan	Marijes Linsangan	mlinsangan@childrensinstitute.org	7328	A			NULL
54	REast	Robyn East	REast@heritageclinic.org	7430M	A			NULL
55	debralee	Debra Lee	dlee@pacificclinics.org	7677	A			NULL
56	gpapa	Gina Papa	gpapa@paralosninos.org	7546	A			NULL
62	martinribeiro	Martin Ribeiro	martinribeiro@all4kids.org	7582	A			NULL
64	andrewk@lacgc.org	Andrew Kurtz	andrewk@lacgc.org	6870	A			NULL
66	mduarte	Marlon Duarte	mduarte@chla.usc.edu	1989	A	Marlon	Duarte	NULL
67	dewing	Dennis Ewing	dewing@exodusrecovery.com	9000	A			NULL
68	eaguilar	Evelyn Vega-Aquilar	eaquilar@VIP-CMHC.org	7480	A			NULL
69	vsalazar	Veronica Salazar	vsalazar@childrensinstitute.org	7328	A			NULL
70	jblackburn	Justin Blackburn	jblackburn@jfsla.org	7693	A			NULL
71	drlingenfelter	Jennifer Lingenfelter	drlingenfelter@gmail.com	7414	A			NULL
72	leahc	Leah Carroll	leahc@lampcommunity.org	7202	A			NULL
73	lspan	Laura Span	lspan@dmh.lacounty.gov	1914	A			NULL
74	lfazio	Linda Fazio	lfazio@dmh.lacounty.gov	7765	A			NULL
75	psacco	Paul Sacco	psacco@dmh.lacounty.gov	1909	A			NULL
76	shannon.williams	Shannon Williams	shannon.williams@dignityhealth.org	7580	A			NULL
77	angela	Angela Kang	angela@ssgapialliance.org	7619	A			NULL
78	trang	Trang H. Hoang	trang@ssgapialliance.org	7619	A			NULL
79	vsimon	Victoria Simon	Vsimon@project180la.com	7400	A			NULL
80	mgarzona	Mayra Garzona	mgarzona@VIP-CMHC.org	7480	A			NULL
81	vgrey	Vanessa Grey	vgrey@lagaycenter.org	7106	A			NULL
82	dkubrin	Diane Kubrin	dkubrin@lagaycenter.org	7106	A			NULL
83	marymartone	Mary Martone	marymartone@vistadelmar.org	7776	A			NULL
85	mpelsman	Mara Pelsman	mpelsman@gatewayshospital.org	1982	A			NULL
86	eclarke	Ebony Clarke	eclarke@gatewayshospital.org	7470	A			NULL
87	emurillo	Elizabeth Murillo	emurillo@gatewayshospital.org	7470a	A			NULL
88	garroyo	Georgina Arroyo	garroyo@gatewayshospital.org	7412	A			NULL
89	aperez	Alex Perez	aperez@gatewayshospital.org	7671	A			NULL
90	RRheault	Roseann Rheault	RRheault@gatewayshospital.org	7470b	A			NULL
91	JBosque	Julie Bosque	JBosque@gatewayshospital.org	7671A	A			NULL
92	LGoff	La Sheia Goff	LGoff@gatewayshospital.org	6757	A			NULL
93	hlevy	Hayley Levy	hlevy@ssgmain.org	7187	A			NULL
94	mshpall	Mariana Shpall	mshpall@lacgc.org	7276	A			NULL
95	lheisen	Linda Heisen	LHeisen@heritageclinic.org	7430M	A			NULL
99	andreagonzalez	Andie Gonzalez	andreagonzalez@hathaway-sycamores.org	7278	A			NULL
100	clarin	Cecelia Larin	clarin@childrensinstitute.org	7780	A			NULL
101	cnava	Camilia Nava	cnava@childrensinstitute.org	7817A	A			NULL
102	cbolanos	Christina Bolanos	cbolanos@hillsides.org	7645	A			NULL
104	jgonzalez	Jose Gonzalez	jgonzalez@pedcenter.org	7582	A			NULL
105	Tufia	Tufia Steidl BH	tsteidl@ehrs.com	7472	A			NULL
106	trodriguez	Tiffany Rodriguez	trodriguez@lacgc.org	7265	A			NULL
107	lkheisen	Linda K. Heisen	lheisen@heritageclinic.org	7785	A			NULL
109	aassatourian	Anahid Assatourian	aassatourian@dmh.lacounty.gov	550	A			NULL
110	kto	Kary To	kto@dmh.lacounty.gov	550	A			NULL
111	Leimert Park	Andrew Kurtz	andrewk@lacgc.org	7276	A			NULL
112	kpaulino	Katrina Paulino	KPaulino@paralosninos.org	7546	A			NULL
113	oakwood	Martin Ribeiro Oakwood	MartinRibeiro@all4kids.org	7300	A	Martin	Ribeiro	NULL
114	Magnolia	Martin Ribeiro Magnolia	MartinRibeiro@all4kids.org]	7782	A	Martin	Ribeiro	NULL
115	ilopez	Irene M. Lopez	ilopez@childrensinstitute.org	7817A	A			NULL
116	cwhite	Cherise White	cwhite@avivacenter.org	7268	A			NULL
117	tarmstrong	Teresa Armstrong	tarmstrong@avivacenter.org	7494	A			NULL
118	vsalazar2121	Veronica Salazar_1221	vsalazar@childrensinstitute.org	7817A	A			NULL
119	vsalazar679	Veronica Salazar_679	vsalazar@childrensinstitute.org	7780	A			NULL
121	lincoln	Mona Sosa	msosa@dhs-inc.org	7520	A			NULL
122	hollywood	Mona Sosa Hollywood	msosa@bhs-inc.org	7521	A			NULL
123	fchargualaf	Frank Chargualaf	fchargualaf@ccsla.org	7104	A			NULL
124	mzelman	Michael Zelman, Psy.D.	mzelman@ehrs.com	7255	A			NULL
125	mzelman1	Michael Zelman, Psy.D.	mzelman@ehrs.com	7255	A			NULL
127	anahid	Anahid Assatourian	aassatourian@dmh.lacounty.gov		A			NULL
128	rmaybin	Roni Maybin	rmaybin@starsinc.com	1557A	A			NULL

VANS Service History

TBL_ID	Provider_ID	Program_ID	Age_Code	Openings	upDated	User_ID
50	7546	8	C	2	4/4/13 3:18 PM	gpara
51	7546	30	C	2	4/4/13 3:18 PM	gpara
52	7546	30	T	2	4/4/13 3:18 PM	gpara
53	7202	45	O	0	4/8/13 4:45 PM	leahc
54	7312	30	C	0	4/10/13 2:02 PM	lynettagore
55	7312	30	T	0	4/10/13 2:02 PM	lynettagore
56	7262	44	A	0	4/18/13 10:26 AM	marechiga
57	7262	44	O	0	4/18/13 10:26 AM	marechiga
58	7262	41	A	0	4/18/13 10:26 AM	marechiga
59	7262	41	O	0	4/18/13 10:26 AM	marechiga
60	1982	20	C	0	4/18/13 12:20 PM	mpelsman
61	1982	20	T	0	4/18/13 12:20 PM	mpelsman
62	1982	5	C	0	4/18/13 12:20 PM	mpelsman
63	1982	5	T	0	4/18/13 12:20 PM	mpelsman
64	1982	13	C	0	4/18/13 12:20 PM	mpelsman
65	1982	13	T	0	4/18/13 12:20 PM	mpelsman
66	1982	27	C	0	4/18/13 12:20 PM	mpelsman
67	1982	31	C	0	4/18/13 12:20 PM	mpelsman
68	1982	31	T	0	4/18/13 12:20 PM	mpelsman
69	1982	29	C	0	4/18/13 12:20 PM	mpelsman
70	7262	44	A	0	4/22/13 1:55 PM	marechiga
71	7278	62	C	0	4/26/13 10:14 AM	andreagonzalez
72	7278	62	T	0	4/26/13 10:14 AM	andreagonzalez
73	7278	59	C	0	4/26/13 10:14 AM	andreagonzalez
74	7278	10	C	0	4/26/13 10:14 AM	andreagonzalez
75	7278	10	T	0	4/26/13 10:14 AM	andreagonzalez
76	7278	46	C	1	4/26/13 10:14 AM	andreagonzalez
77	7278	44	C	0	4/26/13 10:14 AM	andreagonzalez
78	7278	41	C	0	4/26/13 10:14 AM	andreagonzalez
79	7278	16	C	0	4/26/13 10:14 AM	andreagonzalez
80	7278	34	C	0	4/26/13 10:14 AM	andreagonzalez
81	7693	9	O	1	4/26/13 1:49 PM	jblackburn
82	7693	44	O	0	4/26/13 1:49 PM	jblackburn
83	7693	56	A	0	4/26/13 1:49 PM	jblackburn
84	7693	55	C	2	4/26/13 1:49 PM	jblackburn
85	7693	55	O	2	4/26/13 1:49 PM	jblackburn
86	7693	55	T	2	4/26/13 1:49 PM	jblackburn
87	7693	15	O	1	4/26/13 1:49 PM	jblackburn
88	7693	21	A	0	4/26/13 1:49 PM	jblackburn
89	7693	21	O	1	4/26/13 1:49 PM	jblackburn
90	7693	26	O	1	4/26/13 1:49 PM	jblackburn
91	7693	29	O	1	4/26/13 1:49 PM	jblackburn
92	7278	27	C	0	4/26/13 2:16 PM	andreagonzalez
93	7278	31	C	2	4/26/13 2:16 PM	andreagonzalez
94	7278	29	C	0	4/26/13 2:16 PM	andreagonzalez
95	7278	29	T	0	4/26/13 2:16 PM	andreagonzalez
96	7278	30	C	2	4/26/13 2:16 PM	andreagonzalez
97	7278	30	T	1	4/26/13 2:16 PM	andreagonzalez
98	7278	27	C	0	4/26/13 2:17 PM	andreagonzalez
99	7278	31	C	2	4/26/13 2:17 PM	andreagonzalez
100	7278	29	C	0	4/26/13 2:17 PM	andreagonzalez
101	7278	29	T	0	4/26/13 2:17 PM	andreagonzalez
102	7278	30	T	1	4/26/13 2:17 PM	andreagonzalez
103	7278	30	C	2	4/26/13 2:17 PM	andreagonzalez
104	7255	48	A	0	4/29/13 10:34 AM	tsteidl
105	7255	48	O	0	4/29/13 10:34 AM	tsteidl
106	7255	48	T	0	4/29/13 10:34 AM	tsteidl
107	7255	9	A	0	4/29/13 10:34 AM	tsteidl
108	7255	9	O	2	4/29/13 10:34 AM	tsteidl
109	7255	9	T	0	4/29/13 10:34 AM	tsteidl
110	7255	44	A	0	4/29/13 10:34 AM	tsteidl
111	7255	44	O	0	4/29/13 10:34 AM	tsteidl
112	7255	44	T	0	4/29/13 10:34 AM	tsteidl
113	7255	41	A	0	4/29/13 10:34 AM	tsteidl
114	9999999	1	C	1	4/29/13 10:59 AM	VJoshi
115	9999999	1	T	2	4/29/13 10:59 AM	VJoshi
116	9999999	33	C	0	4/29/13 10:59 AM	VJoshi
117	9999999	33	O	2	4/29/13 10:59 AM	VJoshi
118	9999999	33	T	2	4/29/13 10:59 AM	VJoshi
119	9999999	33	A	3	4/29/13 10:59 AM	VJoshi
120	9999999	65	O	0	4/29/13 10:59 AM	VJoshi
121	9999999	65	T	0	4/29/13 10:59 AM	VJoshi
122	9999999	2	O	0	4/29/13 10:59 AM	VJoshi
123	9999999	2	T	1	4/29/13 10:59 AM	VJoshi
124	7581	34	C	0	4/29/13 11:20 AM	rzaragoza
125	7581	34	T	0	4/29/13 11:20 AM	rzaragoza
126	7581	29	C	20	4/29/13 11:20 AM	rzaragoza
127	7581	29	T	20	4/29/13 11:20 AM	rzaragoza

128	7581	30	C	15	4/29/13 11:20 AM	rzaragoza
129	7581	30	T	15	4/29/13 11:20 AM	rzaragoza
130	7581	34	C	0	5/6/13 3:50 PM	rzaragoza
131	7581	34	T	0	5/6/13 3:50 PM	rzaragoza
132	7581	29	C	17	5/6/13 3:50 PM	rzaragoza
133	7581	29	T	17	5/6/13 3:50 PM	rzaragoza
134	7581	30	C	7	5/6/13 3:50 PM	rzaragoza
135	7581	30	T	7	5/6/13 3:50 PM	rzaragoza
136	7581	34	C	0	5/6/13 3:50 PM	rzaragoza
137	7581	34	T	0	5/6/13 3:50 PM	rzaragoza
138	7581	29	C	17	5/6/13 3:50 PM	rzaragoza
139	7581	29	T	17	5/6/13 3:50 PM	rzaragoza
140	7581	30	C	7	5/6/13 3:50 PM	rzaragoza
141	7581	30	T	7	5/6/13 3:50 PM	rzaragoza
142	7265	8	C	0	5/13/13 12:34 PM	trodriguez
143	7265	58	C	0	5/13/13 12:34 PM	trodriguez
144	7265	48	C	0	5/13/13 12:34 PM	trodriguez
145	7265	48	T	0	5/13/13 12:34 PM	trodriguez
146	7265	42	C	0	5/13/13 12:34 PM	trodriguez
147	7265	42	T	0	5/13/13 12:34 PM	trodriguez
148	7265	46	C	0	5/13/13 12:34 PM	trodriguez
149	7265	44	C	0	5/13/13 12:34 PM	trodriguez
150	7265	44	T	0	5/13/13 12:34 PM	trodriguez
151	7265	41	C	0	5/13/13 12:34 PM	trodriguez
152	7785	9	A	0	5/13/13 3:14 PM	lkheisen
153	7785	9	O	0	5/13/13 3:14 PM	lkheisen
154	7785	15	A	0	5/13/13 3:14 PM	lkheisen
155	7785	15	O	0	5/13/13 3:14 PM	lkheisen
156	7785	21	A	0	5/13/13 3:14 PM	lkheisen
157	7785	21	O	0	5/13/13 3:14 PM	lkheisen
158	7785	26	A	0	5/13/13 3:14 PM	lkheisen
159	7785	26	O	0	5/13/13 3:14 PM	lkheisen
160	7785	29	A	0	5/13/13 3:14 PM	lkheisen
161	7785	29	O	0	5/13/13 3:14 PM	lkheisen
162	7776	9	T	0	5/15/13 10:17 AM	marymartone
163	7776	29	C	0	5/15/13 10:17 AM	marymartone
164	7776	29	T	0	5/15/13 10:17 AM	marymartone
165	7776	30	C	1	5/15/13 10:17 AM	marymartone
166	7776	30	T	0	5/15/13 10:17 AM	marymartone
167	7106	56	A	50	5/15/13 1:48 PM	vgrey
168	7619	44	A	10	5/16/13 10:38 PM	angela
169	7619	41	A	5	5/16/13 10:38 PM	angela
170	7619	15	A	0	5/16/13 10:38 PM	angela
171	7619	21	A	0	5/16/13 10:38 PM	angela
172	7619	29	A	0	5/16/13 10:38 PM	angela
173	7328	5	C	0	5/17/13 2:38 PM	vsalazar
174	7328	5	T	0	5/17/13 2:38 PM	vsalazar
175	7328	8	C	3	5/17/13 2:38 PM	vsalazar
176	7328	8	T	0	5/17/13 2:38 PM	vsalazar
177	7328	12	C	0	5/17/13 2:38 PM	vsalazar
178	7328	12	T	0	5/17/13 2:38 PM	vsalazar
179	7328	16	C	0	5/17/13 2:38 PM	vsalazar
180	7328	27	C	3	5/17/13 2:38 PM	vsalazar
181	7328	30	C	0	5/17/13 2:38 PM	vsalazar
182	7328	30	T	0	5/17/13 2:38 PM	vsalazar
183	7581	34	C	0	5/21/13 2:54 PM	rzaragoza
184	7581	34	T	0	5/21/13 2:54 PM	rzaragoza
185	7581	29	C	0	5/21/13 2:54 PM	rzaragoza
186	7581	29	T	0	5/21/13 2:54 PM	rzaragoza
187	7581	30	C	0	5/21/13 2:54 PM	rzaragoza
188	7581	30	T	0	5/21/13 2:54 PM	rzaragoza
189	7268	4	C	0	5/21/13 3:31 PM	lleach
190	7268	12	C	0	5/21/13 3:31 PM	lleach
191	7268	12	T	1	5/21/13 3:31 PM	lleach
192	7268	29	C	0	5/21/13 3:31 PM	lleach
193	7268	29	T	1	5/21/13 3:31 PM	lleach
194	7268	30	C	0	5/21/13 3:31 PM	lleach
195	7268	30	T	1	5/21/13 3:31 PM	lleach
196	7359	30	T	5	5/25/13 4:26 PM	asanchez
197	7359	30	T	5	5/25/13 4:26 PM	asanchez
198	7582	31	T	2	5/29/13 11:16 AM	jgonzalez
199	7582	29	C	0	5/29/13 11:16 AM	jgonzalez
200	7582	29	T	10	5/29/13 11:16 AM	jgonzalez
201	7582	30	C	10	5/29/13 11:16 AM	jgonzalez
202	7582	30	T	10	5/29/13 11:16 AM	jgonzalez
203	7582	31	T	2	5/29/13 11:16 AM	jgonzalez
204	7582	29	C	0	5/29/13 11:16 AM	jgonzalez
205	7582	29	T	10	5/29/13 11:16 AM	jgonzalez
206	7582	30	C	10	5/29/13 11:16 AM	jgonzalez
207	7582	30	T	10	5/29/13 11:16 AM	jgonzalez
208	7582	48	A	0	5/29/13 11:17 AM	jgonzalez
209	7582	48	C	0	5/29/13 11:17 AM	jgonzalez

210	7582	48	T	0	5/29/13 11:17 AM	jgonzalez
211	7582	15	A	0	5/29/13 11:17 AM	jgonzalez
212	7582	15	T	0	5/29/13 11:17 AM	jgonzalez
213	7582	21	A	0	5/29/13 11:17 AM	jgonzalez
214	7582	21	T	0	5/29/13 11:17 AM	jgonzalez
215	7582	34	C	3	5/29/13 11:17 AM	jgonzalez
216	7582	34	T	3	5/29/13 11:17 AM	jgonzalez
217	7582	31	C	0	5/29/13 11:17 AM	jgonzalez
218	7582	48	A	0	5/29/13 11:17 AM	jgonzalez
219	7582	48	C	0	5/29/13 11:17 AM	jgonzalez
220	7582	48	T	0	5/29/13 11:17 AM	jgonzalez
221	7582	15	A	0	5/29/13 11:17 AM	jgonzalez
222	7582	15	T	0	5/29/13 11:17 AM	jgonzalez
223	7582	21	A	0	5/29/13 11:17 AM	jgonzalez
224	7582	21	T	0	5/29/13 11:17 AM	jgonzalez
225	7582	34	C	3	5/29/13 11:17 AM	jgonzalez
226	7582	34	T	3	5/29/13 11:17 AM	jgonzalez
227	7582	31	C	2	5/29/13 11:17 AM	jgonzalez
228	7582	31	T	5	5/29/13 11:17 AM	jgonzalez
229	7582	29	C	0	5/29/13 11:17 AM	jgonzalez
230	7582	29	T	10	5/29/13 11:17 AM	jgonzalez
231	7582	30	C	10	5/29/13 11:17 AM	jgonzalez
232	7582	30	T	10	5/29/13 11:17 AM	jgonzalez
233	7582	31	T	5	5/29/13 11:17 AM	jgonzalez
234	7582	29	C	0	5/29/13 11:17 AM	jgonzalez
235	7582	29	T	10	5/29/13 11:17 AM	jgonzalez
236	7582	30	C	10	5/29/13 11:17 AM	jgonzalez
237	7582	30	T	10	5/29/13 11:17 AM	jgonzalez
238	7582	31	T	5	5/29/13 11:17 AM	jgonzalez
239	7582	29	C	0	5/29/13 11:17 AM	jgonzalez
240	7582	29	T	10	5/29/13 11:17 AM	jgonzalez
241	7582	30	C	10	5/29/13 11:17 AM	jgonzalez
242	7582	30	T	10	5/29/13 11:17 AM	jgonzalez
243	7582	48	A	3	5/29/13 11:24 AM	jgonzalez
245	7582	48	T	28	5/29/13 11:24 AM	jgonzalez
246	7582	15	A	0	5/29/13 11:24 AM	jgonzalez
247	7582	15	T	0	5/29/13 11:24 AM	jgonzalez
248	7582	21	A	0	5/29/13 11:24 AM	jgonzalez
249	7582	21	T	0	5/29/13 11:24 AM	jgonzalez
250	7582	34	C	3	5/29/13 11:24 AM	jgonzalez
251	7582	34	T	3	5/29/13 11:24 AM	jgonzalez
252	7582	31	C	2	5/29/13 11:24 AM	jgonzalez
244	7582	48	C	15	5/29/13 11:24 AM	jgonzalez
253	7472	48	T	10	6/14/13 4:03 PM	Tufia
254	7472	44	T	10	6/14/13 4:03 PM	Tufia
255	7472	34	T	5	6/14/13 4:03 PM	Tufia
256	7472	31	T	8	6/14/13 4:03 PM	Tufia
257	7472	29	T	5	6/14/13 4:03 PM	Tufia
258	7472	30	T	5	6/14/13 4:03 PM	Tufia
259	7582	48	A	3	7/9/13 11:41 AM	jgonzalez
260	7582	48	C	15	7/9/13 11:41 AM	jgonzalez
261	7582	48	T	28	7/9/13 11:41 AM	jgonzalez
262	7582	15	A	0	7/9/13 11:41 AM	jgonzalez
263	7582	15	T	0	7/9/13 11:41 AM	jgonzalez
264	7582	21	A	0	7/9/13 11:41 AM	jgonzalez
265	7582	21	T	0	7/9/13 11:41 AM	jgonzalez
266	7582	34	C	15	7/9/13 11:41 AM	jgonzalez
267	7582	34	T	15	7/9/13 11:41 AM	jgonzalez
268	7582	31	C	15	7/9/13 11:41 AM	jgonzalez
269	7582	48	A	3	7/9/13 11:41 AM	jgonzalez
270	7582	48	C	15	7/9/13 11:41 AM	jgonzalez
271	7582	48	T	28	7/9/13 11:41 AM	jgonzalez
272	7582	15	A	0	7/9/13 11:41 AM	jgonzalez
273	7582	15	T	0	7/9/13 11:41 AM	jgonzalez
274	7582	21	A	0	7/9/13 11:41 AM	jgonzalez
275	7582	21	T	0	7/9/13 11:41 AM	jgonzalez
276	7582	34	C	15	7/9/13 11:41 AM	jgonzalez
277	7582	34	T	15	7/9/13 11:41 AM	jgonzalez
278	7582	31	T	15	7/9/13 11:41 AM	jgonzalez
279	7582	31	T	15	7/9/13 11:41 AM	jgonzalez
280	7582	29	A	0	7/9/13 11:41 AM	jgonzalez
281	7582	29	T	5	7/9/13 11:41 AM	jgonzalez
282	7582	30	C	10	7/9/13 11:41 AM	jgonzalez
283	7582	30	T	10	7/9/13 11:41 AM	jgonzalez
284	7582	48	A	3	7/9/13 11:42 AM	jgonzalez
285	7582	48	C	15	7/9/13 11:42 AM	jgonzalez
286	7582	48	T	28	7/9/13 11:42 AM	jgonzalez
287	7582	15	A	0	7/9/13 11:42 AM	jgonzalez
288	7582	15	T	0	7/9/13 11:42 AM	jgonzalez
289	7582	21	A	0	7/9/13 11:42 AM	jgonzalez
290	7582	21	T	0	7/9/13 11:42 AM	jgonzalez
291	7582	34	C	10	7/9/13 11:42 AM	jgonzalez

292	7582	34	T	10	7/9/13 11:42 AM	jgonzalez
293	7582	31	C	10	7/9/13 11:42 AM	jgonzalez
294	7582	48	A	3	7/9/13 11:43 AM	jgonzalez
295	7582	48	C	15	7/9/13 11:43 AM	jgonzalez
296	7582	48	T	28	7/9/13 11:43 AM	jgonzalez
297	7582	15	A	0	7/9/13 11:43 AM	jgonzalez
298	7582	15	T	0	7/9/13 11:43 AM	jgonzalez
299	7582	21	A	0	7/9/13 11:43 AM	jgonzalez
300	7582	21	T	0	7/9/13 11:43 AM	jgonzalez
301	7582	34	C	10	7/9/13 11:43 AM	jgonzalez
302	7582	34	T	10	7/9/13 11:43 AM	jgonzalez
303	7582	31	C	10	7/9/13 11:43 AM	jgonzalez
304	7582	48	A	10	7/9/13 11:44 AM	jgonzalez
305	7582	48	C	10	7/9/13 11:44 AM	jgonzalez
306	7582	48	T	5	7/9/13 11:44 AM	jgonzalez
307	7582	15	A	0	7/9/13 11:44 AM	jgonzalez
308	7582	15	T	0	7/9/13 11:44 AM	jgonzalez
309	7582	21	A	0	7/9/13 11:44 AM	jgonzalez
310	7582	21	T	0	7/9/13 11:44 AM	jgonzalez
311	7582	34	C	10	7/9/13 11:44 AM	jgonzalez
312	7582	34	T	10	7/9/13 11:44 AM	jgonzalez
313	7582	31	C	10	7/9/13 11:44 AM	jgonzalez
314	7328	5	C	0	7/10/13 1:02 PM	vsalazar
315	7328	5	T	0	7/10/13 1:02 PM	vsalazar
316	7328	8	T	0	7/10/13 1:02 PM	vsalazar
317	7328	8	C	0	7/10/13 1:02 PM	vsalazar
318	7328	12	C	0	7/10/13 1:02 PM	vsalazar
319	7328	12	T	0	7/10/13 1:02 PM	vsalazar
320	7328	16	C	0	7/10/13 1:02 PM	vsalazar
321	7328	27	C	0	7/10/13 1:02 PM	vsalazar
322	7328	30	C	0	7/10/13 1:02 PM	vsalazar
323	7328	30	T	0	7/10/13 1:02 PM	vsalazar
324	7581	34	C	10	7/11/13 4:06 PM	rzaragoza
325	7581	34	T	10	7/11/13 4:06 PM	rzaragoza
326	7581	29	C	10	7/11/13 4:06 PM	rzaragoza
327	7581	29	T	10	7/11/13 4:06 PM	rzaragoza
328	7581	30	C	10	7/11/13 4:06 PM	rzaragoza
329	7581	30	T	10	7/11/13 4:06 PM	rzaragoza
330	7278	27	C	8	7/12/13 11:36 AM	andreagonzalez
331	7278	31	C	2	7/12/13 11:36 AM	andreagonzalez
332	7278	29	C	0	7/12/13 11:36 AM	andreagonzalez
333	7278	29	T	0	7/12/13 11:36 AM	andreagonzalez
334	7278	30	T	1	7/12/13 11:36 AM	andreagonzalez
335	7278	30	C	2	7/12/13 11:36 AM	andreagonzalez
336	7312	30	C	3	7/16/13 3:59 PM	lynettagore
337	7312	30	T	3	7/16/13 3:59 PM	lynettagore
338	7312	30	C	3	7/16/13 3:59 PM	lynettagore
339	7312	30	T	3	7/16/13 3:59 PM	lynettagore
340	7312	30	C	3	7/16/13 3:59 PM	lynettagore
341	7312	30	T	3	7/16/13 3:59 PM	lynettagore
342	7312	30	C	3	7/16/13 4:00 PM	lynettagore
343	7312	30	T	3	7/16/13 4:00 PM	lynettagore
344	7312	30	C	0	7/17/13 3:10 PM	lynettagore
345	7312	30	T	3	7/17/13 3:10 PM	lynettagore
346	7278	62	C	0	7/18/13 5:01 PM	andreagonzalez
348	7278	59	C	95	7/18/13 5:01 PM	andreagonzalez
349	7278	10	C	0	7/18/13 5:01 PM	andreagonzalez
350	7278	10	T	0	7/18/13 5:01 PM	andreagonzalez
351	7278	46	C	2	7/18/13 5:01 PM	andreagonzalez
352	7278	44	C	603	7/18/13 5:01 PM	andreagonzalez
353	7278	41	C	2	7/18/13 5:01 PM	andreagonzalez
354	7278	16	C	10	7/18/13 5:01 PM	andreagonzalez
355	7278	34	C	342	7/18/13 5:01 PM	andreagonzalez
347	7278	62	T	0	7/18/13 5:01 PM	andreagonzalez
356	7278	27	C	10	7/18/13 5:01 PM	andreagonzalez
357	7278	31	C	20	7/18/13 5:01 PM	andreagonzalez
358	7278	29	C	0	7/18/13 5:01 PM	andreagonzalez
359	7278	29	T	0	7/18/13 5:01 PM	andreagonzalez
360	7278	27	C	10	7/18/13 5:39 PM	andreagonzalez
361	7278	31	C	20	7/18/13 5:39 PM	andreagonzalez
362	7749	58	C	0	7/19/13 8:28 AM	dfarah
363	7749	14	C	0	7/19/13 8:28 AM	dfarah
364	7749	34	C	2	7/19/13 8:28 AM	dfarah
365	7749	27	C	2	7/19/13 8:28 AM	dfarah
366	7749	30	C	0	7/19/13 8:28 AM	dfarah
367	7359	30	T	0	7/22/13 1:50 PM	asanchez
368	7104	9	O	0	7/24/13 4:49 PM	glo
369	7104	14	O	0	7/24/13 4:49 PM	glo
370	7104	16	C	0	7/24/13 4:49 PM	glo
371	7104	21	A	0	7/24/13 4:49 PM	glo
372	7104	21	O	0	7/24/13 4:49 PM	glo
373	7104	26	O	0	7/24/13 4:49 PM	glo

374	7104	29	A	0	7/24/13 4:49 PM	glo
375	7104	29	C	0	7/24/13 4:49 PM	glo
376	7104	29	T	0	7/24/13 4:49 PM	glo
377	7104	30	C	0	7/24/13 4:49 PM	glo
378	7255	48	A	4	7/31/13 2:43 PM	mzelman
379	7255	48	O	1	7/31/13 2:43 PM	mzelman
380	7255	48	T	2	7/31/13 2:43 PM	mzelman
381	7255	9	A	0	7/31/13 2:43 PM	mzelman
382	7255	9	T	0	7/31/13 2:43 PM	mzelman
383	7255	9	O	2	7/31/13 2:43 PM	mzelman
384	7255	44	A	2	7/31/13 2:43 PM	mzelman
385	7255	44	O	0	7/31/13 2:43 PM	mzelman
386	7255	44	T	2	7/31/13 2:43 PM	mzelman
387	7255	41	A	0	7/31/13 2:43 PM	mzelman
388	7780	12	C	0	8/1/13 4:12 PM	cnava
389	7780	12	T	0	8/1/13 4:12 PM	cnava
390	7780	30	C	0	8/1/13 4:12 PM	cnava
391	7780	30	T	0	8/1/13 4:12 PM	cnava
392	7581	34	C	10	8/5/13 1:51 PM	rzaragoza
393	7581	34	T	10	8/5/13 1:51 PM	rzaragoza
394	7581	29	C	14	8/5/13 1:51 PM	rzaragoza
395	7581	29	T	14	8/5/13 1:51 PM	rzaragoza
396	7581	30	C	12	8/5/13 1:51 PM	rzaragoza
397	7581	30	T	12	8/5/13 1:51 PM	rzaragoza
398	7780	12	C	0	8/6/13 10:38 AM	cnava
399	7780	12	T	0	8/6/13 10:38 AM	cnava
400	7780	30	C	0	8/6/13 10:38 AM	cnava
401	7780	30	T	0	8/6/13 10:38 AM	cnava
402	7780	12	C	0	8/6/13 10:40 AM	cnava
403	7780	12	T	0	8/6/13 10:40 AM	cnava
404	7780	30	C	0	8/6/13 10:40 AM	cnava
405	7780	30	T	0	8/6/13 10:40 AM	cnava
406	7268	58	C	0	8/6/13 12:45 PM	lleach
407	7268	12	C	1	8/6/13 12:45 PM	lleach
408	7268	12	T	1	8/6/13 12:45 PM	lleach
409	7268	34	C	0	8/6/13 12:45 PM	lleach
410	7268	34	T	0	8/6/13 12:45 PM	lleach
411	7268	29	C	0	8/6/13 12:45 PM	lleach
412	7268	29	T	3	8/6/13 12:45 PM	lleach
413	7268	30	C	0	8/6/13 12:45 PM	lleach
414	7268	30	T	1	8/6/13 12:45 PM	lleach
415	7749	58	C	0	8/12/13 10:48 AM	dfarah
416	7749	44	C	0	8/12/13 10:48 AM	dfarah
417	7749	14	C	0	8/12/13 10:48 AM	dfarah
418	7749	34	C	2	8/12/13 10:48 AM	dfarah
419	7749	27	C	2	8/12/13 10:48 AM	dfarah
420	7749	29	C	0	8/12/13 10:48 AM	dfarah
421	7749	53	C	0	8/12/13 10:48 AM	dfarah
422	7749	67	C	0	8/12/13 10:48 AM	dfarah
423	7749	58	C	0	8/12/13 10:49 AM	dfarah
424	7749	44	C	0	8/12/13 10:49 AM	dfarah
425	7749	14	C	0	8/12/13 10:49 AM	dfarah
426	7749	34	C	2	8/12/13 10:49 AM	dfarah
427	7749	27	C	2	8/12/13 10:49 AM	dfarah
428	7749	29	C	2	8/12/13 10:49 AM	dfarah
429	7749	53	C	0	8/12/13 10:49 AM	dfarah
430	7749	67	C	0	8/12/13 10:49 AM	dfarah
431	7268	58	C	0	8/19/13 3:20 PM	cwhite
432	7268	12	C	1	8/19/13 3:20 PM	cwhite
433	7268	12	T	2	8/19/13 3:20 PM	cwhite
434	7268	34	C	0	8/19/13 3:20 PM	cwhite
435	7268	34	T	0	8/19/13 3:20 PM	cwhite
436	7268	29	C	0	8/19/13 3:20 PM	cwhite
437	7268	29	T	0	8/19/13 3:20 PM	cwhite
438	7268	30	C	0	8/19/13 3:20 PM	cwhite
439	7268	30	T	0	8/19/13 3:20 PM	cwhite
440	7268	58	C	0	8/19/13 3:20 PM	cwhite
441	7268	12	C	1	8/19/13 3:20 PM	cwhite
442	7268	12	T	2	8/19/13 3:20 PM	cwhite
443	7268	34	C	0	8/19/13 3:20 PM	cwhite
444	7268	34	T	0	8/19/13 3:20 PM	cwhite
445	7268	29	C	0	8/19/13 3:20 PM	cwhite
446	7268	29	T	0	8/19/13 3:20 PM	cwhite
447	7268	30	C	0	8/19/13 3:20 PM	cwhite
448	7268	30	T	0	8/19/13 3:20 PM	cwhite
449	7262	44	A	0	8/22/13 2:40 PM	marechiga
450	7262	41	A	8	8/22/13 2:40 PM	marechiga
451	7278	62	C	0	8/26/13 4:44 PM	andreagonzalez
452	7278	62	T	0	8/26/13 4:44 PM	andreagonzalez
453	7278	59	C	7	8/26/13 4:44 PM	andreagonzalez
454	7278	10	C	0	8/26/13 4:44 PM	andreagonzalez
455	7278	10	T	0	8/26/13 4:44 PM	andreagonzalez

456	7278	46	C	20	8/26/13 4:44 PM	andreagonzalez
457	7278	44	C	39	8/26/13 4:44 PM	andreagonzalez
458	7278	41	C	1	8/26/13 4:44 PM	andreagonzalez
459	7278	16	C	7	8/26/13 4:44 PM	andreagonzalez
460	7278	34	C	7	8/26/13 4:44 PM	andreagonzalez
461	7278	62	C	0	8/26/13 4:45 PM	andreagonzalez
462	7278	62	T	0	8/26/13 4:45 PM	andreagonzalez
463	7278	59	C	7	8/26/13 4:45 PM	andreagonzalez
464	7278	10	C	0	8/26/13 4:45 PM	andreagonzalez
465	7278	10	T	0	8/26/13 4:45 PM	andreagonzalez
466	7278	46	C	20	8/26/13 4:45 PM	andreagonzalez
467	7278	44	C	39	8/26/13 4:45 PM	andreagonzalez
468	7278	41	C	1	8/26/13 4:45 PM	andreagonzalez
469	7278	16	C	7	8/26/13 4:45 PM	andreagonzalez
470	7278	34	C	7	8/26/13 4:45 PM	andreagonzalez
471	7278	27	C	6	8/26/13 4:45 PM	andreagonzalez
472	7278	31	C	7	8/26/13 4:45 PM	andreagonzalez
473	7278	29	C	0	8/26/13 4:45 PM	andreagonzalez
474	7278	29	T	0	8/26/13 4:45 PM	andreagonzalez
475	7278	30	T	0	8/26/13 4:45 PM	andreagonzalez
476	7278	30	C	1	8/26/13 4:45 PM	andreagonzalez
477	7278	27	C	6	8/26/13 4:46 PM	andreagonzalez
478	7278	31	C	7	8/26/13 4:46 PM	andreagonzalez
479	7278	29	C	0	8/26/13 4:46 PM	andreagonzalez
480	7278	29	T	0	8/26/13 4:46 PM	andreagonzalez
481	7278	30	T	0	8/26/13 4:46 PM	andreagonzalez
482	7278	30	C	1	8/26/13 4:46 PM	andreagonzalez
483	7202	45	O	0	8/28/13 1:14 PM	leahc
484	7581	34	C	3	8/30/13 2:56 PM	rzaragoza
485	7581	34	T	3	8/30/13 2:56 PM	rzaragoza
486	7581	29	C	10	8/30/13 2:56 PM	rzaragoza
487	7581	29	T	10	8/30/13 2:56 PM	rzaragoza
488	7581	30	C	0	8/30/13 2:56 PM	rzaragoza
489	7581	30	T	0	8/30/13 2:56 PM	rzaragoza
490	7581	34	C	12	8/30/13 6:43 PM	rzaragoza
491	7581	34	T	12	8/30/13 6:43 PM	rzaragoza
492	7581	29	C	14	8/30/13 6:43 PM	rzaragoza
493	7581	29	T	14	8/30/13 6:43 PM	rzaragoza
494	7581	30	C	10	8/30/13 6:43 PM	rzaragoza
495	7581	30	T	10	8/30/13 6:43 PM	rzaragoza
496	7520	48	C	7	9/4/13 9:43 AM	lincoln
497	7520	48	T	7	9/4/13 9:43 AM	lincoln
498	7520	30	C	5	9/4/13 9:43 AM	lincoln
499	7520	30	T	5	9/4/13 9:43 AM	lincoln
500	7520	48	C	7	9/4/13 9:47 AM	lincoln
501	7520	48	T	7	9/4/13 9:47 AM	lincoln
502	7520	30	C	5	9/4/13 9:47 AM	lincoln
503	7520	30	T	5	9/4/13 9:47 AM	lincoln
504	7521	48	A	5	9/4/13 9:50 AM	hollywood
505	7521	44	A	5	9/4/13 9:50 AM	hollywood
506	7521	57	A	5	9/4/13 9:50 AM	hollywood
507	7521	48	A	5	9/4/13 9:55 AM	hollywood
508	7521	44	A	5	9/4/13 9:55 AM	hollywood
509	7521	57	A	5	9/4/13 9:55 AM	hollywood
510	6870	48	C	10	9/4/13 10:39 AM	andrewk@lacgc.org
511	6870	48	T	10	9/4/13 10:39 AM	andrewk@lacgc.org
512	6870	42	C	0	9/4/13 10:39 AM	andrewk@lacgc.org
513	6870	42	T	0	9/4/13 10:39 AM	andrewk@lacgc.org
514	6870	46	C	5	9/4/13 10:39 AM	andrewk@lacgc.org
515	6870	46	T	5	9/4/13 10:39 AM	andrewk@lacgc.org
516	6870	44	C	0	9/4/13 10:39 AM	andrewk@lacgc.org
517	6870	44	T	0	9/4/13 10:39 AM	andrewk@lacgc.org
518	6870	41	C	0	9/4/13 10:39 AM	andrewk@lacgc.org
519	6870	41	T	0	9/4/13 10:39 AM	andrewk@lacgc.org
520	6870	30	C	4	9/4/13 10:42 AM	andrewk@lacgc.org
521	6870	30	T	4	9/4/13 10:42 AM	andrewk@lacgc.org
522	6870	38	C	0	9/4/13 10:42 AM	andrewk@lacgc.org
523	6870	38	T	0	9/4/13 10:42 AM	andrewk@lacgc.org
524	7276	34	C	1	9/4/13 10:44 AM	Leimert Park
525	7276	34	T	0	9/4/13 10:44 AM	Leimert Park
526	7276	31	T	0	9/4/13 10:44 AM	Leimert Park
527	7276	29	C	1	9/4/13 10:44 AM	Leimert Park
528	7276	29	T	1	9/4/13 10:44 AM	Leimert Park
529	7276	53	C	0	9/4/13 10:44 AM	Leimert Park
530	7276	53	T	0	9/4/13 10:44 AM	Leimert Park
531	7276	30	T	2	9/4/13 10:44 AM	Leimert Park
532	7276	30	C	2	9/4/13 10:44 AM	Leimert Park
533	7276	34	T	0	9/4/13 10:44 AM	Leimert Park
534	7276	34	C	1	9/4/13 10:44 AM	Leimert Park
535	7276	31	T	0	9/4/13 10:44 AM	Leimert Park
536	7276	29	C	1	9/4/13 10:44 AM	Leimert Park
537	7276	29	T	1	9/4/13 10:44 AM	Leimert Park

538	7276	53	C	0	9/4/13 10:44 AM	Leimert Park
539	7276	53	T	0	9/4/13 10:44 AM	Leimert Park
540	7276	30	T	1	9/4/13 10:44 AM	Leimert Park
541	7276	30	C	1	9/4/13 10:44 AM	Leimert Park
542	7265	41	T	0	9/4/13 10:45 AM	trodriguez
543	7265	55	C	0	9/4/13 10:45 AM	trodriguez
544	7265	27	C	0	9/4/13 10:45 AM	trodriguez
545	7265	31	C	1	9/4/13 10:45 AM	trodriguez
546	7265	41	T	0	9/4/13 10:45 AM	trodriguez
547	7265	55	C	0	9/4/13 10:45 AM	trodriguez
548	7265	27	C	0	9/4/13 10:45 AM	trodriguez
549	7265	31	C	1	9/4/13 10:45 AM	trodriguez
550	7265	8	C	0	9/4/13 10:46 AM	trodriguez
551	7265	58	C	2	9/4/13 10:46 AM	trodriguez
552	7265	48	C	15	9/4/13 10:46 AM	trodriguez
553	7265	48	T	0	9/4/13 10:46 AM	trodriguez
554	7265	42	C	0	9/4/13 10:46 AM	trodriguez
555	7265	42	T	0	9/4/13 10:46 AM	trodriguez
556	7265	46	C	0	9/4/13 10:46 AM	trodriguez
557	7265	44	C	0	9/4/13 10:46 AM	trodriguez
558	7265	44	T	0	9/4/13 10:46 AM	trodriguez
559	7265	41	C	0	9/4/13 10:46 AM	trodriguez
560	7265	41	T	0	9/4/13 10:46 AM	trodriguez
561	7265	55	C	0	9/4/13 10:46 AM	trodriguez
562	7265	27	C	0	9/4/13 10:46 AM	trodriguez
563	7265	31	T	0	9/4/13 10:46 AM	trodriguez
564	7265	31	C	1	9/4/13 10:46 AM	trodriguez
565	7265	53	C	0	9/4/13 10:46 AM	trodriguez
566	7265	53	T	0	9/4/13 10:46 AM	trodriguez
567	7268	58	C	1	9/4/13 1:59 PM	cwhite
568	7268	12	C	2	9/4/13 1:59 PM	cwhite
569	7268	12	T	2	9/4/13 1:59 PM	cwhite
570	7268	34	C	0	9/4/13 1:59 PM	cwhite
571	7268	34	T	1	9/4/13 1:59 PM	cwhite
572	7268	29	C	0	9/4/13 1:59 PM	cwhite
573	7268	29	T	1	9/4/13 1:59 PM	cwhite
574	7268	30	C	0	9/4/13 1:59 PM	cwhite
575	7268	30	T	1	9/4/13 1:59 PM	cwhite
576	7278	62	C	0	9/10/13 9:30 AM	andreagonzalez
577	7278	62	T	0	9/10/13 9:30 AM	andreagonzalez
578	7278	59	C	7	9/10/13 9:30 AM	andreagonzalez
579	7278	10	C	0	9/10/13 9:30 AM	andreagonzalez
580	7278	10	T	0	9/10/13 9:30 AM	andreagonzalez
581	7278	46	C	20	9/10/13 9:30 AM	andreagonzalez
582	7278	44	C	39	9/10/13 9:30 AM	andreagonzalez
583	7278	41	C	1	9/10/13 9:30 AM	andreagonzalez
584	7278	16	C	7	9/10/13 9:30 AM	andreagonzalez
585	7278	34	C	7	9/10/13 9:30 AM	andreagonzalez
586	7278	27	C	6	9/10/13 9:30 AM	andreagonzalez
587	7278	31	C	7	9/10/13 9:30 AM	andreagonzalez
588	7278	29	C	0	9/10/13 9:30 AM	andreagonzalez
589	7278	29	T	0	9/10/13 9:30 AM	andreagonzalez
590	7278	30	T	0	9/10/13 9:30 AM	andreagonzalez
591	7278	30	C	1	9/10/13 9:30 AM	andreagonzalez
592	7262	44	A	0	9/13/13 4:46 PM	marechiga
593	7262	41	A	0	9/13/13 4:46 PM	marechiga
594	7262	44	A	0	9/16/13 10:51 AM	marechiga
595	7262	41	A	10	9/16/13 10:51 AM	marechiga
596	7581	34	C	11	9/26/13 5:08 PM	rzaragoza
597	7581	34	T	11	9/26/13 5:08 PM	rzaragoza
598	7581	29	C	13	9/26/13 5:08 PM	rzaragoza
599	7581	29	T	13	9/26/13 5:08 PM	rzaragoza
600	7581	30	C	10	9/26/13 5:08 PM	rzaragoza
601	7581	30	T	10	9/26/13 5:08 PM	rzaragoza
602	7538	44	T	0	10/1/13 10:41 AM	lclifton
603	7538	41	C	0	10/1/13 10:41 AM	lclifton
604	7538	34	C	0	10/1/13 10:41 AM	lclifton
605	7538	34	T	0	10/1/13 10:41 AM	lclifton
606	7538	30	C	0	10/1/13 10:41 AM	lclifton
607	7538	30	T	0	10/1/13 10:41 AM	lclifton
608	7538	38	C	2	10/1/13 10:41 AM	lclifton
609	7538	38	T	2	10/1/13 10:41 AM	lclifton
610	7538	44	T	0	10/1/13 10:41 AM	lclifton
611	7538	41	C	0	10/1/13 10:41 AM	lclifton
612	7538	34	C	0	10/1/13 10:41 AM	lclifton
613	7538	34	T	0	10/1/13 10:41 AM	lclifton
614	7538	30	C	0	10/1/13 10:41 AM	lclifton
615	7538	30	T	0	10/1/13 10:41 AM	lclifton
616	7538	38	C	2	10/1/13 10:41 AM	lclifton
617	7538	38	T	2	10/1/13 10:41 AM	lclifton
618	7268	58	C	2	10/3/13 4:35 PM	cwhite
619	7268	12	C	2	10/3/13 4:35 PM	cwhite

620	7268	12	T	2	10/3/13 4:35 PM	cwhite
621	7268	34	C	0	10/3/13 4:35 PM	cwhite
622	7268	34	T	2	10/3/13 4:35 PM	cwhite
623	7268	29	C	0	10/3/13 4:35 PM	cwhite
624	7268	29	T	2	10/3/13 4:35 PM	cwhite
625	7268	30	C	0	10/3/13 4:35 PM	cwhite
626	7268	30	T	2	10/3/13 4:35 PM	cwhite
627	7268	58	C	2	10/3/13 4:36 PM	cwhite
628	7268	12	C	2	10/3/13 4:36 PM	cwhite
629	7268	12	T	2	10/3/13 4:36 PM	cwhite
630	7268	34	C	0	10/3/13 4:36 PM	cwhite
631	7268	34	T	2	10/3/13 4:36 PM	cwhite
632	7268	29	C	0	10/3/13 4:36 PM	cwhite
633	7268	29	T	2	10/3/13 4:36 PM	cwhite
634	7268	30	C	0	10/3/13 4:36 PM	cwhite
635	7268	30	T	2	10/3/13 4:36 PM	cwhite
636	7202	45	O	0	10/7/13 2:33 PM	leahc
637	7538	44	T	0	10/14/13 5:49 PM	lclifton
638	7538	41	C	0	10/14/13 5:49 PM	lclifton
639	7538	34	C	0	10/14/13 5:49 PM	lclifton
640	7538	34	T	0	10/14/13 5:49 PM	lclifton
641	7538	30	C	0	10/14/13 5:49 PM	lclifton
642	7538	30	T	0	10/14/13 5:49 PM	lclifton
643	7538	38	C	4	10/14/13 5:49 PM	lclifton
644	7538	38	T	4	10/14/13 5:49 PM	lclifton
645	7268	58	C	0	10/15/13 12:17 PM	cwhite
646	7268	12	C	0	10/15/13 12:17 PM	cwhite
647	7268	12	T	2	10/15/13 12:17 PM	cwhite
648	7268	34	C	0	10/15/13 12:17 PM	cwhite
649	7268	34	T	2	10/15/13 12:17 PM	cwhite
650	7268	29	C	0	10/15/13 12:17 PM	cwhite
651	7268	29	T	2	10/15/13 12:17 PM	cwhite
652	7268	30	C	0	10/15/13 12:17 PM	cwhite
653	7268	30	T	2	10/15/13 12:17 PM	cwhite
654	7538	44	T	0	10/18/13 9:58 AM	lclifton
655	7538	41	C	0	10/18/13 9:58 AM	lclifton
656	7538	34	C	0	10/18/13 9:58 AM	lclifton
657	7538	34	T	0	10/18/13 9:58 AM	lclifton
658	7538	30	C	0	10/18/13 9:58 AM	lclifton
659	7538	30	T	0	10/18/13 9:58 AM	lclifton
660	7538	38	C	4	10/18/13 9:58 AM	lclifton
661	7538	38	T	4	10/18/13 9:58 AM	lclifton
662	7581	34	C	10	10/21/13 12:59 PM	rzaragoza
663	7581	34	T	10	10/21/13 12:59 PM	rzaragoza
664	7581	29	C	13	10/21/13 12:59 PM	rzaragoza
665	7581	29	T	13	10/21/13 12:59 PM	rzaragoza
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667	7581	30	T	9	10/21/13 12:59 PM	rzaragoza
668	7278	62	C	0	10/28/13 1:14 PM	andreagonzalez
669	7278	62	T	0	10/28/13 1:14 PM	andreagonzalez
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678	7278	27	C	3	10/28/13 1:14 PM	andreagonzalez
679	7278	31	C	7	10/28/13 1:14 PM	andreagonzalez
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714	7278	59	C	7	11/15/13 9:08 AM	andreagonzalez
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738	7581	34	C	3	11/15/13 4:16 PM	rzaragoza
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748	7581	30	C	0	11/15/13 4:21 PM	rzaragoza
749	7581	30	T	6	11/15/13 4:21 PM	rzaragoza

Vacancy Report - Users Information

Number of Users with ID 24

User Name	User ID	Email Address	Status	Age Code	Opening	Last Update
Amanda Sanchez	asanchez	asanchez@didihirsch.org	A	T	0	5/25/13 4:26 PM
Provider ID	**7359**					
Andie Gonzalez	andreagonzalez	andreagonzalez@hathaway-sycamores.org	A	C	0	7/12/13 11:36 AM
Provider ID	**7278**					
Andrew Kurtz	andrewk@lacgc.or	andrewk@lacgc.org	A	C	0	9/4/13 10:39 AM
Provider ID	**6870**					
Provider ID	**7276**					
Angela Kang	angela	angela@ssgapialliance.org	A	A	0	5/16/13 10:38 PM
Provider ID	**7619**					
Camilia Nava	cnava	cnava@childrensinstitute.org	A	C	0	8/1/13 4:12 PM
Provider ID	**7817A**					
Cherise White	cwhite	cwhite@avivacenter.org	A	C	0	8/19/13 3:20 PM
Provider ID	**7268**					
Diane Farah	dfarah	dfarah@emqff.org	A	C	0	7/19/13 8:28 AM
Provider ID	**7749**					
Gwen Lo	glo	glo@amanecerla.org	A	A	0	7/24/13 4:49 PM
Provider ID	**7104**					
Jose Gonzalez	jgonzalez	jgonzalez@pedcenter.org	A	A	0	5/29/13 11:16 AM
Provider ID	**7582**					
Justin Blackburn	jblackburn	jblackburn@jfsla.org	A	A	0	4/26/13 1:49 PM
Provider ID	**7693**					
Leah Carroll	leahc	leahc@lampcommunity.org	A	O	0	10/7/13 2:33 PM
Provider ID	**7202**					
Linda K. Heisen	lkheisen	lheisen@heritageclinic.org	A	A	0	5/13/13 3:14 PM
Provider ID	**7785**					
Lisa Clifton	lclifton	LClifton@stannes.org	A	C	0	10/1/13 10:41 AM
Provider ID	**7538**					
Lorne Leach	lleach	lleach@avivacenter.org	A	C	0	8/6/13 12:45 PM

User Name	User ID	Email Address	Status	Age Code	Opening	Last Update
Provider ID 7268						
LyNetta Gore	lynettagore	lynettagore@imces.org	A	C	0	4/10/13 2:02 PM
Provider ID 7312						
Mara Pelsman	mpelsman	mpelsman@gatewayshospital.org	A	C	0	4/18/13 12:20 PM
Provider ID 1982						
Martha Arechiga	marechiga	marechiga@telecarecorp.com	A	A	0	4/18/13 10:26 AM
Provider ID 7262						
Mary Martone	marymartone	marymartone@vistadelmar.org	A	C	0	5/15/13 10:17 AM
Provider ID 7776						
Michael Zelman, Psy.D.	mzelman	mzelman@ehrs.com	A	A	0	7/31/13 2:43 PM
Provider ID 7255						
Mona Sosa	lincoln	msosa@dhs-inc.org	A	C	5	9/4/13 9:43 AM
Provider ID 7520						
Mona Sosa Hollywood	hollywood	msosa@bhs-inc.org	A	A	5	9/4/13 9:50 AM
Provider ID 7521						
Rafael Zaragoza	rzaragoza	rzaragoza@ecdpla.org	A	C	0	4/29/13 11:20 AM
Provider ID 7581						
Tiffany Rodriguez	trodriguez	trodriguez@lacgc.org	A	C	0	5/13/13 12:34 PM
Provider ID 7265						
Tufia Steidl	tsteidl	tsteidl@ehrs.com	A	A	0	4/29/13 10:34 AM
Provider ID 7255						
Tufia Steidl BH	Tufia	tsteidl@ehrs.com	A	T	5	6/14/13 4:03 PM
Provider ID 7472						
Vanessa Grey	vgrey	vgrey@lagaycenter.org	A	A	50	5/15/13 1:48 PM
Provider ID 7106						
Veronica Salazar	vsalazar	vsalazar@childrensinstitute.org	A	C	0	5/17/13 2:38 PM
Provider ID 7328						

Vacancy Referral Reporting System

L1 – Conceptual Architecture Review

Los Angeles County

Department of Mental Health

04/24/2013

HOPE WELLNESS RECOVERY

LAC DMH

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

Agenda

- Scope of Review
  - Review Participants
- Project Overview
- Solution Architecture (Conceptual View)
- Architecture Principles
- Technology / Tools
- Requirements
  - Functional
  - Non-functional
    - Security
    - Performance / Availability
- Project Risks

Scope of Review

- Review conceptual design of project
- Review proposed technologies and tools
- Identify risks / concerns

Review Participants

- Architecture Review Panel
  - Vandana Joshi – Project Sponsor/Champion
  - Chris Chapman – Enterprise Architecture
  - Junior Togelang – Database Administrator
  - Edward Vidaurri – Project Lead

- Project Team Review Participants
  - Ella Granston – Project Manager

Project Overview

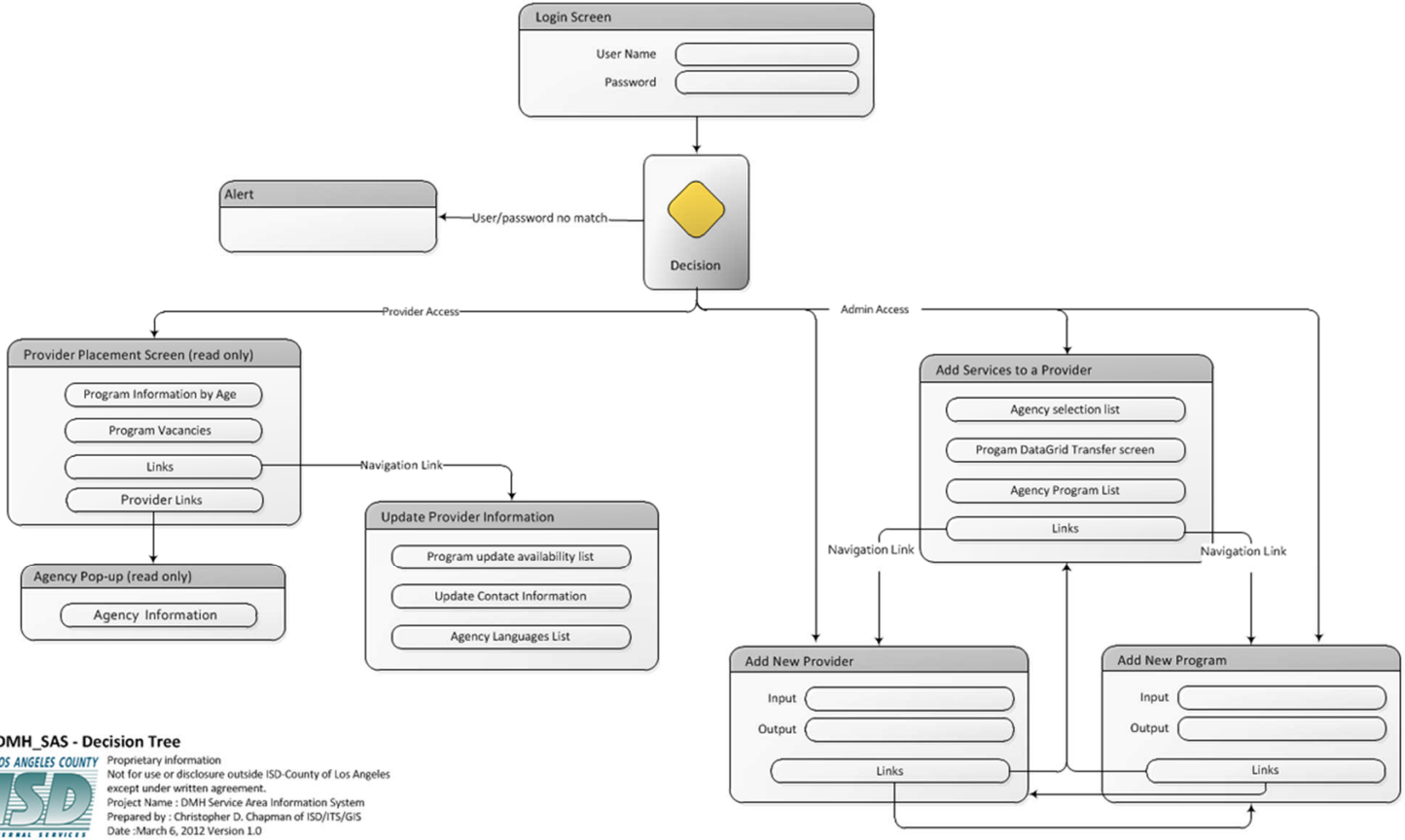
Objectives

- Create an application for providers in SA 4 to search for available program and service vacancies.
- Develop an electronic interface for providers to update program and service vacancies.
- Develop a Vacancy Referral Reporting System (VRRS) using SQL Server 2008 software for providers to update program and service vacancies.
- Develop the Vacancy Referral Reporting System using Visual Studio 2010/ASP.NET and GIS tools
- Provide ongoing Application Maintenance services by ISD/ITS/CAB IDD GIS Technical Support Staff
- Provide ongoing Server Maintenance services by ISD/ITS GIS Technical Support Staff
- Incorporate GIS technology into the VRRS application to improve accuracy and efficiency in client placements.

Conceptual Technical Model

- **Application Type**
  - Customer Service
- **High-level user count estimates**
  - Full access 3,000
  - Read only 5,000
- **User Access**
  - Web browser
- **Volume and Size**
  - Initially services to be piloted in SA 4
  - Eventually the application to be rolled out in each SA
  - Used by both directly operated and contract provider clinic staff
- **Availability**
  - Available ***99%*** of the time
  - Recovered within ***2 hours***
  - Tolerate 0***.5*** hours of data loss
- **Disaster Recovery**
- **???**
- **Shared Services/Delivery Channels**
  - N/A
- **Data Retention and Archive**
  - DMH standard practice

Conceptual Architecture 1

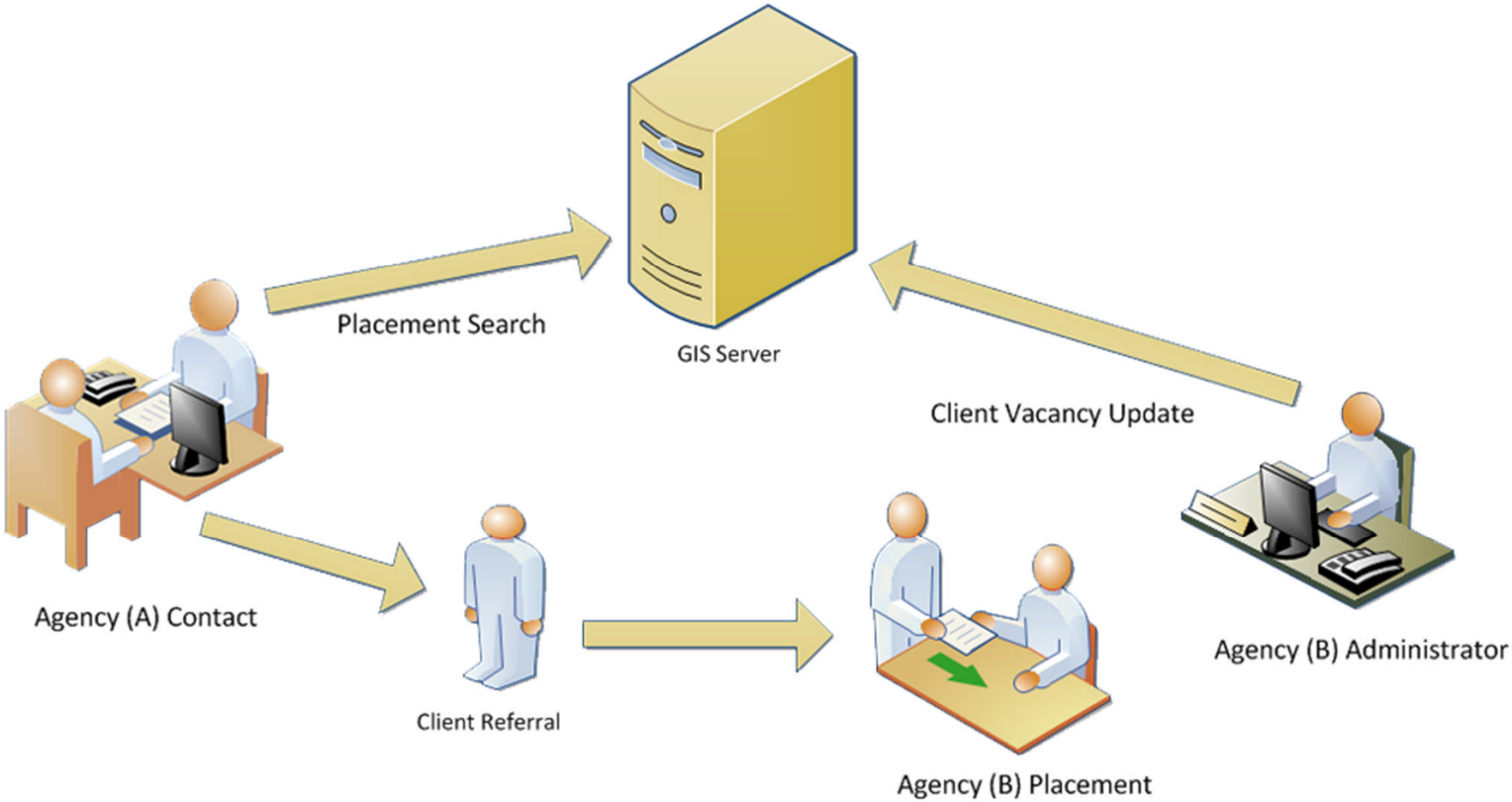


DMH_SAS - Decision Tree

LOS ANGELES COUNTY ISD INTERNAL SERVICES

Proprietary information
Not for use or disclosure outside ISD-County of Los Angeles except under written agreement.
Project Name : DMH Service Area Information System
Prepared by : Christopher D. Chapman of ISD/ITS/GIS
Date :March 6, 2012 Version 1.0

Conceptual Architecture 2



CIOB Architecture Principles

The following CIOB architecture principles should be supported by the project at the conceptual level:

CIOB Architecture Principle	Project Supports? (Yes/No)	Comments
P1: Alignment with Business Drivers	*<Y/N>*	*<Insert Comments>*
P2: Minimize Business Risk		
P3: Cost Effectiveness		
P7: Re-use before Buying, Buy before Building		
P9: Control Technical Diversity		

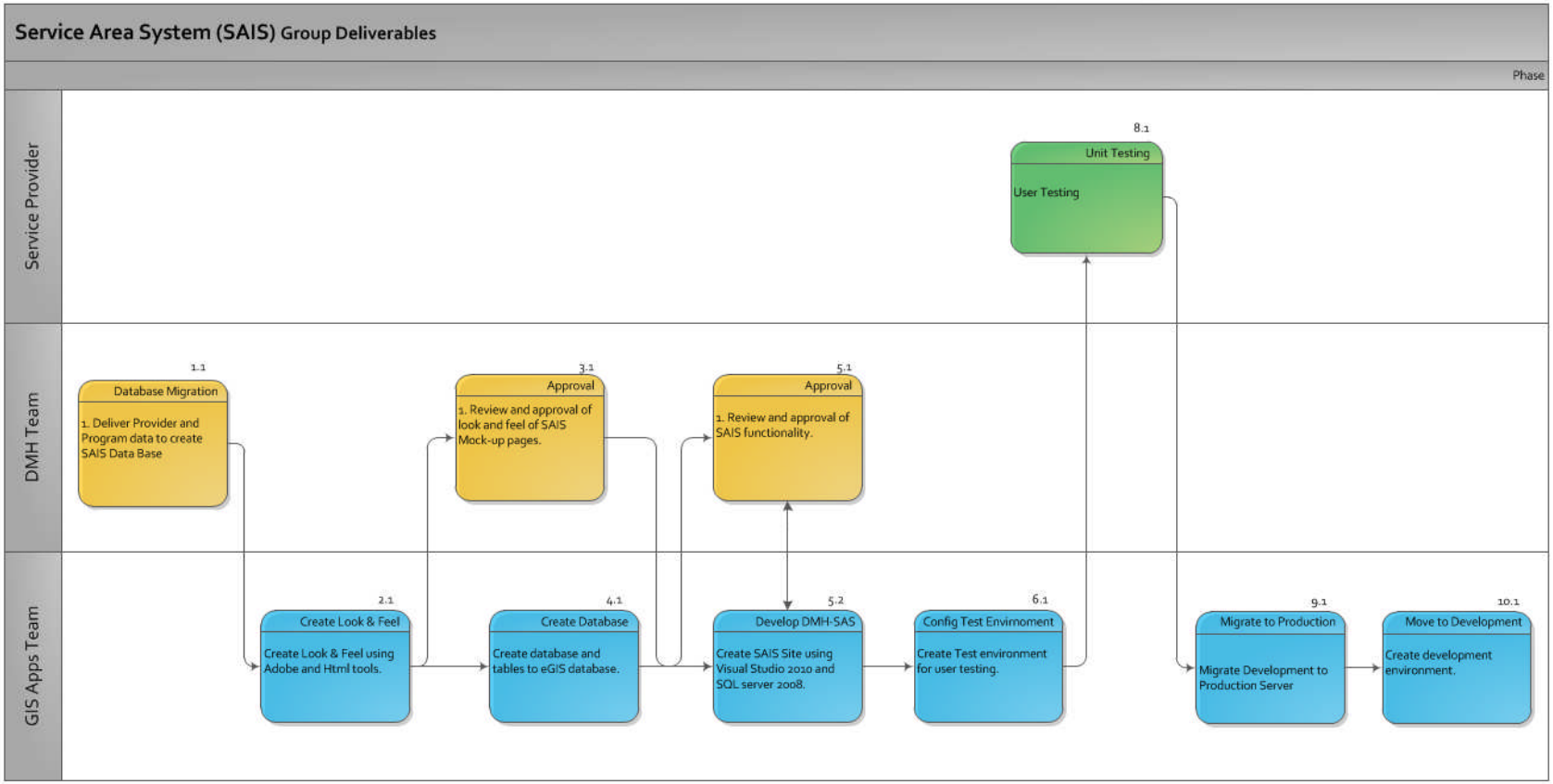
Technology / Tools

Technology/Tool	Function	Comments
JavaScript	Application Functionality	
SQL	Database	
IIS	Webserver	
Cognos/SAS	Reporting	
GIS Tools	Location Search Capabilities	
ASPX.net	Application Development	

Requirements

- Functional
- Login screen that directs user to their agency/admin pages
  - Login Screen
  - Home Screen/User navigation
- Agency placement screen and update information screen.
  - Client Placement Screen
  - Search for Closest Service Location
  - Update Vacancy Screen
  - Change Password
- Administrator functions to create agencies and services.
  - Add Provider Screen
  - Add Services Screen
  - Add Services to Provider Screen
  - Add Users and Privileges

Project Roadmap



DMH Service Area System Group Deliverables

LOS ANGELES COUNTY ISD INTERNAL SERVICES

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Project Name : DMH_Service Area Information System
Prepared by : Christopher D. Chapman of ISD/ITS/GIS
Date : March 6, 2012 Version 1.0

High Level Project Timeline

Phase	Time Allotted
Initiate Project – Project Charter	1 month
Define Requirements – Requirements Document and Workflow	1 month
Design System Hardware/Software Platform	1 month
Develop Application's Microsoft Prototype	3 month
Finalize Development	1 month
Unit testing with DMH personnel	1 month

Project Staffing

Role	Person Assigned
Project Sponsor/Champion	Vandana Joshi, DMH
Project Manager/Administrator	Chris Chapman, IDD/GIS
Application Developer	Chris Chapman, Steven McConaughy, IDD/GIS
System Analyst	Chris Chapman, IDD/GIS
Database Administrator	Junior Togelang, IDD/GIS
Reports	Data-GIS Unit Staff
Training, Development, Presentation	Ella Granston, DMH/SA4 Chris Chapman, Steven McConaughy, IDD/GIS

Project Risks

<List the risks associated with this project>

Architecture Review Results

**** Review Panel to complete this slide after the review occurs***

Review Completed on <mm/dd/yyyy>

Attendees: <List attendees that were present>

Key Discussion Points

<List the key discussion points and decisions from the review>

Review Outcome

<PASS / NO PASS / PASS – with contingencies>

Vacancy Referral Reporting System

L2 – Logical Architecture Review

Los Angeles County

Department of Mental Health

04/24/2013

Agenda

- Scope of Review
  - Review Participants
- Project Overview
- Key Points and Project Decisions
- Logical Architecture
  - Logical View
  - Data View
  - Integration View
  - Data Flow
  - Deployment View
  - Use Case View
  - Security Model
- Architecture Qualities
- Monitoring/Exception Handling/Reporting
- Architecture Principles
- Technology / Tools
- Project Risks

Scope of Review

- Review logical design of project
- Review proposed technologies and tools
- Identify risks / concerns

Review Participants

- Architecture Review Panel
  - Vandana Joshi – Project Sponsor/Champion
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  - Junior Togelang – Database Administrator
  - Edward Vidaurri – Project Lead
- Project Team Review Participants
  - Ella Granston – Project Manager for SA 4

Project Overview

Objectives

- Create an application for providers in SA 4 to search for available program and service vacancies.
- Develop an electronic interface for providers to update program and service vacancies.
- Develop a Vacancy Referral Reporting System (VRRS) using SQL Server 2008 software for providers to update program and service vacancies.
- Develop the Referral Reporting System using Visual Studio 2010/ASP.NET and GIS tools
- Provide ongoing Application Maintenance services by ISD/ITS/CAB IDD GIS Technical Support Staff
- Provide ongoing Server Maintenance services by ISD/ITS GIS Technical Support Staff
- Incorporate GIS technology into the VRRS application to improve accuracy and efficiency in client placements.

