

Glenn County, CA
Health Care Collaborative
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Using Health Outcomes
to Promote Wellness
and Client Engagement

SAMHSA/HRSA Center for Integrated Health Solutions
California PBHCI TA Meeting

Individual Wellness Reports

Developed Individual (Client) Wellness Reports (IWR) to show:

- Breath CO
- Body Mass Index (BMI)
- Blood Pressure
- A1c (Blood Sugar/Diabetes)
- Cholesterol

Data shown at baseline, every six months. It is color coded to show each indicator as:

- ❖ Within normal / healthy range (Green)
- ❖ At risk (Yellow)
- ❖ Outside of the healthy range – indicates a chronic health condition (Red)

Individual Wellness Reports

Effective with Clients:

- Simple, easy to understand information
- Color coded so clients can see which indicators show high-risk
- Shows data every six months for nurse generated indicators
- Every twelve months for lab results and nurse generated indicators

Effective with Staff:

- Simple, easy to understand information
- Color coded so staff know which indicators show chronic health indicators
- Promotes staff accountability for their clients
- Provides incentive to help clients manage their health indicators
- Demonstrates progress toward improving health conditions and highlights opportunities for improvement

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	6-Month Reassessment	12-Month Reassessment
		August 2011	February 2012	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 tobacco 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

System-Level Outcome Data: Management of High Risk Clients

Quarterly Management Review of High Risk Clients

- Analyze data on clients identified as ‘High Risk’ (outside the healthy range) for each health indicator
- Review those High Risk clients over time to determine
 - Progress toward improved health outcomes
 - Regression on health indicator
- Provides a summary of all clients who have same health risk factor
- Provides an opportunity to develop support groups of persons having same health risk factors
- Hold classes to help address chronic health conditions; promote support networks

System-Level Outcome Data: Management of High Risk Clients

By showing several clients on one (or a few pages), staff can quickly determine which clients are successful at improving their health condition(s), and who needs additional support in managing their health.

This approach also establishes a platform for outcome measurement at the macro level:

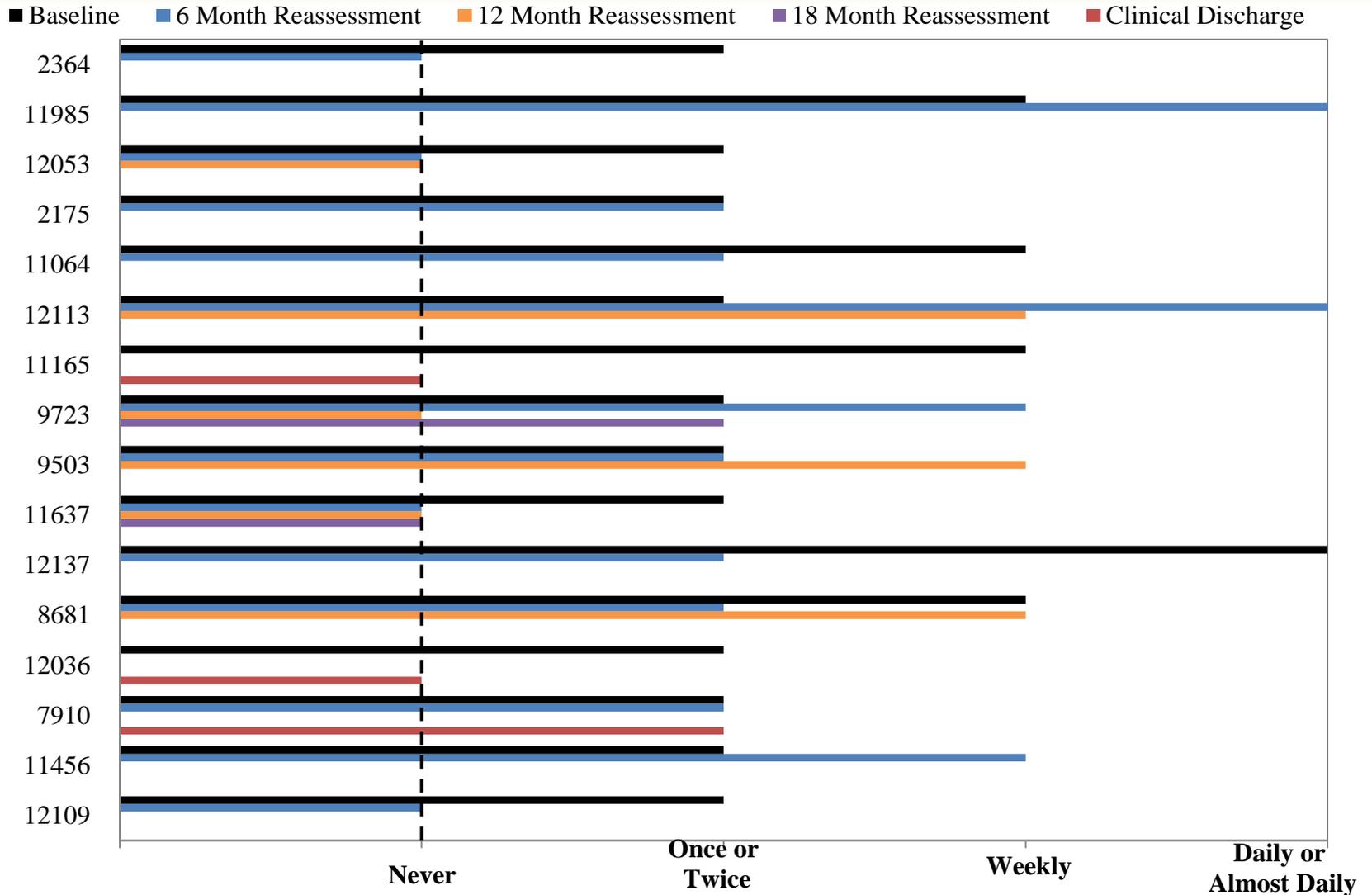
- To comply with future tracking requirements by the state
- Providing support for generating new revenue within a reformed payment structure
- Celebrating successes

