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Using Data to Inform Patient Care

Miami Behavioral Health Center
San Francisco Department of Public Health
Monday, August 11, 2014

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Data as a Tool for Integrated Care

Emy Lou Pesantes, MBA, MSW
Banyan Health Systems
(Miami Behavioral Health Center)
Miami, Florida

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About the Speaker

Ms. Pesantes, MSW, MBA is the Director of Research and Development at Banyan Health Systems (founders of Spectrum Programs, Inc. and Miami Behavioral Health Center). Ms. Pesantes received her M.S.W. and M.B.A. at Florida International University. She has been involved with managing the process evaluation efforts for SAMHSA programs: a Center of Excellence, the System of Care change in Miami-Dade County, a primary and behavioral health care integration, and a Consumer driven grant. Prior to that experience she collected data and implemented an intervention for an NIH funded project with high school students.

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Why is data important?

- Informs audience
- Informs decisions
- Educates consumer

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Methodology for Evaluation Reports

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Dissemination Rationale

- Feedback loop
- Big picture
  - Create user friendly Evaluation Updates to inform
- Conduct focus groups with consumers to inform
- Have discussions with project team highlighting areas of improvement and challenges

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Personalized Feedback Report

Sam, here are your most recent physical health indicators:

The physical health indicators we collect tell us whether your health is at risk. The chart below highlights the areas where you have improved.

Physical Health Indicators	Baseline 10/12/12	6M	12M	18M	24M
Weight	113				
Body Mass Index (BMI) Your body fat based on your weight and height *At risk if 25 or higher*	18				
Blood Pressure The force of your heart pumping blood through your veins *At risk if 140 or higher*	117				
Glucose How much sugar is in your blood *At risk if 100 or higher*	89				
HbA1c Another measure of how much sugar is in your blood *At risk if 5.7 or higher*	5.0				
Total Cholesterol *At risk if 200 or higher*	180				
HDL Cholesterol Good cholesterol *At risk if less than 40*	74				
LDL Cholesterol Bad cholesterol *At risk if 130 or higher*	89				
Triglycerides Fats carried in blood like excess calories, alcohol, or sugar *At risk if 150 or higher*	83				
You rated your overall health as:	Poor	Choose an item.	Choose an item.	Choose an item.	Choose an item.

Recommendations (to be completed by the Wellness Coordinator):

____

____

____

____

Goals (to be completed by Sam):

____

____

____

____

Your next appointment is on: ______________

Reviewed by:

______________________ (Sam's signature)

______________________ (Wellness Coordinator signature)

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Medical Progress Report

SAMHSA PBHCI
Por Tu Salud

Health Indicators Progress Report

Physical Health Indicators		Baseline	3M	6M	9M	12M
Date						
Weight						
Body Mass Index (BMI) Your body fat based on your weight and height [illegible]						
Classification	Normal weight: BMI is 18.5 to 24.9					
	Overweight: BMI is 25 to 29.9					
	Obese: BMI is 30 or more					
Blood Pressure						
Category / systolic / diastolic						
Normal <120 and <80						
Prehypertension 120-139 or 80-89						
High Blood Pressure						
Stage 1 Hypertension 140-159 or 90-99						
Stage 2 Hypertension >=160 or >=100						
Glucose How much sugar is in your blood? *At risk if 100 or higher*						
HbA1c: Another measure of how much sugar is in your blood						
Normal range between 4 and 6%						
Poor sugar regulation over 6%						
Goal for diabetics below 7%						
The higher the A1c level the greater the risk of developing complications of diabetes						
Total Cholesterol *At risk if 200 or higher*						
HDL Cholesterol Good cholesterol *At risk if less than 40*						
LDL Cholesterol Bad cholesterol *At risk if 130 or higher*						
Triglycerides Fats carried in blood like excess calories, alcohol, or sugar *At risk if 150 or higher*						

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Por Tu Salud

Medical Progress Notes

DATE	COMMENTS	INITIALS

Please note:
Highly Favorable: Person served improved more than 75% of his /her health indicators
Favorable: Person served improved more than 50 % of his /her health indicators
Stable: Person served did not present any improvement
Unfavorable: Person served's health indicators show that his/her medical conditions have worsened

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Implement feedback

- Wellness coordinator added information based on meeting with consumers
  - Added information that would give consumers more detailed information about health factors
  - Notes for recommendations
  - Assessment of progress
- Wellness coordinator kept most meaningful information

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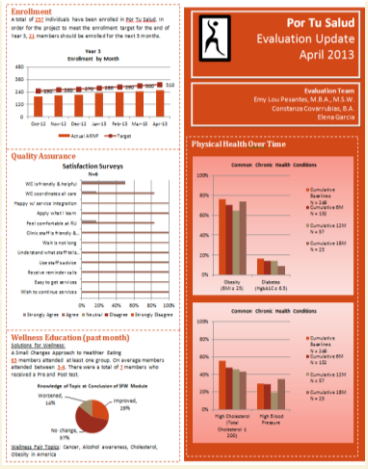
Monthly Data Profile Samples



- Enrollment
- Quality Assurance
- Wellness Education
- Physical Health Characteristics

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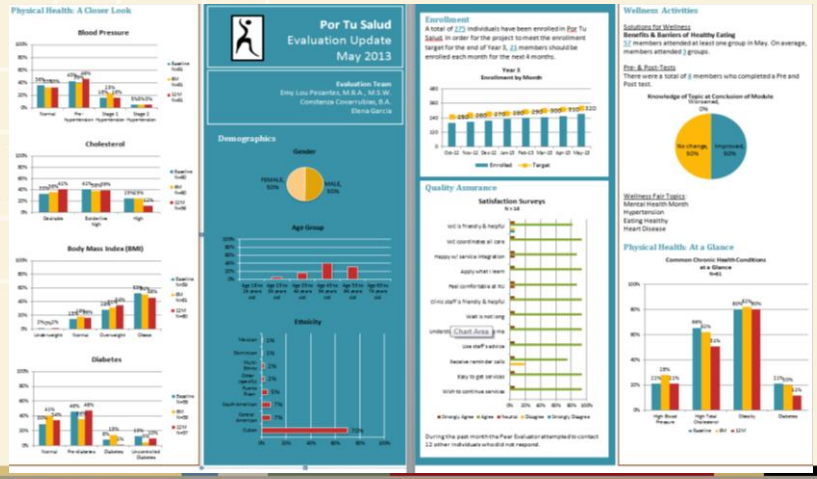
Monthly Data Profile