Technical Model

- **Application Type**
  - Customer Service
- **High-level user count estimates**
  - Full access 3,000
  - Read only 5,000
- **User Access**
  - Web browser
  - **Volume and Size** Initially three services to be piloted in SA 4
  - Eventually the application to be rolled out in each SA
  - Used by both directly operated and contract provider clinic staff
- **Availability**
  - Available ***99%*** of the time
  - Recovered within ***2 hours***
  - Tolerate 0***.5*** hours of data loss
- **Disaster Recovery**
- **Shared Services/Delivery Channels**
  - N/A
- **Data Retention and Archive**
  - DMH standard practice

Key Points and Project Decisions

- Background
  - Department of Mental Health (DMH) is looking to create a web-based application to assist service providers help fill program and service vacancies appropriately. Providers need a tool to update number of available vacancies or slots in their agency and make the information available to other providers for appropriate referrals. The Vacancy Referral Reporting System (VRRS) will allow providers to update this information and share it with other providers. This will improve wait times for consumers to be enrolled in programs and receive appropriate services. The VRRS will include administrative features that will allow clinic staff to add new programs and services as they become available. Providers will be able to search for services in a certain mile radius by language capacity of each clinic thereby providing appropriate and culturally competent referrals.

Key Points and Project Decisions

- Project Decisions

  Pilot in one Service Area and expand to Countywide after testing the functionality and usability of the application.

  Add language capacity of clinics to allow for culturally competent appropriate referral's.

  Make the clinics searchable via a map application for easy referral of clients to other clinics in nearby locations.

  Develop a reporting feature in the application to track number of filled and vacant program slots.

  Make the application available to directly operated and contract provider clinks.

Logical Architecture

Logical view

- Describes the function and relationships of the logical components and layers in the solution architecture

Data view

- Describes the architecturally significant persistent data and information

Integration view

- Describes how the solution components/layers interface with each other and with external systems

Data Flow

- Data flow between solution components/layers and with external systems

Deployment view

- Describes the logical deployment model of the solution architecture

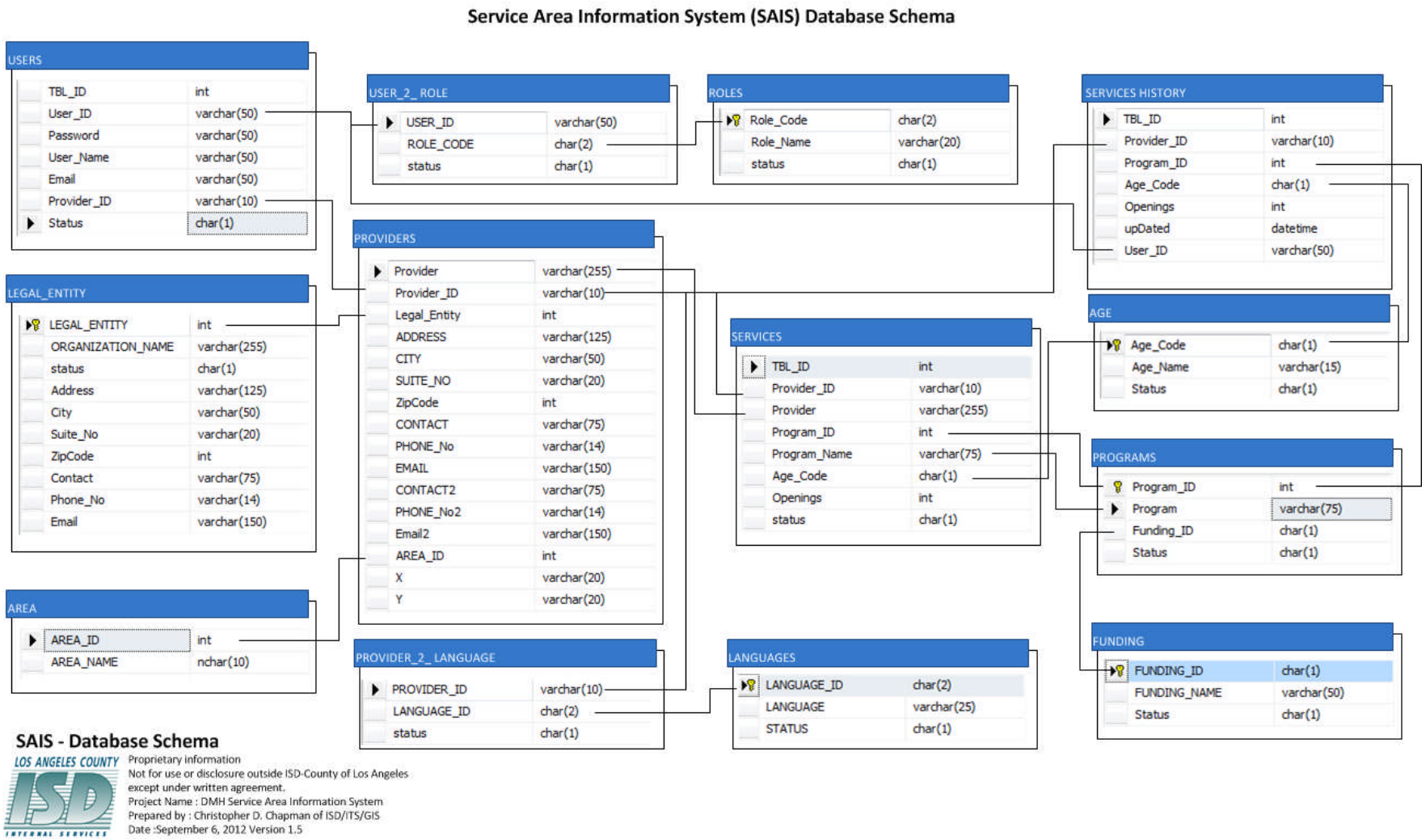
Use Case view

- Describes the set of scenarios and/or use cases that represent some significant, central functionality of the system.

Security Model

- Describes the security model of the project for various aspects (authentication, authorization, encryption, etc.)

Data View

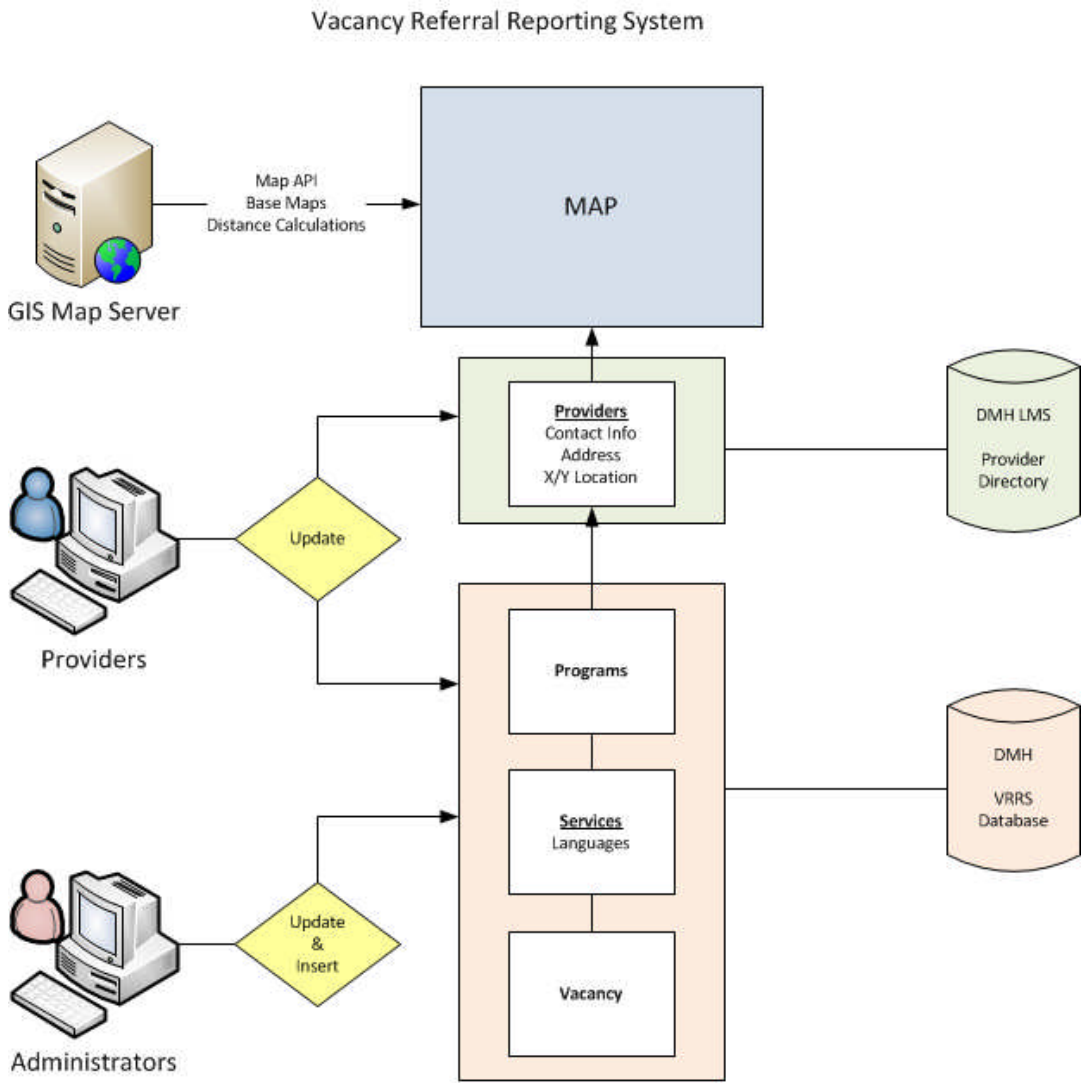


SAIS - Database Schema

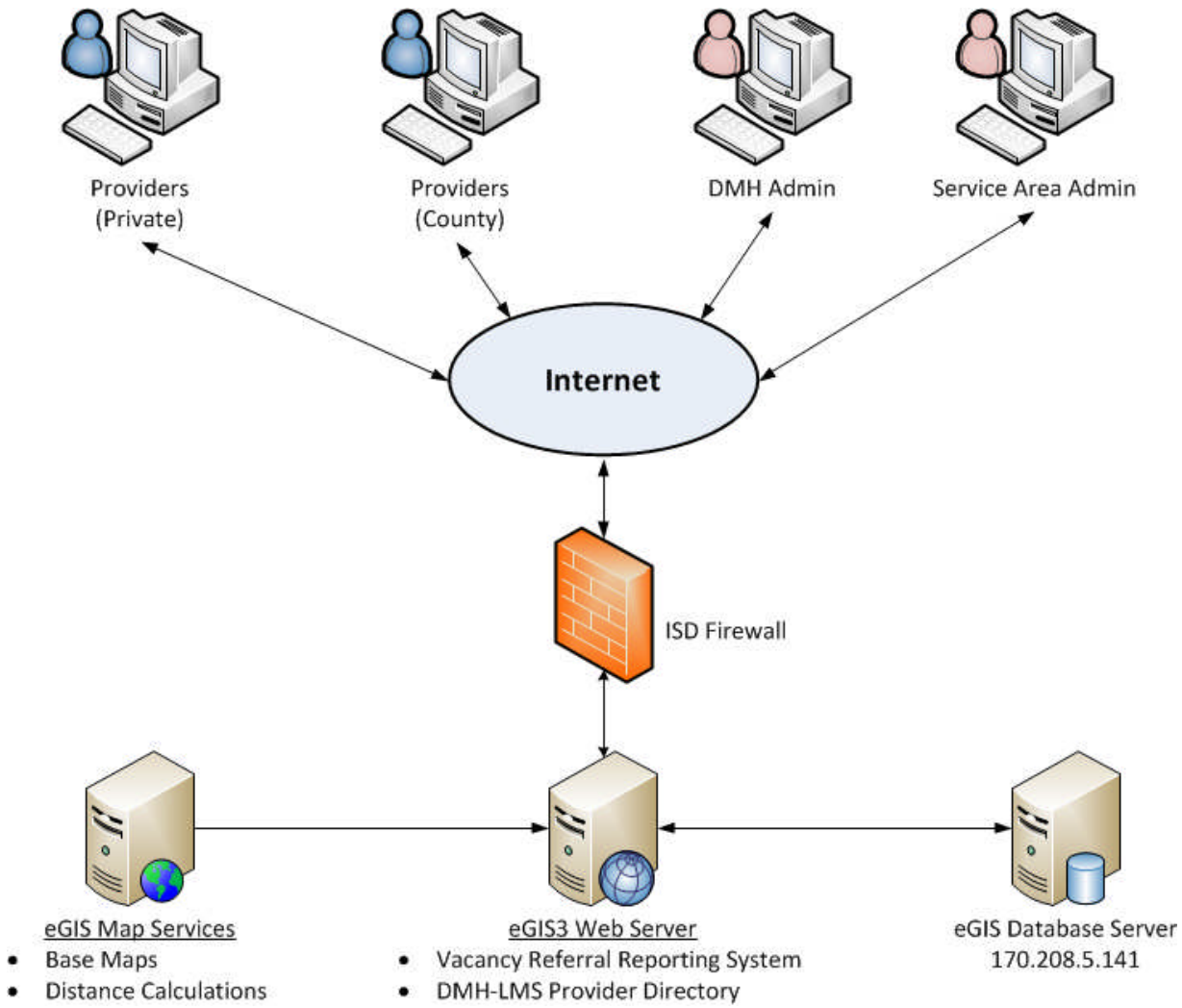
LOS ANGELES COUNTY ISD INTERNAL SERVICES

Proprietary information
Not for use or disclosure outside ISD-County of Los Angeles
except under written agreement.
Project Name : DMH Service Area Information System
Prepared by : Christopher D. Chapman of ISD/ITS/GIS
Date :September 6, 2012 Version 1.5

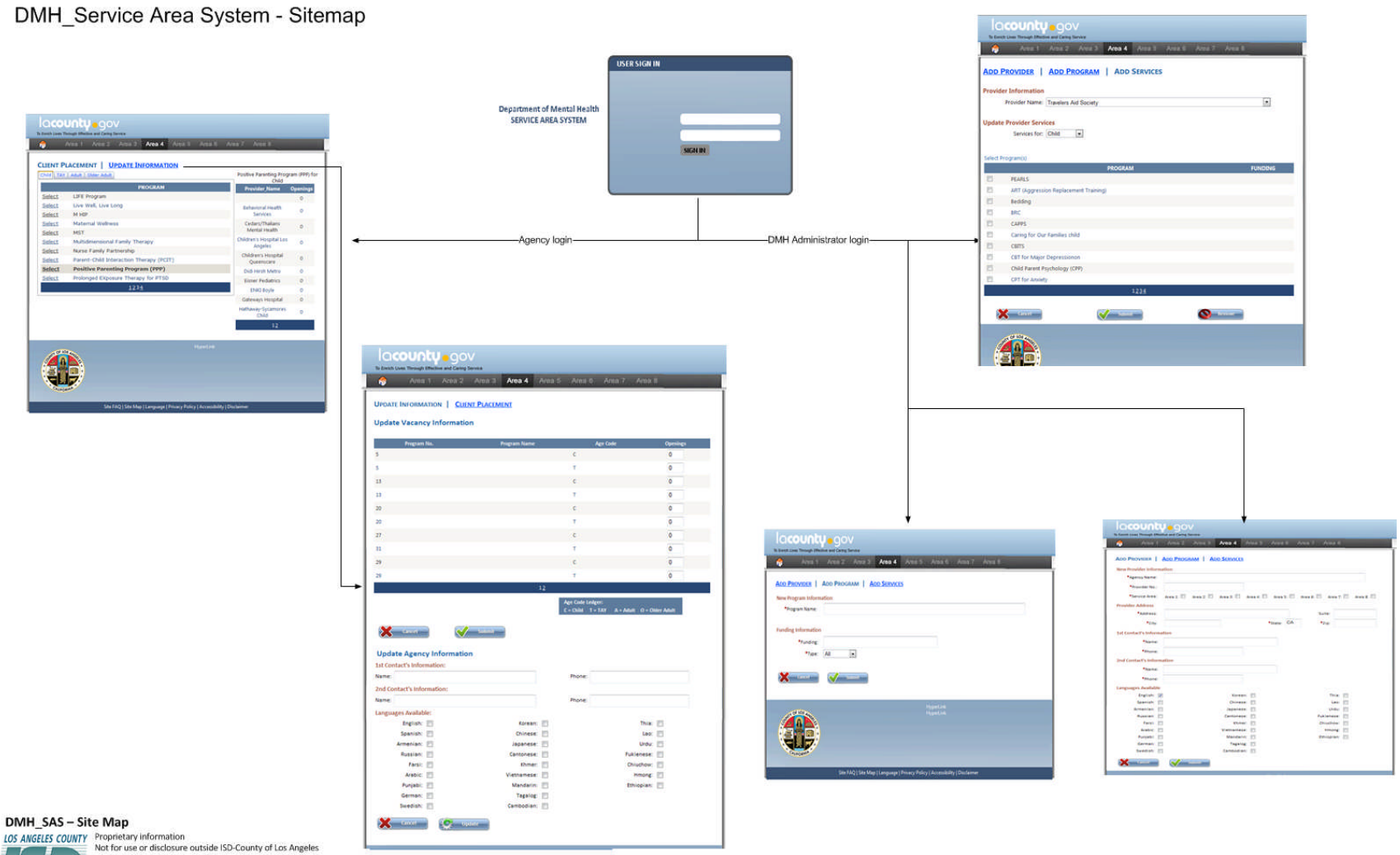
Data Flow / Integration View



Deployment View



Use Case View

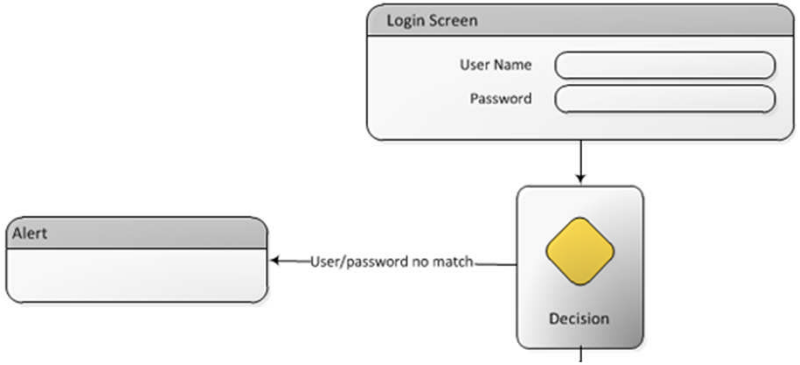


DMH_SAS – Site Map

LOS ANGELES COUNTY ISD INTERNAL SERVICES

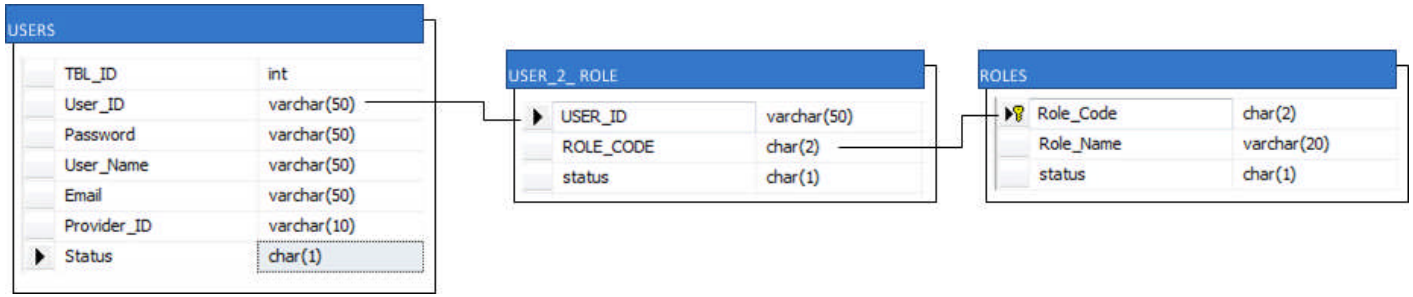
Proprietary information
Not for use or disclosure outside ISD-County of Los Angeles except under written agreement.
Project Name : DMH Service Area Information System
Prepared by : Christopher D. Chapman of ISD/ITS/GIS
Date :August 8, 2011 Version 1.2

Security Model



Authentication
ASP.NET Forms Authentication

Authorization
SQL Server Security Model



Security Descriptions

Overall Processes:

- Application Access:
  - ***Login Prompt***
- Authentication:
  - ***ASP.NET Forms Authentication***
  - ***Internal Account Based***
- Authorization:
  - ***Stored in SQL Table***
  - ***Roles Based:***
    - ***System Admin***
    - ***SA Admin***
    - ***Provider***

Architecture Qualities

- **Scalability**:
  - **Description** : System increase to include the other seven Service Areas
  - **Solution** : User credentials will include Service Area, Provider Identification, Security level (role) to access correct user information.
- **Reliability**, **Availability**:
  - **Description** : Web Based Application with Login screen and user credentials
  - **Solution :** Through JavaScript, .NET, L.A. County eGIS Services and other technologies, application-specific methods help create user friendly solutions
- **Portability**:
  - **Description** : Web based environment
  - **Solution :** Web Based Application simplifies many aspects of delivering application services

CIOB Architecture Principles

The following CIOB architecture principles should be supported by the project at the logical level:

CIOB Architecture Principle	Project Supports? (Yes/No)	Comments / Concerns
P4: Data is a Valuable Asset	Y	
P5: Flexibility/Adaptability/Scalability	Y	
P6: Business Continuity and Manageability	Y	Providers update their office vacancy information only
P8: Flexible Integration	Y	
P9: Control Technical Diversity	Y	

Technology / Tools

Technology/Tool	Version	Function	Comments
SQL Server	2008	RDBMS	
ASP.NET / VB.NET	4.0	Application Code	
Esri JavaScript API	3.4	Mapping API	
Esri ArcGIS Server	10.1	Mapping Service	

Project Risks

Risk	Way to Mitigate / Make Acceptable
Providers not updating vacancy information on a timely manner	Training / Information on why updating vacancy information is beneficial
Resistance to use application	Training

Service Catalog (newScale)

L3 – Infrastructure Review

Los Angeles County

Department of Mental Health

12/10/2010

HOPE WELLNESS RECOVERY

LAC DMH
LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH

Agenda

- Scope of Review
- Review Participants
- Project Overview
- Technical Model
- Hardware Requirements Summary
- Logical Deployment Model
- Physical Infrastructure
- Security Model
- Network/Security Considerations
- Business Continuity
- Performance
- Hardware Specifications
- Architecture Principles
- Project Risks

Scope of Review

- Review infrastructure design of project
- Review proposed technologies and tools
- Identify risks / concerns

Review Participants

- Architecture Review Panel
  - ***Duane Nguyen - Enterprise Architecture***
  - ***Jeff Zito - Information Security***
  - ***Chuck Chiu - Network Operations***

- Project Team Review Participants
  - ***Duane Nguyen - Solution Architect***
  - ***Melvin Mabale - Project SME(s)***

Project Overview

- Objectives
  - *Increase efficiency*
  - *Improve quality of service*
  - *Reduce Risk*

dn1

- Scope
  - *At least 1 hospital is in production use of on-line referrals to DMH Public Guardian*
  - *DMH staff are ordering one or more types of Facilities Services online*
  - *DMH staff are reporting vehicle accidents online*

Slide 5

dn1 same as other review comments - expand and describe more
Duane Nguyen, 1/11/2011

Technical Model

- **Application Type**
  - ***Workflow***
- **High-level user count estimates**
  - Full access ***5,000*** (est.)
    - 3,800 internal
    - 1,200 external
- **User Access**
  - ***Web browser***
- **Volume and Size**
  - ***Initially three services***
  - ***Potentially hundreds of services***
  - ***Used both internally and externally***
- **Availability**
  - Available ***99%*** of the time
  - Recovered within ***2 hours***
  - Tolerate 0***.5*** hours of data loss
- **Disaster Recovery**
- **Shared Services/Delivery Channels**
  - ***N/A***
- **Data Retention and Archive**
  - ***DMH standard practice***

Hardware Requirements Summary (Prod/DR)

- ***High Availability***
  - ***Short recovery time***
- ***Data Retention***
  - ***Standard backup and restore***
- ***DR Tier***
  - ***No HA required (risks are accepted)***
- ***Hardware sharing is possible***
  - ***None***
- ***Recovery Point Objective: Zero***
  - ***Last 24 hours***
- ***Recovery Time Objective: 2-8 hours>***
  - ***2 hours***

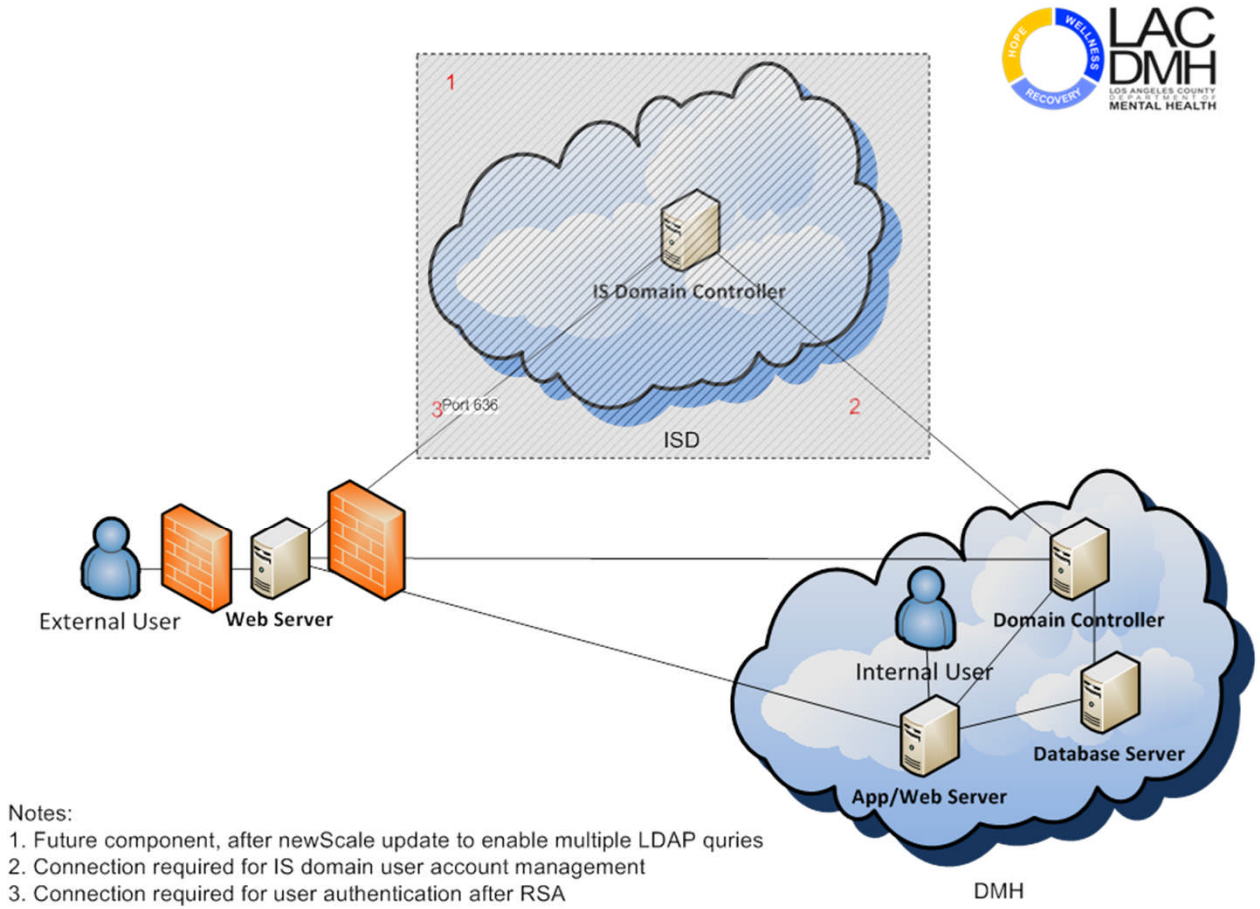
Hardware Requirements Summary (Dev/QA)

- ***High Availability***
  - ***No HA***

- ***Hardware Sizing***
  - ***For QA must be similar to production***
  - ***QA can be smaller in order to reduce costs***
  - ***For DEV minimal hardware for development, no HA or clustering is required.***

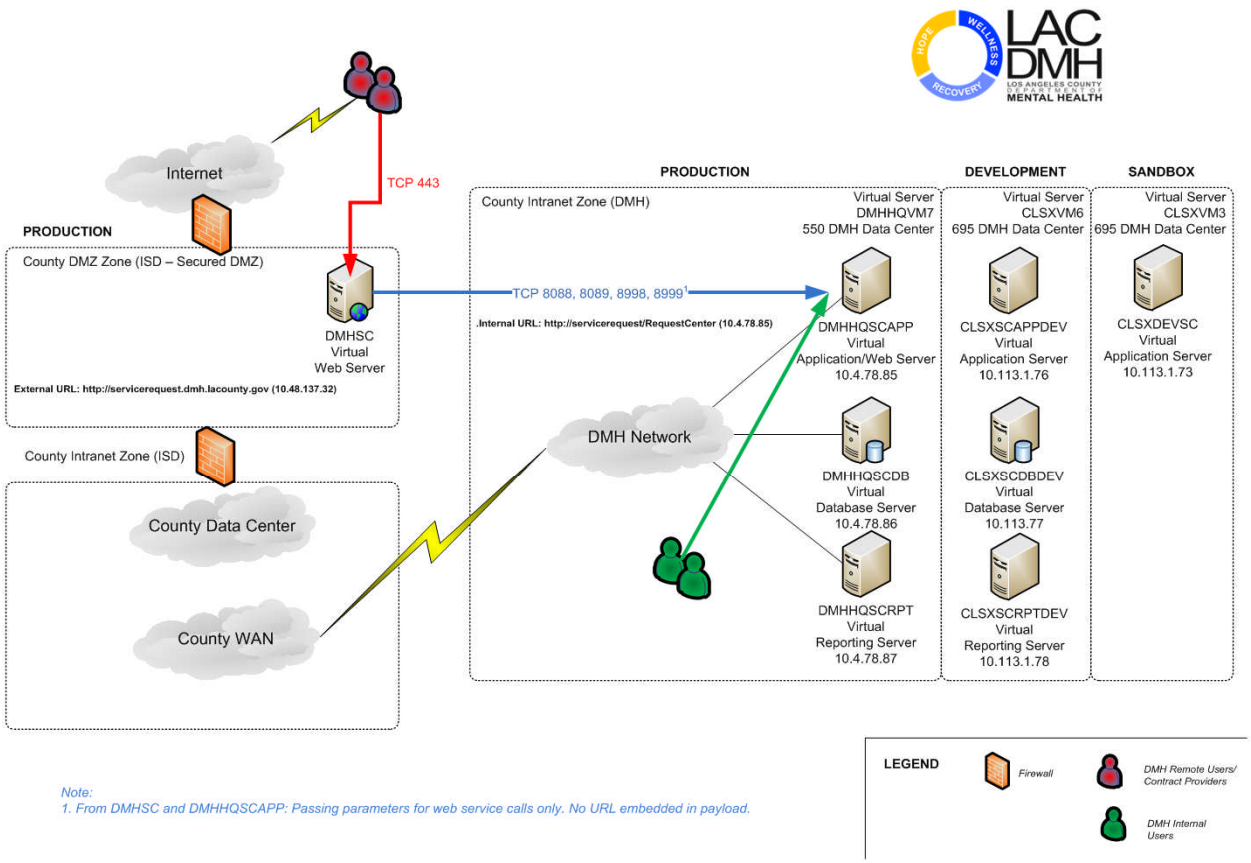
- ***Hardware Sharing is possible***
  - ***Sharing with Test/Train***

Logical Deployment Model



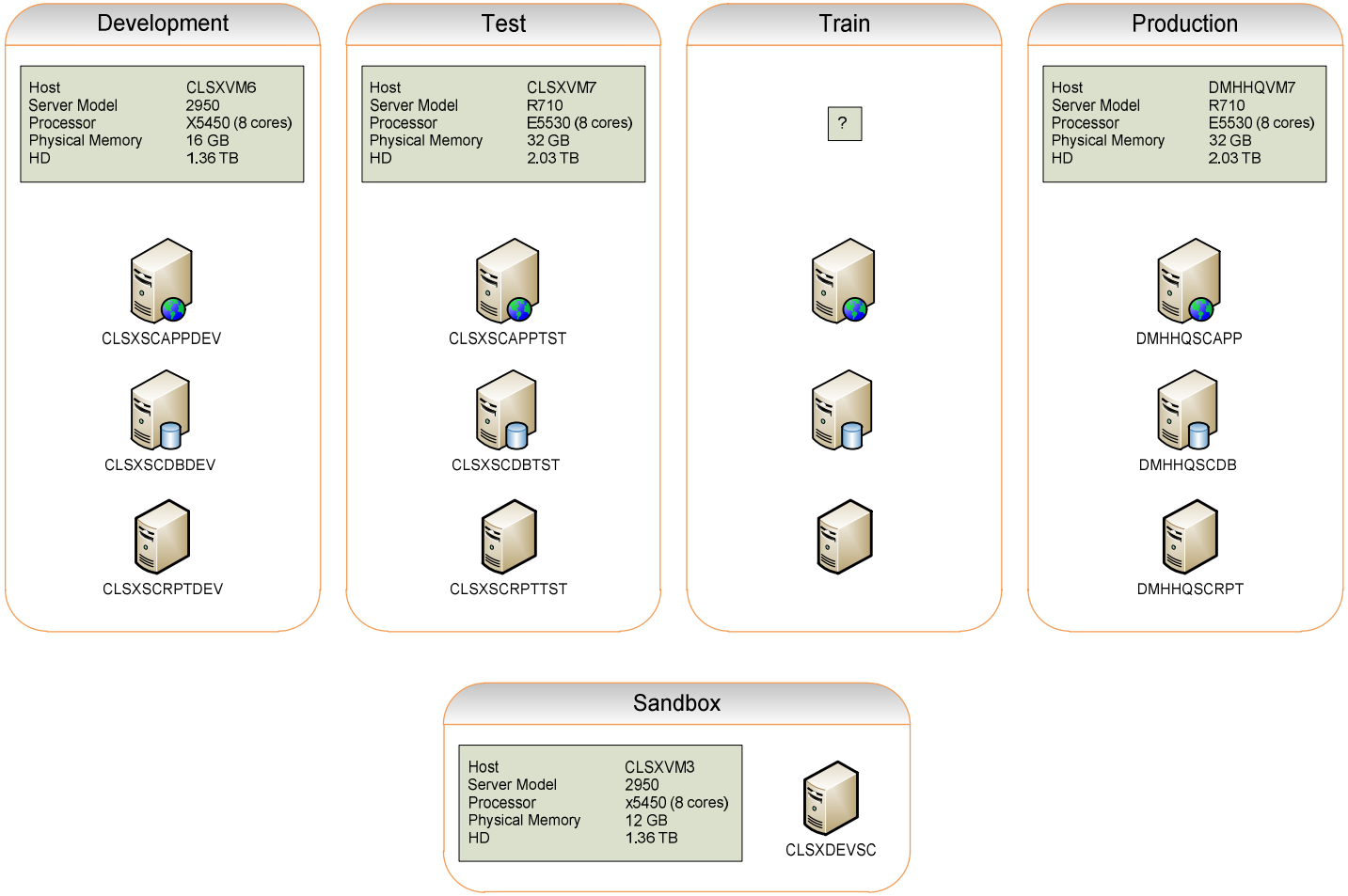
Notes:
1. Future component, after newScale update to enable multiple LDAP quries
2. Connection required for IS domain user account management
3. Connection required for user authentication after RSA

Physical Infrastructure Layout

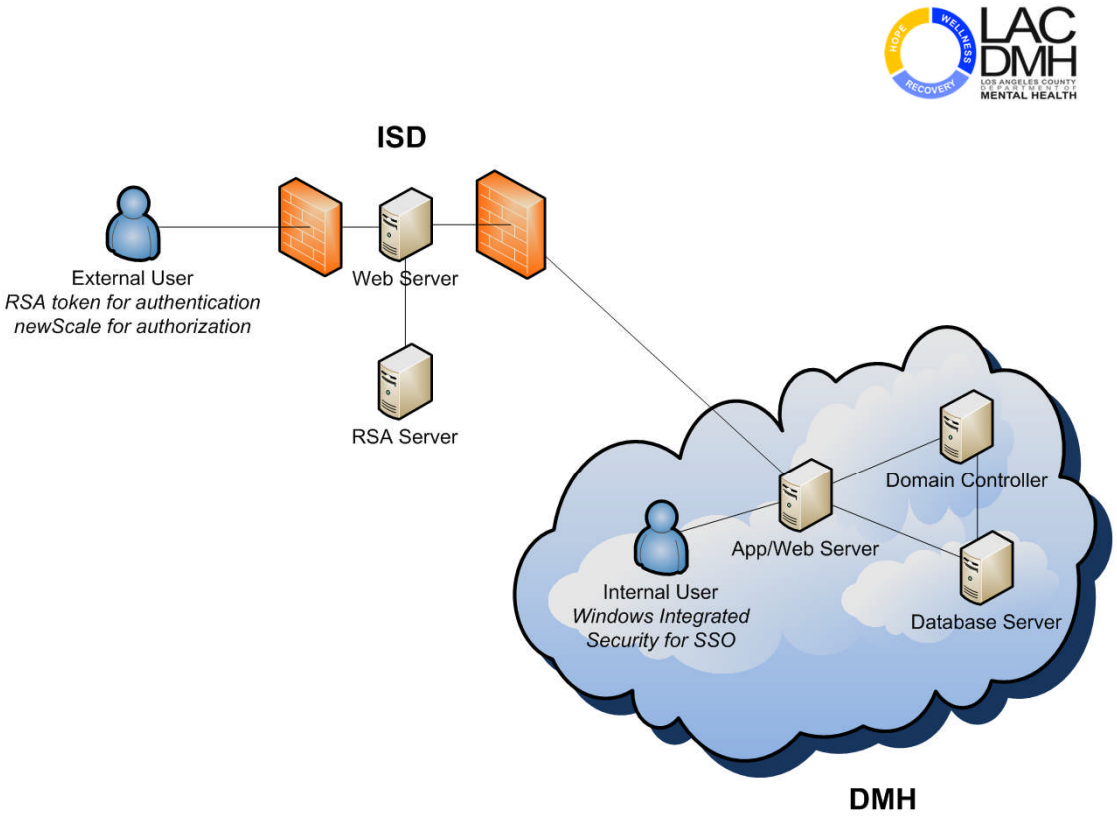


Note:
1. From DMHSC and DMHHQSCAPP: Passing parameters for web service calls only. No URL embedded in payload.

Physical Infrastructure Hardware



Security Model



DMH Service Catalog | Logical Diagram | Confidential

11/5/2010 | 3.0 | Charles Lu

Network/Security Considerations

The following forms are required to be submitted before the project can be deployed:

Form	Organization	Submitted?	Comments / Concerns
MCD Windows Server Customer Requirements - ISD	ISD	Yes	
Server Request Form – DMH	DMH	Yes	
Security exception request	ISD	Yes	Multiple

Network

- Web server located in the DMZ
- Web server access to dmh.co.la.ca.us domain

Security

- Internal users authenticated by ActiveDirectory credentials
- External users challenged by RSA Token
- Only specific ports are open between the presentation layer and the application layer

Business Continuity

- Disaster Recovery:
  - Standard backup and restore
  - Rebuild virtual servers
- High Availability
  - Application does not require HA
  - 2 hour recovery time

dn3

Performance

- Scalability
  - Hardware environment designed to handle many more services
  - Virtual server can be scaled up as needed
- Performance
  - Solution is able to handle user requests at much higher speed than can be submitted

Slide 15

dn3

Insert in some of the information that newScale gave us for medium application sizing. that information is relevant here.
Duane Nguyen, 1/11/2011

Hardware Specifications

Server Information	Server 1: Application Server	Server 2 Database Server	Server 3: Reporting Server
Operating System	Windows 2003 SP2+ or RedHat Linux ES/AS 4	Likely a shared MS SQL2005 Database Server on dedicated hardware. No additional HW spend required. [1]	Windows 2003 SP2+
Server Model	Dell PowerEdge 2970 or equivalent VMware VM		Dell PowerEdge 2970 or equivalent VMware VM
Number and Speed of CPUs	2 x Quad Core 2.5GHz		Quad Core 2.5GHz
Physical Server Memory	8 GB		4 GB
VM Memory allocation	3.5 GB		2 GB
Storage Layout and Configuration (assumes 5-yr growth outlook)	40+ GB local RAID-1 SAN for log growth	OLTP online data: 20GB OLTP logs:10GB DataMart and ReportStore: 10GB	40+ GB local RAID-1 SAN for log growth

Configuration assumes submission of 50-200 requisitions during peak hours

CIOB Architecture Principles

The following CIOB architecture principles should be supported by the infrastructure of the project:

CIOB Architecture Principle	Project Supports? (Yes/No)	Comments / Concerns
P2: Minimize Business Risk	Yes	
P3: Cost Effectiveness	Yes	
P5: Flexibility/Adaptability/Scalability	Yes	
P9: Control Technical Diversity	Yes	

Project Risks

- Vendor's ability to execute in a complex environment

  Examples: inability to query multiple LDAP, inflexible to deal with different user populations.
- Lack of operational data base
- User adoption to cultural change

APS Healthcare

California EQRO

Feb 2013 – Updates to document noted in blue.

- This outline is a compilation of the "Road Map to a PIP" and the PIP Validation Tool that CAEQRO uses in evaluating PIPs. The use of this format for PIP submission will assure that the MHP addresses all of the required elements of a PIP. The MHP is not limited to using this format and may submit evidence of the PIP in other formats which address the required elements.
    - PDSA Cycles can be submitted as separate documents or outlined as part of #3 barrier analysis (understanding causes), #10 interventions (testing change ideas), as well as #15 data analysis and triggering changes. Conducting PDSA cycles is for purposes of learning and testing; many PDSA cycles in themselves do not complete a PIP.
- Your PIP should focus on a consumer-related problem (access, timeliness, outcomes) which is measured (indicators), for which interventions will be applied to create improvement. Simply setting up a monitoring system for some facet of care is not a PIP unless it is focused on improving an indicator.
- Do not set up a PIP to evaluate the effectiveness of a given program; this is a program evaluation. The individuals receiving the intervention need to be related to the identified problem, upon which various interventions (not just a program's services) can be tested and applied to create improvement.
- You are not limited to the space in this document. It will expand, so feel free to use more room than appears to be provided, and include relevant attachments.
- Emphasize the work completed over the past year, if this is a multi-year PIP. A PIP that has not been active and was developed in a prior year may not receive "credit."
- PIPs generally should not last longer than roughly two years. An MHP is advised to consult with CAEQRO before continuing a PIP into a third year.

CAEQRO PIP Outline via Road Map

MHP: County of Los Angeles Department of Mental Health
Date PIP Began:

Title of PIP: IMHT
Clinical: July 1, 2013

Assemble multi-functional team

1. Describe the stakeholders who are involved in developing and implementing this PIP.

LAC-DMH MHP:

- IMHT Program – Maria Funk, Lisa Ruiz, Jesus Ramirez
- MHSA Program – Debbie Innes-Gomberg, Matthew Wells
- Providers – Exodus Recovery, Inc., JWCH/ BHS/SCHARP, Mental Health America, St. Joseph's Center, OPCC, Step up on Second.
- iHOMS Program Staff – Andy - UC San Diego
- QI – Naga Kasarabada, Vandana Joshi, Timothy Beyer, Sandra Chin
- Consumers, Family Members

"Is there really a problem?"

2. Define the problem. Describe the data reviewed and relevant benchmarks that validate the problem exists. Explain why this is a problem priority for the MHP, how it is within the MHP's scope of influence, and what specific consumer population it affects.

Coordination for integrated care planning is needed to meet the specialized and complex health conditions of consumers with mental health, physical health, and/or substance use disorders. Los Angeles County has the second highest homeless population in the country, second only to the city of New York, at 57,737. SAMHSA has estimated a 30% prevalence rate of severe mental illness among homeless population. As such this population has complex needs related to their physical health, mental health and substance use disorders need. The County of Los Angeles, Department of Mental Health has implemented an Integrated Mobile Health Team (IMHT) program under the MHSA Innovations Plan. IMHT is designed to improve and better coordinate the quality of care for individuals with Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED) that meet medical necessity criteria for receiving specialty mental health services who are homeless or have recently moved into Permanent Supportive Housing (PSH) and have other vulnerabilities.

The IMHT model requires the use of specific approaches and strategies to deliver services including using Assertive Community Treatment (ACT) as an Evidence based Practice (EBP) to fidelity to provide IMHT services. Some of the specific approaches include harm Reduction, Motivational Interviewing and Housing First model to provide permanent housing to homeless clients and families, combined with a comprehensive single-team approach to providing primary care, mental health and substance abuse services.

Team Brainstorming: "Why is this happening?"

Root cause analysis to identify challenges/barriers

3. a) What are the likely causes of the problem? Describe the data and other information gathered and analyzed to understand the barriers/causes of the problem that affects the mental health status, functional status, or satisfaction. How did you use the data and information to understand the problem?

b) What are barriers/causes identified that require intervention? <u>Use Table A, and attach any charts, graphs, or tables to display the data.</u>

Table A – List of Validated Causes/Barriers

Describe Cause/Barrier	Briefly describe data examined to validate the barrier

Formulate the study question

4. State the study question. This should be a single question in 1-2 sentences which specifically identifies the problem for improvement, the general intervention, and the desired outcome.

Does integrated care for consumers with physical health, mental health and substance use disorders improve outcomes such as reduced number of inpatient hospitalizations, reduced number of visits to emergency rooms, reduced days of homelessness and reduced incarcerations?

5. Does this PIP include all beneficiaries for whom the study question applies? If not, please explain. (Remember that all PIPs must include Medi-Cal beneficiaries)

Yes. The PIP will examine and study all clients enrolled in the IMHT Programs.

6. Describe the population to be included in the PIP, including the number of beneficiaries.

The IMHT clients are individuals with Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED) that meet medical necessity criteria for receiving specialty mental health services and who are homeless or have recently moved into Permanent Supportive Housing (PSH) and have other vulnerabilities.

7. Describe how the population is being identified for the collection of data.

An Outreach and Engagement Team in each of the five agencies participating in the IMHT program are identifying and enrolling clients into the IMHT program. Once enrolled several baseline and follow-up measures related to client's physical health, mental health and substance use disorders are being completed by the clients such as the PROMIS (Patient Reported Outcomes measurement Information System) Global health Scale to measure quality of life and conduct cost benefit analysis, CHOIS, IMR (Illness management and Recovery Scale) to assess improvements in mental health and client/staff satisfaction scales.

8. a) If a sampling technique was used, how did the MHP ensure that the sample was selected without bias?

N/A. No sample.

b) How many beneficiaries are in the sample? Is the sample size large enough to render a fair interpretation?

Yes. As of March 2014 there are 524 IMHT clients enrolled in the electronic Outcomes Measurement System (iHOMS) managed and maintained by UC San Diego. There are 445 matched clients in the LACDMH-IS system and the iHOMS database.

"How can we try to address the broken elements/barriers?"
Planned interventions

Specify the performance indicators in Table B and the Interventions in Table C.

9. What indicators were selected to measure improvement?

Matched data from LACDMH-IS and iHOMS is being examined for client baseline and follow-up measures. See attached tables.

a) Why were these performance indicators selected?

The selected indicators have both baseline and follow-up measures for Global Health Scale, Illness and Management and Recovery Scale and client satisfaction scales that allows us to measure client's improvement in the treatment plan.

b) How do these performance indicators measure changes in mental health status, functional status, beneficiary satisfaction, or process of care with strong associations for improved outcomes?

Include process indicators that reflect monitoring the application of the interventions.

Remember the difference between *percentage* changed and *percentage points* changed – a very common error in reporting the goal and also in the re-measurement process.

Table B – List of Performance Indicators, Baselines, and Goals

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator (number)	Goal (number)
1	Overall IMR Ratings	See Attachment 1 – Page 38.			
2	IMR - Recovery Sub-Scale	See Attachment 1 – Page 39.			
3	IMR - Management Sub-Scale	See Attachment 1 – Page 40.			

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator (number)	Goal (number)
4	IMR – Substance Use Sub-Scale	See Attachment 1 – Page 41.			
5	MORS Rating	See Attachment 1 – Page 43.			
6.	PROMIS Ratings	See Attachment 1 – Page 44.			
7.	PROMIS – Mental Health Sub Scale	See Attachment 1 – Page 45.			
8.	PROMIS – Physical Health Sub Scale	See Attachment 1 – Page 46.			
9.	Memory CHOIS Ratings	See Attachment 1 – Page 49.			
10.	Strengths CHOIS Ratings	See Attachment 1 – Page 50.			
11.	IMHT Client Outcomes – ER Visit, Hospitalizations, Homelessness and Incarcerations	See Attachment 1 – Pages 57-59.			

10. <u>Use Table C to summarize interventions</u>.

a) In column 2, describe each intervention.
b) In column 3, identify the barriers/causes each intervention is designed to address.
c) In column 4, identify the corresponding indicator which will measure the performance of each intervention.
d) Do not cluster different interventions together.

Table C - Interventions

1) Number of Intervention	2) List each specific intervention	3) Barrier(s)/causes each specific intervention is designed to target	4) Corresponding Indicator	5) Dates Applied
1				
2				
3				
4				
5				
6				
7				

Apply Interventions: "What do we see?"

Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

12. Describe method of the data collection and the sources of the data to be collected. Did you use existing data from your Information System? If not, please explain why.

13. Describe the plan for data analysis. Include contingencies for untoward results.

14. Identify the staff that will be collecting data as well as their qualifications, including contractual, temporary, or consultative personnel.

15. Describe the data analysis process. Did it occur as planned? Did results trigger modifications to the project or its interventions? Did analysis trigger other QI projects?

16. Present objective data results for each performance indicator. Use Table D and attach supporting data as tables, charts, or graphs.
Include the raw numbers that serve as numerator and denominator!

Table D - Table of Results for Each Performance Indicator and Each Measurement Period

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/ denominator)	% improvement achieved
THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS							

"Was the PIP successful?" What are the outcomes?

17. Describe issues associated with data analysis:

a. Data cycles clearly identify when measurements occur. Provide explanation for any analysis occurring less frequently than quarterly. Some activities and outcomes benefit from or require close, routine monitoring.

b. Statistical significance

c. Are there any factors that influence comparability of the initial and repeat measures?

d. Are there any factors that threaten the internal or the external validity?

18. To what extent was the PIP successful? Describe any follow-up activities and their success.

19. Describe how the methodology used at baseline measurement was the same methodology used when the measurement was repeated. Were there any modifications based upon the results?

20. Does data analysis demonstrate an improvement in processes or client outcomes?

21. Describe the "face validity" – how the improvement appears to be the result of the PIP intervention(s).

22. Describe statistical evidence that supports that the improvement is true improvement.

23. Was the improvement sustained over repeated measurements over comparable time periods? Or, what is the plan for monitoring and sustaining improvement?

COUNTY OF LOS ANGELES
MHSA INNOVATION PROGRAM

ANNUAL REPORT
December 2013

LAC DMH LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

HEALTH SERVICES RESEARCH CENTER UNIVERSITY OF CALIFORNIA, SAN DIEGO

harder+company community research

USC Social Work

Integrated Mobile Health Team (IMHT)

IMHT Introduction

The Integrated Mobile Health Team (IMHT) service model is designed to improve and better coordinate the quality of care for individuals with severe mental illness (SMI) or serious emotional disturbance (SED) who meet Medi-Cal medical necessity criteria for receiving specialty mental health services, were homeless or have recently moved into Permanent Supportive Housing (PSH), and have other vulnerabilities. Vulnerabilities include but are not limited to: age, years homeless, and substance abuse and/or other physical health conditions that require ongoing primary care. The IMHT model of care is intended to decrease homelessness and incarcerations and reduce medical and psychiatric emergency room visits by providing integrated mental health, physical health, substance abuse services, and immediate assistance with housing to individuals with SMI or SED.

The IMHT model aims to improve quality of care by using multidisciplinary team that delivers assertive community treatment (ACT), an extensively researched evidence-based practice. The team includes staff that provide mental health, physical health and substance abuse services and work for one agency or under one point of supervision, operate under one set of administrative and operational policies and procedures, and use an integrated medical record/chart.

In addition to providing integrated mental health, physical health, and substance abuse services, IMHT model programs use a Housing First Approach to immediately assist individuals and their families, if applicable, to transition from homelessness to a housing option of their choice. The housing first approach immediately provides housing without requiring individuals to demonstrate “housing readiness” as evidenced by sobriety, psychiatric treatment compliance and/or living successfully in transitional housing prior to being assisted with finding housing.

Services provided by the IMHT include: outreach and engagement, mental and physical health assessment, medication support, crisis intervention, individual/group therapy/counseling, referrals and linkages, housing, benefits establishment, employment and education, life skills, transportation, preventative health education and screenings, substance abuse services, and client and family supportive services. Desired client outcomes include reduced incarcerations, reduced medical and psychiatric ER visits, increased establishment of benefits for which the client is eligible, and increased numbers of clients who are employed, attending school or participating in volunteer activities.

IMHT Providers

The IMHT Model consists of 5 programs: Exodus Recovery Inc., John Wesley Community Health Institute/South Central Health and Rehabilitation Center/Behavioral Health Services, Mental Health America of Los Angeles-Homeless INN Project (HIP), St. Joseph/Ocean Park Community Center and Step-UP on Second/Project 180.

Exodus Recovery, Inc. (Exodus) has worked collaboratively with multiple west side hospitals since 1989 to provide mental health and chemical dependency treatment services. Exodus developed and implemented inpatient psychiatric and chemical dependency treatment programs, intensive psychiatric outpatient clinics and a psychiatric medical group. Exodus provides programs that are accessible, appropriate and appealing to the culturally and ethnically diverse populations they serve. The Exodus Recovery mission is to bring the tools for the best possible quality of life to their clients. Their concept of total health care incorporates the physical, emotional, and spiritual needs of each client. The program strives to create an environment which promotes the dignity of all participating and to develop services maximizing clients’ self-determination. Exodus has been an LA County DMH contractor since 1996.

The mission of **John Wesley Community Health Institute (JWCH)** is to improve the health status of underserved segments of the population of Los Angeles County through the direct provision of coordination of healthcare, health education, and research. JWCH developed and integrated medical and behavioral health team in order to serve the most chronic and vulnerable homeless people in skid row. In their clinics throughout Los Angeles County, JWCH offers primary medical care, outpatient mental health counseling, substance abuse services (including residential services for women and women and children), and outpatient substance abuse services for men and women. JWCH's Center for Community Health in Downtown LA is implementing the IMHT program, and offers medical, dental, and vision care, HIV treatment and support services, case management, mental health and substance abuse services, pharmacy, and assistance with acquiring public benefits and access to housing. JWCH has partnered with South Central Health and Rehabilitation Center and Behavioral Health Services to implement the IMHT service model.

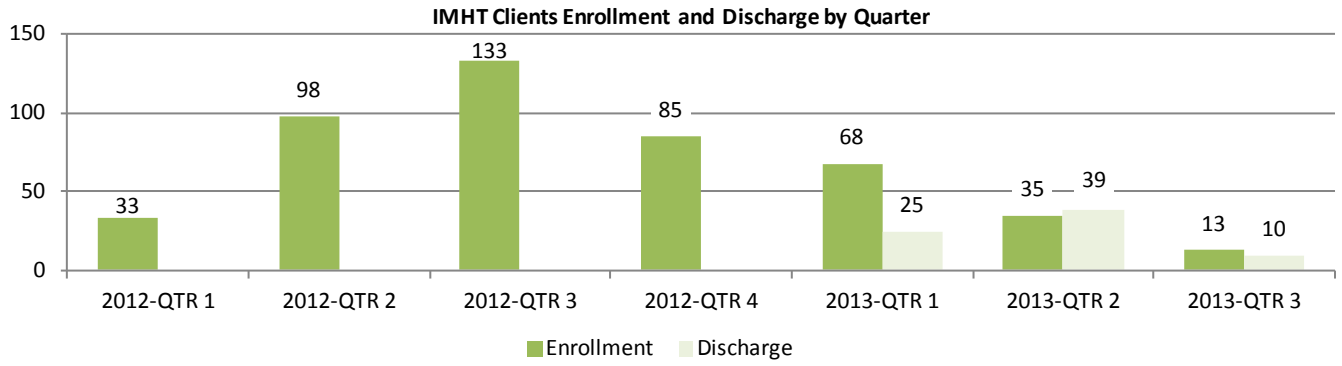
Mental Health America of Los Angeles (MHALA) is dedicated to promoting mental health recovery and wellness. Their purpose is to help everyone reach healthy lives – whether they need is recovery from mental illness or is occasional and caused by everyday life. The MHALA message is that good mental health is fundamental to the health and well-being of everyone in Los Angeles County. Founded in 1924, MHALA is a nonprofit organization that uses service, education, advocacy and training to create opportunities for adults and young adults with mental illness to recover to full, equal lives. MHALA provides integrated services programs based on a nationally recognized and replicated model, homeless assistance services, programs for at-risk veterans, and housing and community development programs.

The mission of **St. Joseph Center** is to provide working poor families, as well as homeless men, women and children of all ages, with the inner resources and tools to become productive, stable and self-supporting members of the community. St. Joseph Center takes a comprehensive view of the challenges that poverty and homelessness create for people, integrating many services into long-term solutions that provide the advantage of sustainable change for more than 6000 men, women, and children annually. In addition to case management and targeted mental health outreach and treatment, St. Joseph Center provide services including housing assistance, job training and referrals to improve employment situations, child care and family recreational activities, a food pantry and free restaurant, and assistance with managing money. St. Joseph Center has partnered with Ocean Park community Center (OPCC) to implement the IMHT service model.

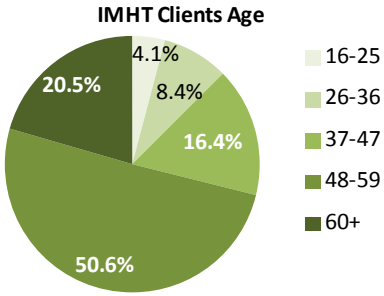
Step UP On Second assists individuals with severe and persistent mental illness in developing opportunities to reintegrate into the community. Step UP is dedicated to longer-term support of people in recovery and their families, offering quality housing, educational, social and work experience. Step UP is committed to increasing public understanding of mental illness. The three core strategies of Step UP include Help: providing members with supported education, rehabilitation, healthcare, social and employment opportunities that support recovery, self-sufficiency, and achievement of determined goals and integration into the community, Hope: providing preventive, proactive measures, advocacy, friendship, a sense of belonging, and the embrace of a respectable community, and Home: the provision of permanent supportive housing of their choosing in which they may thrive. Step UP has partnered with Project 180 to implement the IMHT service model.

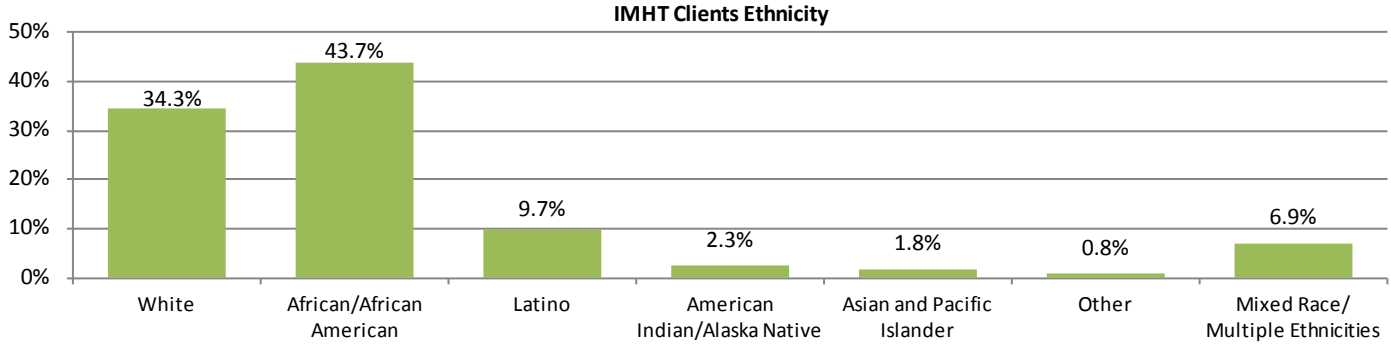
IMHT Enrollment, Discharge, and Demographics by Providers

To date, 465 clients (349 in 2012 and 116 in 2013) have enrolled in INN IMHT programs. New client enrollment in services peaked in the 3rd quarter of 2012 (28.6% of clients). Also, to date, a total of 74 clients have been discharged from INN IMHT programs. Discharge rates were highest during the 2nd quarter of 2013 (52.7% of all discharged clients).The most common discharge reasons for IMHT clients were non-compliance, incarceration, transfer to another program, and client leaving the program (no reason specified).



Current IMHT clients are most likely to be between the ages of 48 to 59 (50.6%). Current clients are also most likely to be African/African American (43.7%) or White (34.3%), and more likely to be male (65.5%; 33.8% are female and 0.8% are classified as other).





IMHT Enrollment, Discharge, and Demographics by Providers

Exodus Recovery, Inc. and St. Joseph Center have the highest enrollment rates of the IMHT programs. Across all IMHT programs, enrollment tended to be highest between the 2nd and 4th quarters of 2012.

	Enrollment by IMHT Providers								
	2012				2013				Total
IMHT Provider	QTR 1	QTR 2	QTR 3	QTR 4	QTR 1	QTR 2	QTR 3	QTR 4	
Exodus Recovery, Inc. Field Based Service	28	32	28	8	8	6	4	0	**114**
JWCH/SCHARP/BHS Field Based Service	0	5	43	14	4	11	4	0	**81**
Mental Health American MHALA-HIP	0	19	19	30	17	5	0	0	**90**
St. Joseph Center/OPCC	5	37	15	22	12	12	5	0	**108**
Step UP On Second/Project 180	0	5	28	11	27	1	0	0	**72**

A total of 74 clients discharged across all IMHT programs. Discharge was most frequent from Exodus Recovery, Inc. and St. Joseph Center/OPCC, the IMHT providers with the largest enrollment.

	Discharge by IMHT Providers				
	2013				Total
IMHT Provider	QTR 1	QTR 2	QTR 3	QTR 4	
Exodus Recovery, Inc. Field Based Service	20	7	5	0	**32**
JWCH/SCHARP/BHS Field Based Service	2	7	0	0	**9**
Mental Health American MHALA-HIP	2	0	0	0	**2**
St. Joseph Center/OPCC	0	21	5	0	**26**
Step UP On Second/Project 180	1	4	0	0	**5**

IMHT Completion of Evaluation Activities

Clinician-Completed Assessments

Completion rates for the baseline and six month assessments for each of the IMHT providers can be found in the table below. Clinician completion rates were higher for the mental health measures—IMR and MORS—compared to the Physical Health Indicators. Because there are many reasons why providers could not complete some assessments at scheduled time points, the completion goal is to have each measure completed for 80% of clients at each time point. Exodus reached this goal for the MORS, IMR and Physical Health Indicators at the baseline assessment. Step UP reached the goal for the MORS at baseline and the IMR at both baseline and six month assessments.

IMHT Clinician Assessment Completion by Measure						
IMHT Provider	MORS		IMR		Physical Health (BMI or BP)	
	Baseline Assessment	6 Month Assessment	Baseline Assessment	6 Month Assessment	Baseline Assessment	6 Month Assessment
Exodus Recovery, Inc. Field Based Service	88%	77%	88%	78%	82%	75%
JWCH/SCHARP/BHS Field Based Service	36%	68%	57%	71%	47%	54%
MHALA-HIP	63%	28%	60%	29%	58%	0%
St. Joseph's Center/OPCC	52%	48%	42%	57%	58%	48%
Step UP On Second/Project 180	79%	80%	81%	83%	44%	19%
Overall IMHT Average	**64%**	**60%**	**65%**	**64%**	**58%**	**39%**

Client-Completed Assessments

Completion rates for the client-completed assessments were lower than for the clinician-completed measures; approximately 40% of IMHT clients completed assessments at the baseline and six month assessments. For both baseline and six month time points, client assessments were most likely to be completed by clients at Step UP On Second/Project 180.

IMHT Client Assessment Completion by Measure								
IMHT Provider	Total PROMIS Global Health		CHOIS Strengths Scale		CHOIS Average Psychosis		CHOIS Average Memory	
	Baseline Assessment	6 Month Assessment	Baseline Assessment	6 Month Assessment	Baseline Assessment	6 Month Assessment	Baseline Assessment	6 Month Assessment
Exodus Recovery, Inc. Field Based Service	11%	37%	11%	35%	11%	35%	11%	35%
JWCH/SCHARP/BHS Field Based Service	22%	52%	22%	52%	22%	52%	22%	52%
MHALA-HIP	51%	12%	51%	12%	51%	12%	51%	12%
St. Joseph's Center/OPCC	32%	34%	31%	33%	31%	34%	31%	34%
Step UP On Second/Project 180	78%	54%	76%	53%	78%	53%	78%	53%
Overall IMHT Average	**39%**	**38%**	**38%**	**37%**	**39%**	**37%**	**39%**	**37%**

IMHT Evaluation Outcomes

Illness Management and Recovery (IMR) Scale

The Illness Management and Recovery (IMR) scale captures clinician-reported recovery through 15 individual items, which make up an overall score and three sub-scales: Recovery, Management, and Substance-Use. All IMR items and scales range from 1 to 5, with lower scores representing greater progress towards recovery.

