



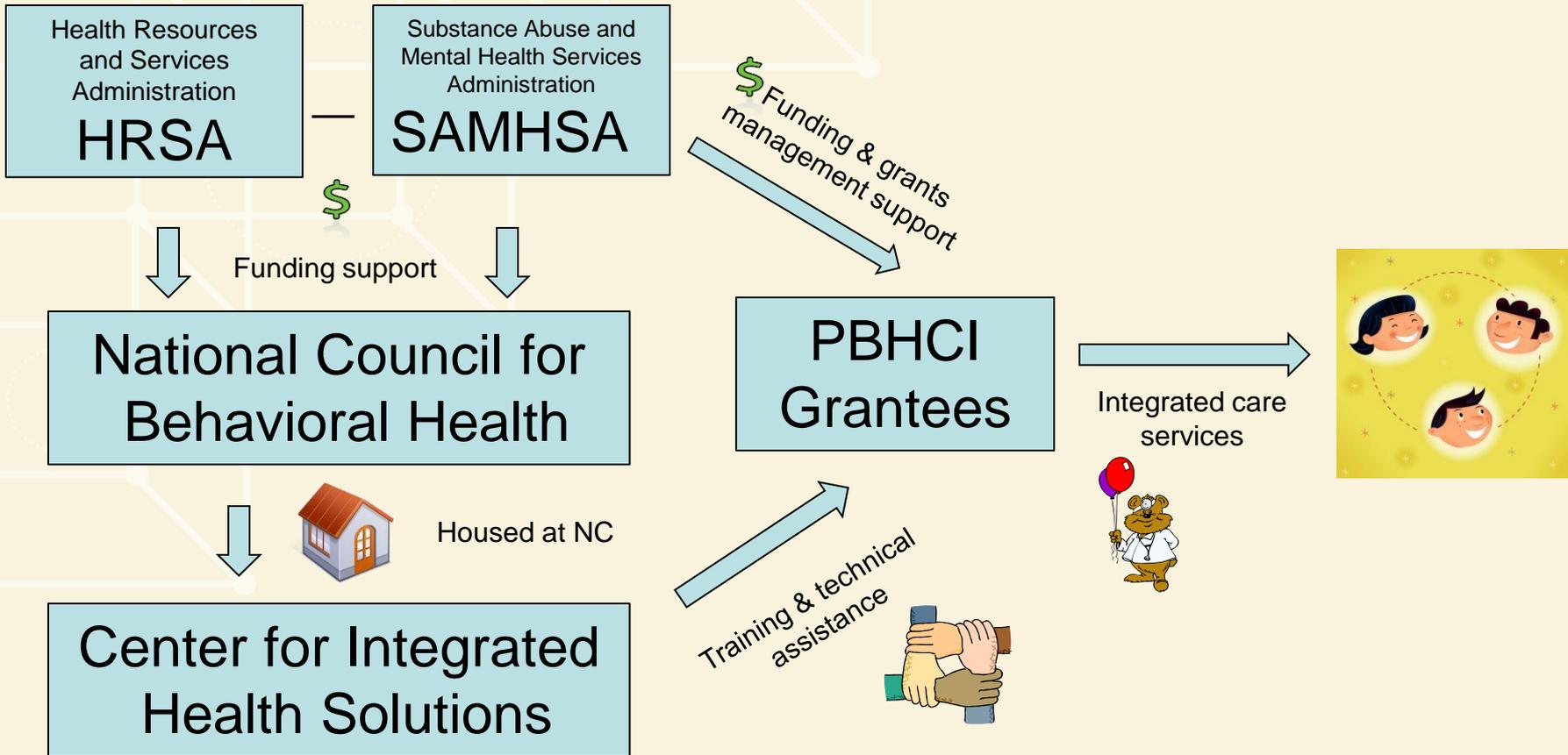
SAMHSA-HRSA Center for Integrated Health Solutions

HHS Region 4 Learning Community In-Person Meeting

February 28-March 1, 2013
Apalachee Center, Inc.
Tallahassee , FL



Connecting the dots...



