Integrating Behavioral Health and Primary Care: The JPS Experience
Presenters

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- Administrator, Trinity Springs Pavilion
JPS Health Network (Tarrant County Hospital District)

JPS Health Network is a 537-bed public hospital system with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents.

As one of Texas’ major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County’s Medicaid and uninsured populations.
JPS Behavioral Health Service Line

1. Psychiatric Emergency Center (19,000+ visits annually)
   - 24-48 Hour Observation
2. Trinity Springs Pavilion (96 Psychiatric Inpatient Beds )
   - 16 adolescent, 60 adult, 20 state hospital alternative beds
3. Psychiatric Consultation/Liaison service
4. Neuro-Psych Consultation Service (Level 1 Trauma Center)
5. Three Partial Hospitalization Programs
6. Four co-located behavioral health outpatient clinics
7. "Urgent Care" type walk-in outpatient clinic
8. School based behavioral health clinic sites
9. Multiple Embedded Behavioral Health Specialists in primary care settings
10. Virtual Psychiatric and Clinical Guidance
11. Significant Peer Support Services in acute levels of care
12. Academic Medical Center
   - 16 Slot Psychiatric Residency
   - Behavioral Health Clinical Rotation/Internship Site annually for JPS Emergency Dept Residents, JPS Family Practice Residents, NP Students, PhD Psychology Interns, Medical Students, PhD Health Psychology, Nursing Students, MSW Students, PA Students, & EMT Students
## JPS DSRIP Projects

### Behavioral Health
- Discharge Management Program
- Partial Hospitalization Program
- Extended Clinic Hours
- Integrated Care
- Virtual Psychiatric and Clinical Guidance
- Central Assessment and Referral Center
- Psych Day Rehab for Homeless

### Community Focused & Care Coordination
- Care Connections for the Homeless
- MedStar Patient Navigation
- Community Connect
- School Based Chronic Disease Care Model
- Journey to Life
- Palliative Care

### Infrastructure
- Innovation & Transformation Center
- Sepsis
- Outcome Based Payments

### Specialized
- Care Transitions
- Rehab Transition
- Coordinated Chronic Heart Failure
- Diabetes Chronic Care Management
- Expanded Pain Management (JPSPG)
- Expand Ophthalmology & Wound Care
- Patient Experience
- Call Center
- Patient Centered Medical Home
Discharge Management Program

This project created a comprehensive Behavioral Health Discharge Management Program.

Transition Managers are responsible for proactive pre- and post-discharge interaction, intervention, and coordination with patients discharged from Trinity Springs Pavilion as they return to the community. The engagement activities are stratified based on the assessed level of risk for readmission. Activities range from simple follow-up calls to home visits and transportation assistance.

We also utilize Peer Support Specialists throughout our continuum as well as a Patient & Family Advisory Council to better inform our discharge/transition practices.
## Readmission Data Analysis Summary

### PHASE 1
- **10 Interviews**
  - Key Points:
    - Readmission Time
      - 0-5 Days: 4 pts
      - 6-15 Days: 3 pts
      - 16-30 Days: 1 pt
      - 31+ Days: 2 pts

### PHASE 2
- **250 Chart Reviews**
  - Reviewed days from DC to readmit
  - Age & Gender
  - Dx Categories
  - Financial Status
  - General Themes
  - Zip Codes

### PHASE 3
- **30 Day Readmission Rate**
  - Established baseline

### PHASE 4
- **Observed over Expected**
  - 18-40 yo Males more likely
  - Dx: Schizophrenia, bipolar, substance abuse, medical, psychosis
  - LOS: 4-10 days
  - Race: AA, PI, Asian, AI
  - Ethnicity: Not Hispanic or Latino

### PHASE 5
- **Predictors of Readmission**
  - Dx: Bipolar, Psychosis, Schizophrenia, substance abuse
  - Age: 55-60 yo
  - Race: Black & Asian
  - Ethnicity: Not Hispanic
  - Zips: 76116, 76010
Observed Over Expected