IMR ITEMS

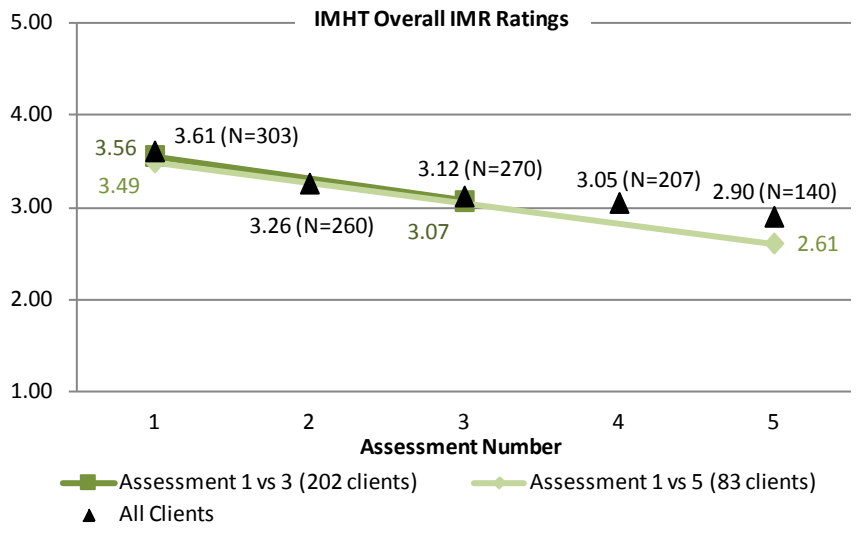
The table below shows mean clinician ratings for each of the items on the IMR. The relatively high items scores at baseline indicate that clients were not very far along in their recovery when they enrolled in INN. According to clinicians, at baseline, clients needed the most improvement in the following domains: time in structured roles, symptom distress, impairment of functioning, relapse prevention planning, and relapse of symptoms. Statistically significant improvements in client recovery, as measured by the IMR, were found by looking at matched samples from baseline to six months (Assessment 1 versus 3) and from baseline to 12 months (Assessment 1 versus 5). Clinicians reported significant progress in all aspects of clients' recovery six months after enrollment, except impairment of functioning through alcohol use (indicated by lower item means). Clinicians also reported significant progress in all aspects of clients' recovery twelve months after enrollment.

IMHT IMR Ratings by Item								
ITEM #	Aspect of Illness Management & Recovery	Baseline (All clients)	Matched Samples					
			Assessment 1 vs. 3			Assessment 1 vs. 5		
1	Progress towards personal goals	3.75 (N=302)	3.72	2.81↓	(N=200)	3.72	2.17↓	(N=82)
2	Knowledge	3.77 (N=303)	3.74	3.10↓	(N=202)	3.63	2.71↓	(N=83)
3	Involvement of family and friends in my mental health treatment	4.03 (N=303)	3.89	3.54↓	(N=202)	3.61	3.24↓	(N=83)
4	Contact with people outside of my family	2.78 (N=303)	2.77	2.27↓	(N=202)	2.57	1.60↓	(N=83)
5	Time in structured roles	4.70 (N=302)	4.66	4.28↓	(N=201)	4.61	3.93↓	(N=83)
6	Symptom distress	4.17 (N=302)	4.10	3.51↓	(N=201)	4.05	3.10↓	(N=83)
7	Impairment of functioning	4.33 (N=303)	4.25	3.61↓	(N=202)	4.12	3.11↓	(N=83)
8	Relapse prevention planning	4.09 (N=302)	4.07	3.75↓	(N=200)	4.02	3.37↓	(N=82)
9	Relapse of symptoms	4.10 (N=301)	4.04	3.67↓	(N=199)	3.93	2.93↓	(N=83)
10	Psychiatric hospitalizations	2.24 (N=301)	2.25	1.73↓	(N=200)	2.74	1.43↓	(N=82)
11	Coping	4.00 (N=303)	3.95	3.43↓	(N=203)	3.90	3.01↓	(N=83)
12	Involvement with self-help activities	3.68 (N=303)	3.54	2.93↓	(N=201)	3.35	2.30↓	(N=79)
13	Using medication effectively	2.96 (N=212)	3.00	2.31↓	(N=147)	3.02	1.95↓	(N=65)
14	Impairment of functioning through alcohol use	2.62 (N=303)	2.60	2.46	(N=201)	2.25	1.88↓	(N=83)
15	Impairment of functioning through drug use	2.65 (N=303)	2.68	2.52↓	(N=202)	2.67	2.18↓	(N=83)

Table provides IMR item means at baseline and subsequent assessments. Values range from 1 to 5, with lower scores representing improvements in recovery and illness management.

OVERALL IMR SCALE

Looking at the Overall IMR scale scores across all IMHT clients, there was a significant decrease in Overall IMR scores six and twelve months after enrollment. This indicates that, on average, INN clients made consistent progress towards their recovery after enrolling in services. Mean IMR scores across all IMHT clients at a given assessment were comparable to scores for clients who completed matched assessments.



Overall IMR scores decreased significantly for clients at Exodus, JWCH, and MHALA three, six, and twelve months after enrollment. Overall IMR scores also decreased significantly for clients at St. Joseph Center and Step UP three months after enrollment.

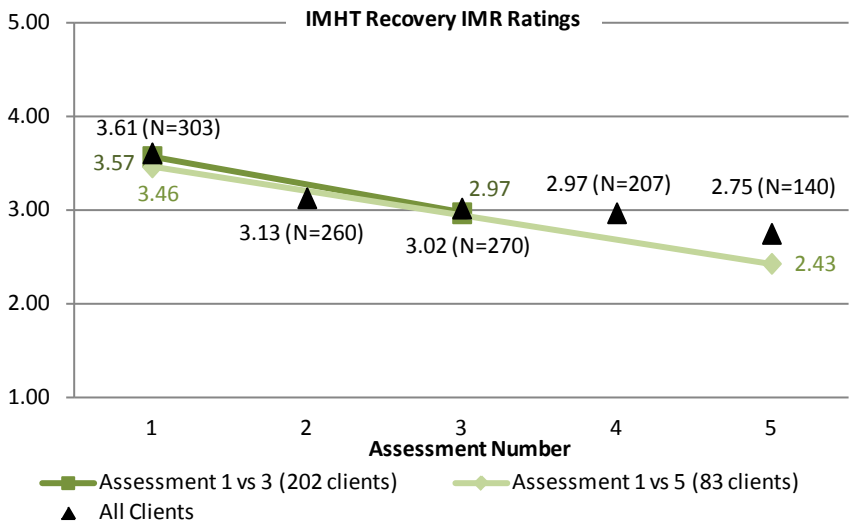
Overall IMR Ratings by IMHT Providers										
IMHT Provider	Baseline (All clients)	Matched Samples								
		Assessment 1 vs. 2			Assessment 1 vs. 3			Assessment 1 vs. 5		
Exodus Recovery, Inc. Field Based Service	3.50 (N=100)	3.51	2.94↓	(N=90)	3.45	2.68↓	(N=81)	3.51	2.33↓	(N=48)
JWCH/SCHARP/BHS Field Based Service	3.70 (N=46)	3.69	3.30↓	(N=25)	3.63	3.02↓	(N=29)	3.40	2.85↓	(N=18)
Mental Health American MHALA-HIP	3.68 (N=54)	3.69	3.40↓	(N=10)	3.61	3.24↓	(N=21)	4.10	3.07↓	(N=4)
St. Joseph Center/OPCC	3.64 (N=45)	3.64	3.44↓	(N=39)	3.71	3.55	(N=21)	3.83	3.48	(N=5)
Step UP On Second/Project 180	3.63 (N=58)	3.69	3.50↓	(N=46)	3.63	3.47↓	(N=50)	3.09	3.01	(N=8)

Table provides Overall IMR means at baseline and subsequent assessments. Values range from 1 to 5, with lower scores representing improvements in recovery and illness management. Assessment 1 vs. 2 was included due to smaller matched samples for the 1 vs. 5 comparisons at the provider-level.

Clinicians reported clinically meaningful improvements in clients' progress towards recovery and ability to manage their health for 63.9% of all IMHT clients at the six month assessment. Focusing on specific providers, over half of all clients at Exodus Recovery, Inc. (82.7%), JWCH/SCHARP/BHS (62.1%), and MHALA (57.1%) made clinically meaningful improvements in their recovery during the first six months of enrollment. Many of the clients from St. Joseph Center/OPCC (47.6%) and Step UP On Second (44.0%) made clinically meaningful improvements in their recovery during the first six months of enrollment.

Clinically Meaningful Changes in Overall IMR Ratings by IMHT Providers		
IMHT Provider	Matched Sample	
	Assessment 1 vs. 3	
	% clients with clinically meaningful improvement	Number of clients in matched sample
Overall IMHT Model	**63.9%**	**(N=202)**
Exodus Recovery, Inc. Field Based Service	82.7%	(N=81)
JWCH/SCHARP/BHS Field Based Service	62.1%	(N=29)
Mental Health American MHALA-HIP	57.1%	(N=21)
St. Joseph Center/OPCC	47.6%	(N=21)
Step UP On Second/Project 180	44.0%	(N=50)

Table provides percent of clients that experienced clinically meaningful improvements in illness management and recovery (indicated by Overall IMR ratings decrea sing at least 0.3 points) six months after enrollment.



RECOVERY SUB-SCALE

There was a significant decrease in scores on the Recovery sub-scale for all IMHT clients; indicating that, on average, clinicians observed that their clients made consistent progress towards recovery since enrolling in INN services.

Recovery scores across all IMHT clients were similar to scores for clients with matched assessments at each time point. IMR Recovery sub-scale scores decreased significantly for clients at Exodus, JWCH, and MHALA three, six, and twelve months after enrollment. IMR Recovery scores decreased significantly for clients at St. Joseph and Step UP three months after enrollment.

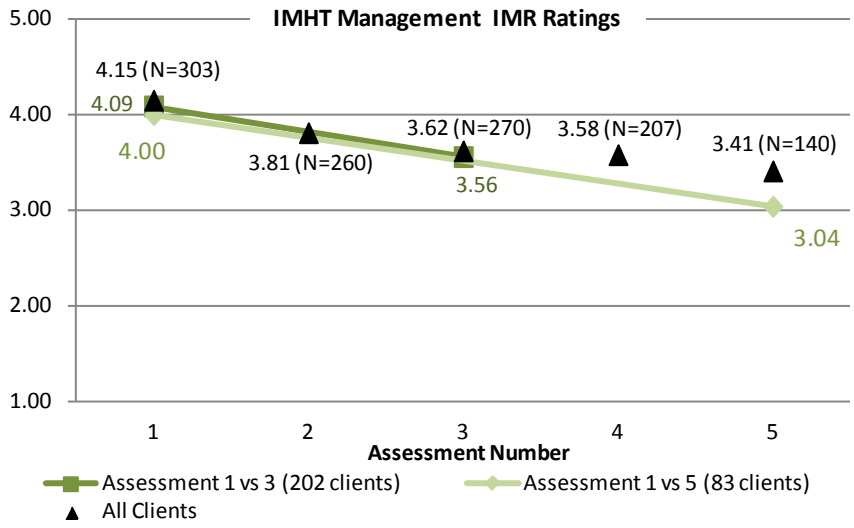
Recovery IMR Ratings by IMHT Providers										
IMHT Provider	Baseline (All clients)	Matched Samples								
		Assessment 1 vs. 2			Assessment 1 vs. 3			Assessment 1 vs. 5		
Exodus Recovery, Inc. Field Based Service	3.51 (N=100)	3.53	2.83↓	(N=90)	3.49	2.54↓	(N=81)	3.56	2.20↓	(N=48)
JWCH/SCHARP/BHS Field Based Service	3.54 (N=46)	3.42	2.98↓	(N=25)	3.41	2.69↓	(N=29)	3.17	2.54↓	(N=18)
Mental Health American MHALA-HIP	3.72 (N=54)	3.70	3.40↓	(N=10)	3.52	3.12↓	(N=21)	4.15	2.95↓	(N=4)
St. Joseph Center/OPCC	3.63 (N=45)	3.56	3.19↓	(N=39)	3.80	3.57	(N=21)	3.84	3.28	(N=5)
Step UP On Second/Project 180	3.74 (N=58)	3.78	3.54↓	(N=46)	3.71	3.50	(N=50)	2.93	2.74	(N=8)

Table provides IMR Recovery sub-scale means at baseline and subsequent assessments. Values range from 1 to 5, with lower scores representing improvements in recovery. Assessment 1 vs. 2 was included due to smaller matched samples for the 1 vs. 5 comparisons at the provider-level.

Clinicians reported clinically meaningful improvements in clients' progress on the Recovery sub-scale of the IMR for 66.3% of all IMHT clients at the six month assessment. Focusing on specific providers, over half of all clients at Exodus Recovery, Inc. (85.2%), JWCH/SCHARP/BHS (72.4%), and MHALA (57.1%) made clinically meaningful improvements in their recovery during the first six months of enrollment. During the same time period, many clients made clinically meaningful improvements in their recovery at Step UP On Second (46.0%) and St. Joseph Center/OPCC (42.9%).

Clinically Meaningful Changes in Recovery IMR Ratings by IMHT Providers		
IMHT Provider	Matched Sample	
	Assessment 1 vs. 3	
	% clients with clinically meaningful improvement	Number of clients in matched sample
Overall IMHT Model	**66.3%**	**(N=202)**
Exodus Recovery, Inc. Field Based Service	85.2%	(N=81)
JWCH/SCHARP/BHS Field Based Service	72.4%	(N=29)
Mental Health American MHALA-HIP	57.1%	(N=21)
St. Joseph Center/OPCC	42.9%	(N=21)
Step UP On Second/Project 180	46.0%	(N=50)

Table provides percent of clients that experienced clinically meaningful improvements in illness recovery (indicated by Recovery IMR ratings decrea sing at least 0.4 points) six months after enrollment.



MANAGEMENT SUB-SCALE

There was a significant decrease in scores on the IMR Management sub-scale for all IMHT clients six and twelve months after enrollment. This indicates that, on average, clients experienced significant progress in managing their mental illness since enrolling in INN services. Management IMR scores across all INN clients were similar to scores for clients with matched assessments at each time point.

IMR Management sub-scale scores decreased significantly for clients at Exodus, JWCH, and MHALA three, six, and twelve months after enrollment. IMR Management scores also decreased significantly for clients at Step UP three and six months after enrollment.

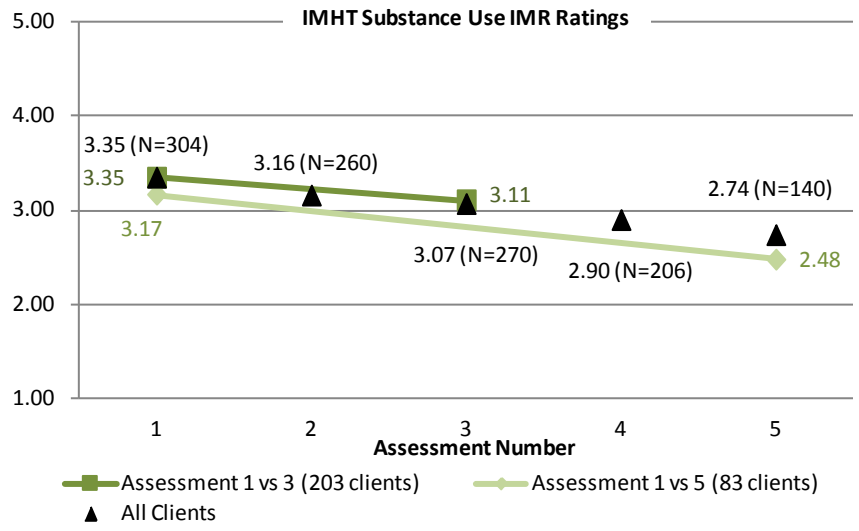
Management IMR Ratings by IMHT Providers										
IMHT Provider	Baseline (All clients)	Matched Samples								
		Assessment 1 vs. 2			Assessment 1 vs. 3			Assessment 1 vs. 5		
Exodus Recovery, Inc. Field Based Service	3.90 (N=100)	3.91	3.41↓	(N=90)	3.82	3.19↓	(N=81)	3.88	2.70↓	(N=48)
JWCH/SCHARP/BHS Field Based Service	4.49 (N=46)	4.65	4.17↓	(N=25)	4.46	3.60↓	(N=29)	4.24	3.33↓	(N=18)
Mental Health American MHALA-HIP	4.41 (N=54)	4.58	3.93↓	(N=10)	4.41	3.80↓	(N=21)	4.88	3.56↓	(N=4)
St. Joseph Center/OPCC	4.19 (N=45)	4.26	4.22	(N=39)	4.34	4.02	(N=21)	4.40	4.15	(N=5)
Step UP On Second/Project 180	4.04 (N=58)	4.14	3.82↓	(N=46)	4.06	3.81↓	(N=50)	3.53	3.41	(N=8)

Table provides IMR Management sub-scale means at baseline and subsequent assessments. Values range from 1 to 5, with lower scores representing improvements in management. Assessment 1 vs. 2 was included due to smaller matched samples for the 1 vs. 5 comparisons at the provider-level.

Clinicians reported clinically meaningful improvements in clients' management of their health for 57.9% of all IMHT clients at the six month assessment. Focusing on specific providers, over half of all clients at Exodus Recovery, Inc. (67.9%), JWCH/SCHARP/BHS (65.5%), and MHALA (52.4%) made clinically meaningful improvements in managing their health during the first six months of enrollment. During the same time period, many clients made clinically meaningful improvements in managing their health at Step UP On Second (46.0%) and St. Joseph Center/OPCC (42.9%).

Clinically Meaningful Changes in Management IMR Ratings by IMHT Providers		
IMHT Provider	Matched Sample	
	Assessment 1 vs. 3	
	% clients with clinically meaningful improvement	Number of clients in matched sample
Overall IMHT Model	**57.9%**	**(N=202)**
Exodus Recovery, Inc. Field Based Service	67.9%	(N=81)
JWCH/SCHARP/BHS Field Based Service	65.5%	(N=29)
Mental Health American MHALA-HIP	52.4%	(N=21)
St. Joseph Center/OPCC	42.9%	(N=21)
Step UP On Second/Project 180	46.0%	(N=50)

Table provides percent of clients that experienced clinically meaningful improvements in illness management (indicated by Management IMR ratings decreasing at least 0.4 points) six months after enrollment.



SUBSTANCE USE SUB-SCALE

There was a significant decrease in IMR Substance Use sub-scale ratings for all IMHT clients six and twelve months after enrollment. This indicates that clinicians observed that INN clients experienced less functional impairment due to alcohol and/or drug use six and twelve months after enrolling in INN services. Substance Use IMR ratings across all IMHT clients were similar to clients with matched assessments at each time point.

Substance Use sub-scale scores decreased significantly for clients at Exodus and JWCH three, six, and twelve months after enrollment.

Substance Use IMR Ratings by IMHT Providers										
IMHT Provider	Baseline (All clients)	Matched Samples								
		Assessment 1 vs. 2			Assessment 1 vs. 3			Assessment 1 vs. 5		
Exodus Recovery, Inc. Field Based Service	3.01 (N=100)	3.03	2.62↓	(N=90)	3.01	2.57↓	(N=81)	3.21	2.31↓	(N=48)
JWCH/SCHARP/BHS Field Based Service	3.61 (N=46)	3.80	3.32↓	(N=25)	3.83	3.14↓	(N=29)	3.28	2.67↓	(N=18)
Mental Health American MHALA-HIP	3.24 (N=54)	3.10	3.60	(N=10)	3.33	3.52	(N=21)	3.50	3.25	(N=4)
St. Joseph Center/OPCC	3.48 (N=46)	3.48	3.43	(N=40)	3.14	3.50	(N=22)	2.60	2.60	(N=5)
Step UP On Second/Project 180	3.72 (N=58)	3.89	3.87	(N=46)	3.74	3.62	(N=50)	2.88	2.63	(N=8)

Table provides IMR Substance Use sub-scale means at baseline and subsequent assessments. Values range from 1 to 5 with lower scores representing decreased impairment associated with substance use. Assessment 1 vs. 2 was included due to smaller matched samples for the 1 vs. 5 comparisons at the provider-level.

Fewer clients made clinically meaningful improvements in the amount of functional impairment they experienced compared to the other IMR subscales. Clinicians reported that 38.9% of all IMHT clients experienced clinically meaningful improvements at the six-month assessment. Clinicians from JWCH/SCHARP/BHS (55.2%) and Exodus Recovery, Inc. (48.2%) were the most likely to report that their clients had a clinically meaningful decrease in their functional impairment due to alcohol and/or drug use.

Clinically Meaningful Changes in Substance Use IMR Ratings by IMHT Providers		
IMHT Provider	Matched Sample	
	Assessment 1 vs. 3	
	% clients with clinically meaningful improvement	Number of clients in matched sample
Overall IMHT Model	**38.9%**	**(N=203)**
Exodus Recovery, Inc. Field Based Service	48.2%	(N=81)
JWCH/SCHARP/BHS Field Based Service	55.2%	(N=29)
Mental Health American MHALA-HIP	19.1%	(N=21)
St. Joseph Center/OPCC	13.6%	(N=22)
Step UP On Second/Project 180	34.0%	(N=50)

Table provides percent of clients that experienced clinically meaningful decreases in alcohol and/or drug related functioning impairment (indicated by Substance Use IMR ratings decreasing at least 0.8 points) six months after enrollment.

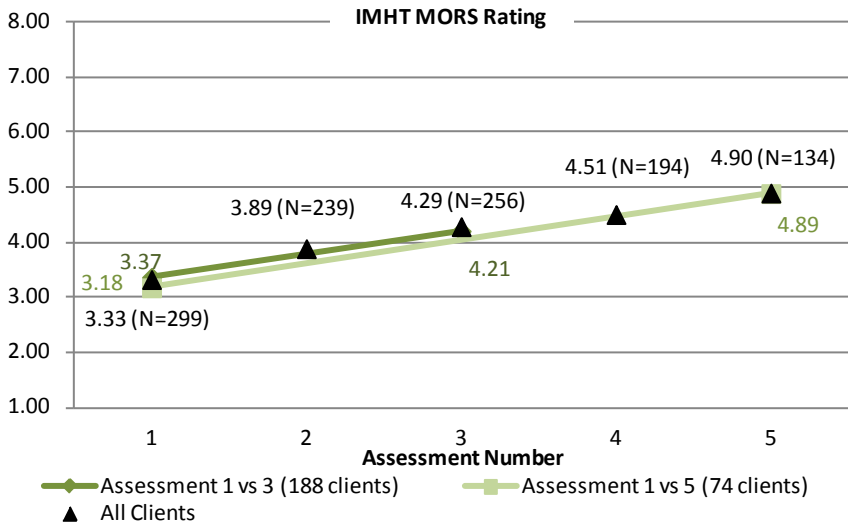
Milestones of Recovery Scale (MORS)

The Milestones of Recovery Scale (MORS) captures clinician-reported recovery through a single-item recovery indicator. Clinicians are asked to place clients into one of the 8 stages of recovery (rated 1 through 8, respectively): extreme risk, high risk/not engaged, high risk/engaged, poorly coping/not engaged, poorly coping/engaged, coping/rehabilitating, early recovery, and advanced recovery. Although the MORS is not a linear scale, higher MORS ratings are associated with greater recovery.

At baseline, IMHT clients were most likely to be categorized in the high risk/engaged stage of recovery (63.5%). Using matched samples six and twelve months after enrollment, IMHT clients were most likely to be in the poorly coping/engaged stage of recovery. This indicates that overall, clinicians witnessed improvement in clients' recovery over six and twelve months.

IMHT MORS Ratings						
Rating #	Milestones of Recovery	Baseline (All clients N=299)	Matched Samples			
			Assessment 1 vs. 3 (N=188)		Assessment 1 vs. 5 (N=74)	
1	Extreme Risk	1.7%	1.6%	4.3%	1.4%	0.0%
2	High risk / Not engaged	9.4%	8.5%	5.3%	9.5%	1.4%
3	High risk / Engaged	63.5%	62.2%	26.6%	70.3%	13.5%
4	Poorly coping / Not engaged	7.7%	9.6%	6.4%	8.1%	8.1%
5	Poorly coping / Engaged	15.1%	15.4%	44.7%	10.8%	51.4%
6	Coping / Rehabilitating	2.7%	2.7%	11.7%	0.0%	23.0%
7	Early Recovery	0.0%	0.0%	1.1%	0.0%	2.7%
8	Advanced Recovery	0.0%	0.0%	0.0%	0.0%	0.0%

Although the MORS was not developed to be used as a linear scale, mean scores indicate that IMHT clients' recovery ratings did significantly increase six and twelve months after enrollment compared to baseline. This indicates that, on average, clinicians observed that clients were in more advanced stages of recovery six and twelve months after enrollment in INN services. Average MORS ratings are also provided for all IMHT clients. In general, MORS ratings for all INN clients were similar to the matched sample at each time point.



MORS scores increased significantly for clients at all IMHT providers twelve months after enrollment. MORS scores increased significantly for clients at Exodus, JWCH, and MHALA three and six months after enrollment.

MORS Ratings by IMHT Providers										
IMHT Provider	Baseline (All clients)	Matched Samples								
		Assessment 1 vs. 2			Assessment 1 vs. 3			Assessment 1 vs. 5		
Exodus Recovery, Inc. Field Based Service	3.03 (N=100)	3.02	3.73↑	(N=86)	3.09	4.35↑	(N=80)	3.00	5.00↑	(N=48)
JWCH/SCHARP/BHS Field Based Service	3.72 (N=29)	3.88	5.18↑	(N=17)	3.73	5.13↑	(N=15)	4.00	5.00↑	(N=7)
Mental Health American MHALA-HIP	3.04 (N=57)	3.00	3.73↑	(N=11)	3.00	4.40↑	(N=20)	3.67	5.17↑	(N=6)
St. Joseph Center/OPCC	3.79 (N=56)	3.88	4.03	(N=40)	4.00	4.19	(N=26)	3.00	4.33↑	(N=6)
Step UP On Second/Project 180	3.51 (N=57)	3.50	3.66	(N=44)	3.53	3.62	(N=47)	3.29	4.29↑	(N=7)

Table provides MORS rating means at baseline and subsequent assessments. Values range from 1 to 8, and although not a linear scale, higher values generally representing increased recovery. Assessment 1 vs. 2 was included due to smaller matched samples for the 1 vs. 5 comparisons at the provider-level.

Clinicians reported clinically meaningful improvements in client recovery for 57.5% of all IMHT clients at the six month assessment. Focusing on specific providers, over half of all clients at JWCH/SCHARP/BHS (80.0%), Exodus Recovery, Inc. (66.3%), and MHALA (65.0%) made clinically meaningful improvements in their recovery during the first six months of enrollment. During the same time period, many clients made clinically meaningful improvements in their recovery at St. Joseph Center/OPCC (46.2%) and Step UP On Second (38.3%).

Clinically Meaningful Changes in MORS Ratings by IMHT Providers		
IMHT Provider	Matched Sample	
	Assessment 1 vs. 3	
	% clients with clinically meaningful improvement	Number of clients in matched sample
Overall IMHT Model	**57.5%**	**(N=188)**
Exodus Recovery, Inc. Field Based Service	66.3%	(N=80)
JWCH/SCHARP/BHS Field Based Service	80.0%	(N=15)
Mental Health American MHALA-HIP	65.0%	(N=20)
St. Joseph Center/OPCC	46.2%	(N=26)
Step UP On Second/Project 180	38.3%	(N=47)

Table provides percent of clients that experienced clinically meaningful improvements in recovery (indicated by higher milestones of recovery, or MORS ratings increasing by 1.0 points) six months after enrollment.

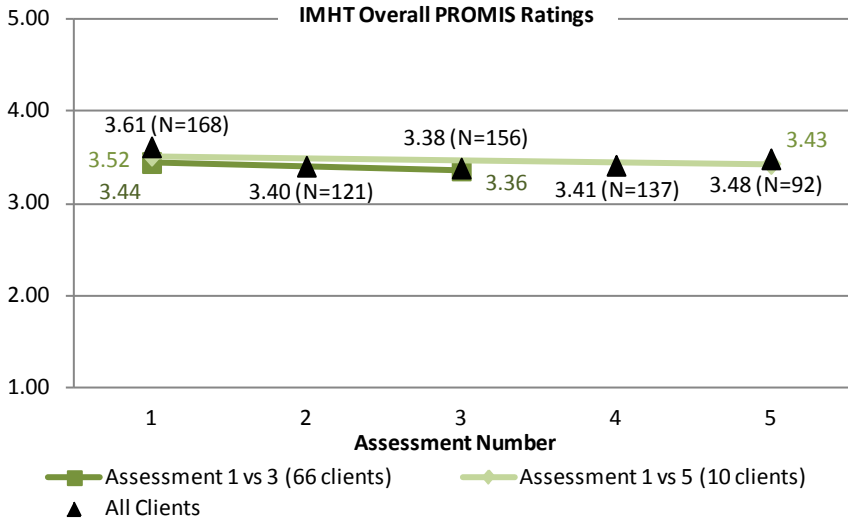
Patient Reported Outcomes Measurement Information System (PROMIS)

The PROMIS Global Health scale is a 10-item measure aimed at assessing client-reported health including: physical health, pain, fatigue, mental health, and social health. Items are used to create a Total Global Health score and two sub-scale scores; Physical Health and Mental Health. PROMIS Global Health scores range from 1 to 5; however, clients are also asked to rate their pain using a scale from 0 (no pain) – 10 (worst imaginable pain), which is then categorized into a 5-point scale. For all PROMIS items and scales, lower scores represent fewer health concerns (i.e. lower scores are desirable).

OVERALL PROMIS GLOBAL HEALTH SCALE

Overall PROMIS Global Health scale scores did not significantly change six and twelve months after enrollment. Mean scores across all IMHT clients at a given assessment were comparable to scores for clients with completed matched assessments.

PROMIS scores increased significantly for clients at Exodus and St. Joseph six months after enrollment.



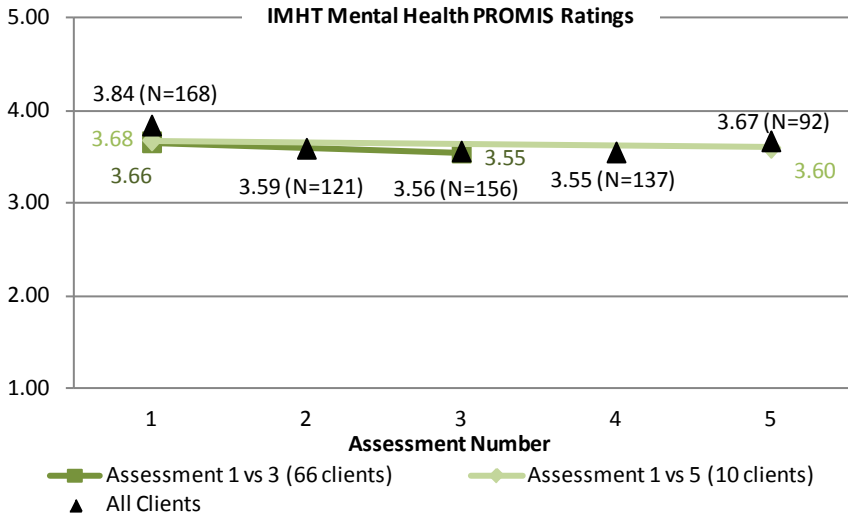
Overall PROMIS Ratings by IMHT Providers							
IMHT Provider	Baseline (All clients)	Matched Samples					
		Assessment 1 vs. 2			Assessment 1 vs. 3		
Exodus Recovery, Inc. Field Based Service	3.87 (N=13)	3.96	3.71	(N=7)	4.00	3.48↓	(N=4)
JWCH/SCHARP/BHS Field Based Service	3.49 (N=18)	3.70	3.80	(N=1)	3.31	3.07	(N=6)
Mental Health American MHALA-HIP	3.92 (N=46)	4.19	4.29	(N=9)	3.94	3.98	(N=8)
St. Joseph Center/OPCC	3.75 (N=35)	3.78	3.38↓	(N=18)	3.78	3.31↓	(N=13)
Step UP On Second/Project 180	3.25 (N=56)	3.19	3.08	(N=40)	3.17	3.27	(N=35)

Table provides Total PROMIS Scale means at baseline and subsequent assessments. Values range from 1 to 5 with lower scores representing improved global health. Assessment 1 vs. 2 was included due to limited or no matched samples for the 1 vs. 5 comparisons at the provider-level.

Across all IMHT providers, 37.9% of all clients reported clinically meaningful improvements in their overall health. Clients at Exodus Recovery, Inc. (75.0%) and St. Joseph Center/OPCC (61.5%) were most likely to report experiencing clinically meaningful improvements in overall health.

Clinically Meaningful Changes in Overall PROMIS Ratings by IMHT Providers		
IMHT Provider	Matched Sample	
	Assessment 1 vs. 3	
	% clients with clinically meaningful improvement	Number of clients in matched sample
Overall IMHT Model	**37.9%**	**(N=66)**
Exodus Recovery, Inc. Field Based Service	75.0%	(N=4)
JWCH/SCHARP/BHS Field Based Service	33.3%	(N=6)
Mental Health American MHALA-HIP	37.5%	(N=8)
St. Joseph Center/OPCC	61.5%	(N=13)
Step UP On Second/Project 180	25.7%	(N=35)

Table provides percent of clients that experienced clinically meaningful improvements in overall health (indicated by Overall PROMIS ratings decreasing at least 0.4 points) six months after enrollment.



MENTAL HEALTH SUB-SCALE

PROMIS Mental Health sub-scale scores did not significantly change six and twelve months after enrollment. Mental Health PROMIS Global Health sub-scale ratings across all IMHT clients were similar to clients with matched assessments at each time point.

Clients at Exodus and St. Joseph reported significant increases in PROMIS Mental Health sub-scale scores six months after enrollment.

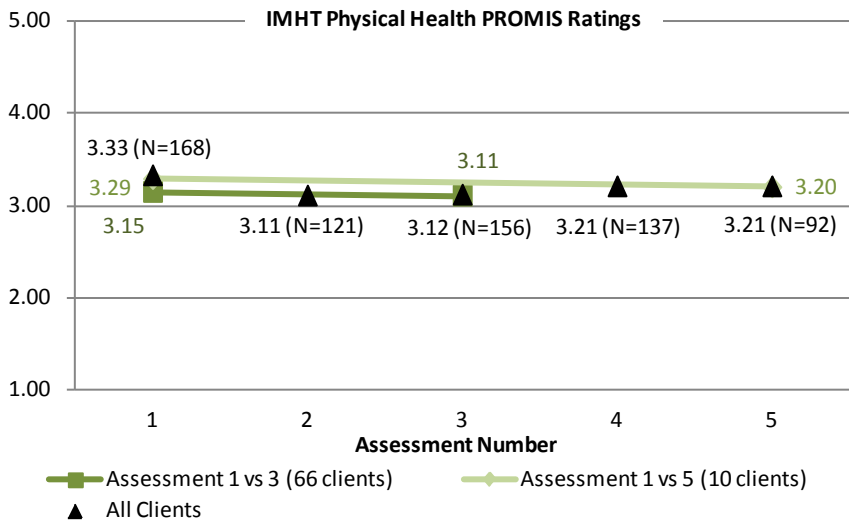
Mental Health PROMIS Ratings by IMHT Providers							
IMHT Provider	Baseline (All clients)	Matched Samples					
		Assessment 1 vs. 2			Assessment 1 vs. 3		
Exodus Recovery, Inc. Field Based Service	4.15 (N=13)	4.25	4.00	(N=7)	4.38	3.81↓	(N=4)
JWCH/SCHARP/BHS Field Based Service	3.77 (N=18)	4.00	4.50	(N=1)	3.43	3.13	(N=6)
Mental Health American MHALA-HIP	4.01 (N=46)	4.19	4.19	(N=9)	4.16	4.03	(N=8)
St. Joseph Center/OPCC	4.07 (N=35)	4.15	3.57↓	(N=18)	4.10	3.42↓	(N=13)
Step UP On Second/Project 180	3.49 (N=56)	3.43	3.34	(N=40)	3.35	3.53	(N=35)

Table provides PROMIS Mental Health sub-scale means at baseline and subsequent assessments. Values range from 1 to 5 with lower scores representing improved mental health. Assessment 1 vs. 2 was included due to limited or no matched samples for the 1 vs. 5 comparisons at the provider-level.

Across all IMHT providers, 34.9% of all clients reported clinically meaningful improvements in their mental health. Clients at Exodus Recovery, Inc. (75.0%) and St. Joseph Center/OPCC (53.9%) were most likely to report clinically meaningful improvements in their mental health.

Clinically Meaningful Changes in Mental Health PROMIS Ratings by IMHT Providers		
IMHT Provider	Matched Sample	
	Assessment 1 vs. 3	
	% clients with clinically meaningful improvement	Number of clients in matched sample
Overall IMHT Model	**34.9%**	**(N=66)**
Exodus Recovery, Inc. Field Based Service	75.0%	(N=4)
JWCH/SCHARP/BHS Field Based Service	16.7%	(N=6)
Mental Health American MHALA-HIP	37.5%	(N=8)
St. Joseph Center/OPCC	53.9%	(N=13)
Step UP On Second/Project 180	25.7%	(N=35)

Table provides percent of clients that experienced clinically meaningful improvements in mental health (indicated by Mental Health PROMIS ratings decreasing at least 0.4 points) six months after enrollment.



PHYSICAL HEALTH SUB-SCALE

PROMIS Physical Health sub-scale scores did not significantly change six and twelve months after enrollment. PROMIS Physical Health sub-scale scores across all IMHT clients were similar to scores for clients with matched assessments at each time point.

PROMIS Physical Health scores did not significantly differ for any IMHT provider three or six months after enrollment compared to baseline.

Physical Health PROMIS Ratings by IMHT Providers							
IMHT Provider	Baseline (All clients)	Matched Samples					
		Assessment 1 vs. 2			Assessment 1 vs. 3		
Exodus Recovery, Inc. Field Based Service	3.48 (N=13)	3.64	3.32	(N=7)	3.56	3.00	(N=4)
JWCH/SCHARP/BHS Field Based Service	3.12 (N=18)	3.00	3.25	(N=1)	3.00	2.79	(N=6)
Mental Health American MHALA-HIP	3.79 (N=46)	4.11	4.28	(N=9)	3.81	3.81	(N=8)
St. Joseph Center/OPCC	3.41 (N=35)	3.39	3.15	(N=18)	3.40	3.13	(N=13)
Step UP On Second/Project 180	2.94 (N=56)	2.86	2.72	(N=40)	2.89	3.01	(N=35)

Table provides PROMIS Physical Health Scale means at baseline and subsequent assessments. Values range from 1 to 5 with lower scores representing improved physical health. Assessment 1 vs. 2 was included due to limited or no matched samples for the 1 vs. 5 comparisons at the provider-level.

Across all IMHT providers, 30.3% of all clients reported clinically meaningful improvements in their physical health. Clients at Exodus Recovery, Inc. (75.0%) and St. Joseph Center/OPCC (46.2%) were most likely to report experiencing clinically meaningful improvements in their physical health.

Clinically Meaningful Changes in Physical Health PROMIS Ratings by IMHT Providers		
IMHT Provider	Matched Sample	
	Assessment 1 vs. 3	
	% clients with clinically meaningful improvement	Number of clients in matched sample
Overall IMHT Model	**30.3%**	**(N=66)**
Exodus Recovery, Inc. Field Based Service	75.0%	(N=4)
JWCH/SCHARP/BHS Field Based Service	33.3%	(N=6)
Mental Health American MHALA-HIP	25.0%	(N=8)
St. Joseph Center/OPCC	46.2%	(N=13)
Step UP On Second/Project 180	20.0%	(N=35)

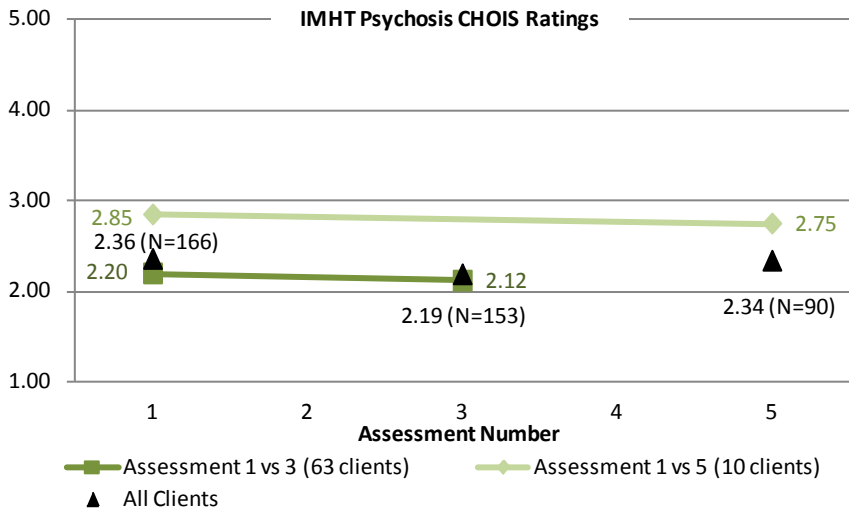
Table provides percent of clients that experienced clinically meaningful improvements in physical health (indicated by Physical Health PROMIS ratings decreasing at least 0.4 points) six months after enrollment.

Creating Healthy Outcomes: Integrated Self-Assessment (CHOIS) Supplement

The CHOIS Supplement is a client-rated recovery-based measure that assesses several mental health related domains, including suicidal ideation, anxiety, trauma, psychosis (i.e. hearing voices), and memory and cognitive impairment. The CHOIS comprises three sub-scales: Psychosis, Memory and Cognitive Impairments, and Strengths. The Psychosis and Memory and Cognitive Impairment sub-scales assess clients' perceptions of their mental health symptoms, while the Strengths sub-scale examines recovery-oriented personal strengths that can assist clients in their recovery. All CHOIS sub-scales range from 1 to 5, with lower scores being desirable. For the Psychosis and Memory and Cognitive Impairment sub-scales, lower scores indicate fewer negative symptoms. For the Strengths sub-scale, lower scores indicate greater personal strengths.

PSYCHOSIS CHOIS SUB-SCALE

Client-reported Psychosis CHOIS sub-scale scores did not significantly change six or twelve months after enrollment compared to baseline. However, Psychosis scores did slightly decrease six and twelve months after enrollment, suggesting some improvement. Forty percent of all IMHT clients reported clinically observable improvements in psychosis-related symptoms (indicated by decreased Psychosis CHOIS sub-scale ratings) twelve months after enrollment; 22.2% reported clinically observable improvements six months after enrollment. Psychosis sub-scale scores across all IMHT clients were similar to clients with matched assessments at each time point.



There were no significant changes in Psychosis sub-scale scores six months after enrollment across any IMHT providers. However, across most IMHT providers, Psychosis CHOIS scores decreased, suggesting some improvement in client-reported mental health. All clients at Exodus with completed baseline and six month CHOIS scores indicated clinically observable improvements in psychosis-related symptoms (indicated by decreased Psychosis CHOIS ratings) six months after enrollment. Twenty-five percent of clients at MHALA and St. Joseph reported clinically observable improvements six months after enrollment, while 16.7% of clients at JWCH and 12.1% of clients at Step UP reported clinically observable improvements in psychosis-related symptoms six months after enrollment.

Psychosis CHOIS Ratings by IMHT Providers				
IMHT Provider	Baseline (All clients)	Matched Sample		
		Assessment 1 vs. 3		
Exodus Recovery, Inc. Field Based Service	3.38 (N=13)	3.25	2.25	(N=4)
JWCH/SCHARP/BHS Field Based Service	3.00 (N=18)	1.92	2.00	(N=6)
Mental Health American MHALA-HIP	2.30 (N=46)	2.44	2.00	(N=8)
St. Joseph Center/OPCC	1.91 (N=33)	1.50	1.42	(N=12)
Step UP On Second/Project 180	2.24 (N=56)	2.32	2.41	(N=33)

Table provides CHOIS Psychosis sub-scale means at baseline and subsequent assessments. Values range from 1 to 5, with lower values representing decreased psychosis-related symptoms.Only Assessment 1 vs. 3 is included due to limited or no matched samples for the 1 vs. 5 comparisons at the provider-level.

Across all IMHT providers, 22.2% of all clients reported clinically meaningful improvements in their psychosis-related symptoms. All of the clients from Exodus Recovery, Inc. (100%) reported clinically meaningful improvements in their psychosis-related symptoms, although the number of clients with both a baseline and six month assessment was small.

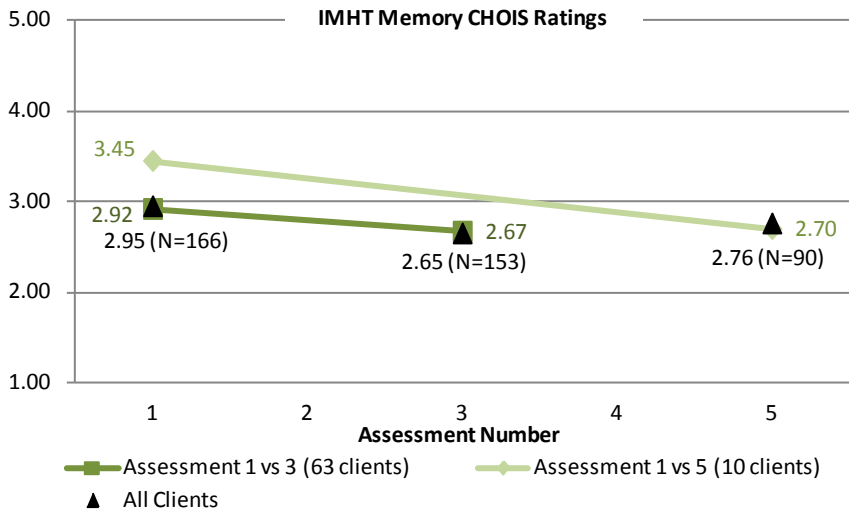
Clinically Meaningful Changes in Psychosis CHOIS Ratings by IMHT Providers		
IMHT Provider	Matched Sample	
	Assessment 1 vs. 3	
	% clients with clinically meaningful improvement	Number of clients in matched sample
Overall IMHT Model	**22.2%**	**(N=63)**
Exodus Recovery, Inc. Field Based Service	100.0%	(N=4)
JWCH/SCHARP/BHS Field Based Service	16.7%	(N=6)
Mental Health American MHALA-HIP	25.0%	(N=8)
St. Joseph Center/OPCC	25.0%	(N=12)
Step UP On Second/Project 180	12.1%	(N=33)

Table provides percent of clients that experienced clinically meaningful improvements in psychosis-related symptoms (indicated by Psychosis CHOIS ratings decreasing at least 0.6 points) six months after enrollment.

MEMORY AND COGNITIVE IMPAIRMENT SUB-SCALE

Client reported Memory and Cognitive Impairment sub-scale scores significantly decreased twelve months after enrollment. This indicates that, on average, clients reported experiencing significantly less cognitive impairment one year after enrolling in INN services. Memory and Cognitive Impairment CHOIS sub-scale ratings across all IMHT clients were similar to clients with matched assessments at each time point.

Memory and Cognitive Impairment CHOIS sub-scale scores were significantly reduced at the six month assessment compared to baseline for clients at Exodus.



Memory CHOIS Ratings by IMHT Providers				
IMHT Provider	Baseline (All clients)	Matched Sample		
		Assessment 1 vs. 3		
Exodus Recovery, Inc. Field Based Service	3.15 (N=13)	3.75	2.00↓	(N=4)
JWCH/SCHARP/BHS Field Based Service	3.22 (N=18)	2.58	2.67	(N=6)
Mental Health American MHALA-HIP	2.80 (N=46)	2.50	3.13	(N=8)
St. Joseph Center/OPCC	3.05 (N=33)	3.33	2.75	(N=12)
Step UP On Second/Project 180	2.88 (N=56)	2.83	2.61	(N=33)

Table provides CHOIS Memory sub-scale means at baseline and subsequent assessments. Values range from 1 to 5, with lower values representing decreased memory and cognitive impairment symptoms.Only Assessment 1 vs. 3 is included due to limited or no matched samples for the 1 vs. 5 comparisons at the provider-level.

Across all IMHT providers, 38.1% of all clients reported clinically meaningful improvements in their cognitive-related symptoms. Clients at Exodus Recovery, Inc. (100%) were most likely to report clinically meaningful improvements in their cognitive-related symptoms, followed by St. Joseph Center/OPCC (50.0%).

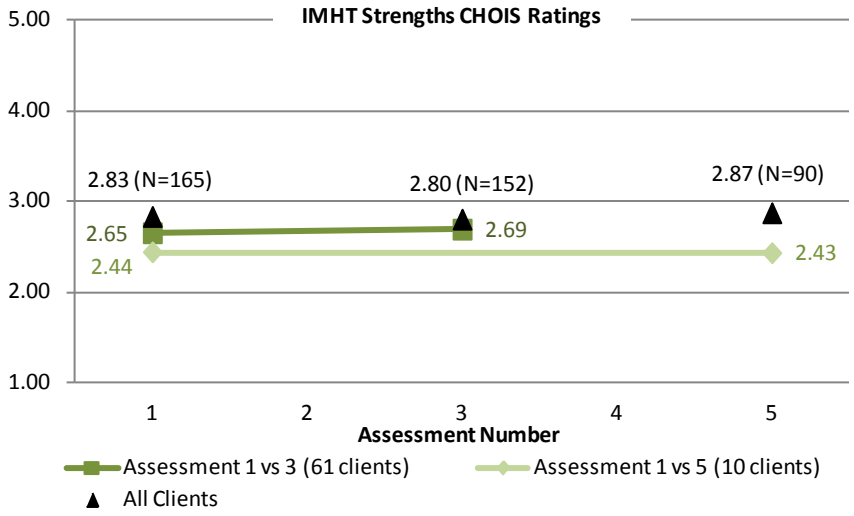
Clinically Meaningful Changes in Memory and Cognitive Impairment CHOIS Ratings by IMHT		
IMHT Provider	Matched Sample	
	Assessment 1 vs. 3	
	% clients with clinically meaningful improvement	Number of clients in matched sample
Overall IMHT Model	**38.1%**	**(N=63)**
Exodus Recovery, Inc. Field Based Service	100.0%	(N=4)
JWCH/SCHARP/BHS Field Based Service	16.7%	(N=6)
Mental Health American MHALA-HIP	12.5%	(N=8)
St. Joseph Center/OPCC	50.0%	(N=12)
Step UP On Second/Project 180	36.4%	(N=33)

Table provides percent of clients that experienced clinically meaningful improvements in memory-related symptoms (indicated by Memory and Cognitive Impairment CHOIS ratings decreasing at least 0.6 points) six months after enrollment.

STRENGTHS SUB-SCALE

There were no significant changes in Strengths scores six or twelve months after enrollment for IMHT clients. Strengths sub-scale ratings across all IMHT clients were similar to clients with matched assessments at each time point.

There were no significant changes in Strengths scores six months after enrollment for any IMHT provider.



Strengths CHOIS Ratings by IMHT Providers				
IMHT Provider	Baseline (All clients)	Matched Sample		
		Assessment 1 vs. 3		
Exodus Recovery, Inc. Field Based Service	2.97 (N=13)	3.06	3.31	(N=4)
JWCH/SCHARP/BHS Field Based Service	2.54 (N=18)	2.09	2.59	(N=6)
Mental Health American MHALA-HIP	3.06 (N=46)	3.37	3.00	(N=8)
St. Joseph Center/OPCC	3.07 (N=33)	2.96	2.61	(N=11)
Step UP On Second/Project 180	2.55 (N=55)	2.42	2.58	(N=32)

Table provides CHOIS Strengths sub-scale means at baseline and subsequent assessments. Values range from 1 to 5, with lower values representing increased personal strengths.Only Assessment 1 vs. 3 is included due to limited or no matched samples for the 1 vs. 5 comparisons at the provider-level.

Across all IMHT providers, 32.8% of all clients reported clinically meaningful improvements in their personal strengths. At the six month assessment, clients at St. Joseph Center (54.6%), followed by MHALA (50.0%), were most likely to report experiencing clinically meaningful improvements in their personal strengths.

Clinically Meaningful Changes in Strengths CHOIS Ratings by IMHT Providers		
IMHT Provider	Matched Sample	
	Assessment 1 vs. 3	
	% clients with clinically meaningful improvement	Number of clients in matched sample
Overall IMHT Model	**32.8%**	**(N=61)**
Exodus Recovery, Inc. Field Based Service	0.0%	(N=4)
JWCH/SCHARP/BHS Field Based Service	16.7%	(N=6)
Mental Health American MHALA-HIP	50.0%	(N=8)
St. Joseph Center/OPCC	54.6%	(N=11)
Step UP On Second/Project 180	28.1%	(N=32)

Table provides percent of clients that experienced clinically meaningful improvements in recovery-related personal strengths (indicated by Strengths CHOIS ratings decreasing at least 0.4 points) six months after enrollment.

Client-Reported Mental Health Items

In addition to the scale scores, two items on the CHOIS are used to independently assess mental well-being. These questions assess suicidal ideation and overall functional impairment due to mental health concerns.

SUICIDAL THOUGHTS

A large proportion of IMHT clients (40.2%) reported on the baseline assessment that they had thoughts of suicide or harming themselves at some point in the previous 7 days. There have been no significant changes in the frequency of suicidal thoughts among IMHT clients from the baseline to the six or twelve month assessments.

In the last 7 days, I had thoughts of ending my life or harming myself.					
	Never	Rarely	Sometimes	Often	Always
Baseline (All clients N=164)	59.8%	18.3%	15.2%	3.7%	3.0%
Assessment 1 vs. 3 (61 clients)	65.6% vs. 68.9%	11.5% vs. 14.8%	16.4% vs. 11.5%	3.3% vs. 3.3%	3.3% vs. 1.6%
Assessment 1 vs. 5 (10 clients)	50.0% vs. 90.0%	10.0% vs. 0.0%	20.0% vs. 0.0%	10.0% vs. 0.0%	10.0% vs. 10.0%

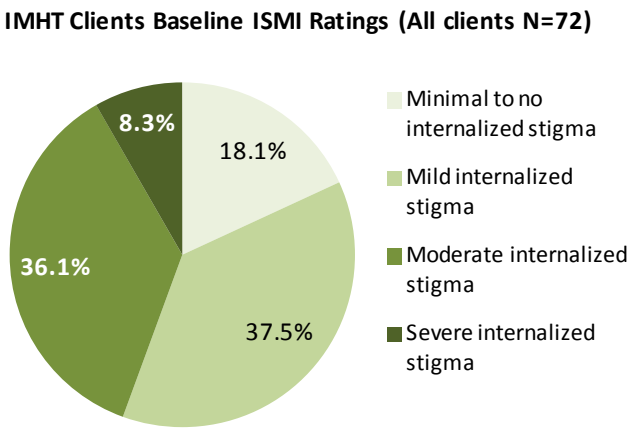
FUNCTIONAL IMPAIRMENT

At baseline, the majority of IMHT clients (70.1%) reported experiencing at least some difficulty in performing daily activities due to their mental health symptoms. There were no significant changes in impairment six or twelve months after enrollment. Fewer IMHT clients reported having problems performing daily activities at both the six and twelve month assessments, which suggests that there was improvement in physical functioning.

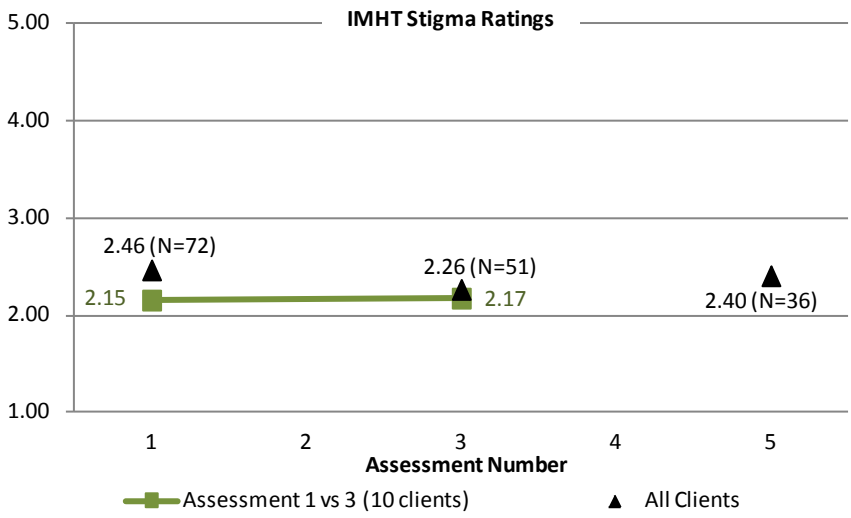
How difficult have any problems reported here made it for you to do your daily activities?				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
Baseline (All clients N=157)	29.9%	38.2%	20.4%	11.5%
Assessment 1 vs. 3 (53 clients)	41.5% vs. 26.4%	30.2% vs. 43.4%	22.6% vs. 26.4%	5.7% vs. 3.8%
Assessment 1 vs. 5 (8 clients)	50.0% vs. 37.5%	12.5% vs. 50.0%	37.5% vs. 12.5%	0.0% vs. 0.0%

Internalized Stigma of Mental Illness (ISMI)

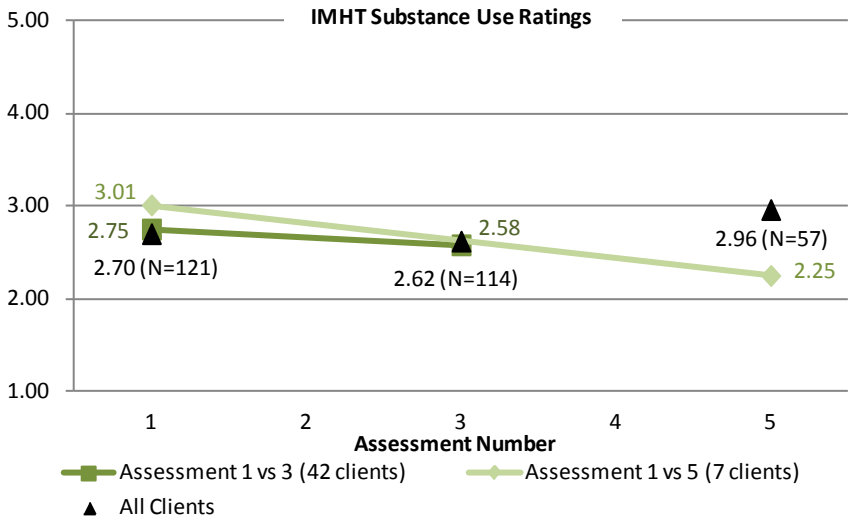
The 10-item Internalized Stigma of Mental Illness (ISMI) scale assesses client-reported experiences with stigma and common stereotypes about mental illness, as well as the ability to resist or be unaffected by internalized stigma. ISMI items and total scale scores range from 1 to 4, with lower scores representing decreased stigma. ISMI scale scores are categorized into four levels of stigma: minimal to no internalized stigma, mild internalized stigma, moderate internalized stigma, and severe internalized stigma.



At baseline, the majority of IMHT clients reported mild (37.5%) or moderate (36.1%) internalized stigma. There were no significant changes in internalized stigma ratings six months after enrollment. However, six months after enrollment, 20.0% of all IMHT clients reported clinically meaningful improvements in mental health stigma (indicated by decreased ISMI ratings). No IMHT clients completed the ISMI at both the baseline and twelve month assessments, so long-term changes in stigma cannot be examined at this time. Mean ISMI ratings across all IMHT clients at a given assessment were comparable to those clients with completed matched assessments.



PROMIS-Derived Substance Use



The 12-item PROMIS-Derived Substance Use measure assesses clients' perception of negative consequences of their alcohol and/or substance use. Item and total scale scores range from 1 to 5, with lower scores indicating fewer client-perceived negative consequences associated with alcohol and/or substance use.

Although there were no significant changes on the PROMIS-Derived Substance Use ratings from the baseline to the six or twelve month assessments, scores did decline. Six months after enrollment, 21.4% of all IMHT clients reported clinically meaningful decreases in negative consequences associated with alcohol and/or drug use. PROMIS-Derived Substance Use ratings across all IMHT clients were similar to IMHT clients with matched assessments at each time point.

Client-Reported Substance Use Items

Clients reported how frequently they used tobacco, alcohol, and illicit drugs on the Physical Health and Behaviors Survey.

TOBACCO USE

At baseline, the majority of IMHT clients (77.6%) reported that they smoked tobacco at least some days. This is a significantly greater proportion than for the overall INN population (38.2%). There were no significant changes in tobacco use across all IMHT clients six or twelve months after enrollment.

Do you smoke tobacco?			
	Not at all	Some days	Every day
Baseline (All clients N=161)	22.4%	11.8%	65.8%
Assessment 1 vs. 3 (62 clients)	17.7% vs. 19.4%	14.5% vs. 22.6%	67.7% vs. 58.1%
Assessment 1 vs. 5 (10 clients)	10.0% vs. 20.0%	30.0% vs. 0.0%	60.0% vs. 80.0%

ALCOHOL USE

At baseline, the majority of all IMHT clients (60.6%) reported consuming alcohol in the prior six months. There were no significant changes in alcohol consumption among IMHT clients six or twelve months after enrollment compared to baseline.

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
Baseline (All clients N=170)	39.4%	16.5%	12.9%	7.6%	23.5%
Assessment 1 vs. 3 (64 clients)	42.2% vs. 34.4%	14.1% vs. 18.8%	14.1% vs. 20.3%	7.8% vs. 10.9%	21.9% vs. 15.6%
Assessment 1 vs. 5 (10 clients)	40.0% vs. 30.0%	10.0% vs. 30.0%	10.0% vs. 10.0%	10.0% vs. 0.0%	30.0% vs. 30.0%

DRUG USE

On the baseline assessment, almost half of IMHT clients (43.4%) reported that they had used drugs in the previous six months. Six months after enrollment there was a significant decrease in drug use, with fewer clients reporting using drugs and fewer clients reporting daily drug use. However, there was no significant change in drug use twelve months after enrollment compared to baseline.

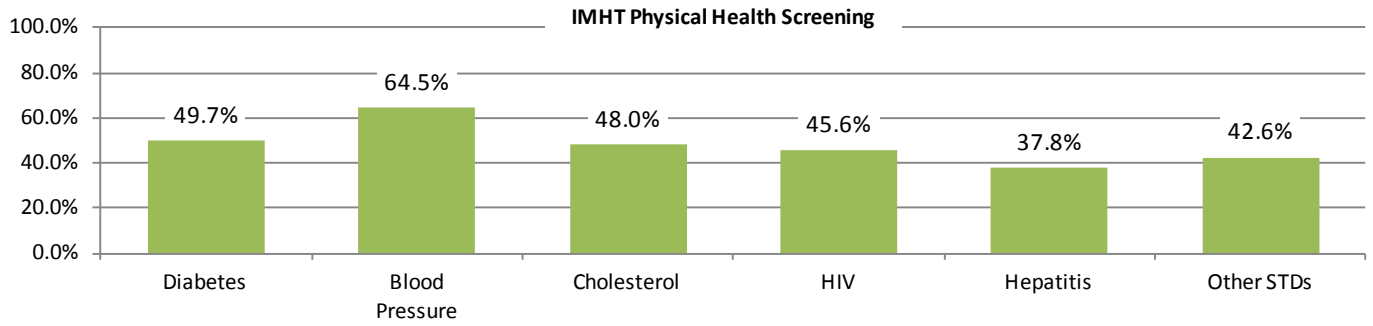
During the last 6 months, how often did you use an illegal drug or use a prescription medication for nonmedical reasons?					
	Never	Less than once a week	1-3 times per week	4 or more times per week	Every day
Baseline (All clients N=166)	56.6%	17.5%	10.2%	5.4%	10.2%
Assessment 1 vs. 3 (62 clients)	51.6% vs. 59.7%	17.7% vs. 25.8%	9.7% vs. 8.1%	8.1% vs. 0.0%	12.9% vs. 6.5%↓
Assessment 1 vs. 5 (10 clients)	60.0% vs. 50.0%	10.0% vs. 20.0%	10.0% vs. 20.0%	0.0% vs. 10.0%	20.0% vs. 0.0%

Clinician- and Client-Reported Physical Health Items

Clinician-reported physical health items are captured on the Physical Health Indicators Survey, which asks clinicians to report on the frequency and outcome of typical medical screening procedures, including: height, weight, and blood pressure, cholesterol, and chronic medical conditions. On the Physical Health and Behaviors Survey, clients are asked how frequently they exercise to assess a dimension of physical health not covered in other measures.

SCREENING

The graph below shows the proportion of clients who were ever screened for each of the physical health conditions during the first twelve months of their enrollment in INN services. Among IMHT clients, the most common screening was for high blood pressure, with almost 65% of all clients being screened at least once in twelve months.



The chart above provides the percentage of all IMHT clients who have ever been screened for these common health conditions since enrolling in Innovation services. All current and discharged Innovation clients are included in the calculation of percentages, N=465.

BODY MASS INDEX (BMI)

Body Mass Index (BMI), which is calculated based on an individual's height and weight, is a common method of determining whether an individual is at a healthy weight. Clinicians are asked to provide clients' height and weight on the Physical Health Indicators Survey, which are used to calculate their BMI. Information from the Centers for Disease Control and Prevention (CDC) was used to transform BMI scores into the weight categories provided in the table below.

At the baseline assessment, a majority of clients were in the overweight or obese categories according to the CDC standards. There were no significant changes in BMI six months after enrollment. Compared to baseline, BMI significantly increased twelve months after enrollment, with additional clients falling into the overweight category.

The increase in BMI is possibly an indication that clients are receiving new medications or taking their existing medications more consistently, as many medications (especially antipsychotics) are known to cause weight gain.

Body Mass Index Categorization				
	Underweight	Normal Weight	Overweight	Obese
Baseline (All clients N=240)	2.9%	39.2%	24.6%	33.3%
Assessment 1 vs. 3 (123 clients)	0.8% vs. 3.3%	36.6% vs. 29.3%	26.0% vs. 29.3%	36.6% vs. 38.2%
Assessment 1 vs. 5 (62 clients)	0.0% vs. 0.0%	38.7% vs. 29.0%	21.0% vs. 29.0%↑	40.3% vs. 41.9%

BLOOD PRESSURE

Clinicians are asked to report clients' systolic and diastolic blood pressure on the Physical Health Indicators Survey. Systolic and diastolic readings are combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. These blood pressure categories, used in the table below, reflect clients' risk for hypertension; additional criteria must be met for a diagnosis of hypertension.

The majority of clients entering an IMHT INN program had normal or Pre-Hypertensive blood pressure. Compared to baseline, there were no significant changes in risk for hypertension based on blood pressure six or twelve months after enrollment for IMHT clients.

Blood Pressure Categorization					
	Normal	Pre-Hypertension	Stage 1 Hypertension	Stage 2 Hypertension	Hypertensive Crisis
Baseline (All clients N=268)	34.7%	39.9%	17.2%	5.6%	2.6%
Assessment 1 vs. 3 (135 clients)	34.8% vs. 25.9%	40.7% vs. 50.4%	16.3% vs. 16.3%	5.9% vs. 6.7%	2.2% vs. 0.7%
Assessment 1 vs. 5 (69 clients)	34.8% vs. 27.5%	42.0% vs. 43.5%	13.0% vs. 23.2%	7.2% vs. 5.8%	2.9% vs. 0.0%

DIABETES

Diabetes risk was determined by combining clients' Fasting Glucose and A1C levels. Clinicians reported Fasting Glucose and A1C levels on the Physical Health Indicators Survey. Individual diabetes risk categories associated with Fasting Glucose and A1C levels were obtained from the American Diabetes Association, and are displayed in the table below. These two indicators were combined into a single risk categorization. If a client was categorized at different levels or risk based on their Fasting Glucose and A1C levels, they were placed into the higher category.

Over half of clients entering an IMHT INN program (58.2%) were either in normal or high-normal categories of diabetes risk; however, 38.3% of clients were in pre-diabetic or diabetic risk categories. This indicates a need for diabetes prevention efforts. Only 3.6% of all incoming IMHT clients had low blood sugar. There were no significant changes in diabetes risk six or twelve months after enrollment for IMHT clients.

Diabetes Categorization					
	Low Blood Sugar	Normal	High Normal	Pre-Diabetic	Diabetic
Baseline (All clients N=196)	3.6%	39.8%	18.4%	23.5%	14.8%
Assessment 1 vs. 3 (75 clients)	2.7% vs. 0.0%	38.7% vs. 37.3%	14.7% vs. 14.7%	21.3% vs. 25.3%	22.7% vs. 22.7%
Assessment 1 vs. 5 (40 clients)	2.5% vs. 0.0%	35.0% vs. 32.5%	12.5% vs. 7.5%	20.0% vs. 22.5%	30.0% vs. 37.5%

CHOLESTEROL

Risk for heart disease was determined by combining information regarding clients' HDL and LDL cholesterol levels, which were collected from clinicians on the Physical Health Indicators Survey. Individual cholesterol risk categories associated with HDL and LDL levels were obtained from the American Heart Association. These two Cholesterol indicators were then combined into a single risk categorization, displayed in the table below. If a client was categorized at different levels or risk based on their HDL and LDL levels, they were placed into the higher category.

Only 26.3% of all IMHT clients were at or below the optimal cholesterol level at the baseline assessment, but close to half (43.2%) were at the near optimal level. Compared to baseline, there were no significant changes in risk for heart disease based on cholesterol level six or twelve months after enrollment for IMHT clients.