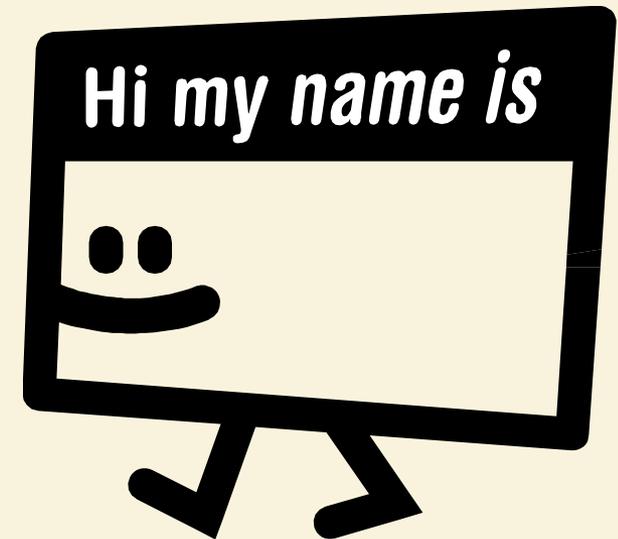
So Tell Us About Yourself...

Each person:

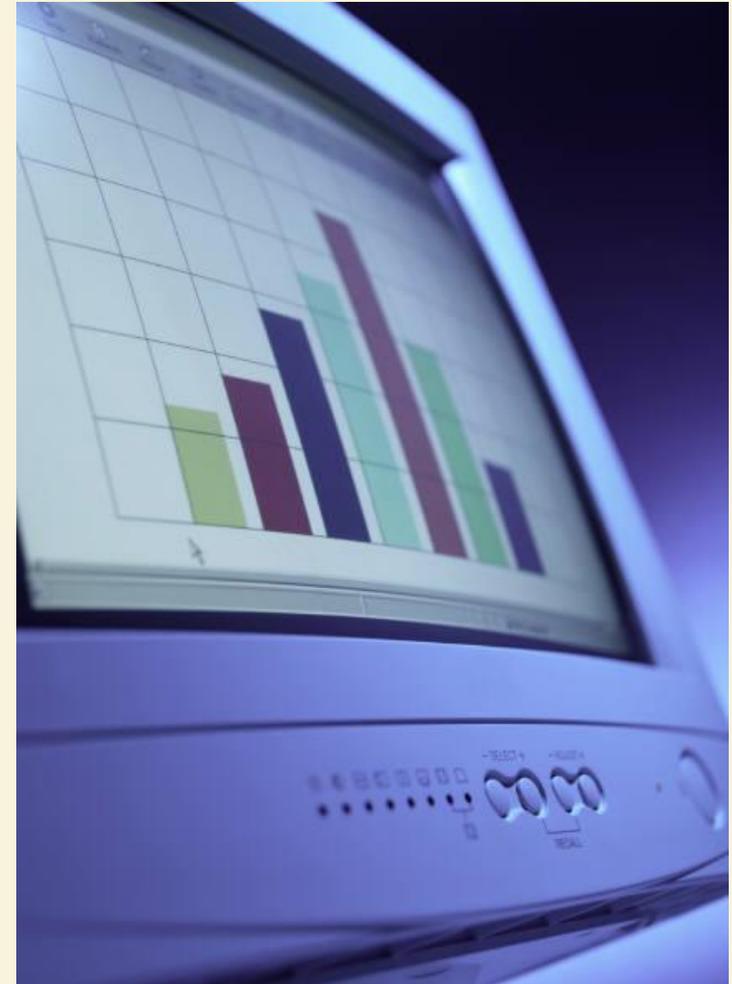
- ✓ **Who you are**
- ✓ **What you do (PBHCI role)**

Each project director (or grantee spokesperson):

- ✓ **Where you are**
- ✓ **What cohort you are in**
- ✓ **What you have achieved in the last 6 months, OR**
- ✓ **What your immediate plans are**



Meeting Theme:
Using Health Information
to Improve Client Care



SAMHSA-HRSA
Center for Integrated Health Solutions



**Strategic Use of Population-Based Information
(groups of patients with similar chronic health
problems) for Improving Health**

How Do Health Registries Work?