**DIAG CLASS: O / E Ratio**
- Medical
- Schizophrenia
- Substance Abuse
- Bipolar Disorder
- Psychosis
- Depression
- Mood Disorder
- Other

**AGE RANGE: O / E Ratio**
- 36 - 40
- 31 - 35
- 26 - 30
- 18 - 25
- 56 - 60
- 46 - 50
- 51 - 55
- 41 - 45
- 61 - 65

**LOS RANGE: O / E Ratio**
- 8-10 days
- 6-7 days
- 5 Days
- 4 Days
- 11-20 Days
- 2 Days
- GT 20 Days
- 3 Days
- 1 Days

**Race: O / E Ratio**
- AMERICAN INDIAN
- ASIAN
- PACIFIC ISLANDER
- BLACK OR AFRICAN AMERICAN
- OTHER
- WHITE OR CAUCASIAN
We then began to refine our analysis by looking at variables that appeared to be particularly high risk by gender.

**DIAG CLASS: Female - O/E RATIO**

- Medical
- Schizophrenia
- Bipolar Disorder
- Psychosis
- Substance Abuse
- Mood Disorder
- Depression
- Other

**DIAG CLASS: Male - O/E RATIO**

- Substance Abuse
- Bipolar Disorder
- Psychosis
- Schizophrenia
- Depression
- Other
- Mood Disorder

**AGE RANGE: Female - O/E RATIO**

- 31 - 35
- 36 - 40
- 26 - 30
- 18 - 25
- 41 - 45
- 61 - 65
- 51 - 55
- 46 - 50
- 56 - 60

**AGE RANGE: Male - O/E RATIO**

- 36 - 40
- 26 - 30
- 56 - 60
- 31 - 35
- 46 - 50
- 18 - 25
- 51 - 55
- 61 - 65
- 41 - 45
We then refined our analysis by looking at rates for readmission by multiple variables (gender, age range, & diagnosis).

**NOTE:** Only included Categories 'More Likely' to Readmit that had 20 or more Index Discharges
PHASE 5: Predictors For Readmission

The Predictive Model analysis process:

1. Identified the independent demographic and clinical variables that were present on admission of each Index visit:
2. Identified the dependent variable: “Index with 1 or more Readmits”
3. Segmented the values in each independent variable into meaningful groups that had sufficient volumes to make a statistically significant impact on the dependent variable
4. Identified the “Reference Group” for each independent variable as the group with the lowest Observed over Expected (O/E ratio)
   - Age Range: 61-65
   - Gender: Female
   - Zip Code: 76102
   - Race: Caucasian
   - Ethnicity: Hispanic
   - Diagnostic Class: Other
The Predictive Model analysis process cont’d:

5. Ran a Logistic Regression analysis to determine the contribution coefficients – odds ratio (Exp(B)) - of each of the independent variable groups on the dependent variable

6. Assign a weighted risk score to each independent variable group with a contribution coefficient > 1
   - Exp(B) 1.0 to 1.49 = 1 point
   - Exp(B) 1.5 to 1.99 = 2 points
   - Exp(B) 2.0 to 2.49 = 3 points
   - Exp(B) 2.5 or greater = 4 points

