



HEALTH

***SAMHSA Primary & Behavioral Health
Care Integration (PBHCI) Program***

***Breakout Session: Clinical Registry
and Related Data Collection Issues***

Grantee's Meeting

April 27, 2010

Overview of RAND's Tasks (1)

Primary Task

Develop evaluation design for PBHCI program that answers 3 questions:

1. Is it possible to integrate the services provided by PC providers & community-based BH agencies?
2. Does integrating PC and BH lead to improvements in health status of populations served?
3. Which integrated models & model components result in better outcomes for the populations served?

Overview of RAND's Tasks (2)

Secondary Task

Develop PBHCI clinical registry that serves three purposes:

- 1. Facilitates grantees' efforts to provide high-quality integrated clinical care for their targeted populations**
- 2. Assists grantees in meeting SAMHSA's PBHCI program reporting requirements**
- 3. Supports a meaningful PBHCI program evaluation**

SAMHSA Data Collection for PBHCI Program

- 1. NOMs measures reported through TRAC**
- 2. Client-level data collection via clinical registry**
 - Descriptive client information
 - Individual health outcome indicators (e.g., BP, BMI, A1C)
 - Service outcome indicators
- 3. Progress reports to SAMHSA**
 - Qualitative program-level information
 - Quantitative aggregate client-level information

Goals for Today's Breakout Session

WHO receives PBHCI assessments?



WHAT data are collected?



WHEN is data collected and entered?



WHERE / HOW are data maintained and queried?



WHY? Support high-quality local and program-wide program evaluation

FAQ's

- “The SF-36 is too expensive. What other measure can we use to measure well-being?”
- “We’ve been collecting all of our data on paper forms; designing our own registry is too complicated and expensive. How might we better manage all our data?”
- “Our PC providers keep their own records at the clinic down the street. How might we better reconcile medications for PC and BH conditions?”

WHO receives PBHCI assessments?

- For example:
 - New consumers
 - Current consumers
 - Attendees of a specialty clinic
 - Consumers without a PCP
 - Consumers taking psychotropic medication
 - Consumers with a pre-existing PC condition

**WHAT WORKS?
WHAT DOESN'T?**

WHAT data are collected?

- For example:
 - Only SAMHSA-required data elements
 - NOMs, BMI, BP, etc.
 - Something in between
 - LOCUS IV, PHQ-9
 - Extensive PC / BH battery
 - AUDIT, SF-36, PTSD instrument, etc.

**WHAT WORKS?
WHAT DOESN'T?**

WHEN is data collected and entered?

- For example:
 - All data entered directly into computer during the assessment
 - NCM screens and enters data
 - Some data entered directly (e.g., NOMs) and others paper forms and entered post hoc
 - NCM enters data when time permits
 - All data collected on forms
 - Single staff person dedicated to data entry

**WHAT WORKS?
WHAT DOESN'T?**

WHERE / HOW are data maintained?

- For example:
 - Paper forms in consumer charts
 - Excel spreadsheet or Access database
 - Data fields within clinic EMR
 - On-line commercial registry

- Also:
 - Single registry
 - Multiple registries
 - BH and PC records are separate
 - BH and PC records are integrated

**WHAT WORKS?
WHAT DOESN'T?**

HOW are data queried?

- For example:
 - Excel
 - Access
 - Crystal reports
 - Other?

**WHAT WORKS?
WHAT DOESN'T?**

Related Issues

- Numeric vs. text data fields
- Quarterly reports

QUESTIONS?

***CLINICAL REGISTRY TOOL
EXTRA SLIDES FOR DISCUSSION***

Do Not Delete

PBHCI CLINICAL REGISTRY

Integrating Behavioral and Physical Health Care Patient Profile

MRN: _____ Encounter Date: mm/dd/yyyy _____ Location ID: _____

Provider Name (Last, First MI) _____ Provider Specialty: _____

A. PATIENT DEMOGRAPHICS

Patient Name (Last, First MI): _____

DOB: mm/dd/yyyy _____ Sex Male Female Patient new to practice

Race: (check all that apply)
 American Indian/Alaska Native Black / African American Hispanic or Latino
 Asian Hawaiian / Pacific Islander
 White

County of residence: _____ Zip code: _____

Preferred language of service: English Spanish Other _____ Can patient consent to own treatment?
 No Yes

Marital status: Civil union Married Cohabiting Single / never married Divorced Widowed

