Behavioral Health and Primary Care Learning Collaborative

Health Care Transformation Initiative

MHMR Tarrant

Behavioral Health and Primary Care Learning Collaborative
Health Care Transformation Initiative

Susan Garnett
Chief Executive Officer
MHMR of Tarrant County

Susan Garnett- MHMR

Behavioral Health and Primary Care Learning Collaborative

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MHMR Tarrant

- Has provided behavioral health services for the past 45 years
- Is the Local Mental Health Authority
- Second-largest community center in Texas

Offer behavioral health services to include:

- Mental health services for adults, adolescents and children
- Crisis services: hotline, mobile crisis outreach, respite and residential
- Homeless services
- Criminal justice services
- Substance abuse services
  - Detox (residential and outpatient)
  - Residential treatment
  - Outpatient clinic services
  - Peer Support Services

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DSRIP Projects That Relate to Behavioral Health and Primary Care Integration

Expand Behavioral Health

- Expansion of behavioral health services through the addition of a new location and expanded hours.

Integrated Health Care

- Integration of primary health care services and behavioral health care services under one roof.

Substance Use Disorder (SUD) Outpatient Integration

- Addition of Licensed Chemical Dependency Counselors (LCDCs) and Peer Support Specialists into all MHMR behavioral health clinics.

Detoxification Unit and Service Expansion

- Expansion of facility beds from 12 to 20 and augmentation of current services with addition of Peer Support Specialists.

Sam Pang, Camille Patterson, Zeba Salim, Jessica Alexander (back row), Karyssa Walsh, Annette Dejesus and Brian Villegas (front row)

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Expand Behavioral Health

Expand Behavioral Health (EBH) Initiative

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1 of 7 innovative initiatives implemented by MHMR Tarrant

An implementation of the Texas Health Care Transformation & Quality Improvement Program: Medicaid 1115 Waiver

Part of the Behavioral Health & Primary Care Learning Collaborative with Region 10 Anchor, JPS Health Network

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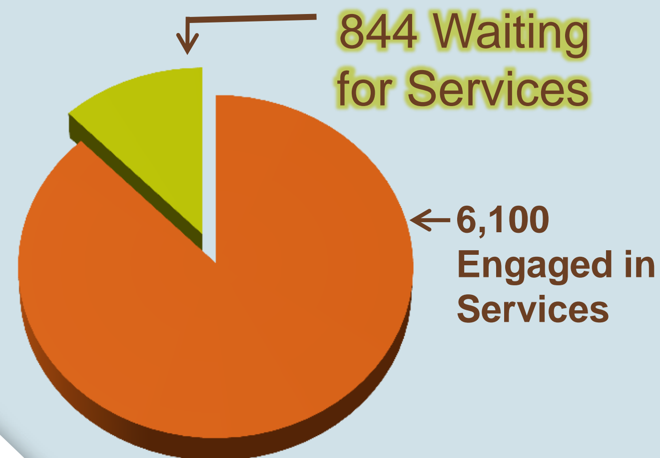
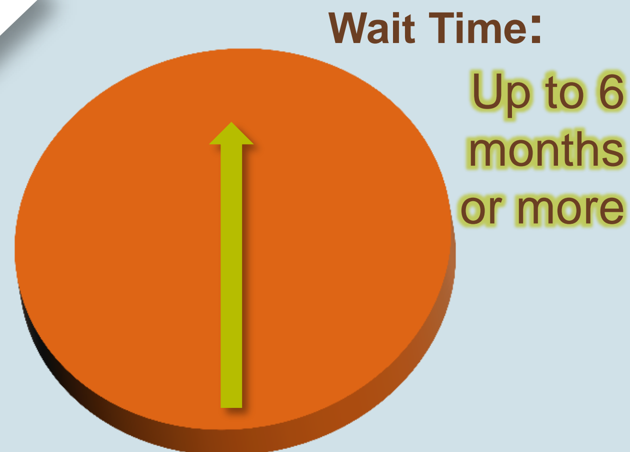
What is the Need for EBH?

Access to behavioral health services is one of the highest needs in the region.



Wait Time:



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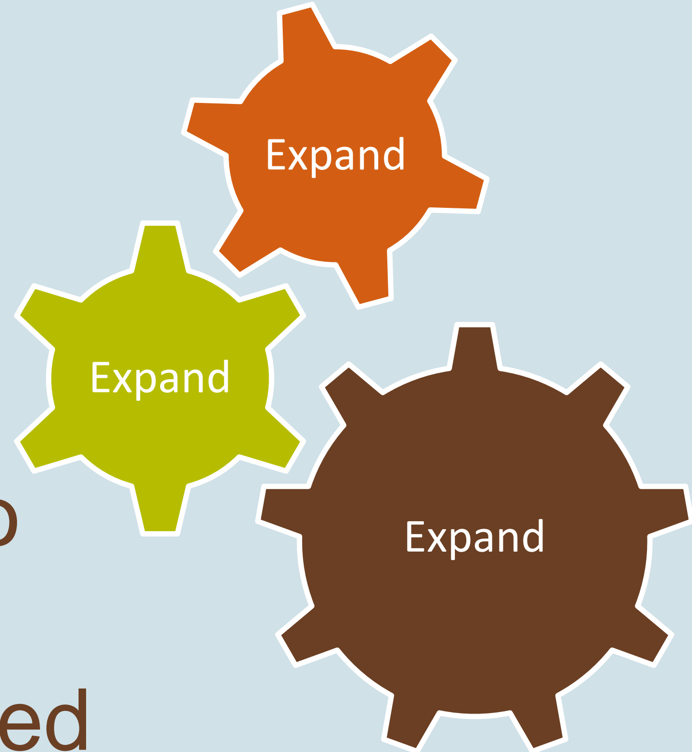
What is the Need for EBH?