   Reference Table 1: Readmission Risk Values by Variable

7. Determine the Risk classification scale based on total Risk Score per visit

8. Calculate the Percentage and Readmit Rates for each Risk Classification
### Readmission Risk Values by Variable

<table>
<thead>
<tr>
<th>COLUMN</th>
<th>CRITERIA</th>
<th>POINT VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DiagClass</td>
<td>Bipolar Disorder</td>
<td>2</td>
</tr>
<tr>
<td>DiagClass</td>
<td>Psychosis</td>
<td>2</td>
</tr>
<tr>
<td>DiagClass</td>
<td>Schizophrenia</td>
<td>2</td>
</tr>
<tr>
<td>DiagClass</td>
<td>Substance Abuse</td>
<td>2</td>
</tr>
<tr>
<td>AgeRange</td>
<td>56 - 60</td>
<td>1</td>
</tr>
<tr>
<td>Race_Name</td>
<td>BLACK OR AFRICAN AMERICAN</td>
<td>1</td>
</tr>
<tr>
<td>Race_Name</td>
<td>ASIAN</td>
<td>4</td>
</tr>
<tr>
<td>Ethnic_Name</td>
<td>NOT HISPANIC OR LATINO</td>
<td>2</td>
</tr>
<tr>
<td>patientzip</td>
<td>76116</td>
<td>1</td>
</tr>
<tr>
<td>patientzip</td>
<td>76010</td>
<td>1</td>
</tr>
</tbody>
</table>
## Predictors For Readmission

### Overview - Readmit Rate Risk

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Readmit Risk Score</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>0</td>
<td>192</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>210</td>
</tr>
<tr>
<td>Medium</td>
<td>3</td>
<td>922</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>450</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>961</td>
</tr>
<tr>
<td>High</td>
<td>6</td>
<td>700</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>3585</td>
</tr>
</tbody>
</table>

Statistics:

- **Average Readmit Risk Score:** 4.16
- **Standard deviation:** 1.698
General Risk Category Engagement Windows

- Low Risk for Readmission – 30 day post discharge engagement window
- Moderate Risk for Readmission – 60 day post discharge engagement window
- High Risk for Readmission – 90 day post discharge engagement window
### Customized Discharge Educational Tools Based on Risk Level

#### Readmission Risk Level
- **Low**
- **Moderate**
- **High**

**Educational tools must be provided to the patient prior to discharge.**

1. **Low** - Standard AVS and Social Services after care plan must be (required) provided to the patient.
2. **Medium** - Standard AVS and Social Services after care plan must be (required) provided to the patient at least one more educational tool.
3. **High** - Standard AVS, Social Services after care plan must be (required) provided to the patient plus two or more educational tools are provided to patient.

#### Educational Tools for Medium Risk for Readmission
- Discharge Preparation Checklist
- Standard AVS
- Social Services after care plan
- Mood tracker log
- Support and community linkage

- Recovery Toolkit
- Medication Tracker/Calendar
- My Wellness Plan
- Recovery and Medication
- Medication Management
- Other

#### Educational Tools for High Risk for Readmission
- Discharge Preparation Checklist
- Standard AVS
- Social Services after care plan
- Mood tracker log
- Support and community linkage

- Recovery Toolkit
- Medication Tracker/Calendar
- My Wellness Plan
- Recovery and Medication
- Medication Management
- Other

**High** - Standard AVS, Social Services after care plan must be (required) provided to the patient plus two or more educational tools are provided to patient prior to discharge. (also required)
Customized Post Discharge Engagement activities Based on Risk Level
## Risk Based Intervention Examples

<table>
<thead>
<tr>
<th>Interventions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appointment with an Embedded Behavioral Health Specialist (EBHS)</td>
<td>• Disease Management Education</td>
</tr>
<tr>
<td>• Group Therapy with an EBHS</td>
<td>• Recovery Messages sent by mail or email</td>
</tr>
<tr>
<td>• Appointment for counseling</td>
<td>• Setup appointment for home visit</td>
</tr>
<tr>
<td>• Appointment with psychologist</td>
<td>• Consultation w/Pharm D regarding meds</td>
</tr>
<tr>
<td>• Group Therapy Session with Transition Coordinator (TC)</td>
<td>• Assistance with establishing a Primary Care Appointment</td>
</tr>
<tr>
<td>• Telephonic Supportive/Mentoring 10-15 minutes phone appointment</td>
<td>• Assistance with establishing with JPS Connection Programs</td>
</tr>
<tr>
<td>• Telephonic Supportive/Mentoring 20-30 minutes phone appointment</td>
<td>• Facilitate process with aftercare at a Substance Abuse Treatment Center</td>
</tr>
<tr>
<td>• Attend appointment with patient at their 1st visit with psychiatrist</td>
<td>• Facilitate process with other community support groups</td>
</tr>
<tr>
<td>• Assist w/navigation of DC meds</td>
<td>• Referral to Partial Hospitalization Program</td>
</tr>
<tr>
<td>• Family Education/Consultation Support</td>
<td></td>
</tr>
</tbody>
</table>

