Presenter

Wayne Young, M.Ed., MBA, LPC, FACHE
• JPS Health Network Senior Vice President, Behavioral Health
• Administrator, Trinity Springs Pavilion
• Administrator, Trinity Springs North
• Chair, AHA Psychiatric and Substance Abuse Governing Council
$950 million tax-supported healthcare system serving residents of Fort Worth and surrounding communities in Tarrant County, Texas.

**John Peter Smith Hospital**
- 573 acute-care beds
- Tarrant County’s only Level I Trauma Center
- 1.7 million+ patient encounters in 2015
- 120,000+ emergency room visits annually
- 60,000 Urgent Care visits/year

- 30 primary care and specialty clinics
- 20 school-based health centers
- Nine residency programs, including the nation’s largest hospital-based family medicine residency
- 1.1 million patient encounters annually
JPS Health Network offers robust Behavioral Health services.

2015 Behavioral Health volumes:
- 20,000 psychiatric emergency visits
- 31,000 psychiatric inpatient days
- 3,500 psychiatric observation days
- 1,500 partial hospitalization days
- 25,000 psychiatric outpatient visits
- 71,000 depression screenings in primary care

Seven Behavioral Health Texas Medicaid 1115 Waiver Projects

- Two psychiatric hospitals (96 and 36 beds)
- Psychiatric Emergency Center
- Integrated Medical Unit
- Six behavioral health clinics
- Walk-in behavioral health clinic
- One behavioral health school-based clinic
- Four partial hospitalization programs
- Day rehab for the homeless
- Virtual Behavioral Health Clinical Guidance
- Six primary care clinics with embedded behavioral health specialists
- Eight Peer Support Specialists
- Psychiatry residency program
# Behavioral Health Outpatient Services

<table>
<thead>
<tr>
<th></th>
<th>Partial Hospitalization</th>
<th>Medication Management</th>
<th>Assessment</th>
<th>Psychological Testing</th>
<th>Psychology</th>
<th>Counseling</th>
<th>Vocational Rehab</th>
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<tbody>
<tr>
<td>Central Arlington</td>
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<td>Behavioral Health</td>
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<td>Northeast Health Center</td>
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<td>Stop Six Health Center</td>
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<td>School-Based Health</td>
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<td>Hemphill Behavioral</td>
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<td>Healing Wings</td>
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<td>Medical Home Southeast</td>
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<td>Tarrant</td>
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</tbody>
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Patient and Family Centered Care

Peer support specialists are increasingly involved in behavioral health services. JPS has eight peer support specialists in the psychiatric emergency center, inpatient, and rehab settings.

The JPS Patient and Family Advisory Council is a group of 12-14 people who express interest in helping JPS improve our services. These partners assist with:

• identifying priority areas for JPS to address
• partner in performance improvement projects
• assist in setting policy and giving input into the impact current policies have on patients and families.
The Case for Integrated Care

Total Healthcare Costs of Patients With and Without Depression

Hypertension: $639 (Without Depression) vs. $1,132 (With Depression)
Arthritis: $623 (Without Depression) vs. $1,262 (With Depression)
Diabetes: $789 (Without Depression) vs. $1,341 (With Depression)
Asthma: $1,175 (Without Depression) vs. $1,303 (With Depression)
Heart Disease: $1,101 (Without Depression) vs. $1,811 (With Depression)

### Mean Age at Time of Death

<table>
<thead>
<tr>
<th>Year</th>
<th>All MH Clients Who Died During Year</th>
<th>MH Male Clients Who Died During Year</th>
<th>MH Female Clients Who Died During Year</th>
<th>Mean Years of Life Lost Per Mental Health Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>55.0</td>
<td>52.4</td>
<td>58.1</td>
<td>28.5</td>
</tr>
<tr>
<td>1998</td>
<td>55.0</td>
<td>53.3</td>
<td>56.6</td>
<td>28.8</td>
</tr>
<tr>
<td>1999</td>
<td>54.0</td>
<td>50.8</td>
<td>57.3</td>
<td>29.3</td>
</tr>
</tbody>
</table>