Presenter:

Fred D. Rachman

MD, CEO, Alliance of Chicago Community Health Services

**Strategic Use of Population-Based Information
(groups of patients with similar chronic health
problems) for Improving Health**

**RAND Data: An Example of
Population Management**

Presenter:

Marian Scheinholtz

Region 4 , SAMHSA Grant Project Officer



Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



Findings: PBHCI Preliminary Follow-up Evaluation Report



Providers Seen from Enrollment to End of First Year

- **Percent of clients seeing Primary Care Provider: 75.6%**
 - This means that for Cohorts I and II, 75.6% of clients had seen a Primary Care Provider at least once by the end of their first year enrolled in PBHCI.
 - Target: 100%

Physical Health Service Utilization from Enrollment to End of First Year

- **Percent of Clients Using Screening/Assessment Service: 83.7%**
 - This means that for Cohorts I and II, 83.7% of clients had a physical health screening/assessment performed at least once by the end of their first year enrolled in PBHCI.
 - **Target: 100%**

Substance Use Service Utilization from Enrollment to End of First Year

- **Percent of Clients Using Screening/Assessment Service: 57.3%**
 - This means that for Cohorts I and II, 57.3% of clients had a substance use screening/assessment performed by the end of their first year enrolled in PBHCI.
 - Target: 100%
- **Percent of Clients Using Referral Service: 6.9%**
 - This means that for Cohorts I and II, 6.9% of clients were given a referral to a substance use provider by the end of their first year enrolled in PBHCI.
 - FYI: 22.0, 27.2% of clients are using illegal substances or binge drinking, respectively

Wellness Service Utilization from Enrollment to End of First Year

- **Percent of Clients Using Any Wellness Service: 70.3%**
 - This means that for Cohorts I and II, 70.3% of clients used any wellness service at all by the end of their first year enrolled in PBHCI.
- **Percent of Clients Using Smoking Cessation: 23.7%**
 - FYI: 61.3% percent of clients are smokers
- **Percent of Clients Using Wellness Education: 46.3%**
- **Percent of Clients Using Exercise: 23.4%**

Quality of Care for Physical Health Conditions

- Patients with diabetes that received education services related to diabetes, nutrition, cooking, physical activity, or exercise within 1 year of enrolling in PBHCI: 66.5%
 - Target: 100%
- Patients with hypertension that received education services related to hypertension, nutrition, cooking, physical activity, or exercise within 1 year of enrolling in PBHCI: 55.2%
 - Target: 100%
- Patients identified as tobacco users who received cessation intervention during the two-year measurement period: 28.6%
 - Target: 100%

BREAK



Strategic Use of Population-Based Information (groups of patients with similar chronic health problems) for Improving Health

How We Use Health Information

Presenter:

Julio Ruiz

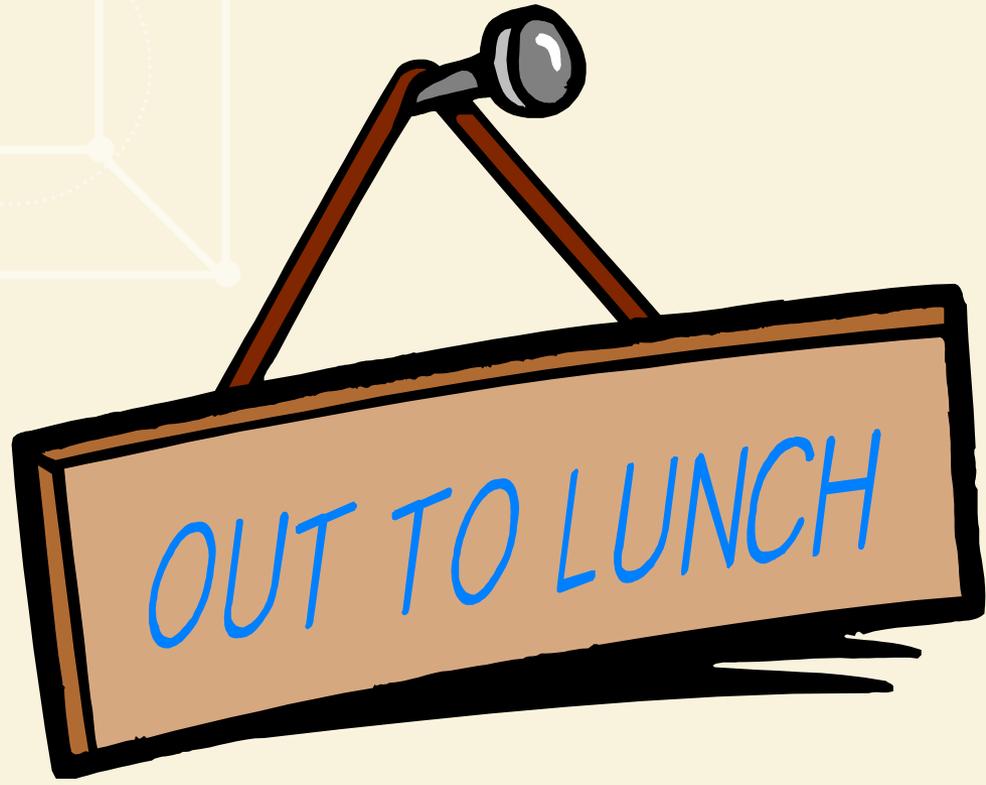
Area General Manager, Banyan Health Systems, Miami, FL

Strategic Use of Population-Based Information (groups of patients with similar chronic health problems) for Improving Health

Team Discussion



- Do we have health indicator reports from our EHRs or a separate registry?
- Do we have the ability to case manage subsets of clients?
- Do we change interventions if groups of clients are not improving? (e.g. diabetes)
- What can we start to implement or improve upon in our population management systems?



How an Individual Moves through the Service System

Presenter:

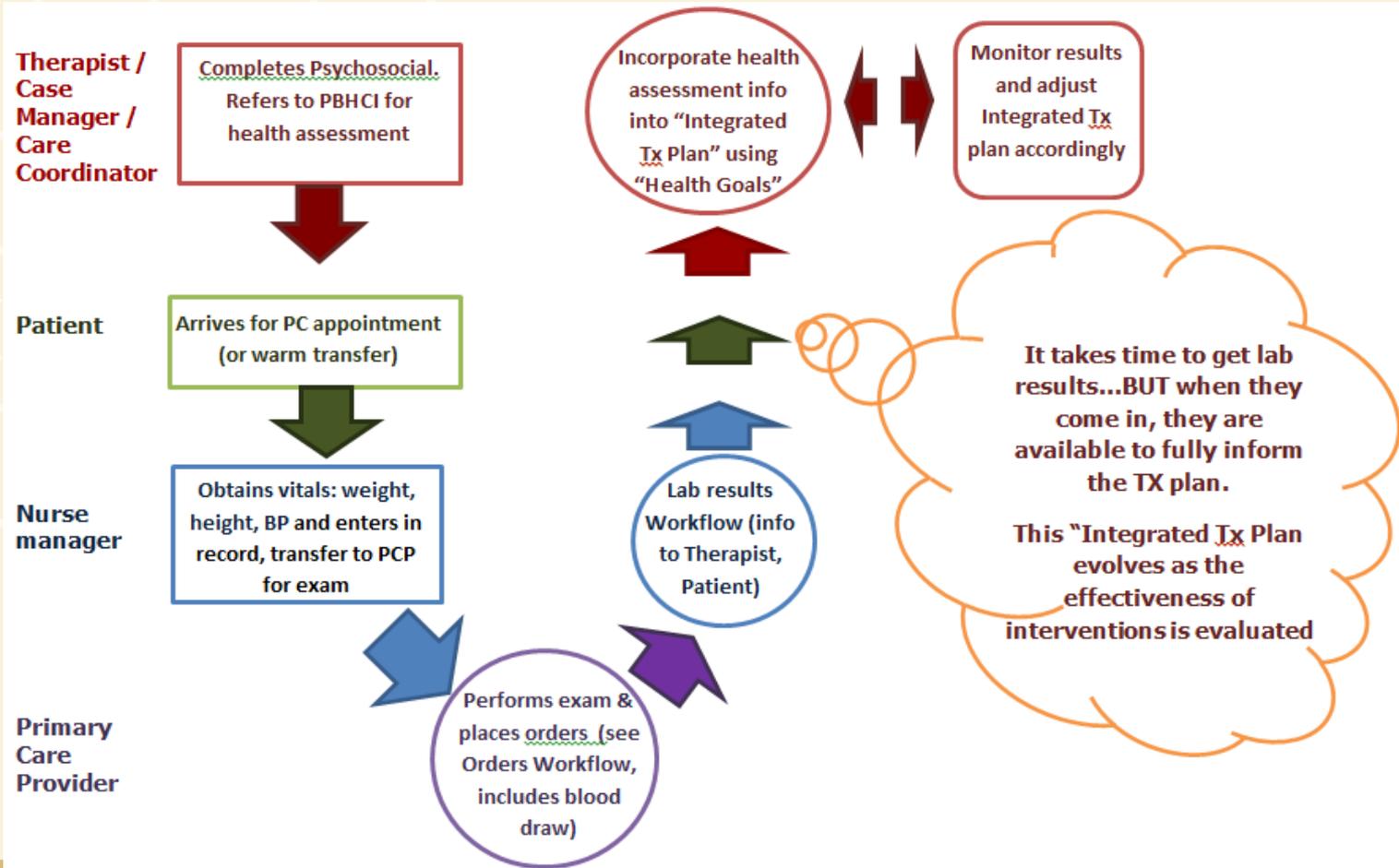
Rick Hankey

*Senior Vice-President/Hospital Administrator, Lifestream
Behavioral Center, Leesburg, FL*

Grantee Group Activity: Integrating Health Data in Integrated Assessment & Treatment Plans

Biopsychosocial Assessment and the Integrated Treatment Plan

New Patient > Assess & Refer to PBHCI > See NCM & PCP > BH Includes Section H: Data in Integrated Treatment (Tx) Planning

