Using Data to Improve Care

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Agenda

- Identifying target audiences of data

- Understanding methods to move information from aggregate to granular level (and vice-versa)

- Incorporating project dashboards and consumer wellness reports into continuous quality improvement (CQI)
Group Discussion

• Which staff in your organization care about project data?
• What specific information are they interested in?
• Is the data they are interested in aligned with MAI-CoC data collection requirements?
• Why are they interested in this data?
MAI-CoC Data Resources Tab at integration.samhsa.gov
Reporting for External Funders, Board of Directors, Administrators

They want to see….

- Cost savings
- Health improvement
COST SAVINGS
(YEAR ONE)
Missouri Health Homes have saved $30,996,642.

REDUCTION IN HOSPITALIZATIONS IN THE FIRST YEAR
9.1%
(CMHC HEALTH HOME CLIENTS)

Missouri Coalition for Community Behavioral Healthcare, Mar 2015.
Reporting for Program Administrators

They want to see....

- Enrollment rates
- Screening rates
- Prevalence of risk factors
- Risk factor improvement rates (consider disparities!)
- Grant requirements
South of Market Mental Health Primary Care Clinic
Process Dashboard, January 31st 2015

403 total clients enrolled
68% active clients
273 active, 130 discharged

Patients enrolled vs SAMHSA Goal
Jan 2013 - July 2015

467 clients
SAMHSA goal enrollment
Dec 2014

405 Current enrollment

550 Grant end goal
(22 pts/month)

455 Grant end projected
enrollment
(9 pts/month)

Engagement rate & Referral count
Jun - Dec 2014

16 clients referred

9 clients engaged

40% 45% 38% 35% 20% referrals engaged

Completed vs. Cancelled Clinics

New Primary Care patients
July - Jan 2014

Days to first appointment, new clients
May - Jan 2014

= area of success
= area of concern
MAI-CoC Enrollment: Actual vs Target

Percent of People with Positive HIV Screens Who Were Prescribed ART - Actual vs Target
HIV Survivorship Rate: Deaths From Complications Related to AIDS over Last 12 Months / Open Cases of People Who Are HIV+ In Last 12 Months
Group Discussion

• What do you want on your program dashboard?
• How does it align with grant data collection requirements?
• What data exceeds grant requirements?
• Why is this data important?
• Who needs to view this dashboard?
• How can you use it to track progress?
They want to see....

- Health status
- Person-centered plan target metrics
- Crisis plan
- Healthcare coordination
## Glenn County Health Care Collaborative
### INDIVIDUAL WELLNESS REPORT

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

### Progress on Key Health Indicators

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

### 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
Group Discussion

• What do you want on your individual wellness reports?
• How does it align with grant data collection requirements?
• Why is this data important?
• Who needs to view it?
• How can you use it to track progress?
Sources for Data Elements

- Centers for Medicaid and Medicare Services
- National Committee for Quality Assurance
- AHRQ
- Institute for Healthcare Improvement
- Grant requirements
- Finance department
- Your peers
Data Visualization Resources

• Stephanie Evergreen – stephanieevergreen.com

• Edward Tufte – edwardtufte.com

• American Evaluation Association – comm.eval.org/DataVisualizationandReporting/home

• Data Fluency: Empowering Your Organization with Effective Data communication by Gemignani
Any Final Questions?