Glenn County Health Care Collaborative Project

NOMS Outcome Data

In the past 30 days, how often have you used alcoholic beverages?

Clients who **used** at Baseline



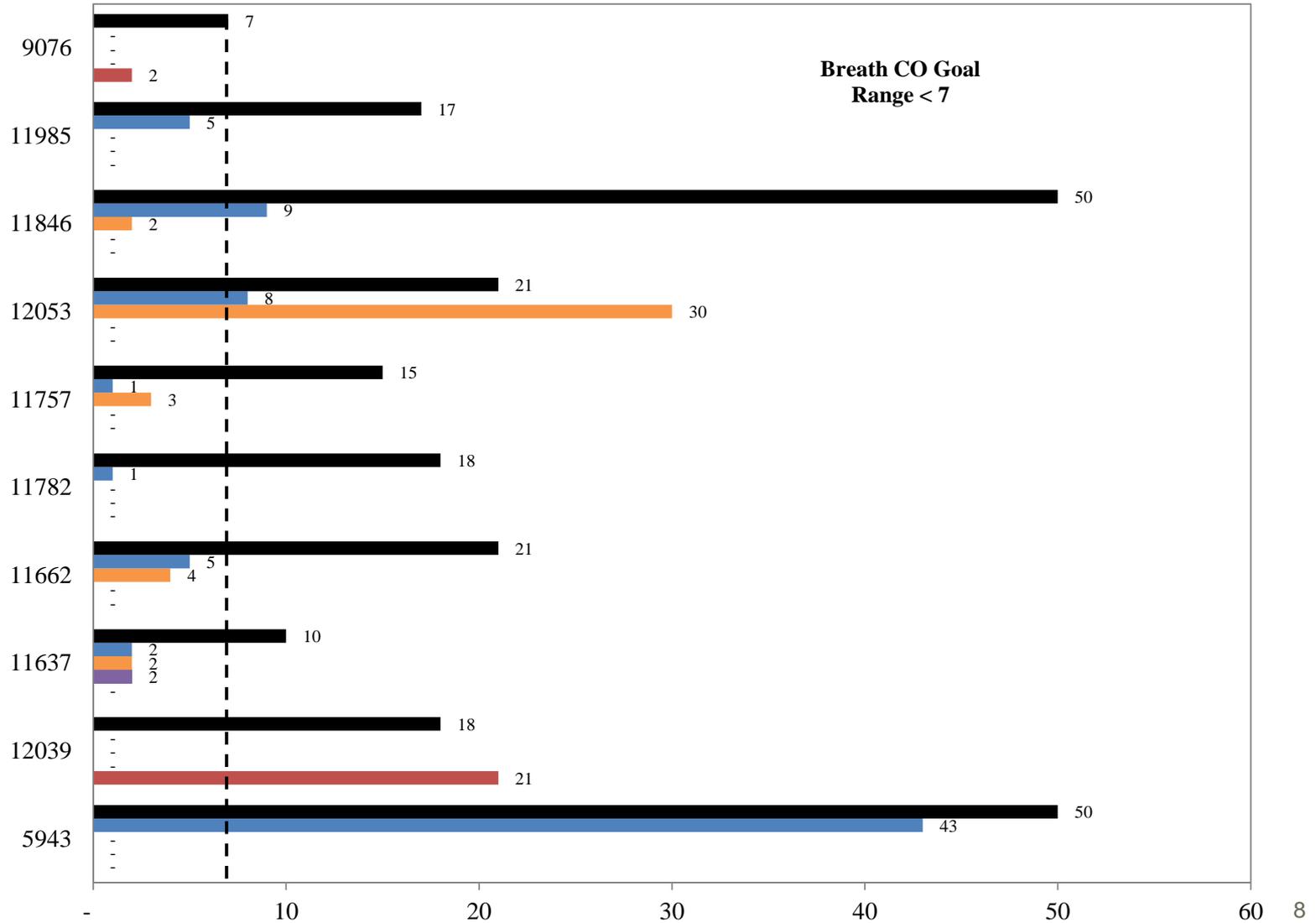
Better



Glenn County Health Care Collaborative Project Primary Care Outcome Data

Breath CO Level for Clients who were At Risk at Baseline (and their Reassessment Values)

■ Baseline ■ 6 Month Reassessment ■ 12 Month Reassessment ■ 18 Month Reassessment ■ Clinical Discharge



Summary

By providing a clear, easy-to-understand summary of health indicators over time, clients, staff, managers, and stakeholders can understand progress on key health indicators.

Individual Wellness Reports promote client engagement, staff accountability, and stakeholder information to improve health outcomes.