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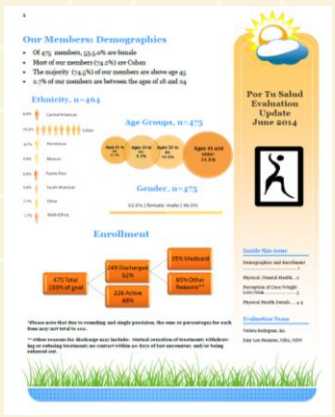

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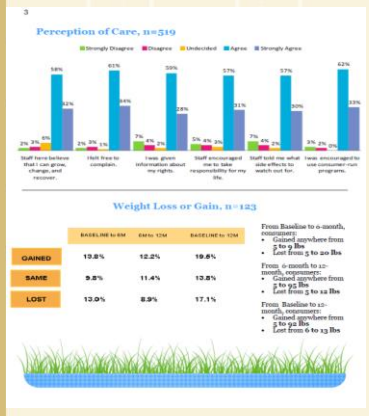

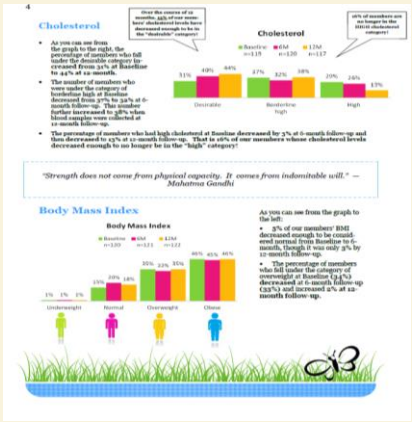

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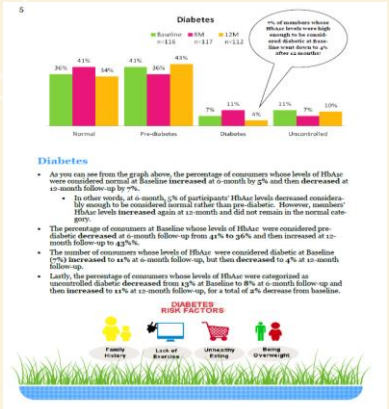

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How was data used to make decisions?

Project Team

- Focused on the areas that were a challenge during monthly staff meetings.
- Incremental changes are important
- Introduced topics for areas that were continuously a challenge
- Addressed individual consumer needs

Executive Management

- Used data for funding opportunities
- Had material to inform board

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Lessons Learned

- Provide feedback earlier on
- Involve consumers in the process
- Data drives decisions
- Be creative in the use of data, stray away from the norm
- Use data to educate consumers

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Data visualization as a tool for integrated care

How to demystify data and turn it into action

Elisa Gill, Lead Evaluator
Alberto Perez-Rendon, Project Manager
San Francisco Department of Public Health

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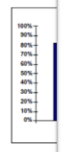
Presenters:

Elisa Gill is the lead evaluator of the PBHCI program at South of Market Mental Health, where she has worked as part of an onsite evaluation team for two years. She is interested in telling stories with data and advancing data-driven quality improvement in the public sector. She has a B.A. from Boston University, where she also worked as a program evaluator and public health research assistant.

Alberto Perez Rendon is the current project manager of the PBHCI program at the South of Market Mental Health Clinic in San Francisco. He has over a decade of experience in planning, implementation and evaluation of public health programs in the non-profit and public sectors. Alberto has worked in both primary care and in mental health settings which gives him a good understanding of the challenges and opportunities encountered in the processes of integration.

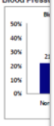
Physical hea



BMI

Metric BMI (B
Less than 18.
18.50-24.99
25.00-29.99
30.00-34.99
35.00-39.99
40.00 or high

Blood Press

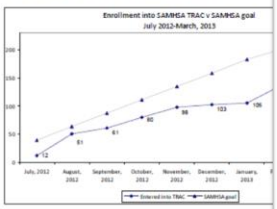


SFGH utilization

SFGH utilization past 12 months, PBHCI enrollees (n=65)			
	N	%	Avg admits
SFGH ER (Medical)			
Admit past 12 mos	26	41%	1.73
SFGH ER (Psych)			
Admit past 12 mos	8	13%	0.19
SFGH Inpatient (med)			
Admit past 12 mos	5	8%	0.09
SFGH inpatient (psych)			
Admit past 12 mos	7	11%	0.22

As of March 25th, there are **155 clients enrolled in TRAC** (SAMHSA calculates 'enr
of clients who are 'enrolled' in TRAC) – to be enrolled in TRAC, a client needs to n

1. Have had at least one primary care visit onsite
2. Currently receive behavioral health care onsite
3. Either a. completed or b. refused to complete NOMS survey



As of March 25th, our reassessment rate (for interviews) is 70% - the target is 80%

As of March 25th, there are 190 patients who are on the integrated 'registry' (part

- Typically, clients are assigned at the first visit with an provider onsite, alt
  assigned when they've received an RN assessment (but before being seen
- This # is the closest estimate of the # that are currently active/being serv
- Approximately 79% of clients who are currently active/being served are
- *The registry is a dynamic list – clients step up, step down, die, move away*
  September, 54 were discharged (or removed from the registry: the most
  is that they are no longer receiving medical or mental health services ons
  were added to the registry-ten clients were added in March alone.
- *158 of 190 patients are also seen at SOMMH (SC or ICM (SFFIRST)*

Provider	Scheduled clinic hours/weekly	Patie
Laurie Noblette	10	
Deb Borne	4	

Referrals to onsite primary care

- 75 patients referred from September – February (average = ~11-12 refer
- Median # of days from referral to first appointment (scheduled) = 34 da
- Average # of days from referral to first appointment (scheduled) = 36.2
- Time to first appointment increasing: average days from referral to first
  = 31.8 days (clients referred from Sept-Dec) vs 39.6 days (clients referre

Clinic Utilization from the LCR

Received list of all encounters coded OBSMPC or OBHOTPC from July 1, 2012 –March 15, 2013

July 1, 2012 - March 15, 2013	Visits, total	Visits (exclude JNP patients after 12/12)
MEA (Avellan)	16	16
MEA (Comia)	21	21
Noblette	194	194
Borne	113	113
Newhard-Parks	209	130
Peirce	21	21
Statistical	17	0
Total	591	495
Average visits/month	70	58

- Total patients seen (unduplicated) = 248 patients (including JNP)
- Total patients seen (excluding patients seen by JNP in 2013) = 206
- Total patients seen by just LN, DB & KP=152

(Question: when did JNP stop providing services at the satellite? Is it likely that she saw patients that DB would not have also seen?)

