OMA NEWSLETTER

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Los Angeles was among four counties selected for an audit of Mental Health Services Act (MHSA) planning, implementation, and outcomes. Specifically, over nine months the audit focused on the following objectives:

- Review and assess the method each county used to establish performance measures and outcomes and evaluate the reasonableness of the methods used to obtain and analyze data.
- Identify key performance measures and outcomes achieved.
- Review and assess the extent to which each county used performance measures and outcomes to improve local mental health systems.
- Identify the types of services provided within each MHSA component.
- Determine the extent to which each county's plan aligned with the services provided and expenditures incurred.
- Determine the degree to which each county employed a stakeholder process consistent with the law when developing its county plan.
- Determine whether MHSA expenditures were allowable and reasonable.

Of the counties audited, Los Angeles was the only county who had no negative findings or recommendations for improvement. In fact, the California State Auditor acknowledged our extensive process of evaluating our programs.

The audit highlighted the extensive efforts Los Angeles County has undergone to create a stakeholder-informed planning process and the time and resources placed into defining programs, provider technical assistance and program monitoring, as well as the tireless efforts of program and information technology staff who have worked continuously since 2006 to develop and refine the Outcome Measures Application (OMA).

As a result of the MHSA Audit, there has been interest across the State in understanding the protocols the Los Angeles County Department of Mental Health has put in place to define MHSA programs and services, establish program expectations and identify, measure and report on outcomes. An anticipated goal of this interest is to create a statewide approach to service delivery and the evaluation of MHSA programs that allows for flexibility related to county economy of scale that is driven by counties and supported by State entities such as the Mental Health Services Oversight and Accountability Commission and the Department of Health Care Services.

The lack of findings and recommendations for Los Angeles County is attributable to the leadership at many levels that supports and cultivates inclusiveness, learning and accountability. Without these values, the resources dedicated to our work would not and will not result in quality services that improve the lives of the clients we serve in the public mental health system.

Debbie Innes-Gomberg, Ph.D.
District Chief, MHSA Implementation & Outcomes Division, Program Support Bureau, County of Los Angeles, Department of Mental Health

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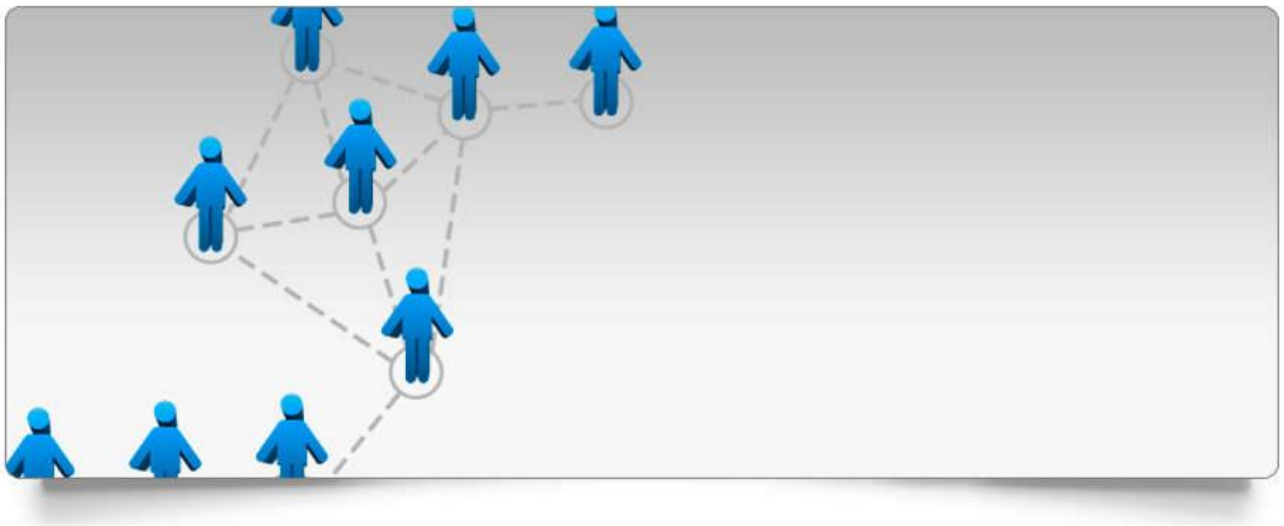
Kara's Corner