- Expand access beyond target population.
- Expand to populations who face challenges accessing needed behavioral health services.



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The Vicious Cycle

Low-income and uninsured residents cannot afford appropriate care and therefore neglect preventative and routine health care.

Diseases go undiagnosed and/or untreated until acute and/or dangerous.

Costly emergency departments are overused, and primary care physicians and specialists are underused.

Higher public cost is incurred than would be possible with earlier intervention and a more organized delivery system.

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How Will EBH Address this Need?

1 Increase access by reducing or eliminating the waitlist.

We will open a new community-based service location in an underserved area.

We will serve 1,150 unique individuals over the next three years.

We will expand existing clinic hours.

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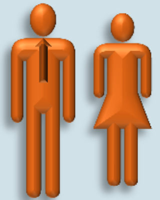
How Will EBH Address this Need?

2 Provide more effective services to those in treatment.

We will increase the number of psychiatrists and behavioral health staff.



Dr. Segars' Office

We will reorganize to offer more effective services to the individuals we currently serve.

The Impact of EBH

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Dr. Segars, Behavioral Health Psychiatrist

[Dr. Segars- MHMR]

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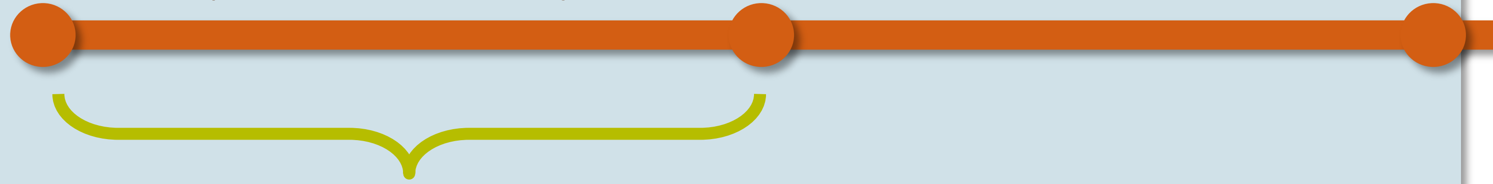
Milestone Timeline

Demonstration Year 2

(10/1/12 to 9/30/13)



Milestone 1 [P-6]

Establish behavioral services in new community-based settings in underserved areas.

Goal

Add one additional community-based setting.

Progress

100% Complete.

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Milestone Timeline

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Demonstration Year 3

(10/1/13 to 9/30/14)

Milestone 2 [P-4]

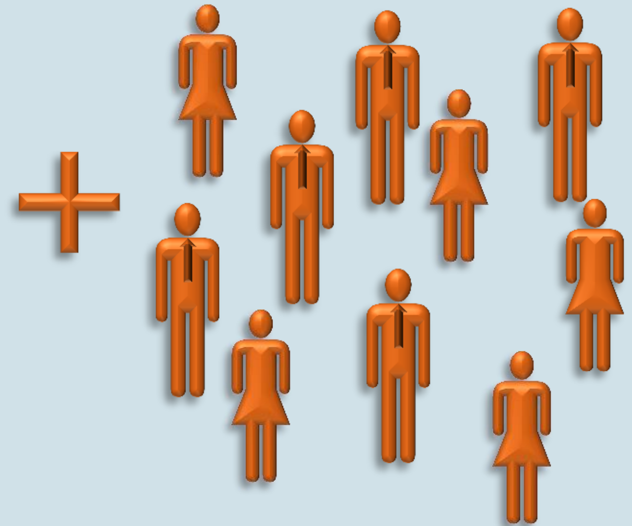
Hire and train staff to operate and manage projects.

Goal

Hire 10 additional behavioral health staff.

Progress

100% Complete.
Staff has been hired and trained.



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Milestone Timeline

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Demonstration Years 3 through 5

(10/1/13 to 9/30/16)

Milestones 3, 5, 7 [I-11]

Increase utilization of community behavioral health care.

Goal

See a total of 1,150 additional unique individuals.

Progress

100% complete for DY3.
Expanding space and capacity
Preparing for expansion of clinic service hours.

BUSINESS HOURS:

Mon.	8:00	to	5:00
Tue.	8:00	to	5:00
Wed	8:00	to	8pm
Thur.	8:00	to	5:00
Fri.	8:00	to	8pm

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Integrated Health Care Initiative

Integrated Health Care Initiative

Behavioral Health and Primary Care Learning Collaborative

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Integrated Health Care

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Integrated Health Care Initiative

MHMR and JPS are partnering to co-locate behavioral health and primary care services at MHMR Tarrant's Homeless Services Clinic.

Brian Villegas (MHMR) & Dawn Zieger (JPS)

Integrating Behavioral Health & Primary Care

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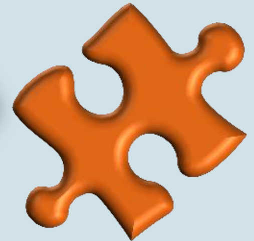
Purpose:

To maximize resources and improve the health outcomes for the target population by providing access to integrated primary care and behavioral health services in a community mental health setting.