The Case for Integrated Care

# The Case for Integrated Care

<table>
<thead>
<tr>
<th>MINIMAL COLLABORATION</th>
<th>BASIC COLLABORATION FROM A DISTANCE</th>
<th>BASIC COLLABORATION ONSITE</th>
<th>CLOSE COLLABORATION/PARTLY COLLABORATED</th>
<th>FULLY INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Separate systems</td>
<td>• Separate systems</td>
<td>• Separate systems</td>
<td>• Some shared systems</td>
<td>• Shared systems and facilities in seamless bio-psychosocial web</td>
</tr>
<tr>
<td>• Separate facilities</td>
<td>• Separate facilities</td>
<td>• Same facilities</td>
<td>• Same facilities</td>
<td>• Consumers and providers have same expectations of system</td>
</tr>
<tr>
<td>• Communication is rare</td>
<td>• Periodic focused communication; mostly written</td>
<td>• Regular communication, occasionally face-to-face</td>
<td>• Face-to-face consultation; coordinated treatment plans</td>
<td>• In-depth appreciation of roles and culture</td>
</tr>
<tr>
<td>• Little appreciation of each other's culture</td>
<td>• View each other as outside resources</td>
<td>• Some appreciation of each other's role and general sense of large picture</td>
<td>• Basic appreciation of each other's role and culture</td>
<td>• Collaborative routines are regular and smooth</td>
</tr>
<tr>
<td>• Little understanding of each other's culture of sharing or influence</td>
<td>• Mental health usually has more influence</td>
<td>• Collaborative routines difficult; time and operation barriers</td>
<td>• Influence sharing</td>
<td>• Conscious influence sharing based on situation and expertise</td>
</tr>
</tbody>
</table>

“Nobody knows my name. Who are you?”

“I help your consumers.”

“I am your consultant.”

“We are a team in the care of consumers.”

“Together, we teach others how to be a team in care of consumers and design a care system.”

Source: SAMHSA: A standard framework for levels of integrated healthcare
Behavioral Health Texas 1115 Medicaid Waiver (DSRIP)

- Discharge Management Program
- Partial Hospitalization Program
- Extended Clinic Hours
- Integrated Care
- Virtual Behavioral Health Clinical Guidance
- Walk-in Clinic and Referral Center
- Day Rehab for the Homeless
Behavioral Health Integration Model

- Monthly Information Packets
- Practice Agreements
- Best Practice Advisories
- Face-to-Face CME’s
- Evidence based library

Information Sharing

- Shared care plan
- Multidisciplinary Case Conference
- Shared Patient Lists

Joint Planning

- Group Visits
- Embedded Behavioral Health Specialists
- Virtual Psychiatric and Clinical Guidance
- Diabetes Education Classes

Integrated Service Delivery

- PHQ-9
- SBIRT
- Tobacco Use
- HbA1c
- LDL

Bi-Directional Screening
Physician Engagement and Barriers

- Perception of time
- Understanding the purpose of integration and its value
- Organizational culture and sensitivity
- Practice agreements and standardization of care
Information Sharing

- Monthly Information Packets
- Practice Agreements
- Best Practice Advisories
- Face-to-Face CME’s
- Evidence based library

Information Sharing

Integrated Planning

- Shared care plan
- Multidisciplinary Case Conference
- Shared Patient Lists

Integrated Service Delivery

- Group Visits
- Embedded BH Specialists
- Virtual Psychiatric and Clinical Guidance
- Diabetes Education Classes

Bi-Directional Screening

- PHQ-9
- SBIRT
- Tobacco Use
- HbA1c
- LDL
Information Sharing – Practice Agreements

- Negotiated with primary care physician leaders and medical directors
- Documented in written agreement
- Approved by Medical Executive Committee
Information Sharing – Practice Agreements

Core elements of our practice agreements:

• Statement of purpose
• Roles and responsibilities
• Screening process
• Referral protocols
• Communication standards
• Patient interventions and transitions
• Strategies for patients in crisis
Clinical Practice Agreement

Coordination of Services between Behavioral Health and Primary Care in the Outpatient Setting

The goal of this agreement is to enhance the coordination of patient care services between Primary Care and Behavioral Health. This agreement will help ensure appropriate levels of care for the patient. The overall goal of specialty behavioral health services is to help the patient attain the highest level of independent function. To this end, these services and interventions will, for the most part, be targeted and time limited to maximize patient stability. The intent is to return the patient to on-going treatment in the medical home once appropriate.

