



Integrated Behavioral Health

JPS Health Network

JPS Health Network

The \$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



1.1 million patient encounters annually



Nine residency programs, including the nation's largest hospital-based family medicine residency



Patient Care Pavilion at John Peter Smith Hospital



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Community Footprint



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JPS Behavioral Health

JPS Health Network has a robust Behavioral Health Service Line

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

7 Behavioral Health 1115 Waiver Projects



Two Psychiatric Hospitals (96 & 36 beds)



4 Partial Hospitalization Programs



Psychiatric Emergency Center



Day Rehab For Homeless



Integrated Medical Unit



Virtual Psychiatric Guidance



6 behavioral health clinics



6 PC Clinics with Embedded BH Specialists



Walk-In BH Clinic



8 Peer Support Specialists



1 BH School-Based Health Center



Psychiatry residency programs



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Behavioral Health Outpatient Services

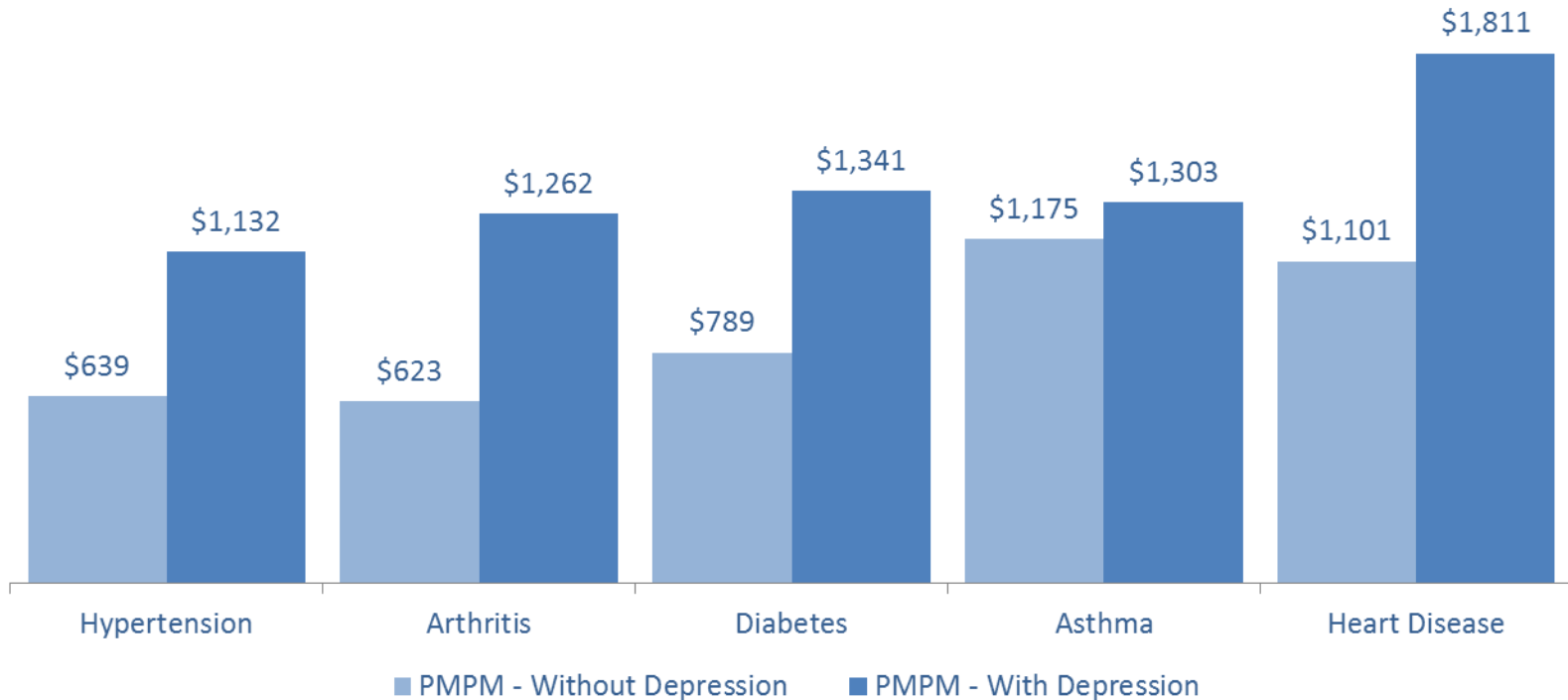


	Partial Hospitalization	Med Mgmt	Assessment	Psychological Testing	Psychology	Counseling	Vocational Rehab
Central Arlington	YES	YES	YES	-	-	YES	-
Northeast	-	YES	YES	-	-	YES	-
Stop Six	-	YES	YES	-	-	YES	-
Viola Pitts	YES	YES	YES	-	YES	-	-
Northeast SBC	-	YES	YES	-	-	YES	-
Hemphill	YES	YES	YES	YES	YES	YES	YES
HEB BH Clinic	YES	YES	-	-	-	-	-
Psych Day Rehab	YES	YES	YES	-	-	YES	YES
Healing Wings	-	YES	YES	YES	YES	YES	-
SE Tarrant Co MH	-	YES	-	YES	-	YES	-

The Case for Integrated Care



Total Healthcare Costs of Patients With and Without Depression



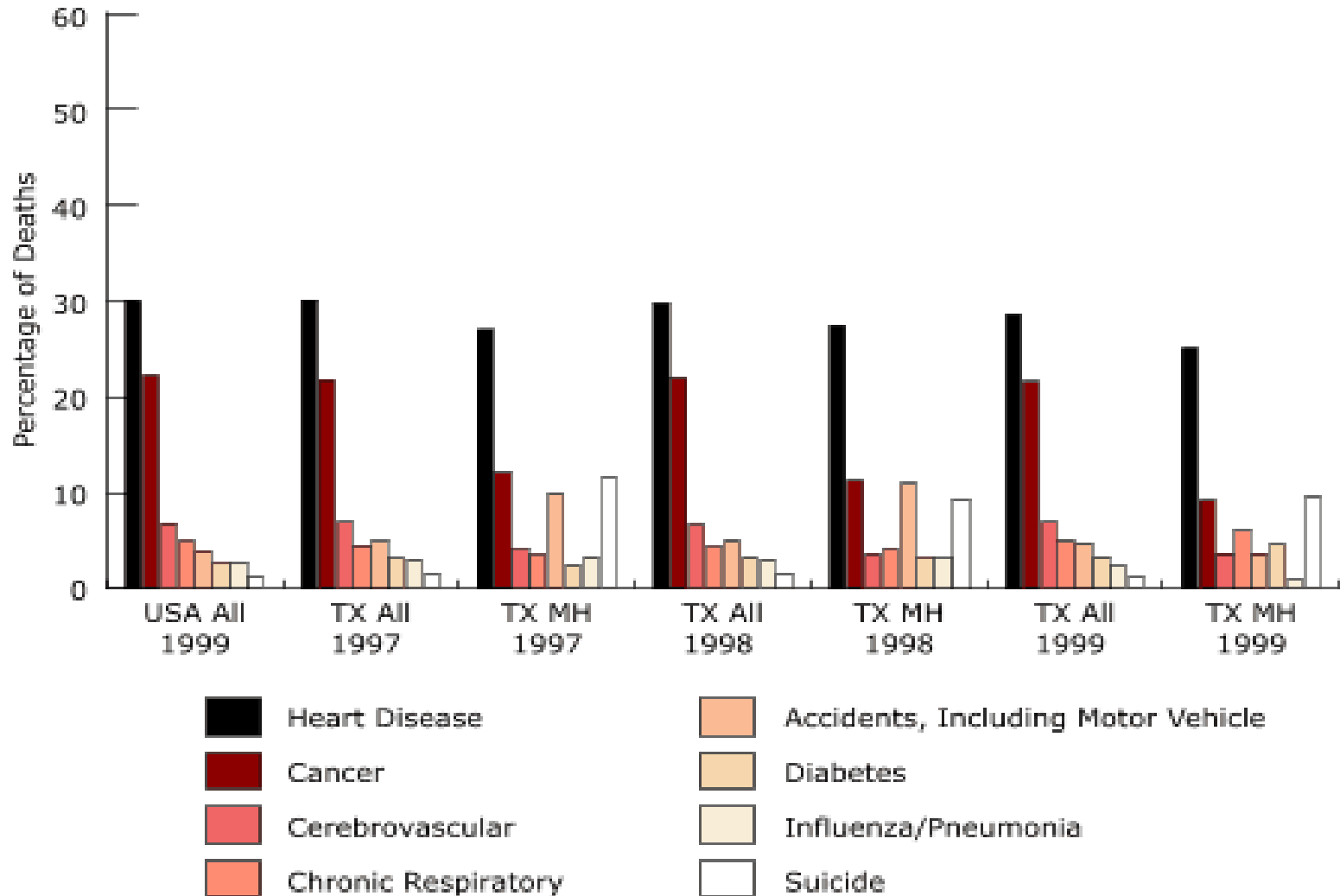
The Case for Integrated Care



Year	Mean Age at Time of Death			Mean Years of Life Lost Per Mental Health Client
	All MH Clients Who Died During Year	MH Male Clients Who Died During Year	MH Female Clients Who Died During Year	
1997	55.0	52.4	58.1	28.5
1998	55.0	53.3	56.6	28.8
1999	54.0	50.8	57.3	29.3

This and next slide reference: Colton CW, Manderscheid RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Prev Chronic Dis* [serial online] 2006 Apr [date cited]. Available from: URL: http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm.

