



**Office of
Mental Health**

Partnership to Support Aging in Place in Communities Severely Impacted by COVID-19 (PSAP) Data Collection Refresher

OMH Office of Population Health and Evaluation
Bureau of Program Research and Evaluation

April 2025

Housekeeping

- This presentation will be **recorded and emailed** to registrants for future reference.
- Please use the **chat or the hand raise** option for questions at any point during the presentation.
- Content in this webinar is restricted to **required** data collection as part of the PSAP grant.
 - Client information, Screenings
 - Common Pitfalls



Data Collection: Required Data Elements

Client Information

This information is the first entered when adding a client to the portal (Add New/ Edit Client)

- Demographics, Insurance, Referral Info, Cognitive Issues, Chronic Pain, Opiate Use, Higher Level of Care

Client information can also be accessed/ updated through 'Search Client'

Screening History

Search Client → Screening History

- Anxiety Screen, Depression Screen, SDOH Screen, Loneliness Screen, Substance Use Screen, Service Needs Screen
- Screenings should be completed at : admission, follow-ups every 90 days, discharge

Acknowledging Challenges and Importance of Collecting Demographics

Challenges

Clients may ask "How is this even relevant?"

Clients may be uncomfortable answering demographic questions such as race and ethnicity.

- Don't assume a client's response-If a client is hesitant to answer, select "unknown" and update data as soon as possible (ex: during follow-up).

Importance

Demographic data benefits the PSAP project by

- providing a picture of who your program serves and who you still need to reach.
- addressing social inequities and how they impact aging in place.
- contributing to grant proposals and other funding opportunities.

Common Pitfalls

Differences between your agency's Electronic Health Record (EHR) and the PSAP Portal

All programs have different ways of collecting information, often tailored towards the needs of the communities they serve.

The OMH PSAP portal allows for all PSAP programs to submit the fields necessary for the PSAP program monitoring and evaluation in one place.

Challenges may present when the PSAP portal:

asks for client information that your agency's EHR **does not collect**

Example:

Agency A's EHR **does not include a field for 'referral source'** so when entering data on the OMH PSAP portal, they select '**unknown**' for referral source. Moving on, Agency A will see if 'referral source' can be **added to the EHR** but if not, they will **track PSAP client referral source on a spreadsheet** which they then can use to enter on the PSAP portal.

Differences between your agency's Electronic Health Record (EHR) and the PSAP Portal

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Challenges may present when the PSAP portal:

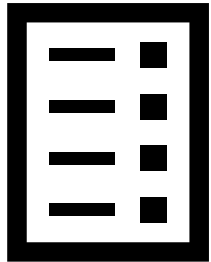
categorizes client information (such as demographic fields) **differently** than your EHR.

Example:

Agency A collects data on income Sources where multiple options can be selected on their EHR. The PSAP portal asks for **Primary Income Source**: Social Security, Pension/ Retirement, Disability, Earned Income, Family, Other, Unknown.

Since only one can be selected as primary, Agency A **confirms with the client which is primary** and enters that onto the PSAP portal. **The agency still can enter all that apply on their EHR.**

Primary Health Insurance



Received Telecare	---Select Received Telecare---
Primary Health Insurance	---Select Primary Health Ins---
Secondary Health Insurance	---Select Primary Health Ins---
Client Suffers from Chronic Pain	Medicaid
Client takes Prescribed Opiates	Medicare
Client Suffers from Cognitive Decline, Dementia, or Alzheimer's Disease	Veteran
Date of First Client Contact	Private Insurance
Admission Date	None
Initial Screening Provider	Other
Referral Source	Unknown
Is the client at risk for placement outside of their home or community or needing a higher level of care	



- Unknown is selected for over 25% of clients enrolled through the first half of PSAP.
- If insurance type is disclosed during a follow-up, update the response to reflect the correct information.

Referral Source

SSN (Last 4 Digits)
Zip Code
Age
Gender
Race
Ethnicity
Primary Language
Living Situation
Partner Status
Primary Income
Received Telecare
Primary Health Insurance
Secondary Health Insurance
Client Suffers from Chronic Pain
Client takes Prescribed Opiates
Client Suffers from Cognitive Decline,
Dementia, or Alzheimer's Disease
Date of First Client Contact
Admission Date
Initial Screening Provider
Referral Source
Is the client at risk for placement
outside of their home or community or
needing a higher level of care

-----Select Provider-----

Partner Agency/Program
Community Organization
Medical Doctor/Hospital
Adult Protective Services
Home Care/Visiting Nurses
Self-Referral
Family
Another Client
Friend
Outreach Event
Police/Law Services
Social Service Agency
Unknown
Other

-----Select Provider-----

---Select if client needing a higher level of care---

- Before selecting 'other', make sure that the referral source does not fall into another category
- If there are multiple referral sources, select the one that **resulted in engagement** (if known).

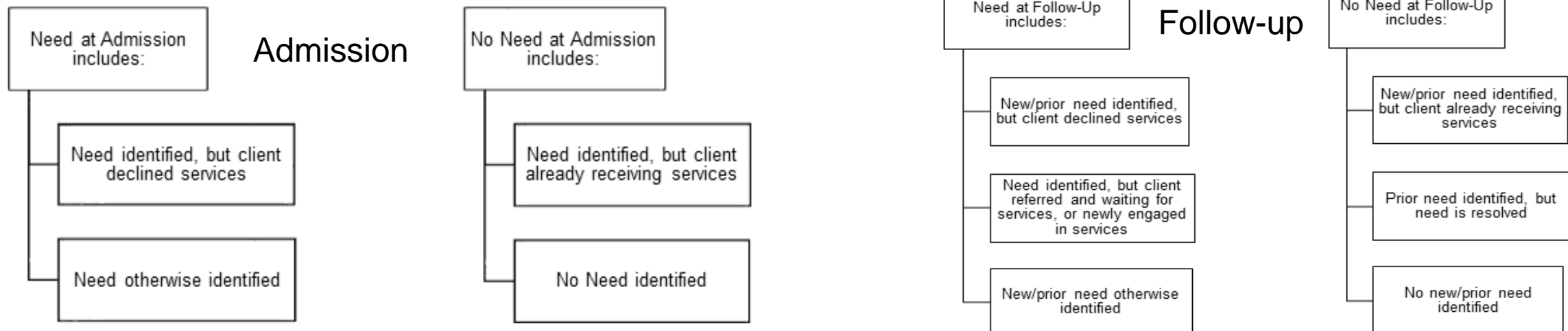


Aging Services Need, Clarifications

Aging Service Need Category	Related Screen
Abuse/Neglect	SDOH (Q7-Q10)
Financial Benefits	SDOH (Q11)
Food Insecurity	SDOH (Q3-Q4)
Housing Safety	SDOH (Q2)
Housing Stability	SDOH (Q1)
Mental Health	PHQ-9, GAD-7
Social Isolation	De Jong Loneliness
Substance Abuse	NIDA Quick Screen, SMAST-G
Transportation	SDOH (Q5)
Utilities	SDOH (Q6)

Along with other factors including clinical assessment and interactions with the client, this table shows how items from other screens we collect can be considered when assessing Aging Service Need.

To assess aging service needs at score categories were collapsed as follows:



Q&A



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