Virtual Behavioral Health Consultation

If the Primary Care Provider desires a Behavioral Health consult, the Virtual Behavioral Health Clinical Guidance Service is available to outpatient Primary Care Providers on a 24/7 basis. The clinical guidance team will offer the first line of assistance to Primary Care Providers with patients that present signs and symptoms of mental illness. The team will have the ability to assist in directing referrals for Behavioral Health to appropriate areas and will provide support to Primary Care Providers with resources and guidance to adequately treat patients who present with behavioral health conditions. This support will include:

- Information and referral assistance
- General information about various mental illnesses and tools to assist with determining an appropriate diagnosis
- An evidence based resource with literature and evidence based practices from multiple sources on behavioral health disorders and topics to be available to medical professionals including guidelines for psychotropic medication indications, diagnosis and symptomology, psychotropic medication administration and monitoring, and appropriate screening, prevention, and interventions in community settings.
- Webinar types of education and training for primary care providers focused on improved identification, diagnosis, and treatment of common behavioral health conditions
- Virtual behavioral health guidance consisting of an interdisciplinary consultative team comprised by a psychiatrist, a master’s level psychiatric social worker and a psychiatric nurse who will ensure virtual psychiatric guidance services are available within 30 minutes on a 24-hour basis to primary care providers.

Standardized Screening

Behavioral Health will provide Primary Care with standardized screening tools to assist with diagnosing individuals with behavioral health issues as well as early detection and intervention. A standardized treatment protocol will be provided to Primary Care providers to begin first line treatment to uncomplicated or mild psychiatric illnesses. The tools used can also help guide physicians to the next level in the referral process.
Embedded Behavioral Health Specialists

Behavioral health will provide primary care with a behavioral health specialist at each of the integrated sites where behavioral health services are currently located. The general behavioral health specialist is typically a social worker or a psychiatric nurse. They will be located within the primary care setting and function as part of the primary care team as well as the behavioral health team. The specialist’s role is to provide support and assistance to both PCPs and their patients without engaging in any form of extended specialty behavioral health care. The role of the behavioral health specialist is to coordinate care and communication between behavioral health and primary care. Their responsibilities are as follows:

- Integrate treatment plan to include behavioral health goals and education for patients with behavioral health issues.
- Follow up with providers and patients being referred to behavioral health and being referred back into primary care.
- Provide immediate access to a behavioral health provider by delivering behavioral health services and interventions in the primary care setting on a stat basis.
- Provide brief, solution focused counseling services in primary care settings as needed.
- Manage the referral process and case load balance between primary care referrals and stable BH patients transitioning back to primary care providers.
- Initiate treatment planning related to behavioral health issues for patients psychiatric illness.

Referrals to Behavioral Health

The following unstable conditions of patients would be appropriate for primary care providers to request consultation and/or refer to behavioral health providers:

- Schizophrenia
- Bipolar spectrum disorders
- Major Depressive disorder with psychosis
- Treatment resistant depression as defined by failure of at least one antidepressant trial at appropriate dosage for 6-8 weeks.
- Newly diagnosed or untreated/unremitting Post Traumatic Stress Disorder
- Borderline Personality Disorder with self-injurious behavior
- Suicidal or homicidal patients (w/o intent or plan)
- Psychiatric Evaluation for ADD/ADHD and medication recommendations
- Any patient insisting upon seeing a mental health professional
- Need for consultation to support on-going medical counseling and or behavior management in the primary care setting
- Patient experiencing significant acute physical and/or emotional distress as a result of life events (e.g. death, divorce, etc.) and the patient’s usual coping skills and resources are overwhelmed
- Patients with primary medical conditions with evidence or diagnosis of comorbid psychiatric illness.
- Psychotherapy, requested by the physician and/or the patient, to address specific emotional/behavioral problems and needs

Other psychiatric conditions not listed above may be referred at the primary care provider’s discretion. Uncomplicated depressive or anxiety disorders should initially be treated by the primary care provider with an adequate (6-8 weeks at an adequate dose) trial of a selective serotonin reuptake inhibitor or other appropriate medication of the primary care provider’s choice. Patients referred for depression should be seen by their primary care provider at the recommended intervals until their first behavioral health appointment.
Clinical Practice Agreement (Cont.)