Expected Outcome:

- Enhanced access to quality health care
- Improved overall health status
- Improved cost-effectiveness of care provided



Population of Focus:

Individuals with severe mental, developmental, and addictions disorders also be homeless, and who are in need.

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Need for Integrated Health Care

Dr. Sureddi- MHMR

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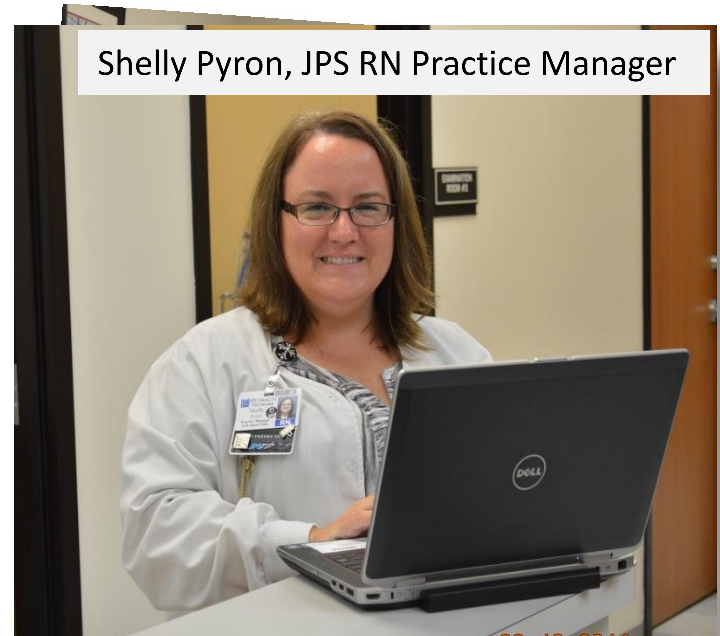
Need for Integrated Health Care

- Individuals living in Texas with severe mental illness have a shorter life expectancy than the general population.
- Nearly two-thirds of deaths within this population are caused by chronic diseases such as hypertension and diabetes.
- Approximately 40%, or 2,800, of individuals currently served by MHMR receive no primary care services from any other source.



Shelly Pyron, JPS RN Practice Manager

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Integrated Health Care Testimonial

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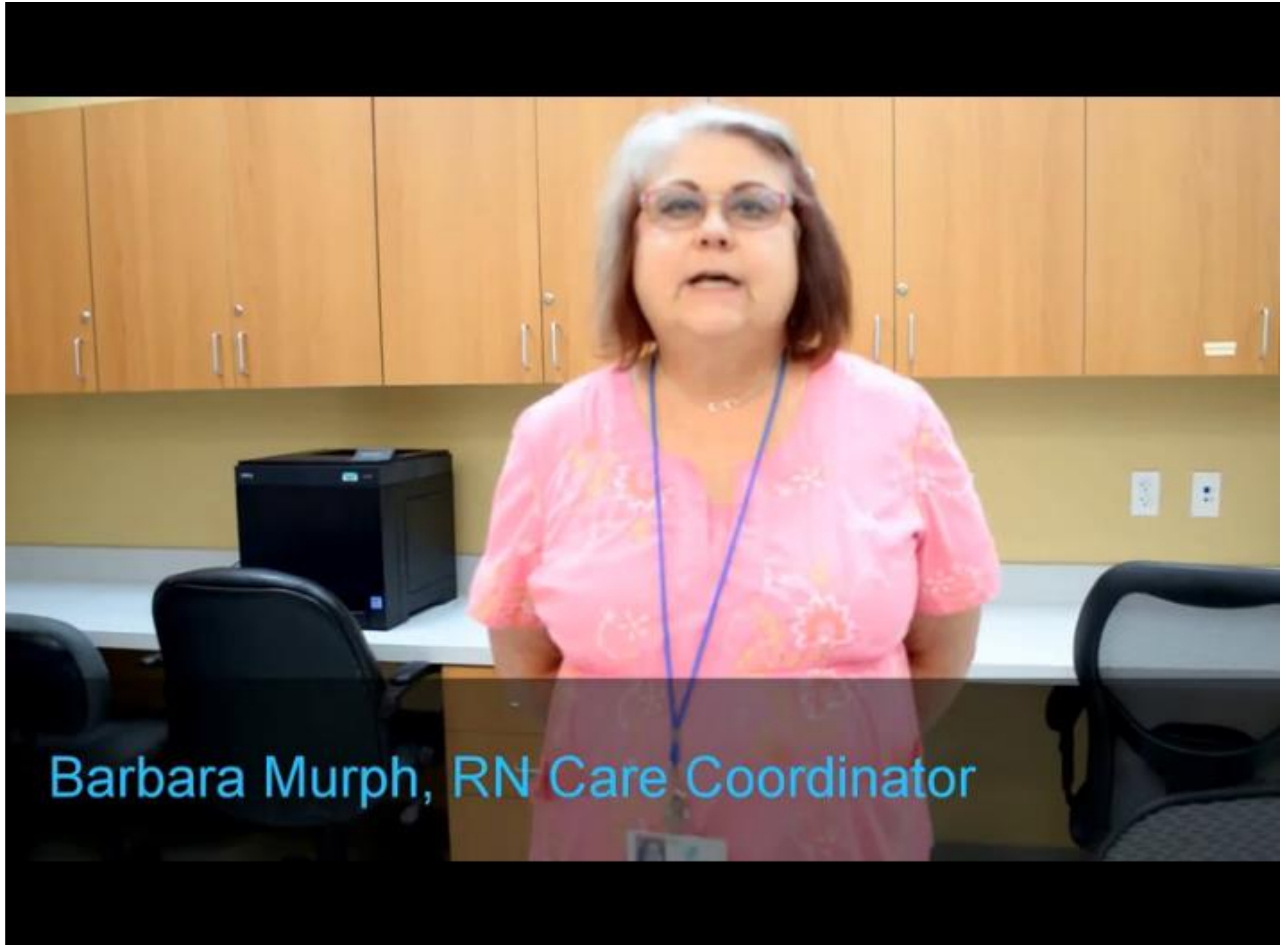

