SAMHSA-HRSA
Center for Integrated Health Solutions

PBHCI Quarterly Evaluator Webinar
Friday, November 16, 2012

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Overview of Webinar

- Poll questions
- Using data to measure the effectiveness of your PBHCI program
- Using data to measure and monitor the health status of individuals and groups of clients
- Grantee example of using data to inform administrative, clinical and consumer indicators

Asking a Question

Questions typed in the question box will be answered after each speaker

Performance Measurement

Performance measurement indicators address how service delivery responds to the needs of the persons served in an integrated/holistic manner (CARF)

Performance Measurement

When collecting data…..

- Consider your purpose
  - Internal QI
  - Accountability to SAMHSA or others
  - Benchmarking
  - Accreditation

Choose metrics that…

- Help you meet your needs
  - Feasible, reliable, informative, already being collected/required by funder or accrediting body
- Result in a balanced portfolio
  - Structure, process, outcome

So many metrics to choose from!

- **Multiple domains**
  - Structural measures
  - Process measures
  - Outcome measures
    - Medical status
    - Behavioral status
  - Real life functional outcomes for persons served
  - Perception of care from the perspective of the person served

- **RAND selection criteria**
  - Clearly operationalized
  - NQF-endorsed (where possible)
  - Reportable using PBHCI data (where possible)

NQF = National Quality Forum

RAND-Selected Domains

- **Structure**: Systems supporting integrated care
- **Process**:
  - Practices supporting integrated care
  - Quality of clinical care
    - Medical status; Behavioral status
- **Intermediate outcomes:** Preliminary indicators of changes in chronic conditions
- **Patient experience:** Perception of care from the perspective of the person served

STRUCTURE

Structure of Integrated Care

- Cross-training for the most common chronic medical and behavioral illnesses prevalent in the population served (CARF)
- Policies regarding initial consent for treatment identify how information will be internally shared, how information is shared by collaborating agencies, the ability of the person served to decline services, the procedures to follow if services are declined (CARF)

http://www.carf.org/healthhomestandards/

PROCESS

Clinical Measures – Medical Status

	NQF Endorsed	PBHCI Data Supported
Screening and Prevention		
Patients identified as **tobacco** users who received cessation intervention during the two-year measurement period (PCPI)	X	X
Diabetes		
Patients with **hemoglobin A1c** (HbA1c) test during the measurement year (NCQA)	X	X
Hypertension		
Patients with a diagnosis of hypertension and whose **blood pressure** (BP) was adequately controlled (BP ≤ 140/90 mmHg) during the measurement year (NCQA)	X	X

Clinical Measures – Behavioral Status

	NQF Endorsed	PBHCI Data Supported
Substance Use		
Engagement in AOD Treatment: Patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit (NCQA)	X	X
Schizophrenia		
Emergency department utilization for mental health conditions for people with schizophrenia (NCQA)	Under consideration	
Depression		
Percentage of patients presenting with depression who were assessed, prior to the initiation of treatment, for the presence of prior or current symptoms and/or behaviors associated with mania or hypomania (CQAIMH)	X	

Clinical Measures - Behavioral Status

	NQF Endorsed	PBHCI Data Supported
Bipolar Disorder		
Percentage of patients with bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide (CQAIMH)	X	
Non-Condition Specific		
Rate of re-admissions to psychiatric hospitals within 30 or 180 days (NOMS)		X

Clinical Measures Resources

- CQAIMH-Center for Quality Assessment and Improvement in Mental Health
- CMS-Centers for Medicare and Medicaid Services
- MCM-Minnesota Community Measurement
- NCQA-National Committee for Quality Assurance
- NOMS-National Outcomes Measurement Set
- PCPI-Physician Consortium for Performance Improvement
- CARF-Commission on the Accreditation of Rehabilitation Facilities

Process

General Program Quality

- Length of time to schedule first appointment (CHCS)

Integrated Care Quality

- % community mental health center patients w/ an annual physical exam (Druss et al., 2001)

INTERMEDIATE OUTCOMES

Intermediate Outcomes

Medical Status

- % diabetic patients whose blood pressure reading is < 130/80 mm/Hg (NCQA)

Behavioral Status

- % of depressed patients who have reached remission at 6 months (+/- 30 days) after initiating treatment (i.e., PHQ-9 score <5) (MCM)

PATIENT EXPERIENCE

Patient Experience

- Proportion of families who report that **services/supports are available when needed**, even in a crisis (CHCS)
- % Consumer/Pts reporting that their **care managers are knowledgeable and competent** (CHCS)

Summary

- Choose metrics that **help you meet your needs**
  - Feasible, reliable, informative, meaningful to clinical staff
- Best measures portfolios are **balanced** across structure, process, outcome
  - Specific measures for most important concepts (e.g., integration)
- Performance measurement **promotes quality care**
  - Help you to more efficiently and effectively meet your program goals!