In response to a physician referral or a patient initiated request for services the patient will be evaluated by licensed clinician member of Behavioral Health Team. This will include initial telephone screening, triage and referral as well as face-to-face evaluation as indicated. Recommendations for specialty mental health services will be made based upon established medical necessity criteria and then prioritized based on availability and need.

Emergent Situations
Emergency situations in which the patient presents in a crisis as a danger to self or others with a plan or intention to act should be taken seriously. The patient should not be left alone and staff should contact 911 to ensure the patient is evaluated for safety. NOTE: an emergency in the outpatient setting should never rely on consultative process.

Case Review/Conference Consults
Behavioral health outpatient consult services will be available for difficult case review and/or integrated service case conferencing on an as needed basis. The intent of this service is to increase effective communication and hand off for cases shared between behavioral health and primary care as well as to provide case review for challenging patient issues related to behavioral health. Patients who may not be appropriate for outpatient behavioral health consultation include:
- Patient needing emergent care (e.g., suicidal or homicidal ideations)
- Patients on pain medications without comorbid psychiatric illness
- Patients with a primary diagnosis of substance dependence for the purpose of detoxification, substance abuse rehabilitation, or withdrawal management.
- Patients stable on benzodiazepines for sedative or hypnotic benefits
- Patients stable on antidepressant medication for depression or anxiety disorders
- Patients with uncomplicated depression prior to at least one (1) antidepressant trial for a 6-8 week period at an appropriate dosage.
- Patients with only a positive depression screen without further evaluation by the primary care provider establishing a diagnosis of depression
- Vascular Cognitive Disorders

Informing Patients of Need for Consult
Patients referred to behavioral health services need to be informed of the need for specialty consultation by the Primary Care Provider. The patient’s agreement with the consultation is essential for successful patient engagement in their health care plan.

Return of Patients to Primary Care
Once a patient is determined to be stable on commonly prescribed psychiatric medications without need for other behavioral health interventions, the patient will be referred back to a primary care provider for continued medication management. A stable psychiatric patient is defined as one of the following:
- A patient on no more than two psychotropic medications
- A patient who has had no change in medication during the past six months
- Able to self-manage mental health treatment needs without requiring on-going multidisciplinary/team-based mental health services
- A patient that meets criteria within Quadrant I and Quadrant III of the Four Quadrant Model.

Behavioral health providers, with concurrence from the patient, will contact the primary care provider to discuss the transfer of care and follow-up recommendation for treatment and monitoring. Behavioral health will retain responsibility for care of patients with unstable psychiatric conditions.

This clinical practice agreement regarding the coordination of care between primary care and behavioral health was implemented on ________.
Information Sharing – Monthly E - Resource

2015

January  Eating Disorders
February  E-Consults
March     Depression
April     Smoking Cessation
May      Bipolar Disorder
June     PTSD
July     Pregnancy and Psychotropic Medications
August  Child and Adolescent Anxiety
September  ADHD
October 2015  Prescribing and Tapering Benzodiazepines
November 2015  Depression
December 2015  Anxiety

2016

January 2016  Insomnia and Sleep Hygiene
February 2016  Domestic Violence

These are also made available on our Virtual Behavioral Health Clinical Guidance website.
Information Sharing – Best Practice Advisory

- Staff trained on screening tool
- Automated alert in electronic medical record prompts providers to document follow-up plan for scores > 9
- Results monitored

Physician Documentation of Follow-Up Plan

Among individuals with PHQ-9 score >9

Before "Best Practice Advisory"  After "Best Practice Advisory"

46.8%  89.4%
Information Sharing – Best Practice Advisory

1. Patient record in EMR prompts depression screening with PHQ-9. After all questions are answered, a total score will populate and assign a severity risk.

2. If the score is >9, the screening creates a “Best Practice Advisory.”

3. If the provider chooses to take action and evaluate further, a smart order set automatically populates (e.g., referrals, medications, follow-up).

4. “Best Practice Advisory” additionally presents recommended intervention based on PHQ-9 Score.