Cholesterol Categorization					
	Optimal Level	Near Optimal Level	Borderline High Risk	High Risk	Very High Risk
Baseline (All clients N=190)	26.8%	43.2%	12.1%	14.7%	3.2%
Assessment 1 vs. 3 (62 clients)	27.4% vs. 25.8%	35.5% vs. 38.7%	17.7% vs. 19.4%	14.5% vs. 14.5%	4.8% vs. 1.6%
Assessment 1 vs. 5 (22 clients)	18.2% vs. 22.7%	27.3% vs. 18.2%	18.2% vs. 22.7%	22.7% vs. 36.4%	13.6% vs. 0.0%

CLIENT-REPORTED PHSYICAL ACTIVITY

On the baseline assessment, the majority of clients reported engaging in physical exercise at least once a week, and 42% of all incoming IMHT clients reported engaging in physical activity at least 4 times per week. There were no changes in physical exercise from the baseline assessment to the six or twelve month assessment for IMHT clients.

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 normal?					
	None	1 time	2 times	3 times	4 or more times
Baseline (All clients N=169)	32.0%	8.9%	7.1%	10.1%	42.0%
Assessment 1 vs. 3 (61 clients)	27.9% vs. 21.3%	8.2% vs. 14.8%	6.6% vs. 16.4%	9.8% vs. 16.4%	47.5% vs. 31.1%
Assessment 1 vs. 5 (10 clients)	0.0% vs. 20.0%	10.0% vs. 10.0%	30.0% vs. 20.0%	10.0% vs. 30.0%	50.0% vs. 20.0%

Clinician- and Client-Reported Medical Care Utilization Items

Clinician-rated medical care utilization was assessed through the Physical Health Indicators Survey, which asks clinicians to indicate whether clients are insured. Clients and clinicians were also asked to provide information on medication adherence. Clients were asked on the Physical Health and Behaviors Survey to indicate how often they took their medications as prescribed, and clinicians were asked on the IMR to report whether clients took their psychiatric medications as prescribed.

INSURANCE

Just under half of all incoming IMHT clients (48.7%) were insured when starting services. The rate of clients with insurance coverage significantly increased twelve months after enrollment. A client was considered insured if they had any form of insurance, including LA County, California State, or federally funded programs.

Is the client insured?	
	% Insured
Baseline (All clients N=261)	48.7%
Assessment 1 vs. 3 (127 clients)	46.5% vs. 48.8%
Assessment 1 vs. 5 (74 clients)	39.2% vs. 52.7% ↑

CLIENT-RATED MEDICATION ADHERENCE

At baseline, just over one-third of all incoming IMHT clients (35.0%) reported taking their medication as prescribed all of the time. Compared to baseline, there were no significant changes in client-reported medication adherence six or twelve months after enrollment for IMHT clients.

In the past month, how often did you take your medications as the doctor prescribed?					
	My doctor hasn't prescribed any medications	Less than half of the time (<50%)	About half of the time (50%)	Nearly all of the time (75%)	All of the time (100%)
Baseline (All clients N=160)	16.3%	11.3%	10.0%	27.5%	35.0%
Assessment 1 vs. 3 (61 clients)	11.5% vs. 6.6%	11.5% vs. 8.2%	11.5% vs. 18.0%	21.3% vs. 26.2%	44.3 vs. 41.0%
Assessment 1 vs. 5 (10 clients)	10.0% vs. 20.0%	20.0% vs. 0.0%	10.0% vs. 10.0%	30.0% vs. 30.0%	30.0% vs. 40.0%

CLINICIAN-RATED PSYCHIATRIC MEDICATION ADHERENCE

Compared to the client report of medication adherence, clinicians were less likely to report that clients took their medications as prescribed. At baseline, clinicians reported that only 16.4% of IMHT clients were taking their medication as prescribed every day, compared to 35.0% of clients who reported taking their medication as prescribed all of the time. Clinician-reported medication adherence significantly improved from baseline to the six and twelve month assessments, with clinicians reporting significantly more IMHT clients taking their medication every day.

How often does s/he take his/her medication as prescribed? (Among those prescribed psychiatric medications)					
	Never	Occasionally	About half the time	Most of the time	Every day
Baseline (All clients N=212)	14.2%	24.5%	19.3%	27.4%	14.6%
Assessment 1 vs. 3 (147 clients)	12.9% vs. 5.4%	25.2% vs. 15.0%	23.1% vs. 12.9%	26.5% vs. 38.1%	12.2% vs. 28.6%↑
Assessment 1 vs. 5 (65 clients)	7.7% vs. 1.5%	30.8% vs. 6.2%	30.8% vs. 16.9%	16.9% vs. 36.9%	13.8% vs. 38.5%↑

Clinician- and Client-Reported Engagement in Emergency Services Items

On the Physical Health and Behaviors Survey, clients were asked how frequently they had visited an emergency room or been hospitalized in the previous six months. Clinicians were also asked on the IMR whether clients had been hospitalized, but this item focused on hospitalizations due to mental health or substance abuse, and not physical illnesses. Client-reported hospitalizations included hospitalizations for any reason.

EMERGENCY ROOM VISITS

Upon entering the INN program, many IMHT clients (68.9%) reported that they had visited an emergency room at least once in the previous six months. The frequency of emergency room visits was not statistically different six or twelve months after enrollment compared to baseline.

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
Baseline (All clients N=167)	31.1%	45.5%	15.0%	4.2%	4.2%
Assessment 1 vs. 3 (63 clients)	41.3% vs. 47.6%	33.3% vs. 36.5%	17.5% vs. 9.5%	4.8% vs. 1.6%	3.2% vs. 4.8%
Assessment 1 vs. 5 (10 clients)	70.0% vs. 80.0%	20.0% vs. 0.0%	10.0% vs. 20.0%	0.0% vs. 0.0%	0.0% vs. 0.0%

CLIENT-REPORTED HOSPITALIZATIONS

About half of all incoming IMHT clients (48.2%) reported on the baseline assessment being hospitalized, for any reason, in the past six months. There were no significant changes in client-reported hospitalizations six or twelve months after enrollment. However, more clients reported that they had not been hospitalized on the six and twelve month assessments compared to baseline. This reduction might become significant as more clients complete the six and twelve month assessments.

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
Baseline (All clients N=166)	51.8%	33.7%	9.6%	3.0%	1.8%
Assessment 1 vs. 3 (64 clients)	59.4% vs. 65.6%	31.3% vs. 23.4%	6.3% vs. 7.8%	1.6% vs. 1.6%	1.6% vs. 1.6%
Assessment 1 vs. 5 (10 clients)	60.0% vs. 90.0%	40.0% vs. 0.0%	0.0% vs. 10.0%	0.0% vs. 0.0%	0.0% vs. 0.0%

CLINICIAN-REPORTED PSYCHIATRIC HOSPITALIZATIONS

At baseline, clinicians reported that 42.9% of all incoming IMHT clients had been hospitalized for mental health or substance abuse reasons in the past year. This is comparable to clients' self-report of hospitalization frequency (48.2% of clients reported being hospitalized for any reason in the past six months). IMHT clinicians reported significantly fewer hospitalizations at the six and twelve month assessments compared to baseline.

When is the last time s/he has been hospitalized for mental heath or substance abuse reasons?					
	No hospitalizations in the past year	In the past 7 to 12 months	In the past 4 to 6 months	In the past 2 to 3 months	Within the last month
Baseline (All clients N=301)	57.1%	6.6%	7.0%	13.3%	15.9%
Assessment 1 vs. 3 (200 clients)	56.0% vs. 63.0%	8.0% vs. 20.0%	8.5% vs. 5.5%	10.0% vs. 4.5%	17.5% vs. 7.0%↓
Assessment 1 vs. 5 (82 clients)	39.0 % vs. 81.7%	7.3% vs. 6.1%	14.6% vs. 3.7%	18.3% vs. 4.9%	20.7% vs. 3.7%↓

Engagement in Constructive Behaviors

On the Physical Health and Behaviors Survey, clients were asked to indicate if they had engaged in paid employment, participated in volunteer activities, or attended school in the previous six months. Only a small proportion of IMHT clients reported being employed (3.6%) or attending school (4.2%) on the baseline assessment. Slightly more IMHT clients reported participating in volunteer activities when entering the program (18.6%). There were no significant changes in engagement in these activities at the six or twelve month assessments.

During the past 6 months, which of the following have you done?	
	% Engaged
Have paid employment?	
Baseline (All clients N=166)	3.6%
Assessment 1 vs. 3 (63 clients)	7.9% vs. 11.1%
Assessment 1 vs. 5 (10 clients)	10.0% vs. 10.0%
Participate in volunteer activities?	
Baseline (All clients N=167)	18.6%
Assessment 1 vs. 3 (64 clients)	21.9% vs. 17.2%
Assessment 1 vs. 5 (10 clients)	10.0% vs. 10.0%
Attend school?	
Baseline (All clients N=165)	4.2%
Assessment 1 vs. 3 (61 clients)	4.9% vs. 13.1%
Assessment 1 vs. 5 (10 clients)	0.0% vs. 10.0%

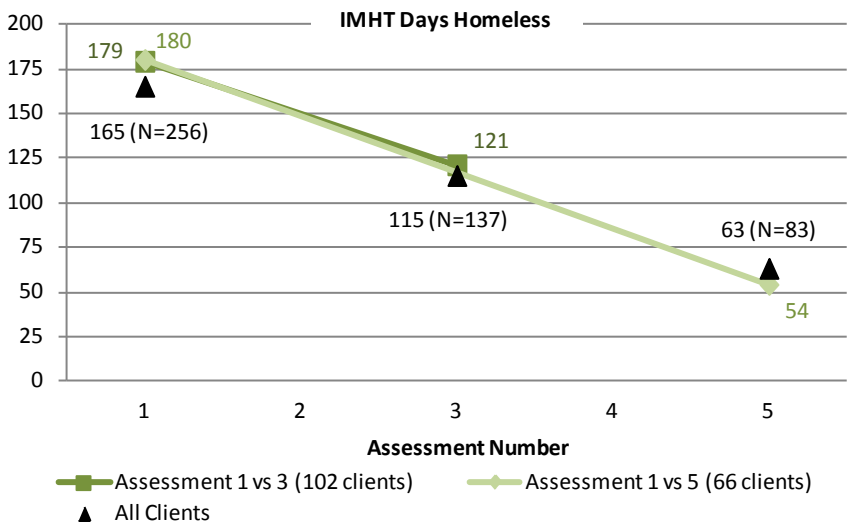
Homelessness and Incarceration

As the IMHT programs were specifically targeting individuals who were homeless or in transitional housing, the number of days homeless, and incidence of incarcerations were of specific interest to IMHT providers. Homelessness was assessed by asking clinicians to indicate on the Physical Health Indicators Survey approximately how many days each client was homeless in the prior six months. On the CHOIS, clients were also asked if they believed they lived in a safe home in the previous 7 days. Incarcerations were assessed via a single-item on the Physical Health and Behaviors Survey that asked clients how many times they had been incarcerated in the previous six months.

AVERAGE DAYS HOMELESS

During the past 6 months, how many days was your client homeless?				
	Never	Less than 1 month	1 to 3 months	4 to 6 months
Baseline (All clients N=256)	4.3%	1.2%	3.9%	90.6%
Assessment 1 vs. 3 (102 clients)	0.0% vs. 3.9%	0.0% vs. 11.8%	1.0% vs. 25.5%	99.0% vs. 58.8%↓
Assessment 1 vs. 5 (66 clients)	0.0% vs. 33.3%	0.0% vs. 30.3%	0.0% vs. 10.6%	100.0% vs. 25.8%↓

At baseline, almost all IMHT clients (90.6%) had been homeless for the majority of the previous six months. Homelessness significantly decreased six and twelve months after enrollment. Six months after enrollment, chronic homelessness (defined as being homeless for at least 4 of the previous 6 months) dropped to fewer than 60% of clients; and by twelve months after enrollment, only 26% of all IMHT clients were experiencing chronic homelessness.



Clinicians across all IMHT providers reported a high incidence of client homelessness at the baseline assessment. Clients at Exodus, JWCH, and St. Joseph had significant reductions in the number of days homeless at the six and twelve months assessments compared to baseline. None of the clinicians from MHALA or Step UP responded to the homeless item at either the baseline assessment and/or the six or twelve month assessment, so change in homelessness at these providers cannot be examined at this time.

Days Homeless by IMHT Providers							
IMHT Provider	Baseline (All clients)	Matched Sample					
		Assessment 1 vs. 3			Assessment 1 vs. 5		
Exodus Recovery, Inc. Field Based Service	168.2 (N=79)	178.4	91.5↓	(N=58)	180.0	24.2↓	(N=49)
JWCH/SCHARP/BHS Field Based Service	180.7 (N=36)	180.3	145.0↓	(N=12)	181.5	112.5	(N=2)
Mental Health American MHALA-HIP	166.4 (N=53)	-	-	(N=0)	-	-	(N=0)
St. Joseph Center/OPCC	172.6 (N=68)	179.6	165.0↓	(N=32)	180.5	141.3↓	(N=15)
Step UP On Second/Project 180	99.2 (N=20)	-	-	(N=0)	-	-	(N=0)

Table provides average days homeless at baseline and subsequent assessments.

LIVED IN SAFE HOME

At baseline, the majority of IMHT clients did not believe they lived in a safe home, with 52.7% of all IMHT clients reporting that they rarely or never lived in a safe home in the previous 7 days. Clients' perception of the safety of their living situation did not significantly differ six months after enrollment, but there was significant improvement twelve months after enrollment. Compared to baseline, at the twelve month assessment, 60% of IMHT clients reported always living in a safe home in the previous 7 days (compared to 20.0% at baseline).

In the last 7 days, I lived in a home that made me feel safe.					
	Always	Often	Sometimes	Rarely	Never
Baseline (All clients N=163)	14.1%	15.3%	17.8%	11.0%	41.7%
Assessment 1 vs. 3 (58 clients)	17.2% vs. 22.4%	13.8% vs. 24.1%	24.1% vs. 19.0%	10.3% vs. 15.5%	34.5% vs. 19.0%
Assessment 1 vs. 5 (10 clients)	20.0% vs. 60.0%↑	0.0% vs. 10.0%	20.0% vs. 0.0%	10.0% vs. 0.0%	50.0% vs. 30.0%

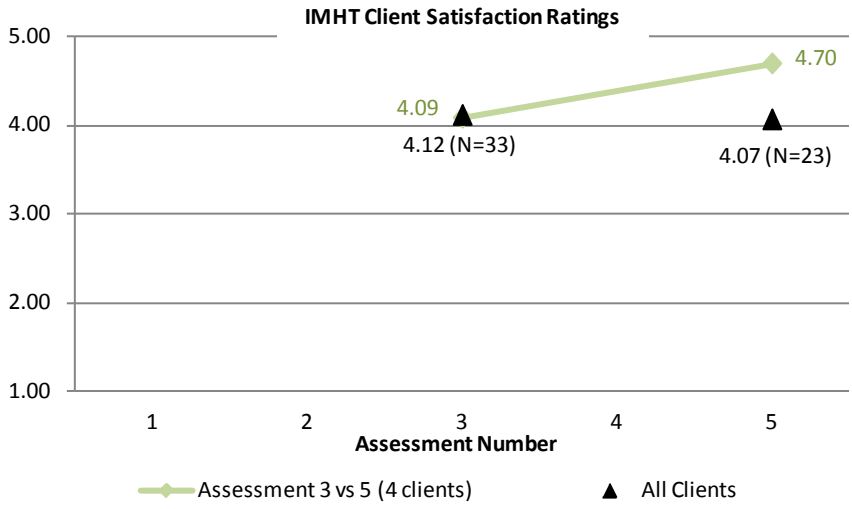
INCARCERATIONS

At baseline, 29.1% of IMHT clients reported that they had been incarcerated in the previous six months. Clients reported fewer incarcerations at the six and twelve month assessments compared to baseline, but these changes were not significant.

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
Baseline (All clients N=158)	70.9%	25.9%	1.3%	0.6%	1.3%
Assessment 1 vs. 3 (57 clients)	73.7% vs. 84.2%	22.8% vs. 12.3%	1.8% vs. 1.8%	0.0% vs. 0.0%	1.8% vs. 1.8%
Assessment 1 vs. 5 (10 clients)	80.0% vs. 90.0%	20.0% vs. 0.0%	0.0% vs. 10.0%	0.0% vs. 0.0%	0.0% vs. 0.0%

Satisfaction with INN Services

At the six month assessment, and every subsequent six months, clients are randomly selected to take either the Satisfaction with Services Survey, the Post-Outcomes Survey, or the ISMI. Approximately one third of clients take each survey at each semiannual follow-up assessment. The Satisfaction with Services Survey assesses client-perceived satisfaction with INN services. Satisfaction items were combined into a comprehensive scale score ranging from 1 to 5, with higher scores representing greater overall satisfaction with INN services. Aggregate responses to the Satisfaction Survey from the six and twelve month assessments are presented in the chart below, along with changes in satisfaction among the matched sample that completed the survey at both the six and twelve month assessments.



Satisfaction with IMHT services was extremely high on both the six and twelve month assessments, with the average satisfaction rating being close to the maximum possible rating (5) across the first year of enrollment.

Client satisfaction increased for IMHT clients from the six month assessment to the twelve month assessment. This increase was not significant, likely due to the small size of the matched sample.

Client-Reported Outcomes

The Post-Outcomes Survey is a 10-item survey that assesses client-perceived outcomes of INN services. Aggregate responses to the Post-Outcomes survey on the six and twelve month assessments are presented in the table below. Responses ranged from Strongly Agree to Strongly Disagree. Clients were most likely to endorse the items: "As a result of INN services I know where to get help when I need it." Clients were least likely to endorse the items: "As a result of INN services my mental health symptoms aren't bothering me as much," and "As a result of INN services, I do better in social situations."

Client-Reported Outcomes			
	Disagree/Strongly Disagree	Neutral	Agree/Strongly Agree
I deal more effectively with daily problems.			
6 months (All clients N=41)	9.8%	31.7%	58.5%
12 months (All clients N=29)	20.7%	27.6%	51.7%
I know where to get help when I need it.			
6 months (All clients N=39)	5.1%	7.7%	87.2%
12 months (All clients N=28)	0.0%	0.0%	100.0%
My physical health has improved.			
6 months (All clients N=40)	10.0%	30.0%	60.0%
12 months (All clients N=28)	35.7%	25.0%	39.3%
I am better able to manage my health care.			
6 months (All clients N=40)	15.0%	30.0%	55.0%
12 months (All clients N=28)	17.9%	32.1%	50.0%
I feel I belong in my community.			
6 months (All clients N=40)	24.4%	19.5%	56.1%
12 months (All clients N=28)	7.1%	46.4%	46.4%
I do better in social situations.			
6 months (All clients N=41)	22.0%	29.3%	48.8%
12 months (All clients N=28)	17.9%	35.7%	46.4%
My mental health symptoms are not bothering me as much.			
6 months (All clients N=40)	27.5%	32.5%	40.0%
12 months (All clients N=28)	25.0%	39.3%	35.7%
I am better able to take care of my needs.			
6 months (All clients N=40)	17.5%	25.0%	57.5%
12 months (All clients N=28)	10.7%	42.9%	46.4%
I am better able to handle things when they go wrong.			
6 months (All clients N=40)	17.5%	35.0%	47.5%
12 months (All clients N=28)	17.9%	42.9%	39.3%
I am better able to do things that I want to do.			
6 months (All clients N=40)	15.0%	27.5%	57.5%
12 months (All clients N=28)	14.3%	46.4%	39.3%

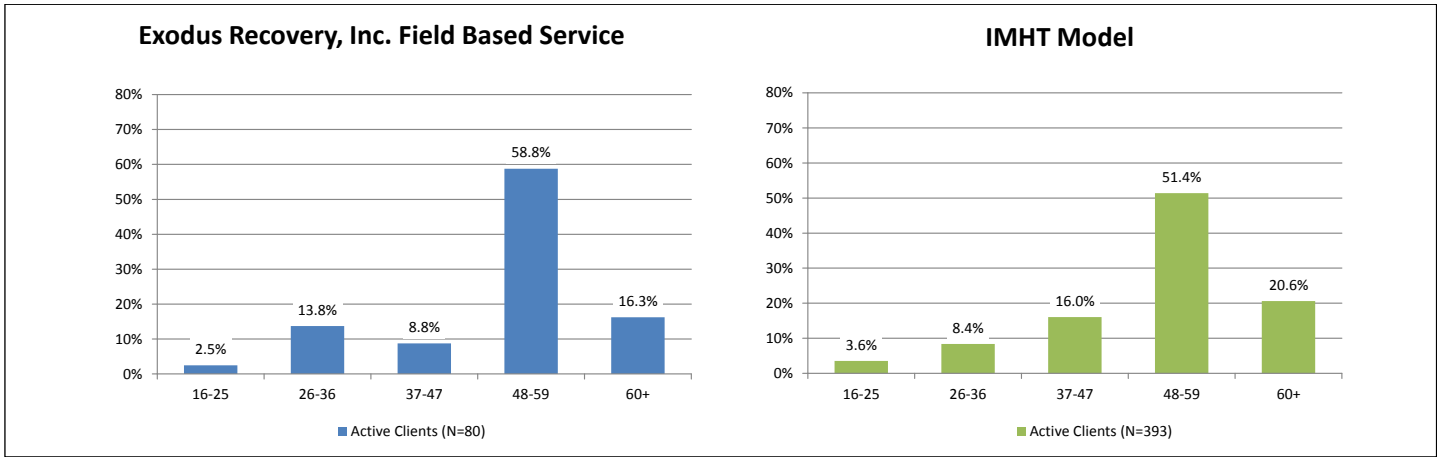
INCORPORATING CLIENT AND CLINICIAN OUTCOMES

Exodus Recovery Inc., Field Based Services

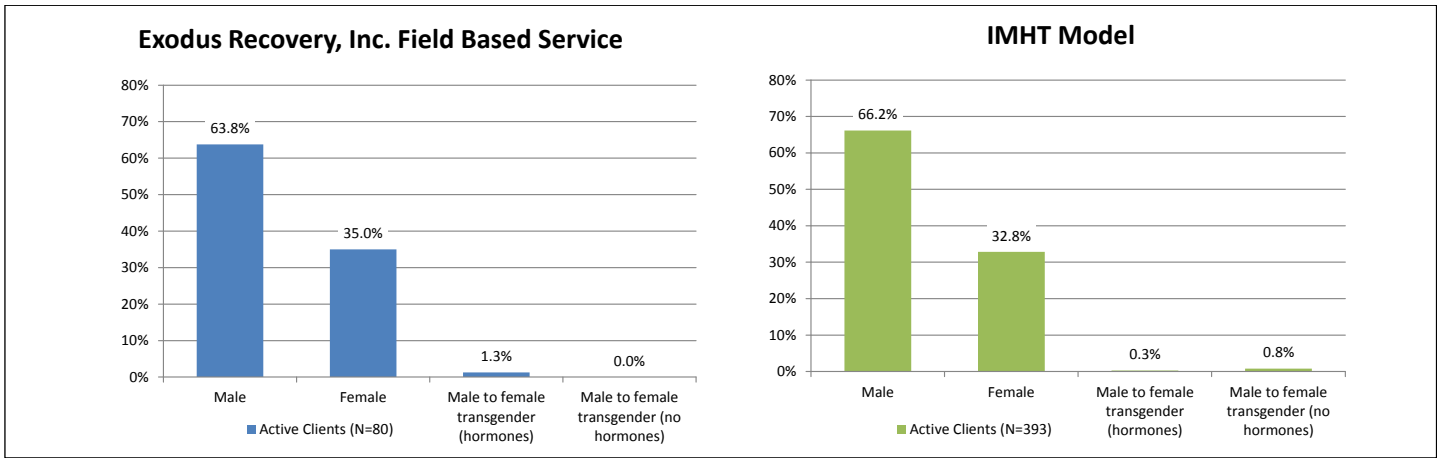
January 2014

CURRENT CLIENT DEMOGRAPHIC INFORMATION

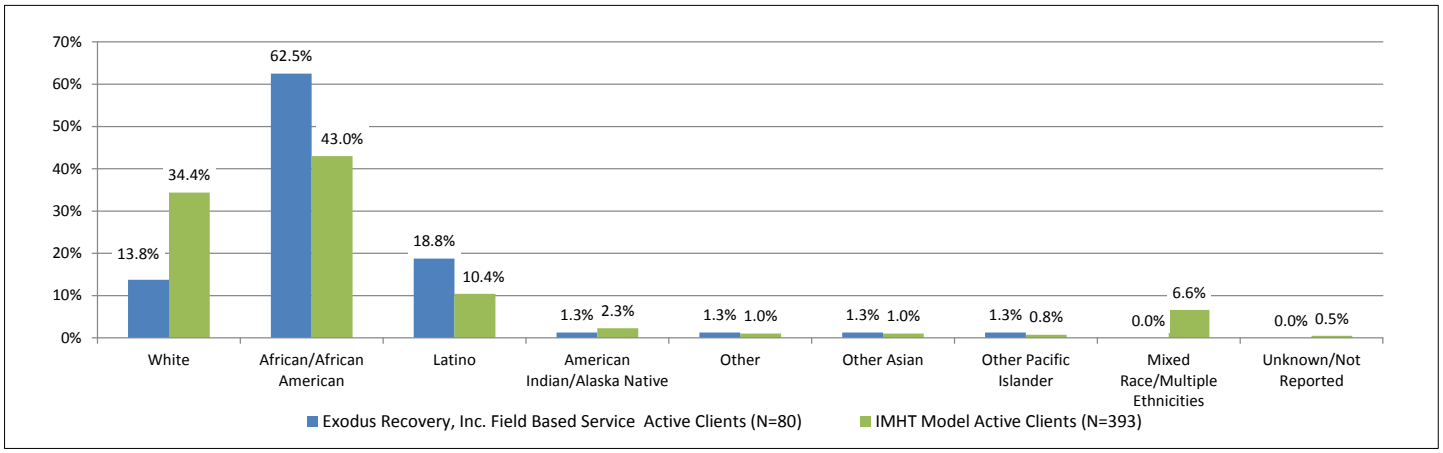
AGE



GENDER



ETHNICITY



CLINICIAN REPORTED RECOVERY OUTCOMES

To assess client recovery, clinicians are asked to complete the **Illness Management and Recovery Scale (IMR) and the Milestones of Recovery Scale (MORS)** at intake (baseline) and during subsequent quarterly follow-up visits. The IMR has 15 individual items, which make up an overall score and three subscales; Substance Use, Recovery (knowledge and goals), and Management (coping with illness outcome). IMR scores range from 1 to 5, with lower scores representing more progress toward recovery.

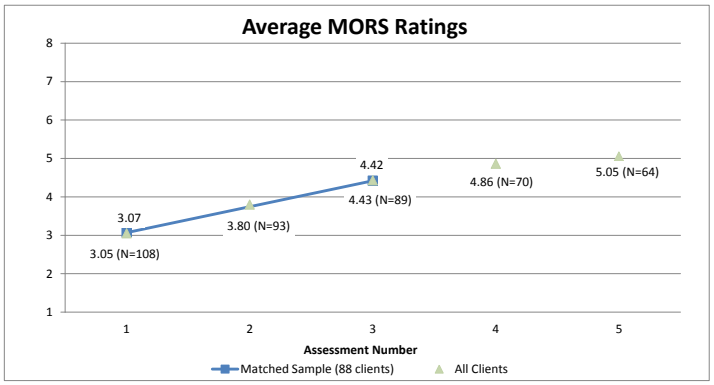
The MORS captures clinician-reported recovery through a single-item recovery indicator. Clinicians are asked to place clients into one of the 8 stages of recovery (rated 1 through 8, respectively): extreme risk, high risk/not engaged, high risk/engaged, poorly coping/not engaged, poorly coping/engaged, coping/rehabilitating, early recovery, and advanced recovery. Ratings are based on a client's 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 the quality of their social support network. Although the MORS is not a linear scale, higher MORS ratings are associated with greater recovery.

Exodus Recovery, Inc. MORS Ratings

		Assessment Number			
Rating #	**Milestones of Recovery Scale**	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 3 (Matched Sample)**	**Change between Assessments 1 and 3**
1	Extreme Risk	0.0%	0.0%	0.0%	0.0%
2	High risk / Not engaged	7.4%	5.7%	2.3%	-3.4%
3	High risk / Engaged	85.2%	87.5%	29.5%	-58.0%
4	Poorly coping / Not engaged	2.8%	1.1%	1.1%	0.0%
5	Poorly coping / Engaged	4.6%	5.7%	58.0%	52.3%
6	Coping / Rehabilitating	0.0%	0.0%	9.1%	9.1%
7	Early Recovery	0.0%	0.0%	0.0%	0.0%
8	Advanced Recovery	0.0%	0.0%	0.0%	0.0%
	Average MORS Score	**3.05 (N=108)**	**3.07 (N=88)**	**4.42 (N=88)**	**1.35**

Provider level analyses use a matched sample of clients with MORS ratings at both the baseline and six month follow-up assessments. There was a significant increase in mean MORS scores for clients at Exodus from the baseline to the six month assessment. Clients were in a more advanced stage of recovery six months after enrolling in Innovation compared to baseline.

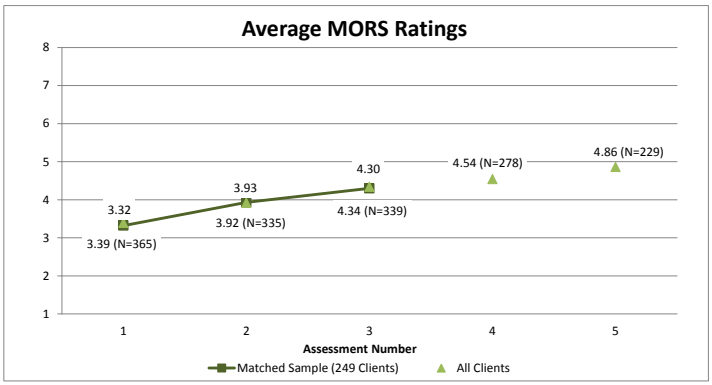
In addition to mean MORS scores for the matched sample, the figure to the right includes mean MORS scores for all Exodus clients at each assessment. Scores for all clients were similar to the matched sample at each assessment.



IMHT MORS Ratings

Model level analyses use a matched sample of clients with MORS ratings on the baseline, and the three and six month assessments. For IMHT clients there was a significant increase in MORS scores from baseline to three months, and from three to six months. MORS scores continue to increase over time, indicating ongoing progress towards client recovery.

	Assessment Number			
Milestones of Recovery Scale	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 2 (Matched Sample)**	**Assessment 3 (Matched Sample)**
Average MORS Score	3.39 (N=365)	3.32 (N=249)	3.93 (N=249)	4.30 (N=249)



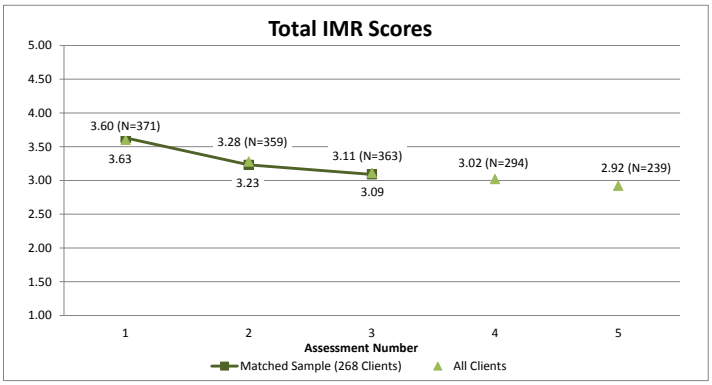
Exodus Recovery, Inc. IMR Scores by Item

ITEM #	Aspect of Illness Management & Recovery	Assessment Number: Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Progress towards personal goals	3.87	3.95	2.36	-1.59
2	Knowledge	3.53	3.54	2.77	-0.77
4	Contact with people outside of my family	2.57	2.63	1.46	-1.17
8	Relapse prevention planning	4.25	4.14	3.91 (N=90)	-0.23
12	Involvement with self-help activities	3.19 (N=107)	3.21 (N=90)	1.97 (N=90)	-1.24
	Recovery Subscale *(mean of items 1, 2, 4, 8, & 12)*	**3.48 (N=108)**	**3.50 (N=91)**	**2.49 (N=91)**	**-1.01**
6	Symptom distress	3.87 (N=107)	3.88 (N=90)	2.99	-0.89
7	Impairment of functioning	3.94	3.96	3.04	-0.92
9	Relapse of symptoms	3.92	3.82	3.38	-0.44
11	Coping	3.86	3.84	3.15	-0.69
	Management Subscale *(mean of items 6, 7, 9, & 11)*	**3.90 (N=108)**	**3.87 (N=91)**	**3.14 (N=91)**	**-0.73**
14	Impairment of functioning through alcohol use	2.06	2.10	1.78	-0.32
15	Impairment of functioning through drug use	2.62	2.58	2.13	-0.45
	Substance Use Subscale *(maximum of items 14 & 15)*	**2.94 (N=108)**	**2.97 (N=91)**	**2.47 (N=91)**	**-0.50**
3	Involvement of family and friends in my mental health treatment	3.41	3.40	2.82	-0.58
5	Time in structured roles	4.49	4.51	3.60	-0.91
10	Psychiatric hospitalizations	3.48	3.37	2.10	-1.27
13	Using medication effectively	3.10 (N=102)	3.03 (N=88)	1.91 (N=87)	-1.12
	Overall IMR Score (*mean of items 1-15)*	**3.48 (N=108)**	**3.46 (N=91)**	**2.63 (N=91)**	**-0.83**

The sample size for each IMR item corresponds with the reported sample size (N) in each column of the Overall IMR score, unless otherwise reported.

IMHT IMR Total Scores

Aspect of Illness Management & Recovery	Assessment Number: Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 2 (Matched Sample)	Assessment 3 (Matched Sample)
Recovery Subscale *(mean of items 1, 2, 4, 8, and 12)*	3.61	3.64	3.16	3.02
Management Subscale *(mean of items 6, 7, 9, and 11)*	4.16	4.20	3.75	3.56
Substance Use Subscale *(the maximum of items 14 and 15)*	3.32	3.36 (N=269)	3.14 (N=269)	3.09 (N=269)
Overall IMR Score	**3.60 (N=371)**	**3.63 (N=268)**	**3.23 (N=268)**	**3.09 (N=268)**

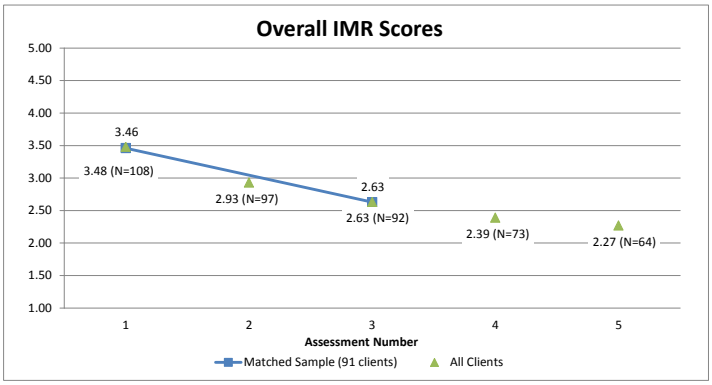


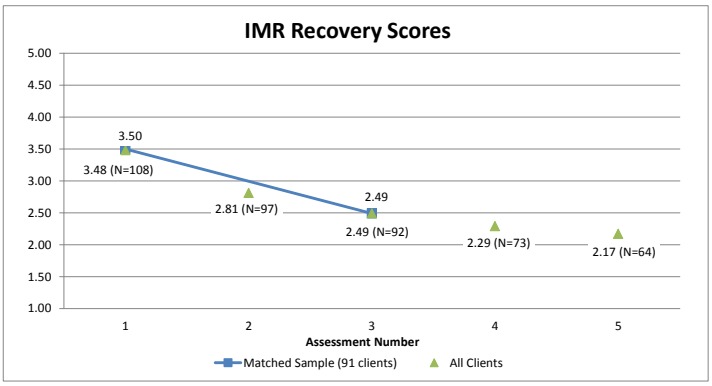
Model level analyses use a matched sample of clients with IMR ratings on the baseline, and the three and six month assessments. For IMHT clients there was a significant decrease in overall IMR scores from the baseline to the three month assessment, and from the three to the six month assessment. This indicates that, on average, clients in the IMHT model made consistent progress towards their recovery after enrolling in services.

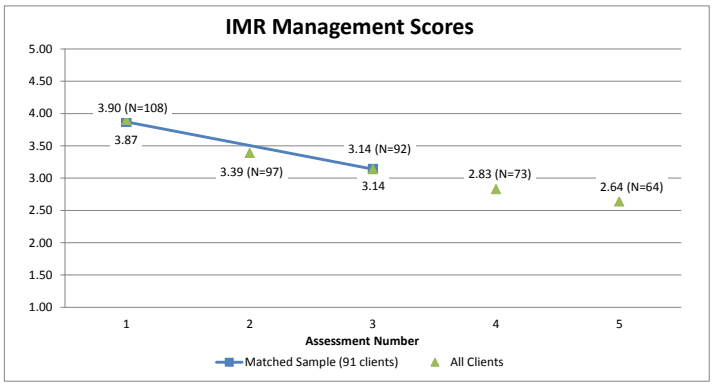
Average scores for all IMHT clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figure to the left.

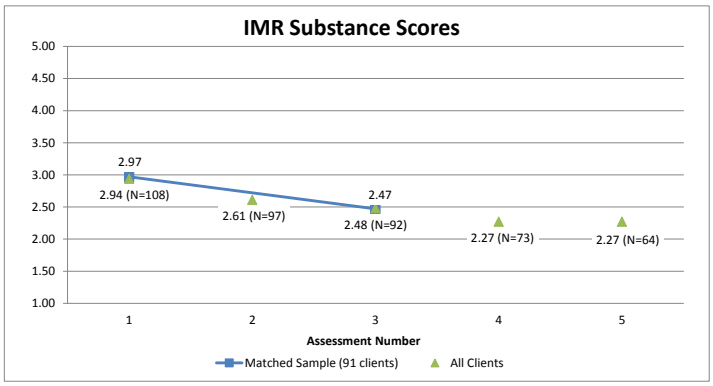
Exodus Recovery, Inc. IMR Scores

Provider level analyses use a matched sample of clients with IMR scores at both the baseline and six month follow-up assessments. There was a significant decrease in overall IMR scores from the baseline to the six month assessment. This indicates that Exodus clients made progress towards their recovery after enrolling in Innovation. Scores were also significantly reduced on the Management, Recovery, and Substance Use subscales from the baseline to the six month assessment. This indicates that clinicians observed that clients made consistent progress towards their recovery, were better able to manage their mental health, and were less likely to be using substances.



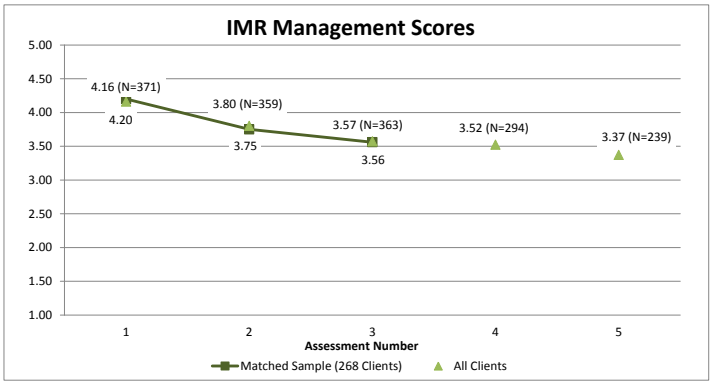


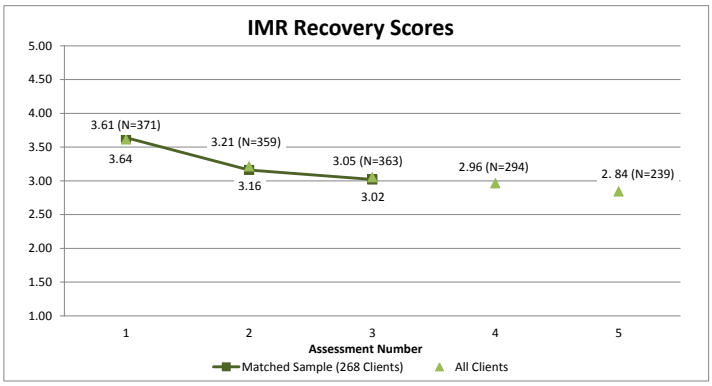


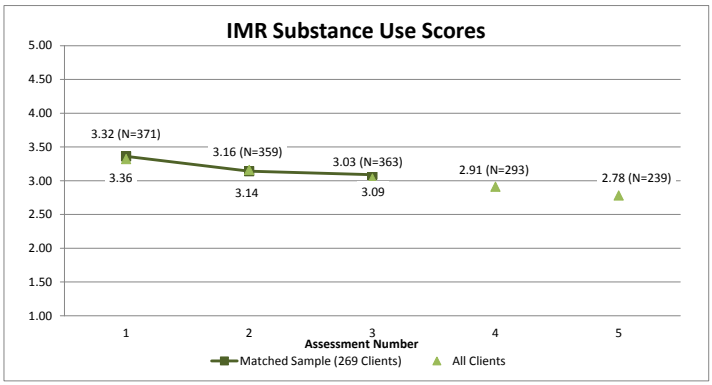


IMHT IMR Subscale Scores

Model level analyses use a matched sample of clients with IMR scores on the baseline, and the three and six month assessments. For IMHT clients, there were significant decreases in IMR Recovery and Management subscale scores from baseline to three months and from three to six months. There were also significant decreases on the Substance Use subscale from baseline to three months and from baseline to six months. This indicates that, on average, clients were less likely to use substances, had made progress towards their recovery, and were better able to manage their mental health after enrolling in Innovation.







CLIENT 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. The Integrated Self-Assessment includes the PROMIS Global Health Scale, the Physical Health and Behaviors Survey, the PROMIS-Derived Substance Use Scale, and the CHOIS Supplement. All measures are distributed semi-annually, except for the PROMIS Global Health, which is distributed quarterly. Additionally, all clients are asked to complete the Internalized Stigma of Mental Illness (ISMI) Scale at baseline, and either the ISMI, Post-Outcomes Survey, or Satisfaction Survey, semi-annually. Results from the Satisfaction and Self-Reported Post-Outcomes Surveys are not detailed in this report.

Paired samples t-tests and chi-square tests were used to examine the statistical significance of changes in scores on the measures over time. These procedures provide evidence that change was due to the benefits of receiving Innovation services and not chance variation. Statistical analysis using paired samples is performed by selecting only the cases that have complete data for each time point being measured.

These matched comparisons show change for individual clients as they progress through services, which allow changes to be more easily attributed to Innovation. Using paired samples decreases sample size, so data for all clients at each assessment point are also presented in each table. 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. The current matched sample analyses evaluate change between Assessment 1 (baseline) and Assessment 3 (the six month assessment). All reported outcomes include current and discharged clients.

PROMIS Global Health

The PROMIS Global Health scale is a 10-item measure aimed at assessing client-reported health including: physical health, pain, fatigue, mental health, and social health. Items are used to create a Total Global Health score and two sub-scale scores; Physical Health and Mental Health. PROMIS Global Health scores range from 1 to 5; however, clients are also asked to rate their pain using a scale from 0 (no pain) – 10 (worst imaginable pain), which is then categorized into a 5-point scale. For all PROMIS items and scales, lower scores represent fewer health concerns (i.e. lower scores are desirable). Clients are asked to complete the PROMIS Global Health at baseline and at subsequent quarterly assessments.

Exodus Recovery, Inc. PROMIS Global Health Scores by Item

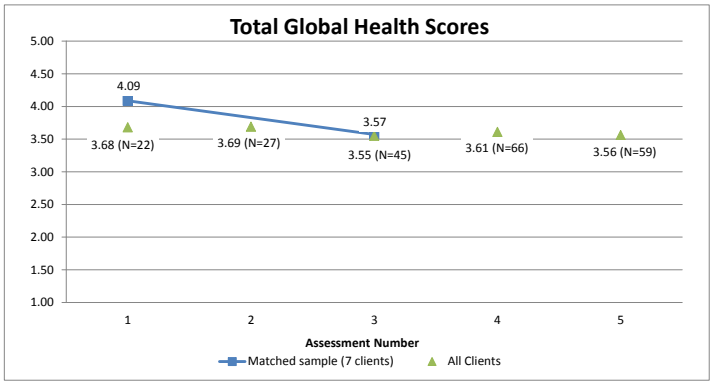
		Assessment Number			
ITEM #	**PROMIS Global Health**	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 3 (Matched Sample)**	**Change between Assessments 1 and 3**
2	Quality of life	3.95	4.29	3.71	-0.58
4	Mental health, including mood and ability to think	4.00	4.43	4.14	-0.29
5	Satisfaction with social activities and relationships	3.91	4.29	4.00	-0.29
8	Bothered by emotional problems, such as feeling anxious, depressed or irritable	3.86	4.29	3.71	-0.58
	Global Mental Health *(mean of items 2, 4, 5, & 8)*	**3.93 (N=22)**	**4.32 (N=7)**	**3.89 (N=7)**	**-0.43**
3	Physical health	3.95	4.29	3.57	-0.72
7	Everyday physical activities	2.91	3.14	2.43	-0.71
9	Fatigue	3.09	4.00	3.00	-1.00
10	Pain rating	3.41	3.86	3.57	-0.29
	Global Physical Health *(mean of items 3, 7, 9, & 10)*	**3.34 (N=22)**	**3.82 (N=7)**	**3.14 (N=7)**	**-0.68**
1	General health	3.86	4.14	3.86	-0.28
6	Ability to carry out regular social roles and activities	3.86	4.14	3.71	-0.43
	Total Global Health Score (*mean of items 1-10*)	**3.68 (N=22)**	**4.09 (N=7)**	**3.57 (N=7)**	**-0.52**

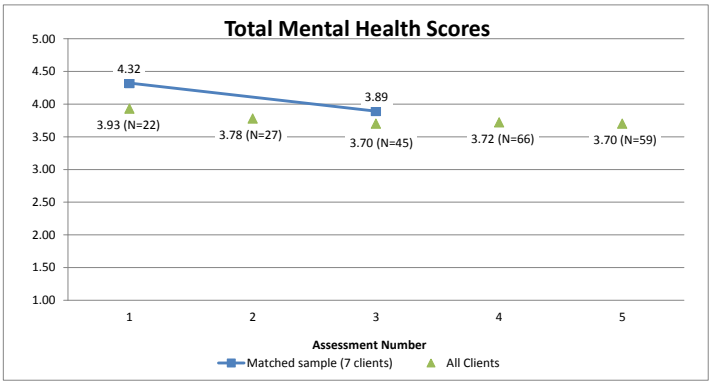
The sample size for each PROMIS item corresponds with the reported sample size (N) in each column of the Total Global Health score, unless otherwise reported.

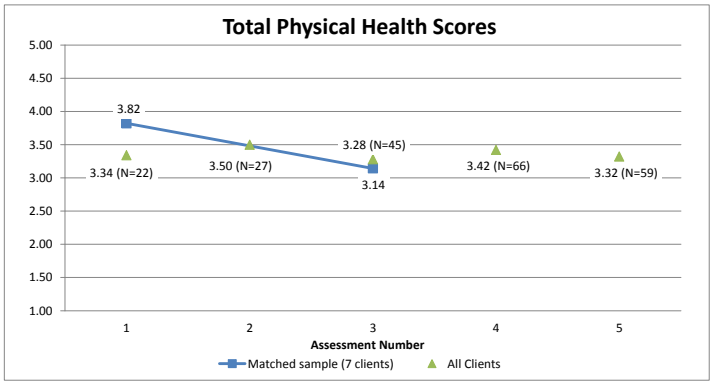
Exodus Recovery, Inc. PROMIS Scores

Provider level analyses use a matched sample of clients with PROMIS scores at both the baseline and six month follow-up assessments. There was a significant decrease in PROMIS Global Health scores for Exodus clients from the baseline to the six month assessment. This indicates that clients reported experiencing fewer health problems after enrolling in Innovation.

Average scores for all clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figures.





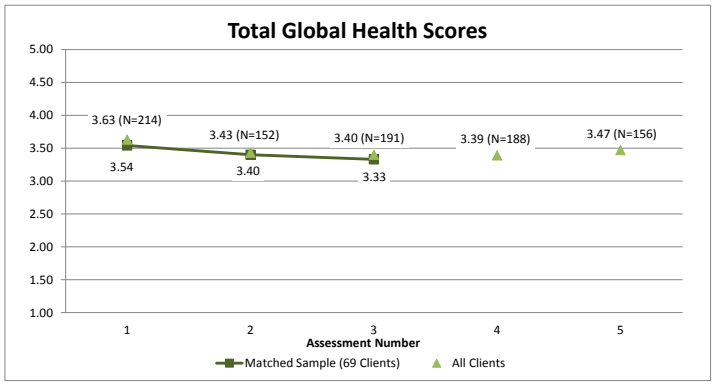


There was a significant decrease in Global Mental Health and Global Physical Health subscale scores from the baseline to the six month assessment. This indicates that, in general, clients reported experiencing both improved mental and physical health after enrolling in Innovation.

IMHT PROMIS Scores

Model level analyses use a matched sample of clients with PROMIS scores on the baseline, and the three and six month assessments. For IMHT clients, there was a significant decrease in Total Global Health scores from the baseline to the six month assessment. This indicates that, on average, clients reported experiencing fewer health problems after enrolling in Innovation.

In addition to PROMIS Global Health scores for the matched sample, the figure to the right includes scores for all clients at each assessment. Scores for all clients were similar to the matched sample at each assessment.



	Assessment Number			
PROMIS Global Health	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 2 (Matched Sample)**	**Assessment 3 (Matched Sample)**
Global Mental Health Subscale ***(mean of items 2, 4, 5, and 10)***	3.87	3.82	3.64	3.49
Global Physical Health Subscale ***(mean of items 3, 6, 7, and 8)***	3.33	3.19	3.05	3.10
Overall Global Health Score	**3.63 (N=214)**	**3.54 (N=69)**	**3.40 (N=69)**	**3.33 (N=69)**

Creating Healthy Outcomes: Integrated Self-Assessment (CHOIS) Supplement

The CHOIS Supplement is a client-rated recovery-based measure that assesses several mental health related domains, including suicidal ideation, anxiety, trauma, psychosis (i.e. hearing voices), and memory and cognitive impairment. The CHOIS contains three subscales: Psychosis, Memory and Cognitive Impairments, and Strengths. The Psychosis and Memory and Cognitive Impairment subscales assess clients' perceptions of their mental health symptoms, while the Strengths subscale examines recovery-oriented personal strengths that can assist clients in their recovery. Strengths items could be incorporated into treatment planning and recovery, and provide a positive point of assessment, an important aspect of being recovery-oriented. In addition to the scale scores, individual CHOIS items provide valuable insight into the clients' perception of their mental health symptoms.

All CHOIS subscales range from 1 to 5, with lower scores being desirable. For the Psychosis and Memory and Cognitive Impairment subscales, lower scores indicate fewer negative symptoms. For the Strengths subscale, lower scores indicate greater personal strengths. The CHOIS Supplement is completed by the client during the baseline and semi-annual assessments.

Exodus Recovery, Inc. CHOIS Scores

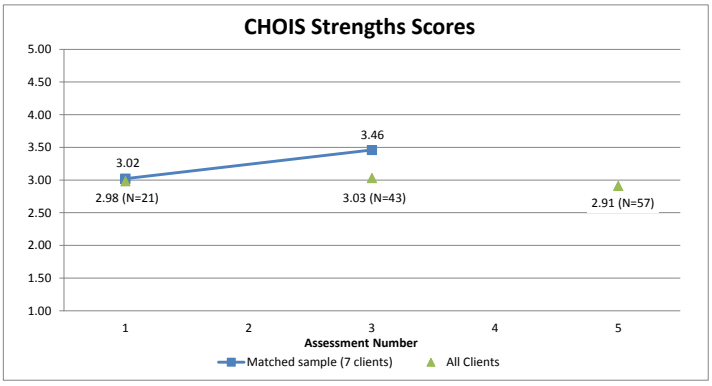
		Assessment Number			
ITEM #	CHOIS Supplement	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Thoughts entered my mind that I had trouble getting rid of.	3.52	3.71	3.14	-0.57
2	I did things I couldn't resist or did things more often than I should.	3.14	3.29	2.86	-0.43
3	I had disturbing memories or images of a stressful experience.	3.95	4.29	3.43	-0.86
4	I had memory problems, such as forgetting names or appointments.	3.10	3.43	2.29	-1.14
5	I had difficulty thinking clearly while doing familiar tasks.	3.14	3.57	2.43	-1.14
6	I believed people were following or trying to harm me or my family.	3.05	3.57	2.29	-1.28
7	I heard voices that no one else could hear.	3.38	3.43	2.71	-0.72
8	I had thoughts of ending my life or harming myself.	2.33	3.00	1.86	-1.14
9	My child(ren) had emotional and/or behavioral problems.	1.94 (N=17)	2.00	1.80 (N=5)	-0.20
10	I felt good about myself.	2.90	3.00	3.43	0.43
11	I had goals and worked towards achieving them.	3.10	2.57	3.29	0.72
12	I felt hopeful about the future.	2.76	3.00	3.29	0.29
13	I was able to handle things.	3.10	3.14	3.43	0.29
14	I felt happy.	2.95	3.14	3.57	0.43
15	I had energy and was full of life.	3.40 (N=20)	3.43	3.71	0.28
16	I felt spiritually connected.	2.86	2.86	3.71	0.85
17	I had contact with people that care about me.	2.81	3.00	3.29	0.29
18	I lived in a home that made me feel safe.	3.52	3.43	3.43	0.00
19	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?	2.44 (N=18)	2.67 (N=6)	2.50 (N=6)	-0.17
	Psychosis score *(mean of items 6 & 7)*	**3.21 (N=21)**	**3.50 (N=7)**	**2.50 (N=7)**	**-1.00**
	Memory score *(mean of items 4 & 5)*	**3.12 (N=21)**	**3.50 (N=7)**	**2.36 (N=7)**	**-1.14**
	Strengths score *(mean of items 10, 11, 12, 13, 14, 15, 16 & 17)*	**2.98 (N=21)**	**3.02 (N=7)**	**3.46 (N=7)**	**0.44**

The sample size for each CHOIS item corresponds with the highest reported sample size (N) in each column of the CHOIS Subscale scores, unless otherwise reported.

IMHT CHOIS Scores

	Assessment Number		
CHOIS Supplement	Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)
Psychosis score *(mean of items 6 & 7)*	2.34 (N=211)	2.25 (N=95)	2.04 (N=95)
Memory score *(mean of items 4 & 5)*	2.95 (N=211)	3.02 (N=95)	2.77 (N=95)
Strengths score *(mean of items 10, 11, 12, 13, 14, 15, 16 & 17)*	2.85 (N=210)	2.82 (N=93)	2.77 (N=93)

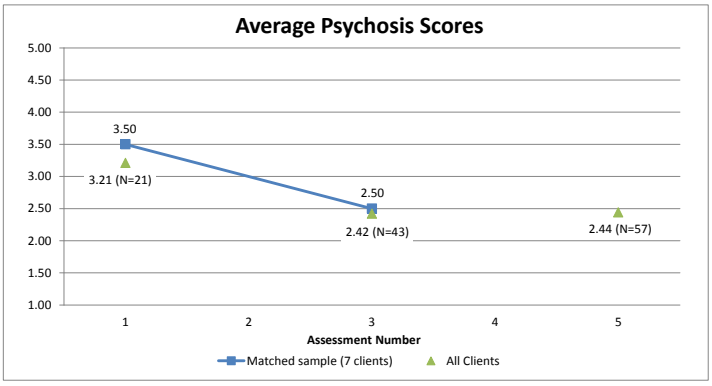
Exodus Recovery, Inc. CHOIS Subscale Scores

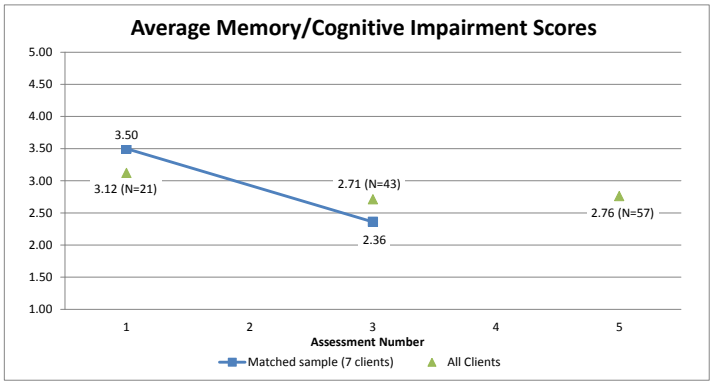


Provider level analyses use a matched sample of clients with CHOIS scores at both the baseline and six month follow-up assessments.

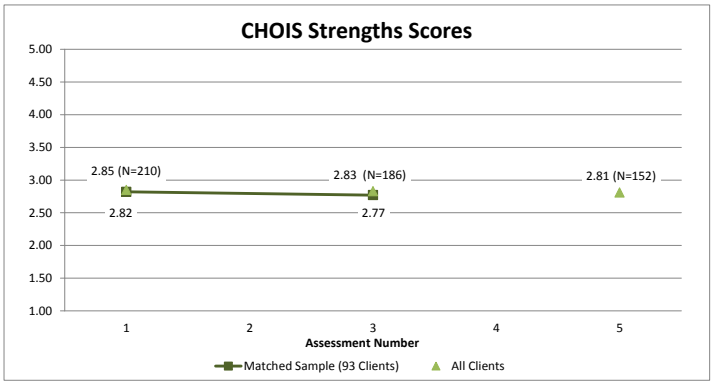
There were significant reductions in the Psychosis and Memory and Cognitive Impairment subscale scores from the baseline to the six month assessment. This indicates that clients reported fewer psychosis and memory related mental health symptoms after enrolling in Innovation.

There was no significant change in Strengths subscale scores from the baseline to the six month assessment.



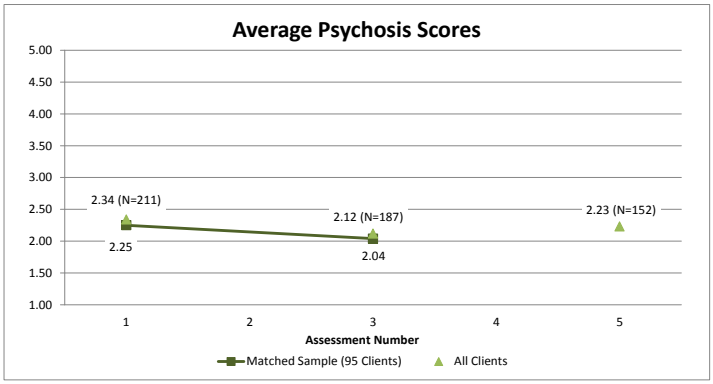


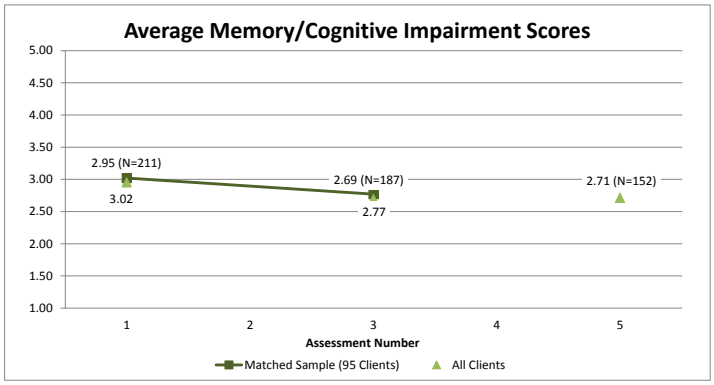
IMHT CHOIS Subscale Scores



Model level analyses use a matched sample of clients with CHOIS scores on the baseline, and six month assessments. For IMHT clients there were no significant changes on any of the CHOIS subscales from the baseline to the six month assessment.

Average scores for all IMHT clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figures.





PROMIS-Derived Substance Use

The 12-item PROMIS-Derived Substance Use scale assesses clients' perceptions of the negative consequences of their alcohol and/ or substance use, including physical (e.g., dizziness), mental (e.g., risk taking, guilt), and social (e.g., others had trouble counting on me, substance use created problems between me and others) consequences. Item and total scale scores range from 1 to 5, with lower scores indicating fewer client-perceived negative consequences associated with alcohol and/or substance use. Paired with the information from the clinician completed IMR Substance Use items, clients responses on this measure can help clinicians encourage a therapeutic dialogue with the client about their substance use.

Clients who indicate on their Physical Health and Behaviors assessment that they have used alcohol, illegal drugs, or off-label prescription medications within the past six months complete the PROMIS-Derived Substance Use Scale at the baseline and semi-annual assessments.

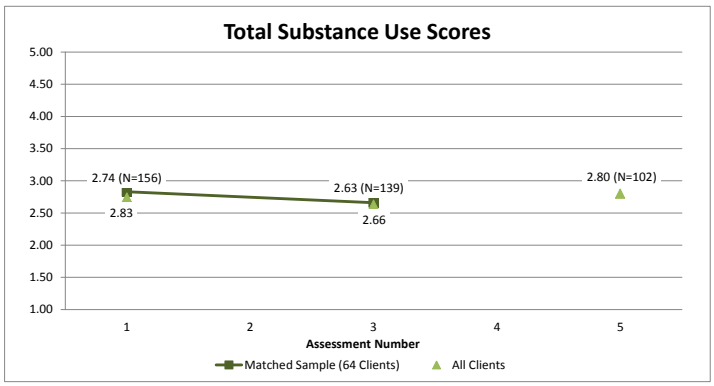
Exodus Recovery, Inc. Substance Use Scores

		Assessment Number			
ITEM #	PROMIS-Derived Substance Use	Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	I used substances (alcohol, illegal drugs) too much.	2.81 (N=16)	2.00	2.50	0.50
2	I used alcohol or substances throughout the day.	2.64 (N=14)	2.67 (N=3)	2.33 (N=3)	-0.34
3	I had an urge to continue drinking or using substances once I started.	3.07	3.25	2.50	-0.75
4	I felt that I should cut down on my alcohol or substance use.	3.40	3.00	2.50	-0.50
5	I felt I needed help for my alcohol or substance use.	2.93	2.25	2.00	-0.25
6	I took risks when I used alcohol or substances.	2.67	2.50	2.00	-0.50
7	I felt guilty when I used alcohol or substances.	3.33	2.75	2.25	-0.50
8	Others complained about my alcohol or substance use.	2.73	2.50	2.25	-0.25
9	Alcohol or substance use created problems between me and others.	3.00	2.25	1.50	-0.75
10	Others had trouble counting on me when I used alcohol or substances.	3.13	2.50	2.50	0.00
11	I felt dizzy after I used alcohol or substances.	3.13	2.50	2.50	0.00
12	Alcohol or substance use made my physical or mental health symptoms worse.	3.07	3.25	2.50	-0.75
	Total Substance Use score *(mean of items 1 - 12)*	**3.00 (N=15)**	**2.62 (N=4)**	**2.28 (N=4)**	**-0.34**

The sample size for each Substance Use item corresponds with the reported sample size (N) in each column of the Total Substance Use score, unless otherwise reported.

IMHT Substance Use Scores

	Assessment Number		
PROMIS-Derived Substance Use	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)
Total Substance Use score *(mean of items 1 - 12)*	2.74 (N=156)	2.83 (N=64)	2.66 (N=64)



Model level analyses use a matched sample of clients with Substance Use scores on the baseline, and the six month assessment. For IMHT clients there was no significant change in scores from the baseline to the six month assessment. As clients continue to receive Innovation services, improvements may become significant.

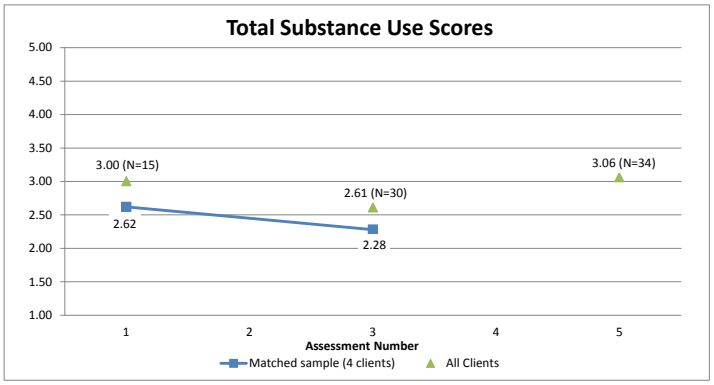
Do you smoke tobacco?			
	Not at all	Some days	Every day
Baseline (All clients N=205)	22.0%	12.2%	65.9%
Assessment 1 Matched Sample (91 clients)	17.6%	14.3%	68.1%
Assessment 3 Matched Sample (91 clients)	18.7%	23.1%	58.2%

Compared to baseline, there was a significant reduction in tobacco use at the six month assessment for IMHT clients.

Exodus Recovery, Inc. Substance Use Scores

On the baseline assessment, about half of clients at Exodus reported that they had not used alcohol (45.5%) or drugs (50.0%) within the previous six months. There were no significant changes in client-reported alcohol or drug use from the baseline to the six month assessment.

There were no significant changes in scores on the PROMIS-Derived Substance Use scale from the baseline to the six month assessment. There were only four clients with a matched baseline and six month assessment so improvements may become significant as more clients enroll in the program.



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
Baseline (All clients N=22)	45.5%	22.7%	22.7%	9.1%	0.0%
Assessment 1 Matched Sample (7 clients)	57.1%	14.3%	28.6%	0.0%	0.0%
Assessment 3 Matched Sample (7 clients)	28.6%	14.3%	42.9%	14.3%	0.0%

During the last 6 months, how often did you use an illegal drug or use a prescription medication for nonmedical reasons?					
	Never	Less than once a week	1-3 times per week	4 or more times per week	Every day
Baseline (All clients N=22)	50.0%	18.2%	18.2%	4.5%	9.1%
Assessment 1 Matched Sample (7 clients)	28.6%	28.6%	14.3%	0.0%	28.6%
Assessment 3 Matched Sample (7 clients)	42.9%	28.6%	14.3%	0.0%	14.3%

Do you smoke tobacco?			
	Not at all	Some days	Every day
Baseline (All clients N=22)	27.3%	18.2%	54.5%
Assessment 1 Matched Sample (7 clients)	14.3%	28.6%	57.1%
Assessment 3 Matched Sample (7 clients)	0.0%	57.1%	42.9%

Compared to baseline, there was no significant change in tobacco use at the six month assessment.

Physical Health and Behaviors

Clients completed the Physical Health and Behaviors Survey at the baseline and semi-annual assessments to measure health behaviors, including substance use, medication adherence, and exercise, service utilization including emergency room visits, hospitalizations, and previous experiences accessing care, and daily activities including housing situation, employment, volunteer activities and education.

Exodus Recovery, Inc. Physical Activity

At the baseline assessment, half of clients (50.0%) at Exodus reported that they engaged in physical activity at least once during a typical week. There was no significant change in physical activity from the baseline to the six month assessment for clients who completed this item at baseline and at the six month assessment.

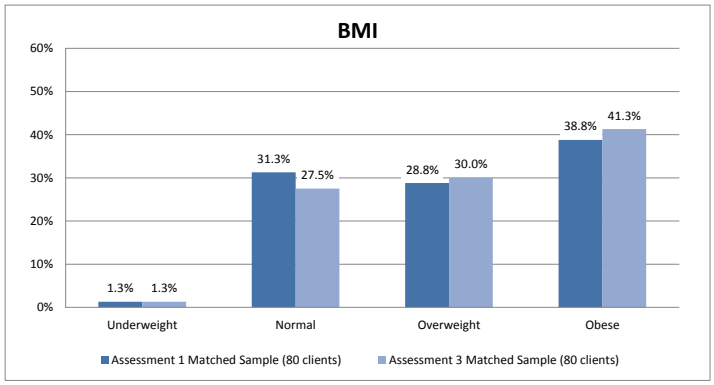
How many times in a usual week do you do 30 minutes of physical activity that increases your heart rate or makes you breathe harder than normal? (for example, walking or jogging, carrying light loads, bicycling, or playing sports)					
	None	1 time	2 times	3 times	4 or more times
Baseline (All clients N=22)	50.0%	9.1%	9.1%	13.6%	18.2%
Assessment 1 Matched Sample (7 clients)	42.9%	0.0%	14.3%	0.0%	42.9%
Assessment 3 Matched Sample (7 clients)	0.0%	28.6%	28.6%	0.0%	42.9%

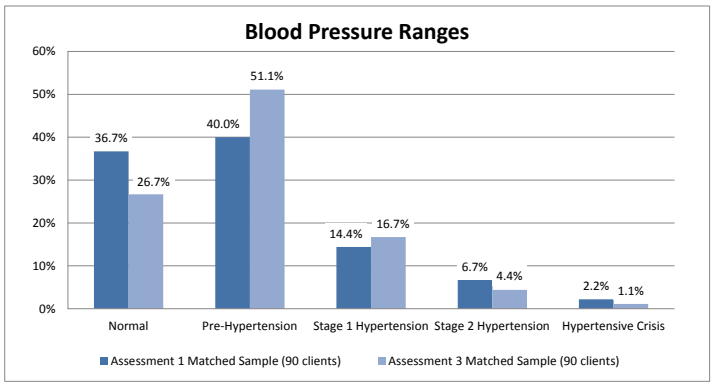
Exodus Recovery, Inc. Physical Health

The figure below shows the proportion of clients who were ever screened for each of the physical health conditions during the first twelve months of their enrollment in Innovation. The most common screening at Exodus was for High Blood Pressure, followed by Diabetes, High Cholesterol, HIV, and Other STDs. Clinicians indicated which screenings were completed on the Physical Health Indicators Survey, which was completed every six months.