The Case for Integrated Care



The Case for Integrated Care



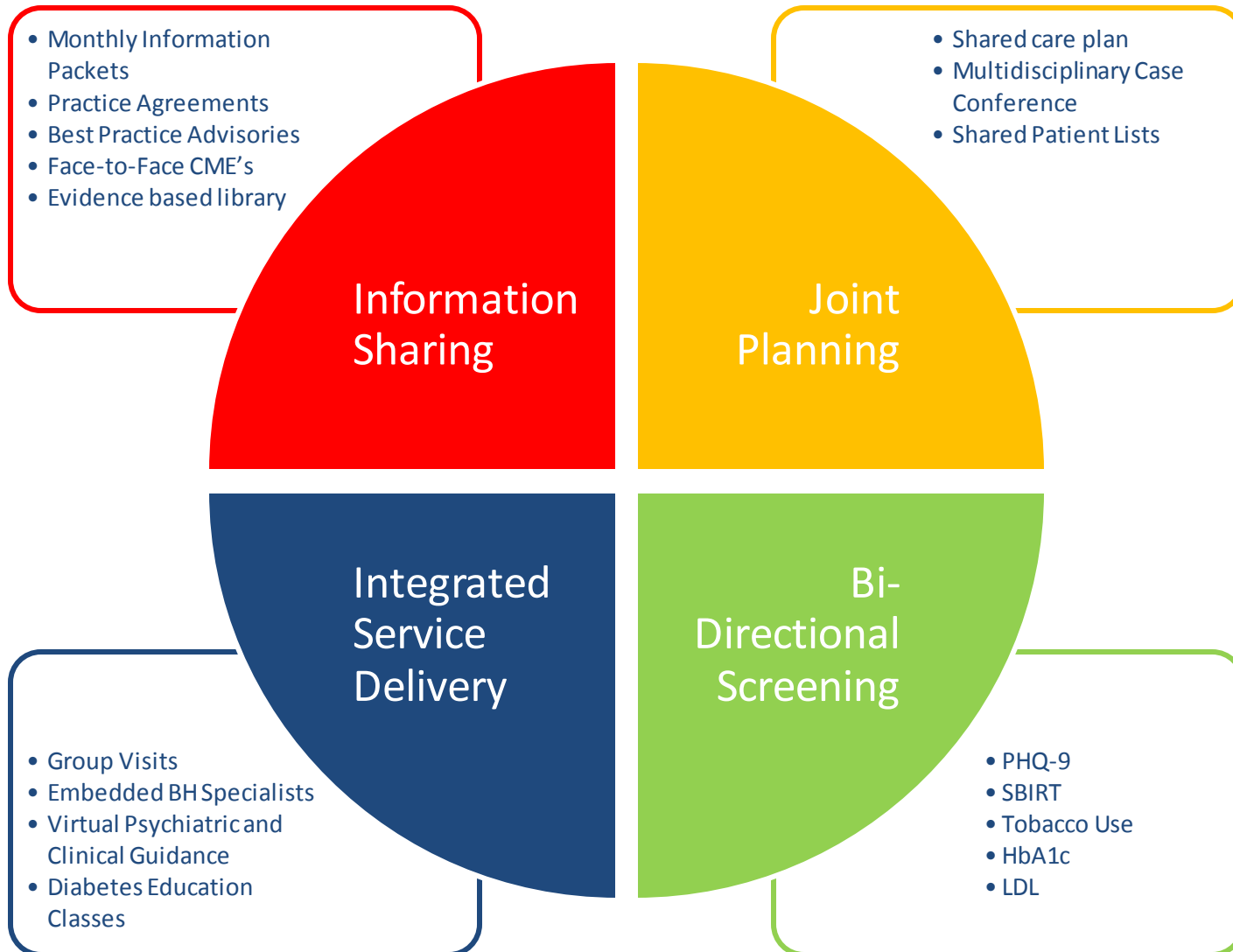
Source: SAMHSA: A standard framework for levels of integrated healthcare

MINIMAL COLLABORATION	BASIC COLLABORATION FROM A DISTANCE	BASIC COLLABORATION ONSITE	CLOSE COLLABORATION/PARTLY COLLABORATED	FULLY INTEGRATED
<ul style="list-style-type: none"> ➤ Separate systems ➤ Separate facilities ➤ Communication is rare ➤ Little appreciation of each other's culture <p>"Nobody knows my name. Who are you?"</p>	<ul style="list-style-type: none"> ➤ Separate systems ➤ Separate facilities ➤ Periodic focused communication; most written ➤ View each other as outside resources ➤ Little understanding of each other's culture of sharing of influence <p>"I help your consumers."</p>	<ul style="list-style-type: none"> ➤ Separate systems ➤ Same facilities ➤ Regular communication, occasionally face-to-face ➤ Some appreciation of each other's role and general sense of large picture ➤ Mental health usually has more influence <p>"I am your consultant."</p>	<ul style="list-style-type: none"> ➤ Some shared systems ➤ Same facilities ➤ Face-to-face consultation; coordinated treatment plans ➤ Basic appreciation of each other's role and cultures ➤ Collaborative routines difficult; time and operation barriers ➤ Influence sharing <p>"We are a team in the care of consumers."</p>	<ul style="list-style-type: none"> ➤ Shared systems and facilities in seamless bio-psychosocial web ➤ Consumers and providers have same expectations of system ➤ In-depth appreciation of roles and culture ➤ Collaborative routines are regular and smooth ➤ Conscious influence sharing based on situation and expertise <p>"Together, we teach others how to be a team in care of consumers and design a care system."</p>

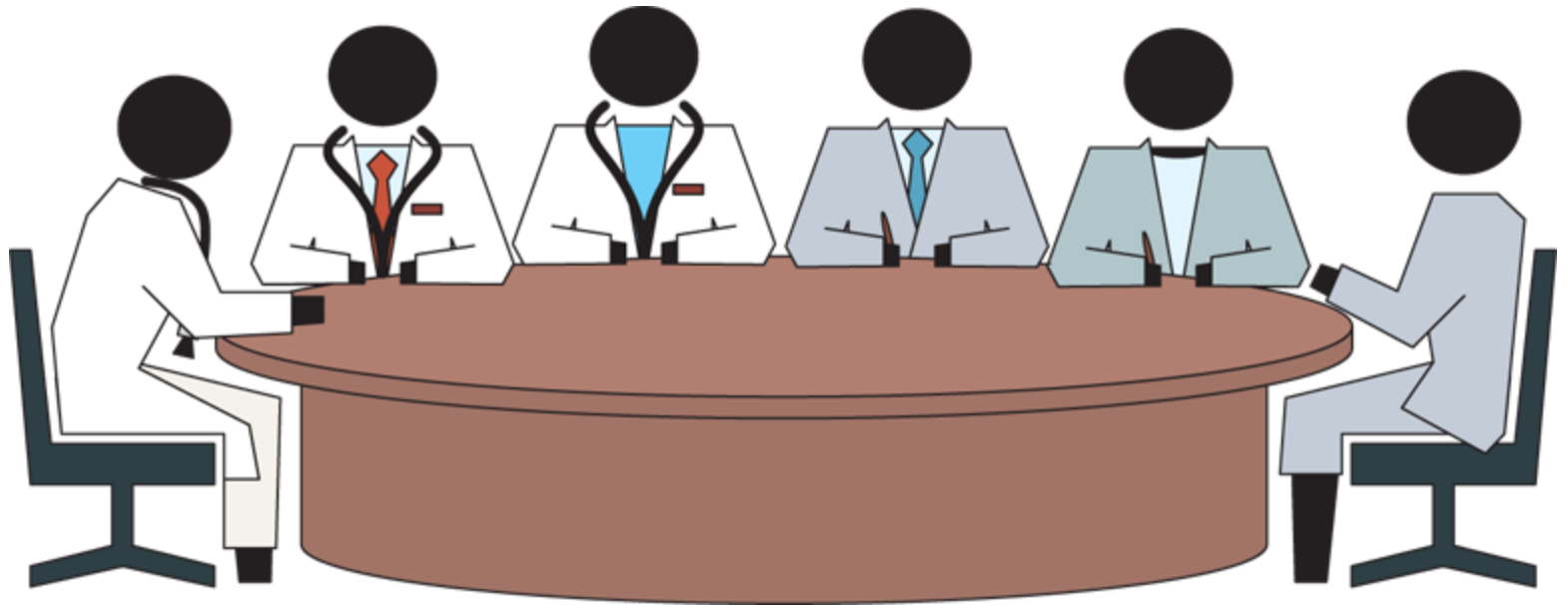
JPS Behavioral Health Integration Model



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Information Sharing - Practice Agreements