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Barbara Murph-MHMR

Integrated Care Model

Clinical Model

The project will function at a Level 4 integration wherein:

- Providers share the same facility
- Regular face-to-face communication – ***"Sense of being part of a team"***
- Providers will develop a integrated treatment plan
- Shared operations (scheduling appointments, medical records, one set of lab work, etc.)
- Patient experiences mental health treatment as part of their regular primary care or vice versa. * ***"Seamless Care"***

*National Council for Behavioral health. *Behavioral Health/Primary Care Integration The Four Quadrant Model and Evidence- Based Practices*. Revised February 2006

Aureka Woller (MHMR) and Edna Frade (JPS)

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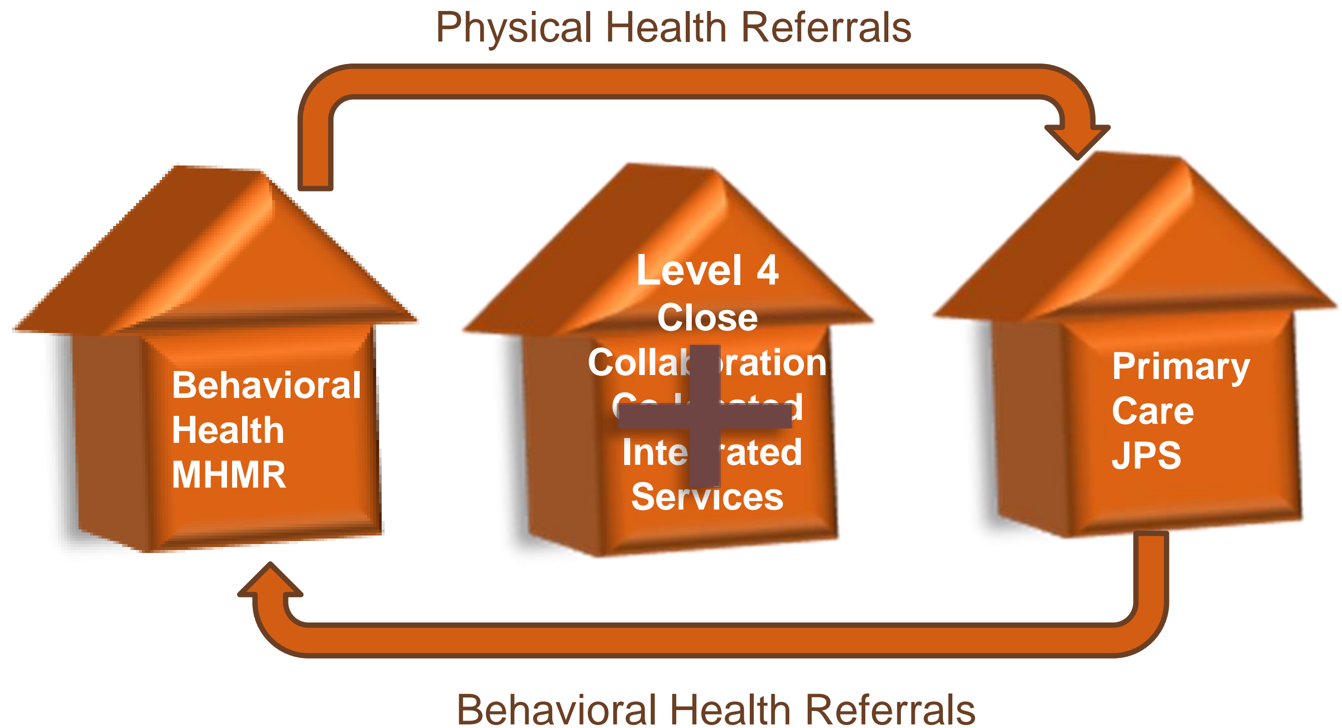
Integrated Care Flow



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Milestone Timeline

Demonstration Year 3

(10/1/13 to 9/30/14)

Milestone1 [P-3]

Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health persons to physical health and vice versa

Goal

100 referrals that are made between providers at the location.

