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# Integrating Behavioral Health and Primary Care via Texas' 1115 Waiver

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AMERICA'S ESSENTIAL HOSPITALS

UTHEALTH NORTHEAST

JPS Centered in Care Powered by Pride

**Why** it is essential to Integrate Primary and Behavioral Healthcare

**What** we are doing about it

**How** the 1115 Waiver supports those efforts

# *Why is Integrated Care essential?*

# CO-MORBIDITY OF MENTAL AND PHYSICAL CONDITIONS

UTHEALTH NORTHEAST

***For adults with mental illness, comorbidity is the rule rather than the exception.***

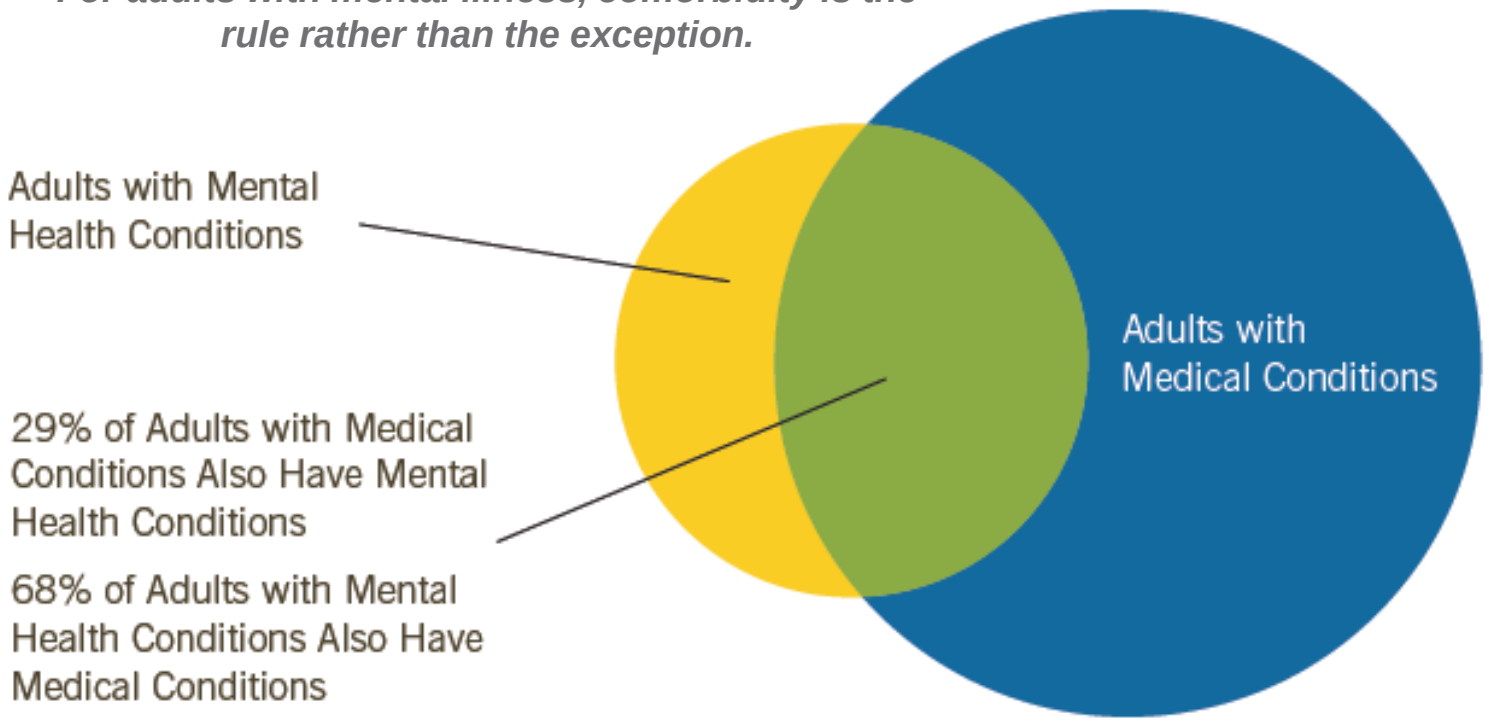



*Diagram and quotes from TRENDWATCH. Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes. American Hospital Association. January 2012.*

# RISK FACTORS

UTHEALTH NORTHEAST

| | |
|---|---|
| **25** | Average years a person with serious mental illness will die younger than the general population |
| **3.4x** | Those with serious mental illness are 3.4x more likely to die of heart disease |
| **2x** | Diabetes doubles the risk for depression |
| **7/10** | Leading causes of death have a psychological and/or behavioral component |

Mental Health System

Physical Health System

"If primary care treats the body, and mental health treats the head, integrated care is rediscovering the neck."

**Alexander Blount, Clinical Professor, Family Medicine and Psychiatry, University of Massachusetts*

UTHEALTH NORTHEAST

# *Does it work?*

# Improved Clinical Outcomes

# &

# Lower Overall Healthcare Costs

# IMPROVED OUTCOMES & COSTS

The addition of psychological interventions for Kaiser clients with serious medical disorders resulted in:

**78%** Reduction in average length of hospitalization

**67%** Reduction in hospitalization frequency

**49%** Decrease in number of prescriptions written

**45%** Decrease in emergency room visits

# STIGMA REDUCTION

**Integrated care reduces stigma.**
**People with mental disorders are treated in the same way as people with other conditions. They stand in the same queues, receive appointments the same way, and see the same health workers.**

**This is important for people's perception of their disorders, as well as the perceptions of family members, friends, community members and the healthcare workers who treat them.**

# The 1115 Waiver

## DSRIP (Delivery System Reform Incentive Payments)

## &

## Learning Collaboratives

# WAIVER MENU

Category 1: Infrastructure Development

Category 2: Innovation and Redesign

# WAIVER MENU – INFRASTRUCTURE DEVELOPMENT

| | |
|---|---|
| 1.11 | Implement technology-assisted services telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services |
| 1.12 | Enhance service availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care |
| 1.13 | Development of behavioral health crisis stabilization services as alternatives to hospitalization. |
| 1.14 | Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas |

# WAIVER MENU – INNOVATION AND REDESIGN

| | |
|---|---|
| 2.13 | Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting. |
| 2.14 | Implement person-centered wellness self-management strategies and self directed financing models that empower consumers to take charge of their own health care. |
| 2.15 | Integrate Primary and Behavioral Health Care Services |
| 2.16 | Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally. |
| 2.17 | Establish improvements in care transition from the inpatient setting for individuals with mental health and / or substance abuse disorders. |
| 2.18 | Recruit, train, and support consumers of mental health services to provide peer support services |
| 2.19 | Develop Care Management Function that integrates primary and behavioral health needs of individuals |

# IMPROVEMENT TARGETS, CATEGORY 3 OUTCOMES, QPI, OH MY!

- Screening and treatment plan for depression
- Treatment plan developed and implemented with primary care and behavioral health expertise
- Individuals receiving both physical and behavioral health care
- Patients screened for depression in primary care clinics
- Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
- Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications
- Diabetes Care: HbA1c Poor Control (>9%)
- Depression Remission at 12 months
- Assessment of risk to self/others

# Northeast Texas

# Regional Healthcare Partnership

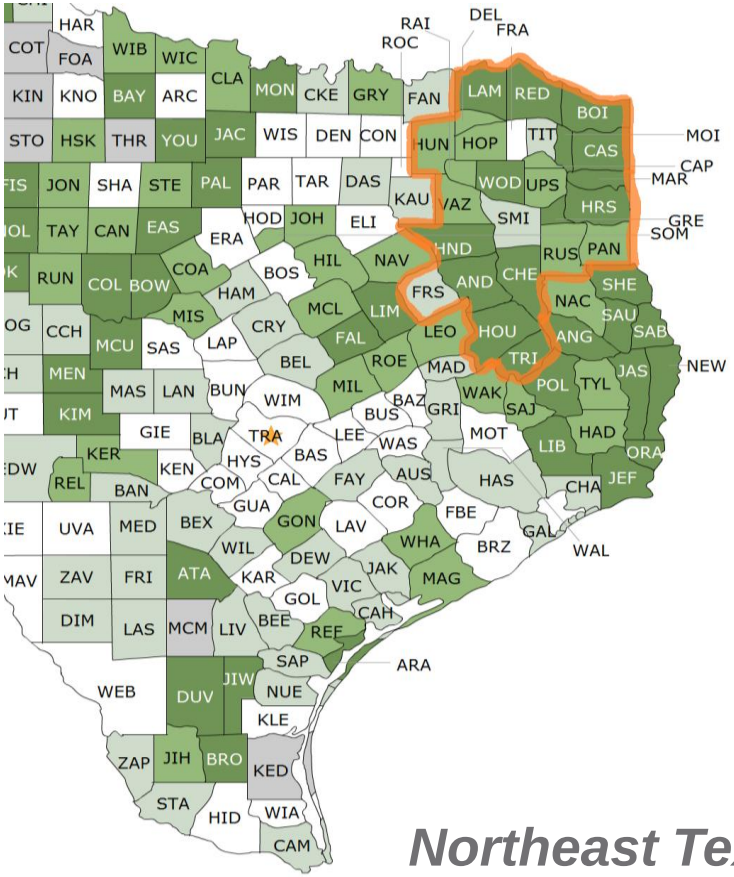
# (RHP) 1

# UT HEALTH NORTHEAST

***As the only academic medical center in Northeast Texas, we serve a region the size of West Virginia, a population of over 1.3 million, and have an annual impact of $361 million.***


***Research  Patient Care  Education***

# Northeast Texas




| | Northeast Texas | Texas |
|---|---|---|
| Population | 1.3 million | 25.1 million |
| Counties | 28 | 254 |
| Rural Population | 53.9% | 17.5% |
| Median Age | 41 | 33.6 |
| Per Capita Income | $19,386 | $24,870 |
| Bachelor's Degree | 13.2% | 25.8% |
| Minority Population | 24.8% | 29.6% |
| Hispanic Origin | 13.1% | 37.6% |

***Northeast Texas is older, poorer, less well educated and at greater risk of early death than the state average.***

# NORTHEAST TEXAS MENTAL HEALTH CHALLENGES

UTHEALTH NORTHEAST

**85,000**

Number of individuals in the region with serious mental illness

**25,000 to 1**

Ratio of patients to mental health providers in some communities, seven times the state average

**65%**

Suicide rate above the state average

# DSRIP PROJECT SUMMARY
# BEHAVIORAL HEALTH INTEGRATION

UTHEALTH NORTHEAST

Increase the number of primary care physicians who routinely include behavioral health screening, counseling and treatment, to deliver integrated care by:

Increasing didactics on mental Illness

Utilizing the PHQ-9 to screen adults for depression

Collaborating with behavioral health staff to treat patients

# AN INTEGRATED CLINIC VISIT

- Patient completes a PHQ-9 assessment with annual paperwork
- Nurse notifies doctor if score is elevated
- Doctor visits with the patient and initiates a warm-handoff to the therapist
- Therapist provides brief counseling and schedules a follow-up therapy session as needed
- CHW provides information on appropriate support groups