- Negotiated with primary care physician leaders and medical directors
- Documented in written agreement
- Approved by Med 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

Improve Screening Rates

Percentage of patients screened with team's selected cross-specialty screening	Numerator: Total number of patients in the population of focus who have received screening with the selected screening tool within the past 12 months
	Denominator: Total patient population of focus for improved care integration at your site.

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

Why should we screen?

1. 43,000 Suicides occur in the US every year. More than 70% of those saw their PCP within 30 days prior to committing suicide.
2. 34% of all accidental deaths and 10% of all suicides in Tarrant County were Substance Abuse related.
3. Individuals with a mental illness live 29.3 years less than individuals without a mental illness.

Bi-Directional Screening - PHQ-9



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



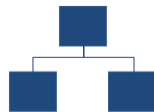
Train staff on how to use screening and how to escalate



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

Bi-Directional Screening - Best Practice Advisory



Staff trained on screening tool



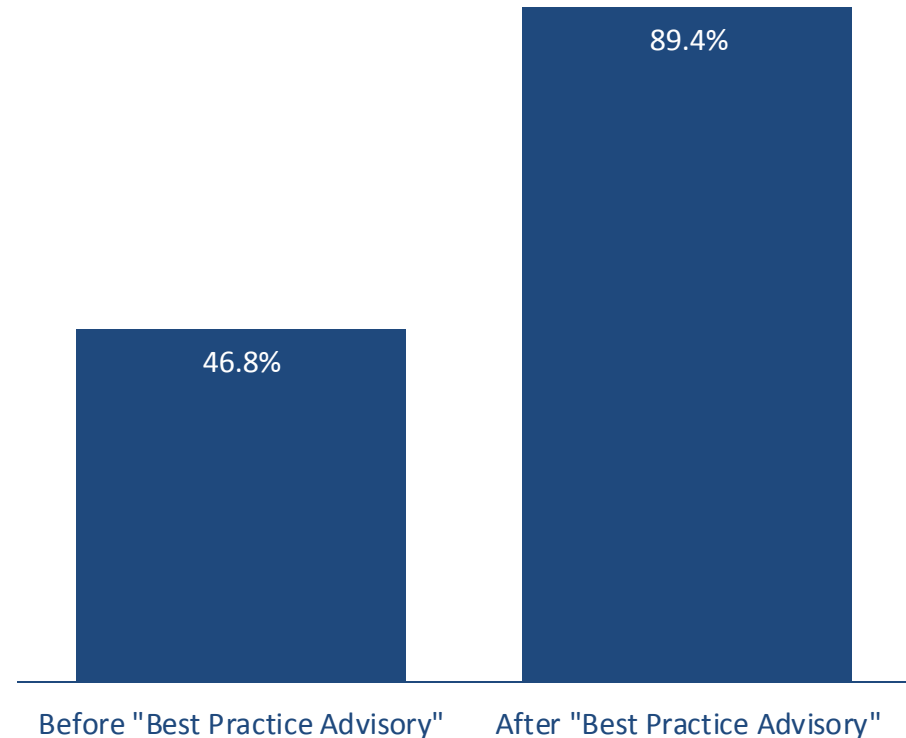
Automated alert in EMR prompts providers to document follow-up plan for scores > 9



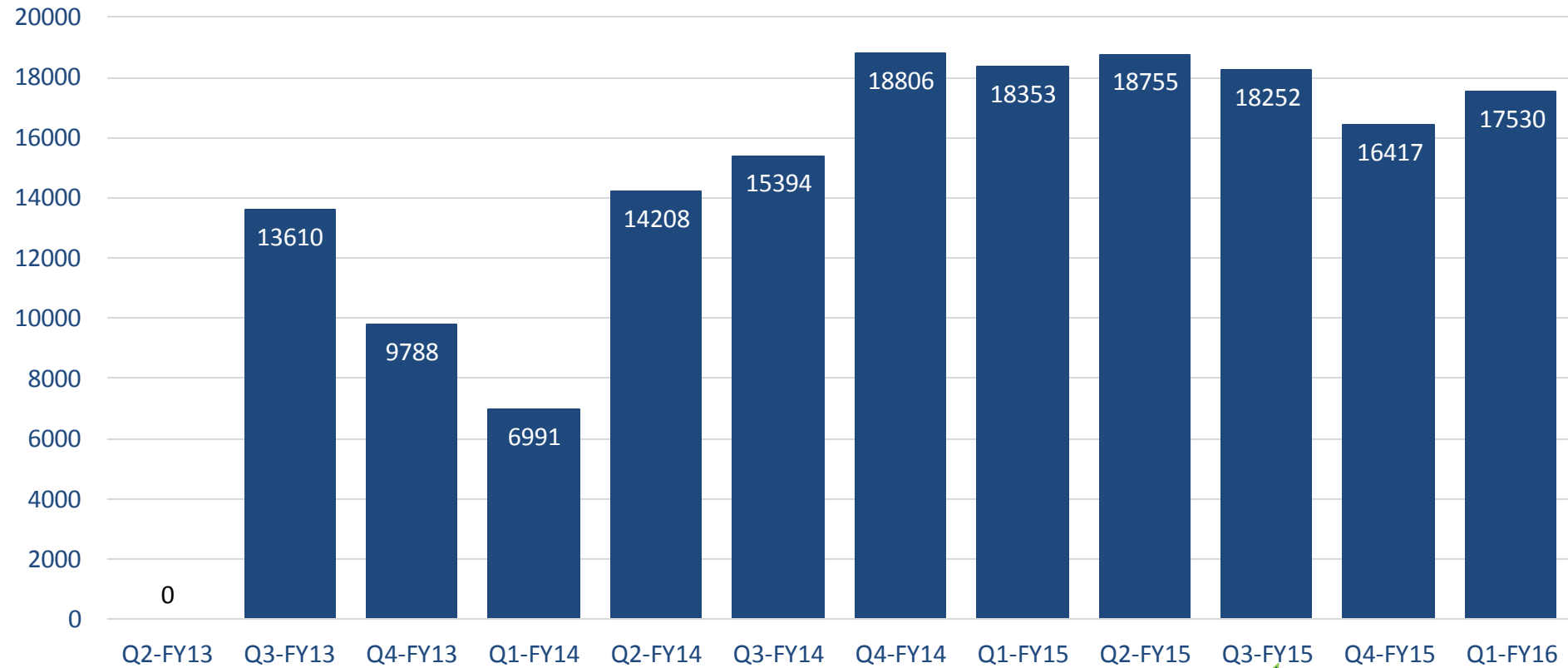
Results monitored

Physician Documentation of Follow-Up Plan

Among individuals with PHQ-9 score >9



Bi-Directional Screening - PHQ-9



Over 168,000
primary care
screenings for
depression

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.

prompted by your thoughts that you would be better off dead or hurting yourself in some way?