Progress

43% complete

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Milestone Timeline

Demonstration Year 3
(10/1/13 to 9/30/14)

Milestone 2 [P-6]

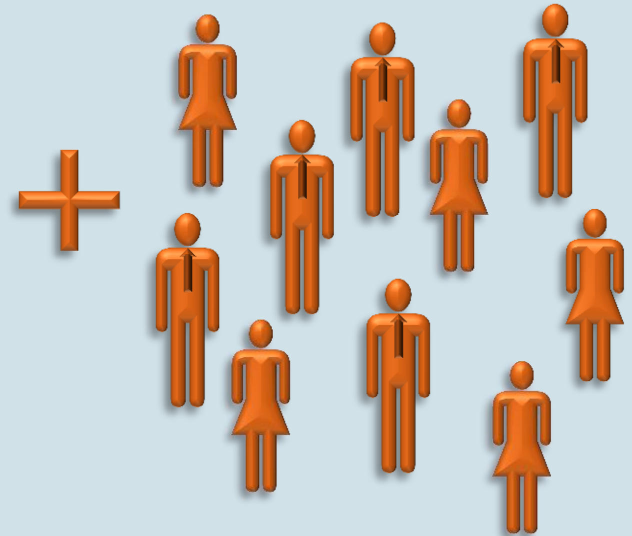
Number of providers achieving Level 4 interaction (close collaboration in a partially integrated system).

Goal

2 providers achieving Level 4 interaction (close collaboration in a partially integrated system).

Progress

100% complete



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Milestone Timeline

Demonstration Years 4 & 5

(10/1/14 to 9/30/16)

Milestones 1 [I-8]

Integrated Services

Goal

See a total of 885 unique individuals receiving both physical and behavioral health care at established location.

Outcome:

Reduce the number of impacted patients with high blood pressure

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Substance Use Disorder (SUD) Outpatient Integration

Integrated Mental Health and Substance Use Treatment

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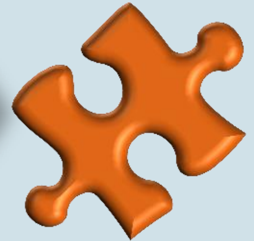
Purpose:

To increase MHMR outpatient sites to provide integrated care at the right time, right treatment and the right setting.

Expected Outcome:

- Promote wellness and adherence to medication
- Decrease ER visits
- Promote recovery in the community
- Less physical and mental health crisis
- Less criminal justice involvement



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Integrated Mental Health and Substance Use Clinic

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Population:

- Severely mentally ill patients with substance use problems
- Many in this group are "safety net" clients who never had addiction treatment of any kind
- Schizophrenia, Major Depression with Psychosis, and Bipolar with psychotic features
- Not the typical population in treatment facilities

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Integrated Mental Health & Substance Use Clinics

- 3 integrated SUD clinics began January 2014.
- 2 more clinics added from May to August.
- 3 more integrated clinics added by October 2014.
- 278 individuals currently receiving co-occurring psychiatric and substance abuse services.
- Treating one disorder and but not the other often leads to increased emergency room visits, increased usage of the criminal justice system and exacerbating the problems of mental health or chemical dependency.

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Services Offered

Based on SAMHSA, IDDT model from Case Western University

1. Multidisciplinary team
2. Comprehensive services
3. Time-unlimited services
4. Substance abuse counseling
5. Family psychoeducation
6. Promotion to overall health wellness
7. Intervention for non-responders (appropriate referrals)
8. Peers Recovery Specialists
   (engagement of individuals, referrals, individual coaching, contacts with family, job readiness, NA/AA groups, etc.)

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Importance of Peer Specialists

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Melanie Campbell, Peer Recovery Coach

Melanie Campbell- MHMR

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Peer Support

"It helps having someone that has walked in your shoes that really understands what your going through and seeing them overcome this and gives me hope that I can do the same."

"The most important was the way the Peer Support Coaches treated you like you were someone and like you belonged."

"Without the program I don't know where I would be right now it has been a blessing to have this help."

Substance Use Disorder (SUDS) Program participants Sharon, Berlinda, Will, David, Charles, Blair, and Leslie stand with SUDS Program workers **Jennifer Hooton** and **Gina Luera** on the staircase at the Omni Theater on July 25. Gina and Jennifer organized the trip.

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Milestone Timeline

Demonstration Year 2

(10/1/12 to 9/30/13)

Milestone 2 [P-2]

Design community-based specialized interventions for target populations.

Goal

Design community-based specialized intervention.

Progress

100% Complete

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Milestone Timeline

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Demonstration Years 3 through 5

(10/1/13 to 9/30/16)

Milestone 1 [I-101]

Improvement milestone of target population reached

Goal

See 1,350 unique individuals

Progress

- 6 clinics opened
- Served=385
- January
  - 385 assessed
  - 278 received wrap around services (individual, group, peer, family)

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Outcomes

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Individuals who have been in program for 3 months or more: **142/278** (51.07% of individuals)

Increased awareness of community resources and support

Improved social skills

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as of June 30th, 2014

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Satisfaction Survey Results

The services I received helped me deal more effectively with my problems.

Answer Options	Response Percent	Response Count
Strongly Agree	45.3%	24
Agree	41.5%	22
Neutral	13.2%	7
Disagree	0.0%	0
Strongly Disagree	0.0%	0

I feel the Counselor's individual and group sessions were a significant part of my recovery.