5. The system will remind staff/providers to screen for depression using the PHQ-9 if the patient has not been screened within the past 12 months.

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## Information Sharing – PHQ-9

<table>
<thead>
<tr>
<th>Score:</th>
<th>Interpretation:</th>
<th>Treatment Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>Mild to Minimal Risk</td>
<td>• Support, educate to call if worsens, follow up as needed</td>
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<tr>
<td>10-14</td>
<td>Moderate Risk</td>
<td>• Antidepressant therapy and/or psychotherapy</td>
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<td></td>
<td></td>
<td>• Behavioral health specialist provides resources, initiates treatment planning and motivational therapy as needed</td>
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<td></td>
<td></td>
<td>• Conduct suicide risk assessment</td>
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<td></td>
<td>• Virtual psychiatric guidance</td>
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<td></td>
<td></td>
<td>• Follow up in 4-8 weeks</td>
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<tr>
<td>15-19</td>
<td>Moderately Severe Risk</td>
<td>• Antidepressant and/or psychotherapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Behavioral health specialist provides resources, initiates treatment planning and motivational therapy as needed</td>
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<td>• Conduct suicide risk assessment</td>
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<td>• Virtual psychiatric guidance</td>
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<td></td>
<td>• Referral to Psychiatry if warranted</td>
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<tr>
<td></td>
<td></td>
<td>• Follow up in 2-4 weeks</td>
</tr>
<tr>
<td>20 or higher</td>
<td>Severe Risk</td>
<td>• Antidepressant, possible augmentation</td>
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<tr>
<td></td>
<td></td>
<td>• Behavioral health specialist provides resources, initiates treatment planning and follows up with patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Conduct Suicide risk assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Follow up in 2-4 weeks</td>
</tr>
<tr>
<td></td>
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<td>• Referral to Psychiatry</td>
</tr>
</tbody>
</table>
Two presentations each year focusing on common behavioral health issues found in Primary Care. Both are done in person and streamed on the internet.

- Management of Anxiety in Primary Care
- Management of Depression in Primary Care
- Prescribing and Tapering Benzodiazepines - Guidelines in Primary Care

These are also made available on our Virtual Behavioral Health Clinical Guidance website.
Behavioral health training for physical health students:
- Family Practice residents
- Emergency medicine residents
- Behavioral Health clinical rotation site for Nurse Practitioner students
- PhD Health Psychology students
- UNTHSC medical students
- Nursing students
- UNTHSC Physician Assistant students
- EMT students

Family Practice Residency
- JPS has largest hospital-based family practice residency in the U.S.
- JPS has a health psychologist who is embedded as a full-time teaching faculty member to help primary care residents better understand and treatment mental health conditions.
Information Sharing – Pop Quiz

What percent of patients with mood disorders receive minimally adequate treatment in general medical settings?

Information Sharing – Evidence-Based Library

Virtual Behavioral Health Clinical Guidance

The diagnosis and management of behavioral health conditions can be complex, and access to psychiatrists and other behavioral health professionals can be challenging.
Information Sharing – Evidence-Based Library

Other topics not visible in this screenshot include bipolar disorder, depression, insomnia, personality disorders, schizophrenia, substance abuse, and links to other resources.
JPS Health Network is a founding member of the Mental Health Connection of Tarrant County (MHC). MHC is a partnership of public and private agencies, as well as individuals in need of behavioral health services and their family members, that was formed in the aftermath of a mass shooting at Wedgewood Christian Church in 1999. The organization came together to improve the mental health service delivery system for its community. MHC members assess the short- and long-term behavioral health needs for the community and provide the resources and supports necessary to care for those who require assistance. In addition, MHC engages its community through a number of initiatives, such as anti-stigma campaigns, and provides a foundation for evaluating research and evidence-based practices to ensure the implementation of appropriate supports, programs and services.
Mental Health Connection of Tarrant County (MHC) has resulted in multiple “spin off” organizations all focusing on improving the mental health system in their community. The five below all started in the last two years. EVERY one of these organizations list hospitals and health systems as part of their membership. In most cases hospital employees serve as board members or in other leadership positions – our participation in the community is critical in this area.