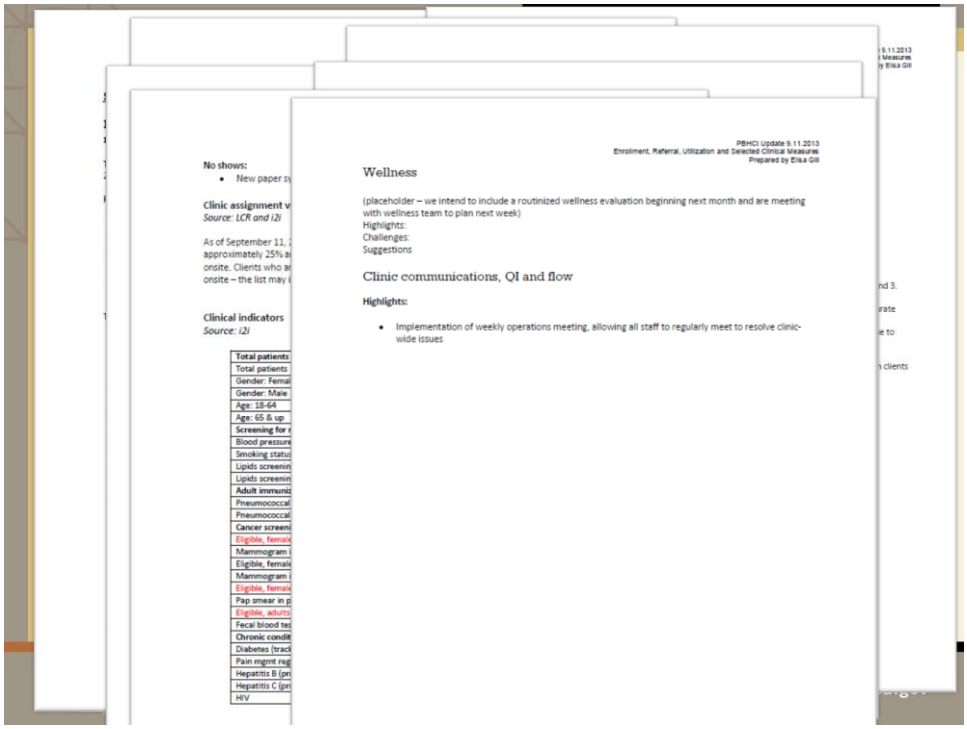
Clinic utilization Jan & Feb 2013 (using LCR encounter data (clinic code SPMC08/HOTPC08)

Total # clinic hours	Total # visits	Overall productivity	Total patients seen
106	123	1.16	93

Note: productivity ranged from 0.33 – 2.5 (median 1.143; average 1.236)
Of the total # of visits, 100 had vitals entered into the LCR (=80%)

COPC/QI Measures: Diabetes Registry (13 patients on the diabetes registry)

- 92% had BP checked within the past six months
- 69% had metabolic labs drawn within the past 6 mos; 85% in the past 12 mos
- 92% (12/13) had HgbA1c 'controlled' at =8.0 at last draw



PBHCI Update 9.11.2013
Enrolment, Referral, Utilization and Selected Clinical Measures
Prepared by Elisa Gill

Wellness

(placeholder – we intend to include a routinized wellness evaluation beginning next month and are meeting with wellness team to plan next week)
Highlights:
Challenges:
Suggestions

Clinic communications, QI and flow

Highlights:

- Implementation of weekly operations meeting, allowing all staff to regularly meet to resolve clinic-wide issues

No shows:

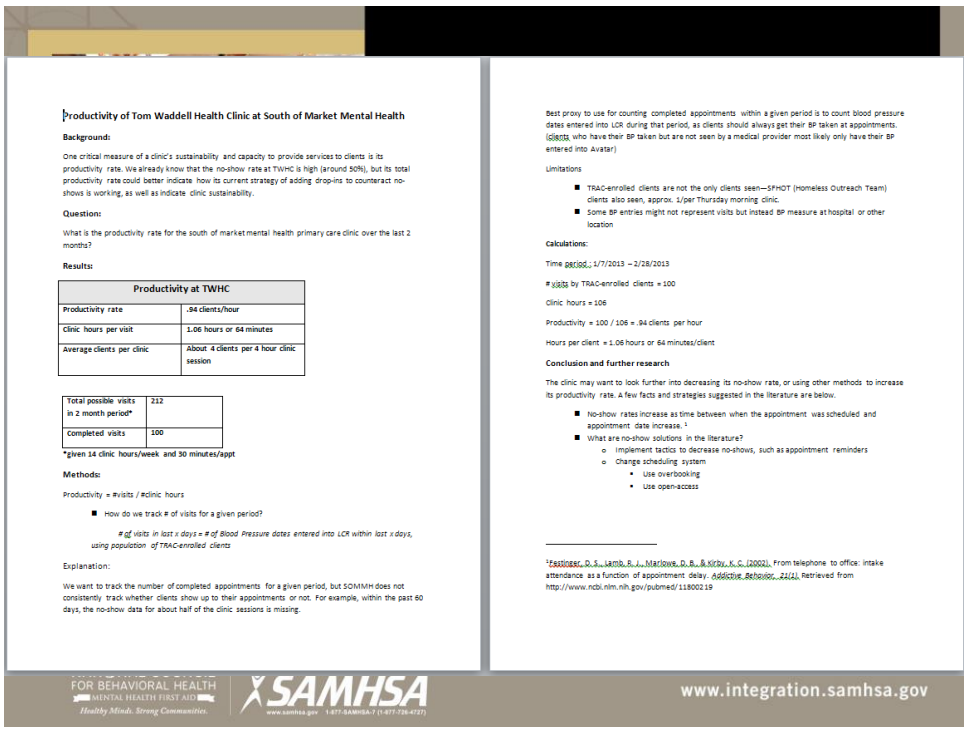
- New paper sy

Clinic assignment v
Source: LCR and i2i

As of September 11, 2
approximately 25% a
onsite. Clients who a
onsite – the list may