Answer Options	Response Percent	Response Count
Strong Agree	61.5%	32
Agree	19.2%	10
Neutral	17.3%	9
Disagree	1.9%	1
Strongly Disagree	0.0%	0

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Challenges and Progress

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Challenges:	Progress:
Expand to all 8 clinics →	Currently at 6 clinics
Training on integrated services →	Providing monthly training
Charting →	95% electronic and paperless
Building 1 team MH + SUDS →	Continuously evolving into more sophisticated system
Space →	4 of 6 clinics have expanded space

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Detoxification Unit and Service Expansion

Billy Gregory Detox Clinic

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- In the 1970s, Billy Gregory was a goat farm where the jail sent people to work while withdrawing

- By 2013, Detox was a 12-bed inpatient unit at "Pine St."

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Billy Gregory Detox Services

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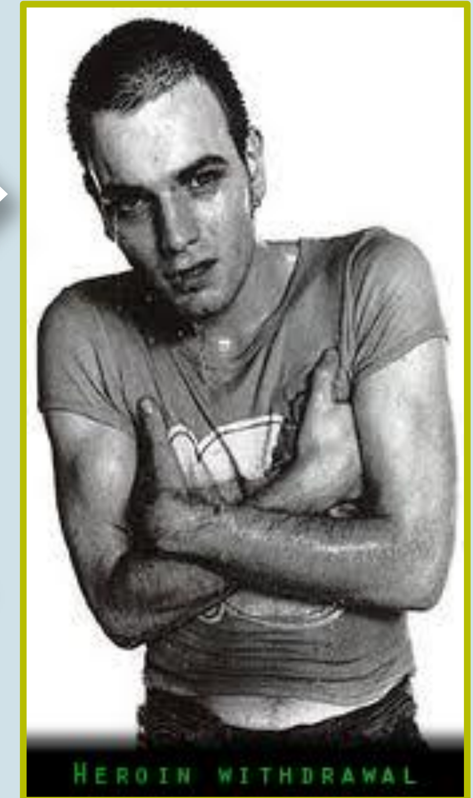
Services Offered

- Inpatient Care
  - Medically-assisted detox
  - Counseling

- **Continuum of Care**
  - Ambulatory Detox
  - Pine St. Residential Treatment
  - Community Addiction Treatment Services
  - After-care meetings



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Need for Detox Expansion

- **Lack of capacity for meeting the needs of target population.**
  - Over 86% of stakeholders felt there are too few detox beds in the community to adequately meet the needs of the community.
  - Wait times to get into treatment are too long.
    - Two or three weeks

- **Need to better address the hardships faced by those needing detox.**
  - Homelessness
  - Unemployment
  - Lack of social supports
  - Lack of primary health care
  - Childcare and transportation

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Detoxification Unit and Services Expansion

- **Funding for development of infrastructure**
  - Expansion from 12 beds to 20 beds

Diana Stedman- LVN

- **Staffing additions**
  - 5 Peer Recovery Coaches
  - 1 Physician Assistant, Director
  - Screening and admissions nursing staff
- **Service enhancement**
  - Integration of primary care
  - Augmentation of counseling curriculum
  - Peer support services

Detox Group Common Area

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Billy Gregory Detox

Addition of Peer Support

- **3-6 months of support**
- **Emotional**
  - Peer mentoring
- **Informational**
  - Recovery coaching
- **Instrumental**
  - Transportation
  - Childcare
  - Housing
  - Health and Social Services
- **Affiliation**
  - Peer-lead support groups
  - Community support groups

LaJohn McDonald & Debbie Pearcy, MHMR Peer Recovery Coaches

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Billy Gregory Detox

Counseling Services

- **Group sessions**
  - Seeking Safety Curriculum
    - Trauma-based
    - Coping and life skills
- **One-on-one sessions**
  - Motivational interviewing
  - Individual coaching
  - Health and wellness plan
  - Goal setting
- **Health Group Sessions**
  - Various daily health topics
  - Smoking cessation

Shay Cummins, RN &
Patrick Babamuboni, Tech

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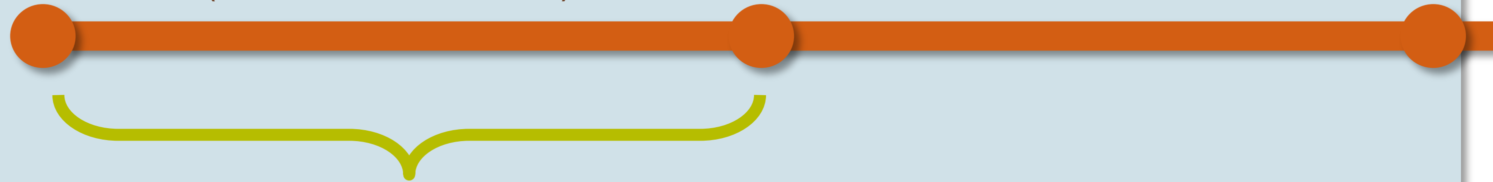
Milestone Timeline

Demonstration Year 2

(10/1/12 to 9/30/13)



Milestone 2 [P-2]

Design community-based specialized interventions for target population.

Goal

Design community-based specialized intervention.