*LIST IS NOT ALL-INCLUSIVE*
Sample Workflow - High Risk for Readmissions

**Level of Intervention Process with HIGH Risk for Readmission**

- **HIGH Risk**
  - Upon admission to TSP & risk is determined, TC will be assigned.
  - Pt will meet w/ PS 24 hrs. upon admission.
  - TC will meet w/ pt. 24 hrs before DC review checklist along w/ AVS.
  - F/U call post 24 & 48 hrs post dc by PS.
  - F/U app't will w/ clinic nurse, TC, psychiatrist w/ 7 days after dc & 30 day app't to be made w/ psychiatrist.

- Weekly contact by TC post 30 days of DC: Must implement at least 3 interventions.
- Bi-weekly contact by TC post 60 days of DC: Must implement at least 2 interventions.
- Monthly contact post 90 days of DC: minimum of at least 1 intervention.

**Additional Interventions**
- Appointment with an Embedded Behavioral Health Specialist (EBHS)
- Group Therapy w/ an EBHS
- Appointment for counseling
- Appointment with psychologist
- Group Therapy Session w/ Transition Coordinator (TC)
- Telephone Support/mentoring 10-15 minutes
- Telephone Support/mentoring 20-30 minutes
- Attend appointment w/ patient at 1st visit w/ psychiatrist
- Medication Navigation of process & assistance programs
- Referral to IST Team
- Family Education/Consultation Support
- Disease Management Education
- Recovery messages sent by mail or email
- Setup appointment for return visit
- Consultation w/ Pharm regarding meds
- Assistance w/ establishing a Primary Care Appointment
- Assistance with establishing JPS Connection Programs
- Facilitate process with after care at a Substance Abuse Treatment Center
- Facilitate process with other community support groups
- Referral to Partial Hospitalization Program
- Collaborate with community case manager

*This is not an all-inclusive list for interventions; interventions will be added per the needs of the care plan.*
Readmission Impact

Readmission Rate - HIGH RISK GROUP

Baseline: 15.79%
Dec-Apr: 11.48%
LEAN Methodology

**Strategic Planning**
What is our True North?
Planning where we are going and how will we get there

**Process Management / Lean Daily Management**
Knowing our processes
Standardizing and measuring them

**Metrics & Dashboards**
Creating Accountability
Measuring performance and progress on our strategy

**Project Portfolio Management**
Working on the Right Things
Objectively evaluating projects to prioritize use of resources

**Process Improvement**
Getting to our goals
Applying proven methodologies to improve outcomes, efficiency and the patient experience

- Lean
- Six Sigma
- Kaizen
- Project Management
Long Acting Injectable Workflow - Initial

Title: BH Long Acting Injectable Medication Workflow

Physician:
- Physician orders LAI and discharges patient
- OP Physician reviews record and information from RN
- Physician enters order into EMR
- Physician 2nd order. Doesn't know patient
- Unable to be seen by OP Pharmacy
- SW ensures follow up for patient
- Doesn’t always include injection site.