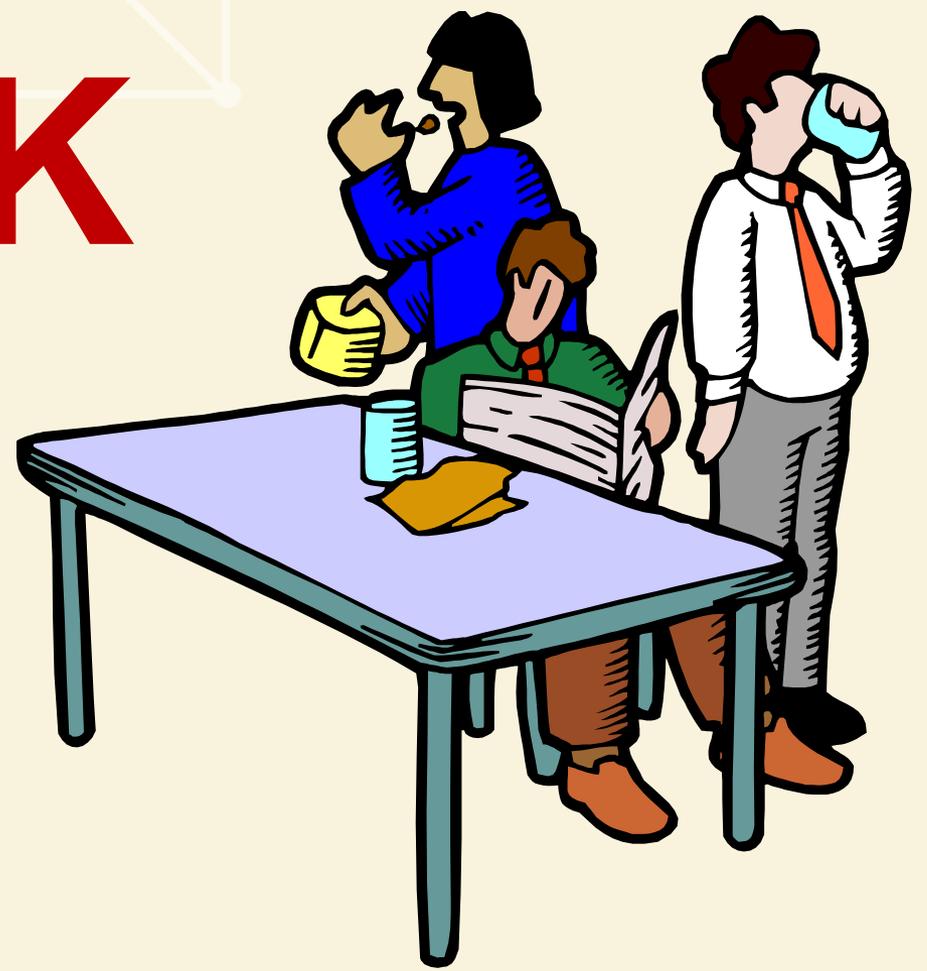


Do your treatment plans include mental health, health and wellness, and if appropriate, substance abuse goals?

Are your behavioral health treatment plan goals periodically updated when your consumers receive updated health reports (e.g., new lab work)?

Are all PC and BH members of the integrated treatment team (e.g., including therapists, psychiatrists, case managers) working with your consumers to actively support their treatment goals?

BREAK



Team Discussion: How Do You Know That Your Wellness Programs Work?

Why are you implementing your current programs?

How do your current programs align with what your population-based health information suggests are priority issues?

Are your wellness programs working?

Are your wellness interventions supported by the current evidence of effectiveness?

How will your wellness programs be sustained in the long term?

What are your plans for sustaining effective wellness interventions with funding and internal policy changes?

Checklist for Evaluating Health Promotion Programs for Persons with Serious Mental Illness: What Works?

This checklist can be used for comparing health promotion programs. Check all that apply. Each of these features is important to consider in evaluating programs that are (a) most effective and (b) also ready for implementation in real-world settings.

Features Associated with Greater Health Promotion Program Effectiveness

- Program has been specifically designed, evaluated, and proven effective for persons with mental illness
- Program has been proven effective in a randomized trial (RCT study) consistent with establishing an “evidence-based practice”
- Outcomes are reported as clinically significant, not just statistically significant (i.e. outcomes include % or total sample weight loss of at least 5% or more and/or reports on clinically significant change in fitness)
- Program consists of active participation in physical activity and nutrition (not just education, class-room, or passive learning)

Checklist for Evaluating Health Promotion Programs for Persons with Serious Mental Illness: What Works?

- Program includes both physical activity and nutrition components (not just one or the other)
- Program includes a component of physical activity/and or nutrition with coaching or supervision by a person with training in fitness and/or nutrition coaching
- Program includes ongoing self-monitoring by the participant and review by the coach or provider of goals and outcomes (e.g. weight, amount of regular physical activity or exercise, nutrition, etc.)
- Duration of program participation is at least 6 months

Checklist for Evaluating Health Promotion Programs for Persons with Serious Mental Illness: What Works?