Total: 9

Depression Risk Total Score

Minimal 1-4 | **Mild 5-9** | Moderate 10-14 | Moderately Severe 15-19 | Severe 20-27

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

BestPractice Advisories

Quality and Compliance (1 Advisory)

PHQ9 score indicates action required; 5-9 Educate patient on Behavioral Health Resources, 10-14 requires follow-up in 2-4 weeks; 15-19 Medications need to be ordered and 20-27 requires a referral to behavioral health clinic

Psych Screening:
PHQ-9: Total : 9

Acknowledge reason:

Action Taken | Patient Refused

Open SmartSet JPS AMB PHQ9 preview

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

Orders

Orders

Ambulatory referral to Behavioral Health

SERTRALINE 25 MG TABLET

CITALOPRAM 10 MG TABLET

BUPROPION HCL 75 MG TABLET

FLUOXETINE 10 MG CAPSULE

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

TOTAL SCORE 19

Interpretation of Total Score		Recommended Interventions
Total Score	Probational Depression Screen	
5-9	Mild Depression	Educate patient on Behavioral Health resources Go to Order Entry
10-14	Moderate Depression	Follow-up within 2 to 4 weeks
15-19	Moderately Severe Depression	Prescribe a preferred antidepressant (fluoxetine, sertraline, citalopram)
20-27	Severe Depression	Referral to Behavioral Health for evaluation

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.

Depression Screening assessed at least once within the measurement period

**PHQ-2 or PHQ-9 has not been completed in the current calendar year.*

**PHQ-2 or PHQ-9 has been completed in the current calendar year.*

Epic Tool: PHQ-2/PHQ-9

Bi-Directional Screening

- PHQ-9



Score:	Interpretation:	Treatment Recommendation
0-9	Mild to Minimal Risk	<ul style="list-style-type: none"> • Support, educate to call if worsens, follow up as needed.
10-14	Moderate Risk	<ul style="list-style-type: none"> • Antidepressant therapy and/or psychotherapy • Behavioral health specialist provides resources, initiates treatment planning and motivational therapy as needed • Conduct suicide risk assessment • Virtual Psychiatric Guidance • Follow up in 4-8 weeks
15-19	Moderately Severe Risk	<ul style="list-style-type: none"> • Antidepressant and/or psychotherapy • Behavioral health specialist provides resources, initiates treatment planning and motivational therapy as needed • Conduct suicide risk assessment • Virtual Psychiatric Guidance • Referral to Psychiatry if warranted • Follow up in 2-4 weeks
20 or higher	Severe Risk	<ul style="list-style-type: none"> • Antidepressant, Possible augmentation • BH specialist provides resources, initiates treatment planning and follows up with patient. • Conduct Suicide risk assessment • Follow up in 2-4 weeks • Referral to Psychiatry

Bi-Directional Screening

- LDL & HbA1c with atypical antipsychotic



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The atypical antipsychotic medications result 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, our system moved to 6 month LDL and HbA1c screenings.

Best Practice Advisory in our EHR

Vital Signs
Screenings
Allergies
Verify Rx B
Reconcile D
Home Medi
History
PROGRES
MyChart Sit
Screening
Hearing/Vis
Plan of
Problem Lis
Care Team
Chronic Condi...

Quality and Compliance (1 Advisory)

! Patient is on antipsychotic medication and has not had a HbA1C and/or LDL ordered/resulted in 6 months

Acknowledge reason:

Labs ordered Patient declines

Accept Cancel

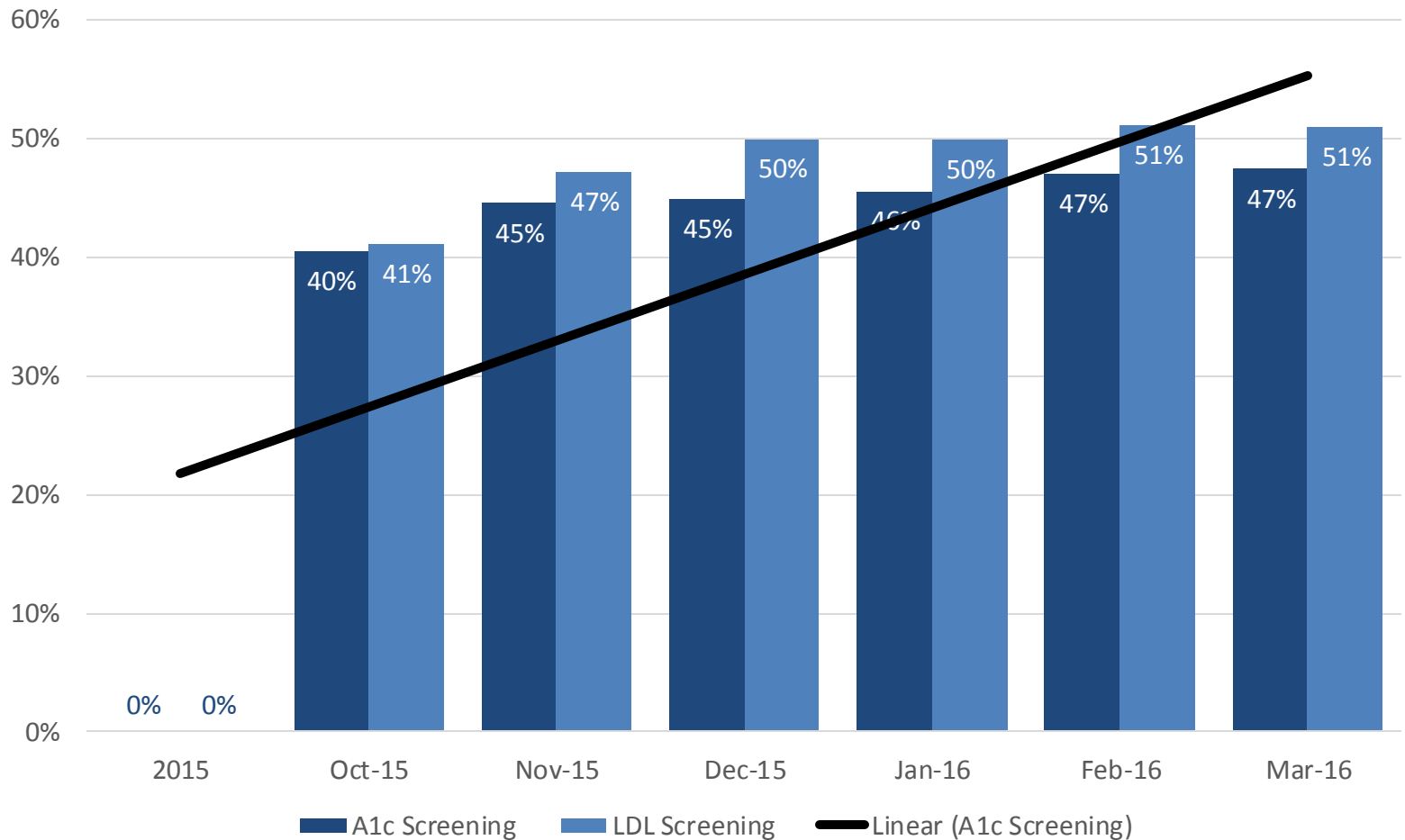
Pain Score 6 6

Bi-Directional Screening

- LDL & HbA1c for those taking atypical



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Improve Coordination

Percentage of patients who received the teams' 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 PC Provider site and the 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 to 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

- Embedded BH Specialists



We currently have embedded behavioral health expertise into multiple settings:

- Primary Care Clinics
 - Family Health Clinic
 - Stop Six Clinic
 - Viola Pitts Clinic
 - Southeast Medical Home
 - Northeast Clinic
 - Northeast School Based Clinic
- Trauma Services
- AIDS/HIV Medical Home (Healing Wings)
- Diabetes Groups
- Co-Facilitating General Medical Condition Groups Throughout System

Integrated Planning

- Shared Care Plans



Our system 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.

Integrated Planning

- Shared Patient Lists



Our 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
 - # of ED Visits in past 6 months
 - # of Hospitalizations in past 6 months
- Embedded Specialists summarize key points from previous visits and reports to providers.
- Drives recommendations for transitioning level of specialty involvement and care

Integrated Planning - Multi-Disciplinary Case Conference



Multidisciplinary Case Conference occur at the request of the patient and/or the providers.

These typically involve the most complex patients.

Improve Outcomes

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

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

- Screening results no longer positive
- Adherence to medication for behavioral health condition (in DS RIP 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

Integrated Service Delivery

- Group Visits



At several primary care clinics, JPS has quarterly Co-Facilitated Medical Groups with the Primary Care Physician and Embedded Specialists.

The groups consist of Diabetes, Hypertension and Congestive Heart Failure cohorts.

