

# Glenn County Health Care Collaborative

Cohort III

## Type of Program:

County Behavioral Health Program

## Primary Care Model:

Partnering with Ampla Health (a local FQHC)

## **Description of Data Collection Process**

Prior to implementing the project, we compiled all of the necessary data collection forms, sorted the questions based on type of service (mental health or primary care), and developed our own data packets (Case Manager Packet and Nurse Packet).

The Case Manager Packet includes all mental health-related NOMs questions, and the Nurse Packet includes all health-related NOMs questions (Section H data). The topics that are included in each data packet is listed on the following slide.

# Description of Data Collection Process *(continued)*

## Case Manager Packet

Record Management

Demographic Data *(only at baseline)*

Violence and Trauma

Functioning

Stability in Housing

Education and Employment

Social Connectedness

Crime and Criminal Justice Status

Military Family and Deployment *(only at baseline)*

Perception of Care *(only at reassessment and discharge)*

Reassessment Status *(only at reassessment)*

Services Received *(only at reassessment and discharge)*

Clinical Discharge Status *(only at discharge)*

## Nurse Packet

Physical Exam

Personal Medical History\*

Family Medical History\*

Lab Work *(only at baseline, annually, and discharge)*

Medication List\*

**\* = not required for TRAC data submission**

## **Description of Data Collection Process *(continued)***

### **Nurse Packet**

Personal Medical History\*

Family Medical History\*

Physical Exam

Lab Work (annually)

Medication List\*

\* = not required for TRAC data submission

## **Description of Data Collection Process *(continued)***

These packets are collected at each client's intake appointment, every six months, and at discharge. Our Registered Nurse completes a Nurse Packet during the client's appointment with our Physician Assistant.

Once the packets are completed, the Case Manager and/or Registered Nurse faxes them to the Project Evaluator (I.D.E.A. Consulting).

## **Description of Data Collection Process *(continued)***

The Case Manager schedules an appointment with our Physician Assistant from Ampla Health. The Case Manager ensures that the client brings all required paperwork to the FQHC to enroll them as a patient at their first appointment at the FQHC.

Following the appointment with the Physician Assistant, the Case Manager schedules a time with the client to go to the lab to complete their blood work. The Case Manager reminds the client to fast overnight, provides transportation to the lab, and brings the client's lab slip. The lab faxes the client's lab results to Ampla Health and Glenn County Behavioral Health, and Glenn County Behavioral Health faxes the lab results to the Project Evaluator who enters the data into TRAC.

## **Description of Data Collection Process *(continued)***

The original copy of the packets and lab work are stored in the clients' charts at Glenn County Behavioral Health, and the faxed copies are stored in secured, locked cabinets at I.D.E.A. Consulting's office.

I.D.E.A. Consulting is responsible for entering the data into TRAC (a federal requirement of the grant) and into an Access Database (for local evaluation).

## **Client Tracking Logs**

I.D.E.A. Consulting developed an Intake Client Tracking Log, a Reassessment Client Tracking Log, and a Discharge Client Tracking Log to ensure that we have received all needed packets and to keep track of clients' reassessment dates. These logs are reviewed on a weekly basis at the PBHCI Weekly Meeting.

A sample of the tracking logs are displayed on the following slides.

# SAMPLE

## PBHCI Client Tracking Log - INTAKE

Client ID	First Name	Last Name	Intake Date	Discharge Date	Case Manager Packet	Nurse Packet	Labs
1	Bea	Well	9/24/2012		X	X	X
3	Bob	Smith	9/12/2012		X	X	X
9	Nick	Valdez	4/8/2012	6/2/2012	X	X	X
5	Greg	Brooks	3/27/2012			X	X
6	Rose	Martinez	3/9/2012		X	X	
7	Jose	Flores	3/5/2012	9/21/2012	X	X	-
4	John	Doe	9/9/2011		X	X	
8	Kelly	Stone	1/16/2011	5/17/2012	X	X	X

Client Status	Number
Active Clients	5
Disenrolled Clients	3
Total Enrolled Clients	8