Clinical indicators
Source: i2i

Total patients
Total patients
Gender: Femal
Gender: Male
Age: 18-64
Age: 65 & up
Screening for c
Blood pressure
Smoking status
Lipids screenin
Lipids screenin
Adult immuniz
Pneumococcal
Pneumococcal
Cancer screeni
Eligible, female
Mammogram i
Eligible, female
Mammogram i
Eligible, female
Pap smear in p
Eligible, adults
Fecal blood tes
Chronic condit
Diabetes (track
Pain mgmt reg
Hepatitis B (pr
Hepatitis C (pr
HIV



Productivity of Tom Waddell Health Clinic at South of Market Mental Health

Background:

One critical measure of a clinic's sustainability and capacity to provide services to clients is its productivity rate. We already know that the no-show rate at TWHC is high (around 50%), but its total productivity rate could better indicate how its current strategy of adding drop-ins to counteract no-shows is working, as well as indicate clinic sustainability.

Question:

What is the productivity rate for the south of market mental health primary care clinic over the last 2 months?

Results:

Productivity at TWHC	
Productivity rate	.94 clients/hour
Clinic hours per visit	1.06 hours or 64 minutes
Average clients per clinic	About 4 clients per 4 hour clinic session

Total possible visits in 2 month period*	212
Completed visits	100

*given 14 clinic hours/week and 30 minutes/appt

Methods:

Productivity = #visits / #clinic hours

- How do we track # of visits for a given period?

# of visits in last x days = # of Blood Pressure dates entered into LCR within last x days, using population of TRAC-enrolled clients

Explanation:

We want to track the number of completed appointments for a given period, but SOMMH does not consistently track whether clients show up to their appointments or not. For example, within the past 60 days, the no-show data for about half of the clinic sessions is missing.

Best proxy to use for counting completed appointments within a given period is to count blood pressure dates entered into LCR during that period, as clients should always get their BP taken at appointments. (clients who have their BP taken but are not seen by a medical provider most likely only have their BP entered into Avatar)

Limitations

- TRAC-enrolled clients are not the only clients seen—SFHOT (Homeless Outreach Team) clients also seen, approx. 1/per Thursday morning clinic.
- Some BP entries might not represent visits but instead BP measure at hospital or other location

Calculations:

Time period : 1/7/2013 – 2/28/2013

visits by TRAC-enrolled clients = 100

Clinic hours = 106

Productivity = 100 / 106 = .94 clients per hour

Hours per client = 1.06 hours or 64 minutes/client

Conclusion and further research

The clinic may want to look further into decreasing its no-show rate, or using other methods to increase its productivity rate. A few facts and strategies suggested in the literature are below.

- No-show rates increase as time between when the appointment was scheduled and appointment date increase. [1]
- What are no-show solutions in the literature?
  - Implement tactics to decrease no-shows, such as appointment reminders
  - Change scheduling system
    - Use overbooking
    - Use open-access

[1] Festinger, D. S., Lamb, R. J., Marlowe, D. B., & Kirby, K. C. (2002). From telephone to office: intake attendance as a function of appointment delay. *Addictive Behavior, 27*(1). Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11800219