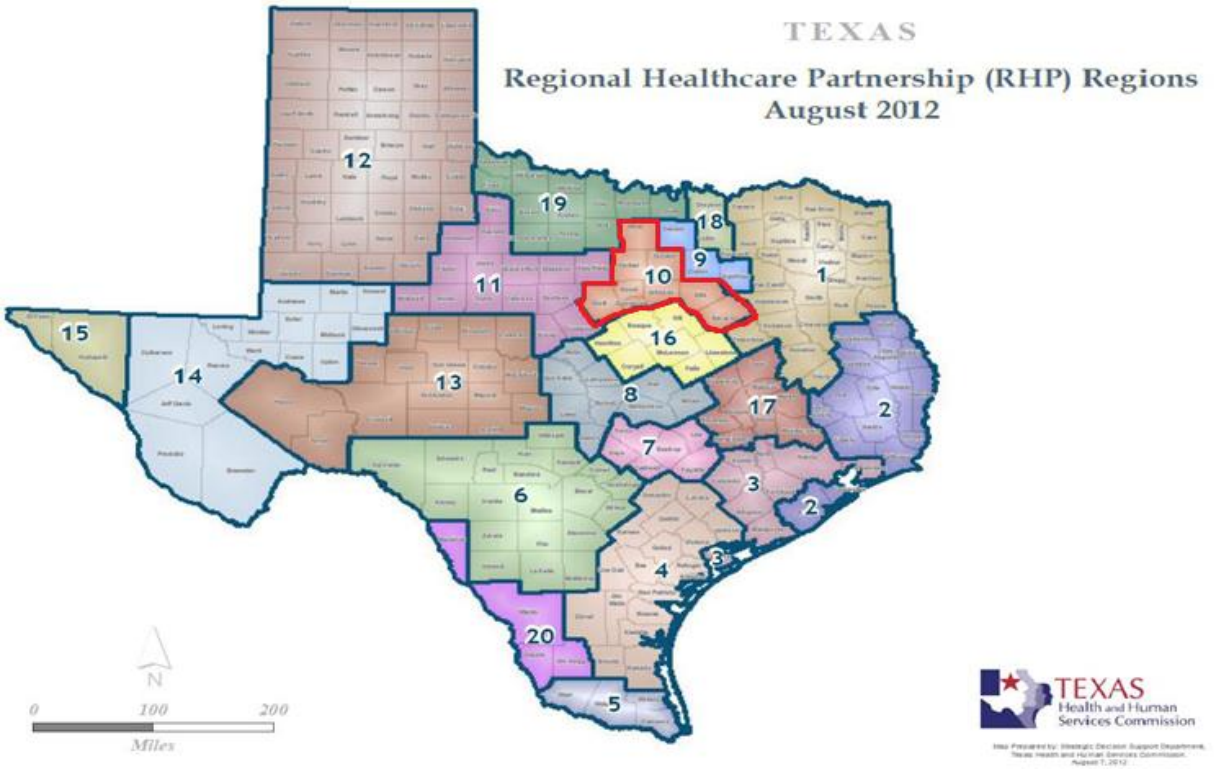
# INTEGRATED CARE
# INTERNAL MEDICINE CLINIC

UTHEALTH NORTHEAST

| | FY 2014 | FY 2015 |
|---|---|---|
| Patients screened with PHQ-9 | 89% | 98% |
| Eligible patients receiving Integrated Care | 24% | 65% |
| Patients with Improved PHQ-9 | 46% | 47% |

# RHP 10 MAP

RHP 10
- 9 counties
- Over 2.4 million people
- Urban center surrounded by rural and suburban communities
- 7,221 square miles
- Largest city in US without public transportation system
- Approximately 18% uninsured and 20% public coverage



# JPS Health Network

Centered in Care
Powered by Pride

The $950 million tax-supported healthcare system serving residents of Fort Worth and surrounding communities in Tarrant County, Texas.

Patient Care Pavilion at John Peter Smith Hospital

John Peter Smith Hospital

- 537 acute-care beds
- Tarrant County's only Level I Trauma Center
- 110,000+ emergency room visits annually

*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*

# JPS Behavioral Health

Centered in Care
Powered by Pride

## JPS Health Network has a robust Behavioral Health Service Line

19,000+ emergency visits
30,000+ outpatient visits
30,000+ inpatient days


Trinity Springs Pavilion


*96 bed Psychiatric Hospital*

*Psychiatric Emergency Center*


*Integrated Medical Unit*


*6 behavioral health clinics*


*Walk-In BH Clinic*


*1 BH School-Based Health Center*


*4 Partial Hospitalization Programs*


*Day Rehab For Homeless*


*Virtual Psychiatric Guidance*


*6 PC Clinics with Embedded BH Specialists*


*8 Peer Support Specialists*


*Psychiatry residency programs*

# 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 | - |
| Central Center | 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 | - |
| SE Tarrant Co MH | - | YES | - | YES | - | YES | - |

Most JPS outpatient behavioral health services are integrated into strategically located JPS Health Centers.

| | Outpatient Visits |
|---|---|
| 2013 | 17,875 |
| 2014 | 32,980 |
| *2015 | 40,334 |

*Projected
- Does not include Virtual Guidance Patients

# PATIENT AND FAMILY CENTERED

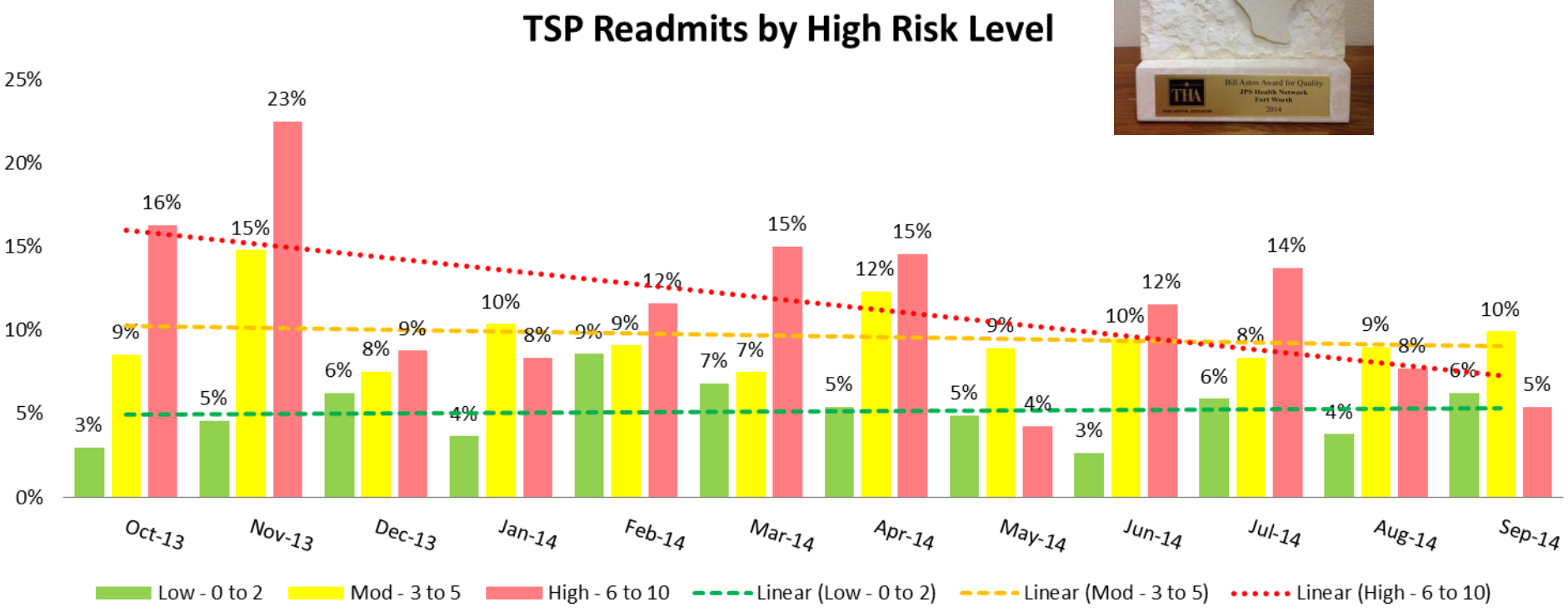
Peer Support Specialists are increasingly involved in our system. Today we have 8 peer support specialists in the PEC, Inpatient, and Rehab settings.

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 us to address
- partner in Performance Improvement Projects
- assist in setting policy and giving input into the impact current policies have on patients and families.

# DISCHARGE MANAGEMENT PROGRAM


TEXAS HOSPITAL ASSOCIATION




We started a risk stratified readmission assessment tool to inform our discharge management program which connects with people after they leave the hospital to promote continued recovery.

# Levels of Integration

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

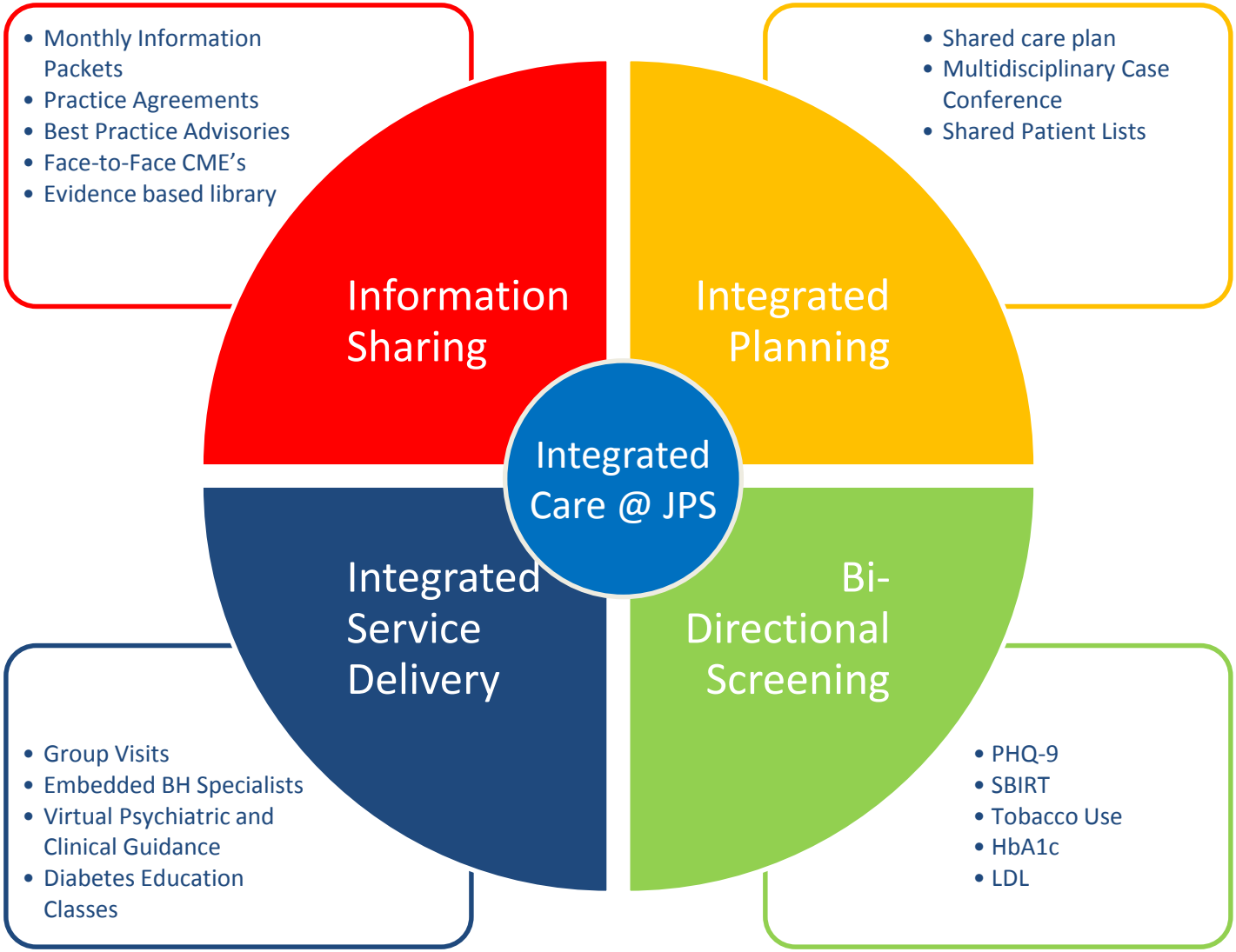
| MINIMAL COLLABORATION | BASIC COLLABORATION FROM A DISTANCE | BASIC COLLABORATION ONSITE | CLOSE COLLABORATION/ PARTLY COLLABORATED | FULLY INTEGRATED |
|---|---|---|---|---|
| ➢ Separate systems<br>➢ Separate facilities<br>➢ Communication is rare<br>➢ Little appreciation of each other's culture |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