Features of Programs Associated with Greater Implementation Readiness

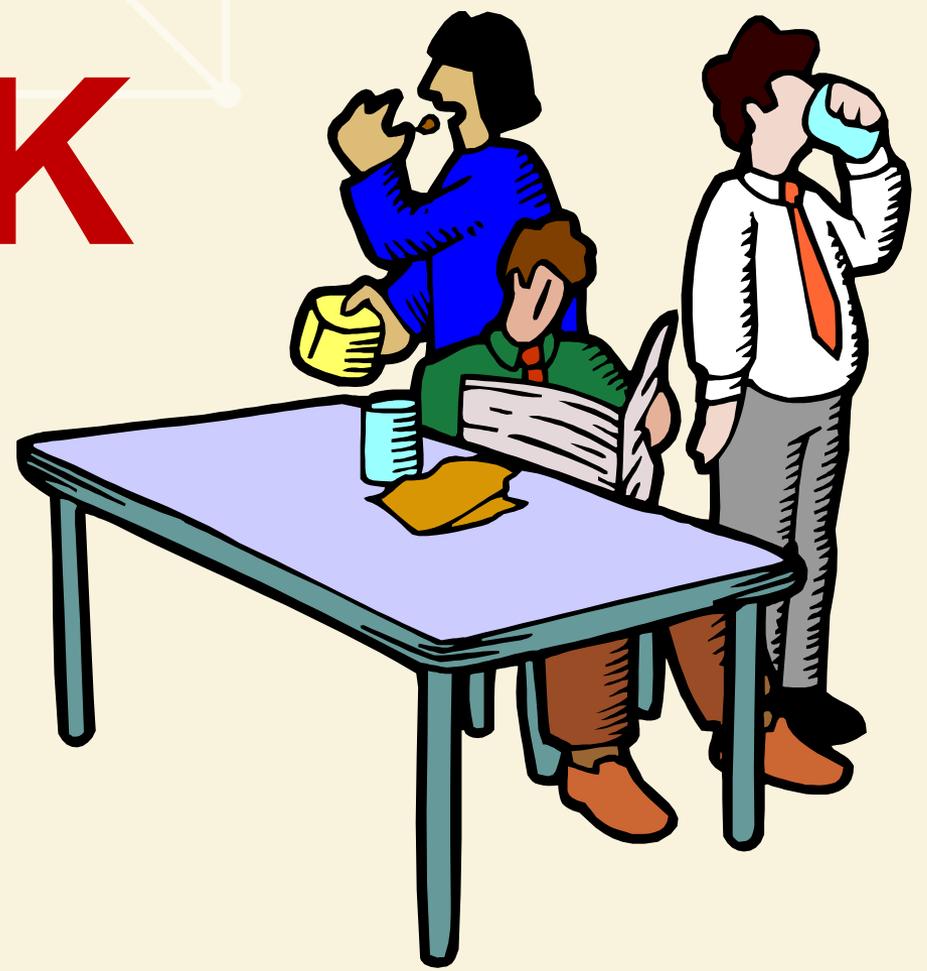
- The program has been implemented at least once outside of the research studies
- The program has been implemented in multiple settings by different agencies outside of the initial research setting
- The program has been implemented and provided without relying on grant funding
- There is an instruction manual for implementing the program designed for providers in real-world settings (not just a research manual)
- Training and implementation technical assistance for the program is available

Action Planning: Tobacco Cessation

Behavioral Health and Wellness Program University of Colorado

Presenter:
Jennifer Hasbrook

BREAK



Grantee Sharing Session

- Do you collect fees from patients? If so, how much?
- How many grantees have received other funding ? Do grantees have additional grants?
- What wellness activities keep clients engaged the most?
Which activities are the most popular?
- What types of additional resources do other grantees use to help fund medication costs? Ex.) Expensive costs of cardio tests for the uninsured
- What is your plan to deal with the increase in documentation as the amount of clients continue to grow?
- Tips on acquiring HMOs for sustainability
- Cohorts I-IV: What is something you would have addressed when you started if you knew what you knew now?
- Are any grantees experiencing patients leaving when they receive Medicaid care?

Grantee Sharing Session

- Are any grantees experiencing patients leaving when they receive Medicaid care?
- Are any grantees from Florida utilizing WRAP? If so, how difficult is it to implement?
- During initial stages – with minimal Medicaid hours – How did other providers manage non emergency but urgent – Medicaid appts. – ie. Clients having the flu and needing to see the provider promptly.

Grantee Sharing Session

- So we have to follow up every 6 months with the NOMS as long as they are receiving services. So someone enrolled in the first 6 months of the grant would get a 42 month follow-up? So there is no such thing as a “discharge” status of “mutually agreed cessation of treatment”
- Is NOMS follow-up requirement of 80 % of intake in 6 months, 80% of intake in 12 months, 80% of intake in 16 months? Or 80% of all follow-ups?

Meeting Wrap Up

Who came up with a plan for:

- ✓ Implementing a registry?
- ✓ Using a registry to inform wellness activities?
- ✓ Improving the integrated treatment plan?
- ✓ Assessing the effectiveness of wellness programs?
- ✓ Tobacco cessation?



THANK YOU

Please remember to complete your evaluation