Patient:
- Patient receives follow up information and medication information at DC
- Patient Arrives within 14–20 days for follow up injection
- Patient did not receive injection at 1st visit
- Receives the injection late!
- Patient receives new appointment to follow up for LAI
- Patient Returns to clinic after medication has arrived
- Patient Receives injection
- Receives next follow up appointment for next injection

OP RN:
- OP RN reviews record and gets vital’s
- Requests order from a physician
- OP RN completes paper order form for LAI
- Order is faxed to OP Pharmacy
- Not always reliable
- RN prepares injection and documents
- Pharmacist fills the order and sends the medication to Clinic within 4 days

Pharmacy:
- Pharmacist Reviews the order
- Orders next dose of LAI for next patient visit.
Long Acting Injectable Administration Rate
Workflow Improvement Results (n=41)

<table>
<thead>
<tr>
<th></th>
<th>6 Months Before</th>
<th>6 Months After</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSP Admissions</td>
<td>1.75</td>
<td>0.16</td>
</tr>
<tr>
<td>Psychiatric Emergency Visits</td>
<td>3.38</td>
<td>0.78</td>
</tr>
</tbody>
</table>
Historically, JPS has utilized a recorded message and “snail-mail” notice to remind patients of their follow-up appointments.

We undertook an effort to determine if utilizing more current methods to remind patients might have an impact on attendance at the first post-discharge appointment.

We met with patients prior to discharge and solicited their preference for either email or text message appointment reminders. The early results indicate there is benefit to electronic appointment reminders.
Electronic Contact Data

First Post Discharge Missed Appointment Rate

- Baseline: 60.90%
- PDSA Cycle 2: 57.14%
- PDSA Cycle 3: 45.57%
Peer Facilitated Groups

• Group were facilitated by Peer Support Specialist on NW and SW units
• LCSW was present at all groups as an additional resource
• Groups focused on presenting discharge planning/relapse prevention information
• Patients were asked to complete a survey at the end of each group
Pilots: Peer Facilitated Groups

Patient level of knowledge/skill before and after activity

<table>
<thead>
<tr>
<th>NW Unit</th>
<th>SW Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>My level of knowledge/skill before this activity</td>
<td>3.48</td>
</tr>
<tr>
<td>My level of knowledge/skill after this activity</td>
<td>4.25</td>
</tr>
</tbody>
</table>
Pilots: Peer Facilitated Groups

Patient Comments from completed surveys regarding benefit of Peer facilitated group

- Giving me more hope that I’m not alone, and that with dedication and hard work, I will be better and successful.
- Join groups that will benefit my mental illness.
- Set goals.
- Help remember to take meds.
- Remember that I need to access my resources before I go to crisis mode.
- Understanding of how important goal setting is in life but especially in recovery. Plan appropriate and stick to your plans and place fail safe back up plans in your overall plan.
- I think these groups are a great addition to the group schedule. It is very informative and enjoyable.
- The advantages/disadvantages of explaining our illness to people and also triggers is extremely beneficial.
- This group will assist in my recovery greatly because I was given the tools to realize a relapse and stop it before it happens
Integrated Care

Our strategy includes four main components:

- Utilization of Practice/Referral Agreements
- Depression Screening in Primary Care
- Embedded Behavioral Health Specialists
- Virtual Psychiatric and Clinical Guidance
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.
# Treatment Guidance – PHQ-9 Results

<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>
</tr>
<tr>
<td>10-14</td>
<td>Moderate Risk</td>
<td>• Antidepressant therapy 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>
</tr>
<tr>
<td></td>
<td></td>
<td>• Conduct suicide risk assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Virtual Psychiatric Guidance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Follow up in 4-8 weeks</td>
</tr>
<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>
</tr>
<tr>
<td></td>
<td></td>
<td>• Conduct suicide risk assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Virtual Psychiatric Guidance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Referral to Psychiatry if warranted</td>
</tr>
<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>
</tr>
<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>
<td></td>
<td>• Referral to Psychiatry</td>
</tr>
</tbody>
</table>
In the last 12 months, we screened 44,694 primary care patients for depression.
Depression screening in JPS Primary Care

