Cohort IX Webinar Series: PBHCI Data Requirements

November 16, 2016

Slides for today’s webinar are available on the CIHS website at:

http://www.integration.samhsa.gov/pbhci-learning-community/webinars
Got Questions?
Please type your questions into the question box and we will address them.

Today’s Presenter
Aaron Surma, MSW
Manager, Quality Improvement
SAMHSA-HRSA Center for Integrated Health Solutions
Agenda

Individual Data Collection Requirements
- Enrollment
- Reassessment
- Discharge

Population Health Management

Available Resources

DATA COLLECTION REQUIREMENTS - ENROLLMENT
Enrollment – Overview

You will collect interview and health information from each consumer who receives PBHCI services at enrollment (baseline) and reassessment (every 6 months).

The NOMs Interview is available on the TRAC website.

Consumer Health Information (Section H)

**Mechanical Indicators**
- Height
- Weight
- BMI
- Waist Circumference
- Blood Pressure
- Breath CO

**Blood Work**
- Fasting Glucose or HbA1c
- Triglycerides
- HDL Cholesterol
- LDL Cholesterol
- Total Cholesterol

The health indicator data collection tool is available on the TRAC website.
Enrollment – How to succeed

Meet your enrollment goal (goal is 100%+. <70% is a potential SAMHSA administrative review).

Create a workflow for collecting enrollment information:
- Identify who collects NOMs information & health indicators
- Protocol for scheduling NOMs interviews & health indicators
- Protocol for entering consumer-level data into TRAC

Enrollment – How to succeed (continued)

Track your performance
- Are we on track to meet our enrollment target for the year?
- Are we collecting complete information at baseline?
Enrollment – Details

- Everyone with an SMI diagnosis who is at risk for a chronic health condition is eligible for PBHCI

- The NOMs interview must be performed within 7 days of an individual receiving PBHCI services
- Anyone can perform a NOMs interview. No special credentials/training required
- NOMs interviews cannot be batch uploaded to TRAC
- Ask your GPO for approval to conduct NOMs interviews over the phone due to special circumstances
- The NOMs interview date is the official enrollment date

Enrollment – Details (continued)

- Mechanical indicators (BMI, waist circumference, blood pressure, breath CO) must be collected within 30 days before/after the enrollment date
- Blood labs (cholesterol panel, HgbA1c or fasting blood glucose) must be collected within 60 days before/after the enrollment date
- Health indicators that are obtained from other providers are valid as long as they were performed within the proper collection window
- Grant funds can be used to pay for labs
DATA COLLECTION REQUIREMENTS - REASSESSMENT

Reassessment – Overview

To track health improvement (or lack thereof) over time, you will reassess (rescreen) all enrolled consumers every 6 months.

Reassessments include NOMs interview and health indicators.
Reassessment – How to succeed

Meet your reassessment goal (goal is 80%-100%. <62% is a potential SAMHSA administrative review).

Have a process for:
- Identifying consumers who are due for reassessment
- Scheduling reassessment visits
- Entering reassessment data into TRAC
Reassessment – How to succeed (continued)

Track your progress:
- Are you reassessing everyone who is due for reassessment?
- Are you collecting all required health indicators at each reassessment?

Reassessment – Details

Reassessments are due 180, 360, 540, 720… days after the enrollment date

NOMs interview and mechanical indicators are due +/- 30 days from the reassessment due date

Blood labs are due +/- 60 days from the reassessment due date

The Services Notification Report in TRAC will tell you when upcoming reassessments are due
DATA COLLECTION REQUIREMENTS - DISCHARGE

Discharge – Overview

If an individual no longer receives PBHCI services (due to moving, no longer in need of services, death, other) they should be discharged from TRAC.
**Discharge – How to succeed**

Set criteria for discharge. Most orgs use 90 days without contact unless it is known that the individual will not return.