Percentage of Clients who have ever been screened for:								
Diabetes	High Blood Pressure	Cholesterol	Asthma*	Emphysema*	Tuberculosis*	HIV	Hepatitis	Other STDs
81.0%	85.1%	79.3%	17.4%	24.0%	43.0%	77.7%	60.3%	73.6%

* Screening for Asthma, Emphysema, and Tuberculosis was only included on the baseline assessment.





Clinicians are asked to provide clients' height and weight on the Physical Health Indicators Survey, which are used to calculate Body Mass Index (BMI). BMI was categorized using the standard categories defined by the Centers for Disease Control and Prevention. There was a significant increase in BMI from the baseline to the six month assessment.

Systolic and diastolic readings are combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. Blood pressure is only one indicator of risk; additional criteria must be met for a diagnosis of hypertension. There were no significant changes in risk for hypertension from the baseline to the six month assessment.

In the past month, how often did you take your medications as the doctor prescribed?					
	My doctor hasn't prescribed any	Less than half the time (<50%)	About half the time (50%)	Nearly all the time (75%)	All the time (100%)
Baseline (All clients N=22)	9.1%	0.0%	31.8%	31.8%	27.3%
Assessment 1 Matched Sample (7 clients)	0.0%	0.0%	14.3%	71.4%	14.3%
Assessment 3 Matched Sample (7 clients)	0.0%	0.0%	28.6%	28.6%	42.9%

Clients were asked how often they took their medications as prescribed. There have been no significant changes in medication adherence to date.

IMHT Physical Activity

At the baseline assessment, a majority of clients in the IMHT model (67.9%) reported that they engaged in physical activity at least once during a typical week. There was no significant change in physical activity from the baseline to the six month assessment for clients who completed this item at baseline and at the six month assessment.

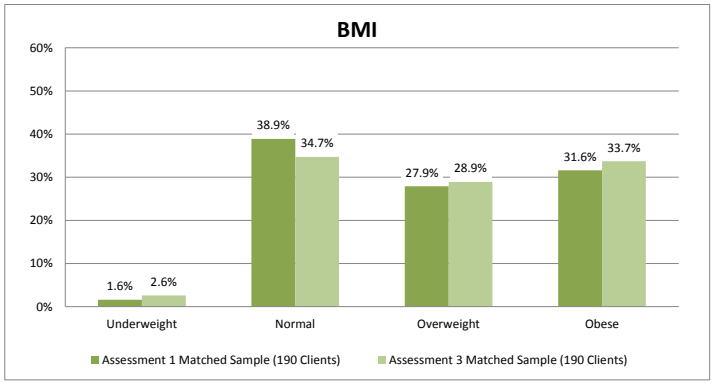
How many times in a usual week do you do 30 minutes of physical activity that increases your heart rate or makes you breathe harder than normal? (for example, walking or jogging, carrying light loads, bicycling, or playing sports)					
	None	1 time	2 times	3 times	4 or more times
Baseline (All clients N=215)	32.1%	7.9%	8.8%	11.6%	39.5%
Assessment 1 Matched Sample (92 clients)	28.3%	8.7%	7.6%	13.0%	42.4%
Assessment 3 Matched Sample (92 clients)	19.6%	17.4%	15.2%	17.4%	30.4%

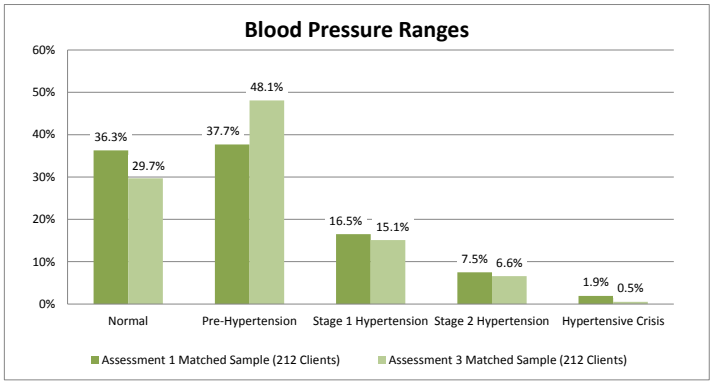
IMHT Physical Health

The figure below shows the proportion of clients who were ever screened for each of the physical health conditions during the first twelve months of their enrollment in Innovation. Within the first year of receiving Innovation services, IMHT clients were most likely to be screened for Diabetes, High Blood Pressure, High Cholesterol, HIV, Hepatitis and other STDs.

Percentage of Clients at 12 Months who have EVER been Screened For:								
Diabetes	High Blood Pressure	Cholesterol	Asthma*	Emphysema*	Tuberculosis*	HIV	Hepatitis	Other STDs
57.9%	70.6%	56.8%	10.8%	16.0%	21.1%	54.4%	45.4%	51.9%

* Screening for Asthma, Emphysema, and Tuberculosis was only included on the baseline assessment.





Clinicians are asked to provide clients' height and weight on the Physical Health Indicators Survey, which are used to calculate Body Mass Index (BMI). BMI was categorized using the standard categories defined by the Centers for Disease Control and Prevention. There were no significant changes in BMI for IMHT clients from the baseline to the six month assessment.

Systolic and diastolic readings are combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. Blood pressure is only one indicator of risk; additional criteria must be met for a diagnosis of hypertension. There were no significant changes in risk for hypertension from the baseline to the six month assessment.

In the past month, how often did you take your medications as the doctor prescribed?					
	My doctor hasn't prescribed any	Less than half the time (<50%)	About half the time (50%)	Nearly all the time (75%)	All the time (100%)
Baseline (All clients N=206)	16.0%	11.7%	11.7%	26.7%	34.0%
Assessment 1 Matched Sample (92 clients)	16.3%	13.0%	12.0%	22.8%	35.9%
Assessment 3 Matched Sample (92 clients)	7.6%	8.7%	17.4%	30.4%	35.9%

Clients were asked how often they took their medications as prescribed. There have been no significant changes in medication adherence to date, however more clients reported that they were taking doctor-prescribed medication at the six month assessment.

IMHT Service Utilization

Model level analyses use a matched sample of clients who completed service utilization items on the baseline, and the six month assessment. There was a significant reduction in the mean frequency of emergency room visits from baseline to the six month assessment for IMHT clients. There was no significant change in the frequency of hospital admissions.

In the past 6 months...	None	1-3 times	4-6 times	7-10 times	More than 10 times
how many times did you go to an emergency room?					
Baseline (All clients N=212)	30.2%	47.6%	14.6%	3.8%	3.8%
Assessment 1 Matched Sample (94 clients)	35.1%	42.6%	13.8%	4.3%	4.3%
Assessment 3 Matched Sample (94 clients)	44.7%	39.4%	11.7%	1.1%	3.2%
how many times were you admitted to a hospital?					
Baseline (All clients N=211)	52.1%	35.1%	8.5%	2.8%	1.4%
Assessment 1 Matched Sample (95 clients)	57.9%	31.6%	6.3%	2.1%	2.1%
Assessment 3 Matched Sample (95 clients)	64.2%	25.3%	8.4%	1.1%	1.1%

Exodus Recovery, Inc. Service Utilization

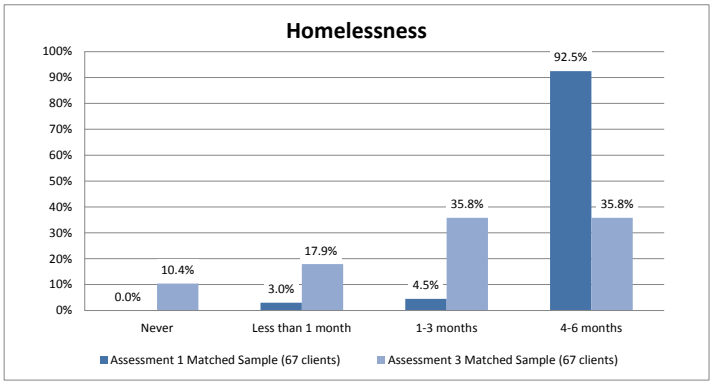
Provider level analyses use a matched sample of clients with completed service utilization items at both the baseline and six month assessments. At the baseline assessment, a majority of clients at Exodus reported that they had visited an emergency room (85.7%) or been hospitalized (63.6%) at least once in the prior six months. There were significant reductions in both emergency room visits and hospitalizations from the baseline to the six month assessment.

In the past 6 months...	None	1-3 times	4-6 times	7-10 times	More than 10 times
how many times did you go to an emergency room?					
Baseline (All clients N=21)	14.3%	42.9%	28.6%	9.5%	4.8%
Assessment 1 Matched Sample (6 clients)	16.7%	16.7%	50.0%	16.7%	0.0%
Assessment 3 Matched Sample (6 clients)	50.0%	50.0%	0.0%	0.0%	0.0%
how many times were you admitted to a hospital?					
Baseline (All clients N=22)	36.4%	36.4%	18.2%	9.1%	0.0%
Assessment 1 Matched Sample (7 clients)	28.6%	28.6%	28.6%	14.3%	0.0%
Assessment 3 Matched Sample (7 clients)	57.1%	42.9%	0.0%	0.0%	0.0%

Exodus Recovery, Inc. Homelessness and Incarcerations

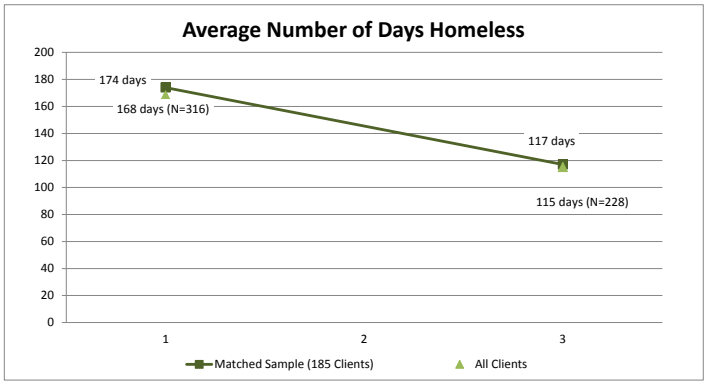
Upon enrolling in the Innovation program, 85.7% of Exodus clients reported that they had not been incarcerated within the previous six months. For clients who completed this item at baseline and during the six month assessment, there were no changes in the frequency of incarcerations.

In 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
Baseline (All clients N=21)	85.7%	9.5%	4.8%	0.0%	0.0%
Assessment 1 Matched Sample (6 clients)	83.3%	16.7%	0.0%	0.0%	0.0%
Assessment 3 Matched Sample (6 clients)	83.3%	16.7%	0.0%	0.0%	0.0%

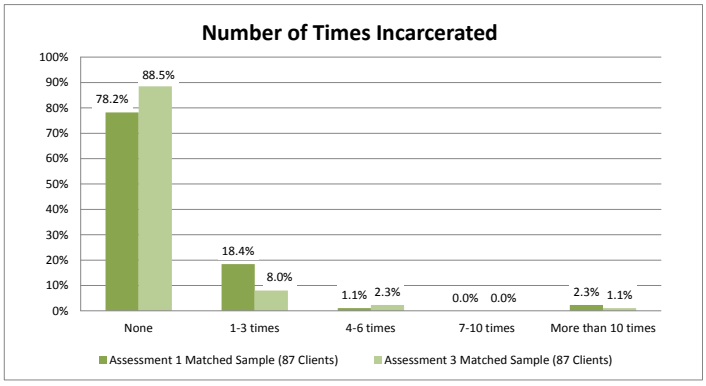


Providers were asked how many days each client had been homeless in the previous six months. At baseline, all of the clients had been homeless during the previous six months. Exodus clients had been homeless for significantly less time during the previous six months at the six month assessment compared with the baseline.

IMHT Homelessness and Incarcerations



For IMHT clients with matched baseline and six month assessments, there was a significant reduction in the number of days homeless in the previous six months from the baseline to the six month assessment.



There was no significant change in the frequency of incarcerations for IMHT clients from the baseline to the six month assessment. However, a greater number of clients reported that they had not been incarcerated in the previous six months at the six month assessment.

Internalized Stigma Mental Illness (ISMI)

The 10-item Internalized Stigma of Mental Illness (ISMI) scale assesses client-reported experiences with stigma and common stereotypes about mental illness, social withdrawal behaviors, as well as the ability to resist or be unaffected by internalized stigma. ISMI items and total scale scores range from 1 (Strongly Disagree) to 4 (Strongly Agree), with lower scores representing decreased stigma. ISMI scale scores are categorized into four levels of stigma: minimal to no internalized stigma, mild internalized stigma, moderate internalized stigma, and severe internalized stigma.

The ISMI is completed by all clients at the baseline assessment to assess existing experiences of stigma prior to joining Innovation. A random sample of clients also completes the ISMI at the semi-annual assessments.

Exodus Recovery, Inc. ISMI Scores by Item

		Assessment Number			
ITEM #	Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Mentally ill people tend to be violent.	2.63	2.33	3.00	0.67
2	People with mental illness make important contributions to society.	2.47	2.67	2.33	-0.34
3	I don't socialize as much as I used to because my mental illness might make me look or behave "weird".	3.11	4.00	2.33	-1.67
4	Having a mental illness has spoiled my life.	2.95	3.00	3.00	0.00
5	I stay away from social situations in order to protect my family or friends from embarrassment.	3.00	2.67	3.33	0.66
6	People without mental illness could not possibly understand me.	2.58	2.33	2.67	0.34
7	People ignore me or take me less seriously just because I have a mental illness.	2.95	3.00	3.00	0.00
8	I can't contribute anything to society because I have a mental illness.	2.53	2.00	2.50 (N=2)	0.50
9	I can have a good, fulfilling life, despite my mental illness.	2.21	2.33	2.33	0.00
10	Others think that I can't achieve much in life because I have a mental illness.	2.95	3.00	2.67	-0.33
	Total Mental Illness Stigma score *(mean of items 1 - 10)*	**2.74 (N=19)**	**2.73 (N=3)**	**2.72 (N=3)**	**-0.01**

The sample size for each ISMI item corresponds with the reported sample size (N) in each column of the Total Mental Illness Stigma score, unless otherwise reported.

At the baseline assessment, a majority of clients at Exodus reported experiencing mild internalized stigma. Significance analyses could not be completed because there were too few clients with matched baseline and six month ISMI scores.

	Assessment Number			
Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
Minimal to no internalized stigma	0.0%	0.0%	0.0%	0.0%
Mild internalized stigma	47.4% (N=9)	33.3% (N=1)	33.3% (N=1)	0.0%
Moderate internalized stigma	36.8% (N=7)	66.7% (N=2)	66.7% (N=2)	0.0%
Severe internalized stigma	15.8% (N=3)	0.0%	0.0%	0.0%

IMHT ISMI Scores

	Assessment Number			
Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
Minimal to no internalized stigma	17.9%	29.6%	29.6%	0.0%
Mild internalized stigma	40.6%	51.9%	55.6%	3.7%
Moderate internalized stigma	31.1%	18.5%	14.8%	-3.7%
Severe internalized stigma	10.4%	0.0%	0.0%	0.0%
Total Mental Illness Stigma score *(mean of items 1 - 10)*	**2.48 (N=106)**	**2.26 (N=27)**	**2.22 (N=27)**	**-0.04**

For IMHT clients with matched baseline and six month ISMI ratings, there was no significant change in total ISMI score from the baseline to the six month assessment.

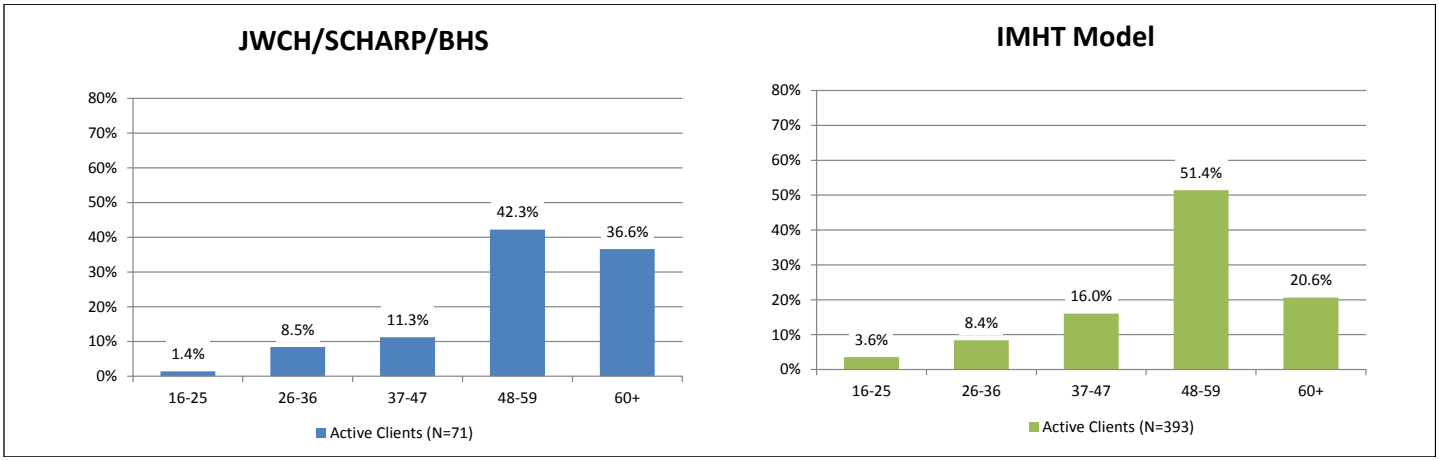
INCORPORATING CLIENT AND CLINICIAN OUTCOMES
JWCH/SCHARP/BHS

WELLNESS • RECOVERY • RESILIENCE

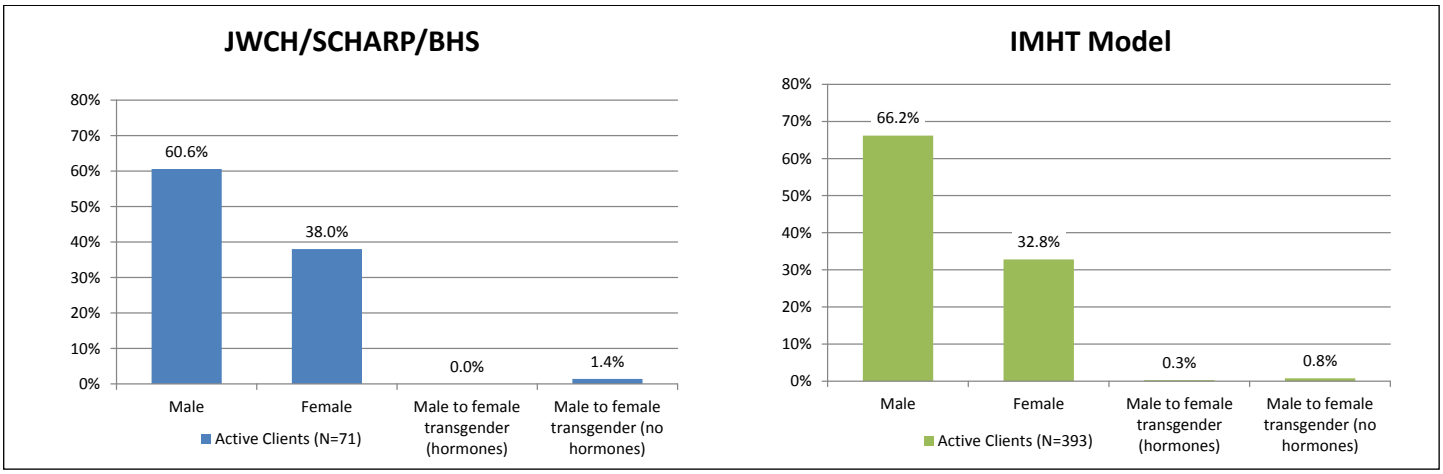
January 2014

CURRENT CLIENT DEMOGRAPHIC INFORMATION

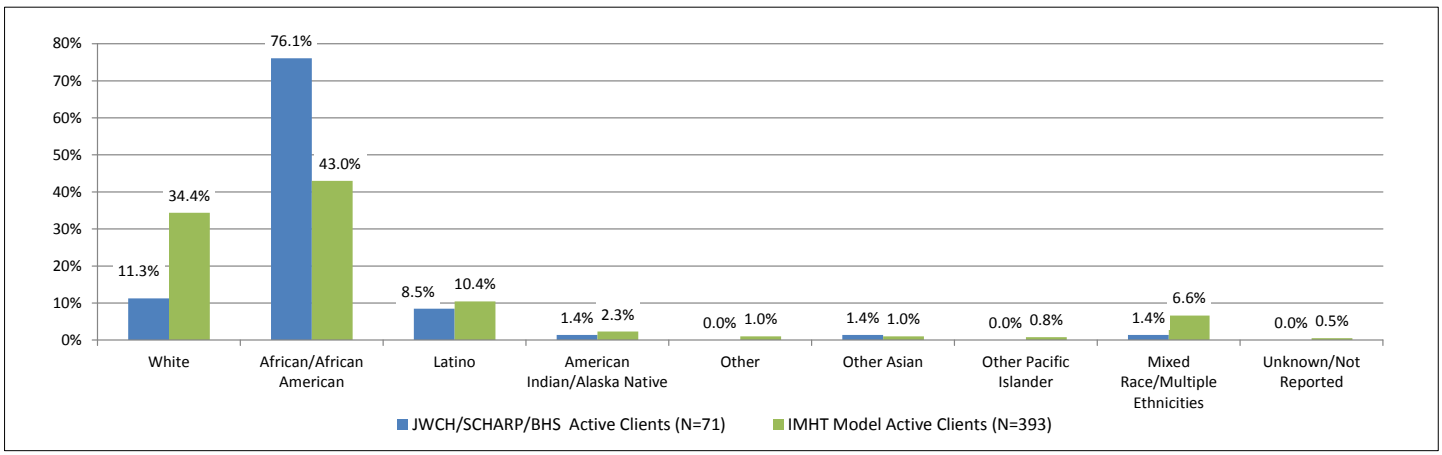
AGE



GENDER



ETHNICITY



CLINICIAN REPORTED RECOVERY OUTCOMES

To assess client recovery, clinicians are asked to complete the **Illness Management and Recovery Scale (IMR) and the Milestones of Recovery Scale (MORS)** at intake (baseline) and during subsequent quarterly follow-up visits. The IMR has 15 individual items, which make up an overall score and three subscales; Substance Use, Recovery (knowledge and goals), and Management (coping with illness outcome). IMR scores range from 1 to 5, with lower scores representing more progress toward recovery.

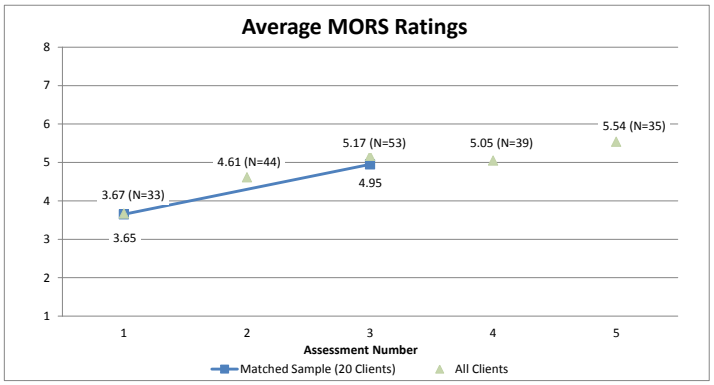
The MORS captures clinician-reported recovery through a single-item recovery indicator. Clinicians are asked to place clients into one of the 8 stages of recovery (rated 1 through 8, respectively): extreme risk, high risk/not engaged, high risk/engaged, poorly coping/not engaged, poorly coping/engaged, coping/rehabilitating, early recovery, and advanced recovery. Ratings are based on a client's 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 the quality of their social support network. Although the MORS is not a linear scale, higher MORS ratings are associated with greater recovery.

JWCH/SCHARP/BHS MORS Ratings

		Assessment Number			
Rating #	Milestones of Recovery Scale	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Extreme Risk	0.0%	0.0%	0.0%	0.0%
2	High risk / Not engaged	24.2%	25.0%	15.0%	-10.0%
3	High risk / Engaged	24.2%	25.0%	5.0%	-20.0%
4	Poorly coping / Not engaged	15.2%	15.0%	5.0%	-10.0%
5	Poorly coping / Engaged	33.3%	30.0%	30.0%	0.0%
6	Coping / Rehabilitating	3.0%	5.0%	35.0%	30.0%
7	Early Recovery	0.0%	0.0%	10.0%	10.0%
8	Advanced Recovery	0.0%	0.0%	0.0%	0.0%
	Average MORS Score	**3.67 (N=33)**	**3.65 (N=20)**	**4.95 (N=20)**	**1.30**

Provider level analyses use a matched sample of clients with MORS ratings at both the baseline and six month follow-up assessments. There was a significant increase in mean MORS scores for clients at JWCH from the baseline to the six month assessment. Clients were in a more advanced stage of recovery six months after enrolling in Innovation compared to baseline.

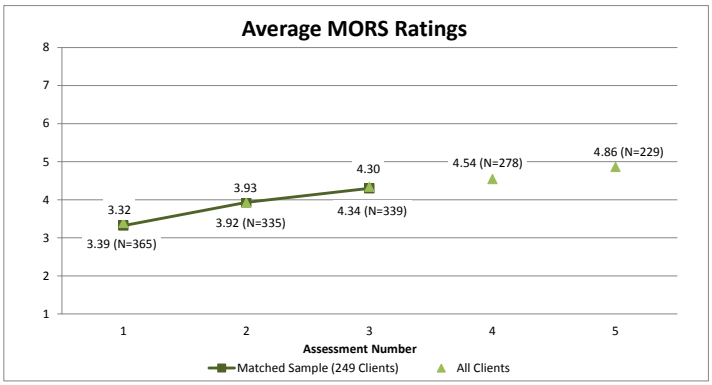
In addition to mean MORS scores for the matched sample, the figure to the right includes mean MORS scores for all JWCH clients at each assessment. Scores for all clients were similar to the matched sample at each assessment.



IMHT MORS Ratings

Model level analyses use a matched sample of clients with MORS ratings on the baseline, and the three and six month assessments. For IMHT clients there was a significant increase in MORS scores from baseline to three months, and from three to six months. MORS scores continue to increase over time, indicating ongoing progress towards client recovery.

	Assessment Number			
Milestones of Recovery Scale	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 2 (Matched Sample)	Assessment 3 (Matched Sample)
Average MORS Score	3.39 (N=365)	3.32 (N=249)	3.93 (N=249)	4.30 (N=249)



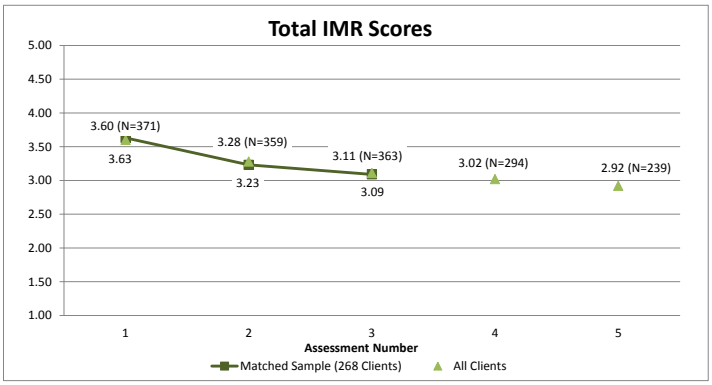
JWCH/SCHARP/BHS IMR Scores by Item

ITEM #	Aspect of Illness Management & Recovery	Assessment Number: Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Progress towards personal goals	3.73 (N=49)	3.62 (N=34)	2.79 (N=34)	-0.83
2	Knowledge	4.12	4.03	2.97	-1.06
4	Contact with people outside of my family	2.14	2.14	2.66	0.52
8	Relapse prevention planning	4.04	3.91	2.66	-1.25
12	Involvement with self-help activities	3.86	3.77	3.14	-0.63
	Recovery Subscale *(mean of items 1, 2, 4, 8, & 12)*	**3.58 (N=50)**	**3.49 (N=35)**	**2.84 (N=35)**	**-0.65**
6	Symptom distress	4.38	4.46	3.69	-0.77
7	Impairment of functioning	4.64	4.57	3.80	-0.77
9	Relapse of symptoms	4.64	4.63	3.89	-0.74
11	Coping	4.22	4.26	3.23	-1.03
	Management Subscale *(mean of items 6, 7, 9, & 11)*	**4.47 (N=50)**	**4.48 (N=35)**	**3.65 (N=35)**	**-0.83**
14	Impairment of functioning through alcohol use	2.82	3.03	2.69	-0.34
15	Impairment of functioning through drug use	3.20	3.40	2.79 (N=34)	-0.61
	Substance Use Subscale *(maximum of items 14 & 15)*	**3.58 (N=50)**	**3.89 (N=35)**	**3.23 (N=35)**	**-0.66**
3	Involvement of family and friends in my mental health treatment	4.08	4.03	4.09	0.06
5	Time in structured roles	4.84 (N=49)	4.82 (N=34)	4.46	-0.36
10	Psychiatric hospitalizations	1.37 (N=49)	1.23	1.23	0.00
13	Using medication effectively	3.13 (N=30)	3.43 (N=23)	2.34 (N=32)	-1.09
	Overall IMR Score (*mean of items 1-15*)	**3.70 (N=50)**	**3.70 (N=35)**	**3.10 (N=35)**	**-0.60**

The sample size for each IMR item corresponds with the reported sample size (N) in each column of the Overall IMR score, unless otherwise reported.

IMHT IMR Total Scores

Aspect of Illness Management & Recovery	Assessment Number: Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 2 (Matched Sample)	Assessment 3 (Matched Sample)
Recovery Subscale *(mean of items 1, 2, 4, 8, and 12)*	3.61	3.64	3.16	3.02
Management Subscale *(mean of items 6, 7, 9, and 11)*	4.16	4.20	3.75	3.56
Substance Use Subscale *(the maximum of items 14 and 15)*	3.32	3.36 (N=269)	3.14 (N=269)	3.09 (N=269)
Overall IMR Score	**3.60 (N=371)**	**3.63 (N=268)**	**3.23 (N=268)**	**3.09 (N=268)**

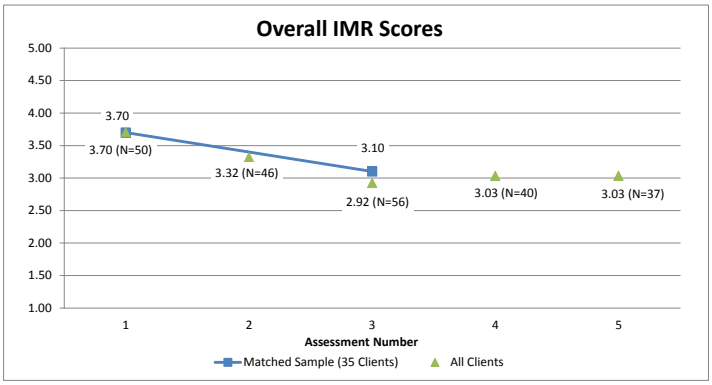


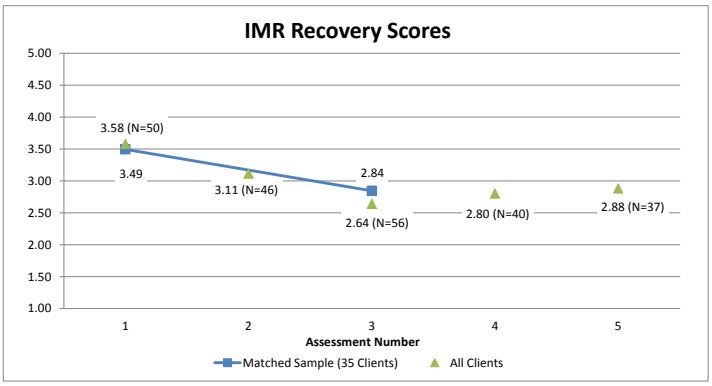
Model level analyses use a matched sample of clients with IMR ratings on the baseline, and the three and six month assessments. For IMHT clients there was a significant decrease in overall IMR scores from the baseline to the three month assessment, and from the three to the six month assessment. This indicates that, on average, clients in the IMHT model made consistent progress towards their recovery after enrolling in services.

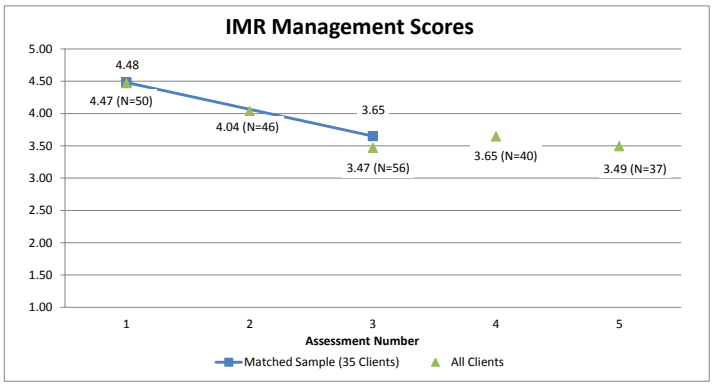
Average scores for all IMHT clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figure to the left.

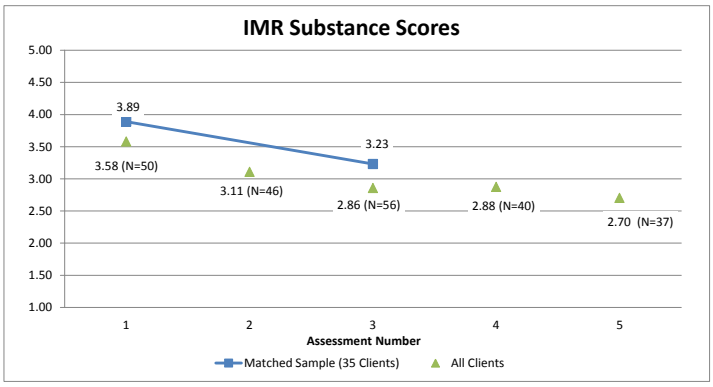
JWCH/SCHARP/BHS IMR Scores

Provider level analyses use a matched sample of clients with IMR scores at both the baseline and six month follow-up assessments. There was a significant decrease in overall IMR scores from the baseline to the six month assessment. This indicates that JWCH clients made progress towards their recovery after enrolling in Innovation. Scores were also significantly reduced on the Management, Recovery, and Substance Use subscales from the baseline to the six month assessment. This indicates that clinicians observed that clients made consistent progress towards their recovery, were better able to manage their mental health, and were less likely to be using substances.



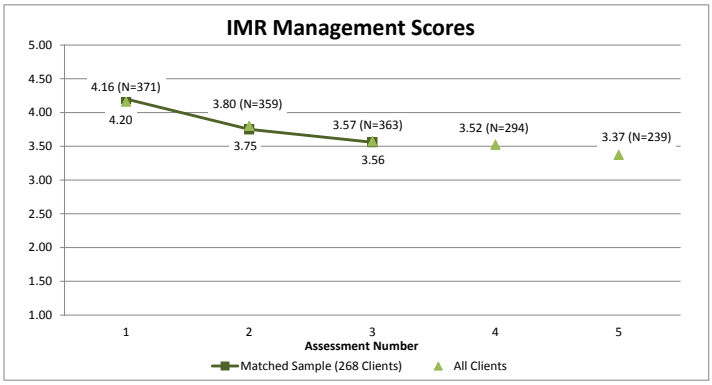


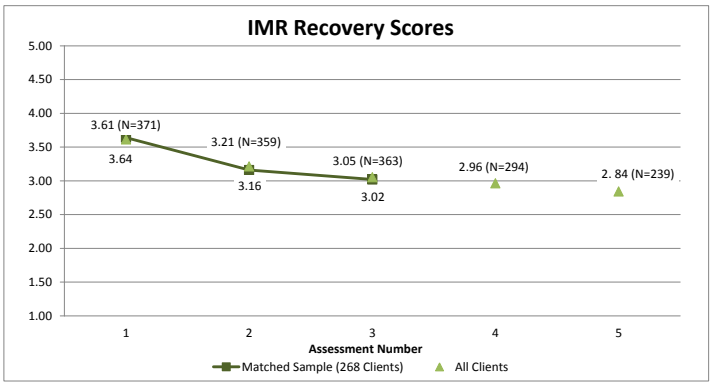


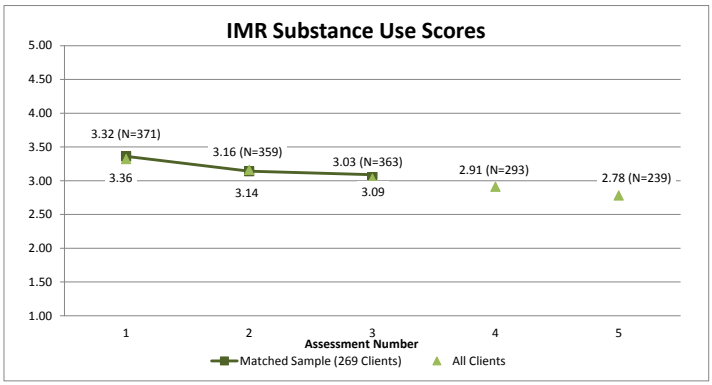


IMHT IMR Subscale Scores

Model level analyses use a matched sample of clients with IMR scores on the baseline, and the three and six month assessments. For IMHT clients, there were significant decreases in IMR Recovery and Management subscale scores from baseline to three months and from three to six months. There were also significant decreases on the Substance Use subscale from baseline to three months and from baseline to six months. This indicates that, on average, clients were less likely to use substances, had made progress towards their recovery, and were better able to manage their mental health after enrolling in Innovation.







CLIENT 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. The Integrated Self-Assessment includes the PROMIS Global Health Scale, the Physical Health and Behaviors Survey, the PROMIS-Derived Substance Use Scale, and the CHOIS Supplement. All measures are distributed semi-annually, except for the PROMIS Global Health, which is distributed quarterly. Additionally, all clients are asked to complete the Internalized Stigma of Mental Illness (ISMI) Scale at baseline, and either the ISMI, Post-Outcomes Survey, or Satisfaction Survey, semi-annually. Results from the Satisfaction and Self-Reported Post-Outcomes Surveys are not detailed in this report.

Paired samples t-tests and chi-square tests were used to examine the statistical significance of changes in scores on the measures over time. These procedures provide evidence that change was due to the benefits of receiving Innovation services and not chance variation. Statistical analysis using paired samples is performed by selecting only the cases that have complete data for each time point being measured.

These matched comparisons show change for individual clients as they progress through services, which allow changes to be more easily attributed to Innovation. Using paired samples decreases sample size, so data for all clients at each assessment point are also presented in each table. 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. The current matched sample analyses evaluate change between Assessment 1 (baseline) and Assessment 3 (the six month assessment). All reported outcomes include current and discharged clients.

PROMIS Global Health

The PROMIS Global Health scale is a 10-item measure aimed at assessing client-reported health including: physical health, pain, fatigue, mental health, and social health. Items are used to create a Total Global Health score and two sub-scale scores; Physical Health and Mental Health. PROMIS Global Health scores range from 1 to 5; however, clients are also asked to rate their pain using a scale from 0 (no pain) – 10 (worst imaginable pain), which is then categorized into a 5-point scale. For all PROMIS items and scales, lower scores represent fewer health concerns (i.e. lower scores are desirable). Clients are asked to complete the PROMIS Global Health at baseline and at subsequent quarterly assessments.

JWCH/SCHARP/BHS PROMIS Global Health Scores by Item

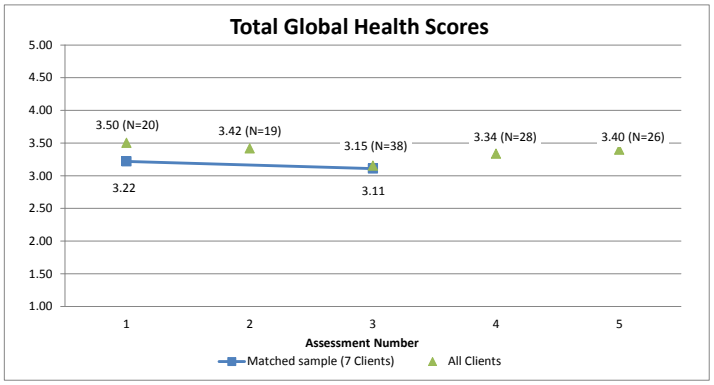
		Assessment Number			
ITEM #	PROMIS Global Health	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
2	Quality of life	3.85	3.86	2.71	-1.15
4	Mental health, including mood and ability to think	3.68 (N=19)	3.17 (N=6)	3.57	0.40
5	Satisfaction with social activities and relationships	3.85	3.71	3.14	-0.57
8	Bothered by emotional problems, such as feeling anxious, depressed or irritable	3.85	3.29	3.14	-0.15
	Global Mental Health *(mean of items 2, 4, 5, & 8)*	**3.78 (N=20)**	**3.44 (N=7)**	**3.14 (N=7)**	**-0.30**
3	Physical health	3.21 (N=19)	2.86	3.14	0.28
7	Everyday physical activities	2.55	2.43	2.86	0.43
9	Fatigue	3.15	3.00	2.57	-0.43
10	Pain rating	3.65	3.29	2.86	-0.43
	Global Physical Health *(mean of items 3, 7, 9, & 10)*	**3.16 (N=20)**	**2.89 (N=7)**	**2.86 (N=7)**	**-0.03**
1	General health	3.63 (N=19)	3.83 (N=6)	3.86	0.03
6	Ability to carry out regular social roles and activities	3.63 (N=19)	3.00 (N=6)	3.29	0.29
	Total Global Health Score (*mean of items 1-10)*	**3.50 (N=20)**	**3.22 (N=7)**	**3.11 (N=7)**	**-0.11**

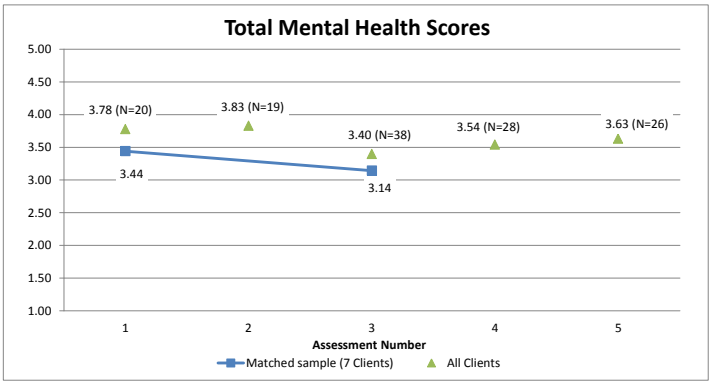
The sample size for each PROMIS item corresponds with the reported sample size (N) in each column of the Total Global Health score, unless otherwise reported.

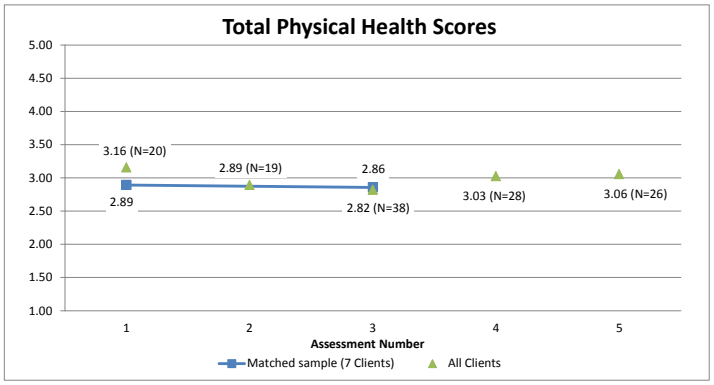
JWCH/SCHARP/BHS PROMIS Scores

Provider level analyses use a matched sample of clients with PROMIS scores at both the baseline and six month follow-up assessments. There was no significant change in PROMIS Global Health scores for JWCH clients from the baseline to the six month assessment.

Average scores for all clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figures.





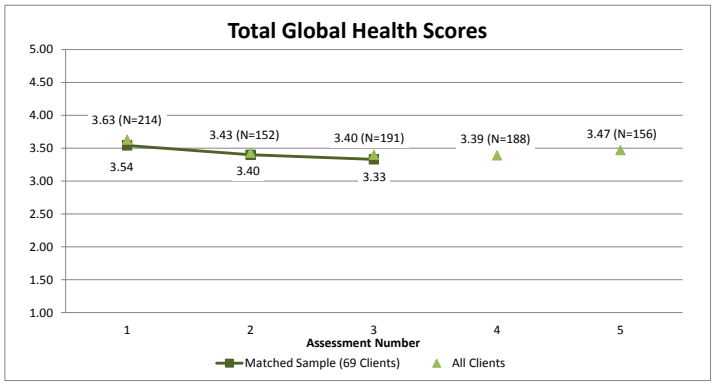


There were no significant changes in either the Global Mental Health or the Global Physical Health subscale scores from the baseline to the six month assessment.

IMHT PROMIS Scores

Model level analyses use a matched sample of clients with PROMIS scores on the baseline, and the three and six month assessments. For IMHT clients, there was a significant decrease in Total Global Health scores from the baseline to the six month assessment. This indicates that, on average, clients reported experiencing fewer health problems after enrolling in Innovation.

In addition to PROMIS Global Health scores for the matched sample, the figure to the right includes scores for all clients at each assessment. Scores for all clients were similar to the matched sample at each assessment.



	Assessment Number			
PROMIS Global Health	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 2 (Matched Sample)**	**Assessment 3 (Matched Sample)**
Global Mental Health Subscale ***(mean of items 2, 4, 5, and 10)***	3.87	3.82	3.64	3.49
Global Physical Health Subscale ***(mean of items 3, 6, 7, and 8)***	3.33	3.19	3.05	3.10
Overall Global Health Score	**3.63 (N=214)**	**3.54 (N=69)**	**3.40 (N=69)**	**3.33 (N=69)**

Creating Healthy Outcomes: Integrated Self-Assessment (CHOIS) Supplement

The CHOIS Supplement is a client-rated recovery-based measure that assesses several mental health related domains, including suicidal ideation, anxiety, trauma, psychosis (i.e. hearing voices), and memory and cognitive impairment. The CHOIS contains three subscales: Psychosis, Memory and Cognitive Impairments, and Strengths. The Psychosis and Memory and Cognitive Impairment subscales assess clients' perceptions of their mental health symptoms, while the Strengths subscale examines recovery-oriented personal strengths that can assist clients in their recovery. Strengths items could be incorporated into treatment planning and recovery, and provide a positive point of assessment, an important aspect of being recovery-oriented. In addition to the scale scores, individual CHOIS items provide valuable insight into the clients' perception of their mental health symptoms.

All CHOIS subscales range from 1 to 5, with lower scores being desirable. For the Psychosis and Memory and Cognitive Impairment subscales, lower scores indicate fewer negative symptoms. For the Strengths subscale, lower scores indicate greater personal strengths. The CHOIS Supplement is completed by the client during the baseline and semi-annual assessments.

JWCH/SCHARP/BHS CHOIS Scores

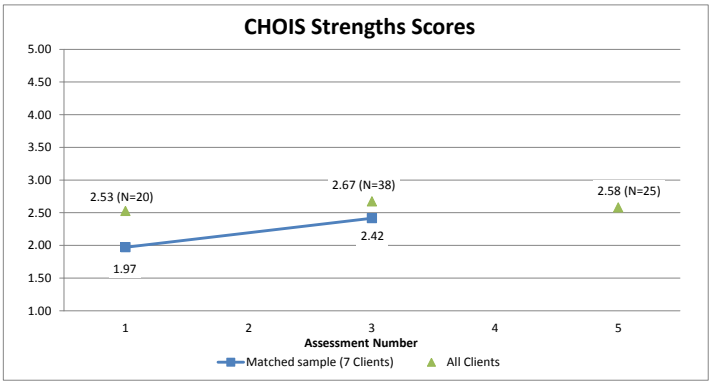
		Assessment Number			
ITEM #	CHOIS Supplement	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Thoughts entered my mind that I had trouble getting rid of.	3.50	2.71	2.86	0.15
2	I did things I couldn't resist or did things more often than I should.	2.55	2.00	2.00	0.00
3	I had disturbing memories or images of a stressful experience.	3.25	2.29	2.43	0.14
4	I had memory problems, such as forgetting names or appointments.	3.55	3.29	2.86	-0.43
5	I had difficulty thinking clearly while doing familiar tasks.	2.85	2.57	2.29	-0.28
6	I believed people were following or trying to harm me or my family.	2.75	2.29	2.29	0.00
7	I heard voices that no one else could hear.	3.40	2.43	2.43	0.00
8	I had thoughts of ending my life or harming myself.	2.10	2.29	2.00	-0.29
9	My child(ren) had emotional and/or behavioral problems.	1.82 (N=17)	1.00 (N=6)	1.00	0.00
10	I felt good about myself.	3.00 (N=19)	2.17 (N=6)	2.57	0.40
11	I had goals and worked towards achieving them.	2.50	1.71	2.29	0.58
12	I felt hopeful about the future.	2.20	1.57	2.71	1.14
13	I was able to handle things.	2.67 (N=18)	2.60 (N=5)	2.29	-0.31
14	I felt happy.	2.70	2.29	2.17 (N=6)	-0.12
15	I had energy and was full of life.	2.90	2.43	2.29	-0.14
16	I felt spiritually connected.	2.40	1.57	3.00	1.43
17	I had contact with people that care about me.	2.05	1.86	2.00	0.14
18	I lived in a home that made me feel safe.	3.50	3.71	2.14	-1.57
19	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?	1.95	1.57	1.71	0.14
	Psychosis score *(mean of items 6 & 7)*	**3.08 (N=20)**	**2.36 (N=7)**	**2.36 (N=7)**	**0.00**
	Memory score *(mean of items 4 & 5)*	**3.20 (N=20)**	**2.93 (N=7)**	**2.57 (N=7)**	**-0.36**
	Strengths score *(mean of items 10, 11, 12, 13, 14, 15, 16 & 17)*	**2.53 (N=20)**	**1.97 (N=7)**	**2.42 (N=7)**	**0.45**

The sample size for each CHOIS item corresponds with the highest reported sample size (N) in each column of the CHOIS Subscale scores, unless otherwise reported.

IMHT CHOIS Scores

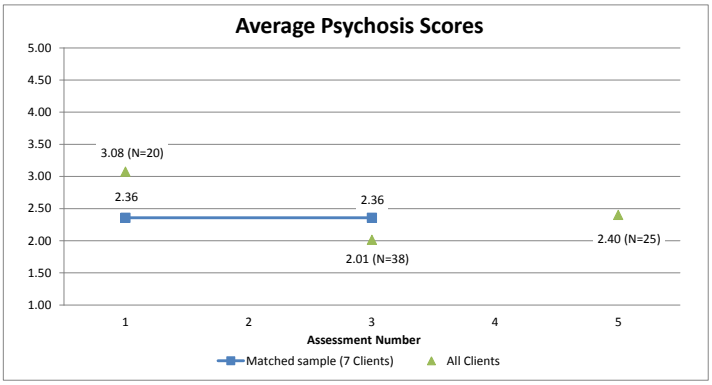
	Assessment Number		
CHOIS Supplement	Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)
Psychosis score *(mean of items 6 & 7)*	2.34 (N=211)	2.25 (N=95)	2.04 (N=95)
Memory score *(mean of items 4 & 5)*	2.95 (N=211)	3.02 (N=95)	2.77 (N=95)
Strengths score *(mean of items 10, 11, 12, 13, 14, 15, 16 & 17)*	2.85 (N=210)	2.82 (N=93)	2.77 (N=93)

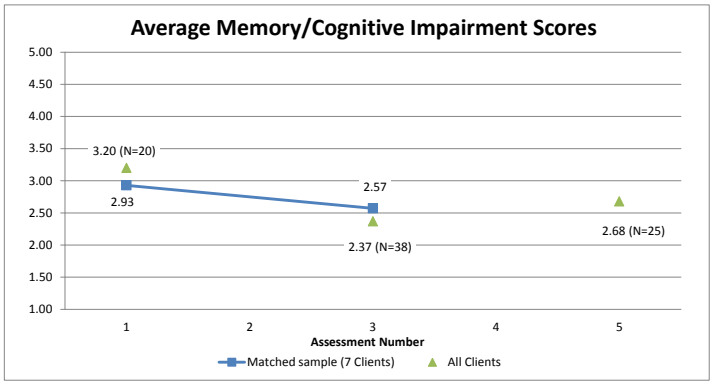
JWCH/SCHARP/BHS CHOIS Subscale Scores



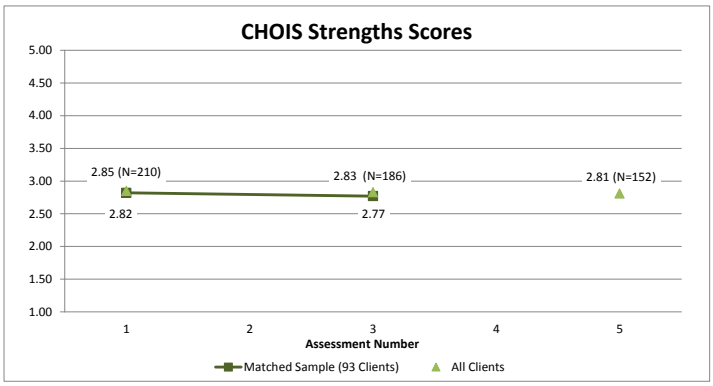
Provider level analyses use a matched sample of clients with CHOIS scores at both the baseline and six month follow-up assessments.

There were no significant changes on any of the three CHOIS subscales from the baseline to the six month assessment.



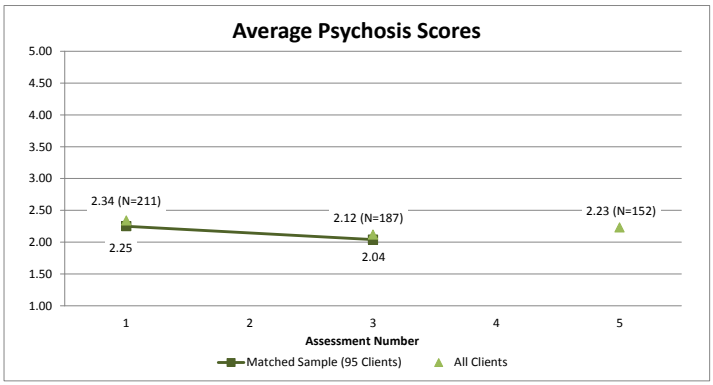


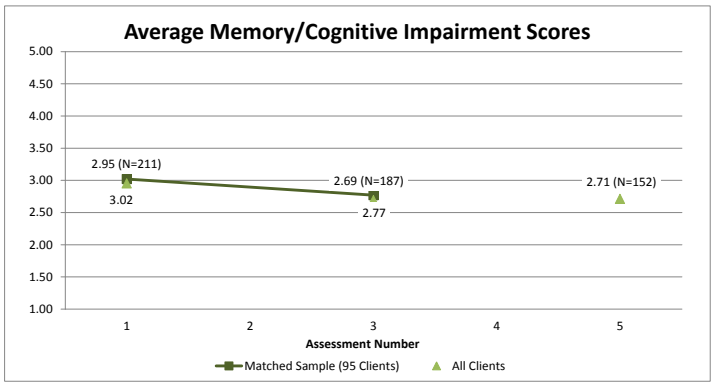
IMHT CHOIS Subscale Scores



Model level analyses use a matched sample of clients with CHOIS scores on the baseline, and six month assessments. For IMHT clients there were no significant changes on any of the CHOIS subscales from the baseline to the six month assessment.

Average scores for all IMHT clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figures.





PROMIS-Derived Substance Use

The 12-item PROMIS-Derived Substance Use scale assesses clients' perceptions of the negative consequences of their alcohol and/ or substance use, including physical (e.g., dizziness), mental (e.g., risk taking, guilt), and social (e.g., others had trouble counting on me, substance use created problems between me and others) consequences. Item and total scale scores range from 1 to 5, with lower scores indicating fewer client-perceived negative consequences associated with alcohol and/or substance use. Paired with the information from the clinician completed IMR Substance Use items, clients responses on this measure can help clinicians encourage a therapeutic dialogue with the client about their substance use.

Clients who indicate on their Physical Health and Behaviors assessment that they have used alcohol, illegal drugs, or off-label prescription medications within the past six months complete the PROMIS-Derived Substance Use Scale at the baseline and semi-annual assessments.

JWCH/SCHARP/BHS Substance Use Scores

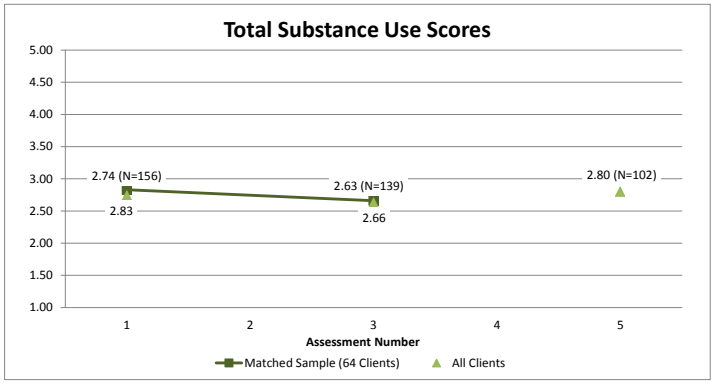
		Assessment Number			
ITEM #	PROMIS-Derived Substance Use	Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	I used substances (alcohol, illegal drugs) too much.	3.14	4.00	2.75	-1.25
2	I used alcohol or substances throughout the day.	2.79	3.75	2.50	-1.25
3	I had an urge to continue drinking or using substances once I started.	2.43	2.25	2.75	0.50
4	I felt that I should cut down on my alcohol or substance use.	3.29	3.25	2.50	-0.75
5	I felt I needed help for my alcohol or substance use.	3.00	3.75	2.25	-1.50
6	I took risks when I used alcohol or substances.	2.93	3.00	2.00	-1.00
7	I felt guilty when I used alcohol or substances.	2.71	4.00	2.00	-2.00
8	Others complained about my alcohol or substance use.	2.43	4.00	2.25	-1.75
9	Alcohol or substance use created problems between me and others.	3.00	4.00	2.00	-2.00
10	Others had trouble counting on me when I used alcohol or substances.	2.77 (N=13)	3.67 (N=3)	2.25	-1.42
11	I felt dizzy after I used alcohol or substances.	2.77 (N=13)	3.67 (N=3)	2.25	-1.42
12	Alcohol or substance use made my physical or mental health symptoms worse.	3.21	4.75	2.50	-2.25
	Total Substance Use score *(mean of items 1 - 12)*	**2.90 (N=14)**	**3.73 (N=4)**	**2.33 (N=4)**	**-1.40**

The sample size for each Substance Use item corresponds with the reported sample size (N) in each column of the Total Substance Use score, unless otherwise reported.

IMHT Substance Use Scores

	Assessment Number		
PROMIS-Derived Substance Use	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)
Total Substance Use score *(mean of items 1 - 12)*	2.74 (N=156)	2.83 (N=64)	2.66 (N=64)

Model level analyses use a matched sample of clients with Substance Use scores on the baseline, and the six month assessment. For IMHT clients there was no significant change in scores from the baseline to the six month assessment. As clients continue to receive Innovation services, improvements may become significant.



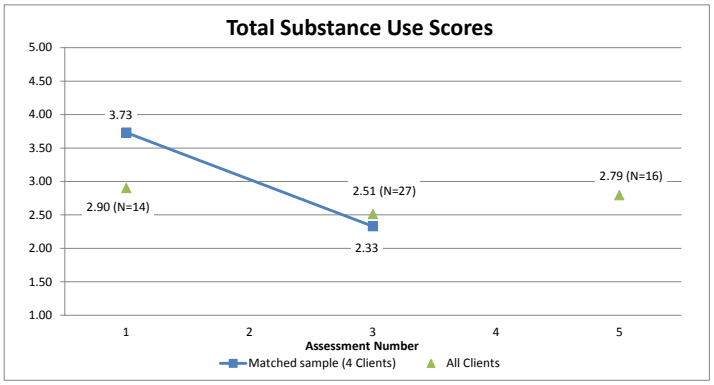
Do you smoke tobacco?			
	Not at all	Some days	Every day
Baseline (All clients N=205)	22.0%	12.2%	65.9%
Assessment 1 Matched Sample (91 clients)	17.6%	14.3%	68.1%
Assessment 3 Matched Sample (91 clients)	18.7%	23.1%	58.2%

Compared to baseline, there was a significant reduction in tobacco use at the six month assessment for IMHT clients.

JWCH/SCHARP/BHS Substance Use Scores

On the baseline assessment, almost half of clients at JWCH reported that they had not used alcohol (40.0%) or drugs (45.0%) within the previous six months. There were no significant changes in client-reported alcohol or drug use from the baseline to the six month assessment.

There were no significant changes in scores on the PROMIS-Derived Substance Use scale from the baseline to the six month assessment. There were only four clients with a matched baseline and six month assessment so improvements may become significant as more clients enroll in the program.



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
Baseline (All clients N=20)	40.0%	30.0%	5.0%	15.0%	10.0%
Assessment 1 Matched Sample (7 clients)	42.9%	14.3%	0.0%	42.9%	0.0%
Assessment 3 Matched Sample (7 clients)	28.6%	28.6%	14.3%	14.3%	14.3%

During the last 6 months, how often did you use an illegal drug or use a prescription medication for nonmedical reasons?					
	Never	Less than once a week	1-3 times per week	4 or more times per week	Every day
Baseline (All clients N=20)	45.0%	25.0%	5.0%	15.0%	10.0%
Assessment 1 Matched Sample (6 clients)	66.7%	0.0%	0.0%	16.7%	16.7%
Assessment 3 Matched Sample (6 clients)	66.7%	33.3%	0.0%	0.0%	0.0%

Do you smoke tobacco?			
	Not at all	Some days	Every day
Baseline (All clients N=19)	10.5%	21.1%	68.4%
Assessment 1 Matched Sample (6 clients)	16.7%	50.0%	33.3%
Assessment 3 Matched Sample (6 clients)	66.7%	0.0%	33.3%

Compared to baseline, there was a significant reduction in tobacco use at the six month assessment.

Physical Health and Behaviors

Clients completed the Physical Health and Behaviors Survey at the baseline and semi-annual assessments to measure health behaviors, including substance use, medication adherence, and exercise, service utilization including emergency room visits, hospitalizations, and previous experiences accessing care, and daily activities including housing situation, employment, volunteer activities and education.

JWCH/SCHARP/BHS Physical Activity

At the baseline assessment, a majority of clients (65.0%) at JWCH reported that they engaged in physical activity at least once during a typical week. There was no significant change in physical activity from the baseline to the six month assessment for clients who completed this item at baseline and at the six month assessment.

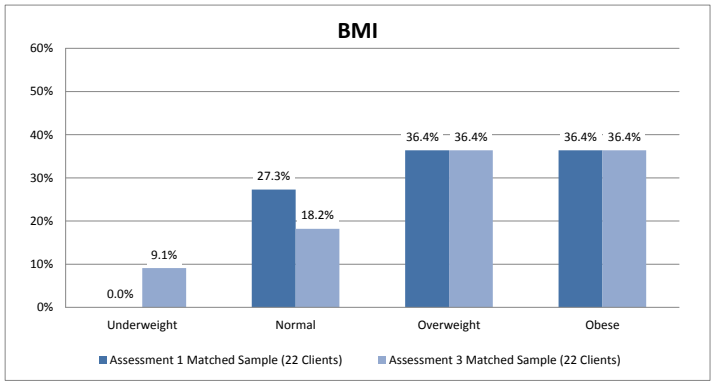
How many times in a usual week do you do 30 minutes of physical activity that increases your heart rate or makes you breathe harder than normal? (for example, walking or jogging, carrying light loads, bicycling, or playing sports)					
	None	1 time	2 times	3 times	4 or more times
Baseline (All clients N=20)	35.0%	5.0%	15.0%	5.0%	40.0%
Assessment 1 Matched Sample (7 clients)	0.0%	14.3%	14.3%	14.3%	57.1%
Assessment 3 Matched Sample (7 clients)	28.6%	28.6%	14.3%	14.3%	14.3%

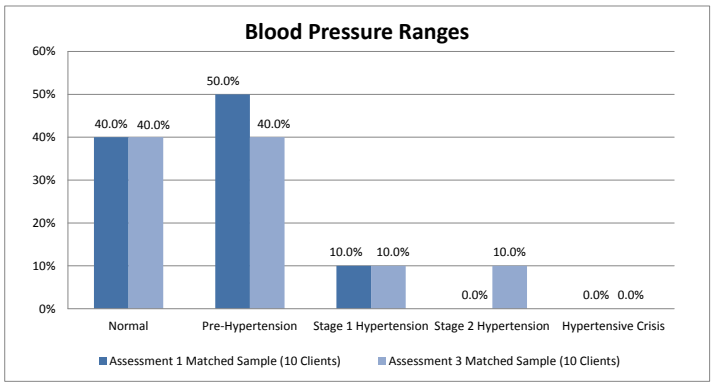
JWCH/SCHARP/BHS Physical Health

The figure below shows the proportion of clients who were ever screened for each of the physical health conditions during the first twelve months of their enrollment in Innovation. The most common screening at JWCH was for High Blood Pressure, followed by Diabetes, High Cholesterol, HIV, and Hepatitis. Clinicians indicated which screenings were completed on the Physical Health Indicators Survey, which was completed every six months.

Percentage of Clients who have ever been screened for:								
Diabetes	High Blood Pressure	Cholesterol	Asthma*	Emphysema*	Tuberculosis*	HIV	Hepatitis	Other STDs
28.4%	54.5%	29.5%	2.3%	3.4%	8.0%	26.1%	25.0%	20.5%

* Screening for Asthma, Emphysema, and Tuberculosis was only included on the baseline assessment.





Clinicians are asked to provide clients' height and weight on the Physical Health Indicators Survey, which are used to calculate Body Mass Index (BMI). BMI was categorized using the standard categories defined by the Centers for Disease Control and Prevention. There was no significant change in BMI from the baseline to the six month assessment.

Systolic and diastolic readings are combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. Blood pressure is only one indicator of risk; additional criteria must be met for a diagnosis of hypertension. There were no significant changes in risk for hypertension from the baseline to the six month assessment.

In the past month, how often did you take your medications as the doctor prescribed?					
	My doctor hasn't prescribed any	Less than half the time (<50%)	About half the time (50%)	Nearly all the time (75%)	All the time (100%)
Baseline (All clients N=19)	10.5%	21.1%	5.3%	31.6%	31.6%
Assessment 1 Matched Sample (6 clients)	0.0%	33.3%	0.0%	16.7%	50.0%
Assessment 3 Matched Sample (6 clients)	0.0%	0.0%	0.0%	50.0%	50.0%

Clients were asked how often they took their medications as prescribed. There have been no significant changes in medication adherence to date.

IMHT Physical Activity

At the baseline assessment, a majority of clients in the IMHT model (67.9%) reported that they engaged in physical activity at least once during a typical week. There was no significant change in physical activity from the baseline to the six month assessment for clients who completed this item at baseline and at the six month assessment.

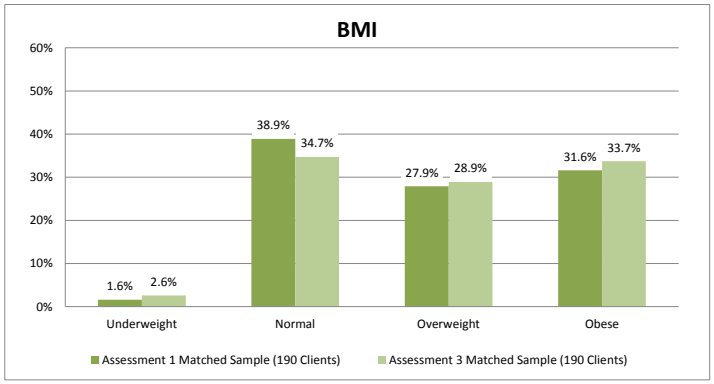
How many times in a usual week do you do 30 minutes of physical activity that increases your heart rate or makes you breathe harder than normal? (for example, walking or jogging, carrying light loads, bicycling, or playing sports)					
	None	1 time	2 times	3 times	4 or more times
Baseline (All clients N=215)	32.1%	7.9%	8.8%	11.6%	39.5%
Assessment 1 Matched Sample (92 clients)	28.3%	8.7%	7.6%	13.0%	42.4%
Assessment 3 Matched Sample (92 clients)	19.6%	17.4%	15.2%	17.4%	30.4%

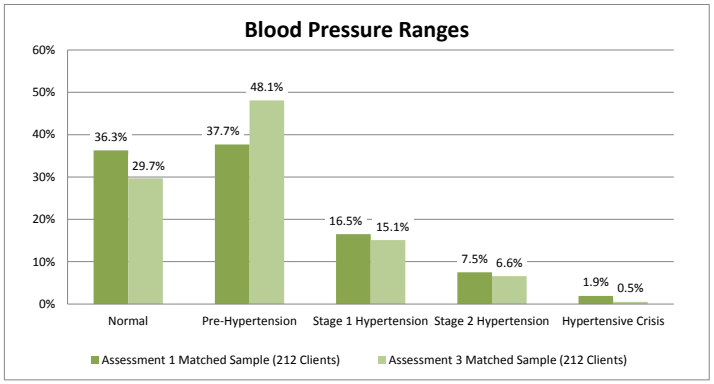
IMHT Physical Health

The figure below shows the proportion of clients who were ever screened for each of the physical health conditions during the first twelve months of their enrollment in Innovation. Within the first year of receiving Innovation services, IMHT clients were most likely to be screened for Diabetes, High Blood Pressure, High Cholesterol, HIV, Hepatitis and other STDs.