▪

# BEHAVIORAL HEALTH DSRIP AT JPS

- 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

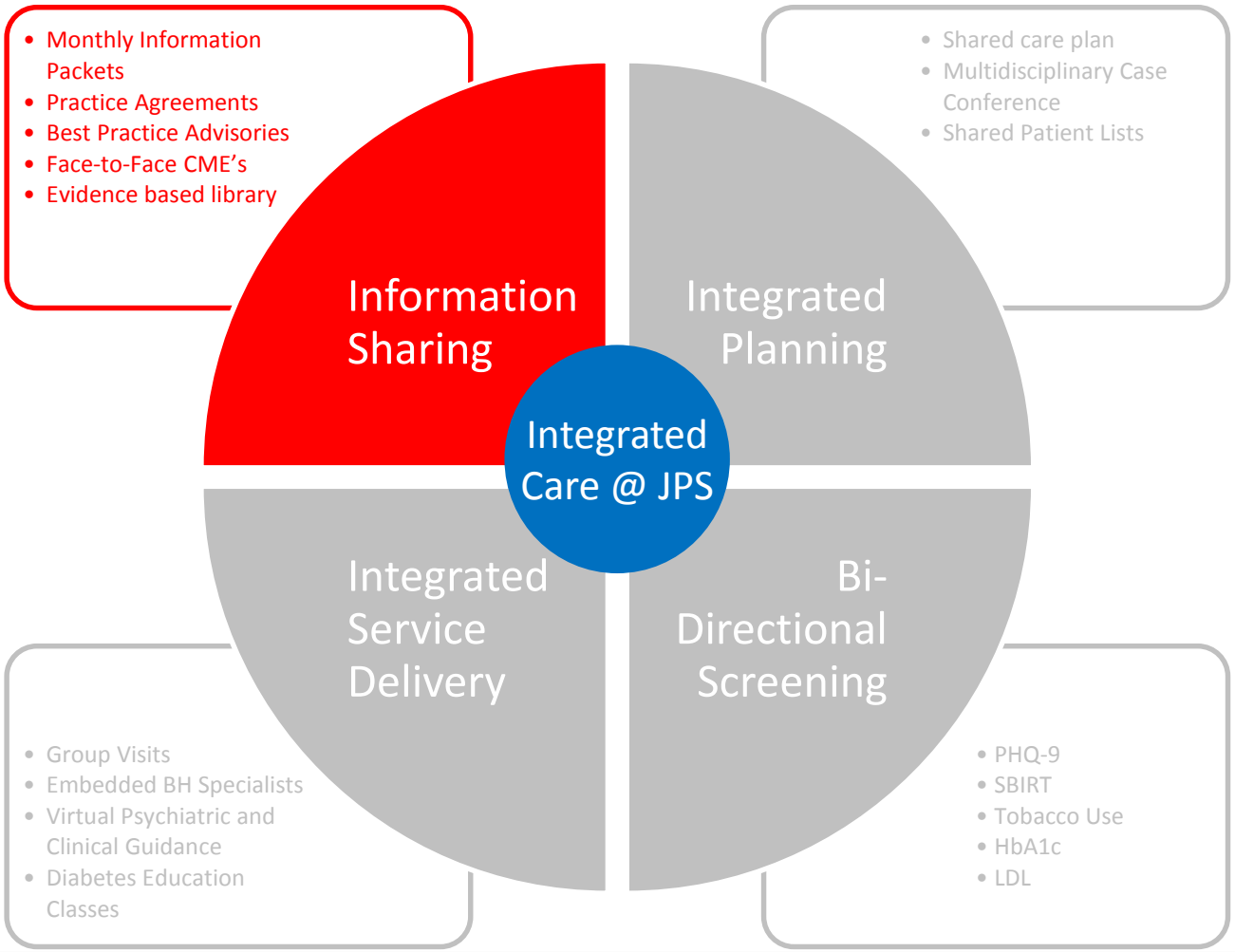
# JPS Behavioral Health Integration Model



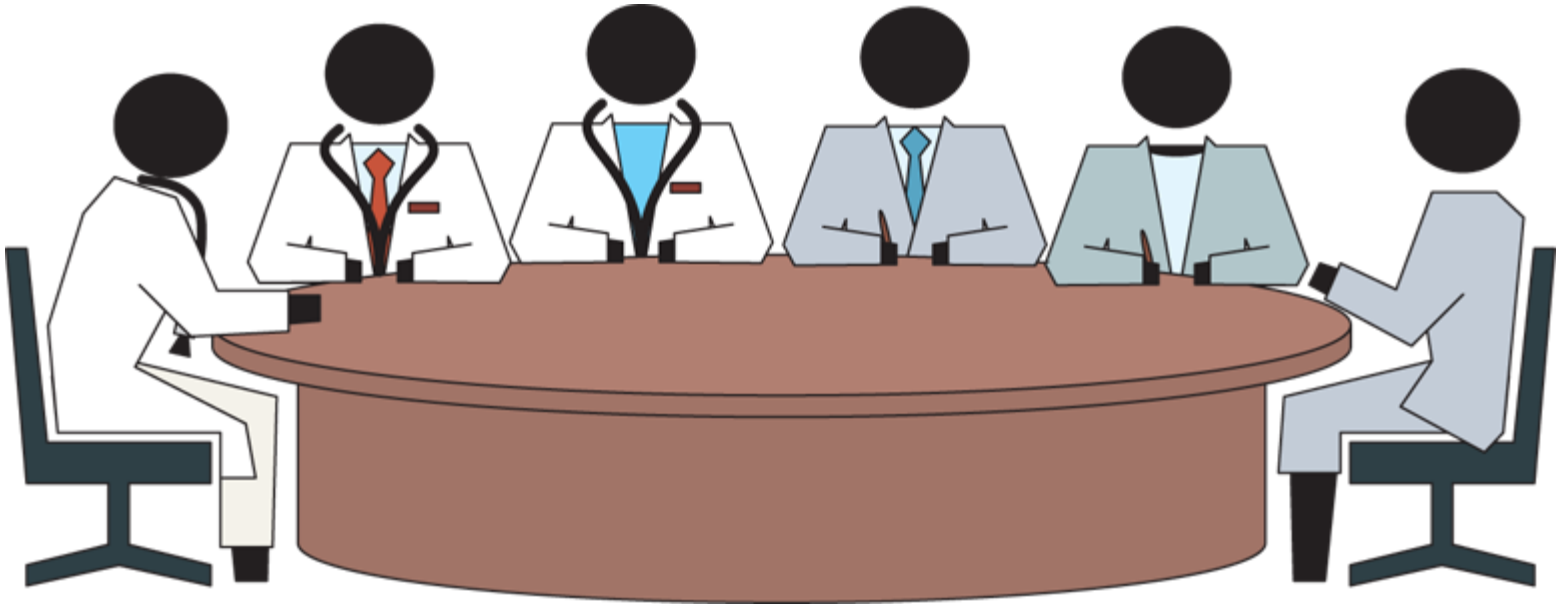
# PHYSICIAN ENGAGEMENT AND BARRIERS

- Perception of Time
- Understanding the purpose of integration and its value
- Organizational culture and sensitivity
- Practice agreements and standardization of care.

# INFORMATION SHARING



# 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 (1 OF 3)

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

# INFORMATION SHARING
# - PRACTICE AGREEMENTS (1 OF 3)

**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.

# INFORMATION SHARING
## - PRACTICE AGREEMENTS (2 OF 3)

**Clinical Practice Agreement (Cont.)**

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.

# INFORMATION SHARING
## - PRACTICE AGREEMENTS (3 OF 3)

**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 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.

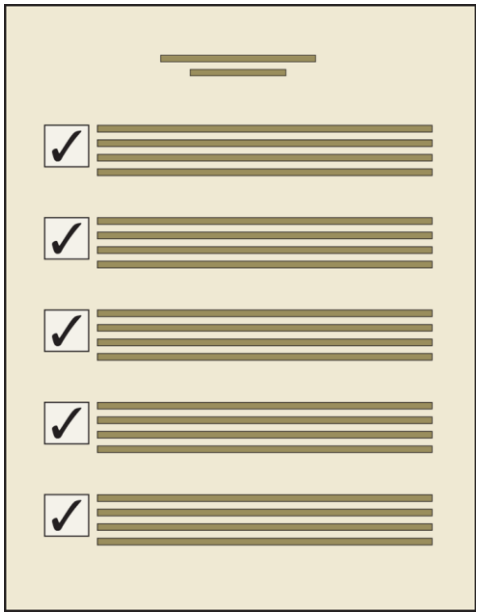
Return of Patients to Primary Care
Once a patient is determined to be stable on commonly prescribed psychiatric medications without need for other behavioral health interventions, the patient will be referred back to a primary care provider for continued medication management. A stable psychiatric patient 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 INFORMATION PACKETS



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

# INFORMATION SHARING - BEST PRACTICE ADVISORY

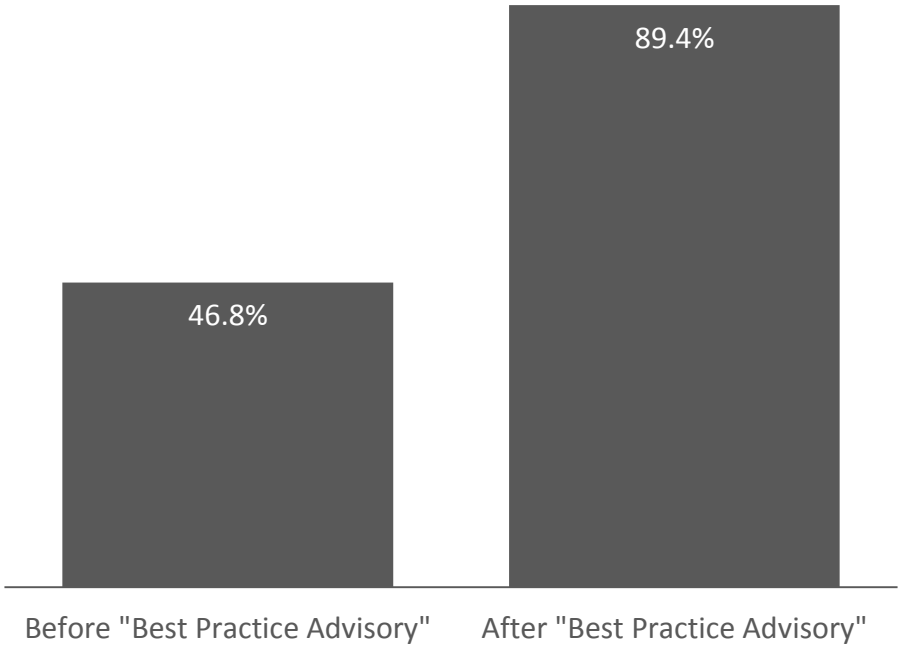
Staff trained on screening tool

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

Results monitored

## Physician Documentation of Follow-Up Plan

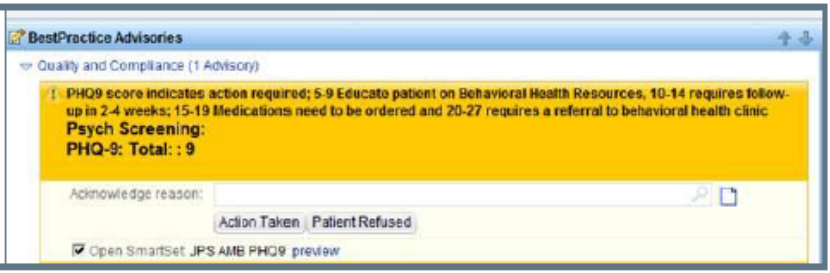
*Among individuals with PHQ-9 score >9*



# 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.

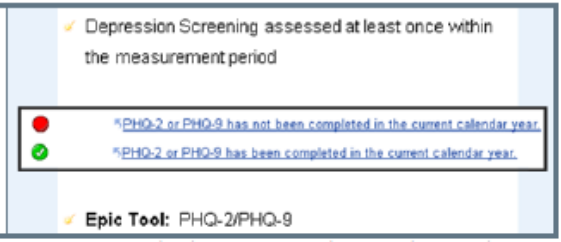

2. If the score is >9, the screening creates a "Best Practice Advisory."




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.