USING DATA TO INFORM CLIENT CARE FROM THE GRANTEE'S PERSPECTIVE

Laura Jacobus-Kantor, Ph.D.
Senior Research Scientist
NORC at the University of Chicago

Project Overview

- HIP (Health Integration Project)
- Family Services Inc. Gaithersburg, MD
- Strategic Partners: Threshold Services Inc. and CCI
- Approximately 525 clients served to date
- Approximately 50% have community-based PCPs
- Reassessment rate at end of FY 2012: 88%

Evaluation Overview

Our evaluation includes all SAMHSA-required data and additional data such as:

- alcohol use
- drug use
- self-reported health information using the SF-36

Mechanical health data is also collected during interim three-month appointments.

Evaluation Overview

Use of data to support CQI – Continuous Quality Improvement.

Use of data to:

- Monitor client/program progress
- Target interventions to specific sub-groups of clients
- Provide meaningful feedback to providers, clients and partners.

Evaluation Overview

- Most of our evaluations will have sufficient power to detect change.
- The biggest threat to evaluation efforts may be missing data.
- Requires an ongoing monitoring of data to ensure that information is being collected and clients are receiving needed clinical care.
- Can be accomplished in many ways, we are using an Access database and related queries/reports.

Access Database - Overview

Baseline Health

TRAC ID	Name	PCP	DOB	BL Visit Date	BL Height	BL Weight	BL Waist	BL BP Systolic	BL BP Diastolic	BL Lab Date
FS0001	Amanda	Dr. Jones	1/1/1950	2/1/2011	62	155	84	120	80	2/5/201
FS0002	Betty	Dr. Kitson	2/2/1951	2/1/2011	61	145	82	125	90	2/7/201
FS0003	Cathy	Dr. Currin	3/3/1952	2/2/2011	60	180	90	127	100	2/7/201
FS0004	Debra	Dr. Pina	4/4/1953	2/4/2011	54	175	90	130	90	
FS0005	Elizabeth	Dr. Winger	5/5/1954	2/5/2011	53	155	85	128	110	3/1/201
FS0006	Frank	Dr. Miller	6/6/1955	2/7/2011	72	245	120	160	120	2/15/201
Fs0007	Gerry	Dr. Hernandez	7/7/1956	2/15/2011	64	260	125	140	110	2/15/201
FS0008	Henry	Dr. Currin	8/8/1957	2/17/2011	70	255	130	135	100	
FS0009	Isabel	Dr. Duffy	9/9/1958	2/19/2011	66	180	100	135	90	2/20/201
FS0010	Jane	Dr Levinson	10/10/1959	2/22/2011	67	174	94	142	100	3/1/201
FS0011	Kate	Dr. Hyde	11/11/1960	2/23/2011	70	166	93	137	91	3/2/201
FS0012	Linda	Dr. Jones	12/12/1961	3/1/2011	64	156	85	120	90	3/20/201
FS0013	Mandy	Dr. Winger	1/1/1962	3/2/2011	63	167	87	120	90	
FS0014	Noah	Dr. Duncan	2/2/1963	3/4/2011	69	199	92	125	100	3/7/201
FS0015	Odessa	Dr. Leo	3/3/1964	3/7/2011	59	310	130	127	90	3/7/201
FS0016	Penelope	Dr. Kitson	4/4/1965	3/9/2011	56	298	105	130	110	3/15/201
FS0017	Quinn	Dr. Bergman	5/5/1966	3/12/2011	58	168	91	120	80	3/15/201
FS0018	Rachel	Dr. Hernandez	6/6/1967	3/15/2011	64	254	107	135	90	3/15/201
FS0019	Steven	Dr. Levinson	7/7/1968	3/17/2011	70	274	110	110	90	3/19/201
FS0020	Timothy	Dr. Jones	8/8/1969	3/19/2011	75	244	115	127	100	3/22/201
FS0021	Ulysses	Dr. Duncan	9/9/1970	3/19/2011	56	265	117	140	110	
FS0022	Veronica	Dr. Hyde	10/10/1971	3/21/2011	58	210	95	137	109	3/25/201
FS0023	Wendy	Dr. Pina	11/11/1972	3/22/2011	59	285	109	130	90	3/22/201
FS0024	Xander	Dr. Miller	12/12/1973	3/24/2011	74	285	120	150	120	3/27/201
FS0025	Yolanda	Dr. Jones	1/1/1974	4/2/2011	58	235	117	140	110	4/5/201
FS0026	Zev	Dr. Currin	2/2/1975	4/5/2011	72	300	126	135	95	5/1/201