Autumn is the season for change and we are definitely in tune with the season. The kids have gone back to school, summer-lite traffic on the freeways is gone, meetings are back in full swing, and a lot of planning, planning, and more planning is happening. I'm not sure how all of you are feeling, but it feels like we are in a whirlwind, preparing for huge changes quickly approaching. Our unit is in the process of planning for major changes to the Outcome Measures Application (OMA) that we use for Full Service Partnership (FSP) and Field Capable Clinical Services (FCCS). We are also preparing to take over data collection from California Institute for Mental Health (CiMH) for Managing and Adapting Practice (MAP), Trauma Focused Cognitive Behavior Therapy (TF-CBT), and Positive Parenting Program (Triple P) for Prevention and Early Intervention (PEI). We continue to plan for increased access to reports and electronic submission of outcomes data into OMA and PEI OMA. On a much larger scale, DMH has also been planning for the transition to our own electronic health record and new claiming system called IBHIS, the Integrated Behavioral Health Information System. And of the course, the biggest change our whole system is planning for is health care reform including new and innovative ways to competitively provide high quality, efficient yet effective mental health services under the Affordable Care Act.

As we brace ourselves for all the impending changes, I hope you all find a way to provide input to assist in the creation of an improved system. Undoubtedly there will be something or someone who will be left out, something no one thought about, or someone will always come forward who said they could have done it better, so I encourage you to get involved to ensure your voice is heard. Since this is our last newsletter before the end of the year, I hope you all have a wonderful time creating special memories with families and friends over the holidays.

What is IFCCS?



Intensive Field Capable Clinical Service (IFCCS) is a new program that was launched on June 1, 2013, and is based on Los Angeles County's Shared Core Practice Model. It is intended to expedite Katie A. Subclass members' access to Medi-Cal services, including new services called Intensive Home Based Services (IHBS) and Intensive Care Coordination (ICC). Katie A. Subclass members are DCFS children and youth who are in need of intensive mental health services, often in programs like Wraparound, Treatment Foster Care, D-Rate homes, psychiatric hospitals, and residential treatment centers, as well as children/youth who frequently move between different placements due to their behavioral health needs.

Children/Youth (ages birth to 15-years-old) are referred from one of four "hot spot" locations, as these locations often come into contact with our most high-need clients. Children referred from Exodus Recovery Urgent Care Centers (UCCs) or the Emergency Response Command Post, as well as children discharging from Psychiatric Hospitalizations, or those that come into contact with the DMH Field Response Operation Team receive immediate access to ICC, which includes targeted case management through a child and family team process. The team is responsible for continually identifying and engaging all appropriate members of the team (including natural supports), coordinating care, and linking the child/youth and family to identified resources. The team is also responsible for examining the client's underlying needs and provides a full range of services, as well as community resources to meet those needs. Along with ICC, IFCCS providers provide IHBS. These are rehabilitative services that are strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth's functioning and are aimed at building skills to increase success in the home and in the community.

Services are delivered countywide, which means that service providers are expected to move with children/youth throughout Los Angeles County if they experience placement disruptions. IFCCS providers respond with a face to face contact with the client within 24 hours of receiving the referral. Services are provided whenever they are needed 24 hours a day, 7 days a week and the child/youth does not have to have an identified placement to start receiving services. To evaluate the effectiveness of the program, we collect outcome measures for children and youth enrolled in the program. Specifically, we use the Youth Outcome Questionnaires and the Outcome Measures Application Form for FCCS.

For more information about IFCCS, contact Kaliah Salas: gsalas@dmh.lacounty.gov

Provider Roster

If you are working on a client whose outcomes are still being held and worked on by another provider, you need to contact that other provider to coordinate services with them. We've created a new Provider Roster to help you find those staff members you need to talk to.

You can see the latest version of the Provider Roster on the wiki, right here:

http://dmhoma.pbworks.com/w/page/68140239/Provider%20Roster

We're hoping to keep the Roster up-to-date with the changes in staff. If you haven't already sent in your information, or if you need to add or change it, please follow this link to our simple Provider Roster form.

https://docs.google.com/forms/d/1ltm1DuZ5L0yQ3DtMe2UI925isjBSAZfG2XjG5SzNpTs/viewform

Don't Double Click!

When you open a program in Windows, what do you do?

click *click*

Right? Well, a double click on the mouse in the OMA or the PEI OMA is not necessary. In fact, it can be harmful. Sometimes, if you're fast enough on the double click, you can accidentally create extra programs or extra assessments.