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Clinic Productivity & New Clients
May-July 2013
= existing client
= new client
May 2013 | Clients seen each clinic
new clients per week
Mon
1 Wed
Thurs
0
6 Mon
Wed
Thurs
3
13 Mon
Wed
Thurs
1
20 Mon
Wed
Thurs
0
27 Mon
Wed
Thurs
3
Full Clinic
Goal: 4 new clients/ week
May Avg.: 1.4
Elisa Gill 8.28.2013
rated
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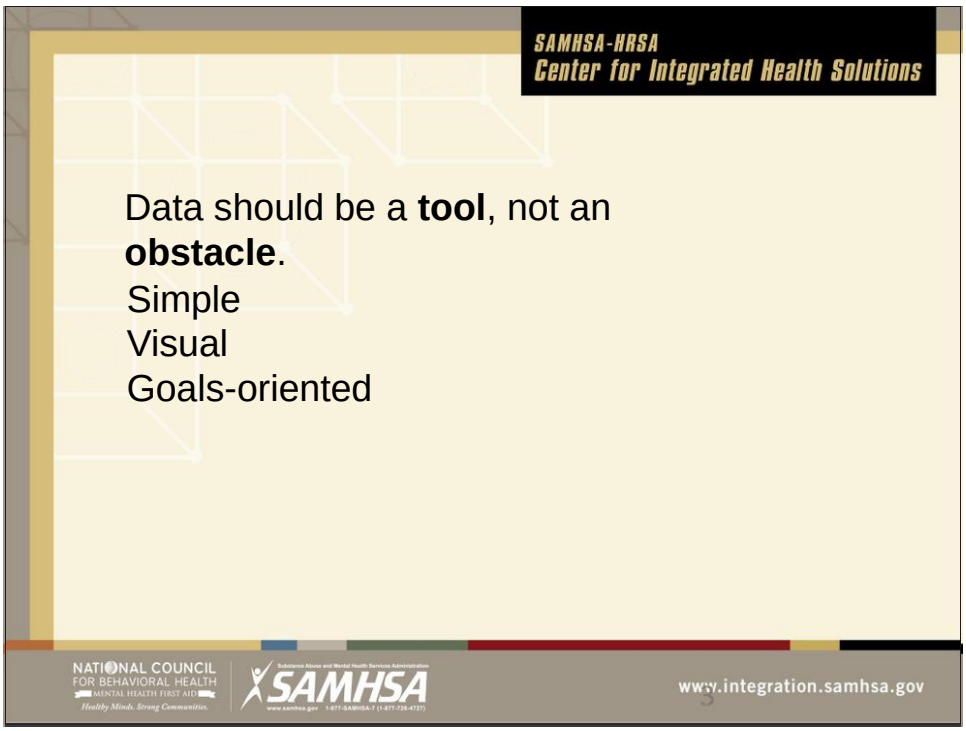
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Data should be a **tool**, not an **obstacle**.
Simple
Visual
Goals-oriented
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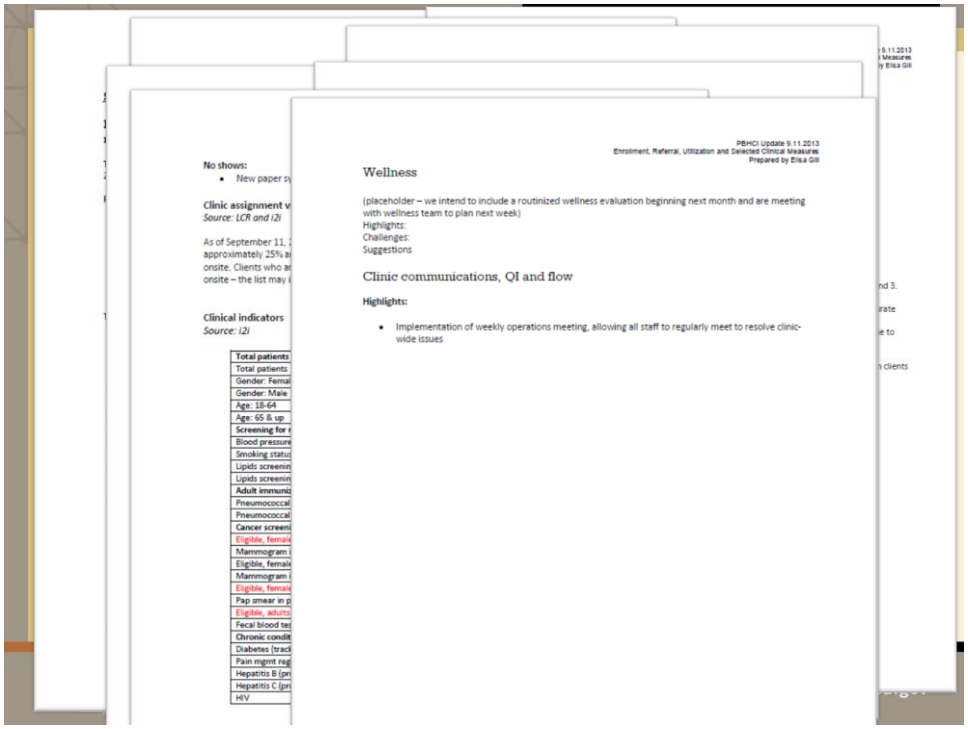

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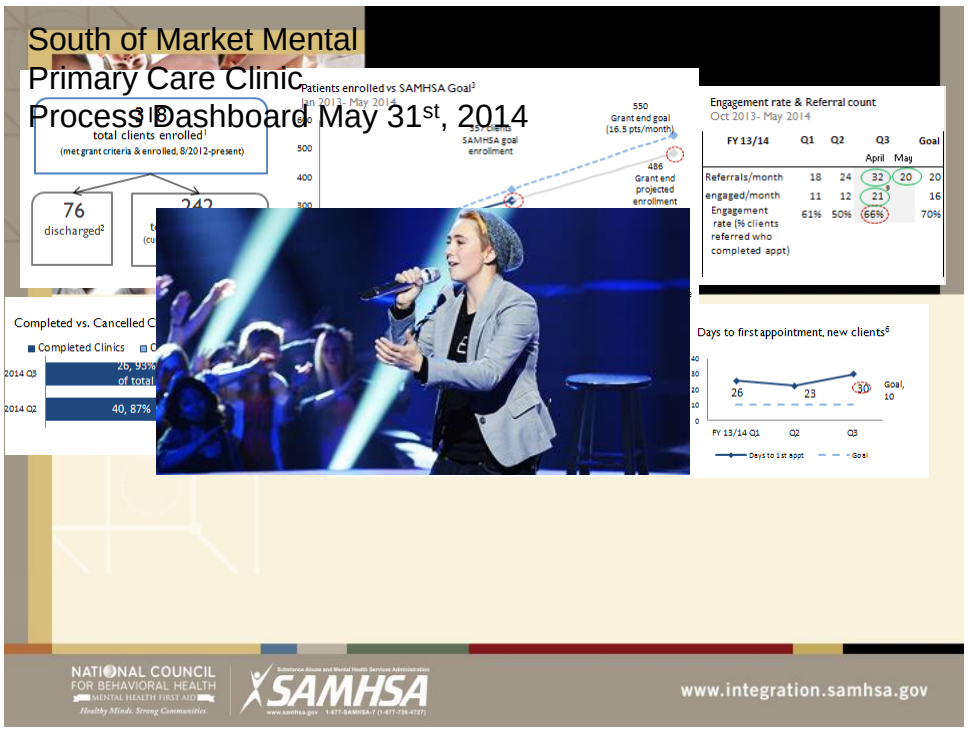
Blood pressure
Smoking status
Lipids screenin
Lipids screenin
Adult immuniz
Pneumococcal
Pneumococcal
Cancer screeni
Eligible, female
Mammogram i
Eligible, female
Mammogram i
Eligible, female
Pap smear in p
Eligible, adults
Fecal blood tes
Chronic condit
Diabetes (track
Pain mgmt reg
Hepatitis B (pr
Hepatitis C (pr
HIV