Percentage of Clients at 12 Months who have EVER been Screened For:								
Diabetes	High Blood Pressure	Cholesterol	Asthma*	Emphysema*	Tuberculosis*	HIV	Hepatitis	Other STDs
57.9%	70.6%	56.8%	10.8%	16.0%	21.1%	54.4%	45.4%	51.9%

* Screening for Asthma, Emphysema, and Tuberculosis was only included on the baseline assessment.





Clinicians are asked to provide clients' height and weight on the Physical Health Indicators Survey, which are used to calculate Body Mass Index (BMI). BMI was categorized using the standard categories defined by the Centers for Disease Control and Prevention. There were no significant changes in BMI for IMHT clients from the baseline to the six month assessment.

Systolic and diastolic readings are combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. Blood pressure is only one indicator of risk; additional criteria must be met for a diagnosis of hypertension. There were no significant changes in risk for hypertension from the baseline to the six month assessment.

In the past month, how often did you take your medications as the doctor prescribed?					
	My doctor hasn't prescribed any	Less than half the time (<50%)	About half the time (50%)	Nearly all the time (75%)	All the time (100%)
Baseline (All clients N=206)	16.0%	11.7%	11.7%	26.7%	34.0%
Assessment 1 Matched Sample (92 clients)	16.3%	13.0%	12.0%	22.8%	35.9%
Assessment 3 Matched Sample (92 clients)	7.6%	8.7%	17.4%	30.4%	35.9%

Clients were asked how often they took their medications as prescribed. There have been no significant changes in medication adherence to date, however more clients reported that they were taking doctor-prescribed medication at the six month assessment.

IMHT Service Utilization

Model level analyses use a matched sample of clients who completed service utilization items on the baseline, and the six month assessment. There was a significant reduction in the mean frequency of emergency room visits from baseline to the six month assessment for IMHT clients. There was no significant change in the frequency of hospital admissions.

In the past 6 months...	None	1-3 times	4-6 times	7-10 times	More than 10 times
how many times did you go to an emergency room?					
Baseline (All clients N=212)	30.2%	47.6%	14.6%	3.8%	3.8%
Assessment 1 Matched Sample (94 clients)	35.1%	42.6%	13.8%	4.3%	4.3%
Assessment 3 Matched Sample (94 clients)	44.7%	39.4%	11.7%	1.1%	3.2%
how many times were you admitted to a hospital?					
Baseline (All clients N=211)	52.1%	35.1%	8.5%	2.8%	1.4%
Assessment 1 Matched Sample (95 clients)	57.9%	31.6%	6.3%	2.1%	2.1%
Assessment 3 Matched Sample (95 clients)	64.2%	25.3%	8.4%	1.1%	1.1%

JWCH/SCHARP/BHS Service Utilization

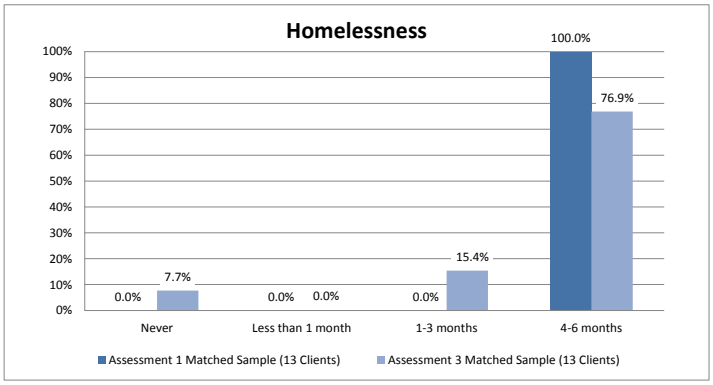
Provider level analyses use a matched sample of clients with completed service utilization items at both the baseline and six month assessments. At the baseline assessment, over half of clients at JWCH reported that they had visited an emergency room (55.0%) and about a third had been hospitalized (32.6%) at least once in the prior six months. There were no significant reductions in service utilization from the baseline to the six month assessment.

In the past 6 months...	None	1-3 times	4-6 times	7-10 times	More than 10 times
how many times did you go to an emergency room?					
Baseline (All clients N=20)	45.0%	50.0%	0.0%	0.0%	5.0%
Assessment 1 Matched Sample (7 clients)	42.9%	42.9%	0.0%	0.0%	14.3%
Assessment 3 Matched Sample (7 clients)	71.4%	28.6%	0.0%	0.0%	0.0%
how many times were you admitted to a hospital?					
Baseline (All clients N=19)	68.4%	26.3%	5.3%	0.0%	0.0%
Assessment 1 Matched Sample (7 clients)	71.4%	14.3%	14.3%	0.0%	0.0%
Assessment 3 Matched Sample (7 clients)	85.7%	14.3%	0.0%	0.0%	0.0%

JWCH/SCHARP/BHS Homelessness and Incarcerations

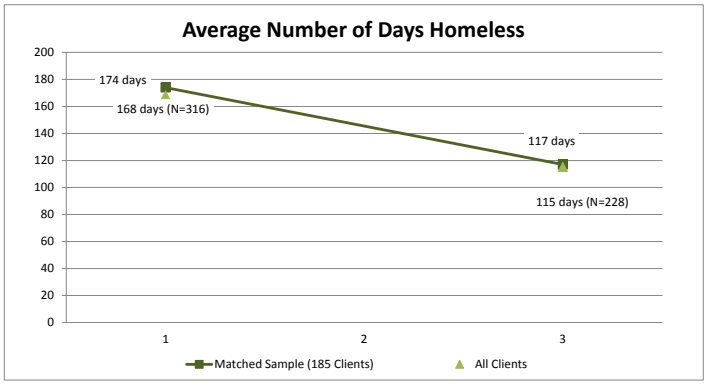
Upon enrolling in the Innovation program, 80.0% of JWCH clients reported that they had not been incarcerated within the previous six months. All of the clients with matched baseline and six month assessments reported that they had not been incarcerated in the previous six months on both the baseline and the six month assessment.

In 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
Baseline (All clients N=20)	80.0%	20.0%	0.0%	0.0%	0.0%
Assessment 1 Matched Sample (7 clients)	100.0%	0.0%	0.0%	0.0%	0.0%
Assessment 3 Matched Sample (7 clients)	100.0%	0.0%	0.0%	0.0%	0.0%

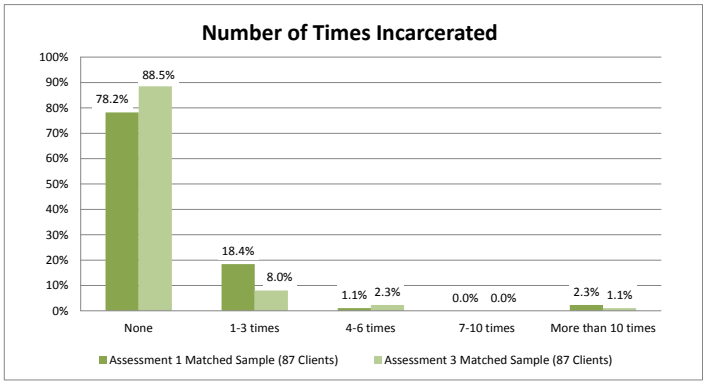


Providers were asked how many days each client had been homeless in the previous six months. At baseline, all of the clients had been homeless during the previous six months. JWCH clients had been homeless for significantly less time over the previous six months at the six month assessment compared with the baseline.

IMHT Homelessness and Incarcerations



For IMHT clients with matched baseline and six month assessments, there was a significant reduction in the number of days homeless in the previous six months from the baseline to the six month assessment.



There was no significant change in the frequency of incarcerations for IMHT clients from the baseline to the six month assessment. However, a greater number of clients reported that they had not been incarcerated in the previous six months at the six month assessment.

Internalized Stigma Mental Illness (ISMI)

The 10-item Internalized Stigma of Mental Illness (ISMI) scale assesses client-reported experiences with stigma and common stereotypes about mental illness, social withdrawal behaviors, as well as the ability to resist or be unaffected by internalized stigma. ISMI items and total scale scores range from 1 (Strongly Disagree) to 4 (Strongly Agree), with lower scores representing decreased stigma. ISMI scale scores are categorized into four levels of stigma: minimal to no internalized stigma, mild internalized stigma, moderate internalized stigma, and severe internalized stigma.

The ISMI is completed by all clients at the baseline assessment to assess existing experiences of stigma prior to joining Innovation. A random sample of clients also completes the ISMI at the semi-annual assessments.

JWCH/SCHARP/BHS ISMI Scores by Item

		Assessment Number			
ITEM #	Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Mentally ill people tend to be violent.	2.57 (N=7)	3.00	3.00	0.00
2	People with mental illness make important contributions to society.	2.00	2.00	2.00	0.00
3	I don't socialize as much as I used to because my mental illness might make me look or behave "weird".	2.67	3.00	3.00	0.00
4	Having a mental illness has spoiled my life.	3.00	3.00	3.00	0.00
5	I stay away from social situations in order to protect my family or friends from embarrassment.	3.17	3.00	3.00	0.00
6	People without mental illness could not possibly understand me.	2.83	4.00	4.00	0.00
7	People ignore me or take me less seriously just because I have a mental illness.	3.50	4.00	3.00	-1.00
8	I can't contribute anything to society because I have a mental illness.	2.71 (N=7)	3.00	1.00	-2.00
9	I can have a good, fulfilling life, despite my mental illness.	1.67	1.00	1.00	0.00
10	Others think that I can't achieve much in life because I have a mental illness.	3.33	3.00	1.00	-2.00
	Total Mental Illness Stigma score *(mean of items 1 - 10)*	**2.75 (N=6)**	**2.90 (N=1)**	**2.40 (N=1)**	**-0.50**

The sample size for each ISMI item corresponds with the reported sample size (N) in each column of the Total Mental Illness Stigma score, unless otherwise reported.

At the baseline assessment, a majority of clients at JWCH reported experiencing moderate internalized stigma. Significance analyses could not be completed because there were too few clients with matched baseline and six month ISMI scores.

	Assessment Number			
Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
Minimal to no internalized stigma	0.0%	0.0%	0.0%	0.0%
Mild internalized stigma	33.3% (N=2)	0.0%	100.0% (N=1)	100.0%
Moderate internalized stigma	50.0% (N=3)	100.0% (N=1)	0.0%	-100.0%
Severe internalized stigma	16.7% (N=1)	0.0%	0.0%	0.0%

IMHT ISMI Scores

	Assessment Number			
Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
Minimal to no internalized stigma	17.9%	29.6%	29.6%	0.0%
Mild internalized stigma	40.6%	51.9%	55.6%	3.7%
Moderate internalized stigma	31.1%	18.5%	14.8%	-3.7%
Severe internalized stigma	10.4%	0.0%	0.0%	0.0%
Total Mental Illness Stigma score *(mean of items 1 - 10)*	**2.48 (N=106)**	**2.26 (N=27)**	**2.22 (N=27)**	**-0.04**

For IMHT clients with matched baseline and six month ISMI ratings, there was no significant change in total ISMI score from the baseline to the six month assessment.

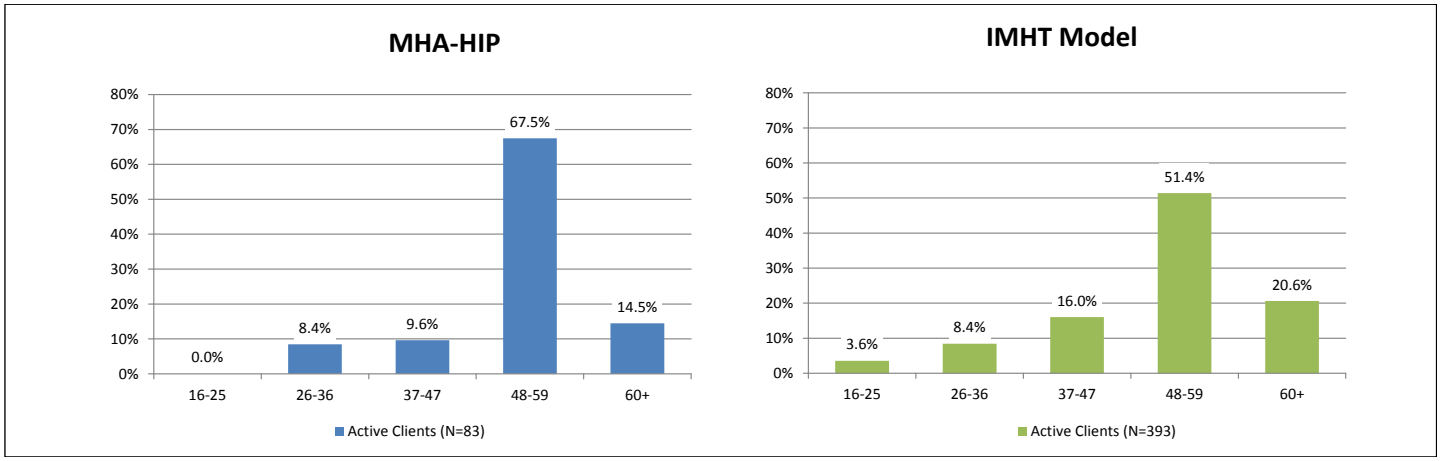
INCORPORATING CLIENT AND CLINICIAN OUTCOMES

Mental Health America—HIP

January 2014

CURRENT CLIENT DEMOGRAPHIC INFORMATION

AGE



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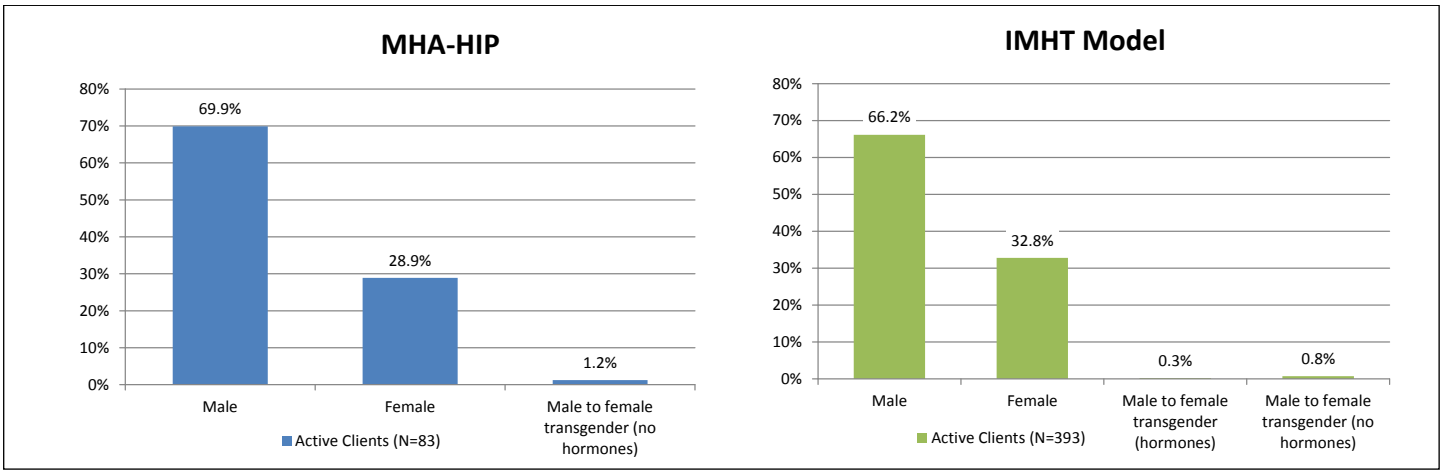
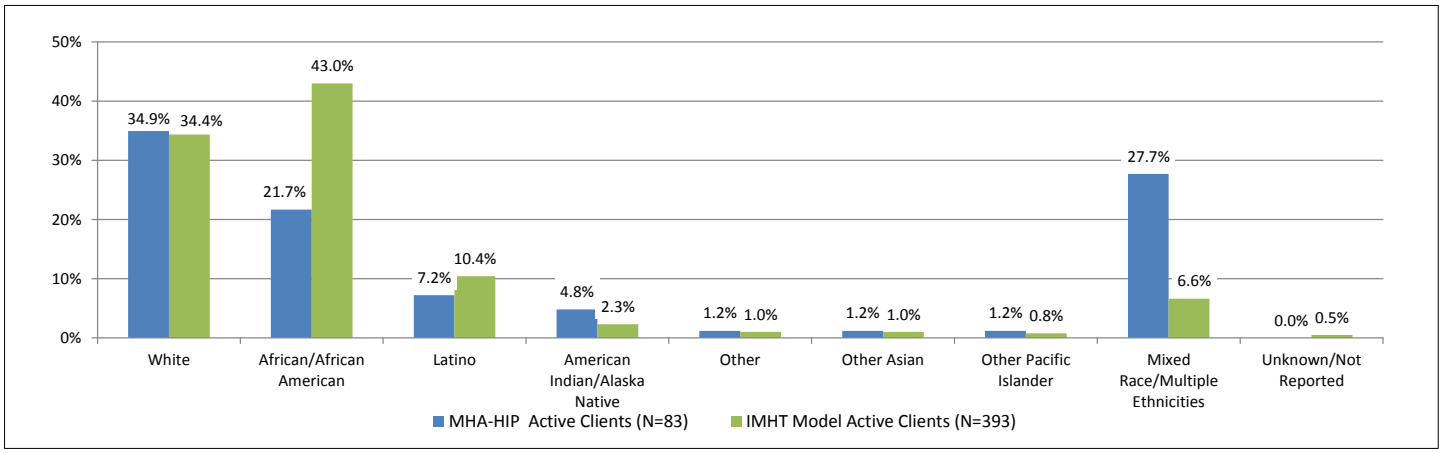


ETHNICITY



CLINICIAN REPORTED RECOVERY OUTCOMES

To assess client recovery, clinicians are asked to complete the **Illness Management and Recovery Scale (IMR) and the Milestones of Recovery Scale (MORS)** at intake (baseline) and during subsequent quarterly follow-up visits. The IMR has 15 individual items, which make up an overall score and three subscales; Substance Use, Recovery (knowledge and goals), and Management (coping with illness outcome). IMR scores range from 1 to 5, with lower scores representing more progress toward recovery.

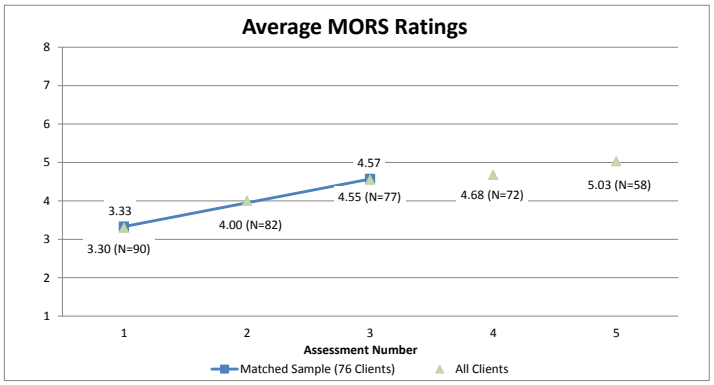
The MORS captures clinician-reported recovery through a single-item recovery indicator. Clinicians are asked to place clients into one of the 8 stages of recovery (rated 1 through 8, respectively): extreme risk, high risk/not engaged, high risk/engaged, poorly coping/not engaged, poorly coping/engaged, coping/rehabilitating, early recovery, and advanced recovery. Ratings are based on a client's 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 the quality of their social support network. Although the MORS is not a linear scale, higher MORS ratings are associated with greater recovery.

MHA-HIP MORS Ratings

		Assessment Number			
Rating #	**Milestones of Recovery Scale**	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 3 (Matched Sample)**	**Change between Assessments 1 and 3**
1	Extreme Risk	1.1%	1.3%	0.0%	-1.3%
2	High risk / Not engaged	2.2%	2.6%	1.3%	-1.3%
3	High risk / Engaged	80.0%	77.6%	26.3%	-51.3%
4	Poorly coping / Not engaged	0.0%	0.0%	0.0%	0.0%
5	Poorly coping / Engaged	15.6%	17.1%	60.5%	43.4%
6	Coping / Rehabilitating	1.1%	1.3%	10.5%	9.2%
7	Early Recovery	0.0%	0.0%	1.3%	1.3%
8	Advanced Recovery	0.0%	0.0%	0.0%	0.0%
	Average MORS Score	**3.30 (N=90)**	**3.33 (N=76)**	**4.57 (N=76)**	**1.24**

Provider level analyses use a matched sample of clients with MORS ratings at both the baseline and six month follow-up assessments. There was a significant increase in mean MORS scores for clients at MHA from the baseline to the six month assessment. Clients were in a more advanced stage of recovery six months after enrolling in Innovation compared to baseline.

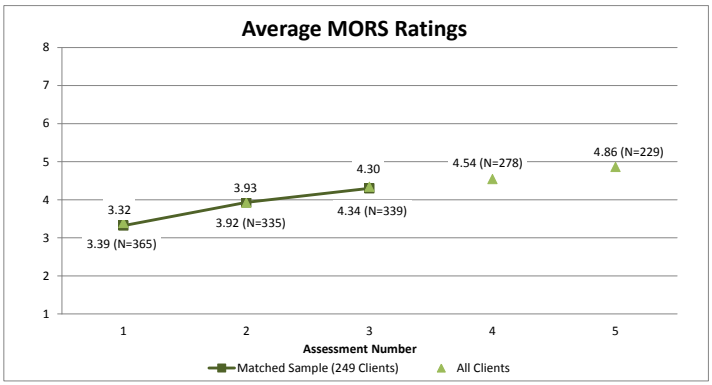
In addition to mean MORS scores for the matched sample, the figure to the right includes mean MORS scores for all MHA clients at each assessment. Scores for all clients were similar to the matched sample at each assessment.



IMHT MORS Ratings

Model level analyses use a matched sample of clients with MORS ratings on the baseline, and the three and six month assessments. For IMHT clients there was a significant increase in MORS scores from baseline to three months, and from three to six months. MORS scores continue to increase over time, indicating ongoing progress towards client recovery.

	Assessment Number			
Milestones of Recovery Scale	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 2 (Matched Sample)**	**Assessment 3 (Matched Sample)**
Average MORS Score	3.39 (N=365)	3.32 (N=249)	3.93 (N=249)	4.30 (N=249)



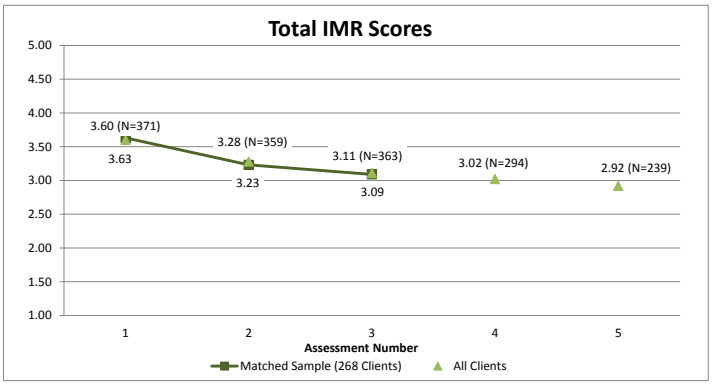
MHA-HIP IMR Scores by Item

ITEM #	Aspect of Illness Management & Recovery	Assessment Number: Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Progress towards personal goals	3.64	3.76	2.82	-0.94
2	Knowledge	3.82	3.85	3.37	-0.48
4	Contact with people outside of my family	2.94	2.94	2.47 (N=77)	-0.47
8	Relapse prevention planning	3.97	4.00	3.66 (N=77)	-0.34
12	Involvement with self-help activities	4.15	4.13	3.64 (N=77)	-0.49
	Recovery Subscale *(mean of items 1, 2, 4, 8, & 12)*	**3.70 (N=87)**	**3.73 (N=78)**	**3.19 (N=78)**	**-0.54**
6	Symptom distress	4.43	4.47	3.55	-0.92
7	Impairment of functioning	4.38	4.44	3.63	-0.81
9	Relapse of symptoms	4.67	4.64	3.48 (N=77)	-1.16
11	Coping	4.02	4.06	3.38	-0.68
	Management Subscale *(mean of items 6, 7, 9, & 11)*	**4.37 (N=87)**	**4.40 (N=78)**	**3.51 (N=78)**	**-0.89**
14	Impairment of functioning through alcohol use	2.72	2.74	2.49	-0.25
15	Impairment of functioning through drug use	2.09	2.13	2.31	0.18
	Substance Use Subscale *(maximum of items 14 & 15)*	**3.16 (N=87)**	**3.22 (N=78)**	**3.12 (N=78)**	**-0.10**
3	Involvement of family and friends in my mental health treatment	4.44	4.47	3.47	-1.00
5	Time in structured roles	4.66	4.74	4.53 (N=77)	-0.21
10	Psychiatric hospitalizations	1.67	1.63	1.52 (N=77)	-0.11
13	Using medication effectively	2.74 (N=38)	2.88 (N=34)	2.80 (N=69)	-0.08
	Overall IMR Score (*mean of items 1-15*)	**3.66 (N=87)**	**3.69 (N=78)**	**3.14 (N=78)**	**-0.55**

The sample size for each IMR item corresponds with the reported sample size (N) in each column of the Overall IMR score, unless otherwise reported.

IMHT IMR Total Scores

Aspect of Illness Management & Recovery	Assessment Number: Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 2 (Matched Sample)	Assessment 3 (Matched Sample)
Recovery Subscale *(mean of items 1, 2, 4, 8, and 12)*	3.61	3.64	3.16	3.02
Management Subscale *(mean of items 6, 7, 9, and 11)*	4.16	4.20	3.75	3.56
Substance Use Subscale *(the maximum of items 14 and 15)*	3.32	3.36 (N=269)	3.14 (N=269)	3.09 (N=269)
Overall IMR Score	**3.60 (N=371)**	**3.63 (N=268)**	**3.23 (N=268)**	**3.09 (N=268)**

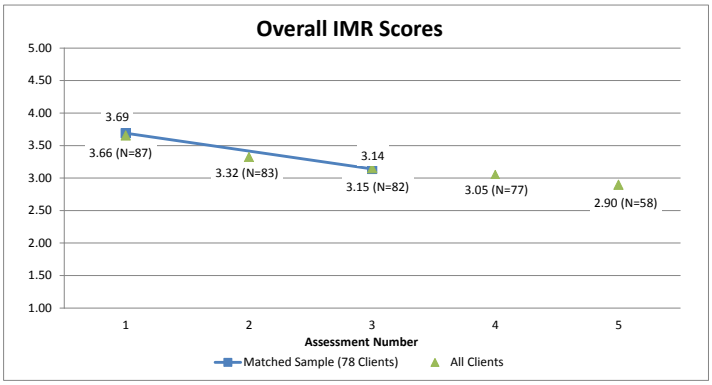


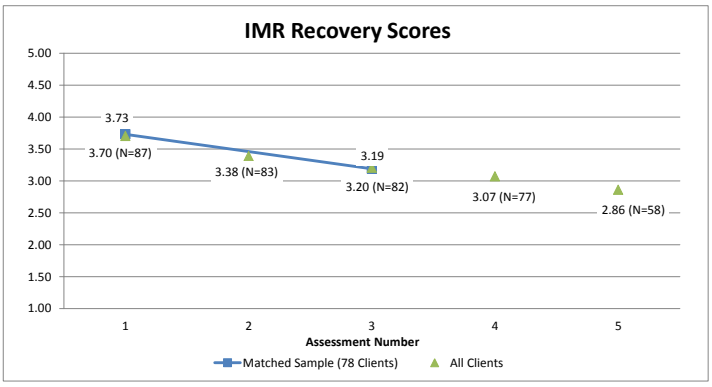
Model level analyses use a matched sample of clients with IMR ratings on the baseline, and the three and six month assessments. For IMHT clients there was a significant decrease in overall IMR scores from the baseline to the three month assessment, and from the three to the six month assessment. This indicates that, on average, clients in the IMHT model made consistent progress towards their recovery after enrolling in services.

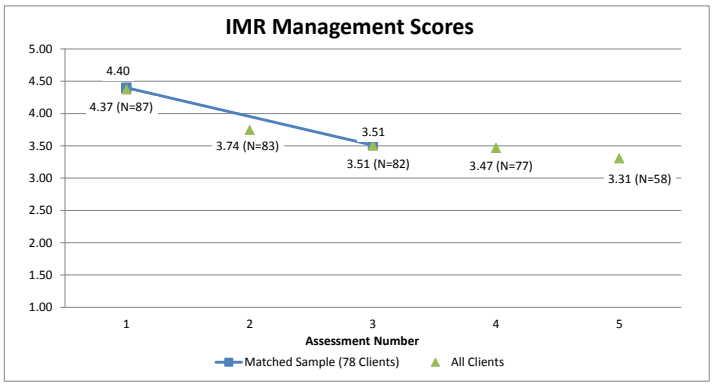
Average scores for all IMHT clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figure to the left.

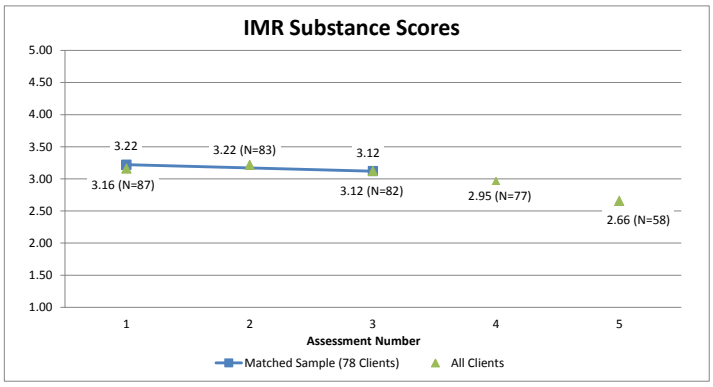
MHA-HIP IMR Scores

Provider level analyses use a matched sample of clients with IMR scores at both the baseline and six month follow-up assessments. There was a significant decrease in overall IMR scores from the baseline to the six month assessment. This indicates that MHA clients made progress towards their recovery after enrolling in Innovation. Scores were also significantly reduced on the Management and Recovery subscales from the baseline to the six month assessment. This indicates that clinicians observed that clients made consistent progress towards their recovery, and were better able to manage their mental health. There was no significant change on the Substance Use subscale.



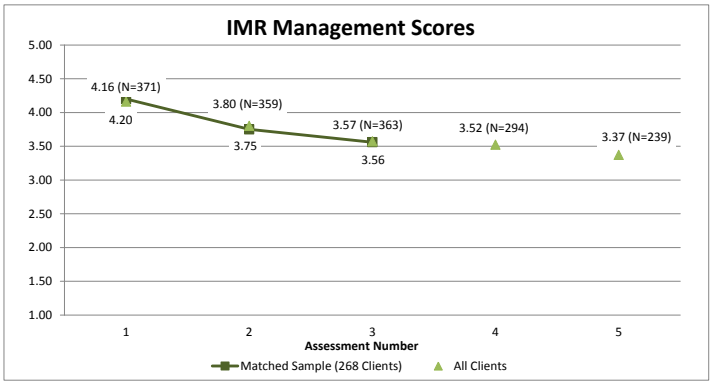


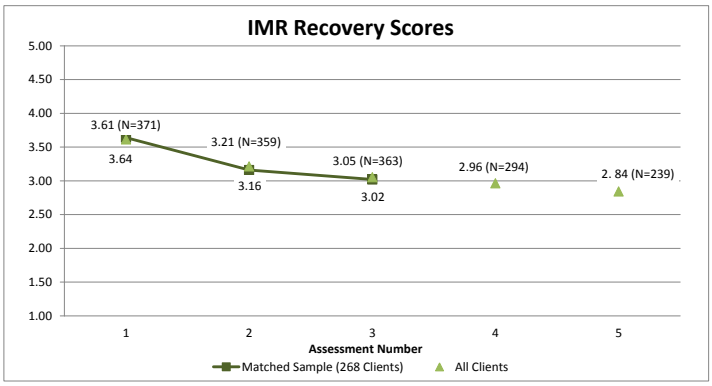


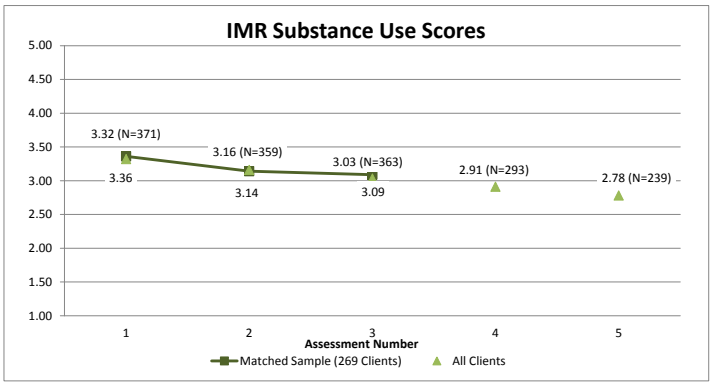


IMHT IMR Subscale Scores

Model level analyses use a matched sample of clients with IMR scores on the baseline, and the three and six month assessments. For IMHT clients, there were significant decreases in IMR Recovery and Management subscale scores from baseline to three months and from three to six months. There were also significant decreases on the Substance Use subscale from baseline to three months and from baseline to six months. This indicates that, on average, clients were less likely to use substances, had made progress towards their recovery, and were better able to manage their mental health after enrolling in Innovation.







CLIENT 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. The Integrated Self-Assessment includes the PROMIS Global Health Scale, the Physical Health and Behaviors Survey, the PROMIS-Derived Substance Use Scale, and the CHOIS Supplement. All measures are distributed semi-annually, except for the PROMIS Global Health, which is distributed quarterly. Additionally, all clients are asked to complete the Internalized Stigma of Mental Illness (ISMI) Scale at baseline, and either the ISMI, Post-Outcomes Survey, or Satisfaction Survey, semi-annually. Results from the Satisfaction and Self-Reported Post-Outcomes Surveys are not detailed in this report.

Paired samples t-tests and chi-square tests were used to examine the statistical significance of changes in scores on the measures over time. These procedures provide evidence that change was due to the benefits of receiving Innovation services and not chance variation. Statistical analysis using paired samples is performed by selecting only the cases that have complete data for each time point being measured.

These matched comparisons show change for individual clients as they progress through services, which allow changes to be more easily attributed to Innovation. Using paired samples decreases sample size, so data for all clients at each assessment point are also presented in each table. 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. The current matched sample analyses evaluate change between Assessment 1 (baseline) and Assessment 3 (the six month assessment). All reported outcomes include current and discharged clients.

PROMIS Global Health

The PROMIS Global Health scale is a 10-item measure aimed at assessing client-reported health including: physical health, pain, fatigue, mental health, and social health. Items are used to create a Total Global Health score and two sub-scale scores; Physical Health and Mental Health. PROMIS Global Health scores range from 1 to 5; however, clients are also asked to rate their pain using a scale from 0 (no pain) – 10 (worst imaginable pain), which is then categorized into a 5-point scale. For all PROMIS items and scales, lower scores represent fewer health concerns (i.e. lower scores are desirable). Clients are asked to complete the PROMIS Global Health at baseline and at subsequent quarterly assessments.

MHA-HIP Global Health Scores by Item

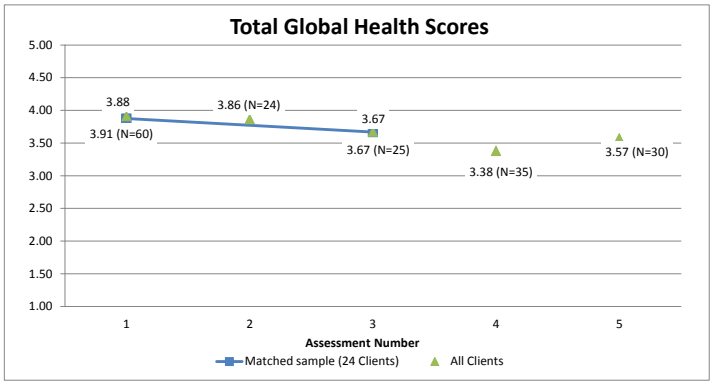
		Assessment Number			
ITEM #	**PROMIS Global Health**	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 3 (Matched Sample)**	**Change between Assessments 1 and 3**
2	Quality of life	4.43	4.46	3.83 (N=23)	-0.63
4	Mental health, including mood and ability to think	3.86 (N=59)	4.04	3.83	-0.21
5	Satisfaction with social activities and relationships	4.00	4.08	4.04	-0.04
8	Bothered by emotional problems, such as feeling anxious, depressed or irritable	3.92	4.04	3.42	-0.62
	Global Mental Health *(mean of items 2, 4, 5, & 8)*	**4.05 (N=60)**	**4.16 (N=24)**	**3.78 (N=24)**	**-0.38**
3	Physical health	4.27	4.29	4.29	0.00
7	Everyday physical activities	3.17	2.83	2.71	-0.12
9	Fatigue	3.73	3.67	3.29	-0.38
10	Pain rating	3.70	3.46	3.38	-0.08
	Global Physical Health *(mean of items 3, 7, 9, & 10)*	**3.72 (N=60)**	**3.56 (N=24)**	**3.42 (N=24)**	**-0.14**
1	General health	4.30	4.37	4.25	-0.12
6	Ability to carry out regular social roles and activities	3.70	3.50	3.67	0.17
	Total Global Health Score (*mean of items 1-10)*	**3.91 (N=60)**	**3.88 (N=24)**	**3.67 (N=24)**	**-0.21**

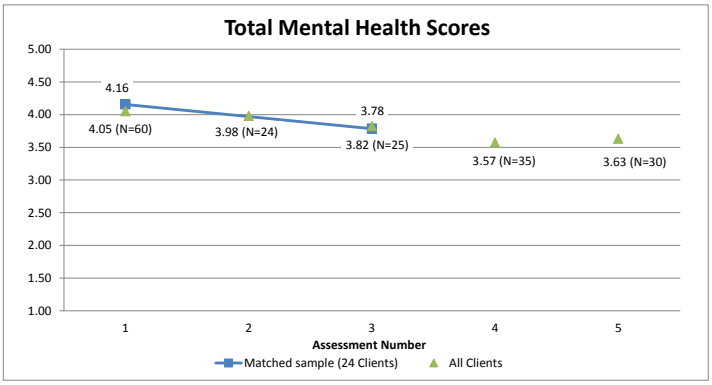
The sample size for each PROMIS item corresponds with the reported sample size (N) in each column of the Total Global Health score, unless otherwise reported.

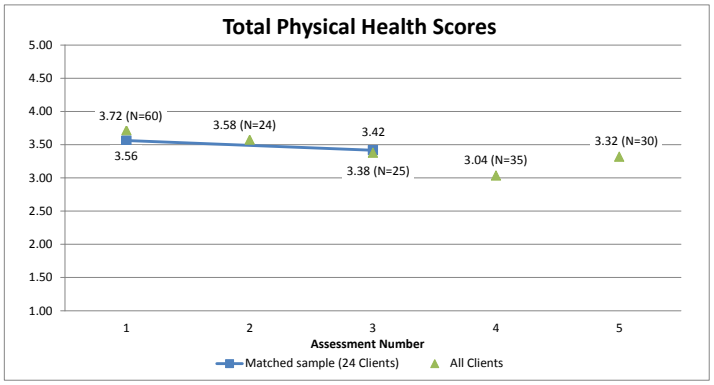
MHA-HIP PROMIS Scores

Provider level analyses use a matched sample of clients with PROMIS scores at both the baseline and six month follow-up assessments. There was no significant change in PROMIS Global Health scores for MHA clients from the baseline to the six month assessment.

Average scores for all clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figures.





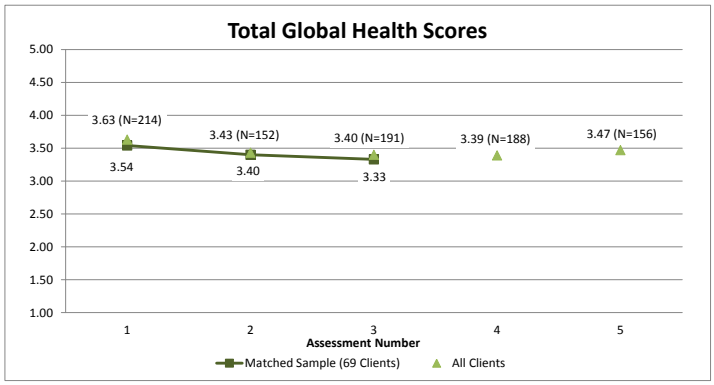


There was a significant reduction in Global Mental Health subscale scores from the baseline to the six month assessment. This indicates that clients reported improved mental health after enrolling in Innovation. There were no significant changes on the Global Physical Health subscale.

IMHT PROMIS Scores

Model level analyses use a matched sample of clients with PROMIS scores on the baseline, and the three and six month assessments. For IMHT clients, there was a significant decrease in Total Global Health scores from the baseline to the six month assessment. This indicates that, on average, clients reported experiencing fewer health problems after enrolling in Innovation.

In addition to PROMIS Global Health scores for the matched sample, the figure to the right includes scores for all clients at each assessment. Scores for all clients were similar to the matched sample at each assessment.



	Assessment Number			
PROMIS Global Health	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 2 (Matched Sample)**	**Assessment 3 (Matched Sample)**
Global Mental Health Subscale ***(mean of items 2, 4, 5, and 10)***	3.87	3.82	3.64	3.49
Global Physical Health Subscale ***(mean of items 3, 6, 7, and 8)***	3.33	3.19	3.05	3.10
Overall Global Health Score	**3.63 (N=214)**	**3.54 (N=69)**	**3.40 (N=69)**	**3.33 (N=69)**

Creating Healthy Outcomes: Integrated Self-Assessment (CHOIS) Supplement

The CHOIS Supplement is a client-rated recovery-based measure that assesses several mental health related domains, including suicidal ideation, anxiety, trauma, psychosis (i.e. hearing voices), and memory and cognitive impairment. The CHOIS contains three subscales: Psychosis, Memory and Cognitive Impairments, and Strengths. The Psychosis and Memory and Cognitive Impairment subscales assess clients' perceptions of their mental health symptoms, while the Strengths subscale examines recovery-oriented personal strengths that can assist clients in their recovery. Strengths items could be incorporated into treatment planning and recovery, and provide a positive point of assessment, an important aspect of being recovery-oriented. In addition to the scale scores, individual CHOIS items provide valuable insight into the clients' perception of their mental health symptoms.

All CHOIS subscales range from 1 to 5, with lower scores being desirable. For the Psychosis and Memory and Cognitive Impairment subscales, lower scores indicate fewer negative symptoms. For the Strengths subscale, lower scores indicate greater personal strengths. The CHOIS Supplement is completed by the client during the baseline and semi-annual assessments.

MHA-HIP CHOIS Scores

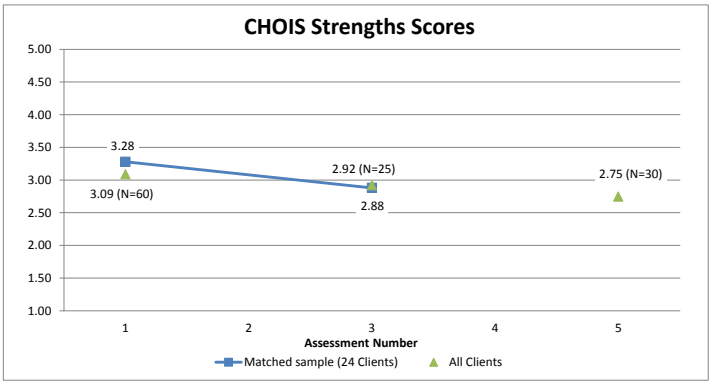
		Assessment Number			
ITEM #	CHOIS Supplement	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Thoughts entered my mind that I had trouble getting rid of.	3.30	3.29	3.04	-0.25
2	I did things I couldn't resist or did things more often than I should.	2.44 (N=59)	2.54	2.38	-0.16
3	I had disturbing memories or images of a stressful experience.	3.18	3.21	2.74 (N=23)	-0.47
4	I had memory problems, such as forgetting names or appointments.	2.98 (N=58)	3.00	3.33	0.33
5	I had difficulty thinking clearly while doing familiar tasks.	2.60 (N=58)	2.79	2.91 (N=22)	0.12
6	I believed people were following or trying to harm me or my family.	2.08 (N=59)	1.92	1.79	-0.13
7	I heard voices that no one else could hear.	2.22 (N=59)	2.17	1.79	-0.38
8	I had thoughts of ending my life or harming myself.	1.66 (N=59)	1.71	1.57 (N=23)	-0.14
9	My child(ren) had emotional and/or behavioral problems.	1.73 (N=55)	2.14 (N=21)	2.50 (N=14)	0.36
10	I felt good about myself.	3.17 (N=59)	3.21	2.83 (N=23)	-0.38
11	I had goals and worked towards achieving them.	3.23	3.42	2.78 (N=23)	-0.64
12	I felt hopeful about the future.	3.13	3.67	3.04 (N=23)	-0.63
13	I was able to handle things.	2.77	2.83	2.67	-0.16
14	I felt happy.	3.22	3.42	3.13	-0.29
15	I had energy and was full of life.	3.69 (N=59)	3.87	3.68 (N=22)	-0.19
16	I felt spiritually connected.	3.04 (N=57)	3.17 (N=23)	2.83	-0.34
17	I had contact with people that care about me.	2.53	2.67	2.21	-0.46
18	I lived in a home that made me feel safe.	3.59 (N=59)	3.54	3.00	-0.54
19	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?	2.24 (N=59)	2.46	2.42	-0.04
	Psychosis score *(mean of items 6 & 7)*	**2.14 (N=60)**	**2.04 (N=24)**	**1.79 (N=24)**	**-0.25**
	Memory score *(mean of items 4 & 5)*	**2.79 (N=60)**	**2.90 (N=24)**	**3.19 (N=24)**	**0.29**
	Strengths score *(mean of items 10, 11, 12, 13, 14, 15, 16 & 17)*	**3.09 (N=60)**	**3.28 (N=24)**	**2.88 (N=24)**	**-0.40**

The sample size for each CHOIS item corresponds with the highest reported sample size (N) in each column of the CHOIS Subscale scores, unless otherwise reported.

IMHT CHOIS Scores

	Assessment Number		
CHOIS Supplement	Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)
Psychosis score *(mean of items 6 & 7)*	2.34 (N=211)	2.25 (N=95)	2.04 (N=95)
Memory score *(mean of items 4 & 5)*	2.95 (N=211)	3.02 (N=95)	2.77 (N=95)
Strengths score *(mean of items 10, 11, 12, 13, 14, 15, 16 & 17)*	2.85 (N=210)	2.82 (N=93)	2.77 (N=93)

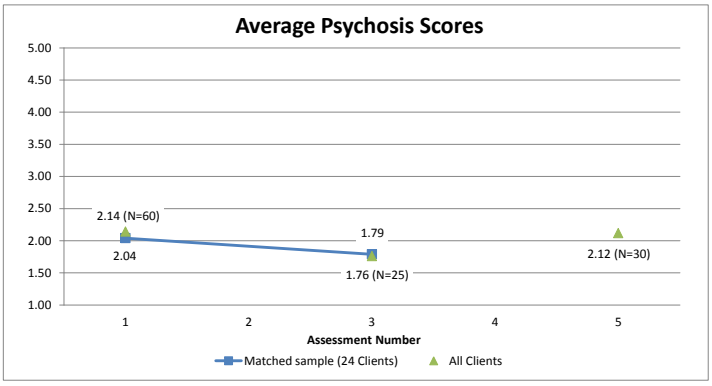
MHA-HIP CHOIS Subscale Scores

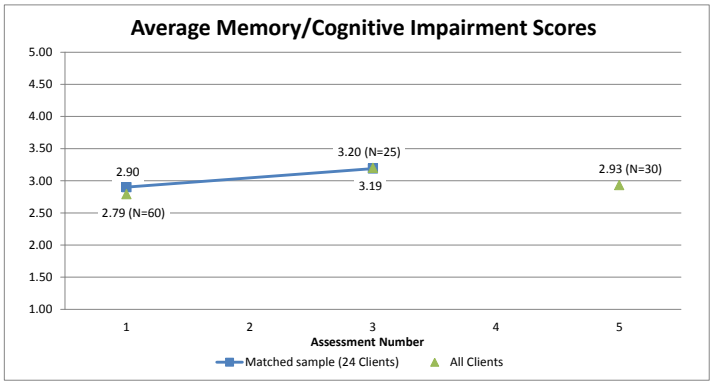


Provider level analyses use a matched sample of clients with CHOIS scores at both the baseline and six month follow-up assessments.

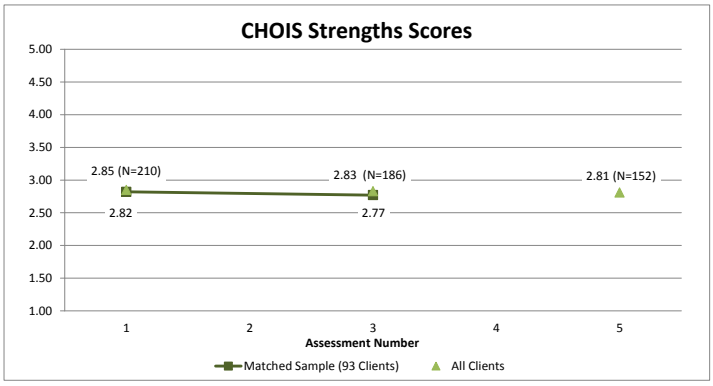
There was a significant reduction in scores on the Strengths subscale from the baseline to the six month assessment. This indicates that clients reported having greater recovery-oriented personal strengths after enrolling in Innovation.

There were no significant changes on the Psychosis or Memory and Cognitive Impairment subscales.



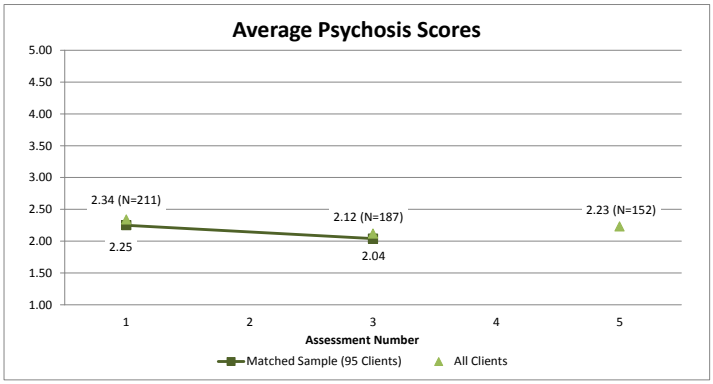


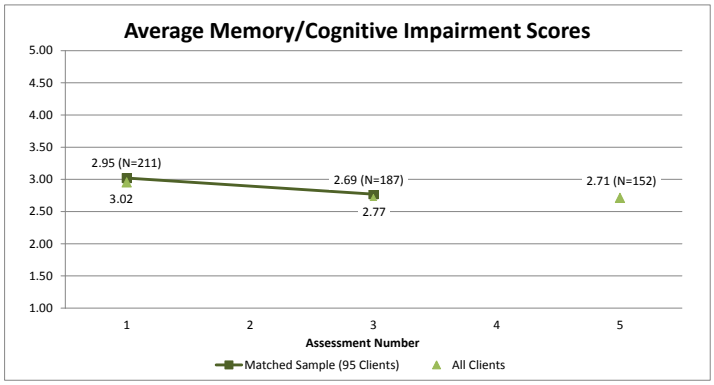
IMHT CHOIS Subscale Scores



Model level analyses use a matched sample of clients with CHOIS scores on the baseline, and six month assessments. For IMHT clients there were no significant changes on any of the CHOIS subscales from the baseline to the six month assessment.

Average scores for all IMHT clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figures.





PROMIS-Derived Substance Use

The 12-item PROMIS-Derived Substance Use scale assesses clients' perceptions of the negative consequences of their alcohol and/ or substance use, including physical (e.g., dizziness), mental (e.g., risk taking, guilt), and social (e.g., others had trouble counting on me, substance use created problems between me and others) consequences. Item and total scale scores range from 1 to 5, with lower scores indicating fewer client-perceived negative consequences associated with alcohol and/or substance use. Paired with the information from the clinician completed IMR Substance Use items, clients responses on this measure can help clinicians encourage a therapeutic dialogue with the client about their substance use.

Clients who indicate on their Physical Health and Behaviors assessment that they have used alcohol, illegal drugs, or off-label prescription medications within the past six months complete the PROMIS-Derived Substance Use Scale at the baseline and semi-annual assessments.

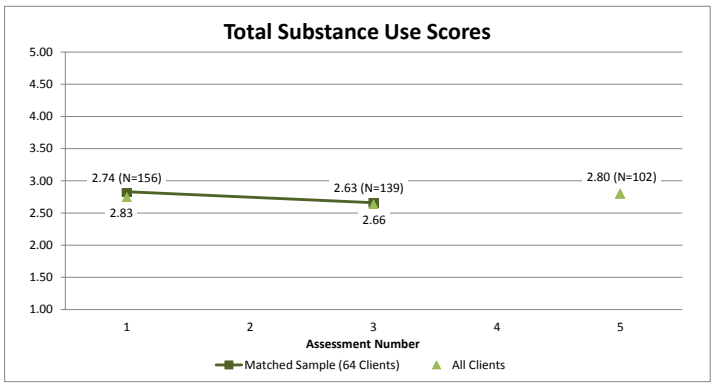
MHA-HIP Substance Use Scores

		Assessment Number			
ITEM #	PROMIS-Derived Substance Use	Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	I used substances (alcohol, illegal drugs) too much.	3.09 (N=47)	3.05	2.95	-0.10
2	I used alcohol or substances throughout the day.	3.17	3.21	2.74	-0.47
3	I had an urge to continue drinking or using substances once I started.	3.39	3.16	2.58	-0.58
4	I felt that I should cut down on my alcohol or substance use.	3.38 (N=45)	3.37	3.26	-0.11
5	I felt I needed help for my alcohol or substance use.	2.80	2.47	2.53	0.06
6	I took risks when I used alcohol or substances.	2.46	2.32	2.17 (N=18)	-0.15
7	I felt guilty when I used alcohol or substances.	2.70	3.16	3.11	-0.05
8	Others complained about my alcohol or substance use.	2.48	2.74	2.63	-0.11
9	Alcohol or substance use created problems between me and others.	2.65	2.79	2.79	0.00
10	Others had trouble counting on me when I used alcohol or substances.	2.36 (N=44)	2.42	2.37	-0.05
11	I felt dizzy after I used alcohol or substances.	2.36 (N=44)	2.42	2.37	-0.05
12	Alcohol or substance use made my physical or mental health symptoms worse.	2.87	2.68	2.58	-0.10
	Total Substance Use score *(mean of items 1 - 12)*	**2.82 (N=46)**	**2.82 (N=19)**	**2.68 (N=19)**	**-0.14**

The sample size for each Substance Use item corresponds with the reported sample size (N) in each column of the Total Substance Use score, unless otherwise reported.

IMHT Substance Use Scores

	Assessment Number		
PROMIS-Derived Substance Use	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)
Total Substance Use score *(mean of items 1 - 12)*	2.74 (N=156)	2.83 (N=64)	2.66 (N=64)



Model level analyses use a matched sample of clients with Substance Use scores on the baseline, and the six month assessment. For IMHT clients there was no significant change in scores from the baseline to the six month assessment. As clients continue to receive Innovation services, improvements may become significant.

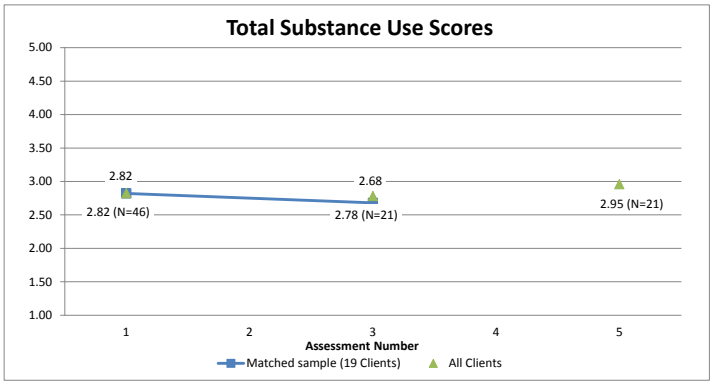
Do you smoke tobacco?			
	Not at all	Some days	Every day
Baseline (All clients N=205)	22.0%	12.2%	65.9%
Assessment 1 Matched Sample (91 clients)	17.6%	14.3%	68.1%
Assessment 3 Matched Sample (91 clients)	18.7%	23.1%	58.2%

Compared to baseline, there was a significant reduction in tobacco use at the six month assessment for IMHT clients.

MHA-HIP Substance Use Scores

On the baseline assessment, a majority of clients at MHA reported that they had used alcohol (71.7%) and about a third reported that they had used drugs (36.2%) within the previous six months. There was a significant reduction in self-reported alcohol use from the baseline to the six month assessment, and no significant change in drug use.

There were no significant changes in scores on the PROMIS-Derived Substance Use scale from the baseline to the six month assessment.



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
Baseline (All clients N=60)	28.3%	15.0%	11.7%	13.3%	31.7%
Assessment 1 Matched Sample (24 clients)	25.0%	8.3%	16.7%	25.0%	25.0%
Assessment 3 Matched Sample (24 clients)	29.2%	16.7%	29.2%	4.2%	20.8%

During the last 6 months, how often did you use an illegal drug or use a prescription medication for nonmedical reasons?					
	Never	Less than once a week	1-3 times per week	4 or more times per week	Every day
Baseline (All clients N=58)	63.8%	13.8%	6.9%	5.2%	10.3%
Assessment 1 Matched Sample (21 clients)	57.1%	19.0%	9.5%	14.3%	0.0%
Assessment 3 Matched Sample (21 clients)	47.6%	23.8%	19.0%	9.5%	0.0%

Do you smoke tobacco?			
	Not at all	Some days	Every day
Baseline (All clients N=56)	25.0%	3.6%	71.4%
Assessment 1 Matched Sample (23 clients)	13.0%	0.0%	87.0%
Assessment 3 Matched Sample (23 clients)	13.0%	8.7%	78.3%

Compared to baseline, there was no significant change in tobacco use at the six month assessment.

Physical Health and Behaviors

Clients completed the Physical Health and Behaviors Survey at the baseline and semi-annual assessments to measure health behaviors, including substance use, medication adherence, and exercise, service utilization including emergency room visits, hospitalizations, and previous experiences accessing care, and daily activities including housing situation, employment, volunteer activities and education.

MHA-HIP Physical Activity

At the baseline assessment, a majority of clients (57.6%) at MHA reported that they engaged in physical activity at least once during a typical week. There was no significant change in physical activity from the baseline to the six month assessment for clients who completed this item at baseline and at the six month assessment.

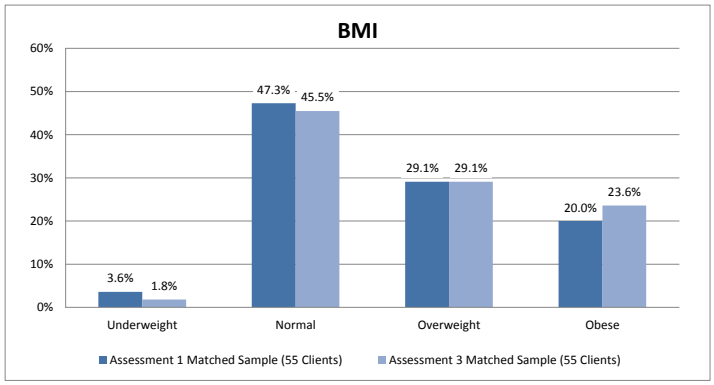
How many times in a usual week do you do 30 minutes of physical activity that increases your heart rate or makes you breathe harder than normal? (for example, walking or jogging, carrying light loads, bicycling, or playing sports)					
	None	1 time	2 times	3 times	4 or more times
Baseline (All clients N=59)	42.4%	3.4%	6.8%	15.3%	32.2%
Assessment 1 Matched Sample (22 clients)	50.0%	4.5%	4.5%	18.2%	22.7%
Assessment 3 Matched Sample (22 clients)	36.4%	13.6%	13.6%	13.6%	22.7%

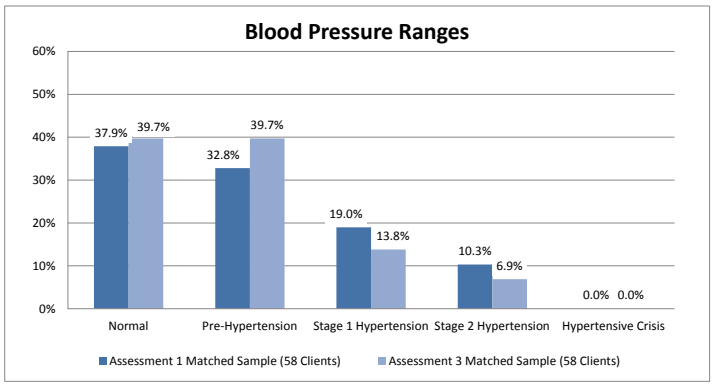
MHA-HIP Physical Health

The figure below shows the proportion of clients who were ever screened for each of the physical health conditions during the first twelve months of their enrollment in Innovation. The most common screening at MHA was for High Blood Pressure, followed by High Cholesterol, Diabetes, HIV, Other STDs, and Hepatitis. Clinicians indicated which screenings were completed on the Physical Health Indicators Survey, which was completed every six months.

Percentage of Clients who have ever been screened for:								
Diabetes	High Blood Pressure	Cholesterol	Asthma*	Emphysema*	Tuberculosis*	HIV	Hepatitis	Other STDs
79.8%	87.2%	81.9%	22.3%	16.0%	18.1%	75.5%	72.3%	76.6%

* Screening for Asthma, Emphysema, and Tuberculosis was only included on the baseline assessment.





Clinicians are asked to provide clients' height and weight on the Physical Health Indicators Survey, which are used to calculate Body Mass Index (BMI). BMI was categorized using the standard categories defined by the Centers for Disease Control and Prevention. There was a significant increase in BMI from the baseline to the six month assessment.

Systolic and diastolic readings are combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. Blood pressure is only one indicator of risk; additional criteria must be met for a diagnosis of hypertension. There were no significant changes in risk for hypertension from the baseline to the six month assessment.

In the past month, how often did you take your medications as the doctor prescribed?					
	My doctor hasn't prescribed any	Less than half the time (<50%)	About half the time (50%)	Nearly all the time (75%)	All the time (100%)
Baseline (All clients N=59)	22.0%	11.9%	6.8%	18.6%	40.7%
Assessment 1 Matched Sample (24 clients)	29.2%	20.8%	8.3%	16.7%	25.0%
Assessment 3 Matched Sample (24 clients)	4.2%	12.5%	16.7%	50.0%	16.7%

Clients were asked how often they took their medications as prescribed. There was a significant improvement in medication adherence from the baseline to the six month assessment, and more clients reported that they were taking physician prescribed medications.

IMHT Physical Activity

At the baseline assessment, a majority of clients in the IMHT model (67.9%) reported that they engaged in physical activity at least once during a typical week. There was no significant change in physical activity from the baseline to the six month assessment for clients who completed this item at baseline and at the six month assessment.

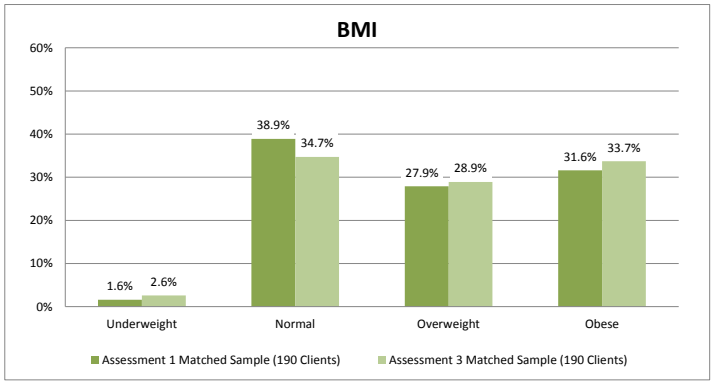
How many times in a usual week do you do 30 minutes of physical activity that increases your heart rate or makes you breathe harder than normal? (for example, walking or jogging, carrying light loads, bicycling, or playing sports)					
	None	1 time	2 times	3 times	4 or more times
Baseline (All clients N=215)	32.1%	7.9%	8.8%	11.6%	39.5%
Assessment 1 Matched Sample (92 clients)	28.3%	8.7%	7.6%	13.0%	42.4%
Assessment 3 Matched Sample (92 clients)	19.6%	17.4%	15.2%	17.4%	30.4%

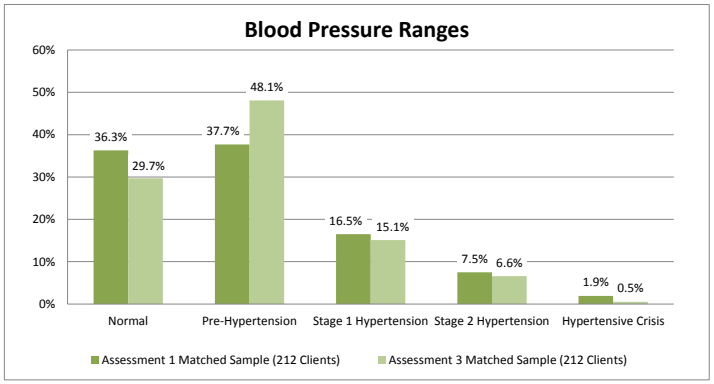
IMHT Physical Health

The figure below shows the proportion of clients who were ever screened for each of the physical health conditions during the first twelve months of their enrollment in Innovation. Within the first year of receiving Innovation services, IMHT clients were most likely to be screened for Diabetes, High Blood Pressure, High Cholesterol, HIV, Hepatitis and other STDs.

Percentage of Clients at 12 Months who have EVER been Screened For:								
Diabetes	High Blood Pressure	Cholesterol	Asthma*	Emphysema*	Tuberculosis*	HIV	Hepatitis	Other STDs
57.9%	70.6%	56.8%	10.8%	16.0%	21.1%	54.4%	45.4%	51.9%

* Screening for Asthma, Emphysema, and Tuberculosis was only included on the baseline assessment.





Clinicians are asked to provide clients' height and weight on the Physical Health Indicators Survey, which are used to calculate Body Mass Index (BMI). BMI was categorized using the standard categories defined by the Centers for Disease Control and Prevention. There were no significant changes in BMI for IMHT clients from the baseline to the six month assessment.

Systolic and diastolic readings are combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. Blood pressure is only one indicator of risk; additional criteria must be met for a diagnosis of hypertension. There were no significant changes in risk for hypertension from the baseline to the six month assessment.

In the past month, how often did you take your medications as the doctor prescribed?					
	My doctor hasn't prescribed any	Less than half the time (<50%)	About half the time (50%)	Nearly all the time (75%)	All the time (100%)
Baseline (All clients N=206)	16.0%	11.7%	11.7%	26.7%	34.0%
Assessment 1 Matched Sample (92 clients)	16.3%	13.0%	12.0%	22.8%	35.9%
Assessment 3 Matched Sample (92 clients)	7.6%	8.7%	17.4%	30.4%	35.9%

Clients were asked how often they took their medications as prescribed. There have been no significant changes in medication adherence to date, however more clients reported that they were taking doctor-prescribed medication at the six month assessment.

IMHT Service Utilization

Model level analyses use a matched sample of clients who completed service utilization items on the baseline, and the six month assessment. There was a significant reduction in the mean frequency of emergency room visits from baseline to the six month assessment for IMHT clients. There was no significant change in the frequency of hospital admissions.

In the past 6 months...	None	1-3 times	4-6 times	7-10 times	More than 10 times
how many times did you go to an emergency room?					
Baseline (All clients N=212)	30.2%	47.6%	14.6%	3.8%	3.8%
Assessment 1 Matched Sample (94 clients)	35.1%	42.6%	13.8%	4.3%	4.3%
Assessment 3 Matched Sample (94 clients)	44.7%	39.4%	11.7%	1.1%	3.2%
how many times were you admitted to a hospital?					
Baseline (All clients N=211)	52.1%	35.1%	8.5%	2.8%	1.4%
Assessment 1 Matched Sample (95 clients)	57.9%	31.6%	6.3%	2.1%	2.1%
Assessment 3 Matched Sample (95 clients)	64.2%	25.3%	8.4%	1.1%	1.1%

MHA-HIP Service Utilization

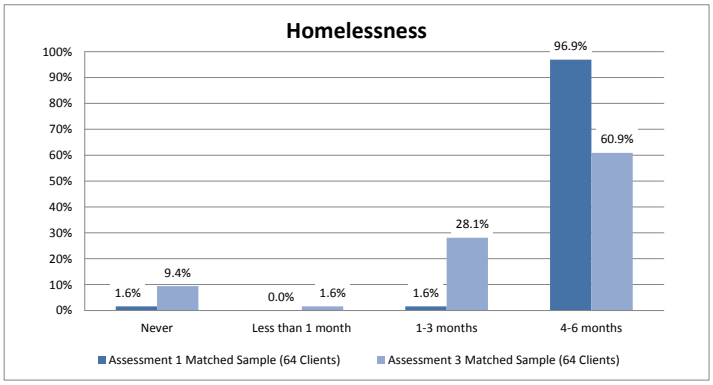
Provider level analyses use a matched sample of clients with completed service utilization items at both the baseline and six month assessments. At the baseline assessment, a majority of clients at MHA reported that they had visited an emergency room (78.0%) and almost half had been hospitalized (44.1%) at least once in the prior six months. There were no significant reductions in service utilization from the baseline to the six month assessment.