In some cases, these extra assessments will be deleted overnight when OMA or PEI OMA reloads the data overnight. In some cases, you're going to find yourself stuck with errors that will prevent you from doing any data entry on that client. Programs, in particular, have caused people a lot of problems: duplicate programs mean that you need the MHSA staff to delete a program before you can do anything.

So remember: OMA and PEI OMA are SINGLE CLICK programs. Don't Double Click, or you might end up stuck!

Coming Up…

OMA Forms and Hands-On Trainings are available to all OMA users. We recommend you attend training if your last training was more than two years ago because the system is constantly changing. Visit OMA Wiki for a schedule of trainings: http://dmhoma.pbworks.com

OMA Users' Group is for our providers. Take advantage of this opportunity to dialogue with DMH folks about OMA issues. Next meeting: Wed, November 20, 2013, from 10:00 – 11:30 a.m. at 695 S. Vermont Ave, 15th Floor Glass Conference Room, L.A., 90005. To participate via Webinar, email John Flynn: jflynn@dmh.lacounty.gov

OMA Lab is open to all OMA users who want one-on-one assistance from the data team to tackle some of your pending Data Change/Deletion Requests. Offered every other Monday from 10am–Noon. Next OMA lab: November 4, 2013. Space is limited. Please RSVP with John Flynn: jflynn@dmh.lacounty.gov

PEI Outcomes Questionnaire and Data Entry Trainings are available to all PEI providers. Training schedules are posted on the PEI page of the OMA Wiki.

Staff Feature: George Eckart

Describe what you do in the Implementation and Outcomes Division. I do a little bit of everything in our Division. My main responsibilities include training providers in the use of outcome measures (specifically the PTSD-RI, GAD-7 & the DERS) and analyzing outcome data for use by providers and Administration. I also really enjoyed being part of the PEI Technical Assistance team. It was privilege meeting so many dedicated staff around the County and playing a small role in assisting providers with PEI implementation and the use of outcomes.

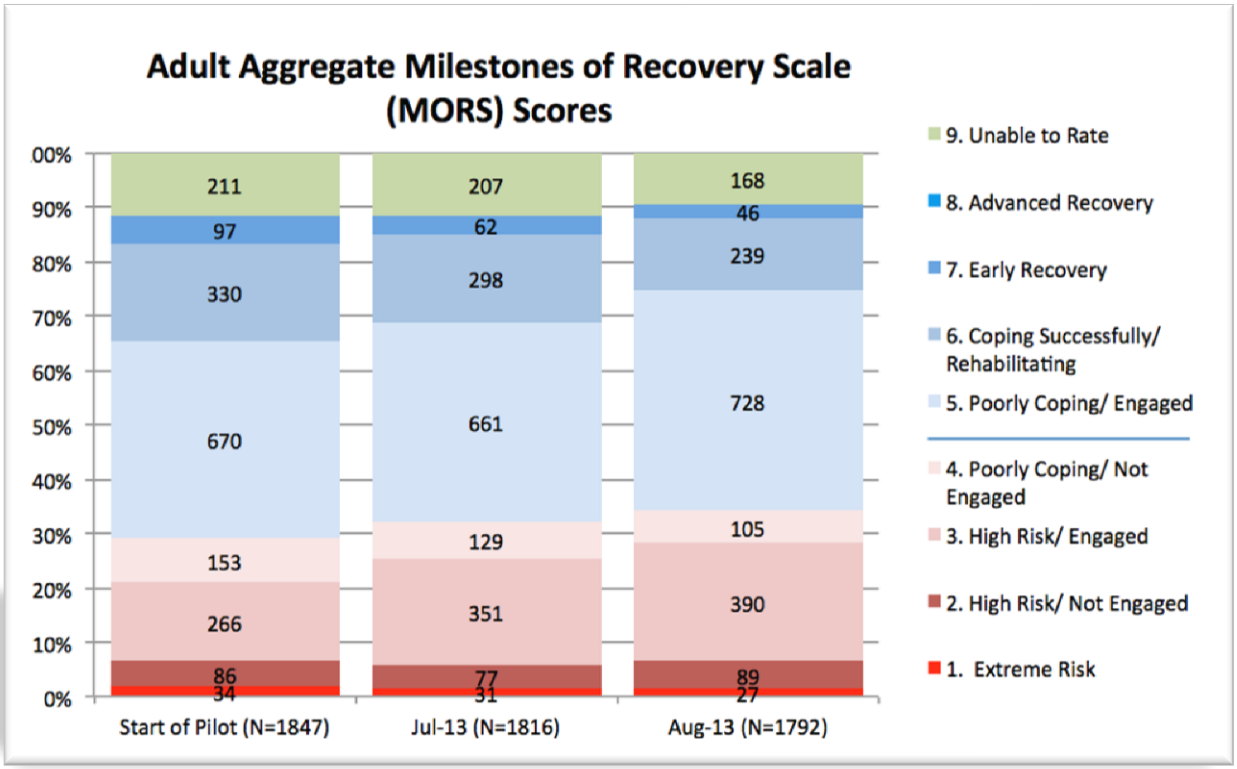
Some of us know that you didn't always work in the field of mental health, rather you worked in radio. Can you talk a little about your career in radio and how you made your way to mental health? I have enjoyed three great epochs in my life with each associated with a particular career focus. For about 12 years, I pursued a career in radio broadcasting. I actually worked for 5 radio stations as on-air announcer and production specialist. My second epoch was marked by my involvement in the church. I attended seminary and worked as a self-supporting lay-leader (non-ordained minister) in a couple of fellowships in Southern California. I began graduate study in Psychology in 1989 and eventually earned my Ph.D. in 1995. I worked in a county contract agency for 15 years before coming to DMH. I may have just enough time for one more "great career epoch" in the future.