N.E.W. (Northeast Wisconsin)
Mental Health Connection
Integrated Planning

- Monthly Information Packets
- Practice Agreements
- Best Practice Advisories
- Face-to-Face CME’s
- Evidence based library

Integrated Planning

- Shared care plan
- Multidisciplinary Case Conference
- Shared Patient Lists

Information Sharing

- Group Visits
- Embedded BH Specialists
- Virtual Psychiatric and Clinical Guidance
- Diabetes Education Classes

Bi-Directional Screening

- PHQ-9
- SBIRT
- Tobacco Use
- HbA1c
- LDL

Integrated Service Delivery
Integrated Planning – Shared Care Plans

JPS is transitioning to shared care plans as a way to improve coordination and integration of care.

- Work in progress
- Broader than behavioral health and primary care
- Allows all specialties and primary care to see, edit and document problems, goals, interventions and outcomes
- Seen in the same format from the same screen for all disciplines involved
Shared patient lists were created to identify patients shared between a behavioral health provider and primary care provider at the same location.

- Identifies key metrics:
  - BP
  - HbA1c
  - PHQ-9
  - Diagnoses
  - Medications
  - Number of emergency visits in past six months
  - Number of hospitalizations in past six months

- Embedded specialists summarize key points from previous visits and reports to providers

- Drives recommendations for transitioning level of specialty involvement and care
Multidisciplinary Case Conference occurs at the request of the patient and/or the providers.

These typically involve the most complex patients.
**Bi-Directional Screening**

- Monthly Information Packets
- Practice Agreements
- Best Practice Advisories
- Face-to-Face CME’s
- Evidence based library

- Shared care plan
- Multidisciplinary Case Conference
- Shared Patient Lists

- Group Visits
- Embedded BH Specialists
- Virtual Psychiatric and Clinical Guidance
- Diabetes Education Classes

- PHQ-9
- SBIRT
- Tobacco Use
- HbA1c
- LDL
What is the average time between the experience of the first symptoms of a mood disorder to initiation of treatment?

Bi-Directional Screening – PHQ-9

Standardize screening administration and follow-up processes across primary care practices.

Train staff on how to use screening and how to escalate.

Work with IT to develop MER reporting specs and create reports.

Automate alerts in EMR prompting providers to screen patients at routine intervals.

Include recommended guidelines in EMR for provider action.

Monitor and share results to inform quality improvement.
More than 168,000 primary care screenings for depression.
Bi-Directional Screening – 12-Month Remission Rates

- **Baseline**: 11.1%
- **2015**: 34.2%
- **Oct-15**: 31.9%
- **Nov-15**: 30.3%
- **Dec-15**: 33.3%
- **Jan-16**: 32.5%
Bi-Directional Screening – Trauma in Refugee Population

• Started a screening pilot April 11 in our International Health Clinic

• Tarrant County has approximately 1,500 refugees resettled in our community each year. After being screened at the Health Department, they are all scheduled for their first healthcare visit at this clinic.

• In addition to the PHQ-9, JPS will be completing a trauma screening utilizing the PCL-C (PTSD Checklist).

• This effort was initiated at the request of the primary care physician who leads this clinic.
Approximately 500 trauma patients a year are positive for alcohol on arrival. Our behavioral health team engages them utilizing SBIRT.
Bi-Directional Screening – Tobacco Use and Treatment

- 2015-Q1: Tobacco Screening - 92%, Tobacco Use Treatment Offered/Provided - 43%
- 2015-Q2: Tobacco Screening - 99%, Tobacco Use Treatment Offered/Provided - 70%
- 2015-Q3: Tobacco Screening - 100%, Tobacco Use Treatment Offered/Provided - 82%
- 2015-Q4: Tobacco Screening - 100%, Tobacco Use Treatment Offered/Provided - 80%
- 2016-Q1: Tobacco Screening - 100%, Tobacco Use Treatment Offered/Provided - 95%

Legend:
- Tobacco Screening
- Tobacco Use Treatment Offered/Provided
Bi-Directional Screening – HbA1c (lower is better)
The atypical antipsychotic medication results in an average weight gain of 8% to 28%. Two of the medications also result in increased risk for diabetes due to their impact on glucose levels.