South of Market Mental Primary Care Clinic Process Dashboard May 31st, 2014



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d Health Solutions
MONTHLY GOAL
15
NEW PATIENT REFERRAL
June
14
New Patients
REFERRALS MADE
18
NEW PATIENTS
MAY
12
New Patients
LIVE
May 12th
759-3577
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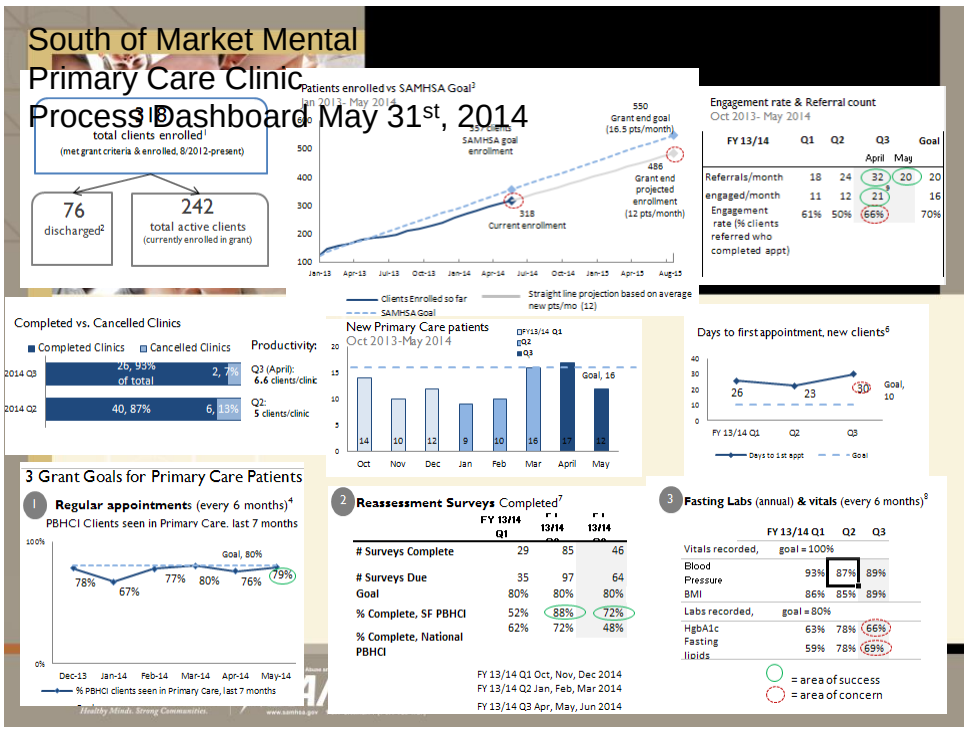
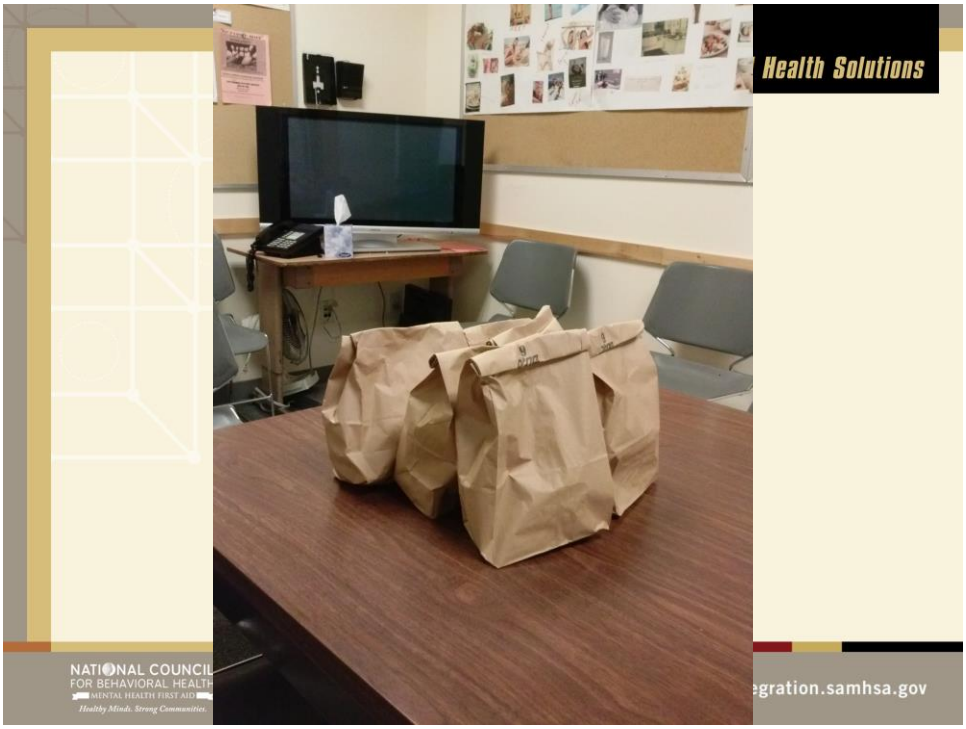

South of Market Mental Primary Care Clinic
Process Dashboard May 31st, 2014
318
total clients enrolled1
(met grant criteria & enrolled, 8/2012-present)
76
discharged2
242
total active clients
(currently enrolled in grant)
Patients enrolled vs SAMHSA Goal3
Jan 2013- May 2014
550
Grant end goal
(16.5 pts/month)
SAMHSA goal enrollment
486
Grant end projected enrollment
(12 pts/month)
318
Current enrollment
Clients Enrolled so far
SAMHSA Goal
Straight line projection based on average new pts/mo (12)
Engagement rate & Referral count
Oct 2013- May 2014
FY 13/14 Q1 Q2 Q3 April May Goal
Referrals/month 18 24 32 20 20
engaged/month 11 12 21 16
Engagement rate (% clients referred who completed appt) 61% 50% 66% 70%
Completed vs. Cancelled Clinics
Completed Clinics
Cancelled Clinics
2014 Q3
26, 93% of total
2, 7%
2014 Q2
40, 87%
6, 13%
Productivity:
Q3 (April): 6.6 clients/clinic
Q2: 5 clients/clinic
New Primary Care patients
Oct 2013-May 2014
FY13/14 Q1
Q2
Q3
Goal, 16
Oct 14 Nov 10 Dec 12 Jan 9 Feb 10 Mar 16 April 17 May
Days to first appointment, new clients6
26 23 30
Goal, 10
FY 13/14 Q1 Q2 Q3
Days to 1st appt
Goal
3 Grant Goals for Primary Care Patients
1 Regular appointments (every 6 months)4
PBHCI Clients seen in Primary Care. last 7 months
100%
0%
Goal, 80%
78% 67% 77% 80% 76% 79%
Dec-13 Jan-14 Feb-14 Mar-14 Apr-14 May-14
% PBHCI clients seen in Primary Care, last 7 months
2 Reassessment Surveys Completed7
FY 13/14 Q1
Surveys Complete 29 85 46
Surveys Due 35 97 64
Goal 80% 80% 80%
% Complete, SF PBHCI 52% 88% 72%
% Complete, National PBHCI 62% 72% 48%
FY 13/14 Q1 Oct, Nov, Dec 2014
FY 13/14 Q2 Jan, Feb, Mar 2014
FY 13/14 Q3 Apr, May, Jun 2014
3 Fasting Labs (annual) & vitals (every 6 months)8
FY 13/14 Q1 Q2 Q3
Vitals recorded, goal = 100%
Blood Pressure 93% 87% 89%
BMI 86% 85% 89%
Labs recorded, goal = 80%
HgbA1c 63% 78% 66%
Fasting lipids 59% 78% 69%
= area of success
= area of concern