Outstanding Items	Number
Missing Case Manager Packets	1
Missing Nurse Packets	0
Missing Labs	2

**X = Completed**

# SAMPLE

Federal Timeliness Indicator:  
 TOTAL # and % Completed on Time: 5/5 (100%)

## PBHCI Client Tracking Log - REASSESSMENT

Due February 28, 2013								
Due Date	Interval	Client ID	Name	Case Manager Packet	Nurse Packet	Labs	Completed on Time?	Comment
February 28, 2013	Semi-Annual (6 mo)	1	Bea Well	X	X		Yes	Completed
February 28, 2013	Semi-Annual (6 mo)	3	Bob Smith	X	X		Yes	Completed
February 28, 2013	Semi-Annual (18 mo)	4	John Doe	X	X		Yes	Completed
February 28, 2013	Annual (12 mo)	5	Greg Brooks	X	X	-	Yes	Completed
February 28, 2013	Annual (12 mo)	6	Rose Martinez	X	X	X	Yes	Completed
<b>Percent Completed on Time:</b>								<b>100%</b>

**X = Completed**

**SAMPLE**

**PBHCI Client Tracking Log - DISCHARGE**

Client ID	First Name	Last Name	Intake Date	Discharge Date	Case Manager Packet	Nurse Packet	Labs	Discharge Reason
7	Jose	Flores	3/5/2012	9/21/2012	X	X	X	In an IMD
8	Kelly	Stone	1/16/2011	5/17/2012	X	X	-	Withdrew from/refused treatment
9	Nick	Valdez	4/8/2012	6/2/2012	X	-	-	Withdrew from/refused treatment

**X = Completed**

## **Data Retrieval**

Our Project Evaluator retrieves clients' NOMs data and H Data from the Access Database and TRAC to create system-level outcome data graphs and Individual Wellness Reports. These system-level and client-level reports are extremely important in developing wellness activities and helping our clients achieve healthy outcomes.

## **System-Level Outcome Data Graphs: Breath CO**

We developed system-level outcome data graphs on each of our key health indicators. These graphs illustrate clients' improvement, or regression, on the indicators over time (at baseline, every six months, annually, and/or at discharge).

This summary-level data shows all clients who are “at risk” for each health indicator. This helps the team to see “at a glance” all of the clients who are “at risk” for each indicator. This helps the HCC Team to plan group activities and examine progress over time on an aggregate level. On the graphs, we show a vertical dotted line that shows the “normal” zone.