Progress

100% Complete

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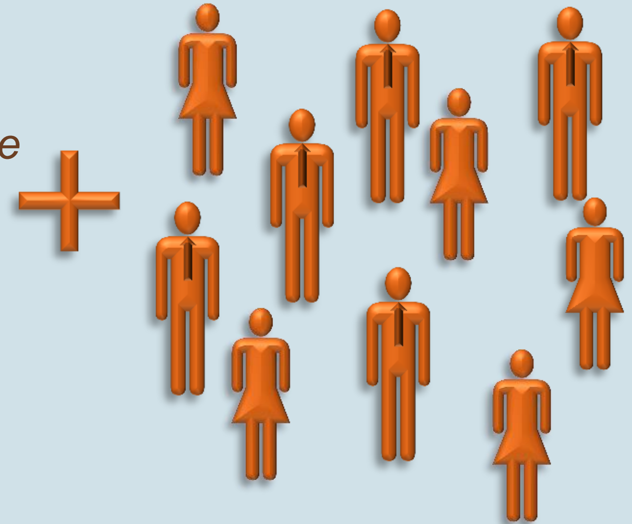
Milestone Timeline

Demonstration Year 3
(10/1/13 to 9/30/14)

Milestone 1 [P-3]

Enroll and serve individuals with targeted complex needs (Substance use diagnosis and homeless, MH, and/or legal issues.



Goal

Current population of 500 receive enhanced services.

Progress

100% Complete

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Milestone Timeline

Demonstration Years 4 & 5

(10/1/14 to 9/30/16)

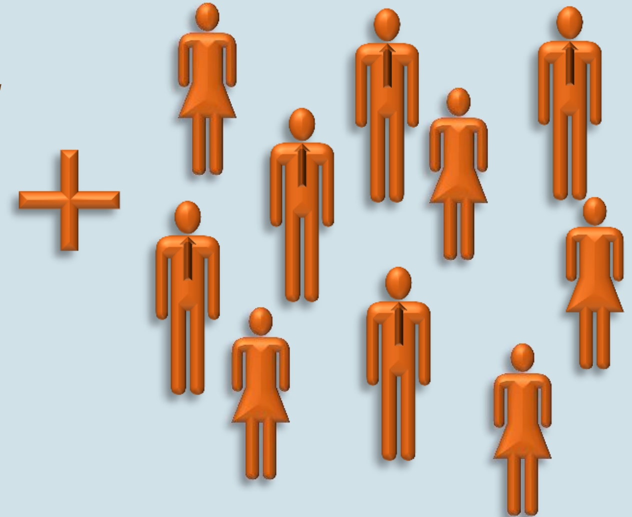
Milestone 1 [I-101]

Serve additional patients needing detoxification services, to include enhanced services.

Goal

See 550 additional unique individuals.

Goal is a 10% improvement in overall quality of life by DY5 measured by SF-36 Health Survey.



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The Focus on Community Impact

- **Addressing the opiate epidemic**
  - Embracing the new paradigm in care
    - Coordination of Opiate Replacement Therapy (ORT)
  - Pregnant females on opiates
    - Coordination of ORT services
    - Residential treatment
- **Right care at the right time in the right place**
  - **Partnering with diversion programs**
    - Child Protective Services
    - Department of Corrections programs
    - Veteran Diversion programs
- **Promoting overall wellness**
  - **Partnering with healthcare systems**
    - JPS Healthcare
    - Tarrant County Medical Education and Research Foundation (TCMERF)
    - Tarrant County Health Department
    - Community smoking cessation programs

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INITIATIVES and PARTNERSHIPS have allowed us to impact the community and promote overall wellness

PHYSICAL

EMOTIONAL

SPIRITUAL

ENVIRONMENTAL

INTELLECTUAL

OCCUPATIONAL

SOCIAL

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The Integration Project

Tobacco Use & Behavioral Health

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- According to CDC, persons with behavioral health diagnoses are about twice as likely to smoke
- The prevalence rates are extremely high for individuals with behavioral health conditions:
  - 60% of people with lifetime depression are either current or former smokers
  - 70% of people with bipolar disorder smoke
  - 88% of people with schizophrenia are current smokers
- MHMR Addiction Services population
  - **80.5%** smokers as opposed to **19.5%** smokers in the general population.

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The Integration Project

Services: Smoking-Cessation Screening and Intervention

- Screening and treatment provided in a behavioral health setting.

Geographic region served: Region 10

Population of focus: Individuals with mental health, substance abuse, and co-occurring disorders who may or may not be homeless.

At least 1050 to be served in 2014

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Screening

Screening Tool

The *Fagerstrom Test for Nicotine Dependence (Fagerstrom)*

- 8 question survey
- Selected because it is the most widely used and studied measure of physical dependence on tobacco

What is the Fagerstrom Test for Nicotine Dependence?

- Designed to test the intensity the individual has to nicotine addiction.
- An overall score of nicotine dependence is obtained based on how the individual responds to each question on the Fagerstrom.