Education (highest level): Never attended / kindergarten only Grade 12 / GED College 1-3 yrs College 4yrs or more
 Grades 1-8 Grades 9-11

B. INSURANCE (Check all that apply)

Indian Health Service Medicare (managed care) None
 Medicaid Military Health Care Private Health Insurance
 Medicare (fee for service) Non-US Insurance State-Specific Plan (non-Medicaid)

C. PERSONAL MEDICAL HISTORY

*Cardiovascular Disease Yes No DK

*Diabetes Yes No DK

*Hypertension Yes No DK

Other: _____

*Substance Abuse/Dependence (lifetime) Yes No DK
 If yes, drug of choice? _____
 Longest clean time? _____

*Tobacco (lifetime) Yes No DK
 If yes, Cigs Smokeless
 Longest clean time? _____

D. FAMILY MEDICAL HISTORY

*Cardiovascular Disease Yes No DK

*Diabetes Yes No DK

*Hypertension Yes No DK

Other: _____

*Substance Abuse/Dependence Yes No DK

*Tobacco Yes No DK

E. MENTAL HEALTH HISTORY

Axis I (note primary): _____ Current GAF: _____

Axis II (note primary): _____ Highest GAF within the year: _____

F. *MEDICATION HISTORY

*Previous medications (list): _____

PBHCI CLINICAL REGISTRY

Integrating Behavioral and Physical Health Care **Psychosocial Assessment**

	Date mm/dd/yyyy	Date mm/dd/yyyy	Date mm/dd/yyyy	Date mm/dd/yyyy
A. PSYCHOSOCIAL ISSUES				
Employ/Education problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Housing problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Legal problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
*Social support (LOCUS IV Recov ^a)	<input type="checkbox"/> No <input type="checkbox"/> Yes Score:			
B. MENTAL HEALTH SYMPTOMS				
Depression (e.g. PHQ-9 score)				
Other:				
Other:				
C. GENERAL HEALTH / WELL-BEING (e.g., SF-36 and subscales^a)				
General mental health				
Bodily pain				
General health perc.				
Physical functioning				
Role limitations, MH				
Role limitations, PH				
Social functioning				
Vitality				
D. SUICIDE				
Feel suicidal?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	Contract for safety:	Contract for safety:	Contract for safety:	Contract for safety:
Suicide attempts in last 30 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
E. HOSPITAL USE				
Psych inpatient in last 30 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes Total days:			
ER visits in last 30 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes Total visits:			