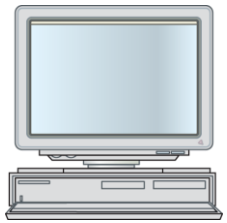
# BI-DIRECTIONAL SCREENING - PHQ-9

| Score: | Interpretation: | Treatment Recommendation |
|---|---|---|
| 0-9 | Mild to Minimal Risk | • Support, educate to call if worsens, follow up as needed. |
| 10-14 | Moderate Risk | • Antidepressant therapy and/or psychotherapy<br>• Behavioral health specialist provides resources, initiates treatment planning and motivational therapy as needed<br>• Conduct suicide risk assessment<br>• Virtual Psychiatric Guidance<br>• Follow up in 4-8 weeks |
| 15-19 | Moderately Severe Risk | • Antidepressant and/or psychotherapy<br>• Behavioral health specialist provides resources, initiates treatment planning and motivational therapy as needed<br>• Conduct suicide risk assessment<br>• Virtual Psychiatric Guidance<br>• Referral to Psychiatry if warranted<br>• Follow up in 2-4 weeks |
| 20 or higher | Severe Risk | • Antidepressant, Possible augmentation<br>• BH specialist provides resources, initiates treatment planning and follows up with patient.<br>• Conduct Suicide risk assessment<br>• Follow up in 2-4 weeks<br>• Referral to Psychiatry |

# 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
- Benzodiazepine Prescribing and Tapering Guidelines in Primary Care



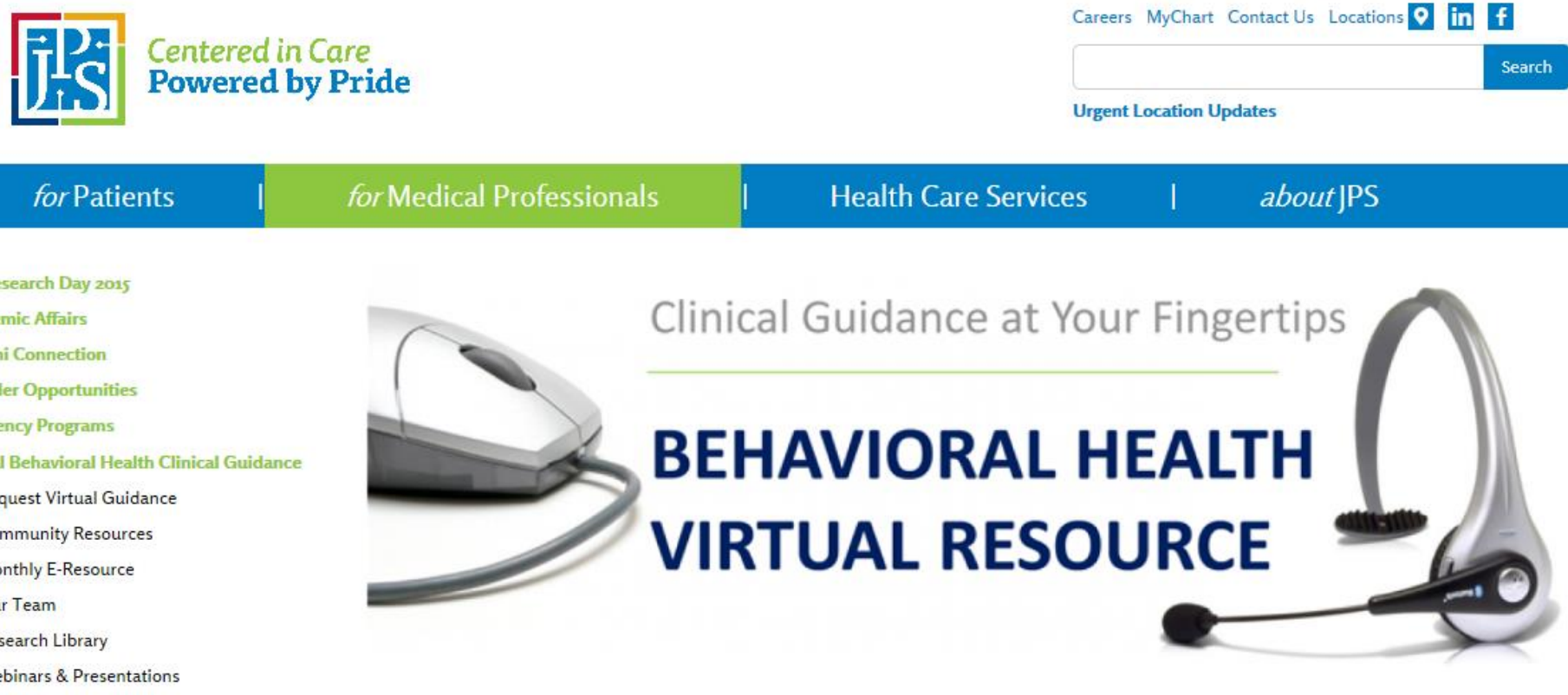
These are also made available on our Virtual Guidance Provider Resource Page

# POP QUIZ

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

Wang, P. S., et al., 2002. Adequacy of Treatment for Serious Mental Illness in the United States. American Journal Public Health. 92(1): 92–98. 21.8

# INFORMATION SHARING
## - EVIDENCE BASED LIBRARY




**www.jpsbehavioralhealth.org**

# INFORMATION SHARING
## - EVIDENCE BASED LIBRARY

for Patients | for Medical Professionals | Health Care Services | about JPS

- JPS Research Day 2015
- Academic Affairs
- Alumni Connection
- Provider Opportunities
- Residency Programs
- Virtual Behavioral Health Clinical Guidance
  - Request Virtual Guidance
  - Community Resources
  - Monthly E-Resource
  - Our Team
  - Research Library
  - Webinars & Presentations

**Research Library**

- Anxiety Disorders
- Best Practice Guidelines for Behavioral Health
- Bipolar Disorder
- Depression
- Insomnia
- Personality Disorders
- Schizophrenia
- Substance Abuse
- Virtual Website Links

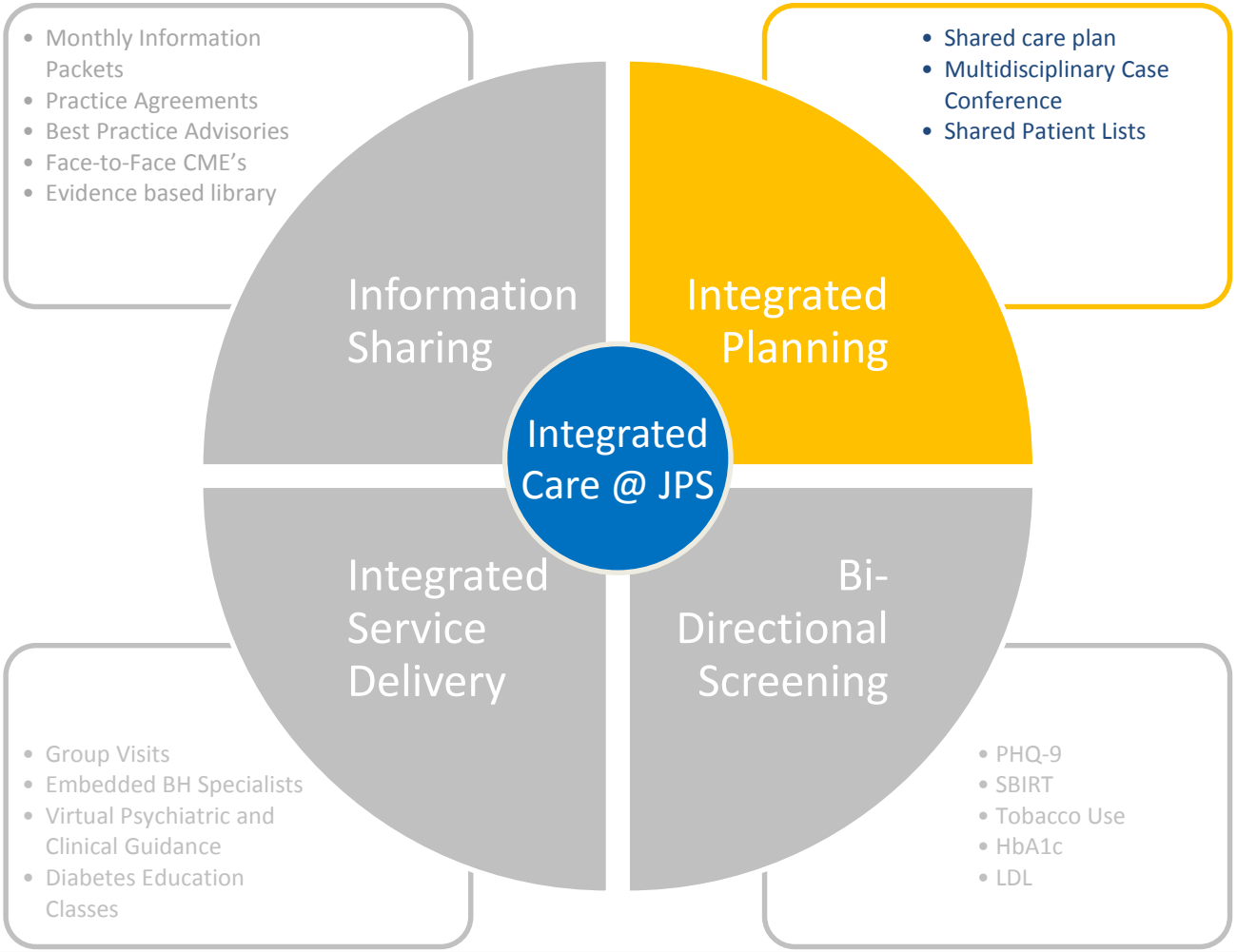
**Related Info Links**

- Request Virtual Guidance
- Monthly E-Resource
- Research Library
- Community Resources
- Webinars & Presentations
- Our Team