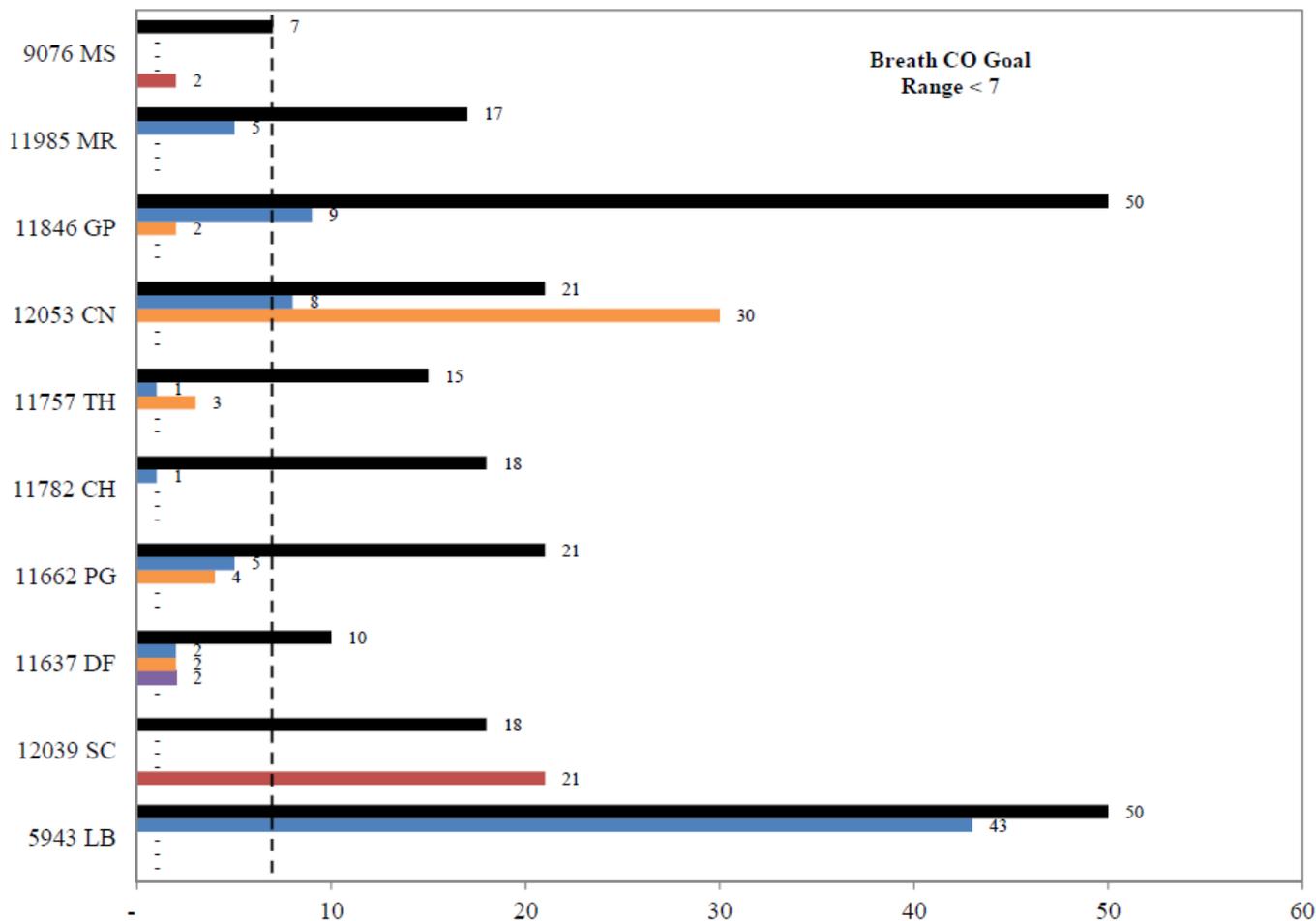
The following slide provides an example of the outcome data graph for the Breath CO indicator, for clients who were in the “at risk” range at baseline. This graph allows the HCC Team to see if clients have improved, or regressed, their Breath CO level over time.



### 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



Current Data, through January 15, 2013

\* These clients do not have a Baseline value.