^a Scoring instructions in Appendix

PBHCI CLINICAL REGISTRY

Integrating Behavioral and Physical Health Care Psychosocial Treatment Plan

		Date mm/dd/yyyy	Clinician	Date mm/dd/yyyy	Clinician	Date mm/dd/yyyy	Clinician	Date mm/dd/yyyy	Clinician
Problem Type (Check all that apply)		Tx Goals (List all)	Actions (Check all that apply)	Goal Status	Actions (Check all that apply)	Goal Status	Actions (Check all that apply)	Goal Status	Actions (Check all that apply)
A. PSYCHOSOCIAL									
<input type="checkbox"/> Employment/ Education		<input type="checkbox"/> Consult with CM <input type="checkbox"/> Referral <input type="checkbox"/> Other:	Met: Not:	<input type="checkbox"/> Consult with CM <input type="checkbox"/> Referral <input type="checkbox"/> Other:	Met: Not:	<input type="checkbox"/> Consult w CM <input type="checkbox"/> Referral: <input type="checkbox"/> Other:	Met: Not:	<input type="checkbox"/> Consult w CM <input type="checkbox"/> Referral: <input type="checkbox"/> Other:	Follow-up Who: When:
<input type="checkbox"/> Housing		<input type="checkbox"/> Consult with CM <input type="checkbox"/> Referral <input type="checkbox"/> Other:		<input type="checkbox"/> Consult with CM <input type="checkbox"/> Referral <input type="checkbox"/> Other:		<input type="checkbox"/> Consult with CM <input type="checkbox"/> Referral <input type="checkbox"/> Other:		<input type="checkbox"/> Consult with CM <input type="checkbox"/> Referral <input type="checkbox"/> Other:	Follow-up Who: When:
<input type="checkbox"/> Legal		<input type="checkbox"/> Consult with CM <input type="checkbox"/> Referral <input type="checkbox"/> Other:		<input type="checkbox"/> Consult with CM <input type="checkbox"/> Referral <input type="checkbox"/> Other:		<input type="checkbox"/> Consult with CM <input type="checkbox"/> Referral <input type="checkbox"/> Other:		<input type="checkbox"/> Consult with CM <input type="checkbox"/> Referral <input type="checkbox"/> Other:	Follow-up Who: When:
<input type="checkbox"/> Social Support		<input type="checkbox"/> Consult with CM <input type="checkbox"/> Referral <input type="checkbox"/> Other:		<input type="checkbox"/> Consult with CM <input type="checkbox"/> Referral <input type="checkbox"/> Other:		<input type="checkbox"/> Consult with CM <input type="checkbox"/> Referral <input type="checkbox"/> Other:		<input type="checkbox"/> Consult with CM <input type="checkbox"/> Referral <input type="checkbox"/> Other:	Follow-up Who: When:
B. MENTAL HEALTH									
<input type="checkbox"/> Diagnosis/ Symptom:		<input type="checkbox"/> Psychotherapy type: _____ <input type="checkbox"/> Start/Stop date: _____ <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: <input type="checkbox"/> Other:	Met: Not:	<input type="checkbox"/> Psychotherapy type: _____ <input type="checkbox"/> Start/Stop date: _____ <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: <input type="checkbox"/> Other:	Met: Not:	<input type="checkbox"/> Psychotherapy type: _____ <input type="checkbox"/> Start/Stop date: _____ <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: <input type="checkbox"/> Other:	Met: Not:	<input type="checkbox"/> Psychotherapy typ _____ <input type="checkbox"/> Start/Stop date: _____ <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: <input type="checkbox"/> Other:	Follow-up Who: When:
<input type="checkbox"/> Diagnosis/ Symptom:		<input type="checkbox"/> Psychotherapy type: _____ <input type="checkbox"/> Start/Stop date: _____ <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: <input type="checkbox"/> Other:	Met: Not:	<input type="checkbox"/> Psychotherapy type: _____ <input type="checkbox"/> Start/Stop date: _____ <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: <input type="checkbox"/> Other:	Met: Not:	<input type="checkbox"/> Psychotherapy type: _____ <input type="checkbox"/> Start/Stop date: _____ <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: <input type="checkbox"/> Other:	Met: Not:	<input type="checkbox"/> Psychotherapy typ _____ <input type="checkbox"/> Start/Stop date: _____ <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: <input type="checkbox"/> Other:	Follow-up Who: When:

PBHCI CLINICAL REGISTRY

Integrating Behavioral and Physical Health Care Substance Use Assessment and Treatment Plan

	Date: mm/dd/yyyy	Date: mm/dd/yyyy	Date: mm/dd/yyyy	Date: mm/dd/yyyy
A. ALCOHOL				
*Ask: Risky drinking ^a in last 30 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes Describe:			
AUDIT ^a score				
Advise to reduce to moderate levels?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Assess patient's goals	<input type="checkbox"/> No <input type="checkbox"/> Yes Describe:			
Assist with treatment Check all that apply	<input type="checkbox"/> Behavioral Intervention <input type="checkbox"/> Medication - add/dc/chng <input type="checkbox"/> Referral to: <input type="checkbox"/> Other:	<input type="checkbox"/> Behavioral Intervention <input type="checkbox"/> Medication - add/dc/chng <input type="checkbox"/> Referral to: <input type="checkbox"/> Other:	<input type="checkbox"/> Behavioral Intervention <input type="checkbox"/> Medication - add/dc/chng <input type="checkbox"/> Referral to: <input type="checkbox"/> Other:	<input type="checkbox"/> Behavioral Intervention <input type="checkbox"/> Medication - add/dc/chng <input type="checkbox"/> Referral to: <input type="checkbox"/> Other:
Arrange follow-up	Who: When:	Who: When:	Who: When:	Who: When:
B. ILLICIT DRUGS				
*Ask: Illicit drug use in last 30 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes Describe:			
Advise to quit?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Assess: Willing to quit?	<input type="checkbox"/> No <input type="checkbox"/> Yes When:			
Assist with treatment Check all that apply	<input type="checkbox"/> Behavioral Intervention <input type="checkbox"/> Medication - add/dc/chng <input type="checkbox"/> Referral to: <input type="checkbox"/> Other:	<input type="checkbox"/> Behavioral Intervention <input type="checkbox"/> Medication - add/dc/chng <input type="checkbox"/> Referral to: <input type="checkbox"/> Other:	<input type="checkbox"/> Behavioral Intervention <input type="checkbox"/> Medication - add/dc/chng <input type="checkbox"/> Referral to: <input type="checkbox"/> Other:	<input type="checkbox"/> Behavioral Intervention <input type="checkbox"/> Medication - add/dc/chng <input type="checkbox"/> Referral to: <input type="checkbox"/> Other:
Arrange follow-up	Who: When:	Who: When:	Who: When:	Who: When:
C. TOBACCO				
*Ask: Use in last 30 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes Describe:			
Advise to quit?	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Assess: Willing to quit?	<input type="checkbox"/> No <input type="checkbox"/> Yes When:			
Assist to quit: Check all that apply	<input type="checkbox"/> Behavioral Intervention <input type="checkbox"/> Med/NRT - add/dc/chng <input type="checkbox"/> Referral to: <input type="checkbox"/> Other:	<input type="checkbox"/> Behavioral Intervention <input type="checkbox"/> Med/NRT - add/dc/chng <input type="checkbox"/> Referral to: <input type="checkbox"/> Other:	<input type="checkbox"/> Behavioral Intervention <input type="checkbox"/> Med/NRT - add/dc/chng <input type="checkbox"/> Referral to: <input type="checkbox"/> Other:	<input type="checkbox"/> Behavioral Intervention <input type="checkbox"/> Med/NRT - add/dc/chng <input type="checkbox"/> Referral to: <input type="checkbox"/> Other:
Arrange follow-up	Who: When:	Who: When:	Who: When:	Who: When:

^a Scoring instructions in Appendix

PBHCI CLINICAL REGISTRY

Integrating Behavioral and Physical Health Care Primary Care Assessment

	Date mm/dd/yyyy		Date mm/dd/yyyy		Date mm/dd/yyyy		Date mm/dd/yyyy	
A. PHYSICAL EXAM	Value	Flag	Value	Flag	Value	Flag	Value	Flag
*Height (inches) ¹		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
*Weight (lbs) ¹		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
*BMI (lbs) ¹		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Waist circ. (inches)		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
*BP (mmHg) ¹		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Pulse (bpm)		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Respiration/min		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Eye		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Foot		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Skin		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Thyroid		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Other (specify)		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
B. LABS								
*LDL Cholesterol ²		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
*HDL Cholesterol ²		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
*Total Cholesterol ²		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
*Triglycerides ²		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
*Glucose / HbA1C ²		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
LFT		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Albumin		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Ur		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
GFR		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
TSH ¹		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Urine drug screen (specify)		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Other (specify)		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

¹At least quarterly ²At least annually

PBHCI CLINICAL REGISTRY

Integrating Behavioral and Physical Health Care Primary Care Treatment Plan

	Date mm/dd/yyyy		Date mm/dd/yyyy		Date mm/dd/yyyy		Date mm/dd/yyyy	
	Clinician		Clinician		Clinician		Clinician	
Problem Type (Check all that apply)	Tx Goals (List all)	Actions (Check all that apply)	Goal Status	Actions (Check all that apply)	Goal Status	Actions (Check all that apply)	Goal Status	Actions (Check all that apply)
<input type="checkbox"/> *Diabetes Specific dx: (list all)		<input type="checkbox"/> Diabetes Educat. <input type="checkbox"/> Diet <input type="checkbox"/> Phys Activity <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: Other:	Met: Not:	<input type="checkbox"/> Diabetes Educat. <input type="checkbox"/> Diet <input type="checkbox"/> Phys Activity <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: Other:	Met: Not:	<input type="checkbox"/> Diabetes Educat. <input type="checkbox"/> Diet <input type="checkbox"/> Phys Activity <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: Other:	Met: Not:	<input type="checkbox"/> Diabetes Educat. <input type="checkbox"/> Diet <input type="checkbox"/> Phys Activity <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: Other:
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
<input type="checkbox"/> *Hypertension Specific dx: (list all)		<input type="checkbox"/> HTN Educat. <input type="checkbox"/> Diet <input type="checkbox"/> Phys Activity <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: Other:	Met: Not:	<input type="checkbox"/> HTN Educat. <input type="checkbox"/> Diet <input type="checkbox"/> Phys Activity <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: Other:	Met: Not:	<input type="checkbox"/> HTN Educat. <input type="checkbox"/> Diet <input type="checkbox"/> Phys Activity <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: Other:	Met: Not:	<input type="checkbox"/> HTN Educat. <input type="checkbox"/> Diet <input type="checkbox"/> Phys Activity <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: Other:
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
<input type="checkbox"/> *Obesity Specific dx: (list all)		<input type="checkbox"/> Obesity Educat. <input type="checkbox"/> Diet <input type="checkbox"/> Phys Activity <input type="checkbox"/> Behavioral Interv. <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: Other:	Met: Not:	<input type="checkbox"/> Obesity Educat. <input type="checkbox"/> Diet <input type="checkbox"/> Phys Activity <input type="checkbox"/> Behavioral Interv. <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: Other:	Met: Not:	<input type="checkbox"/> Obesity Educat. <input type="checkbox"/> Diet <input type="checkbox"/> Phys Activity <input type="checkbox"/> Behavioral Interv. <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: Other:	Met: Not:	<input type="checkbox"/> Obesity Educat. <input type="checkbox"/> Diet <input type="checkbox"/> Phys Activity <input type="checkbox"/> Behavioral Interv. <input type="checkbox"/> Med add/dc/chng <input type="checkbox"/> Referral: Other:
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
<input type="checkbox"/> Other Specific dx: (list all)			Met: Not:		Met: Not:		Met: Not:	
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
<input type="checkbox"/> Other Specific dx: (list all)			Met: Not:		Met: Not:		Met: Not:	
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
<input type="checkbox"/> Other Specific dx: (list all)			Met: Not:		Met: Not:		Met: Not:	
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:

LOCUS IV/ RECOVERY ENVIRONMENT SCORE

Scoring Instructions: Each evaluation parameter is defined along a scale of one to five. Each score in the scale is defined by one or more criteria, which are designated by separate letters. Only one of these criteria need be met for a score to be assigned to the subject. The evaluator should select the highest score or rating in which at least one of the criteria is met. There will, on occasion, be instances where there will be some ambiguity about whether a subject has met criteria for a score on the scale within one of the parameters. This may be due to inadequate information, conflicting information, or simply to difficulty in making a judgment about whether the available information is consistent with any of the criteria for that score. Clinical experience must be applied judiciously in making determinations in this regard, and the rating or criterion that provides the closest approximation to the actual circumstance should be selected. However, there will be instances when it will remain difficult to make this determination. In these cases the highest score in which it is more likely than not that least one criterion has been met should generally be assigned. The result will be that any errors will be made on the side of caution

1 - Highly Supportive Environment

- a- Abundant sources of support with ample time and interest to provide for both material and emotional needs in all circumstances.
- b- Effective involvement of Assertive Community Treatment Team (ACT) or other similarly highly supportive resources.
(Selection of this criterion pre-empts higher ratings)

2 - Supportive Environment

- a- Supportive resources are not abundant, but are capable of and willing to provide significant aid in times of need.
- b- Some elements of the support system are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes.
- c- Professional supports are available and effectively engaged (i.e. ICM).
(Selection of this criterion pre-empts higher ratings)

3 - Limited Support in Environment

- a- A few supportive resources exist in current environment and may be capable of providing some help if needed.
- b- Usual sources of support may be somewhat ambivalent, alienated, difficult to access, or have a limited amount of resources they are willing or able to offer when needed.
- c- Persons who have potential to provide support have incomplete ability to participate in treatment and make necessary changes.
- d- Resources may be only partially utilized even when available.
- e- Limited constructive engagement with any professional sources of support which are available.

4 - Minimal Support in Environment

- a- Very few actual or potential sources of support are available.
- b- Usual supportive resources display little motivation or willingness to offer assistance or they are dysfunctional or hostile toward client.
- c- Existing supports are unable to provide sufficient resources to meet material or emotional needs.
- d- Client may be alienated and unwilling to use supports available in a constructive manner.

5 - No Support in Environment

- a- No sources for assistance are available in environment either emotionally or materially.

Reference: LOCUS: LEVEL OF CARE UTILIZATION SYSTEM FOR PSYCHIATRIC AND ADDICTION SERVICES. Adult Version 2010, AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRISTS. March 20, 2009 © 1996-2009 American Association of Community Psychiatrists

Review of Data Elements in PBHCI Clinical Registry

REQUIRED

- Documentation of screening
- Physical exam:
 - Blood pressure
 - BMI
- Laboratory:
 - HbA1C
- Interview
 - General MH symptoms

RECOMMENDED

- Documentation of follow-up
- Physical exam:
 - Waist circumference
 - Foot exam
- Laboratory:
 - LFT
- Interview
 - Depression severity