Reporting – Missing Reassessmen

Missing Reassessments

TRAC ID	Client Name	Location	Therapist	Reassessment Due	Due Date	Last Day to Complete
FS0002	Betty	Threshold	Dr. Miller	9 Month Reassessment	10/15/2012	11/14/2012
FS0003	Cathy	Threshold	Dr. Green	12 Month Reassessment	10/20/2012	11/19/2012
Fs0007	Gerry	Threshold	Dr. Miller	15 Month Reassessment	10/25/2012	11/24/2012
FS0008	Henry	Threshold	Dr. Levin	24 Month Reassessment	11/27/2012	11/26/2012
FS0017	Quinn	Threshold	Dr. Levin	18 Month Reassessment	11/8/2012	12/8/2012
FS0019	Steven	Threshold	Dr. Miller	12 Month Reassessment	11/9/2012	12/9/2012
FS0020	Timothy	Threshold	Dr. Levin	15 Month Reassessment	11/14/2012	12/14/2012
FS0023	Wendy	Threshold	Dr. Saslow	6 Month Reassessment	11/18/2012	12/18/2012
FS0024	Xander	Threshold	Dr. Patel	24 Month Reassessment	11/19/2012	12/19/2012
FS0026	Zev	Threshold	Dr. Patel	18 Month Reassessment	11/23/2012	12/23/2012
FS0001	Amanda	Family Services	Dr. Jones	6 Month Reassessment	10/14/2012	11/13/2012
FS0005	Elizabeth	Family Services	Dr. Patel	6 Month Reassessment	10/22/2012	11/21/2012
FS0006	Frank	Family Services	Dr. Jones	9 Month Reassessment	10/24/2012	11/23/2012
FS0013	Mandy	Family Services	Dr. White	6 Month Reassessment	10/29/2012	11/28/2012
FS0014	Noah	Family Services	Dr. Jones	12 Month Reassessment	11/1/2012	12/01/2012
FS0015	Odessa	Family Services	Dr. Jones	18 Month Reassessment	11/1/2012	12/1/2012
FS0016	Penelope	Family Services	Dr. Gabbidon	24 Month Reassessment	11/5/2012	12/5/2012
FS0021	Ulysses	Family Services	Dr. Patel	18 Month Reassessment	11/15/2012	12/15/2012
FS0022	Veronica	Family Services	Dr. Jones	15 Month Reassessment	11/17/2012	12/17/2012
FS0025	Yolanda	Family Services	Dr. White	12 Month Reassessment	11/22/2012	12/22/2012

Reporting – CCI Staff

Similar to TRAC-generated report

Only lists clients with missing visit information

Our version contains client names, clinic information, and BH provider information

Also includes information on interim appointments (3-month, 9-month etc.)