**Anxiety Disorders**

| Screening Tools | Treatment Guidelines | Patient Resources |
|---|---|---|
| Generalized Anxiety Disorder Screening Scale (.pdf) | Clinical Guidelines for the Management of Anxiety (.pdf) | Anxiety Patient Instructions (Adult) (.pdf) |
| GAD-7 Anxiety Scale (.pdf) | Management of Anxiety in Adults (NHS) (.pdf) | Anxiety Patient Instructions (Child) (.pdf) |
| | Drug Treatment Guidelines for Anxiety Disorders (.pdf) | Relaxation (.pdf) |
| | Management of Generalized Anxiety Disorder (.pdf) | Unhelpful Thinking Styles (.pdf) |
| | Treatment Guidelines for Generalized Anxiety Disorder (.pdf) | |

# INTEGRATED PLANNING



# 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

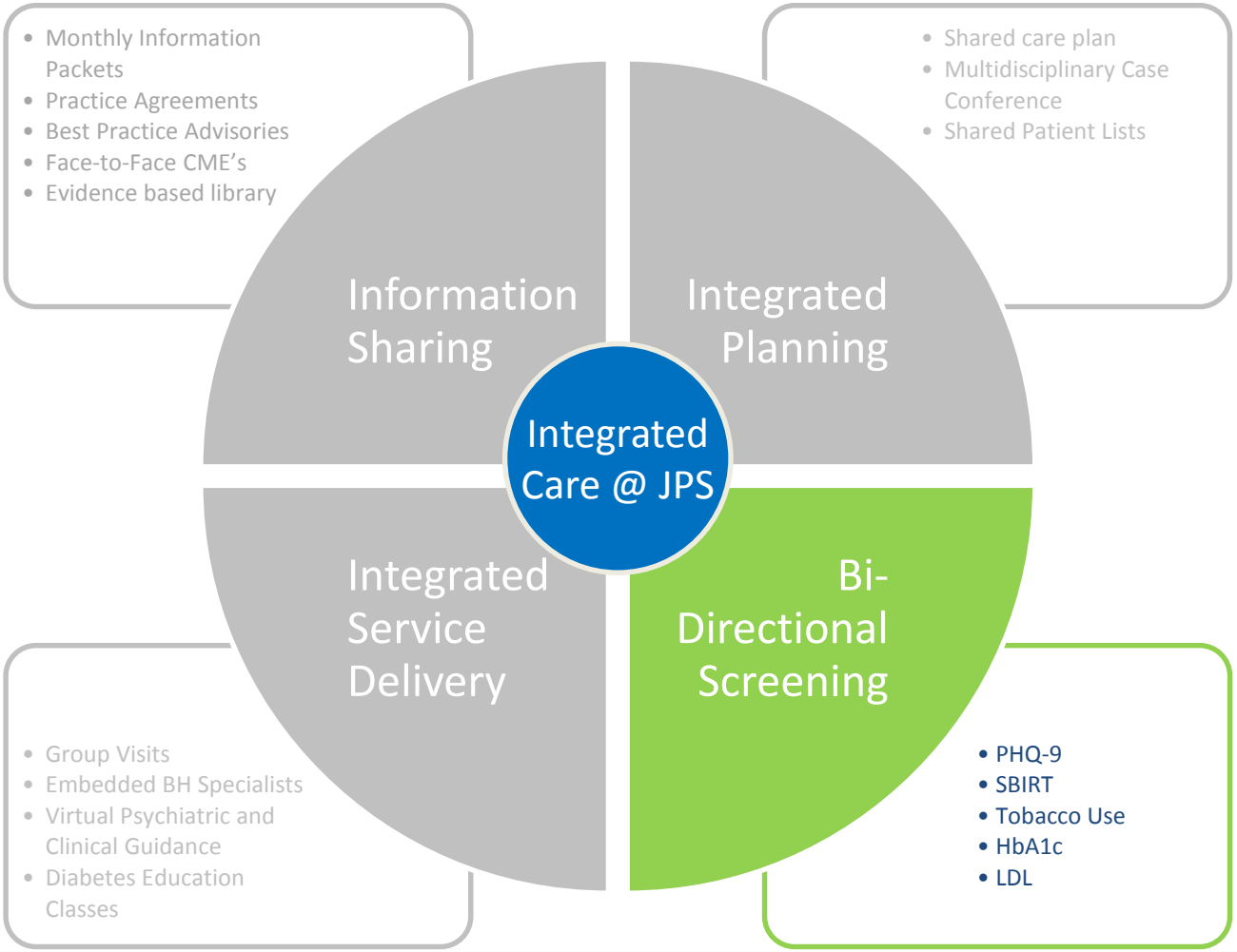
- Identifies key metrics:
  - BP
  - HbA1c
  - PHQ-9
  - Diagnoses
  - Medications
  - # of ED Visits in past 6 months
  - # of Hospitalizations in past 6 months
- Embedded Specialists summarize key points from previous visits and reports to providers
- Drives recommendations for transitioning level 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.

# BI-DIRECTIONAL SCREENING



# POP QUIZ

What is the average time between the experience of the first symptoms of a mood disorder to initiation of treatment?



Wang, et al., Delay and failure in treatment seeking after first onset of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry. 2007 Oct; 6(3): 177–185. 4y

# 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

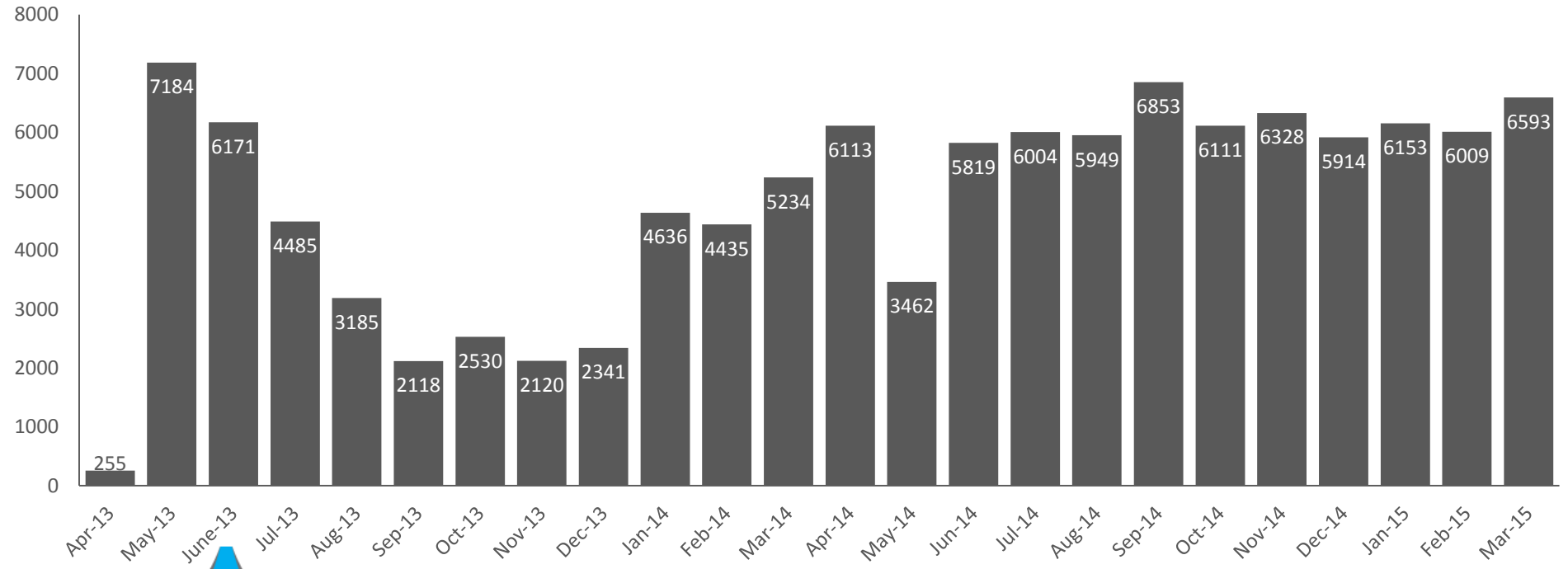
Automate alerts in EMR prompting providers to screen patients at routine intervals

Include recommended guidelines in EMR for provider action

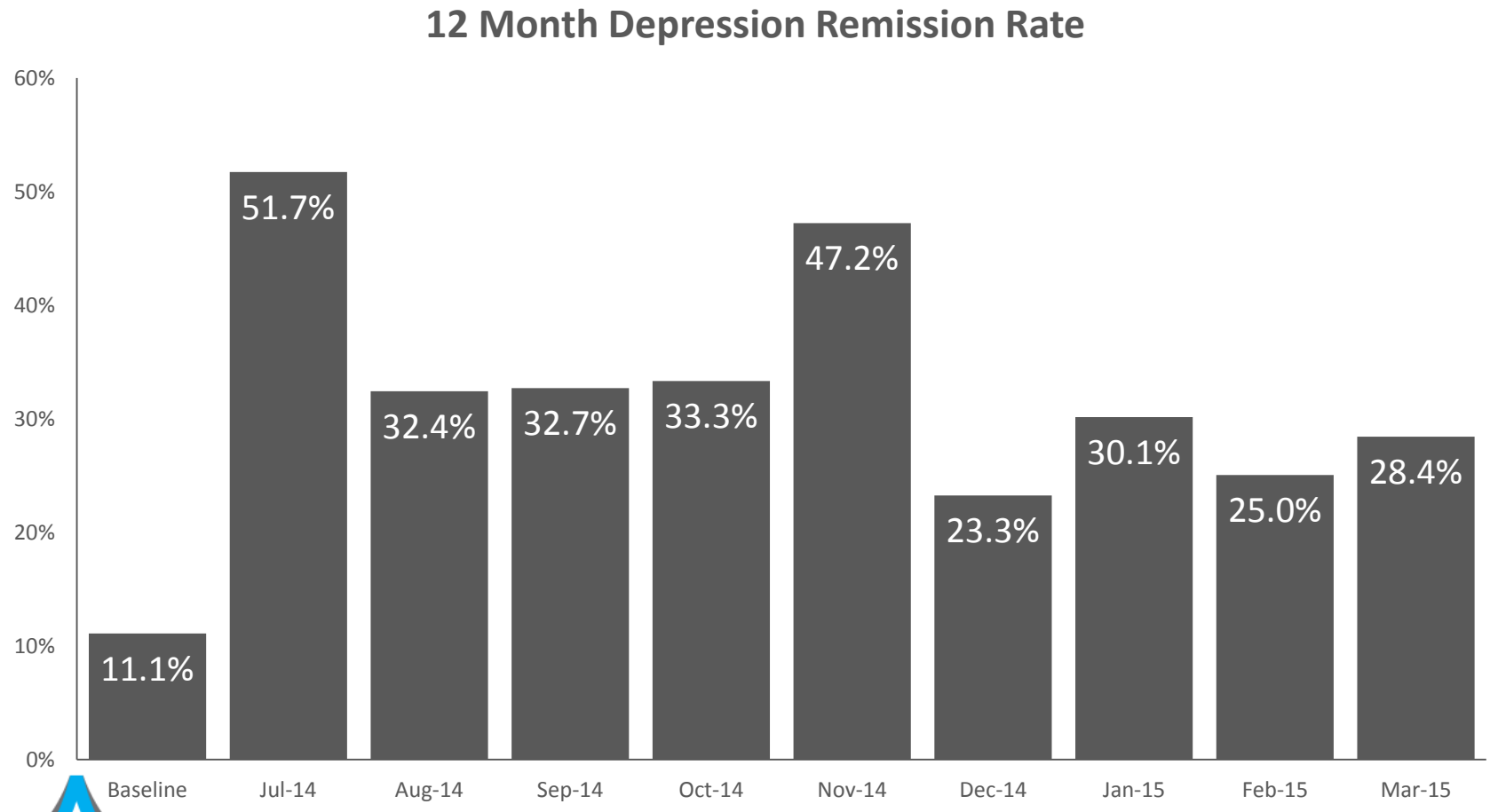
Monitory and share results to inform quality improvement