In the past 6 months...	None	1-3 times	4-6 times	7-10 times	More than 10 times
how many times did you go to an emergency room?					
Baseline (All clients N=59)	22.0%	54.2%	13.6%	6.8%	3.4%
Assessment 1 Matched Sample (22 clients)	31.8%	54.5%	9.1%	4.5%	0.0%
Assessment 3 Matched Sample (22 clients)	40.9%	45.5%	9.1%	0.0%	4.5%
how many times were you admitted to a hospital?					
Baseline (All clients N=59)	55.9%	32.2%	8.5%	3.4%	0.0%
Assessment 1 Matched Sample (24 clients)	66.7%	29.2%	0.0%	4.2%	0.0%
Assessment 3 Matched Sample (24 clients)	66.7%	29.2%	0.0%	4.2%	0.0%

MHA-HIP Homelessness and Incarcerations

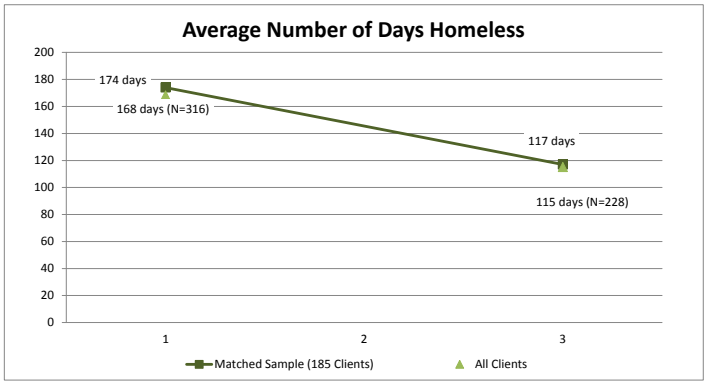
Upon enrolling in the Innovation program, 72.4% of MHA clients reported that they had not been incarcerated within the previous six months. Compared to the baseline, clients were significantly less likely to have been incarcerated in the previous six months at the six month assessment.

In 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
Baseline (All clients N=58)	72.4%	24.1%	3.4%	0.0%	0.0%
Assessment 1 Matched Sample (24 clients)	70.8%	25.0%	4.2%	0.0%	0.0%
Assessment 3 Matched Sample (24 clients)	91.7%	8.3%	0.0%	0.0%	0.0%

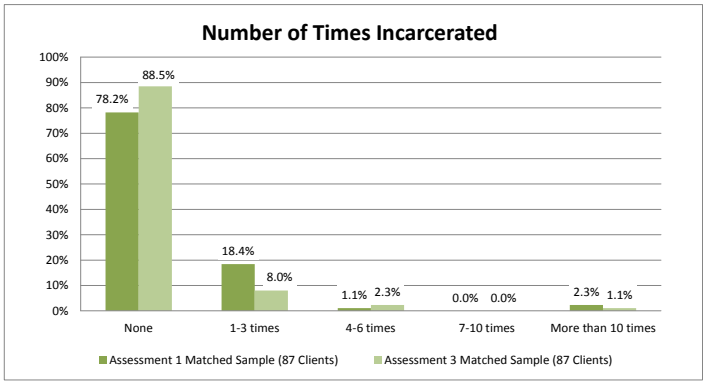


Providers were asked how many days each client had been homeless in the previous six months. At baseline, almost all of the clients had been homeless during the previous six months. MHA clients had been homeless for significantly less time over the previous six months at the six month assessment compared with the baseline.

IMHT Homelessness and Incarcerations



For IMHT clients with matched baseline and six month assessments, there was a significant reduction in the number of days homeless in the previous six months from the baseline to the six month assessment.



There was no significant change in the frequency of incarcerations for IMHT clients from the baseline to the six month assessment. However, a greater number of clients reported that they had not been incarcerated in the previous six months at the six month assessment.

Internalized Stigma Mental Illness (ISMI)

The 10-item Internalized Stigma of Mental Illness (ISMI) scale assesses client-reported experiences with stigma and common stereotypes about mental illness, social withdrawal behaviors, as well as the ability to resist or be unaffected by internalized stigma. ISMI items and total scale scores range from 1 (Strongly Disagree) to 4 (Strongly Agree), with lower scores representing decreased stigma. ISMI scale scores are categorized into four levels of stigma: minimal to no internalized stigma, mild internalized stigma, moderate internalized stigma, and severe internalized stigma.

The ISMI is completed by all clients at the baseline assessment to assess existing experiences of stigma prior to joining Innovation. A random sample of clients also completes the ISMI at the semi-annual assessments.

MHA-HIP ISMI Scores by Item

		Assessment Number			
ITEM #	Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Mentally ill people tend to be violent.	2.55	2.20	2.10	-0.10
2	People with mental illness make important contributions to society.	2.32	2.20	2.10	-0.10
3	I don't socialize as much as I used to because my mental illness might make me look or behave "weird".	2.50	2.50	2.40	-0.10
4	Having a mental illness has spoiled my life.	2.43 (N=21)	2.50	2.50	0.00
5	I stay away from social situations in order to protect my family or friends from embarrassment.	2.00	2.20	2.10	-0.10
6	People without mental illness could not possibly understand me.	2.09	2.40	2.10	-0.30
7	People ignore me or take me less seriously just because I have a mental illness.	2.36	2.30	2.30	0.00
8	I can't contribute anything to society because I have a mental illness.	2.09	2.30	2.00	-0.30
9	I can have a good, fulfilling life, despite my mental illness.	2.00	2.10	2.20	0.10
10	Others think that I can't achieve much in life because I have a mental illness.	2.27	2.10	2.20	0.10
	Total Mental Illness Stigma score *(mean of items 1 - 10)*	**2.26 (N=22)**	**2.28 (N=10)**	**2.20 (N=10)**	**-0.08**

The sample size for each ISMI item corresponds with the reported sample size (N) in each column of the Total Mental Illness Stigma score, unless otherwise reported.

At the baseline assessment, a majority of clients at MHA reported experiencing mild internalized stigma. There was no significant change in ISMI scores from the baseline to the six month assessment.

	Assessment Number			
Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
Minimal to no internalized stigma	31.8% (N=7)	30.0% (N=3)	20.0% (N=2)	-10.0%
Mild internalized stigma	45.5% (N=10)	60.0% (N=6)	80.0% (N=8)	20.0%
Moderate internalized stigma	18.2% (N=4)	10.0% (N=1)	0.0%	-10.0%
Severe internalized stigma	4.5% (N=1)	0.0%	0.0%	0.0%

IMHT ISMI Scores

	Assessment Number			
Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
Minimal to no internalized stigma	17.9%	29.6%	29.6%	0.0%
Mild internalized stigma	40.6%	51.9%	55.6%	3.7%
Moderate internalized stigma	31.1%	18.5%	14.8%	-3.7%
Severe internalized stigma	10.4%	0.0%	0.0%	0.0%
Total Mental Illness Stigma score *(mean of items 1 - 10)*	**2.48 (N=106)**	**2.26 (N=27)**	**2.22 (N=27)**	**-0.04**

For IMHT clients with matched baseline and six month ISMI ratings, there was no significant change in total ISMI score from the baseline to the six month assessment.

INCORPORATING CLIENT AND CLINICIAN OUTCOMES

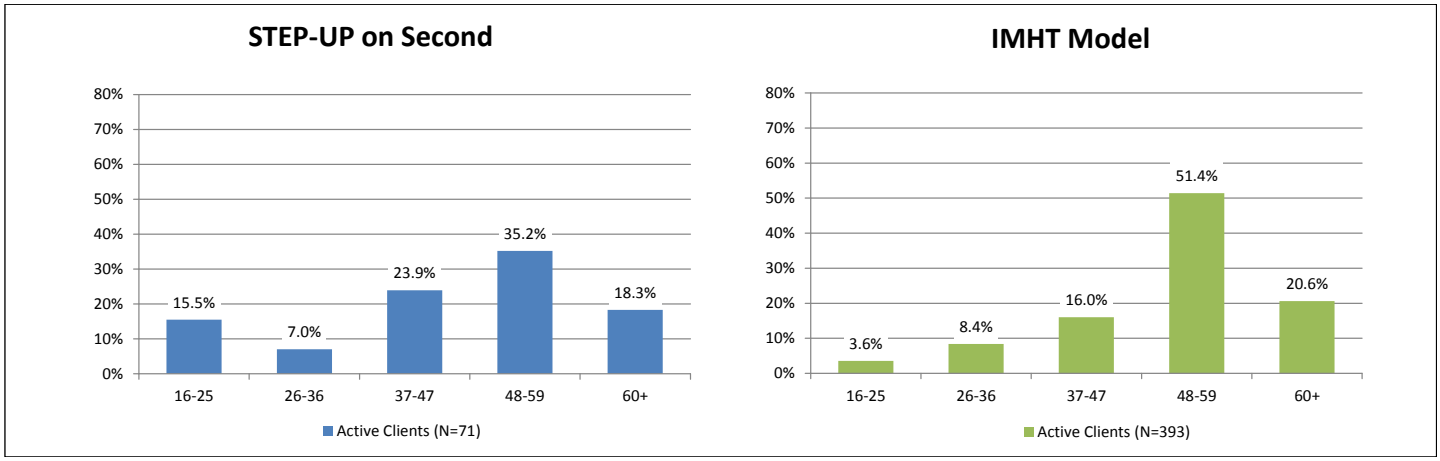
Step Up on Second

January 2014

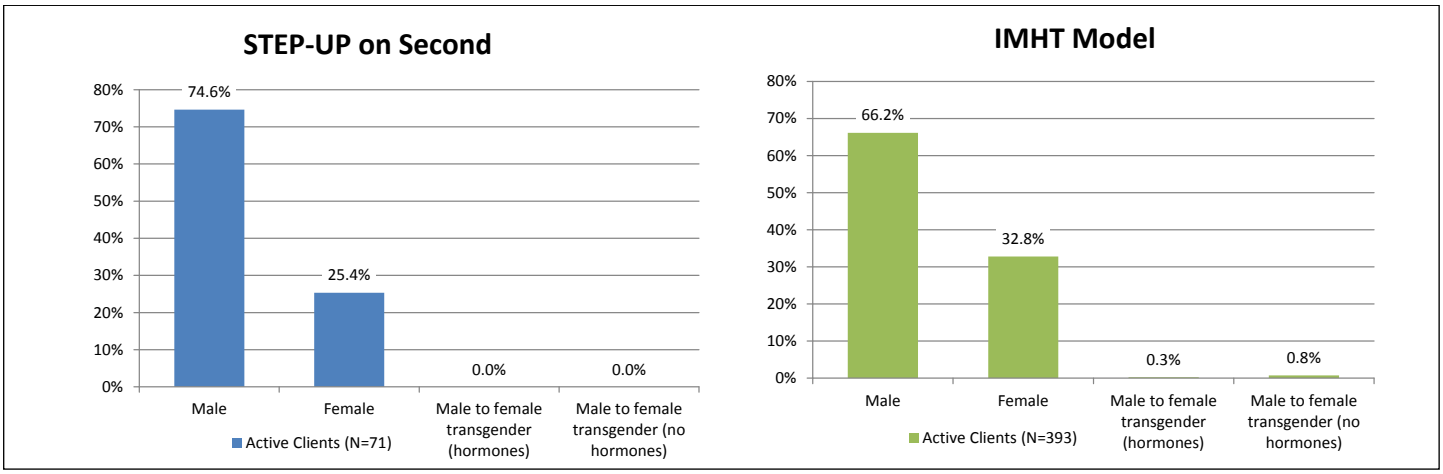
WELLNESS • RECOVERY • RESILIENCE

CURRENT CLIENT DEMOGRAPHIC INFORMATION

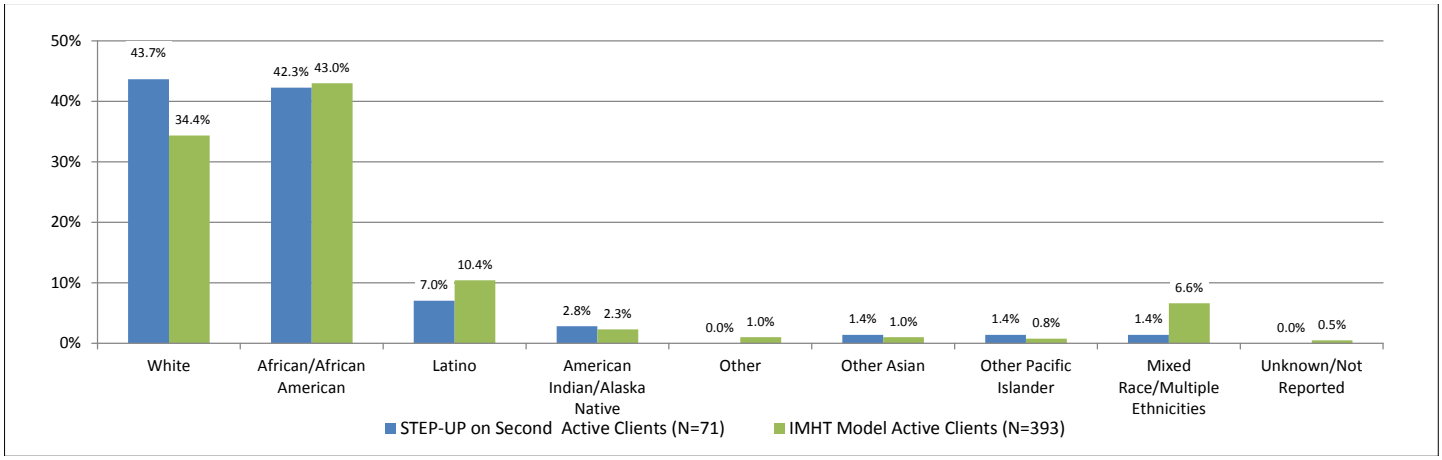
AGE



GENDER



ETHNICITY



CLINICIAN REPORTED RECOVERY OUTCOMES

To assess client recovery, clinicians are asked to complete the **Illness Management and Recovery Scale (IMR) and the Milestones of Recovery Scale (MORS)** at intake (baseline) and during subsequent quarterly follow-up visits. The IMR has 15 individual items, which make up an overall score and three subscales; Substance Use, Recovery (knowledge and goals), and Management (coping with illness outcome). IMR scores range from 1 to 5, with lower scores representing more progress toward recovery.

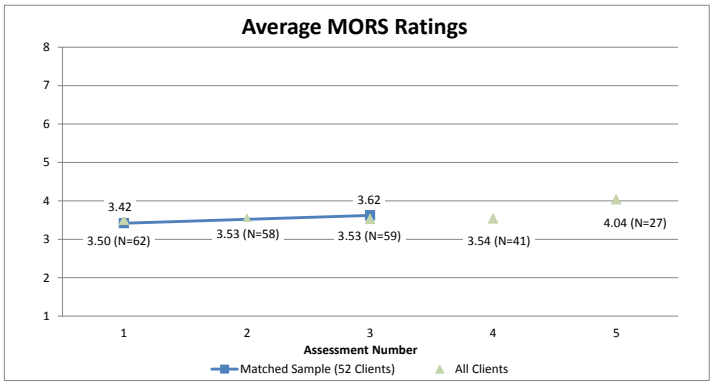
The MORS captures clinician-reported recovery through a single-item recovery indicator. Clinicians are asked to place clients into one of the 8 stages of recovery (rated 1 through 8, respectively): extreme risk, high risk/not engaged, high risk/engaged, poorly coping/not engaged, poorly coping/engaged, coping/rehabilitating, early recovery, and advanced recovery. Ratings are based on a client's 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 the quality of their social support network. Although the MORS is not a linear scale, higher MORS ratings are associated with greater recovery.

Step Up MORS Ratings

		Assessment Number			
Rating #	**Milestones of Recovery Scale**	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 3 (Matched Sample)**	**Change between Assessments 1 and 3**
1	Extreme Risk	4.8%	5.8%	13.5%	7.7%
2	High risk / Not engaged	12.9%	15.4%	5.8%	-9.6%
3	High risk / Engaged	41.9%	38.5%	26.9%	-11.6%
4	Poorly coping / Not engaged	16.1%	17.3%	21.2%	3.9%
5	Poorly coping / Engaged	16.1%	17.3%	25.0%	7.7%
6	Coping / Rehabilitating	8.1%	5.8%	7.7%	1.9%
7	Early Recovery	0.0%	0.0%	0.0%	0.0%
8	Advanced Recovery	0.0%	0.0%	0.0%	0.0%
	Average MORS Score	**3.50 (N=62)**	**3.42 (N=52)**	**3.62 (N=52)**	**0.20**

Provider level analyses use a matched sample of clients with MORS ratings at both the baseline and six month follow-up assessments. There was no significant change in mean MORS scores for clients at Step Up from the baseline to the six month assessment.

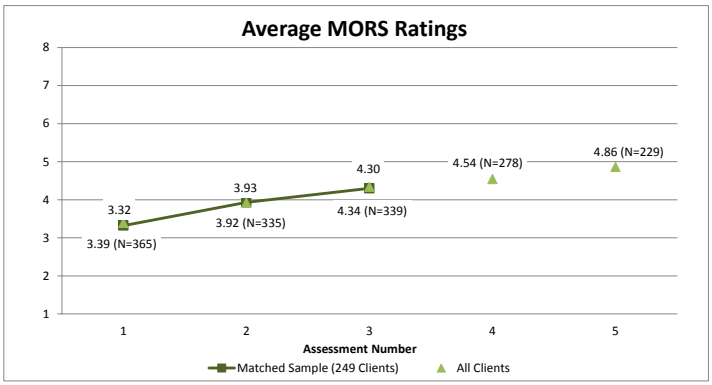
In addition to mean MORS scores for the matched sample, the figure to the right includes mean MORS scores for all Step Up clients at each assessment. Scores for all clients were similar to the matched sample at each assessment.



IMHT MORS Ratings

Model level analyses use a matched sample of clients with MORS ratings on the baseline, and the three and six month assessments. For IMHT clients there was a significant increase in MORS scores from baseline to three months, and from three to six months. MORS scores continue to increase over time, indicating ongoing progress towards client recovery.

	Assessment Number			
Milestones of Recovery Scale	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 2 (Matched Sample)**	**Assessment 3 (Matched Sample)**
Average MORS Score	3.39 (N=365)	3.32 (N=249)	3.93 (N=249)	4.30 (N=249)



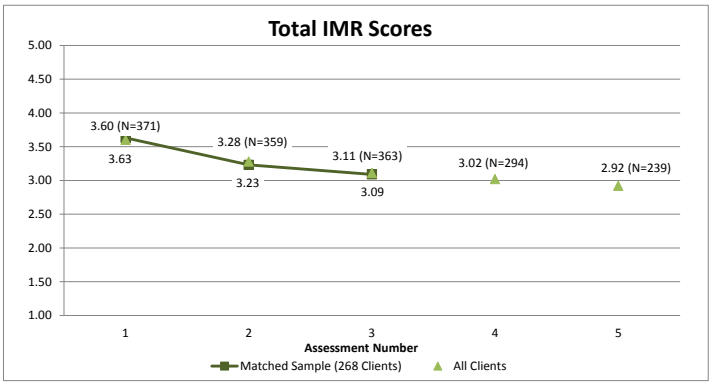
Step Up IMR Scores by Item

ITEM #	Aspect of Illness Management & Recovery	Assessment Number: Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Progress towards personal goals	3.62	3.62	3.51	-0.11
2	Knowledge	3.78	3.85	3.49	-0.36
4	Contact with people outside of my family	3.24 (N=62)	3.17 (N=54)	3.09	-0.08
8	Relapse prevention planning	4.23 (N=62)	4.30 (N=54)	4.02	-0.28
12	Involvement with self-help activities	3.85 (N=62)	3.74 (N=54)	3.58	-0.16
	Recovery Subscale *(mean of items 1, 2, 4, 8, & 12)*	**3.75 (N=63)**	**3.74 (N=55)**	**3.54 (N=55)**	**-0.20**
6	Symptom distress	4.05	4.04	3.82	-0.22
7	Impairment of functioning	4.35	4.36	3.93	-0.43
9	Relapse of symptoms	4.06	4.18	3.94 (N=54)	-0.24
11	Coping	3.76 (N=62)	3.78	3.78 (N=54)	0.00
	Management Subscale *(mean of items 6, 7, 9, & 11)*	**4.06 (N=63)**	**4.09 (N=55)**	**3.87 (N=55)**	**-0.22**
14	Impairment of functioning through alcohol use	2.81	2.89	2.83 (N=54)	-0.06
15	Impairment of functioning through drug use	2.86	2.93	3.00	0.07
	Substance Use Subscale *(maximum of items 14 & 15)*	**3.73 (N=63)**	**3.80 (N=55)**	**3.69 (N=55)**	**-0.11**
3	Involvement of family and friends in my mental health treatment	4.37	4.38	4.02	-0.36
5	Time in structured roles	4.86	4.84	4.89	0.05
10	Psychiatric hospitalizations	1.61 (N=61)	1.68 (N=53)	1.77 (N=53)	0.09
13	Using medication effectively	2.82 (N=44)	2.85 (N=40)	3.00 (N=44)	0.15
	Overall IMR Score (*mean of items 1-15*)	**3.64 (N=63)**	**3.66 (N=55)**	**3.53 (N=55)**	**-0.13**

The sample size for each IMR item corresponds with the reported sample size (N) in each column of the Overall IMR score, unless otherwise reported.

IMHT IMR Total Scores

Aspect of Illness Management & Recovery	Assessment Number: Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 2 (Matched Sample)	Assessment 3 (Matched Sample)
Recovery Subscale *(mean of items 1, 2, 4, 8, and 12)*	3.61	3.64	3.16	3.02
Management Subscale *(mean of items 6, 7, 9, and 11)*	4.16	4.20	3.75	3.56
Substance Use Subscale *(the maximum of items 14 and 15)*	3.32	3.36 (N=269)	3.14 (N=269)	3.09 (N=269)
Overall IMR Score	**3.60 (N=371)**	**3.63 (N=268)**	**3.23 (N=268)**	**3.09 (N=268)**



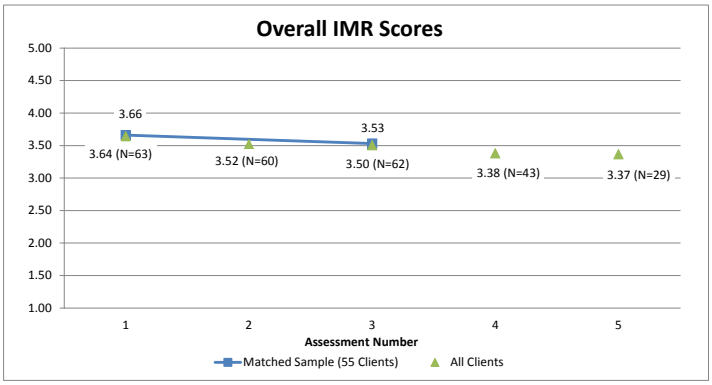
Model level analyses use a matched sample of clients with IMR ratings on the baseline, and the three and six month assessments. For IMHT clients there was a significant decrease in overall IMR scores from the baseline to the three month assessment, and from the three to the six month assessment. This indicates that, on average, clients in the IMHT model made consistent progress towards their recovery after enrolling in services.

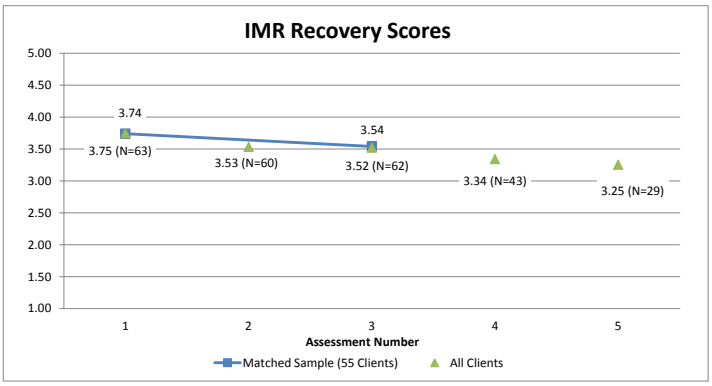
Average scores for all IMHT clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figure to the left.

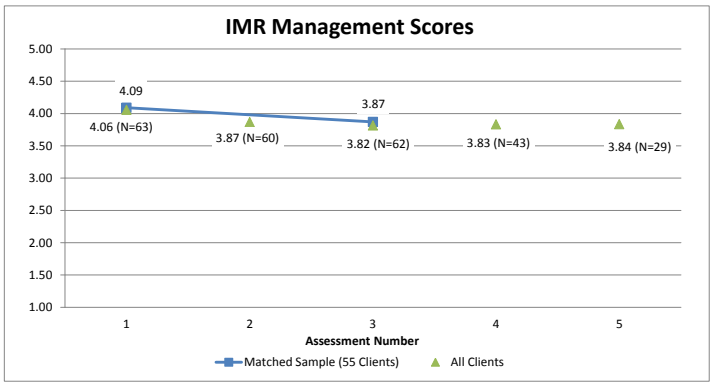
Step Up IMR Scores

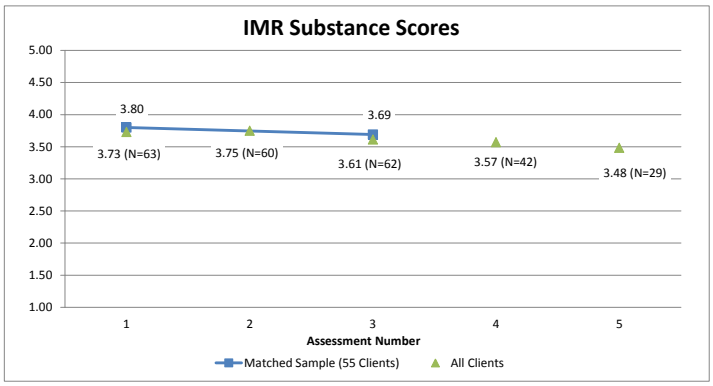
Provider level analyses use a matched sample of clients with IMR scores at both the baseline and six month follow-up assessments. There was no significant change in overall IMR scores from the baseline to the six month assessment.

Scores were significantly reduced on the Management subscale from the baseline to the six month assessment. This indicates that clinicians observed that clients were better able to manage their mental health. There were no significant changes on the Recovery or Substance Use subscale



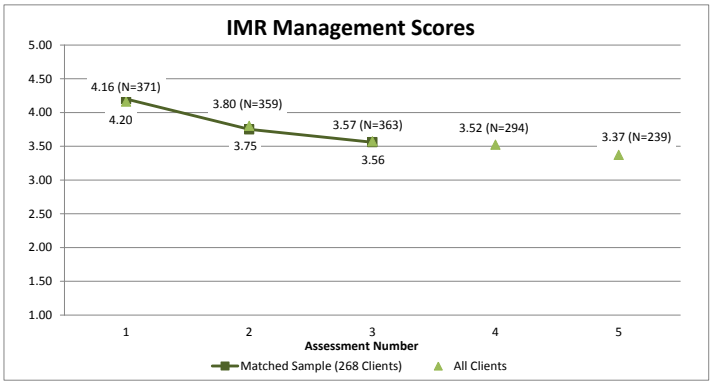


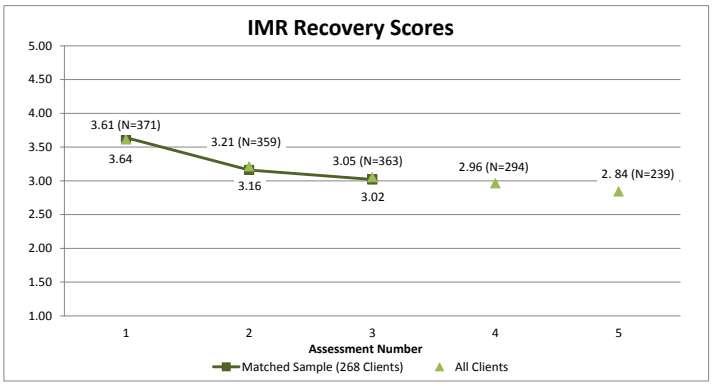


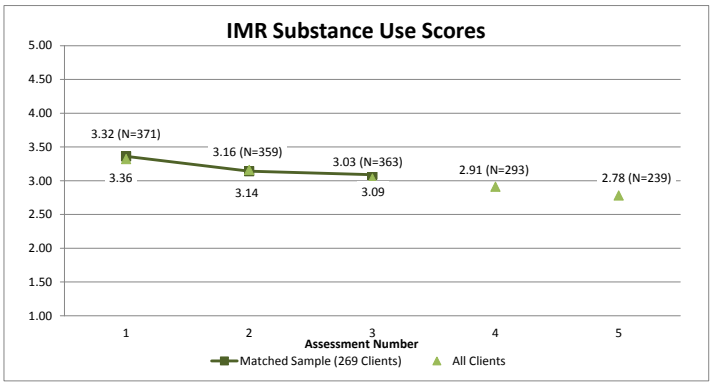


IMHT IMR Subscale Scores

Model level analyses use a matched sample of clients with IMR scores on the baseline, and the three and six month assessments. For IMHT clients, there were significant decreases in IMR Recovery and Management subscale scores from baseline to three months and from three to six months. There were also significant decreases on the Substance Use subscale from baseline to three months and from baseline to six months. This indicates that, on average, clients were less likely to use substances, had made progress towards their recovery, and were better able to manage their mental health after enrolling in Innovation.







CLIENT 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. The Integrated Self-Assessment includes the PROMIS Global Health Scale, the Physical Health and Behaviors Survey, the PROMIS-Derived Substance Use Scale, and the CHOIS Supplement. All measures are distributed semi-annually, except for the PROMIS Global Health, which is distributed quarterly. Additionally, all clients are asked to complete the Internalized Stigma of Mental Illness (ISMI) Scale at baseline, and either the ISMI, Post-Outcomes Survey, or Satisfaction Survey, semi-annually. Results from the Satisfaction and Self-Reported Post-Outcomes Surveys are not detailed in this report.

Paired samples t-tests and chi-square tests were used to examine the statistical significance of changes in scores on the measures over time. These procedures provide evidence that change was due to the benefits of receiving Innovation services and not chance variation. Statistical analysis using paired samples is performed by selecting only the cases that have complete data for each time point being measured.

These matched comparisons show change for individual clients as they progress through services, which allow changes to be more easily attributed to Innovation. Using paired samples decreases sample size, so data for all clients at each assessment point are also presented in each table. 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. The current matched sample analyses evaluate change between Assessment 1 (baseline) and Assessment 3 (the six month assessment). All reported outcomes include current and discharged clients.

PROMIS Global Health

The PROMIS Global Health scale is a 10-item measure aimed at assessing client-reported health including: physical health, pain, fatigue, mental health, and social health. Items are used to create a Total Global Health score and two sub-scale scores; Physical Health and Mental Health. PROMIS Global Health scores range from 1 to 5; however, clients are also asked to rate their pain using a scale from 0 (no pain) – 10 (worst imaginable pain), which is then categorized into a 5-point scale. For all PROMIS items and scales, lower scores represent fewer health concerns (i.e. lower scores are desirable). Clients are asked to complete the PROMIS Global Health at baseline and at subsequent quarterly assessments.

Step Up Global Health Scores by Item

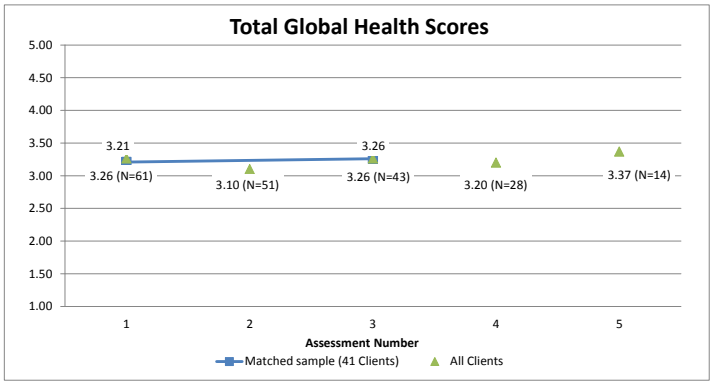
		Assessment Number			
ITEM #	**PROMIS Global Health**	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 3 (Matched Sample)**	**Change between Assessments 1 and 3**
2	Quality of life	3.65 (N=60)	3.53 (N=40)	3.44	-0.09
4	Mental health, including mood and ability to think	3.59	3.56	3.61	0.05
5	Satisfaction with social activities and relationships	3.42 (N=60)	3.27	3.56	0.29
8	Bothered by emotional problems, such as feeling anxious, depressed or irritable	3.44	3.29	3.37	0.08
	Global Mental Health *(mean of items 2, 4, 5, & 8)*	**3.52 (N=61)**	**3.41 (N=41)**	**3.49 (N=41)**	**0.08**
3	Physical health	3.36	3.46	3.51	0.05
7	Everyday physical activities	2.52 (N=60)	2.60 (N=40)	2.54	-0.06
9	Fatigue	3.00 (N=58)	2.95	2.97 (N=40)	0.02
10	Pain rating	2.92	2.80	3.05	0.25
	Global Physical Health *(mean of items 3, 7, 9, & 10)*	**2.95 (N=61)**	**2.96 (N=41)**	**3.01 (N=41)**	**0.05**
1	General health	3.33	3.39	3.29	-0.10
6	Ability to carry out regular social roles and activities	3.39	3.24	3.24	0.00
	Total Global Health Score (*mean of items 1-10)*	**3.26 (N=61)**	**3.21 (N=41)**	**3.26 (N=41)**	**0.05**

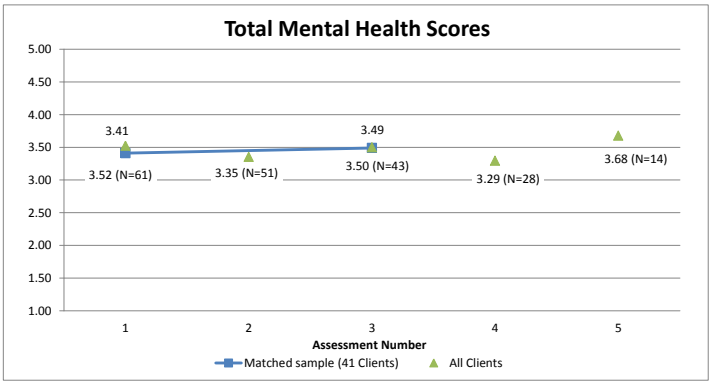
The sample size for each PROMIS item corresponds with the reported sample size (N) in each column of the Total Global Health score, unless otherwise reported.

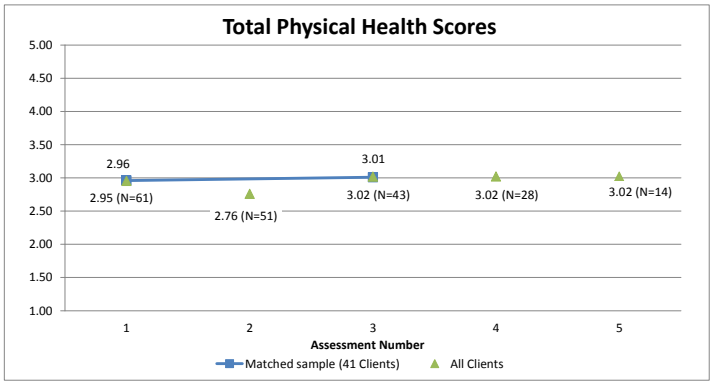
Step Up PROMIS Scores

Provider level analyses use a matched sample of clients with PROMIS scores at both the baseline and six month follow-up assessments. There were no significant changes in PROMIS Global Health scores, or scores on the Mental and Physical Health subscales for Step Up clients from the baseline to the six month assessment.

Average scores for all clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figures.



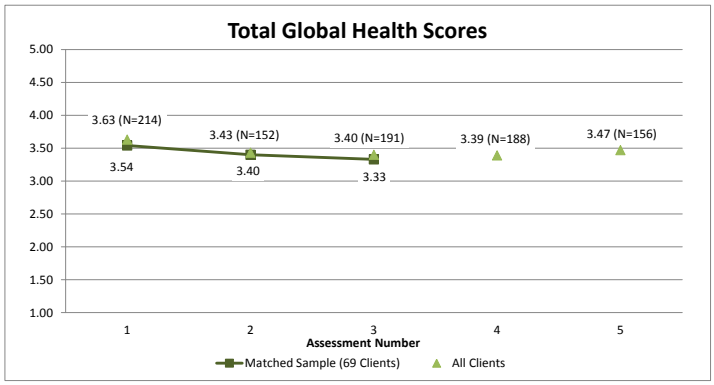




IMHT PROMIS Scores

Model level analyses use a matched sample of clients with PROMIS scores on the baseline, and the three and six month assessments. For IMHT clients, there was a significant decrease in Total Global Health scores from the baseline to the six month assessment. This indicates that, on average, clients reported experiencing fewer health problems after enrolling in Innovation.

In addition to PROMIS Global Health scores for the matched sample, the figure to the right includes scores for all clients at each assessment. Scores for all clients were similar to the matched sample at each assessment.



	Assessment Number			
PROMIS Global Health	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 2 (Matched Sample)**	**Assessment 3 (Matched Sample)**
Global Mental Health Subscale ***(mean of items 2, 4, 5, and 10)***	3.87	3.82	3.64	3.49
Global Physical Health Subscale ***(mean of items 3, 6, 7, and 8)***	3.33	3.19	3.05	3.10
Overall Global Health Score	**3.63 (N=214)**	**3.54 (N=69)**	**3.40 (N=69)**	**3.33 (N=69)**

Creating Healthy Outcomes: Integrated Self-Assessment (CHOIS) Supplement

The CHOIS Supplement is a client-rated recovery-based measure that assesses several mental health related domains, including suicidal ideation, anxiety, trauma, psychosis (i.e. hearing voices), and memory and cognitive impairment. The CHOIS contains three subscales: Psychosis, Memory and Cognitive Impairments, and Strengths. The Psychosis and Memory and Cognitive Impairment subscales assess clients' perceptions of their mental health symptoms, while the Strengths subscale examines recovery-oriented personal strengths that can assist clients in their recovery. Strengths items could be incorporated into treatment planning and recovery, and provide a positive point of assessment, an important aspect of being recovery-oriented. In addition to the scale scores, individual CHOIS items provide valuable insight into the clients' perception of their mental health symptoms.

All CHOIS subscales range from 1 to 5, with lower scores being desirable. For the Psychosis and Memory and Cognitive Impairment subscales, lower scores indicate fewer negative symptoms. For the Strengths subscale, lower scores indicate greater personal strengths. The CHOIS Supplement is completed by the client during the baseline and semi-annual assessments.

Step Up CHOIS Scores

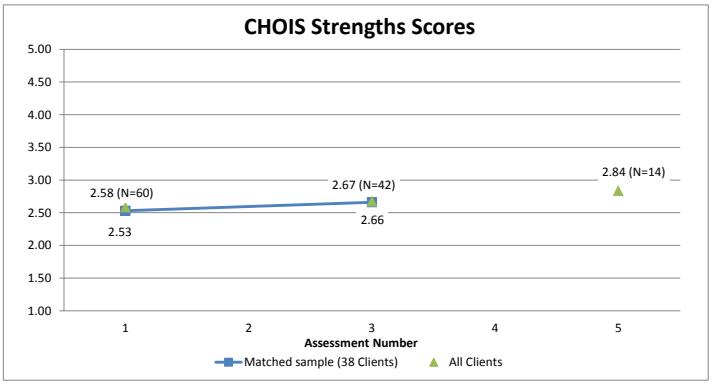
		Assessment Number			
ITEM #	CHOIS Supplement	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Thoughts entered my mind that I had trouble getting rid of.	2.77	2.79	2.67	-0.12
2	I did things I couldn't resist or did things more often than I should.	2.27 (N=60)	2.44	2.42 (N=38)	-0.02
3	I had disturbing memories or images of a stressful experience.	2.90 (N=60)	2.89 (N=38)	2.97 (N=38)	0.08
4	I had memory problems, such as forgetting names or appointments.	3.10 (N=60)	3.13 (N=38)	2.66 (N=38)	-0.47
5	I had difficulty thinking clearly while doing familiar tasks.	2.63 (N=59)	2.54 (N=37)	2.39 (N=38)	-0.15
6	I believed people were following or trying to harm me or my family.	2.30 (N=60)	2.41	2.21	-0.20
7	I heard voices that no one else could hear.	2.15	2.31	2.41	0.10
8	I had thoughts of ending my life or harming myself.	1.50 (N=60)	1.53 (N=38)	1.74 (N=38)	0.21
9	My child(ren) had emotional and/or behavioral problems.	1.62 (N=48)	1.40 (N=30)	1.92 (N=24)	0.52
10	I felt good about myself.	2.59 (N=58)	2.51 (N=37)	2.62	0.11
11	I had goals and worked towards achieving them.	2.46 (N=59)	2.46 (N=37)	2.76 (N=38)	0.30
12	I felt hopeful about the future.	2.47 (N=59)	2.45 (N=38)	2.33	-0.12
13	I was able to handle things.	2.37 (N=60)	2.34 (N=38)	2.62	0.28
14	I felt happy.	2.67 (N=60)	2.61 (N=38)	2.67	0.06
15	I had energy and was full of life.	2.68 (N=60)	2.58 (N=38)	2.79 (N=38)	0.21
16	I felt spiritually connected.	2.71 (N=59)	2.79 (N=38)	2.82	0.03
17	I had contact with people that care about me.	2.68 (N=60)	2.47 (N=38)	2.71 (N=38)	0.24
18	I lived in a home that made me feel safe.	3.19 (N=59)	3.03 (N=37)	3.13 (N=38)	0.10
19	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?	1.93 (N=56)	1.85 (N=34)	1.97 (N=35)	0.12
	Psychosis score *(mean of items 6 & 7)*	**2.24 (N=61)**	**2.36 (N=39)**	**2.31 (N=39)**	**-0.05**
	Memory score *(mean of items 4 & 5)*	**2.87 (N=61)**	**2.85 (N=39)**	**2.59 (N=39)**	**-0.26**
	Strengths score *(mean of items 10, 11, 12, 13, 14, 15, 16 & 17)*	**2.58 (N=60)**	**2.53 (N=38)**	**2.66 (N=38)**	**0.13**

The sample size for each CHOIS item corresponds with the highest reported sample size (N) in each column of the CHOIS Subscale scores, unless otherwise reported.

IMHT CHOIS Scores

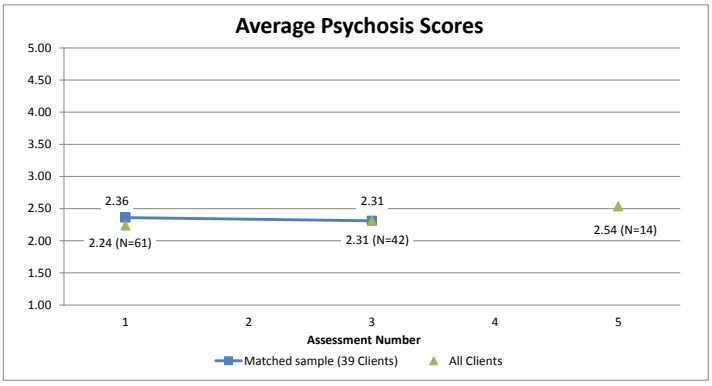
	Assessment Number		
CHOIS Supplement	Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)
Psychosis score *(mean of items 6 & 7)*	2.34 (N=211)	2.25 (N=95)	2.04 (N=95)
Memory score *(mean of items 4 & 5)*	2.95 (N=211)	3.02 (N=95)	2.77 (N=95)
Strengths score *(mean of items 10, 11, 12, 13, 14, 15, 16 & 17)*	2.85 (N=210)	2.82 (N=93)	2.77 (N=93)

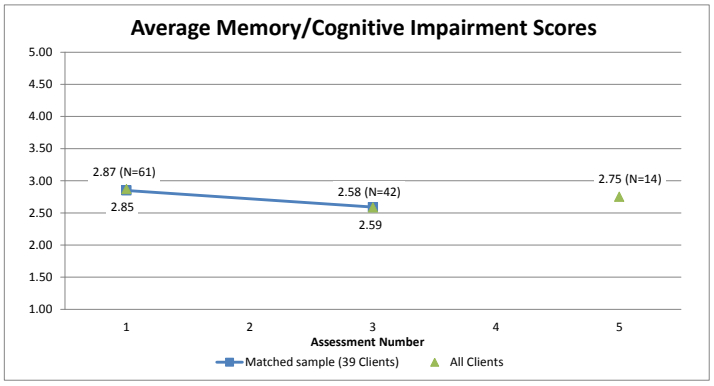
Step Up CHOIS Subscale Scores



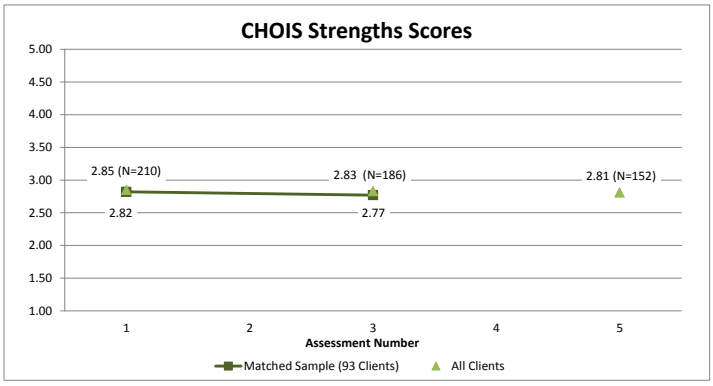
Provider level analyses use a matched sample of clients with CHOIS scores at both the baseline and six month follow-up assessments.

There were no significant changes in any of the CHOIS subscales from the baseline to the six month assessment.



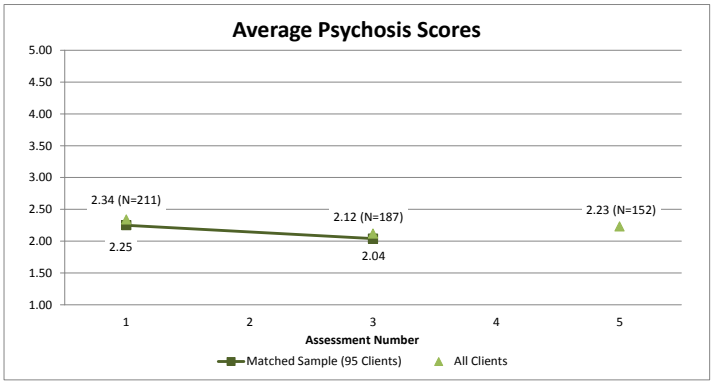


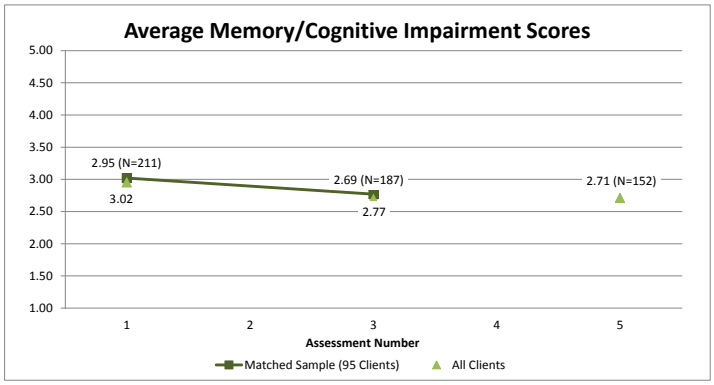
IMHT CHOIS Subscale Scores



Model level analyses use a matched sample of clients with CHOIS scores on the baseline, and six month assessments. For IMHT clients there were no significant changes on any of the CHOIS subscales from the baseline to the six month assessment.

Average scores for all IMHT clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figures.





PROMIS-Derived Substance Use

The 12-item PROMIS-Derived Substance Use scale assesses clients' perceptions of the negative consequences of their alcohol and/ or substance use, including physical (e.g., dizziness), mental (e.g., risk taking, guilt), and social (e.g., others had trouble counting on me, substance use created problems between me and others) consequences. Item and total scale scores range from 1 to 5, with lower scores indicating fewer client-perceived negative consequences associated with alcohol and/or substance use. Paired with the information from the clinician completed IMR Substance Use items, clients responses on this measure can help clinicians encourage a therapeutic dialogue with the client about their substance use.

Clients who indicate on their Physical Health and Behaviors assessment that they have used alcohol, illegal drugs, or off-label prescription medications within the past six months complete the PROMIS-Derived Substance Use Scale at the baseline and semi-annual assessments.

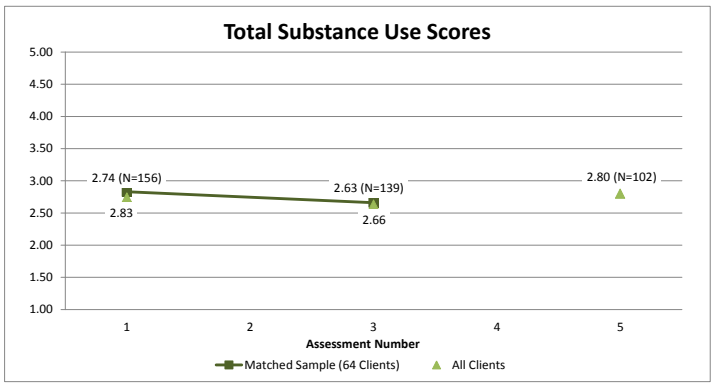
Step Up Substance Use Scores

		Assessment Number			
ITEM #	PROMIS-Derived Substance Use	Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	I used substances (alcohol, illegal drugs) too much.	2.82	2.73	2.81	0.08
2	I used alcohol or substances throughout the day.	2.93	2.81	2.65	-0.16
3	I had an urge to continue drinking or using substances once I started.	2.86	2.77	2.85	0.08
4	I felt that I should cut down on my alcohol or substance use.	3.09	3.12	3.12	0.00
5	I felt I needed help for my alcohol or substance use.	2.36	2.35	2.69	0.34
6	I took risks when I used alcohol or substances.	2.61	2.65	2.58	-0.07
7	I felt guilty when I used alcohol or substances.	2.74 (N=42)	2.64 (N=25)	2.76 (N=25)	0.12
8	Others complained about my alcohol or substance use.	2.42 (N=43)	2.40 (N=25)	2.38	-0.02
9	Alcohol or substance use created problems between me and others.	2.53 (N=43)	2.56 (N=25)	2.81	0.25
10	Others had trouble counting on me when I used alcohol or substances.	2.34	2.42	2.50	0.08
11	I felt dizzy after I used alcohol or substances.	2.34	2.42	2.50	0.08
12	Alcohol or substance use made my physical or mental health symptoms worse.	2.59	2.46	2.96	0.50
	Total Substance Use score *(mean of items 1 - 12)*	**2.64 (N=44)**	**2.61 (N=26)**	**2.72 (N=26)**	**0.11**

The sample size for each Substance Use item corresponds with the reported sample size (N) in each column of the Total Substance Use score, unless otherwise reported.

IMHT Substance Use Scores

	Assessment Number		
PROMIS-Derived Substance Use	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)
Total Substance Use score *(mean of items 1 - 12)*	2.74 (N=156)	2.83 (N=64)	2.66 (N=64)



Model level analyses use a matched sample of clients with Substance Use scores on the baseline, and the six month assessment. For IMHT clients there was no significant change in scores from the baseline to the six month assessment. As clients continue to receive Innovation services, improvements may become significant.

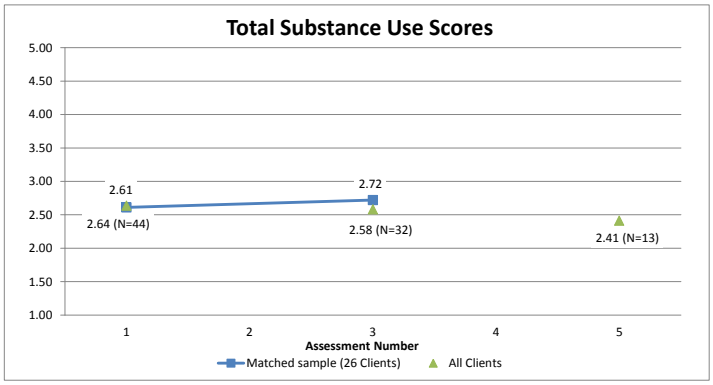
Do you smoke tobacco?			
	Not at all	Some days	Every day
Baseline (All clients N=205)	22.0%	12.2%	65.9%
Assessment 1 Matched Sample (91 clients)	17.6%	14.3%	68.1%
Assessment 3 Matched Sample (91 clients)	18.7%	23.1%	58.2%

Compared to baseline, there was a significant reduction in tobacco use at the six month assessment for IMHT clients.

Step Up Substance Use Scores

On the baseline assessment, about half of clients at Step Up reported that they had used alcohol (57.1%) or drugs (48.4%) within the previous six months. There were no significant changes in self-reported alcohol or drug use from the baseline to the six month assessment.

There were no significant changes in scores on the PROMIS-Derived Substance Use scale from the baseline to the six month assessment.



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
Baseline (All clients N=63)	42.9%	12.7%	19.0%	6.3%	19.0%
Assessment 1 Matched Sample (39 clients)	46.2%	12.8%	20.5%	5.1%	15.4%
Assessment 3 Matched Sample (39 clients)	38.5%	17.9%	20.5%	7.7%	15.4%

During the last 6 months, how often did you use an illegal drug or use a prescription medication for nonmedical reasons?					
	Never	Less than once a week	1-3 times per week	4 or more times per week	Every day
Baseline (All clients N=62)	51.6%	24.2%	12.9%	6.5%	4.8%
Assessment 1 Matched Sample (36 clients)	50.0%	27.8%	8.3%	5.6%	8.3%
Assessment 3 Matched Sample (36 clients)	58.3%	27.8%	8.3%	0.0%	5.6%

Do you smoke tobacco?			
	Not at all	Some days	Every day
Baseline (All clients N=58)	17.2%	15.5%	67.2%
Assessment 1 Matched Sample (36 clients)	13.9%	13.9%	72.2%
Assessment 3 Matched Sample (36 clients)	11.1%	30.6%	58.3%

Compared to baseline, there was no significant change in tobacco use at the six month assessment.

Physical Health and Behaviors

Clients completed the Physical Health and Behaviors Survey at the baseline and semi-annual assessments to measure health behaviors, including substance use, medication adherence, and exercise, service utilization including emergency room visits, hospitalizations, and previous experiences accessing care, and daily activities including housing situation, employment, volunteer activities and education.

Step Up Physical Activity

At the baseline assessment, a majority of clients (76.2%) at Step Up reported that they engaged in physical activity at least once during a typical week. There was no significant change in physical activity from the baseline to the six month assessment for clients who completed this item at baseline and at the six month assessment.

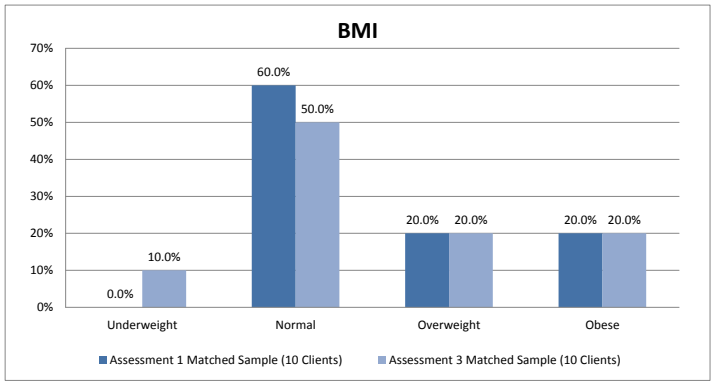
How many times in a usual week do you do 30 minutes of physical activity that increases your heart rate or makes you breathe harder than normal? (for example, walking or jogging, carrying light loads, bicycling, or playing sports)					
	None	1 time	2 times	3 times	4 or more times
Baseline (All clients N=63)	23.8%	11.1%	7.9%	11.1%	46.0%
Assessment 1 Matched Sample (39 clients)	20.5%	10.3%	7.7%	17.9%	43.6%
Assessment 3 Matched Sample (39 clients)	15.4%	15.4%	15.4%	17.9%	35.9%

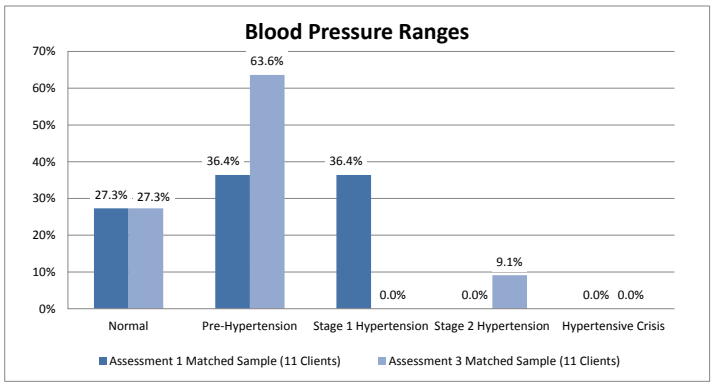
Step Up Physical Health

The figure below shows the proportion of clients who were ever screened for each of the physical health conditions during the first twelve months of their enrollment in Innovation. The most common screening at Step Up was for High Blood Pressure, followed by Diabetes. Clinicians indicated which screenings were completed on the Physical Health Indicators Survey, which was completed every six months.

Percentage of Clients who have ever been screened for:								
Diabetes	High Blood Pressure	Cholesterol	Asthma*	Emphysema*	Tuberculosis*	HIV	Hepatitis	Other STDs
20.3%	44.3%	16.5%	2.5%	6.3%	7.6%	17.7%	16.5%	12.7%

* Screening for Asthma, Emphysema, and Tuberculosis was only included on the baseline assessment.





Clinicians are asked to provide clients' height and weight on the Physical Health Indicators Survey, which are used to calculate Body Mass Index (BMI). BMI was categorized using the standard categories defined by the Centers for Disease Control and Prevention. There was no significant change in BMI from the baseline to the six month assessment.

Systolic and diastolic readings are combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. Blood pressure is only one indicator of risk; additional criteria must be met for a diagnosis of hypertension. There were no significant changes in risk for hypertension from the baseline to the six month assessment.

In the past month, how often did you take your medications as the doctor prescribed?					
	My doctor hasn't prescribed any	Less than half the time (<50%)	About half the time (50%)	Nearly all the time (75%)	All the time (100%)
Baseline (All clients N=57)	15.8%	19.3%	12.3%	26.3%	26.3%
Assessment 1 Matched Sample (37 clients)	13.5%	13.5%	18.9%	18.9%	35.1%
Assessment 3 Matched Sample (37 clients)	13.5%	8.1%	18.9%	27.0%	32.4%

Clients were asked how often they took their medications as prescribed. There was no significant change in medication adherence from the baseline to the six month assessment.

IMHT Physical Activity

At the baseline assessment, a majority of clients in the IMHT model (67.9%) reported that they engaged in physical activity at least once during a typical week. There was no significant change in physical activity from the baseline to the six month assessment for clients who completed this item at baseline and at the six month assessment.

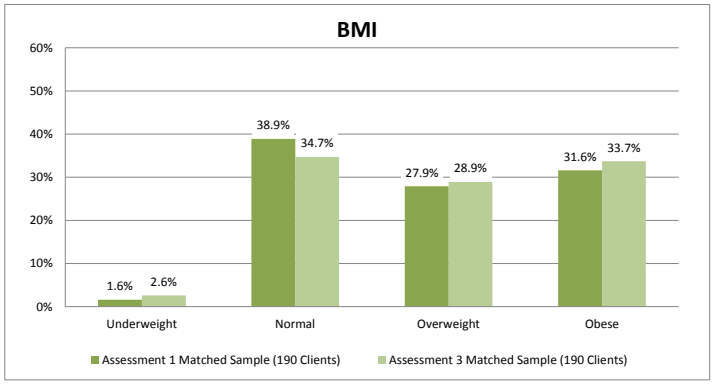
How many times in a usual week do you do 30 minutes of physical activity that increases your heart rate or makes you breathe harder than normal? (for example, walking or jogging, carrying light loads, bicycling, or playing sports)					
	None	1 time	2 times	3 times	4 or more times
Baseline (All clients N=215)	32.1%	7.9%	8.8%	11.6%	39.5%
Assessment 1 Matched Sample (92 clients)	28.3%	8.7%	7.6%	13.0%	42.4%
Assessment 3 Matched Sample (92 clients)	19.6%	17.4%	15.2%	17.4%	30.4%

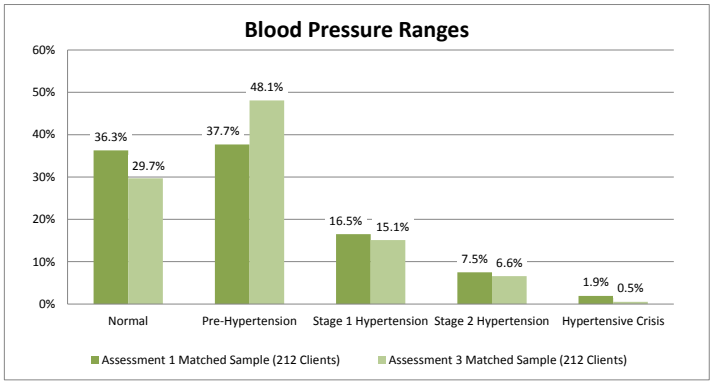
IMHT Physical Health

The figure below shows the proportion of clients who were ever screened for each of the physical health conditions during the first twelve months of their enrollment in Innovation. Within the first year of receiving Innovation services, IMHT clients were most likely to be screened for Diabetes, High Blood Pressure, High Cholesterol, HIV, Hepatitis and other STDs.

Percentage of Clients at 12 Months who have EVER been Screened For:								
Diabetes	High Blood Pressure	Cholesterol	Asthma*	Emphysema*	Tuberculosis*	HIV	Hepatitis	Other STDs
57.9%	70.6%	56.8%	10.8%	16.0%	21.1%	54.4%	45.4%	51.9%

* Screening for Asthma, Emphysema, and Tuberculosis was only included on the baseline assessment.





Clinicians are asked to provide clients' height and weight on the Physical Health Indicators Survey, which are used to calculate Body Mass Index (BMI). BMI was categorized using the standard categories defined by the Centers for Disease Control and Prevention. There were no significant changes in BMI for IMHT clients from the baseline to the six month assessment.

Systolic and diastolic readings are combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. Blood pressure is only one indicator of risk; additional criteria must be met for a diagnosis of hypertension. There were no significant changes in risk for hypertension from the baseline to the six month assessment.

In the past month, how often did you take your medications as the doctor prescribed?					
	My doctor hasn't prescribed any	Less than half the time (<50%)	About half the time (50%)	Nearly all the time (75%)	All the time (100%)
Baseline (All clients N=206)	16.0%	11.7%	11.7%	26.7%	34.0%
Assessment 1 Matched Sample (92 clients)	16.3%	13.0%	12.0%	22.8%	35.9%
Assessment 3 Matched Sample (92 clients)	7.6%	8.7%	17.4%	30.4%	35.9%

Clients were asked how often they took their medications as prescribed. There have been no significant changes in medication adherence to date, however more clients reported that they were taking doctor-prescribed medication at the six month assessment.

IMHT Service Utilization

Model level analyses use a matched sample of clients who completed service utilization items on the baseline, and the six month assessment. There was a significant reduction in the mean frequency of emergency room visits from baseline to the six month assessment for IMHT clients. There was no significant change in the frequency of hospital admissions.

In the past 6 months...	None	1-3 times	4-6 times	7-10 times	More than 10 times
how many times did you go to an emergency room?					
Baseline (All clients N=212)	30.2%	47.6%	14.6%	3.8%	3.8%
Assessment 1 Matched Sample (94 clients)	35.1%	42.6%	13.8%	4.3%	4.3%
Assessment 3 Matched Sample (94 clients)	44.7%	39.4%	11.7%	1.1%	3.2%
how many times were you admitted to a hospital?					
Baseline (All clients N=211)	52.1%	35.1%	8.5%	2.8%	1.4%
Assessment 1 Matched Sample (95 clients)	57.9%	31.6%	6.3%	2.1%	2.1%
Assessment 3 Matched Sample (95 clients)	64.2%	25.3%	8.4%	1.1%	1.1%

Step Up Service Utilization

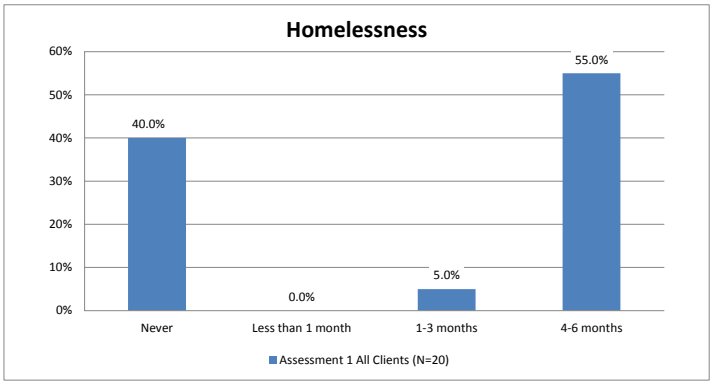
Provider level analyses use a matched sample of clients with completed service utilization items at both the baseline and six month assessments. At the baseline assessment, about half of clients at Step Up reported that they had visited an emergency room (58.1%) or been hospitalized (50.8%) at least once in the prior six months. There were no significant reductions in service utilization from the baseline to the six month assessment.

In the past 6 months...	None	1-3 times	4-6 times	7-10 times	More than 10 times
how many times did you go to an emergency room?					
Baseline (All clients N=62)	41.9%	38.7%	11.3%	3.2%	4.8%
Assessment 1 Matched Sample (40 clients)	45.0%	35.0%	10.0%	5.0%	5.0%
Assessment 3 Matched Sample (40 clients)	40.0%	40.0%	12.5%	2.5%	5.0%
how many times were you admitted to a hospital?					
Baseline (All clients N=61)	49.2%	37.7%	9.8%	0.0%	3.3%
Assessment 1 Matched Sample (38 clients)	52.6%	36.8%	7.9%	0.0%	2.6%
Assessment 3 Matched Sample (38 clients)	60.5%	21.1%	15.8%	0.0%	2.6%

Step Up Homelessness and Incarcerations

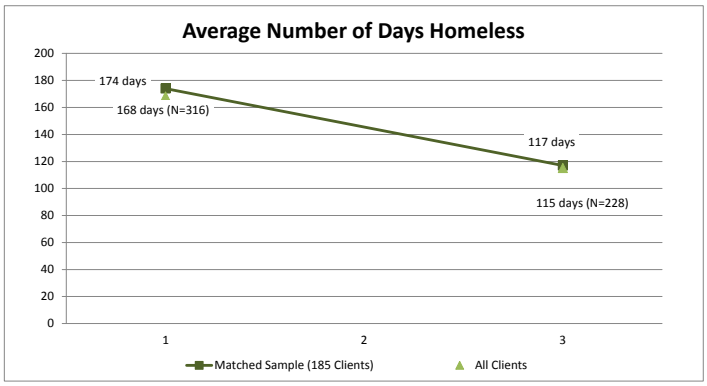
Upon enrolling in the Innovation program, 69.6% of Step Up clients reported that they had not been incarcerated within the previous six months. There was no significant change in the frequency of incarcerations from the baseline to the six month assessment.

In 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
Baseline (All clients N=56)	69.6%	28.6%	0.0%	0.0%	1.8%
Assessment 1 Matched Sample (33 clients)	78.8%	18.2%	0.0%	0.0%	3.0%
Assessment 3 Matched Sample (33 clients)	84.8%	9.1%	3.0%	0.0%	3.0%

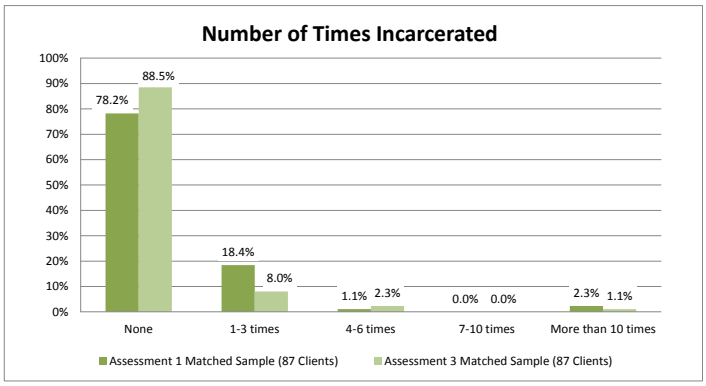


Providers were asked how many days each client had been homeless in the previous six months. At baseline, a majority of the clients had been homeless during the previous six months. There were no clients with a matched baseline and six month assessment, so significance analyses could not be completed.

IMHT Homelessness and Incarcerations



For IMHT clients with matched baseline and six month assessments, there was a significant reduction in the number of days homeless in the previous six months from the baseline to the six month assessment.



There was no significant change in the frequency of incarcerations for IMHT clients from the baseline to the six month assessment. However, a greater number of clients reported that they had not been incarcerated in the previous six months at the six month assessment.

Internalized Stigma Mental Illness (ISMI)

The 10-item Internalized Stigma of Mental Illness (ISMI) scale assesses client-reported experiences with stigma and common stereotypes about mental illness, social withdrawal behaviors, as well as the ability to resist or be unaffected by internalized stigma. ISMI items and total scale scores range from 1 (Strongly Disagree) to 4 (Strongly Agree), with lower scores representing decreased stigma. ISMI scale scores are categorized into four levels of stigma: minimal to no internalized stigma, mild internalized stigma, moderate internalized stigma, and severe internalized stigma.