Depression risk identified by PHQ-9 in primary care patients not already being seen in JPS Behavioral Health Services

- Minimal: 0.54%
- Mild: 0.70%
- Moderate: 1.14%
- Moderately Severe: 1.22%
- Severe: 1.15%
Embedded Behavioral Health Specialists

We currently have embedded behavioral health expertise into multiple settings:

- Primary Care Clinics
- Trauma Services
- AIDS/HIV Medical Home
- Diabetes Groups
- Co-Facilitating General Medical Condition Groups Throughout System
Virtual Psychiatric and Clinical Guidance

Education
Evidence base practice
Case specific consultation
Virtual Guidance Services Website Visits

July 2013: 453
August 2013: 1064
September 2013: 658
October 2013: 458
November 2013: 576
December 2013: 100
January 2014: 538
February 2014: 677
March 2014: 712
The Learning Collaborative model organizes multiple groups with varying needs into a process of group learning, where all teams use the Model for Improvement and learn from each other’s successes and challenges. The main elements of the program model are the following:

• A pre-work period in which teams get organized to improve care,
• A series of Learning Sessions where experts share information and approaches to improvement changes (participating teams will serve as experts later in the collaborative),
• Action periods, following each learning session, in which changes are tested and implemented by the teams, and
• A congress where teams share results and lessons learned of the 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></td>
<td>Denominator: Total patient population of focus for improved care integration at your site.</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
Patients Screened for Depression at Integrated Locations

- **Patients Screened**
- **Median**
- **Goal**

**Graph Data:**
- January: 73.30%
- February: 75.50%
- March: 79.30%
- April: 79.80%
- May: 82%

**Screening Rates**

- Centered in Care
- Powered by Pride
### Improve Coordination

<table>
<thead>
<tr>
<th>Percentage of patients who received the teams’ selected integrated care intervention in past 12 months.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> Number of patients in the population of focus who have received the selected integrated care intervention in the past 12 months</td>
</tr>
<tr>
<td><strong>Denominator:</strong> Total patient population of focus for improved care integration at your site.</td>
</tr>
</tbody>
</table>

- 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 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)
Patients Receiving BH and PC Interventions at the Same Location

- Patients Receiving BH and PC Interventions at the Same Location
- Median
- Goal

<table>
<thead>
<tr>
<th>Month</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>8.30%</td>
</tr>
<tr>
<td>February</td>
<td>9.10%</td>
</tr>
<tr>
<td>March</td>
<td>9.60%</td>
</tr>
<tr>
<td>April</td>
<td>10%</td>
</tr>
<tr>
<td>May</td>
<td>10.40%</td>
</tr>
</tbody>
</table>
## 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
Patients with HbA1c >9.0

- BH Patients with HbA1c <9.0 (Lower is Better)
- Median
- Goal

Month: January, February, March, April, May

Percentages: 42.40%, 40.10%, 38.10%, 38.40%, 36.42%
Learning Collaborative Data Reporting

Data reporting instructions

Report all shared measures you are tracking each month, between the 1st and the 15th of the month, for the prior month.

For example, your numbers for the full month of February are due between March 1st and March 15th. All measures reported will be benchmarked against all other providers reporting that measure and shared back to you.

For any questions about monthly reporting, please contact Gillian Franklin at jpa@health.org and (817) 702-3100.

- **Facility name:**
  - Please select

- **Email address:**
  - 

- **Data month:**
  - Please select

**Percentage of patients screened with team’s selected cross-saturity screening**

**Numerator:**

Total number of patients in the population of focus who have received screening with the selected tool within the past 12 months.

**Denominator:**

Total patient population of focus for improved care integration at your site.

**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.

**Percentage of patients receiving integrated care whose condition improved**

**Numerator:**

Number of patients in the population of focus whose care has been documented as improved in past 12 months, as measured by the selected indicator.

**Denominator:**

Total patient population of focus for improved care integration at your site.
Thank you

Questions?
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