Set a process for discharge
- Scan your list of enrolled consumers for people who should be discharged
- Collect final NOMs and health indicators, if possible
- Create a process for entering discharge information into TRAC

**Discharge – Details**

Discharge from PBHCI does not mean discharge from your organization

If you discharge someone, they can resume PBHCI services in the future. Use the same consumer ID that you used the first time they were enrolled.
South of Market Mental Health Primary Care Clinic
Process Dashboard, March 2014
As of March 12, 2014

282
total clients enrolled
(met grant criteria & enrolled, 4/2012-present)

67
discharged

215
total active clients
(currently enrolled in grant)

Completed vs. Cancelled Clinics
Jan 2014-Mar 2014

36 (84%)
Completed Clinics

7 (16%)
Cancelled Clinics

Clinic hours lost 25

Patients enrolled vs SAMHSA Goal
Jan 2013- Mar 2014

316
315

282

Referrals to primary care by BH providers
Aug 2013-Mar 2014

Completed
No-show (never completed)
Apt in future/Unknown

Goal, 2 total
# Population Health Management

Glenn County Health Care Collaborative

## Individual Wellness Report

### 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><strong>Lungs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breathing CO (0-5)</td>
<td>25</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td><strong>Weight</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>BMI (18.5-24.9)</td>
<td>25.8</td>
<td>28.1</td>
<td>25.2</td>
</tr>
<tr>
<td></td>
<td>Weight</td>
<td>162.0</td>
<td>174.0</td>
<td>158.0</td>
</tr>
<tr>
<td></td>
<td>Waist Circumference</td>
<td>35.5</td>
<td>31.5</td>
<td>32.2</td>
</tr>
<tr>
<td><strong>Blood Pressure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Systolic BP (90-140)</td>
<td>135</td>
<td>135</td>
<td>114</td>
</tr>
<tr>
<td></td>
<td>Diastolic BP (60-90)</td>
<td>80</td>
<td>75</td>
<td>70</td>
</tr>
<tr>
<td><strong>Blood Sugar</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fasting Glucose (70-100)</td>
<td>115</td>
<td>-</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td>Hemoglobin A1c (4.0-6.0)</td>
<td>5.6</td>
<td>-</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Heart Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Cholesterol (125-200)</td>
<td>197</td>
<td>-</td>
<td>189</td>
</tr>
<tr>
<td></td>
<td>LDL Cholesterol (30-129)</td>
<td>111</td>
<td>-</td>
<td>101</td>
</tr>
<tr>
<td></td>
<td>HDL Cholesterol (40+)</td>
<td>76</td>
<td>-</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>Triglycerides (50-149)</td>
<td>53</td>
<td>-</td>
<td>54</td>
</tr>
</tbody>
</table>

### Client Wellness Goal(s):
- Sea Well will lose 5 pounds within 6 months.
- Sea Well will maintain her excellent progress in reducing/stopping her tobacco use.

### Client Mental Health Goal(s):
- Sea Well will sleep at least 7 hours each night to decrease symptoms of depression.
# Team Huddle Report

## Most Recent

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Care Coordinator</th>
<th>Date last seen</th>
<th>Blood pressure</th>
<th>Breath co</th>
<th>BMI</th>
<th>Risk level</th>
<th>Enrolled in NEW-R</th>
<th>Enrolled in smoking group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bob</td>
<td>Marley</td>
<td>Carol</td>
<td>7/13/2016</td>
<td>125/100</td>
<td>25</td>
<td>32</td>
<td>High</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Talib</td>
<td>Kweli</td>
<td>Carol</td>
<td>10/15/2016</td>
<td>145/99</td>
<td>30</td>
<td>32</td>
<td>High</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lauryn</td>
<td>Hill</td>
<td>Mike</td>
<td>6/5/2016</td>
<td>145/90</td>
<td>8</td>
<td>26</td>
<td>Med</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Clibo</td>
<td>Matto</td>
<td>Carol</td>
<td>1/1/2016</td>
<td>130/70</td>
<td>5</td>
<td>23</td>
<td>Low</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Poly</td>
<td>Styrene</td>
<td>Carol</td>
<td>11/2/2016</td>
<td>130/70</td>
<td>3</td>
<td>23</td>
<td>Low</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Jason</td>
<td>Molina</td>
<td>Mike</td>
<td>10/29/2016</td>
<td>145/90</td>
<td>20</td>
<td>20</td>
<td>Med</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

## VITALS: Percent improving/maintaining outcomes among active SAMHSA consumers

Double click cell counts for consumer detail.