In order to help address these concerns, JPS moved to six-month LDL and HbA1c screenings.
Bi-Directional Screening – LDL and HbA1c for those taking atypical
Integrated Service Delivery

- Monthly Information Packets
- Practice Agreements
- Best Practice Advisories
- Face-to-Face CME’s
- Evidence based library

Information Sharing

- Shared care plan
- Multidisciplinary Case Conference
- Shared Patient Lists

Integrated Planning

- Group Visits
- Embedded BH Specialists
- Virtual Psychiatric and Clinical Guidance
- Diabetes Education Classes

Integrated Service Delivery

- PHQ-9
- SBIRT
- Tobacco Use
- HbA1c
- LDL

Bi-Directional Screening
Who is the preferred source of help for mental health?

A. Psychiatrists
B. Psychologists
C. Counselors, ministers, primary care physician
D. Friends and family
Integrated Service Delivery – Group Visits

At several primary care clinics, JPS host quarterly co-facilitated medical groups with the primary care physician and behavioral health embedded specialists.

The groups consist of hypertension and congestive heart failure cohorts.
JPS currently has embedded behavioral health expertise in multiple settings:

- **Primary Care Clinics**
  - Family Health Center
  - Medical Home Southeast Tarrant
  - Stop Six Health Center
  - Northeast Health Center
  - Viola Pitts Health Center
  - Northeast School-Based Health Center

- **Trauma Services**

- **Healing Wings** (HIV/AIDS and infectious disease medical home)

- **Diabetes groups**

- **Co-facilitating general medical condition groups throughout network**
Integrated Service Delivery – Collaboration: Homeless

Integrated Care Through Collaboration

- Our local mental health authority is MHMR of Tarrant County.
- They are an invaluable partner in our path to integration.
JPS partners with Hurst-Euless-Bedford ISD to provide integrated care through a school based clinic.
There are two locations where JPS partners with Fort Worth ISD to provide integrated care Family Resource Centers established by the school districts.

- Northside SBC
- Forest Oak SBC
Structured outpatient program focused on patients with both a mental health issue and a substance use disorder.
There is a project being developed where JPS will be the primary care provider in a clinic primarily focused on delivering services to a population with serious mental illness.
With intentional integration JPS and the local mental health authority integrate care for those receiving services in our county jail.
For patients experiencing an acute medical condition that requires significant Medicare care and/or monitoring, JPS created the “Integrated Medical Unit.”

There are no specific standards in Texas for a “Med-Psych Unit.”

As a result, JPS created a unit where patients requiring significant psychiatric intervention are co-located in a common Med-Surg unit.

The internal medicine physician and the psychiatrist round together and the behavioral health service complements therapeutic activity and behavioral health discharge planning.
The virtual resource program is a psychiatric guidance service designed to foster integration of behavioral healthcare in primary care settings. The service is available by phone or email seven days a week, 24-hours a day, at no cost to participating primary care providers.

Program includes:

- Virtual guidance
- Monthly e-resource
- Research library
- Community resources
- Webinars and presentations
- Education
- Evidence-based practice
- Case specific consultation
Integrated Service Delivery – Virtual Behavioral Health Clinical Guidance

Virtual Services

- 2013-Q3: 104
- 2013-Q4: 308
- 2014-Q1: 483
- 2014-Q2: 465
- 2014-Q3: 639
- 2014-Q4: 806
- 2015-Q1: 745
- 2015-Q2: 1102
- 2015-Q3: 629
- 2015-Q4: 990
- 2016-Q1: 1080
Integrated Service Delivery – Virtual Behavioral Health Clinical Guidance

Virtual Website Visits

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-Q3</td>
<td>2175</td>
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<tr>
<td>2013-Q4</td>
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<td>2015-Q4</td>
<td>2267</td>
</tr>
<tr>
<td>2016-Q1</td>
<td>2797</td>
</tr>
</tbody>
</table>
Primary care providers can speak with a psychiatrist about evidence-based and best practice medication algorithms within 30 minutes.