Overall goal is to screen >90% of 1050 individuals in programs

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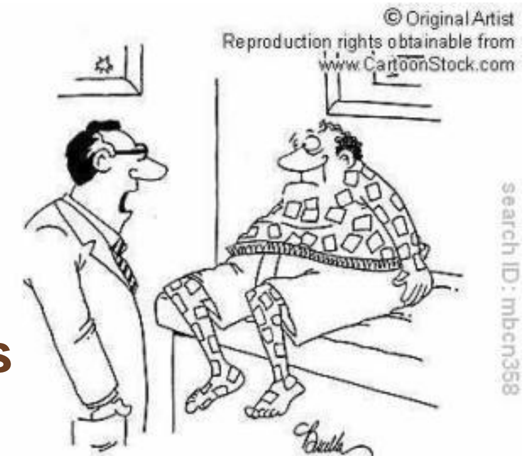
Intervention

- **Staff trained** using the University of Massachusetts Medical School Tobacco Treatment for Specialist Course

May, 2014- July, 2014

- **Nicotine Replacement Therapy (NRT)**
  - 91 unduplicated persons receiving NRT's
- **Smoking Cessation Group**
  - 130 group sessions system-wide have been provided monthly at all MH and AdS locations
- **Referral to community resources and programs**



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Data Collection & Monthly Measures

Data Collection

How is data collected using the Fagerstrom?

- Fagerstrom is completed prior to admission into services.
- Individuals complete on their own or with assistance.
- Forms completed on pen and paper with a few sites using the online version on a computer.
- Staff and interns data enter the Fagerstrom into Fluid Survey if it is completed on paper.
- Data pulls are done each month and data rigorously cleaned.

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AIMS Statement

Aim 1: Percentage of patients screened with team's selected cross-specialty screening (Fagerstrom).

Aim 1

Month	Feb	March	April	May	June
Value	0.2	0.36	0.5	0.56	0.68

Goal: Increase from 7% to 90% (945/1050)

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AIMS Statement

Aim 2: Percentage of patients who received the team's selected integrated care intervention in past 12 months.

Aim 2

Month	Value
Feb	0.15
March	0.21
April	0.66
May	0.49
June	0.61

Goal: Increase from 0% to 33% (350/1050)

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AIMS Statement

Aim 3: Percentage of patients receiving integrated care whose condition improved.

- Intervention began in April and consists of four group sessions on separate topics.
- Typical completion time for the four sessions ranges from six to eight weeks.
- Follow-up Fagerstroms are collected after the completion of all four sessions.
- Fagerstrom test looks at risk reduction rather than complete elimination of tobacco use.
- Data is currently being collected and analyzed.
- Goal: Increase from 0% to 13% (140/1050).

Behavioral Health and Primary Care Learning Collaborative

Plan-Do-Study-Act

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Health Care Transformation Initiative

PDSA - Cycle 1

Goal: Increasing motivational level and thus willingness to participate in a smoking cessation program.

Steps involved:

- Individual completes baseline Fagerstrom but does not want to make quit attempt.
- Individual presented with facts and statistics as to the devastating impact on a person's health if they continued to use tobacco/nicotine products.
- Follow-up with questions from the Fagerstrom.

Findings:

- No change in the level of motivation was observed.
- Gaps in the data collection process were identified, leading to initiation of PDSA Cycle 2.

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PDSA - Cycle 2

Goal: Improve quality of data collected by identifying gaps and implementing appropriate processes.

Steps involved:

- Outcomes team goes to individuals clinics, observes the process, and identifies gaps in the data entry and retrieval process.
- Team redesigns the process at each clinic to address gaps in the previous process.
- Cycles are repeated to test for improvement in ability to capture usable data.

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PDSA - Cycle 2

Detox Clinic Findings:

- Incorrect identifiers being used
- Incorrect dates
  - admit date vs entered date
- Fagerstrom not administered to all individuals
  - Non-smokers not being captured
- Data loss during acquisition from survey site due to formatting changes in Excel

Surveys captured went from 30% to 98% to 100%.

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Plan for the Future

- Survey >90% of all individuals in programs.
- Continue PDSA cycles to improve electronic data collection to report 100% of the surveys completed.
- Increase individual participation in smoking cessation programs to 33% of those identified as smokers.
- Achieve overall risk reduction for 13% of the tobacco users who participated in the intervention.

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Because of these Transformation Initiatives, and largely due to the participation of our Community Partners, we are able to offer.........

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Thank you!

Any Questions?

MHMR Behavioral Health-Primary Care Learning Collaborative Site Visit
August 25th, 2014
Sign in Sheet

Name	Signature	Organization
Heather Beal	[signature]	JPS, RHP10
Chris Wall	[signature]	JPS Project Director
Stevie Hansen	[signature]	MHMRTC
Edna C Nicholes	[signature]	MHMRTC
Dan Corley	[signature]	LRMHMRC
Tracy Kollert	[signature]	MHMRTC
Camille Patterson	[signature]	MHMRTC
Marion Johnson	[signature]	RHP 10
Jamie Hixson	[signature]	THR
Wayne Young	[signature]	JPS
Brenda Gomez	[signature]	JPS
Teneisha Kennard	[signature]	JPS
Erica Hilliard	[signature]	JPS
Grace White	[signature]	MHMR
Janelle Shepard	[signature]	THR
Keena Pace	[signature]	MHMR
Jeremy Carter	[signature]	THR

MHMR Behavioral Health-Primary Care Learning Collaborative Site Visit
August 25th, 2014
Sign in Sheet

Name	Signature	Organization
Kelly Guy LMSW	[illegible]	Kindred Healthcare - Transitional Care
Robert Johnson	[illegible]	LRMHMRC
Margie Freeman	[illegible]	THRFW
C Nati	C Nati MD	MHMRTC
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Charissa Huey	[illegible]	THSW
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Zeba Salim	[illegible]	MHMRTC
Jessica Alexander	[illegible]	MHMRTC