The ISMI is completed by all clients at the baseline assessment to assess existing experiences of stigma prior to joining Innovation. A random sample of clients also completes the ISMI at the semi-annual assessments.

Step Up ISMI Scores by Item

		Assessment Number			
ITEM #	Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Mentally ill people tend to be violent.	2.59 (N=39)	1.83	1.67	-0.16
2	People with mental illness make important contributions to society.	2.39 (N=38)	2.33	2.80 (N=5)	0.47
3	I don't socialize as much as I used to because my mental illness might make me look or behave "weird".	2.46 (N=39)	1.83	1.83	0.00
4	Having a mental illness has spoiled my life.	2.54	1.50	1.83	0.33
5	I stay away from social situations in order to protect my family or friends from embarrassment.	2.42 (N=38)	1.67	2.33	0.66
6	People without mental illness could not possibly understand me.	2.22	1.33	1.67	0.34
7	People ignore me or take me less seriously just because I have a mental illness.	2.51	1.50	1.40 (N=5)	-0.10
8	I can't contribute anything to society because I have a mental illness.	2.08	1.33	1.50 (N=4)	0.17
9	I can have a good, fulfilling life, despite my mental illness.	2.16	2.67	2.00 (N=4)	-0.67
10	Others think that I can't achieve much in life because I have a mental illness.	2.51	1.67	1.25 (N=4)	-0.42
	Total Mental Illness Stigma score *(mean of items 1 - 10)*	**2.39 (N=37)**	**1.77 (N=6)**	**1.87 (N=6)**	**0.10**

The sample size for each ISMI item corresponds with the reported sample size (N) in each column of the Total Mental Illness Stigma score, unless otherwise reported.

At the baseline assessment, a majority of clients at Step Up reported experiencing moderate internalized stigma. There was no significant change in ISMI scores from the baseline to the six month assessment.

	Assessment Number			
Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
Minimal to no internalized stigma	27.0% (N=10)	83.3% (N=5)	66.7% (N=4)	-16.6%
Mild internalized stigma	27.0% (N=10)	16.7% (N=1)	33.3% (N=2)	16.6%
Moderate internalized stigma	37.8% (N=14)	0.0%	0.0%	0.0%
Severe internalized stigma	8.1% (N=3)	0.0%	0.0%	0.0%

IMHT ISMI Scores

	Assessment Number			
Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
Minimal to no internalized stigma	17.9%	29.6%	29.6%	0.0%
Mild internalized stigma	40.6%	51.9%	55.6%	3.7%
Moderate internalized stigma	31.1%	18.5%	14.8%	-3.7%
Severe internalized stigma	10.4%	0.0%	0.0%	0.0%
Total Mental Illness Stigma score *(mean of items 1 - 10)*	**2.48 (N=106)**	**2.26 (N=27)**	**2.22 (N=27)**	**-0.04**

For IMHT clients with matched baseline and six month ISMI ratings, there was no significant change in total ISMI score from the baseline to the six month assessment.

INCORPORATING CLIENT AND CLINICIAN OUTCOMES

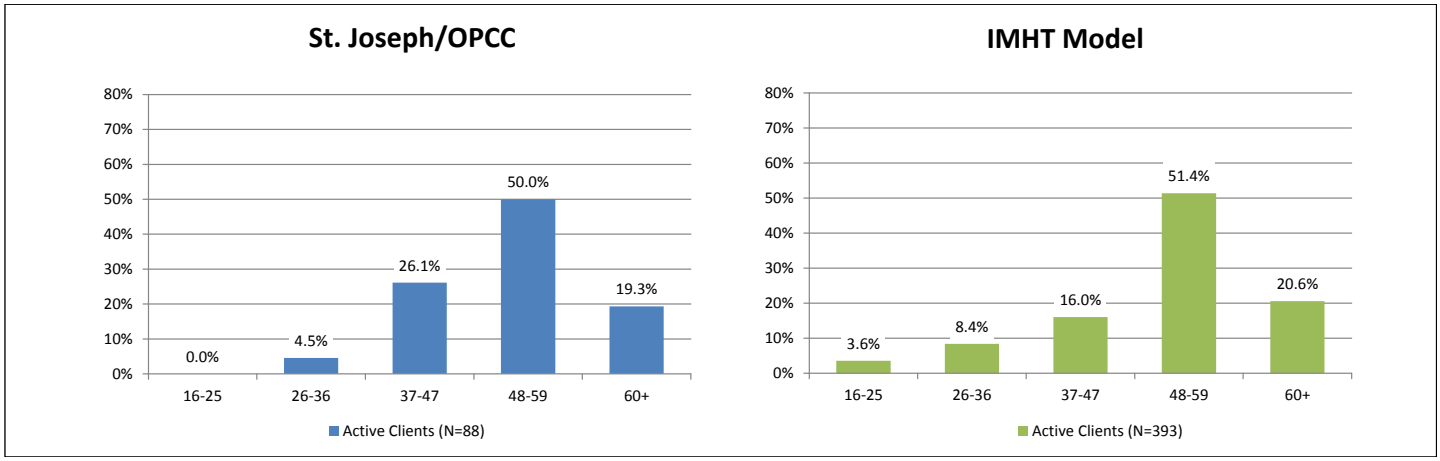
St. Joseph Center/OPCC

January 2014

WELLNESS • RECOVERY • RESILIENCE

CURRENT CLIENT DEMOGRAPHIC INFORMATION

AGE



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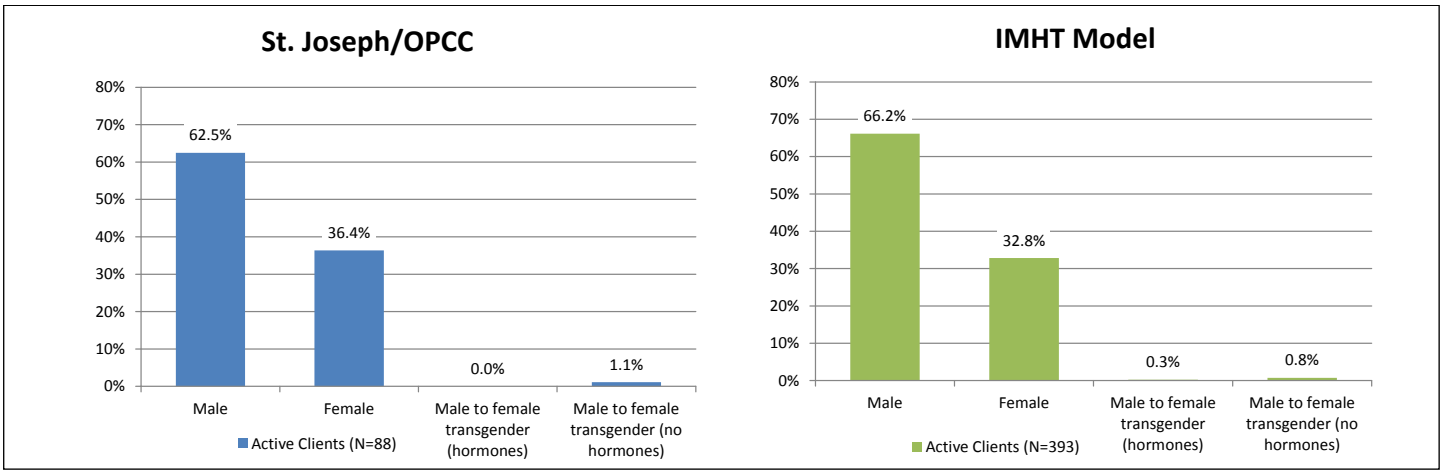
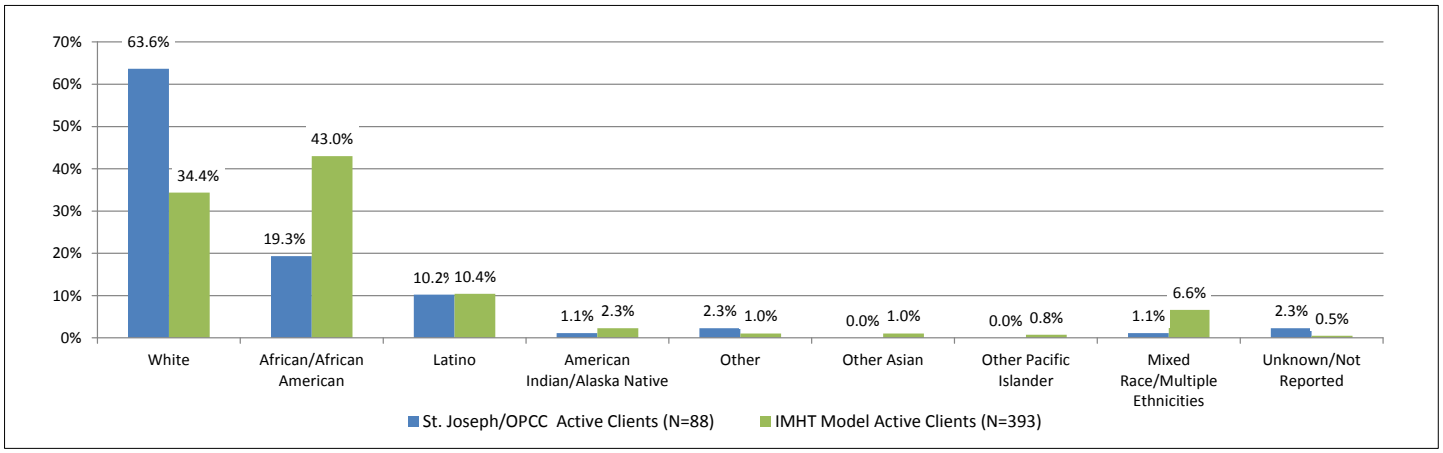


ETHNICITY



CLINICIAN REPORTED RECOVERY OUTCOMES

To assess client recovery, clinicians are asked to complete the **Illness Management and Recovery Scale (IMR) and the Milestones of Recovery Scale (MORS)** at intake (baseline) and during subsequent quarterly follow-up visits. The IMR has 15 individual items, which make up an overall score and three subscales; Substance Use, Recovery (knowledge and goals), and Management (coping with illness outcome). IMR scores range from 1 to 5, with lower scores representing more progress toward recovery.

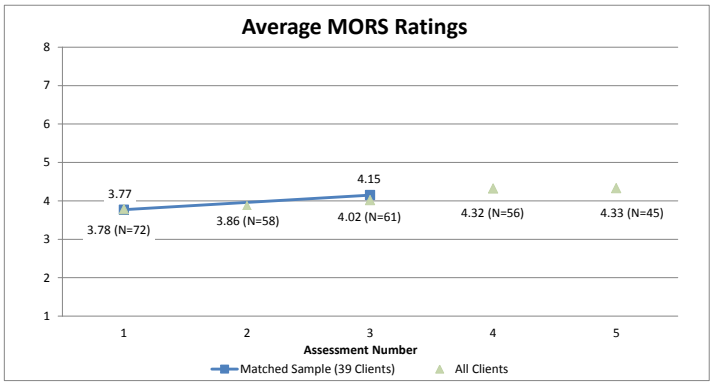
The MORS captures clinician-reported recovery through a single-item recovery indicator. Clinicians are asked to place clients into one of the 8 stages of recovery (rated 1 through 8, respectively): extreme risk, high risk/not engaged, high risk/engaged, poorly coping/not engaged, poorly coping/engaged, coping/rehabilitating, early recovery, and advanced recovery. Ratings are based on a client's 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 the quality of their social support network. Although the MORS is not a linear scale, higher MORS ratings are associated with greater recovery.

St. Joseph/OPCC MORS Ratings

		Assessment Number			
Rating #	Milestones of Recovery Scale	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Extreme Risk	2.8%	5.1%	2.6%	-2.5%
2	High risk / Not engaged	8.3%	10.3%	7.7%	-2.6%
3	High risk / Engaged	40.3%	30.8%	30.8%	0.0%
4	Poorly coping / Not engaged	11.1%	15.4%	2.6%	-12.8%
5	Poorly coping / Engaged	31.9%	33.3%	43.6%	10.3%
6	Coping / Rehabilitating	5.6%	5.1%	12.8%	7.7%
7	Early Recovery	0.0%	0.0%	0.0%	0.0%
8	Advanced Recovery	0.0%	0.0%	0.0%	0.0%
	Average MORS Score	**3.78 (N=72)**	**3.77 (N=39)**	**4.15 (N=39)**	**0.38**

Provider level analyses use a matched sample of clients with MORS ratings at both the baseline and six month follow-up assessments. There was a significant increase in mean MORS scores for clients at St. Joseph/OPCC from the baseline to the six month assessment. Clients were in a more advanced stage of recovery six months after enrolling in Innovation compared to baseline.

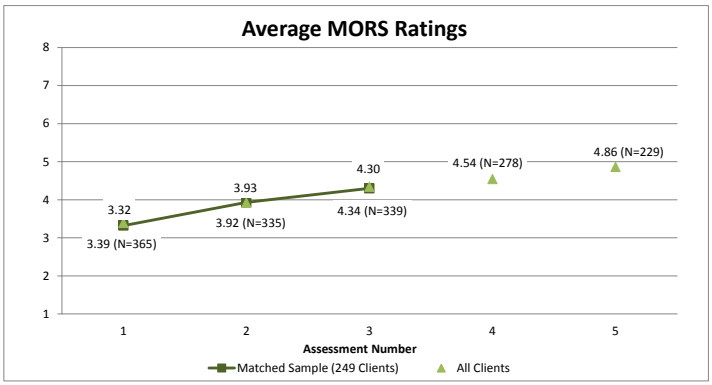
In addition to mean MORS scores for the matched sample, the figure to the right includes mean MORS scores for all St. Joseph/OPCC clients at each assessment. Scores for all clients were similar to the matched sample at each assessment.



IMHT MORS Ratings

Model level analyses use a matched sample of clients with MORS ratings on the baseline, and the three and six month assessments. For IMHT clients there was a significant increase in MORS scores from baseline to three months, and from three to six months. MORS scores continue to increase over time, indicating ongoing progress towards client recovery.

	Assessment Number			
Milestones of Recovery Scale	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 2 (Matched Sample)	Assessment 3 (Matched Sample)
Average MORS Score	3.39 (N=365)	3.32 (N=249)	3.93 (N=249)	4.30 (N=249)



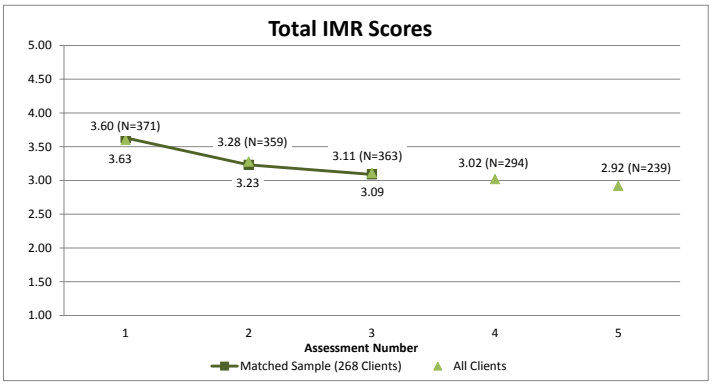
St. Joseph/OPCC IMR Scores by Item

ITEM #	Aspect of Illness Management & Recovery	Assessment Number: Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Progress towards personal goals	3.56	3.72	3.36	-0.36
2	Knowledge	3.56	3.78	3.25	-0.53
4	Contact with people outside of my family	3.22	3.11	2.78	-0.33
8	Relapse prevention planning	3.83	3.86	3.69	-0.17
12	Involvement with self-help activities	3.65	3.86	3.83	-0.03
	Recovery Subscale *(mean of items 1, 2, 4, 8, & 12)*	**3.56 (N=63)**	**3.67 (N=36)**	**3.38 (N=36)**	**-0.29**
6	Symptom distress	4.25	4.36	4.08	-0.28
7	Impairment of functioning	4.59	4.75	4.11 (N=35)	-0.64
9	Relapse of symptoms	3.74 (N=61)	3.62 (N=34)	3.50	-0.12
11	Coping	4.19	4.36	3.92	-0.44
	Management Subscale *(mean of items 6, 7, 9, & 11)*	**4.19 (N=63)**	**4.27 (N=36)**	**3.90 (N=36)**	**-0.37**
14	Impairment of functioning through alcohol use	3.18 (N=62)	2.83 (N=36)	2.95	0.12
15	Impairment of functioning through drug use	2.73 (N=62)	2.75 (N=36)	2.54	-0.21
	Substance Use Subscale *(maximum of items 14 & 15)*	**3.59 (N=63)**	**3.32 (N=37)**	**3.38 (N=37)**	**0.06**
3	Involvement of family and friends in my mental health treatment	4.27	4.42	4.08	-0.34
5	Time in structured roles	4.70	4.61	4.61	0.00
10	Psychiatric hospitalizations	1.84	1.56	1.36	-0.20
13	Using medication effectively	2.66 (N=38)	3.18 (N=17)	2.62 (N=26)	-0.56
	Overall IMR Score (*mean of items 1-15*)	**3.63 (N=63)**	**3.67 (N=36)**	**3.39 (N=36)**	**-0.28**

The sample size for each IMR item corresponds with the reported sample size (N) in each column of the Overall IMR score, unless otherwise reported.

IMHT IMR Total Scores

Aspect of Illness Management & Recovery	Assessment Number: Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 2 (Matched Sample)	Assessment 3 (Matched Sample)
Recovery Subscale *(mean of items 1, 2, 4, 8, and 12)*	3.61	3.64	3.16	3.02
Management Subscale *(mean of items 6, 7, 9, and 11)*	4.16	4.20	3.75	3.56
Substance Use Subscale *(the maximum of items 14 and 15)*	3.32	3.36 (N=269)	3.14 (N=269)	3.09 (N=269)
Overall IMR Score	**3.60 (N=371)**	**3.63 (N=268)**	**3.23 (N=268)**	**3.09 (N=268)**

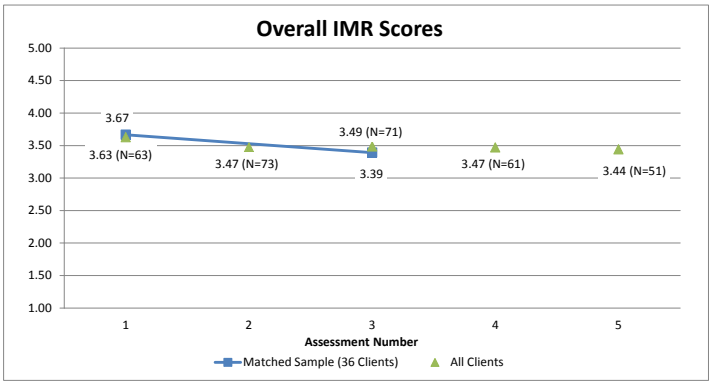


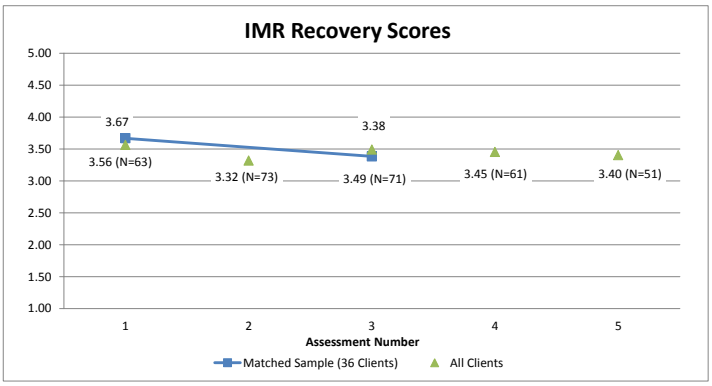
Model level analyses use a matched sample of clients with IMR ratings on the baseline, and the three and six month assessments. For IMHT clients there was a significant decrease in overall IMR scores from the baseline to the three month assessment, and from the three to the six month assessment. This indicates that, on average, clients in the IMHT model made consistent progress towards their recovery after enrolling in services.

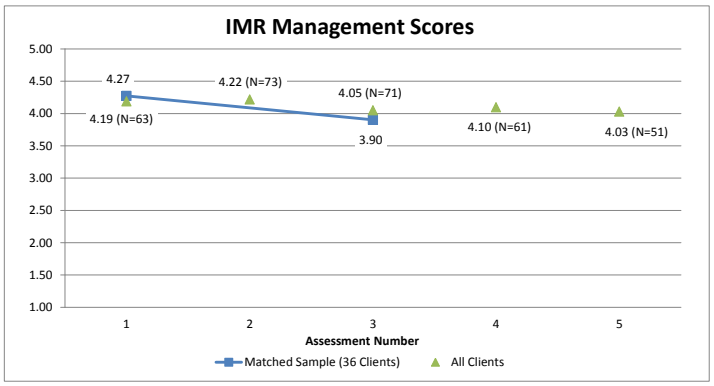
Average scores for all IMHT clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figure to the left.

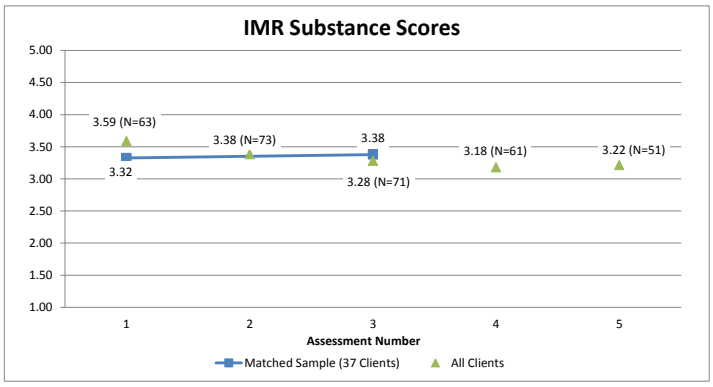
St. Joseph/OPCC IMR Scores

Provider level analyses use a matched sample of clients with IMR scores at both the baseline and six month follow-up assessments. There was a significant decrease in overall IMR scores from the baseline to the six month assessment. This indicates that St. Joseph/OPCC clients made progress towards their recovery after enrolling in Innovation. Scores were also significantly reduced on the Management and Recovery subscales from the baseline to the six month assessment. This indicates that clinicians observed that clients made consistent progress towards their recovery, and were better able to manage their mental health. There was no significant change on the Substance Use subscale.



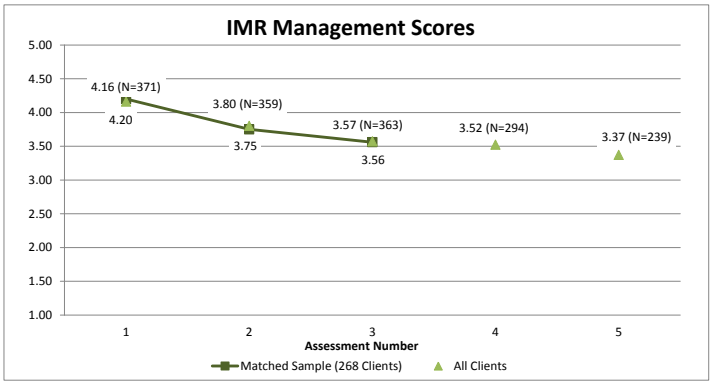


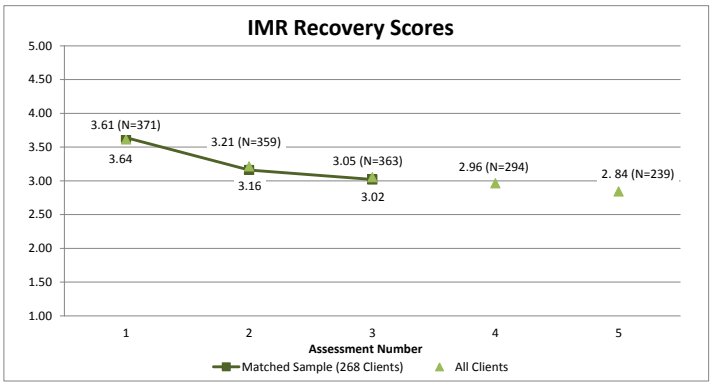


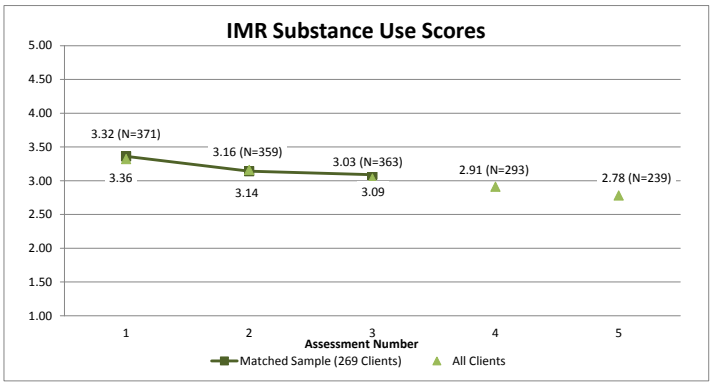


IMHT IMR Subscale Scores

Model level analyses use a matched sample of clients with IMR scores on the baseline, and the three and six month assessments. For IMHT clients, there were significant decreases in IMR Recovery and Management subscale scores from baseline to three months and from three to six months. There were also significant decreases on the Substance Use subscale from baseline to three months and from baseline to six months. This indicates that, on average, clients were less likely to use substances, had made progress towards their recovery, and were better able to manage their mental health after enrolling in Innovation.







CLIENT 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. The Integrated Self-Assessment includes the PROMIS Global Health Scale, the Physical Health and Behaviors Survey, the PROMIS-Derived Substance Use Scale, and the CHOIS Supplement. All measures are distributed semi-annually, except for the PROMIS Global Health, which is distributed quarterly. Additionally, all clients are asked to complete the Internalized Stigma of Mental Illness (ISMI) Scale at baseline, and either the ISMI, Post-Outcomes Survey, or Satisfaction Survey, semi-annually. Results from the Satisfaction and Self-Reported Post-Outcomes Surveys are not detailed in this report.

Paired samples t-tests and chi-square tests were used to examine the statistical significance of changes in scores on the measures over time. These procedures provide evidence that change was due to the benefits of receiving Innovation services and not chance variation. Statistical analysis using paired samples is performed by selecting only the cases that have complete data for each time point being measured.

These matched comparisons show change for individual clients as they progress through services, which allow changes to be more easily attributed to Innovation. Using paired samples decreases sample size, so data for all clients at each assessment point are also presented in each table. 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. The current matched sample analyses evaluate change between Assessment 1 (baseline) and Assessment 3 (the six month assessment). All reported outcomes include current and discharged clients.

PROMIS Global Health

The PROMIS Global Health scale is a 10-item measure aimed at assessing client-reported health including: physical health, pain, fatigue, mental health, and social health. Items are used to create a Total Global Health score and two sub-scale scores; Physical Health and Mental Health. PROMIS Global Health scores range from 1 to 5; however, clients are also asked to rate their pain using a scale from 0 (no pain) – 10 (worst imaginable pain), which is then categorized into a 5-point scale. For all PROMIS items and scales, lower scores represent fewer health concerns (i.e. lower scores are desirable). Clients are asked to complete the PROMIS Global Health at baseline and at subsequent quarterly assessments.

St. Joseph/OPCC PROMIS Global Health Scores by Item

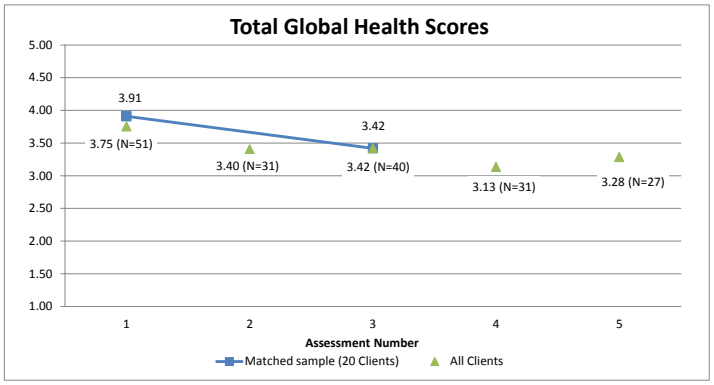
		Assessment Number			
ITEM #	**PROMIS Global Health**	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 3 (Matched Sample)**	**Change between Assessments 1 and 3**
2	Quality of life	4.26 (N=50)	4.55	3.60	-0.95
4	Mental health, including mood and ability to think	4.06	4.25	3.40	-0.85
5	Satisfaction with social activities and relationships	4.08	4.20	3.63 (N=19)	-0.57
8	Bothered by emotional problems, such as feeling anxious, depressed or irritable	3.92 (N=50)	4.25	3.75	-0.50
	Global Mental Health *(mean of items 2, 4, 5, & 8)*	**4.08 (N=51)**	**4.31 (N=20)**	**3.60 (N=20)**	**-0.71**
3	Physical health	3.90 (N=50)	3.95	3.80	-0.15
7	Everyday physical activities	2.98	3.00	2.70	-0.30
9	Fatigue	3.24	3.45	3.15	-0.30
10	Pain rating	3.41	3.55	3.10	-0.45
	Global Physical Health *(mean of items 3, 7, 9, & 10)*	**3.38 (N=51)**	**3.49 (N=20)**	**3.19 (N=20)**	**-0.30**
1	General health	3.90	4.05	3.85	-0.20
6	Ability to carry out regular social roles and activities	3.80 (N=50)	3.79 (N=19)	3.20	-0.59
	Total Global Health Score (*mean of items 1-10)*	**3.75 (N=51)**	**3.91 (N=20)**	**3.42 (N=20)**	**-0.49**

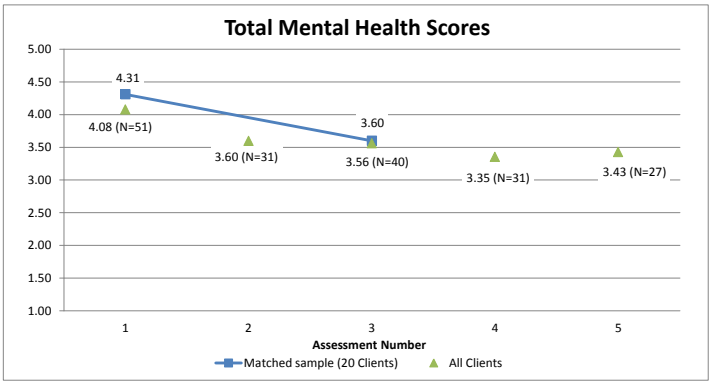
The sample size for each PROMIS item corresponds with the reported sample size (N) in each column of the Total Global Health score, unless otherwise reported.

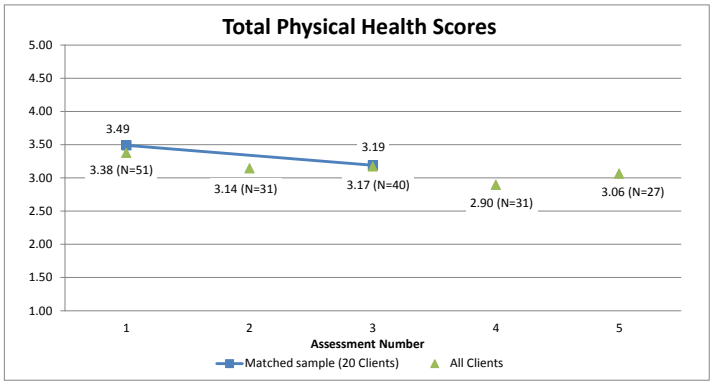
St. Joseph/OPCC PROMIS Scores

Provider level analyses use a matched sample of clients with PROMIS scores at both the baseline and six month follow-up assessments. There was a significant decrease in PROMIS Global Health scores for St. Joseph/OPCC clients from the baseline to the six month assessment. This indicates that clients reported experiencing fewer health problems after enrolling in Innovation.

Average scores for all clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figures.





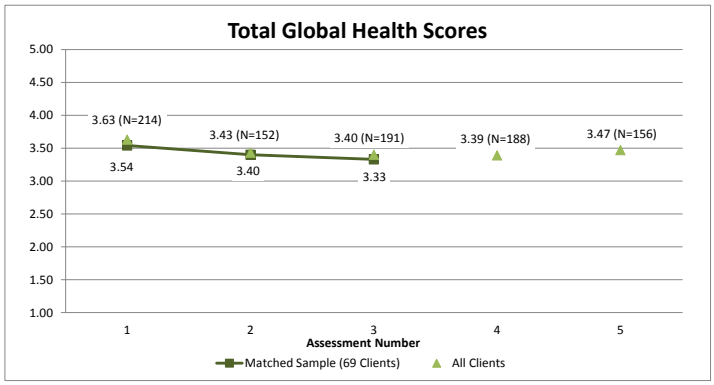


There was a significant decrease in Global Mental Health subscale scores from the baseline to the six month assessment. This indicates that, in general, clients reported experiencing improved mental health after enrolling in Innovation. There was no significant change in Global Physical Health subscale scores.

IMHT PROMIS Scores

Model level analyses use a matched sample of clients with PROMIS scores on the baseline, and the three and six month assessments. For IMHT clients, there was a significant decrease in Total Global Health scores from the baseline to the six month assessment. This indicates that, on average, clients reported experiencing fewer health problems after enrolling in Innovation.

In addition to PROMIS Global Health scores for the matched sample, the figure to the right includes scores for all clients at each assessment. Scores for all clients were similar to the matched sample at each assessment.



	Assessment Number			
PROMIS Global Health	**Baseline (All Clients)**	**Assessment 1 (Matched Sample)**	**Assessment 2 (Matched Sample)**	**Assessment 3 (Matched Sample)**
Global Mental Health Subscale ***(mean of items 2, 4, 5, and 10)***	3.87	3.82	3.64	3.49
Global Physical Health Subscale ***(mean of items 3, 6, 7, and 8)***	3.33	3.19	3.05	3.10
Overall Global Health Score	**3.63 (N=214)**	**3.54 (N=69)**	**3.40 (N=69)**	**3.33 (N=69)**

Creating Healthy Outcomes: Integrated Self-Assessment (CHOIS) Supplement

The CHOIS Supplement is a client-rated recovery-based measure that assesses several mental health related domains, including suicidal ideation, anxiety, trauma, psychosis (i.e. hearing voices), and memory and cognitive impairment. The CHOIS contains three subscales: Psychosis, Memory and Cognitive Impairments, and Strengths. The Psychosis and Memory and Cognitive Impairment subscales assess clients' perceptions of their mental health symptoms, while the Strengths subscale examines recovery-oriented personal strengths that can assist clients in their recovery. Strengths items could be incorporated into treatment planning and recovery, and provide a positive point of assessment, an important aspect of being recovery-oriented. In addition to the scale scores, individual CHOIS items provide valuable insight into the clients' perception of their mental health symptoms.

All CHOIS subscales range from 1 to 5, with lower scores being desirable. For the Psychosis and Memory and Cognitive Impairment subscales, lower scores indicate fewer negative symptoms. For the Strengths subscale, lower scores indicate greater personal strengths. The CHOIS Supplement is completed by the client during the baseline and semi-annual assessments.

St. Joseph/OPCC CHOIS Scores

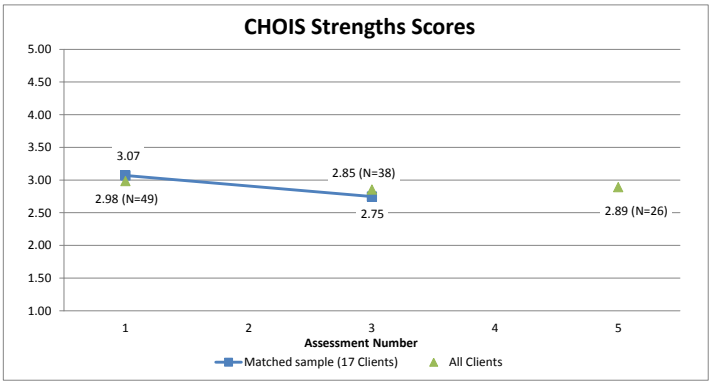
		Assessment Number			
ITEM #	CHOIS Supplement	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Thoughts entered my mind that I had trouble getting rid of.	3.45	3.61	3.33	-0.28
2	I did things I couldn't resist or did things more often than I should.	2.29	2.67	2.67	0.00
3	I had disturbing memories or images of a stressful experience.	3.33 (N=48)	3.89	3.33	-0.56
4	I had memory problems, such as forgetting names or appointments.	3.12	3.56	3.17	-0.39
5	I had difficulty thinking clearly while doing familiar tasks.	3.02	3.28	2.50	-0.78
6	I believed people were following or trying to harm me or my family.	2.31	2.06	1.33	-0.73
7	I heard voices that no one else could hear.	1.70 (N=46)	1.53 (N=17)	1.67	0.14
8	I had thoughts of ending my life or harming myself.	1.67	1.39	1.12 (N=17)	-0.27
9	My child(ren) had emotional and/or behavioral problems.	1.41 (N=37)	1.47 (N=15)	1.50 (N=6)	0.03
10	I felt good about myself.	3.27	3.50	2.81 (N=16)	-0.69
11	I had goals and worked towards achieving them.	2.79 (N=48)	2.94	2.94 (N=17)	0.00
12	I felt hopeful about the future.	3.02 (N=48)	3.44	2.69 (N=16)	-0.75
13	I was able to handle things.	2.68 (N=47)	2.67	2.35 (N=17)	-0.32
14	I felt happy.	3.19 (N=48)	3.12 (N=17)	2.81 (N=16)	-0.31
15	I had energy and was full of life.	3.52 (N=48)	3.71 (N=17)	3.06 (N=17)	-0.65
16	I felt spiritually connected.	2.77 (N=48)	2.78	2.82 (N=17)	0.04
17	I had contact with people that care about me.	2.59	2.39	2.50 (N=16)	0.11
18	I lived in a home that made me feel safe.	3.94	4.00	2.50 (N=16)	-1.50
19	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?	2.35	2.33	2.18 (N=17)	-0.15
	Psychosis score *(mean of items 6 & 7)*	**2.02 (N=49)**	**1.78 (N=18)**	**1.50 (N=18)**	**-0.28**
	Memory score *(mean of items 4 & 5)*	**3.07 (N=49)**	**3.42 (N=18)**	**2.83 (N=18)**	**-0.59**
	Strengths score *(mean of items 10, 11, 12, 13, 14, 15, 16 & 17)*	**2.98 (N=49)**	**3.07 (N=17)**	**2.75 (N=17)**	**-0.32**

The sample size for each CHOIS item corresponds with the highest reported sample size (N) in each column of the CHOIS Subscale scores, unless otherwise reported.

IMHT CHOIS Scores

	Assessment Number		
CHOIS Supplement	Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)
Psychosis score *(mean of items 6 & 7)*	2.34 (N=211)	2.25 (N=95)	2.04 (N=95)
Memory score *(mean of items 4 & 5)*	2.95 (N=211)	3.02 (N=95)	2.77 (N=95)
Strengths score *(mean of items 10, 11, 12, 13, 14, 15, 16 & 17)*	2.85 (N=210)	2.82 (N=93)	2.77 (N=93)

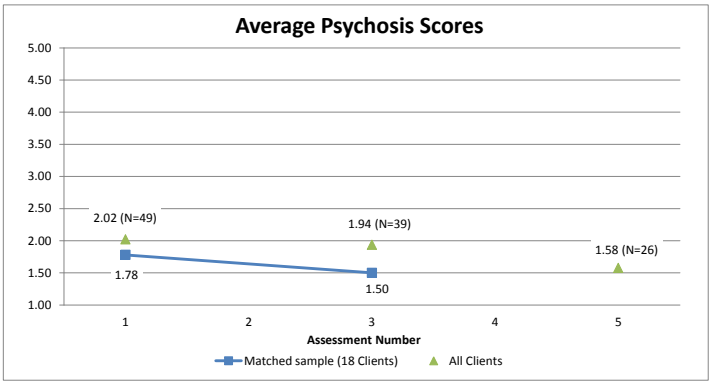
St. Joseph/OPCC CHOIS Subscale Scores

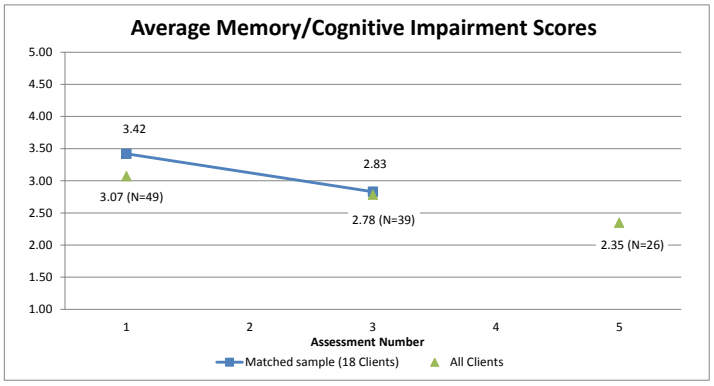


Provider level analyses use a matched sample of clients with CHOIS scores at both the baseline and six month follow-up assessments.

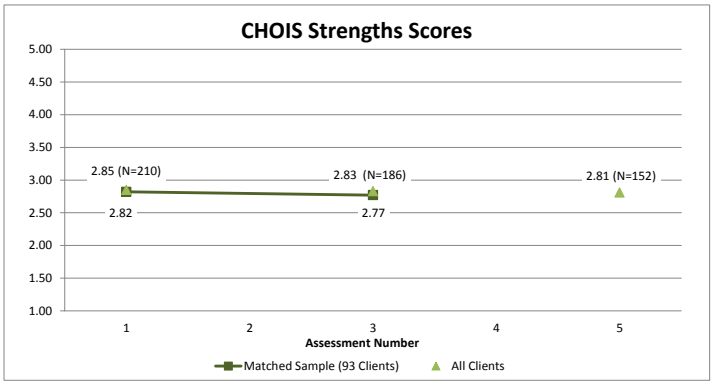
There was a significant improvement in scores on the Strengths and Memory and Cognitive Impairment subscales from the baseline to the six month assessment. This indicates that clients reported having greater recovery-oriented personal strengths and less cognitive impairment after enrolling in Innovation.

There was no significant change in mean Psychosis subscale scores from the baseline to the six month assessment.



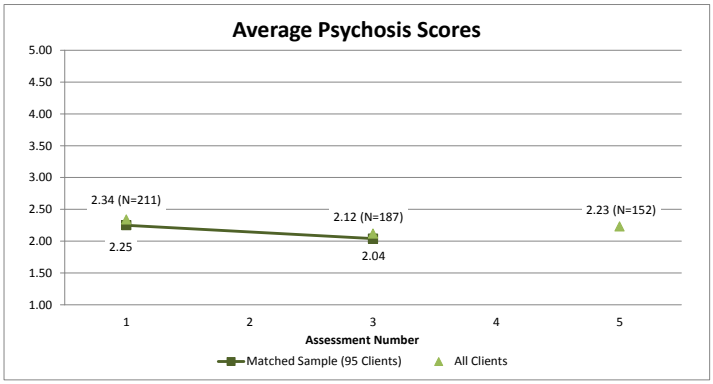


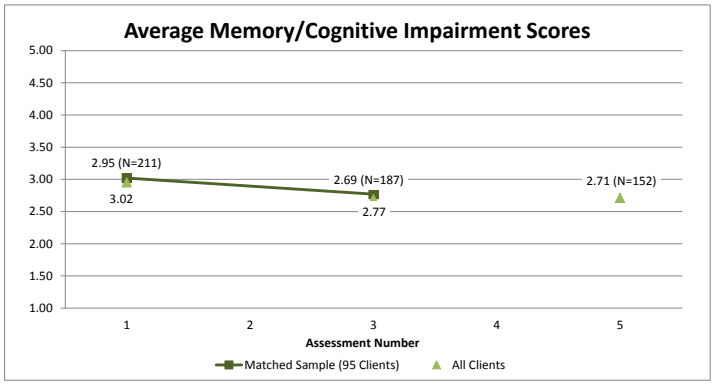
IMHT CHOIS Subscale Scores



Model level analyses use a matched sample of clients with CHOIS scores on the baseline, and six month assessments. For IMHT clients there were no significant changes on any of the CHOIS subscales from the baseline to the six month assessment.

Average scores for all IMHT clients at each assessment were comparable to the scores for clients with completed matched assessments as can be seen in the figures.





PROMIS-Derived Substance Use

The 12-item PROMIS-Derived Substance Use scale assesses clients' perceptions of the negative consequences of their alcohol and/ or substance use, including physical (e.g., dizziness), mental (e.g., risk taking, guilt), and social (e.g., others had trouble counting on me, substance use created problems between me and others) consequences. Item and total scale scores range from 1 to 5, with lower scores indicating fewer client-perceived negative consequences associated with alcohol and/or substance use. Paired with the information from the clinician completed IMR Substance Use items, clients responses on this measure can help clinicians encourage a therapeutic dialogue with the client about their substance use.

Clients who indicate on their Physical Health and Behaviors assessment that they have used alcohol, illegal drugs, or off-label prescription medications within the past six months complete the PROMIS-Derived Substance Use Scale at the baseline and semi-annual assessments.

St. Joseph/OPCC Substance Use Scores

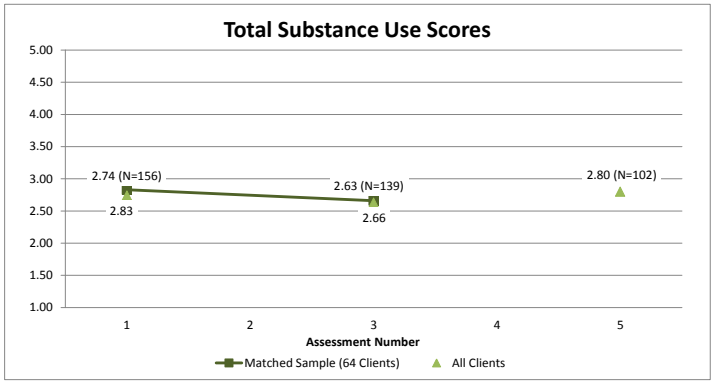
		Assessment Number			
ITEM #	PROMIS-Derived Substance Use	Baseline (All clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	I used substances (alcohol, illegal drugs) too much.	2.92	3.73	3.36	-0.37
2	I used alcohol or substances throughout the day.	3.16	3.91	2.90 (N=10)	-1.01
3	I had an urge to continue drinking or using substances once I started.	2.65	3.09	3.09	0.00
4	I felt that I should cut down on my alcohol or substance use.	3.03	3.36	3.64	0.28
5	I felt I needed help for my alcohol or substance use.	2.30	2.82	2.18	-0.64
6	I took risks when I used alcohol or substances.	2.42 (N=36)	3.00	2.27	-0.73
7	I felt guilty when I used alcohol or substances.	2.31 (N=36)	2.36	2.36	0.00
8	Others complained about my alcohol or substance use.	2.39 (N=36)	3.09	3.09	0.00
9	Alcohol or substance use created problems between me and others.	2.49	3.18	2.91	-0.27
10	Others had trouble counting on me when I used alcohol or substances.	2.30	2.64	2.18	-0.46
11	I felt dizzy after I used alcohol or substances.	2.30	2.64	2.18	-0.46
12	Alcohol or substance use made my physical or mental health symptoms worse.	2.68	3.45	2.73	-0.72
	Total Substance Use score *(mean of items 1 - 12)*	**2.58 (N=37)**	**3.11 (N=11)**	**2.76 (N=11)**	**-0.35**

The sample size for each Substance Use item corresponds with the reported sample size (N) in each column of the Total Substance Use score, unless otherwise reported.

IMHT Substance Use Scores

	Assessment Number		
PROMIS-Derived Substance Use	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)
Total Substance Use score *(mean of items 1 - 12)*	2.74 (N=156)	2.83 (N=64)	2.66 (N=64)

Model level analyses use a matched sample of clients with Substance Use scores on the baseline, and the six month assessment. For IMHT clients there was no significant change in scores from the baseline to the six month assessment. As clients continue to receive Innovation services, improvements may become significant.



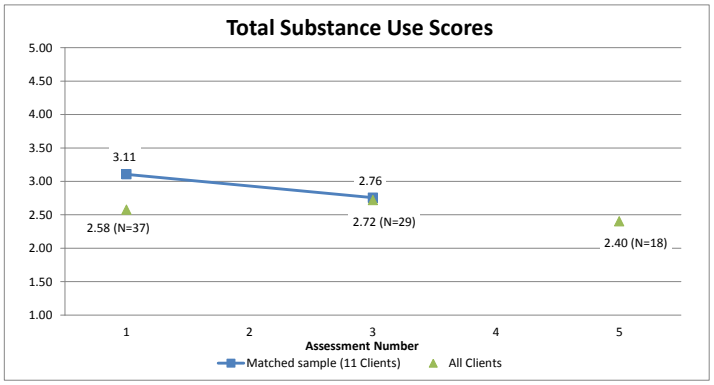
Do you smoke tobacco?			
	Not at all	Some days	Every day
Baseline (All clients N=205)	22.0%	12.2%	65.9%
Assessment 1 Matched Sample (91 clients)	17.6%	14.3%	68.1%
Assessment 3 Matched Sample (91 clients)	18.7%	23.1%	58.2%

Compared to baseline, there was a significant reduction in tobacco use at the six month assessment for IMHT clients.

St. Joseph/OPCC Substance Use Scores

On the baseline assessment, a majority of clients at St. Joseph/ OPCC reported that they had used alcohol (66.7%) and just under half reported using drugs (42.0%) within the previous six months. There were no significant changes in client-reported alcohol or drug use from the baseline to the six month assessment.

There were no significant changes in scores on the PROMIS-Derived Substance Use scale from the baseline to the six month assessment.



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
Baseline (All clients N=51)	33.3%	21.6%	11.8%	7.8%	25.5%
Assessment 1 Matched Sample (19 clients)	42.1%	21.1%	5.3%	5.3%	26.3%
Assessment 3 Matched Sample (19 clients)	31.6%	5.3%	31.6%	15.8%	15.8%

During the last 6 months, how often did you use an illegal drug or use a prescription medication for nonmedical reasons?					
	Never	Less than once a week	1-3 times per week	4 or more times per week	Every day
Baseline (All clients N=50)	58.0%	12.0%	12.0%	4.0%	14.0%
Assessment 1 Matched Sample (18 clients)	55.6%	5.6%	11.1%	5.6%	22.2%
Assessment 3 Matched Sample (18 clients)	77.8%	5.6%	5.6%	0.0%	11.1%

Do you smoke tobacco?			
	Not at all	Some days	Every day
Baseline (All clients N=50)	26.0%	12.0%	62.0%
Assessment 1 Matched Sample (19 clients)	31.6%	15.8%	52.6%
Assessment 3 Matched Sample (19 clients)	31.6%	21.1%	47.4%

Compared to baseline, there was no significant change in tobacco use at the six month assessment.

Physical Health and Behaviors

Clients completed the Physical Health and Behaviors Survey at the baseline and semi-annual assessments to measure health behaviors, including substance use, medication adherence, and exercise, service utilization including emergency room visits, hospitalizations, and previous experiences accessing care, and daily activities including housing situation, employment, volunteer activities and education.

St. Joseph/OPCC Physical Activity

At the baseline assessment, a majority of clients (78.4%) at St. Joseph/OPCC reported that they engaged in physical activity at least once during a typical week. There was no significant change in physical activity from the baseline to the six month assessment for clients who completed this item at baseline and at the six month assessment.

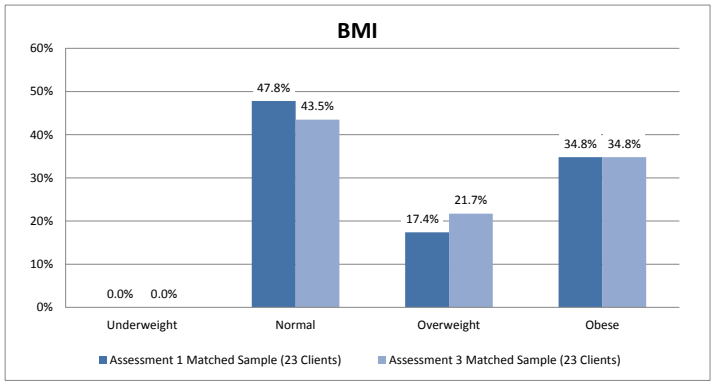
How many times in a usual week do you do 30 minutes of physical activity that increases your heart rate or makes you breathe harder than normal? (for example, walking or jogging, carrying light loads, bicycling, or playing sports)					
	None	1 time	2 times	3 times	4 or more times
Baseline (All clients N=51)	21.6%	9.8%	9.8%	9.8%	49.0%
Assessment 1 Matched Sample (17 clients)	23.5%	11.8%	5.9%	0.0%	58.8%
Assessment 3 Matched Sample (17 clients)	11.8%	17.6%	11.8%	29.4%	29.4%

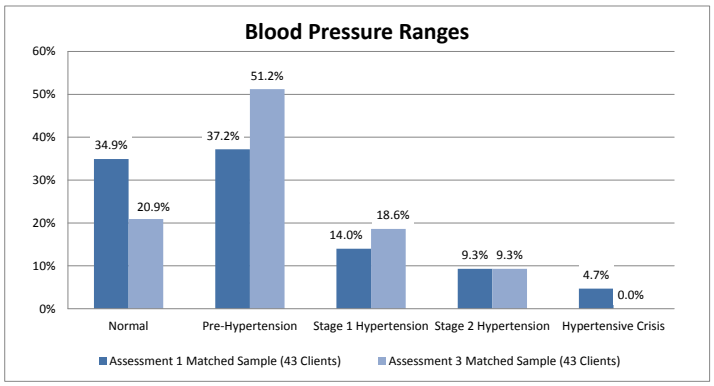
St. Joseph/OPCC Physical Health

The figure below shows the proportion of clients who were ever screened for each of the physical health conditions during the first twelve months of their enrollment in Innovation. The most common screening at St. Joseph/OPCC was for High Blood Pressure, followed by Diabetes, High Cholesterol, HIV, and other STDs. Clinicians indicated which screenings were completed on the Physical Health Indicators Survey, which was completed every six months.

Percentage of Clients who have ever been screened for:								
Diabetes	High Blood Pressure	Cholesterol	Asthma*	Emphysema*	Tuberculosis*	HIV	Hepatitis	Other STDs
63.6%	72.1%	60.5%	7.0%	23.3%	20.2%	58.9%	43.4%	58.9%

* Screening for Asthma, Emphysema, and Tuberculosis was only included on the baseline assessment.





Clinicians are asked to provide clients' height and weight on the Physical Health Indicators Survey, which are used to calculate Body Mass Index (BMI). BMI was categorized using the standard categories defined by the Centers for Disease Control and Prevention. There was no significant change in BMI from the baseline to the six month assessment.

Systolic and diastolic readings are combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. Blood pressure is only one indicator of risk; additional criteria must be met for a diagnosis of hypertension. There were no significant changes in risk for hypertension from the baseline to the six month assessment.

In the past month, how often did you take your medications as the doctor prescribed?					
	My doctor hasn't prescribed any	Less than half the time (<50%)	About half the time (50%)	Nearly all the time (75%)	All the time (100%)
Baseline (All clients N=49)	14.3%	4.1%	10.2%	32.7%	38.8%
Assessment 1 Matched Sample (18 clients)	16.7%	0.0%	5.6%	22.2%	55.6%
Assessment 3 Matched Sample (18 clients)	5.6%	11.1%	16.7%	5.6%	61.1%

Clients were asked how often they took their medications as prescribed. There have been no significant changes in medication adherence to date.

IMHT Physical Activity

At the baseline assessment, a majority of clients in the IMHT model (67.9%) reported that they engaged in physical activity at least once during a typical week. There was no significant change in physical activity from the baseline to the six month assessment for clients who completed this item at baseline and at the six month assessment.

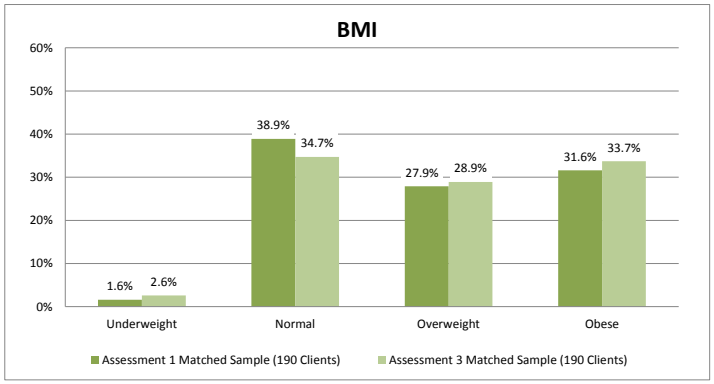
How many times in a usual week do you do 30 minutes of physical activity that increases your heart rate or makes you breathe harder than normal? (for example, walking or jogging, carrying light loads, bicycling, or playing sports)					
	None	1 time	2 times	3 times	4 or more times
Baseline (All clients N=215)	32.1%	7.9%	8.8%	11.6%	39.5%
Assessment 1 Matched Sample (92 clients)	28.3%	8.7%	7.6%	13.0%	42.4%
Assessment 3 Matched Sample (92 clients)	19.6%	17.4%	15.2%	17.4%	30.4%

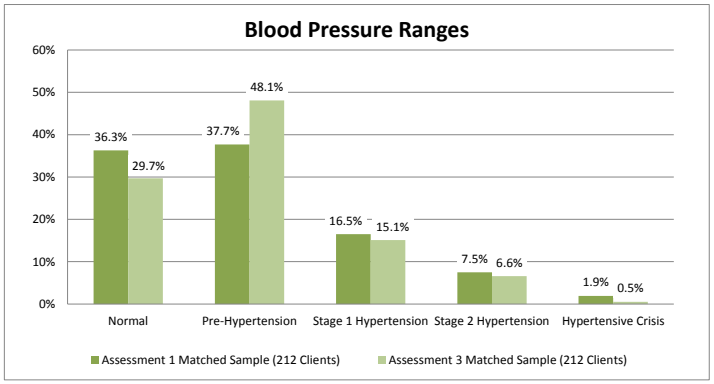
IMHT Physical Health

The figure below shows the proportion of clients who were ever screened for each of the physical health conditions during the first twelve months of their enrollment in Innovation. Within the first year of receiving Innovation services, IMHT clients were most likely to be screened for Diabetes, High Blood Pressure, High Cholesterol, HIV, Hepatitis and other STDs.

Percentage of Clients at 12 Months who have EVER been Screened For:								
Diabetes	High Blood Pressure	Cholesterol	Asthma*	Emphysema*	Tuberculosis*	HIV	Hepatitis	Other STDs
57.9%	70.6%	56.8%	10.8%	16.0%	21.1%	54.4%	45.4%	51.9%

* Screening for Asthma, Emphysema, and Tuberculosis was only included on the baseline assessment.





Clinicians are asked to provide clients' height and weight on the Physical Health Indicators Survey, which are used to calculate Body Mass Index (BMI). BMI was categorized using the standard categories defined by the Centers for Disease Control and Prevention. There were no significant changes in BMI for IMHT clients from the baseline to the six month assessment.

Systolic and diastolic readings are combined into a single indicator of risk for hypertension using the categories defined by the American Heart Association. Blood pressure is only one indicator of risk; additional criteria must be met for a diagnosis of hypertension. There were no significant changes in risk for hypertension from the baseline to the six month assessment.

In the past month, how often did you take your medications as the doctor prescribed?					
	My doctor hasn't prescribed any	Less than half the time (<50%)	About half the time (50%)	Nearly all the time (75%)	All the time (100%)
Baseline (All clients N=206)	16.0%	11.7%	11.7%	26.7%	34.0%
Assessment 1 Matched Sample (92 clients)	16.3%	13.0%	12.0%	22.8%	35.9%
Assessment 3 Matched Sample (92 clients)	7.6%	8.7%	17.4%	30.4%	35.9%

Clients were asked how often they took their medications as prescribed. There have been no significant changes in medication adherence to date, however more clients reported that they were taking doctor-prescribed medication at the six month assessment.

IMHT Service Utilization

Model level analyses use a matched sample of clients who completed service utilization items on the baseline, and the six month assessment. There was a significant reduction in the mean frequency of emergency room visits from baseline to the six month assessment for IMHT clients. There was no significant change in the frequency of hospital admissions.

In the past 6 months...	None	1-3 times	4-6 times	7-10 times	More than 10 times
how many times did you go to an emergency room?					
Baseline (All clients N=212)	30.2%	47.6%	14.6%	3.8%	3.8%
Assessment 1 Matched Sample (94 clients)	35.1%	42.6%	13.8%	4.3%	4.3%
Assessment 3 Matched Sample (94 clients)	44.7%	39.4%	11.7%	1.1%	3.2%
how many times were you admitted to a hospital?					
Baseline (All clients N=211)	52.1%	35.1%	8.5%	2.8%	1.4%
Assessment 1 Matched Sample (95 clients)	57.9%	31.6%	6.3%	2.1%	2.1%
Assessment 3 Matched Sample (95 clients)	64.2%	25.3%	8.4%	1.1%	1.1%

St. Joseph/OPCC Service Utilization

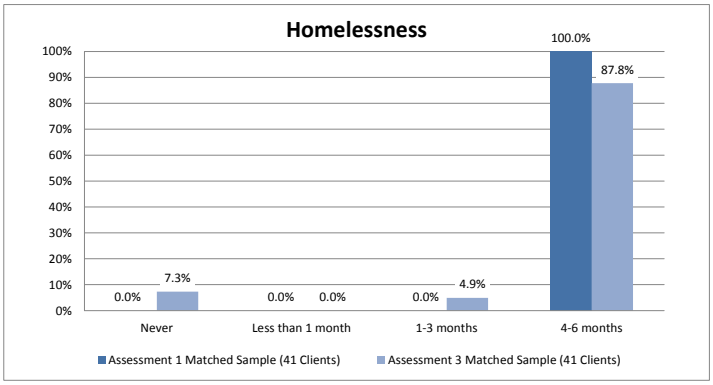
Provider level analyses use a matched sample of clients with completed service utilization items at both the baseline and six month assessments. At the baseline assessment, a majority of clients at St. Joseph/OPCC reported that they had visited an emergency room (74.0%) and close to half had been hospitalized (48.0%) at least once in the prior six months. There were no significant changes in service utilization from the baseline to the six month assessment.

In the past 6 months...	None	1-3 times	4-6 times	7-10 times	More than 10 times
how many times did you go to an emergency room?					
Baseline (All clients N=50)	26.0%	52.0%	20.0%	0.0%	2.0%
Assessment 1 Matched Sample (19 clients)	21.1%	52.6%	21.1%	0.0%	5.3%
Assessment 3 Matched Sample (19 clients)	47.4%	31.6%	21.1%	0.0%	0.0%
how many times were you admitted to a hospital?					
Baseline (All clients N=50)	52.0%	38.0%	4.0%	4.0%	2.0%
Assessment 1 Matched Sample (19 clients)	63.2%	31.6%	0.0%	0.0%	5.3%
Assessment 3 Matched Sample (19 clients)	63.2%	26.3%	10.5%	0.0%	0.0%

St. Joseph/OPCC Homelessness and Incarcerations

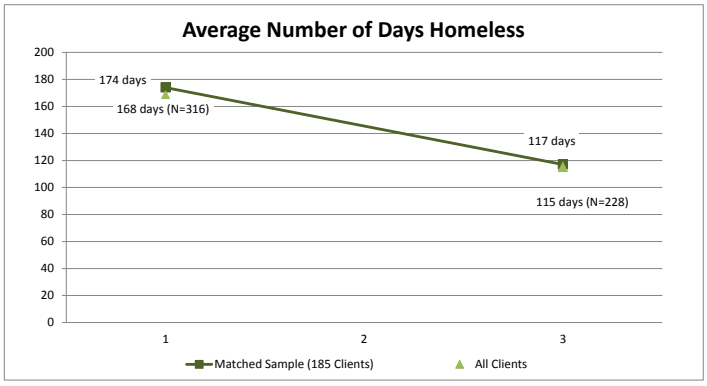
Upon enrolling in the Innovation program, 67.4% of St. Joseph/OPCC clients reported that they had not been incarcerated within the previous six months. There was no significant change in the frequency of incarcerations from the baseline to the six month assessment.

In 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
Baseline (All clients N=43)	67.4%	27.9%	0.0%	2.3%	2.3%
Assessment 1 Matched Sample (17 clients)	76.5%	17.6%	0.0%	0.0%	5.9%
Assessment 3 Matched Sample (17 clients)	88.2%	5.9%	5.9%	0.0%	0.0%

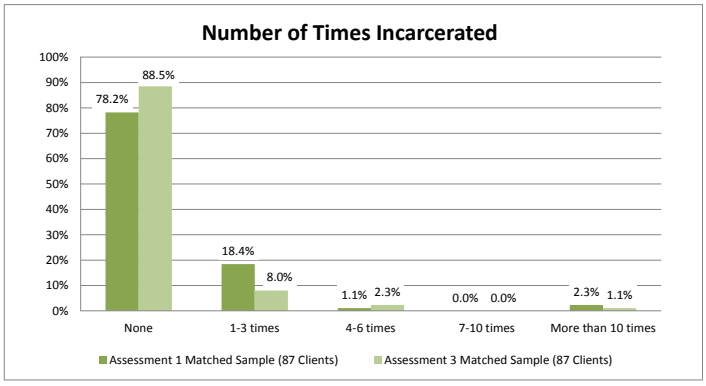


Providers were asked how many days each client had been homeless in the previous six months. At baseline, all of the clients had been homeless during the previous six months. St. Joseph/OPCC clients had been homeless for significantly less time over the previous six months at the six month assessment compared with the baseline.

IMHT Homelessness and Incarcerations



For IMHT clients with matched baseline and six month assessments, there was a significant reduction in the number of days homeless in the previous six months from the baseline to the six month assessment.



There was no significant change in the frequency of incarcerations for IMHT clients from the baseline to the six month assessment. However, a greater number of clients reported that they had not been incarcerated in the previous six months at the six month assessment.

Internalized Stigma Mental Illness (ISMI)

The 10-item Internalized Stigma of Mental Illness (ISMI) scale assesses client-reported experiences with stigma and common stereotypes about mental illness, social withdrawal behaviors, as well as the ability to resist or be unaffected by internalized stigma. ISMI items and total scale scores range from 1 (Strongly Disagree) to 4 (Strongly Agree), with lower scores representing decreased stigma. ISMI scale scores are categorized into four levels of stigma: minimal to no internalized stigma, mild internalized stigma, moderate internalized stigma, and severe internalized stigma.

The ISMI is completed by all clients at the baseline assessment to assess existing experiences of stigma prior to joining Innovation. A random sample of clients also completes the ISMI at the semi-annual assessments.

St. Joseph/OPCC ISMI Scores by Item

		Assessment Number			
ITEM #	Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
1	Mentally ill people tend to be violent.	2.76 (N=21)	2.57	2.71	0.14
2	People with mental illness make important contributions to society.	2.59	2.14	2.14	0.00
3	I don't socialize as much as I used to because my mental illness might make me look or behave "weird".	2.36	2.14	2.43	0.29
4	Having a mental illness has spoiled my life.	2.85 (N=20)	2.43	2.29	-0.14
5	I stay away from social situations in order to protect my family or friends from embarrassment.	2.41	2.43	2.29	-0.14
6	People without mental illness could not possibly understand me.	2.40 (N=20)	2.29	2.29	0.00
7	People ignore me or take me less seriously just because I have a mental illness.	2.82	2.86	2.57	-0.29
8	I can't contribute anything to society because I have a mental illness.	1.95 (N=21)	1.57	1.57	0.00
9	I can have a good, fulfilling life, despite my mental illness.	2.24 (N=21)	2.14	2.00	-0.14
10	Others think that I can't achieve much in life because I have a mental illness.	2.90 (N=21)	3.14	2.71	-0.43
	Total Mental Illness Stigma score *(mean of items 1 - 10)*	**2.53 (N=22)**	**2.37 (N=7)**	**2.30 (N=7)**	**-0.07**

The sample size for each ISMI item corresponds with the reported sample size (N) in each column of the Total Mental Illness Stigma score, unless otherwise reported.

At the baseline assessment, a majority of clients at St. Joseph/OPCC reported experiencing mild internalized stigma. There was no significant change in ISMI scores from the baseline to the six month assessment.

	Assessment Number			
Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
Minimal to no internalized stigma	9.1% (N=2)	0.0%	28.6% (N=2)	28.6%
Mild internalized stigma	54.5% (N=12)	85.7% (N=6)	42.9% (N=3)	-42.8%
Moderate internalized stigma	22.7% (N=5)	14.3% (N=1)	28.6% (N=2)	14.3%
Severe internalized stigma	13.6% (N=3)	0.0%	0.0%	0.0%

IMHT ISMI Scores

	Assessment Number			
Internalized Stigma of Mental Illness (ISMI)	Baseline (All Clients)	Assessment 1 (Matched Sample)	Assessment 3 (Matched Sample)	Change between Assessments 1 and 3
Minimal to no internalized stigma	17.9%	29.6%	29.6%	0.0%
Mild internalized stigma	40.6%	51.9%	55.6%	3.7%
Moderate internalized stigma	31.1%	18.5%	14.8%	-3.7%
Severe internalized stigma	10.4%	0.0%	0.0%	0.0%
Total Mental Illness Stigma score *(mean of items 1 - 10)*	**2.48 (N=106)**	**2.26 (N=27)**	**2.22 (N=27)**	**-0.04**

For IMHT clients with matched baseline and six month ISMI ratings, there was no significant change in total ISMI score from the baseline to the six month assessment.