We also know that you have an interesting collection of gadgets and some other fun stuff. Can you talk a little about your interests and hobbies? I find almost everything fascinating! I especially love gadgets of an electronic nature. I am a licensed Ham radio operator (No, it's not the same thing as Citizen's Band) and have been part of a Disaster Communications team with the LA County Sheriff's Department in the past. My wife and I keep tabs on our cat via a Cat-Cam we set up 8 months ago. Now, we can occasionally "tune-in" and see what she is up to. Scary! I love photography, the "paranormal," neuroscience and any gadget that purports to connect with these things. I also have interest in primitive things…like traditional archery (think Robin Hood without the tights). I have crafted my own bows, arrows and leather good. I also enjoy camping and fishing and can throw a tomahawk fairly well.

What are some things you would like to accomplish in your lifetime? I would love to fly ultra-light aircraft, drive a Harley and write at least one book. Unfortunately, my wife frowns on the first two (she thinks these things may be too dangerous for me). I would also like to learn more about wine and explore Alaska.

What are five things you can't live without and why? (1) Jesus Christ for obvious reasons. (2) My wife who loves me more than I thought possible. (3) My curiosity, which continually drives me to learn more about this fascinating world and the people in it. (4) My friends who keep me grounded (the cat fits in here some place). (5) "Pizza Fridays" have become the perfect way to end a busy week.

Tell us three random facts about yourself. (1) Breakfast is my favorite meal. (2) I am a long-time dog lover who has found a place in my heart for cats. Our cat Sasha remarkably allows me to recline beneath her after dinner every night! So she thinks! (3) I love University of Illinois sports. Unfortunately, football and the Illini do not often go together. Yes, we have been that bad for a very long time.



In July of 2013 a new Full Service Partnership (FSP) Integration Pilot was launched involving five legal entities for Adult FSP, one Adult Directly Operated FSP, and one legal entity for Older Adult FSP. The Pilot is a new approach that allows for expanded FSP enrollment criteria, has a new notification process, and features closer tracking of client recovery and level of service. The purpose of the FSP Integration Pilot is to increase the number of clients served, increase the number of clients discharged from/transitioned out of public, county mental health system with adequate supports, optimize length of enrollment for clients in different phases of recovery, and advance clients' progress through phases of recovery during service. As part of the evaluation of the pilot a dashboard has been created and will be reviewed and discussed on a monthly basis for the duration of the pilot. The following metrics are being collected and reported monthly in the dashboard:

- Number of new clients enrolled
- Focal Population and Ethnicity of current enrollees
- Aggregated Milestones of Recovery Scale (MORS) Scores for all clients at the start of the pilot and monthly
- Aggregated Client Level of Service profiles for each provider
- Monthly Employment status and Residential Status for clients
- Number of Disenrollments sorted by reason for disenrollment

Data from the dashboard will be used to evaluate Pilot objectives and increase data-informed decision-making and improve service quality that should result in increased access and capacity of FSP programs.