<table>
<thead>
<tr>
<th>Flow Labels</th>
<th>Values</th>
<th>current</th>
<th>consumers with 2+ BMI while in</th>
<th>Percent maintaining/improving BMI</th>
<th>consumers with 2+ systolic while in program</th>
<th>Percent maintaining/improving systolic</th>
<th>consumers with 2+ diastolic while in program</th>
<th>Percent maintaining/improving diastolic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Manager 1</td>
<td>22</td>
<td>14</td>
<td>57%</td>
<td>18</td>
<td>50%</td>
<td>18</td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td>Care Manager 2</td>
<td>24</td>
<td>21</td>
<td>52%</td>
<td>21</td>
<td>45%</td>
<td>21</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>Care Manager 3</td>
<td>32</td>
<td>15</td>
<td>44%</td>
<td>20</td>
<td>45%</td>
<td>20</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Care Manager 4</td>
<td>13</td>
<td>10</td>
<td>40%</td>
<td>10</td>
<td>70%</td>
<td>10</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>Care Manager 5</td>
<td>5</td>
<td>4</td>
<td>35%</td>
<td>4</td>
<td>75%</td>
<td>4</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Care Manager 6</td>
<td>20</td>
<td>19</td>
<td>50%</td>
<td>19</td>
<td>42%</td>
<td>19</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>124</td>
<td>88</td>
<td>50%</td>
<td>32</td>
<td>31%</td>
<td>32</td>
<td>34%</td>
<td></td>
</tr>
</tbody>
</table>
NOM Health Domains: Baseline to 6 Months

- **Breath CO**
  - 40% Always POSITIVE
  - 20% IMPROVED (Negative -> Positive)
  - 40% WORSENERD (Positive -> Negative)

- **Wrist Circumference**
  - 10% WORSENERD (Positive -> Negative)

- **BMI**
  - 20% Always AT-RISK

- **Blood Pressure**
  - 20% Always POSITIVE
  - 50% IMPROVED (Negative -> Positive)
  - 10% WORSENERD (Positive -> Negative)

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**Healthcare Utilization Financial Data**

**Acute/Inpatient vs Outpatient Charges**

- **Inpatient/Acute Charges**
  - $2,223,083
- **Outpatient Charges**
  - $1,662,966
  - $785,693.00
  - $534,973.00

**Federal Fiscal Year: Oct 1 – Sept 30**

C Esquivel, MD, MBA
Health Integration Project

Hospital Usage

- ED admits
  - 342 consumers
  - 618 less ED admits in year post HIP enrollment
  - Average of $1429 per admit
  - Estimated annual savings $883,122

<table>
<thead>
<tr>
<th>Year Pre Enrollment in HIP</th>
<th>Year Post Enrollment in HIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sum of ED admits</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>1590</td>
</tr>
</tbody>
</table>

Cost Estimate

<table>
<thead>
<tr>
<th>Year Pre Enrollment in HIP</th>
<th>Year Post Enrollment in HIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$2,539,333</td>
</tr>
<tr>
<td>$500,000</td>
<td>$1,656,211</td>
</tr>
<tr>
<td>$1,000,000</td>
<td></td>
</tr>
<tr>
<td>$1,500,000</td>
<td></td>
</tr>
<tr>
<td>$2,000,000</td>
<td></td>
</tr>
<tr>
<td>$2,500,000</td>
<td></td>
</tr>
</tbody>
</table>

Registry Options

SPSS & Access registry examples are available on the CIHS website.
RESOURCES AVAILABLE TO YOU

Resources

**CIHS** - Aaron Surma. AaronS@thenationalcouncil.org and/or your regional liaison.

**GPO** - Your regional SAMHSA grant project officer

**TRAC** - TRAC helpdesk (trachelp@westat.com) and the General info and training section of the TRAC website.

**Other grantees** – listserv, evaluation affinity group calls (November 29!), regional meetings
Reminder

What?
Next Webinar in the Series: Creating Your Wellness Component – Selecting & Implementing Evidence-based Practices

When?
Wednesday, November 30, 2016 • 2:00 – 3:30 PM EST

Who should attend?
Project directors, peer wellness coaches, wellness coordinators

What will you learn?
• Essential elements of a comprehensive wellness program
• Sustaining wellness services
• Evidence-based wellness services, including Million Hearts Campaign protocols

Please complete the survey that follows this webinar!