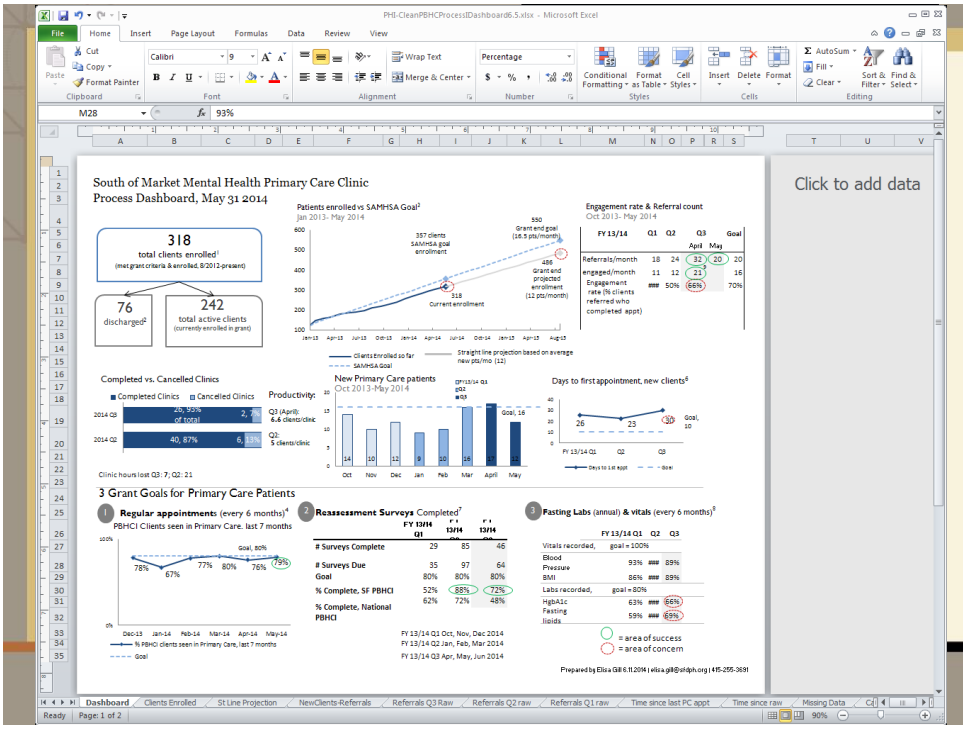


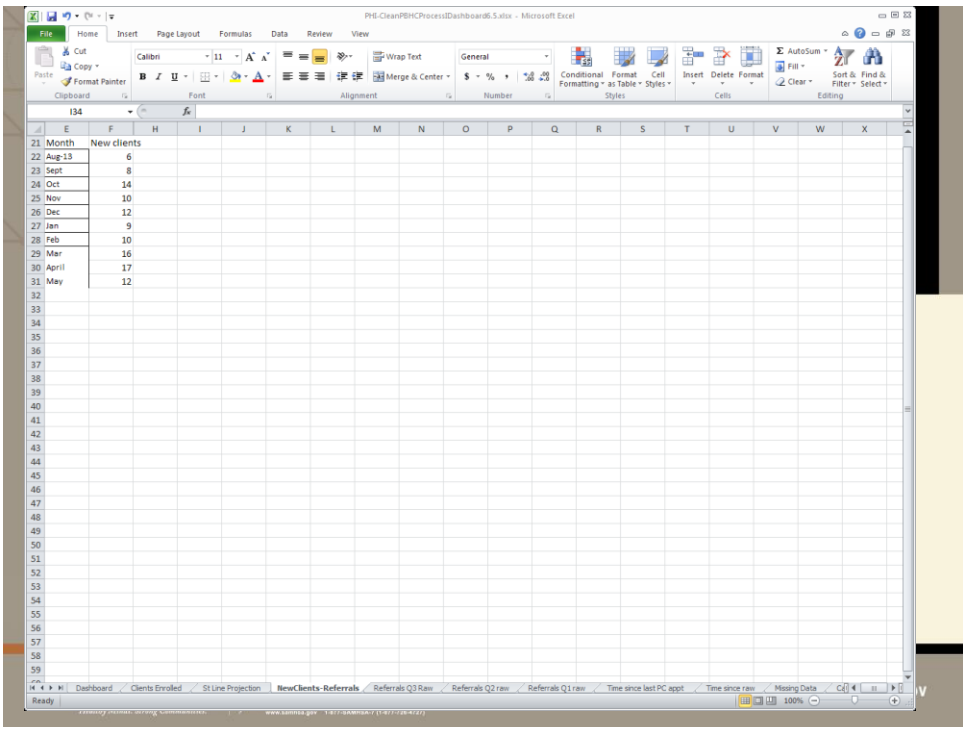
SAMHSA-HRSA
Center for Integrated Health Solutions