Integrated Service Delivery - Diabetes Education Classes



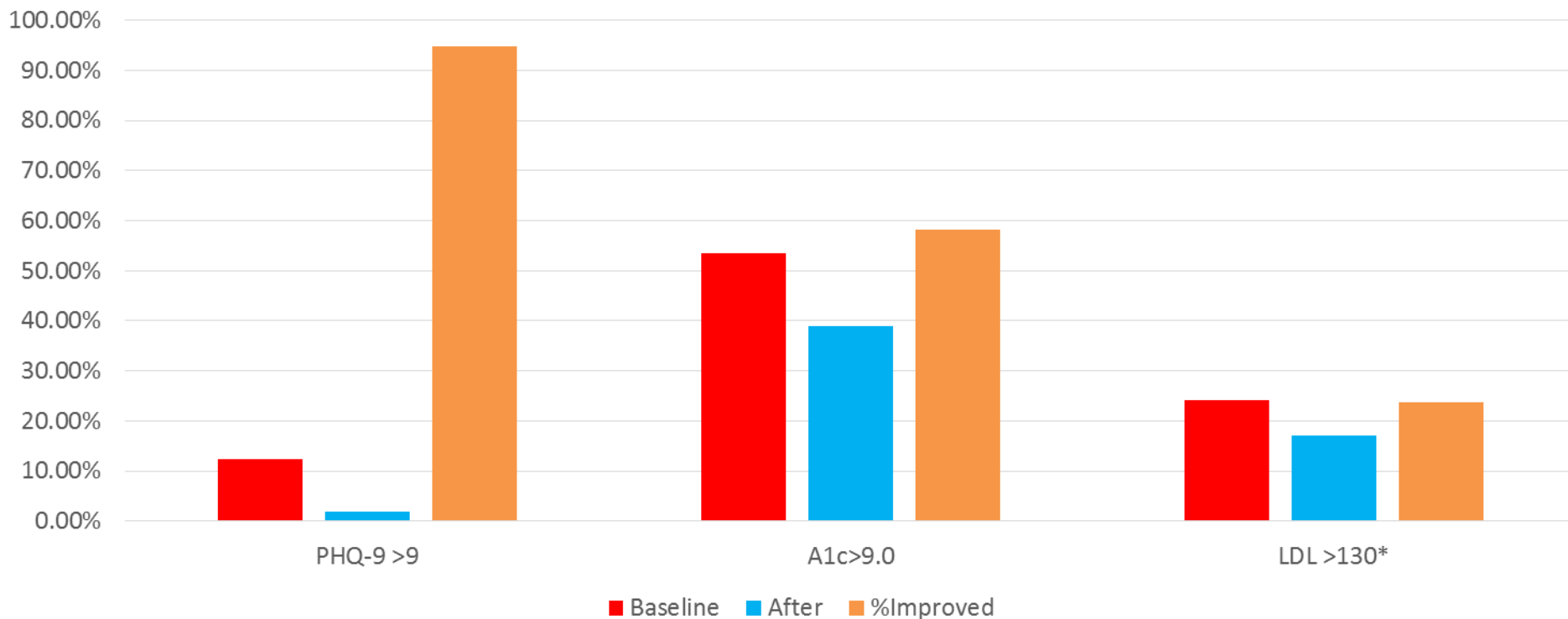
We have eight Diabetic Education Groups at various locations in both English and Spanish. Each of the group cohorts meet for four weeks.

Embedded specialists lead the 4th group to discuss depression, coping skills, and stress management related to their medical conditions and lifestyle changes.

Co-Facilitated Diabetes Groups

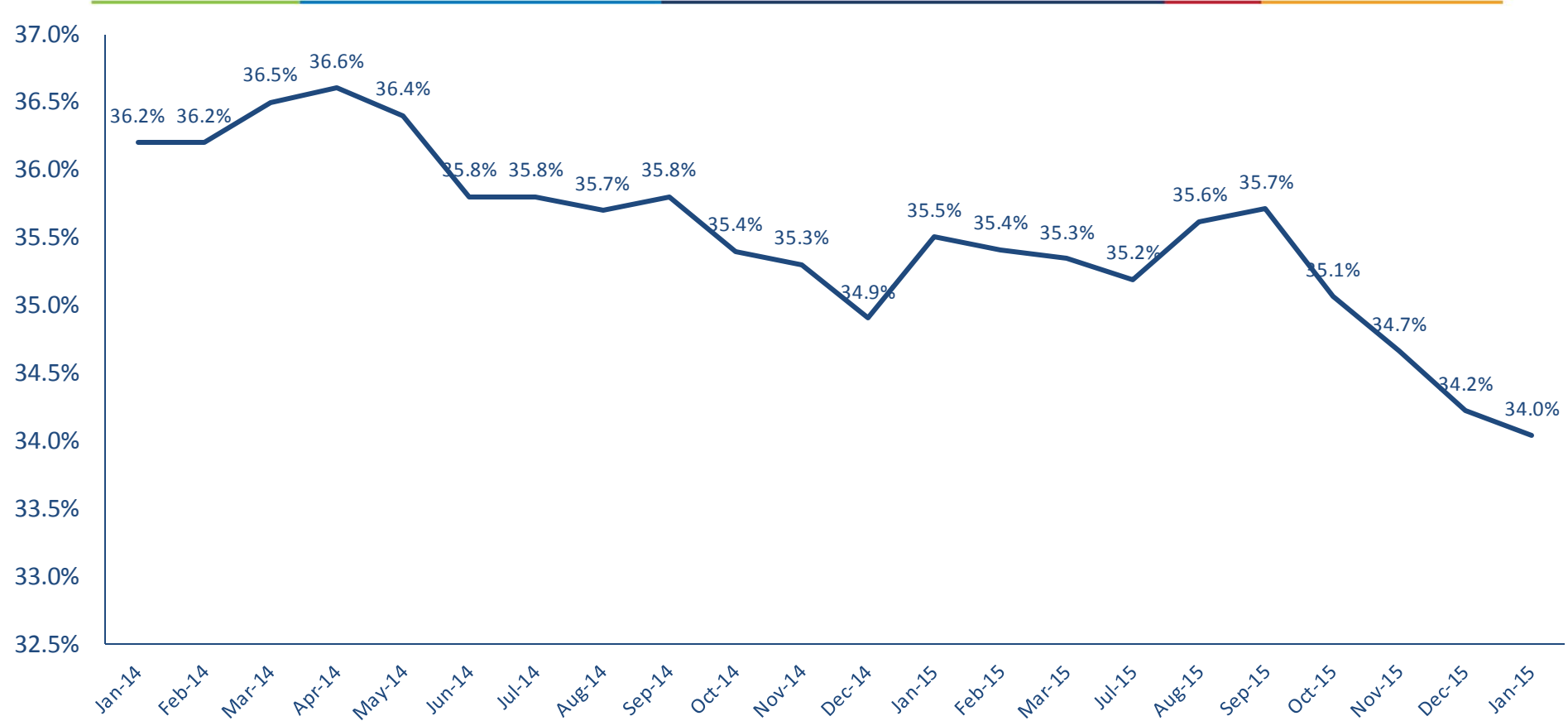
N=316

7/1/2015 – 1/31/2016



***Those with an LDL >130mg/dl had an average decrease by 59mg/dl during this period**

Bi-Directional Screening - HbA1c (lower is better)



Virtual Psychiatric & Clinical Guidance



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.