# BI-DIRECTIONAL SCREENING - PHQ-9

Over 100,000 primary care screenings for depression

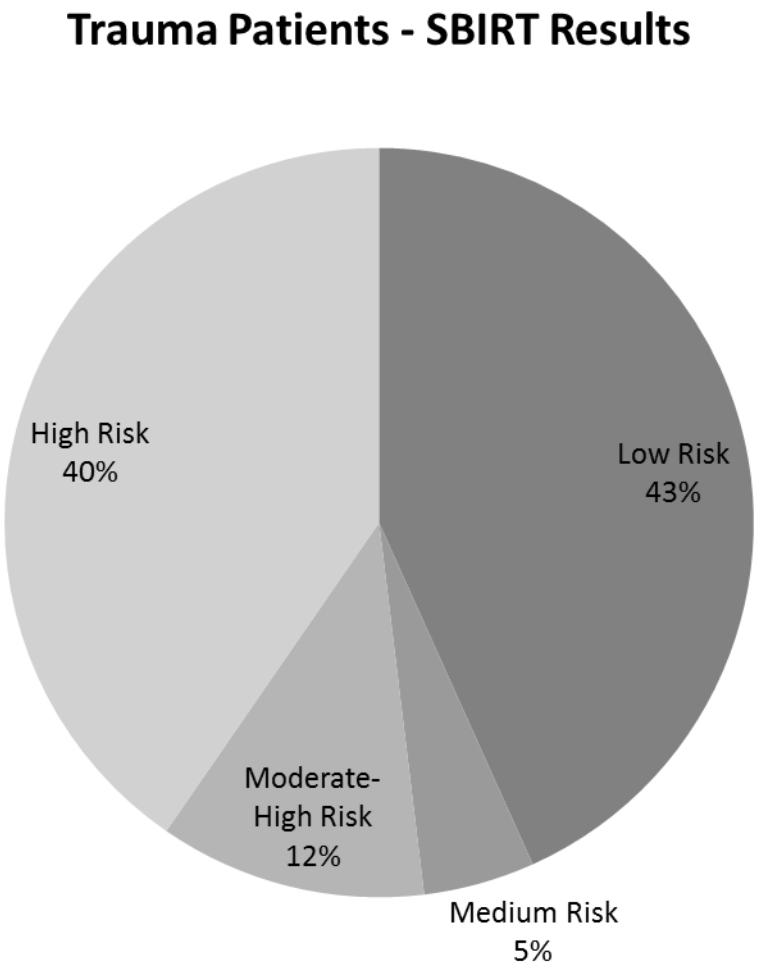


# BI-DIRECTIONAL SCREENING - 12 MONTH REMISSION RATES

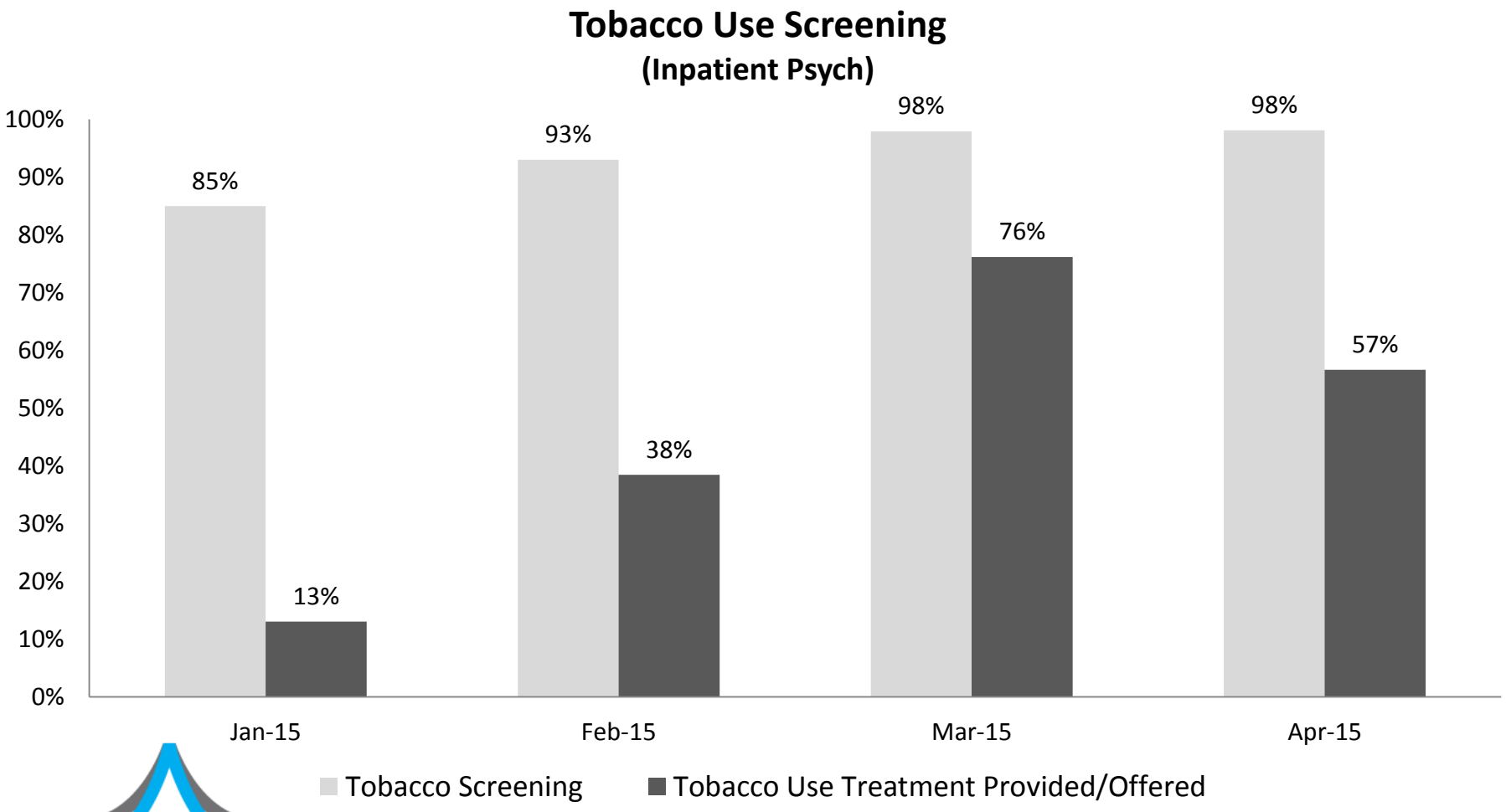


# BI-DIRECTIONAL SCREENING - SBIRT

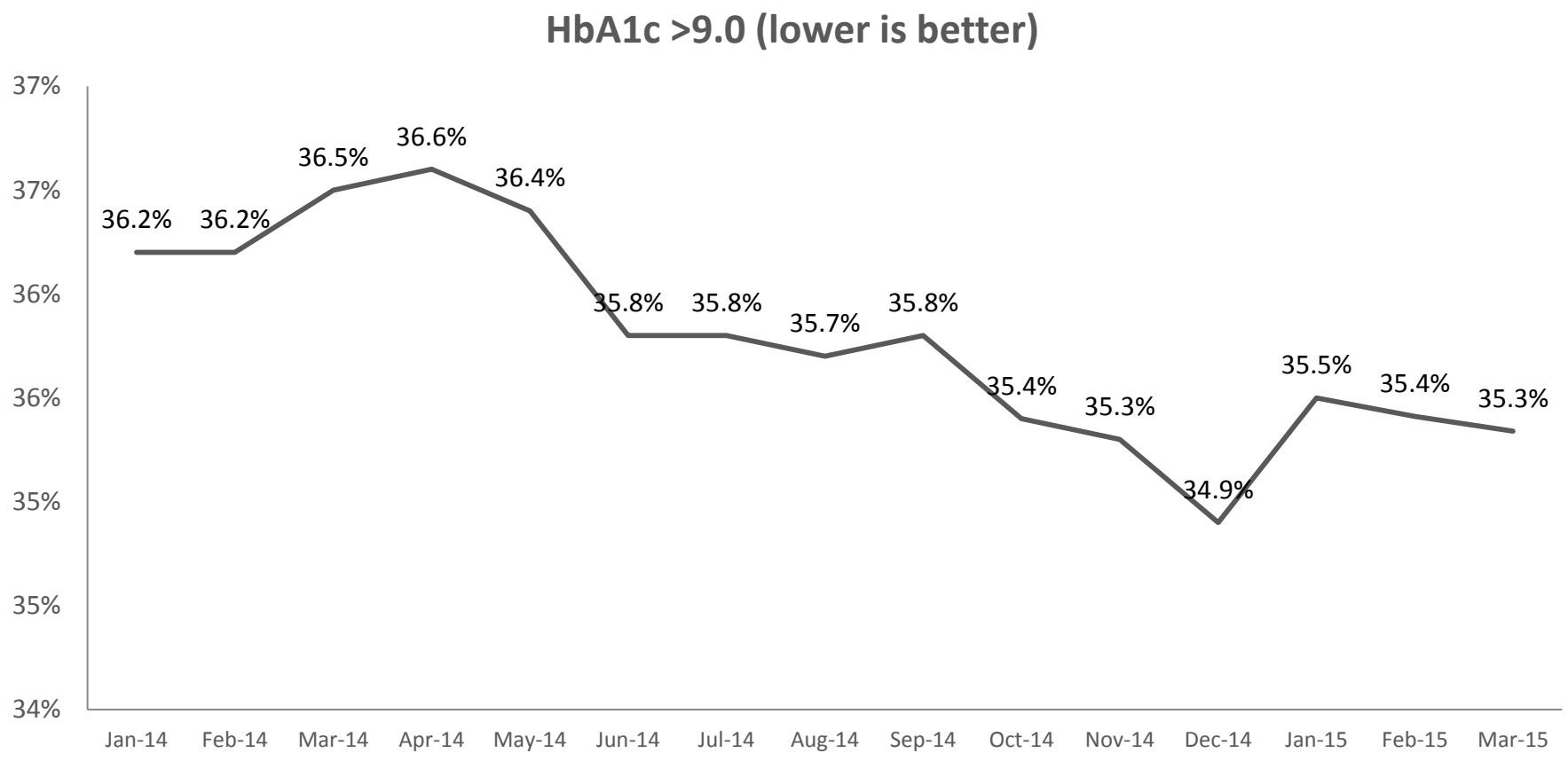
Approximately 500 trauma patients are year are positive for alcohol on arrival. Our Behavioral Health team engages them utilizing SBIRT