Reporting – Missing Lab Data

Lab Data

TRAC ID	Client Name	Location	CCI or Community PCP	PCP	PCP Phone #	BL Lab Date	Last Lab Date
FS0001	Amanda	Family Services	Community PCP	Dr. Jones	301-555-5555	2/1/2011	1/31/2012
FS0002	Betty	Threshold	CCI	Dr. Jones	301-555-5555	2/1/2011	2/5/2012
FS0003	Cathy	Threshold	Community PCP	Dr. Kitson	301-555-5555	2/2/2011	2/7/2012
FS0005	Elizabeth	Family Services	CCI	Dr. Currin	301-555-5555	2/4/2011	2/4/2011
FS0006	Frank	Family Services	Community PCP	Dr. Pina	301-555-5555	2/5/2011	2/7/2012
Fs0007	Gerry	Threshold	CCI	Dr. Winger	301-555-5555	2/7/2011	2/5/2012
FS0008	Henry	Threshold	Community PCP	Dr. Miller	301-555-5555	2/15/2011	2/15/2011
FS0013	Mandy	Family Services	CCI	Dr. Hernandez	301-555-5555	2/17/2011	2/15/2011
FS0014	Noah	Family Services	CCI	Dr. Currin	301-555-5555	2/19/2011	2/19/2011
FS0015	Odessa	Family Services	Community PCP	Dr. Duffy	301-555-5555	2/22/2011	2/19/2012
FS0016	Penelope	Family Services	Community PCP	Dr Levinson	301-555-5555	2/23/2011	2/25/2012
FS0017	Quinn	Threshold	CCI	Dr. Hyde	301-555-5555	3/1/2011	3/5/2012
FS0019	Steven	Threshold	CCI	Dr. Jones	301-555-5555	3/2/2011	3/2/2011
FS0020	Timothy	Threshold	CCI	Dr. Winger	301-555-5555	3/4/2011	3/7/2012
FS0021	Ulysses	Family Services	Community PCP	Dr. Duncan	301-555-5555	3/7/2011	3/9/2012
FS0022	Veronica	Family Services	CCI	Dr. Leo	301-555-5555	3/9/2011	3/9/2012
FS0023	Wendy	Threshold	CCI	Dr. Kitson	301-555-5555	3/12/2011	3/12/2011
FS0024	Xander	Threshold	Community PCP	Dr. Bergman	301-555-5555	3/15/2011	3/15/2012
FS0025	Yolanda	Family Services	CCI	Dr. Hernandez	301-555-5555	3/17/2011	3/19/2012
FS0026	Zev	Threshold	CCI	Dr. Levinson	301-555-5555	3/19/2011	3/19/2011

Reporting – Project Staff

Query that pulls the last lab date for every client

Tailor report to only pull clients with:

- Out-of-date lab information
- By Site
- By PCP

HIP Client Health Report

Client Name: Jane Doe **TRACID:** 12345

Indicator (Goal)	12/12/2011	2/6/2012	8/8/2012
BMI (18.5 -24.9)	48*	45*	42*
Weight	300	280	260
BP Systolic (<=120)	140*	110	125*
BP Diastolic (<=90)	120*	110*	90
LDL (<100)	160*	140*	110*
HDL (>60)	40*	50*	65
Triglycerides (<150)	300*	200*	145
Fasting Glucose (<100)	200*	170*	95
HbA1c (<5.7)	10*	5	9*
Lab Date	12/23/2011	2/9/2012	9/1/2012
Smoking	Yes*	Yes*	Yes*
AUDIT-Alcohol (<8)	0	9*	7
DAST-Drug Use (<3)	4*	2	0
PHQ9 –Depression (<10)	12*	6	6

Client Health Goals and Readiness: This is where the provider can write notes and goals for the client.

Action Steps:

- **Action Step 1**
- **Action Step 2**
- **Action Step 3**

Readiness Ruler

- Sample HIP Health Report provided to therapists, psychiatrists and other BH staff.
- BH staff asked to incorporate information from health report into treatment planning.
- Importance of training for BH staff

Glenn County Health Care Collaborative
INDIVIDUAL WELLNESS REPORT

Name: **Bea Well**
Clinician: **John Smith**
Case Manager: **Jane Doe**

Normal*
Caution
At Risk

Progress on Key Health Indicators

Category	Indicator (Goal)	Baseline *August 2011*	6-Month Reassessment *February 2012*	12-Month Reassessment *July 2012*
Lungs	Breath CO (0-6)	25	8	5
Weight	BMI (18.5-24.9)	25.8	28.1	25.3
	Weight	162.0	174.0	158.0
	Waist Circumference	35.5	31.5	32.2
Blood Pressure	Systolic BP (90-140)	133	135	114
	Diastolic BP (60-90)	80	75	80
Blood Sugar	Fasting Glucose (70-99)	115	-	115
	Hemoglobin A1C (4.0-5.6)	5.4	-	5.4
Heart Health	Total Cholesterol (125-200)	197	-	189
	LDL Cholesterol (20-129)	111	-	103
	HDL Cholesterol (40+)	76	-	73
	Triglycerides (30-149)	52	-	64

Client Wellness Goal(s):

Bea Well will lose 5 pounds within 6 months.

Bea Well will maintain her excellent progress in reducing/stopping her tobacoo use.

Client Mental Health Goal(s):

Bea Well will sleep at least 7 hours each night to decrease symptoms of depression.

Action Step(s):

Bea Well will walk for 20 minutes five days per week.

Bea Well will eat at least 3 servings of vegetables every day.

Bea Well will go to bed by 10 pm at least 5 nights per week.

Client Signature: *Bea Well* ***Staff Signature:*** *John Smith* ***Date:*** *9/15/2012*

* Please note that some values in the "Normal" Range may be considered too low.

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Conclusion

Questions?

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FINAL COMMENTS