CONFIDENTIAL

1/16/2013

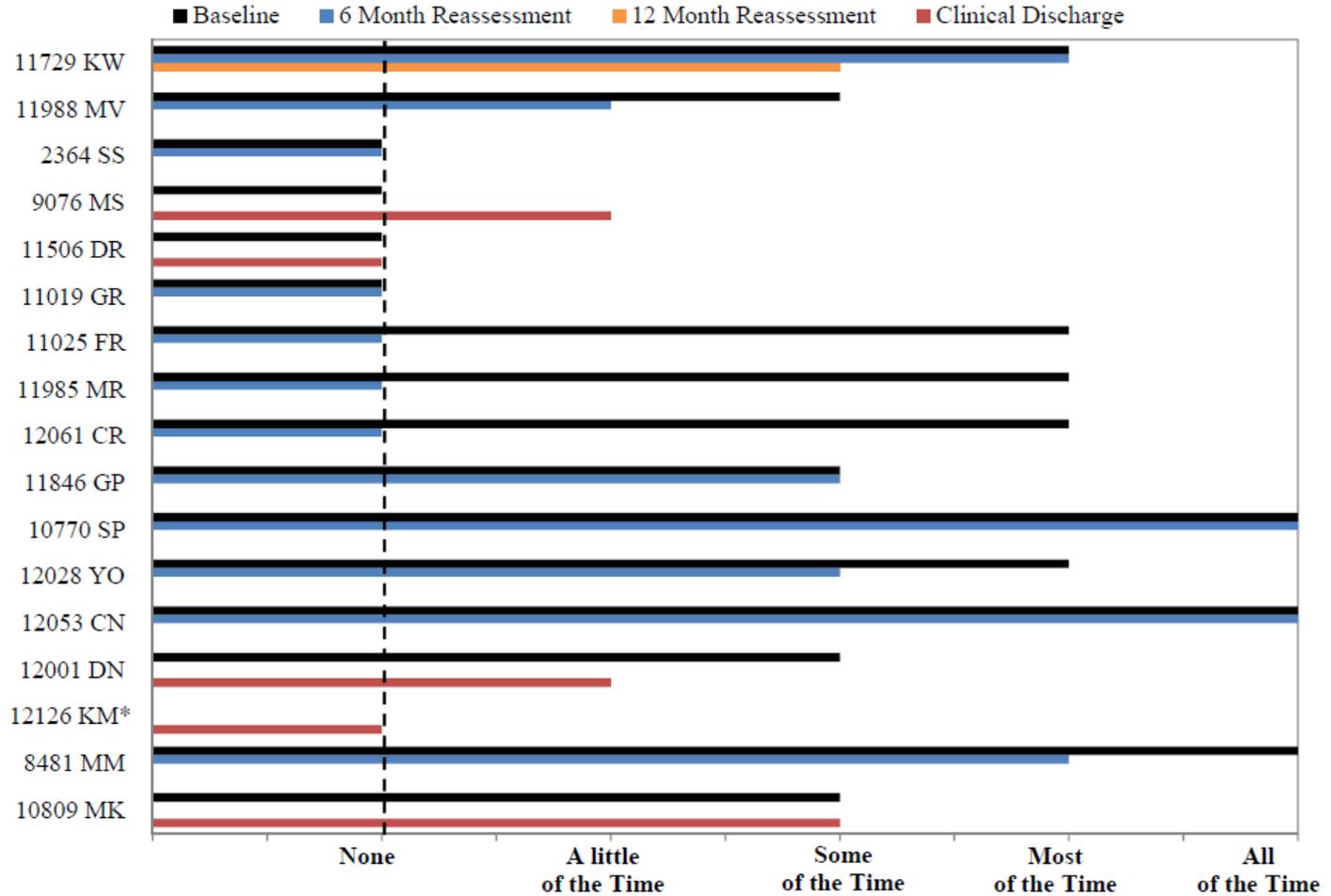
## **System-Level Outcome Data Graphs: Depression**

Our system-level outcome data graphs also include graphs on each of our key mental health indicators from the NOMs data.

The following slide provides an example of the outcome data graph for the NOMs question: “During the past 30 days, about how often did you feel so depressed that nothing could cheer you up?” This data helps the HCC Team to identify clients who show signs of depression; and progress over time towards ameliorating their symptoms of depressions.

**Glenn County Health Care Collaborative Project  
NOMS Outcome Data**

*During the past 30 days, about how often did you feel so depressed that nothing could cheer you up?*



Current Data, through January 15, 2013

\* These clients do not have a Baseline value.

CONFIDENTIAL

1/16/2013

## Individual Wellness Report

I.D.E.A. Consulting, in collaboration with the Glenn County HCC Team, developed Individual Wellness Reports for each client enrolled in our project.

These reports include the client's values on our key primary care indicators over time. The client's values are color coded to indicate whether each value is in the normal range (green), in the caution range (yellow), or in the "at risk" range (red). The report also provides space to list the client's wellness goals, mental health goals, and action steps.

Clients receive a copy of their report at baseline and an updated report every six months. The client's HCC Clinician and/or HCC Case Manager reviews the report with the client, celebrates their successes, and assists them in developing appropriate goals and action steps.

Individual Wellness Reports are an excellent tool in reinforcing positive behaviors and motivating our clients to make healthy choices.

## 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 <i>August 2011</i>	6-Month Reassessment <i>February 2012</i>	12-Month Reassessment <i>July 2012</i>
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

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

## Summary

By using data to inform managers, staff, and clients of progress towards system performance, client outcomes, and improved health indicators, we can work together to celebrate success and identify areas for improvement.