**Provider Satisfaction with Access to Behavioral Health Expertise**

- **Baseline**: 18.20%
- **2015**: 91.60%
- **2016**: 95.45%

**Use of Evidence-Based Protocols**

- **Baseline**: 6.3%
- **2015**: 94.3%
- **2016**: 93.5%
JPS has eight diabetic education groups at various locations in both English and Spanish. Each of the group cohorts meet for eight weeks.

Behavioral health embedded specialists lead the eighth group to discuss depression, coping skills, and stress management related to their medical conditions and lifestyle changes.
• Review patients’ medications and make recommendations for psychotropic and non-psychotropic medications for patients with complex medication profiles
• Support for patients with medication-related questions or problems
• Facilitate inpatient groups on medication-related topics (three times per week)
• Actively sees patients receiving care in at Healing Wings (HIV+/AIDS clinic) with complex medication regimens.
• Teach psychopharmacology lectures for the Psychiatry, Emergency, and Family Medicine residents
Region 10 currently has seven organizations operating in the nine Texas counties of RHP 10 that are participating in the Integrated Care Learning Collaborative.

- Baylor Health Care System
- Helen Farabee Center
- JPS Health Network
- Lakes Regional MHMR Center
- MHMR of Tarrant County
- Pecan Valley Centers
- Wise Regional Health System

http://rhp10txlc.com/
### Integrated Service Delivery –
Learning Collaborative: Improve Screening Rates

<table>
<thead>
<tr>
<th>Percentage of patients screened with team’s selected cross-specialty screening</th>
<th>Numerator: Total number of patients in the population of focus who have received screening with the selected screening tool within the past 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator: Total patient population of focus for improved care integration at your site</td>
<td></td>
</tr>
</tbody>
</table>

#### Behavioral health screenings for primary care settings:
- PHQ2/PHQ9
- SBIRT (Screening, Brief Intervention and Referral to Treatment)
- Tobacco use screening
- Alcohol abuse screening (audit), MAST
- Drug abuse screening (DAST)
- Screening for risk of harm to self or others

#### Physical health screenings commonly done in behavioral health settings:
- Diabetes screening
- Hypertension screening
- BMI calculation
- COPD screening
- Cardiovascular disease screening
- HIV, STD, hepatitis

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**LEARNING COLLABORATIVE**
## Integrated Service Delivery – Learning Collaborative: Improve Outcomes

| Percentage of patients who received the team’s selected integrated care intervention in past 12 months. | Numerator: Number of patients in the population of focus who have received the selected integrated care intervention in the past 12 months |
| Denominator: Total patient population of focus for improved care integration at your site. |

- Patients with a shared care plan documented at both the primary care (PC) provider site and the behavioral health (BH) provider site
- Patients whose treatment plans include goals for both PC and BH
- Patients whose care was covered in care coordination conferences with PC and BH providers in the past 12 months (note: teams focusing on more complex patients may want to track patients covered in coordination conferences at more frequent interval; they could use the different interval in addition to or instead of the 12-month interval)
- Patients receive a visit with both their PC provider and BH provider within a set time period (e.g. past 60 days for more complex patients)
### Integrated Service Delivery – Learning Collaborative: Improve Outcomes

<table>
<thead>
<tr>
<th>Percentage of patients receiving integrated care whose condition improved</th>
<th>Numerator: Number of patients in population of focus whose condition has been documented as improved in past 12 months, as measured by selected indicator.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator: Total patient population of focus for improved care integration at your site</td>
<td></td>
</tr>
</tbody>
</table>

**Examples of improvement in behavioral health conditions in primary care settings:**

- Screening results no longer positive
- Adherence to medication for behavioral health condition (in DSRIP category 3)
- Completion of counseling for behavioral health condition, based on documented achievement of 1+ treatment plan goals
- Reduced PHQ-9 score for all patients with initial scores over 10, to less than 10
- Reduced PHQ-9 score for all patients with initial scores over 10, to less than 5
- Behavioral health condition in remission
- Abstinence from alcohol or other drug use
- Reduced alcohol or other drug use

**Examples of improvement in primary care conditions in behavioral health settings:**

- Screening results no longer positive
- Reduced tobacco use
- Discontinued tobacco use
- HbA1c less than 9%
- BP to <140/90
- LDL-C control
- Patients engaged in or received treatment for STD, HIV, hepatitis
Thank You

QUESTIONS?

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