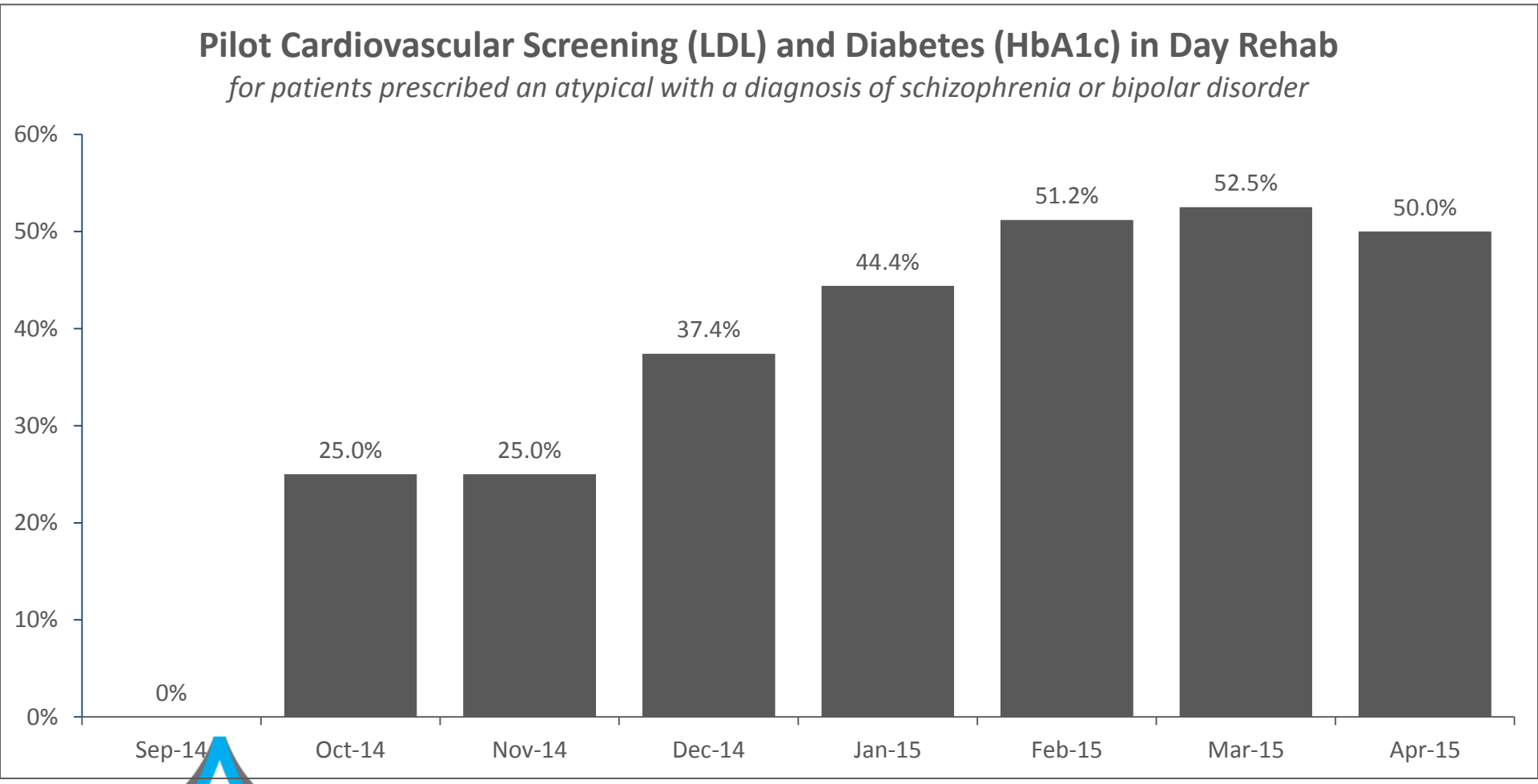
# BI-DIRECTIONAL SCREENING - TOBACCO USE



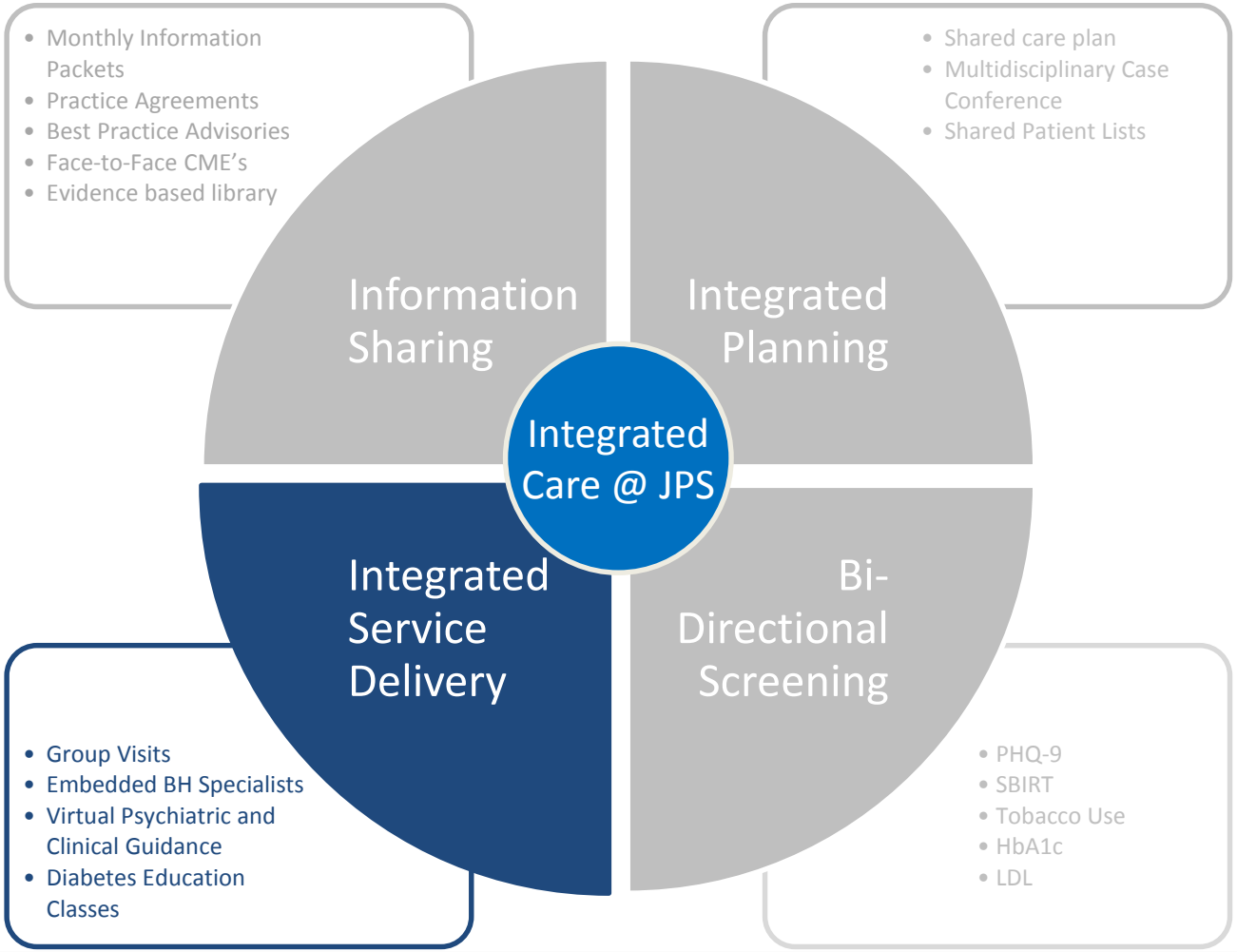
# BI-DIRECTIONAL SCREENING - HBCA1C



# BI-DIRECTIONAL SCREENING - LDL



# INTEGRATED SERVICE DELIVERY



# POP QUIZ

Who is the preferred source of help for mental health?

A. Psychiatrists
B. Psychologists
C. Counselors, Ministers, PCP
D. Friends and Family

# INTEGRATED SERVICE DELIVERY - GROUP VISITS

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

The groups consist of hypertension and CHF cohorts

# INTEGRATED SERVICE DELIVERY - COMMUNITY MENTAL HEALTH CENTER

Co-location of primary care within a MHMR behavioral health setting for the homeless population to provide convenience for target population of a “one stop shop”.

- Improved access to primary care for individuals with behavioral health conditions
- Provide service coordination to assure seamless care
- Reduce cost of care by diverting individuals out of the ED.

<u>Role collaboration plays</u>

- Collaboration, coordination, communication and consultation between these two positions on the integrated care team have been crucial for the successful outcome for individuals.
  - Coordination of information sharing
  - Coordination of appointment scheduling
  - Coordination of appropriate level of care
  - Coordination of needed resources
  - Direct face-to-face communication & consultation regarding critical cases

# INTEGRATED SERVICE DELIVERY - EMBEDDED BH SPECIALISTS

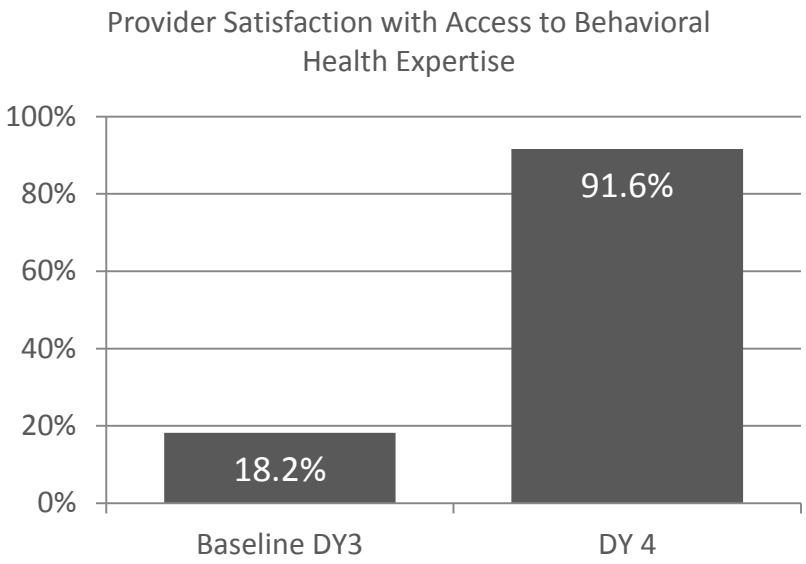
We currently have embedded behavioral health expertise into multiple settings:

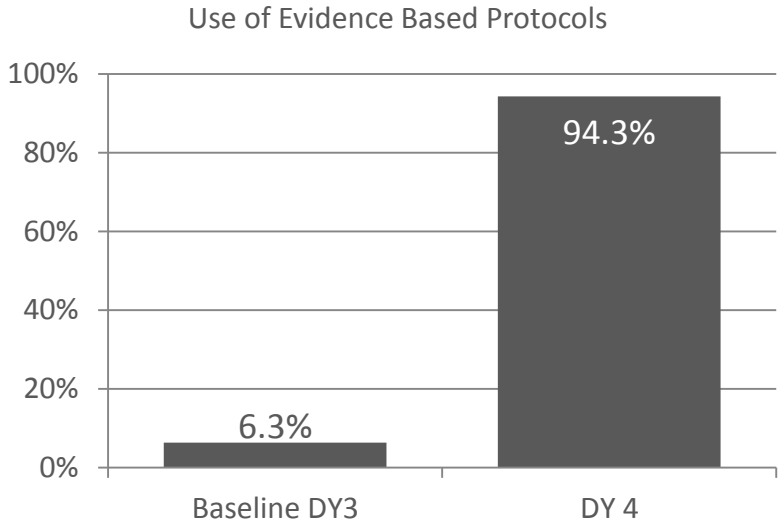
- Primary Care Clinics
- Trauma Services
- AIDS/HIV Medical Home
- Diabetes Groups
- Co-Facilitating General Medical Condition Groups Throughout System