- Education
- Evidence base practice
- Case specific consultation

Program includes:

- Virtual guidance
- Monthly e-resource
- Research library
- Community resources
- Webinars and presentations



Clinical Guidance at your fingertips.

www.jpshhealthnet.org 1-855-336-8790

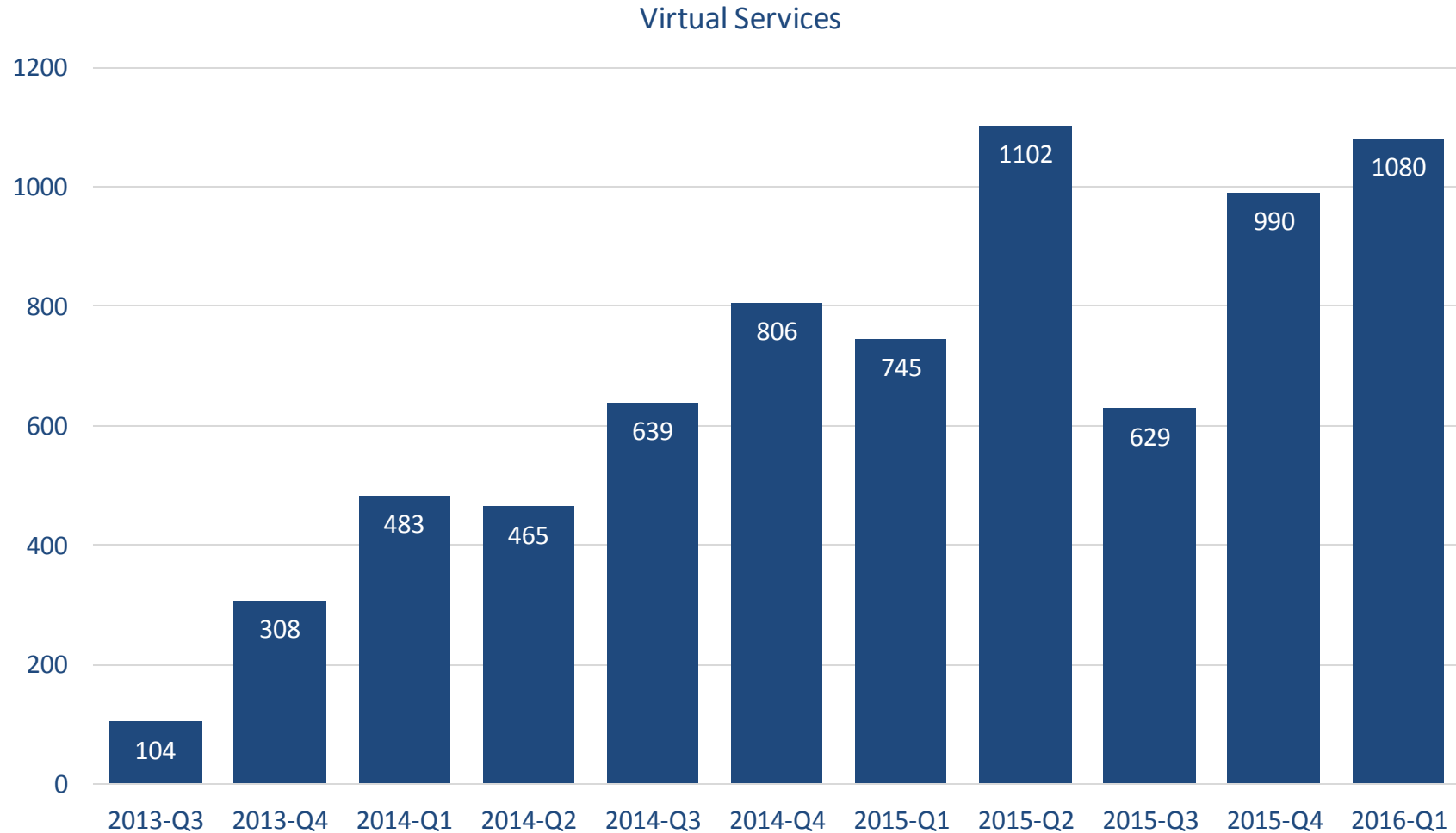
For medical professionals

JPS Health Network

The screenshot shows the website for the Behavioral Health Virtual Resource. The header includes the JPS logo and tagline 'Centered in Care Powered by Pride'. A navigation bar has links for 'For Patients', 'Health Care Services', 'For Medical Professionals', 'Academics & Research', and 'about JPS'. The main content area features the title 'Clinical Guidance at Your Fingertips' and 'BEHAVIORAL HEALTH VIRTUAL RESOURCE' with an image of a headset. Below this is a section titled 'Virtual Behavioral Health Clinical Guidance' with a paragraph explaining the service and a list of related info links including 'Request Virtual Guidance', 'Monthly E-Resource', 'Research Library', 'Community Resources', 'Webinars & Presentations', and 'Our Team'.