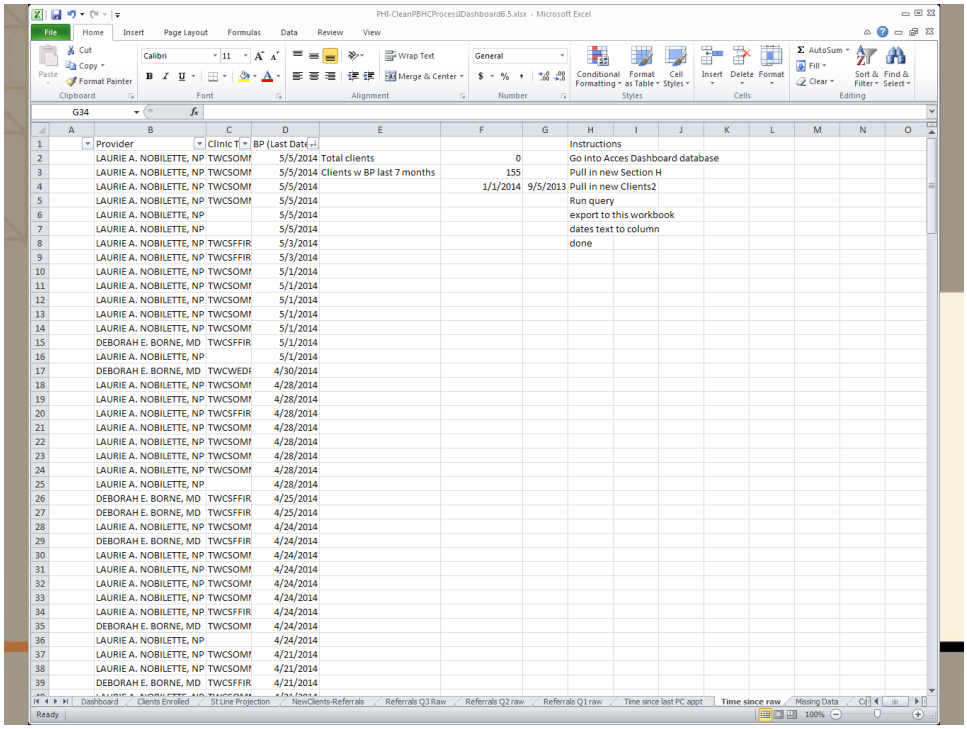
Data should be a **tool**, not an **obstacle**.

Simple
Visual
Goals-oriented

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID
Healthy Minds. Strong Communities.
SAMHSA
www.integration.samhsa.gov


South of Market Mental Health Primary Care Clinic
Process Dashboard, May 31 2014
318
total clients enrolled
76
discharged
242
total active clients
Patients enrolled vs SAMHSA Goal
Engagement rate & Referral count
Completed vs. Cancelled Clinics
New Primary Care patients
Days to first appointment, new clients
3 Grant Goals for Primary Care Patients
Regular appointments (every 6 months)
Reassessment Surveys Completed
Fasting Labs (annual) & vitals (every 6 months)
Click to add data


Month
New clients
Aug-13 6
Sept 8
Oct 14
Nov 10
Dec 12
Jan 9
Feb 10
Mar 16
April 17
May 12



	A	B	C	D	E	F	G	H
1		Provider	Clinic T	BP (Last Date				Instructions
2		LAURIE A. NOBILETTE, NP	TWCSOMI	5/5/2014	Total clients	0		Go into Acces Dashboard database
3		LAURIE A. NOBILETTE, NP	TWCSOMI	5/5/2014	Clients w BP last 7 months	155		Pull in new Section H
4		LAURIE A. NOBILETTE, NP	TWCSOMI	5/5/2014		1/1/2014	9/5/2013	Pull in new Clients2
5		LAURIE A. NOBILETTE, NP	TWCSOMI	5/5/2014				Run query
6		LAURIE A. NOBILETTE, NP		5/5/2014				export to this workbook
7		LAURIE A. NOBILETTE, NP		5/5/2014				dates text to column
8		LAURIE A. NOBILETTE, NP	TWCSFFIR	5/3/2014				done
9		LAURIE A. NOBILETTE, NP	TWCSFFIR	5/3/2014				
10		LAURIE A. NOBILETTE, NP	TWCSOMI	5/1/2014				
11		LAURIE A. NOBILETTE, NP	TWCSOMI	5/1/2014				
12		LAURIE A. NOBILETTE, NP	TWCSOMI	5/1/2014				
13		LAURIE A. NOBILETTE, NP	TWCSOMI	5/1/2014				
14		LAURIE A. NOBILETTE, NP	TWCSOMI	5/1/2014				
15		DEBORAH E. BORNE, MD	TWCSFFIR	5/1/2014				
16		LAURIE A. NOBILETTE, NP		5/1/2014				
17		DEBORAH E. BORNE, MD	TWCWEDI	4/30/2014				
18		LAURIE A. NOBILETTE, NP	TWCSOMI	4/28/2014				
19		LAURIE A. NOBILETTE, NP	TWCSOMI	4/28/2014				
20		LAURIE A. NOBILETTE, NP	TWCSFFIR	4/28/2014				
21		LAURIE A. NOBILETTE, NP	TWCSOMI	4/28/2014				
22		LAURIE A. NOBILETTE, NP	TWCSOMI	4/28/2014				
23		LAURIE A. NOBILETTE, NP	TWCSOMI	4/28/2014				
24		LAURIE A. NOBILETTE, NP	TWCSOMI	4/28/2014				
25		LAURIE A. NOBILETTE, NP		4/28/2014				
26		DEBORAH E. BORNE, MD	TWCSFFIR	4/25/2014				
27		DEBORAH E. BORNE, MD	TWCSFFIR	4/25/2014				
28		LAURIE A. NOBILETTE, NP	TWCSOMI	4/24/2014				
29		DEBORAH E. BORNE, MD	TWCSFFIR	4/24/2014				
30		LAURIE A. NOBILETTE, NP	TWCSOMI	4/24/2014				
31		LAURIE A. NOBILETTE, NP	TWCSOMI	4/24/2014				
32		LAURIE A. NOBILETTE, NP	TWCSOMI	4/24/2014				
33		LAURIE A. NOBILETTE, NP	TWCSOMI	4/24/2014				
34		LAURIE A. NOBILETTE, NP	TWCSFFIR	4/24/2014				
35		DEBORAH E. BORNE, MD	TWCSOMI	4/24/2014				
36		LAURIE A. NOBILETTE, NP		4/24/2014				
37		LAURIE A. NOBILETTE, NP	TWCSOMI	4/21/2014				
38		LAURIE A. NOBILETTE, NP	TWCSOMI	4/21/2014				
39		DEBORAH E. BORNE, MD	TWCSFFIR	4/21/2014