Integrated Service Delivery

- Virtual Psychiatric & Clinical Guidance

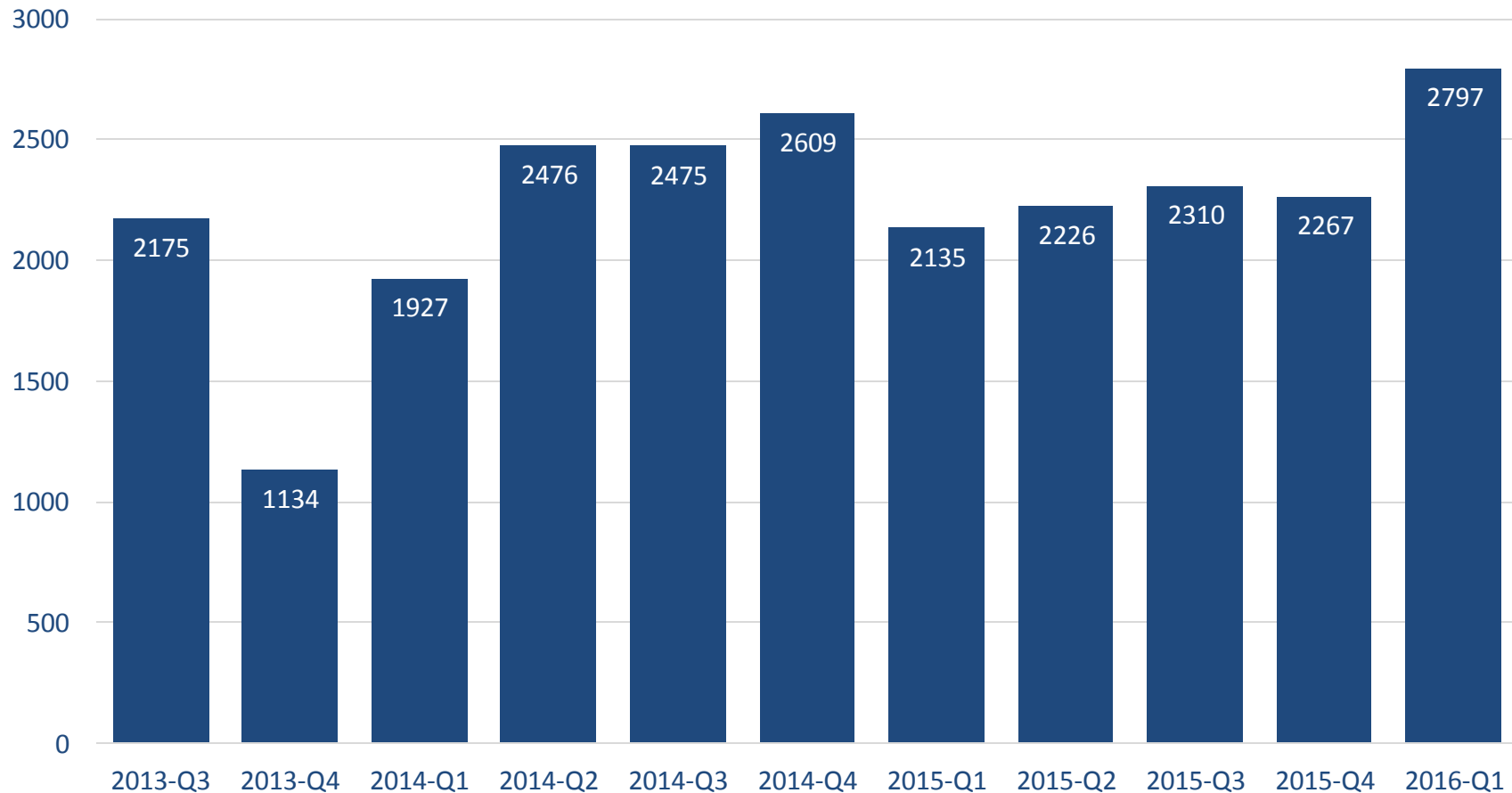


Integrated Service Delivery

- Virtual Psychiatric & Clinical Guidance



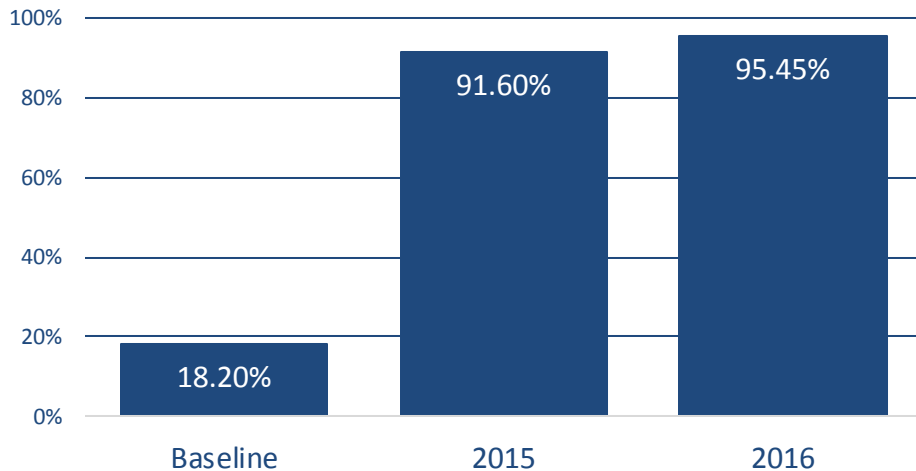
Virtual Website Visits



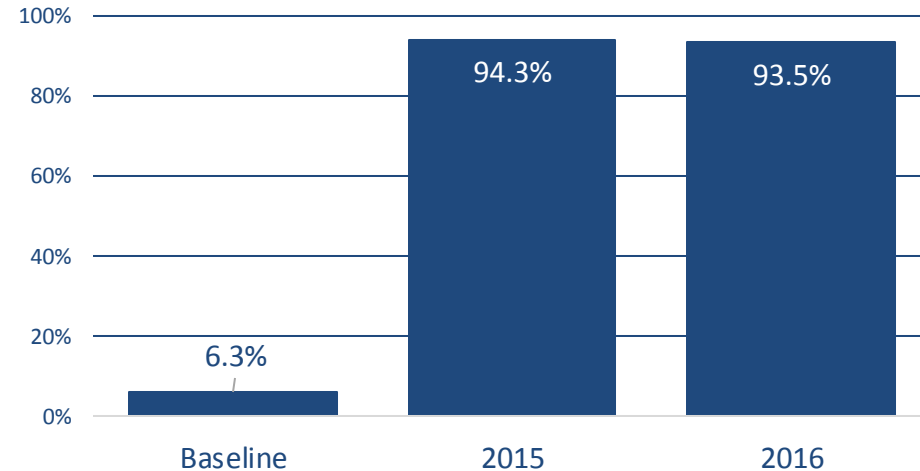
Integrated Service Delivery - Virtual Psychiatric & Clinical Guidance



Provider Satisfaction with Access to Behavioral Health Expertise



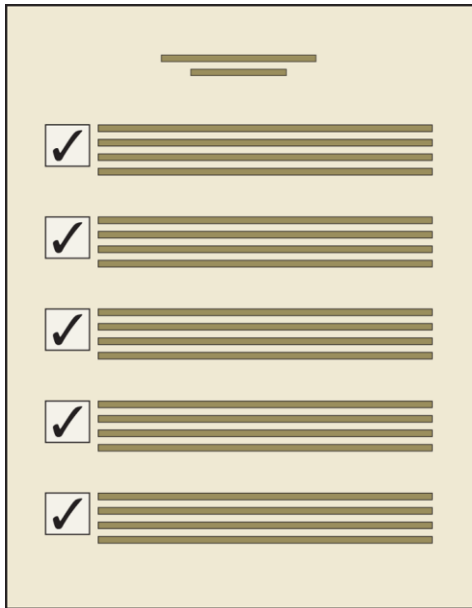
Use of Evidence Based Protocols



Primary care providers can speak with a psychiatrist about evidence based and best practice medication algorithms within 30 minutes.

Information Sharing

- Monthly Information Packets



- October 2013
 - November 2013
 - December 2013
 - January 2014
 - February 2014
 - March 2014
 - April 2014
 - May 2014
 - June 2014
 - July 2014
 - August 2014
 - September 2014
 - October 2014
 - November 2014
 - December 2014
 - January 2015
 - February 2015
 - March 2015
 - April 2015
 - May 2015
 - June 2015
 - July 2015
 - August 2015
 - September 2015
 - October 2015
 - November 2015
 - December 2015
 - January 2016
 - February 2016
- Depression
 - Anxiety
 - Insomnia
 - Bipolar
 - Schizophrenia
 - PTSD
 - Integrated Healthcare
 - Psych Meds and Pregnancy
 - Metabolic Side Effects from Antipsychotics
 - Domestic Violence
 - Substance Abuse
 - Antidepressant-Anticonvulsants for Chronic Pain
 - Prescribing and Tapering Benzodiazepines
 - Importance of Integrated Healthcare
 - Insomnia & Sleep Hygiene
 - Eating Disorders
 - E-Consults
 - Depression
 - Smoking Cessation
 - Bipolar Disorder
 - PTSD
 - Pregnancy and Psychotropic Medications
 - Child and Adolescent Anxiety
 - ADHD
 - Prescribing and Tapering Benzodiazepines
 - Depression
 - Anxiety
 - Insomnia and Sleep Hygiene
 - Domestic Violence

These are also made available on our Virtual Guidance Provider Resource Page

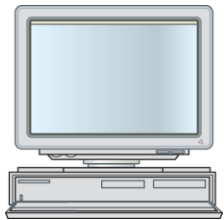
Information Sharing

- Face-to-Face CME's



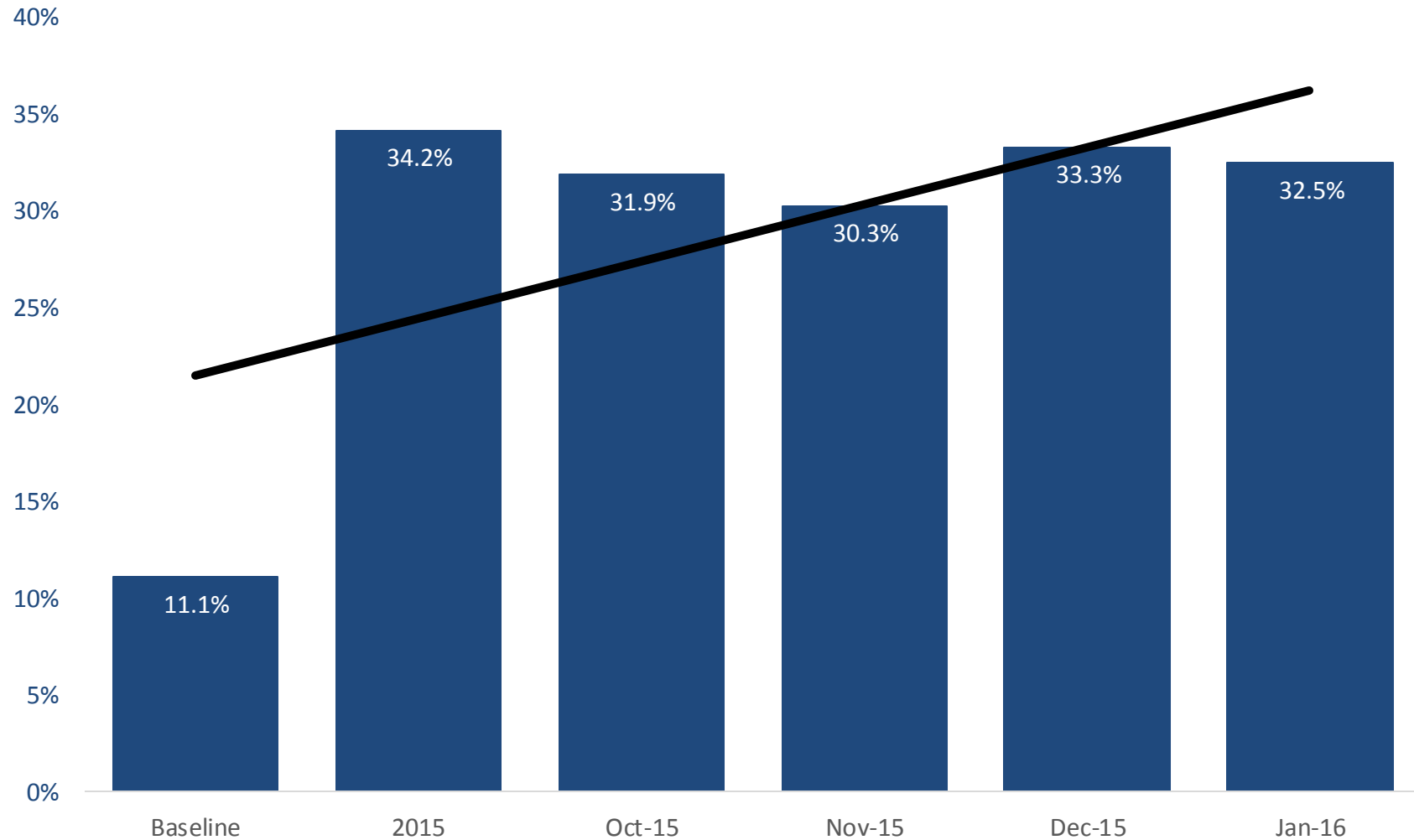
Two presentations each year focusing on common behavioral health issues found in Primary Care. Both are done in person and streamed on the internet

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



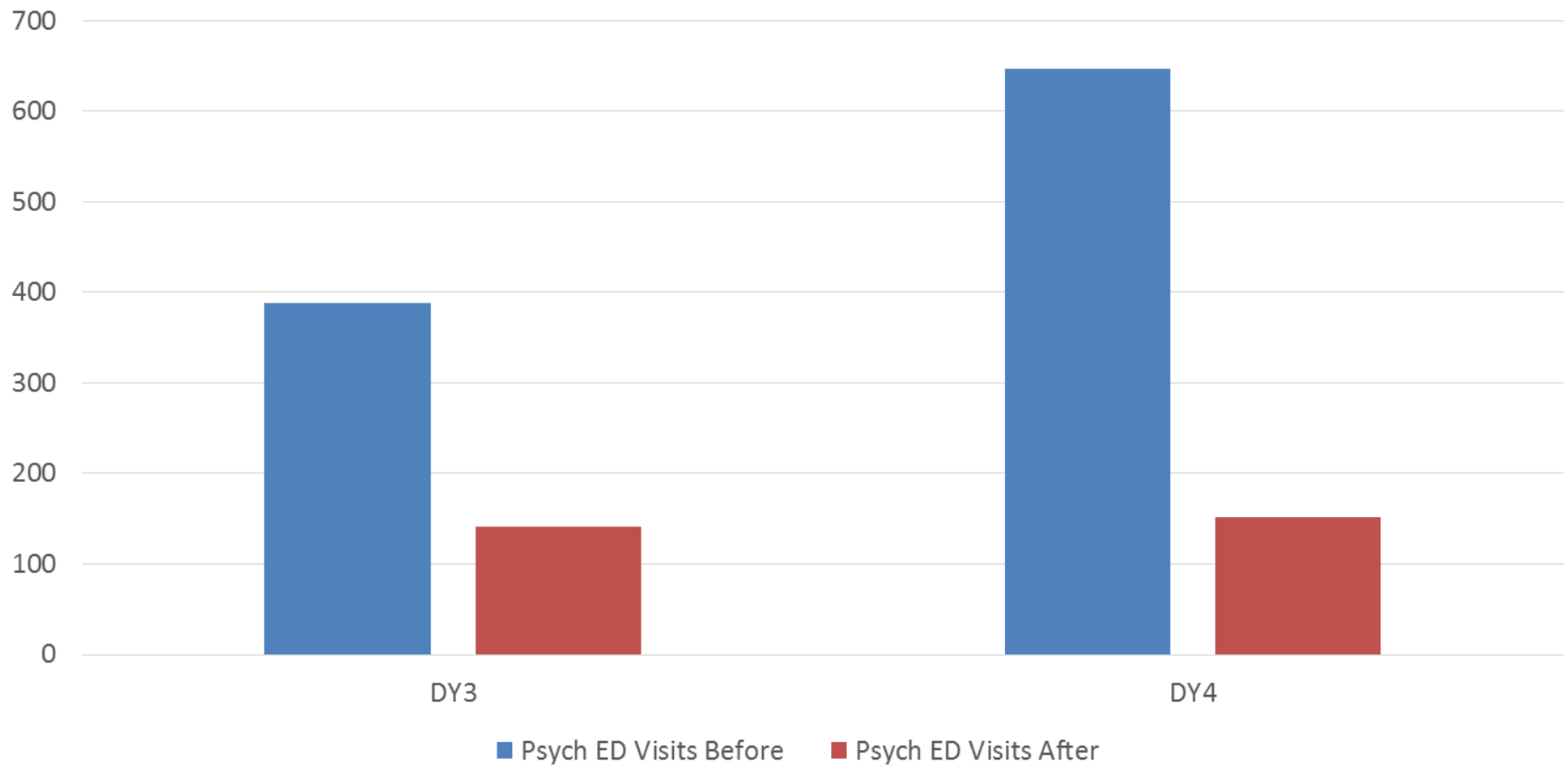
These are also made available on our Virtual Guidance Provider Resource Page

Bi-Directional Screening - 12 Month Remission Rates



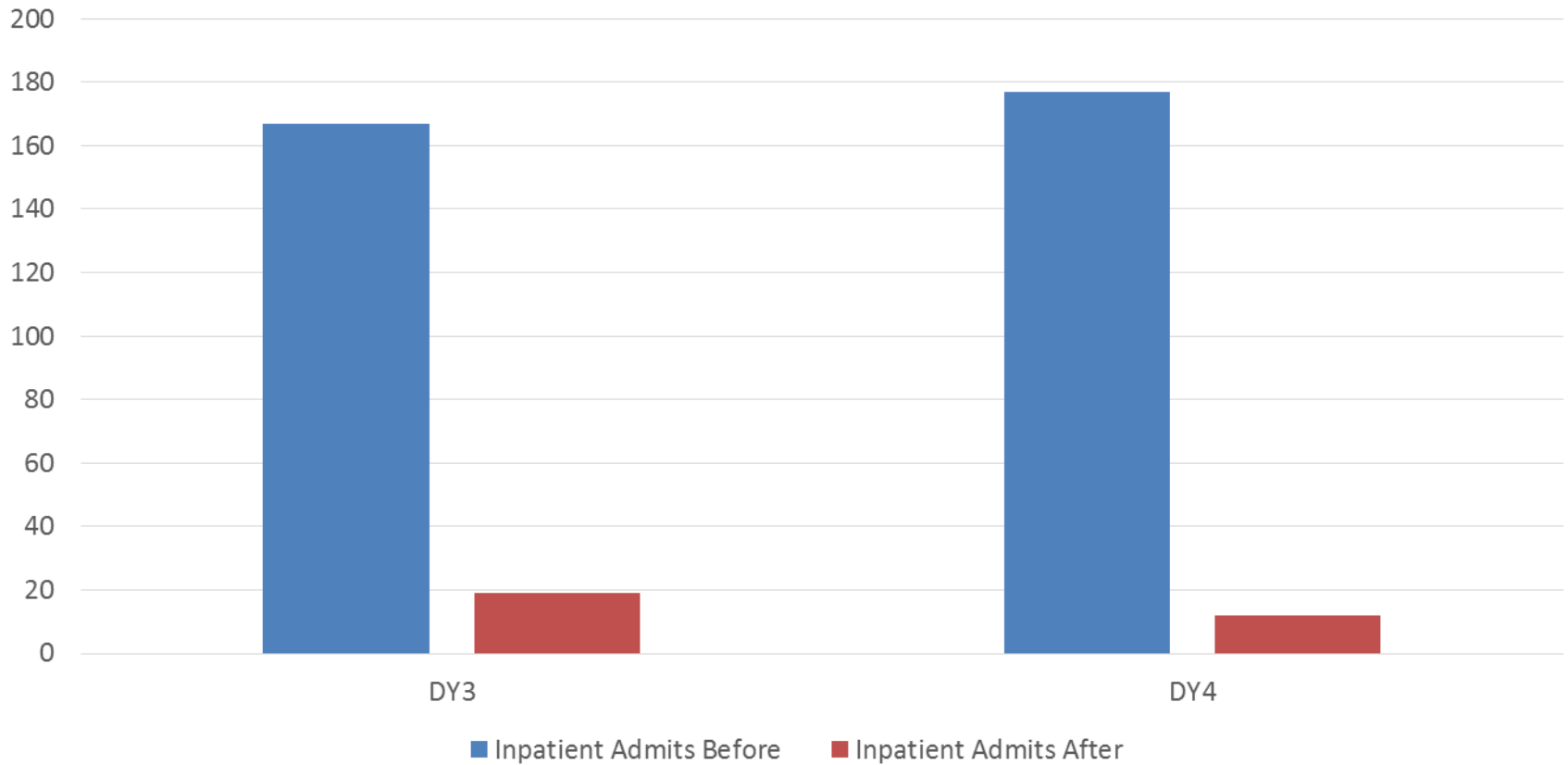
Impact of Integrated Care at JPS

Reduced Psych ED Visits



Impact of Integrated Care at JPS

Reduced Inpatient Utilization



Thank You



QUESTIONS?