# INTEGRATED SERVICE DELIVERY
## - VIRTUAL PSYCHIATRIC & CLINICAL GUIDANCE

- Education
- Evidence base practice
- Case specific consultation

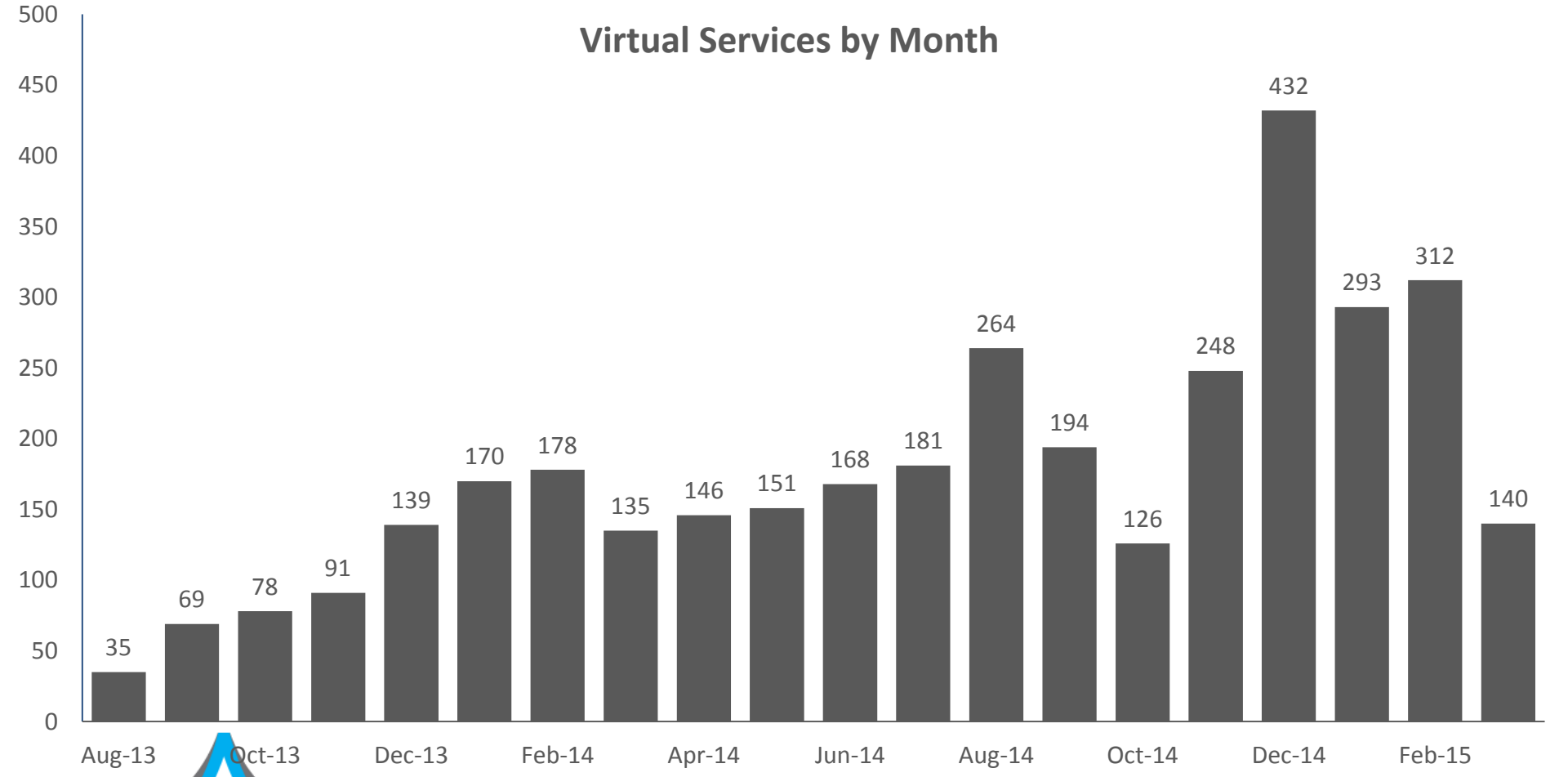
# INTEGRATED SERVICE DELIVERY - VIRTUAL PSYCHIATRIC & CLINICAL GUIDANCE



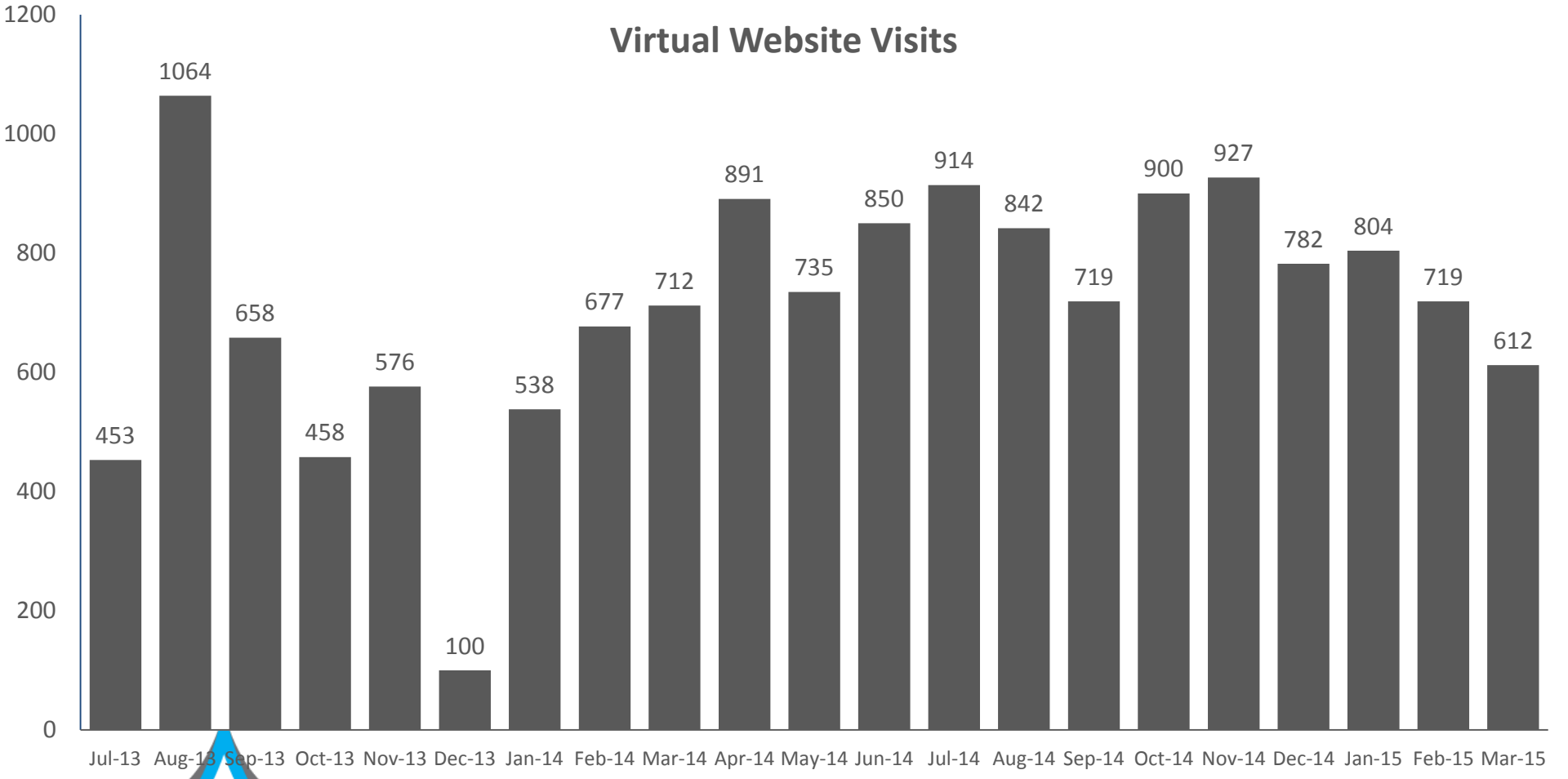




Primary care providers can speak with a psychiatrist about evidence based and best practice medication algorithms within 30 minutes.

# INTEGRATED SERVICE DELIVERY
## - VIRTUAL PSYCHIATRIC & CLINICAL GUIDANCE



# INTEGRATED SERVICE DELIVERY
## - VIRTUAL PSYCHIATRIC & CLINICAL GUIDANCE



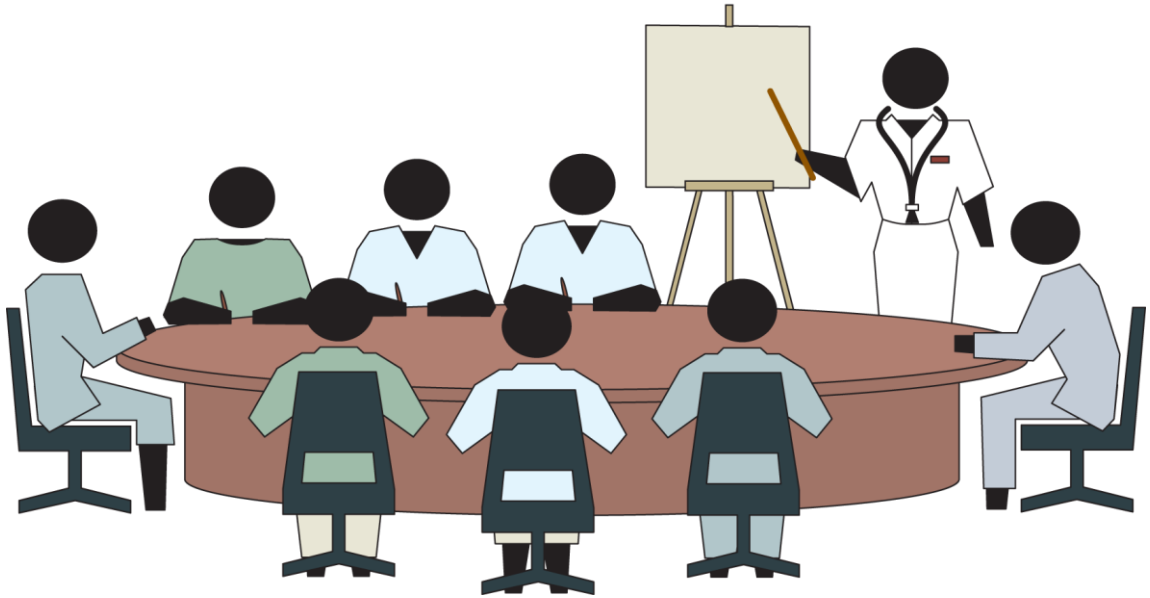
# INTEGRATED SERVICE DELIVERY - CLINICAL PHARMACISTS

- Review patients' medications and make recommendations for psychotropic and non-psychotropic medications
- Support for patients with medication related questions or problems
- Facilitate inpatient groups on medication-related topics (3 x/week)
- Soon to see patients receiving care in our HIV+/AIDS Clinic with complex medication regimens
- Teach psychopharmacology lectures for the Psychiatry, Emergency, & Family Medicine Residents

# 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 eight weeks.

Embedded specialists lead the 8th group to discuss depression, coping skills, and stress management related to their medical conditions and lifestyle changes.



# LEARNING COLLABORATIVES & THE 1115 WAIVER

***The Learning Collaborative approach focuses on spreading, adopting, and adapting best practices across multiple settings and creating changes in organizations that promote the delivery of effective interventions and services.***

- Required for all regions and Performing Providers
- Promote strong collaborative learning and sharing which maximizes individual and collective performance.
- Adapted from the IHI (Institute for Healthcare Improvement) Breakthrough Series Model

# RHP 1 LEARNING COLLABORATIVE INTEGRATED CARE





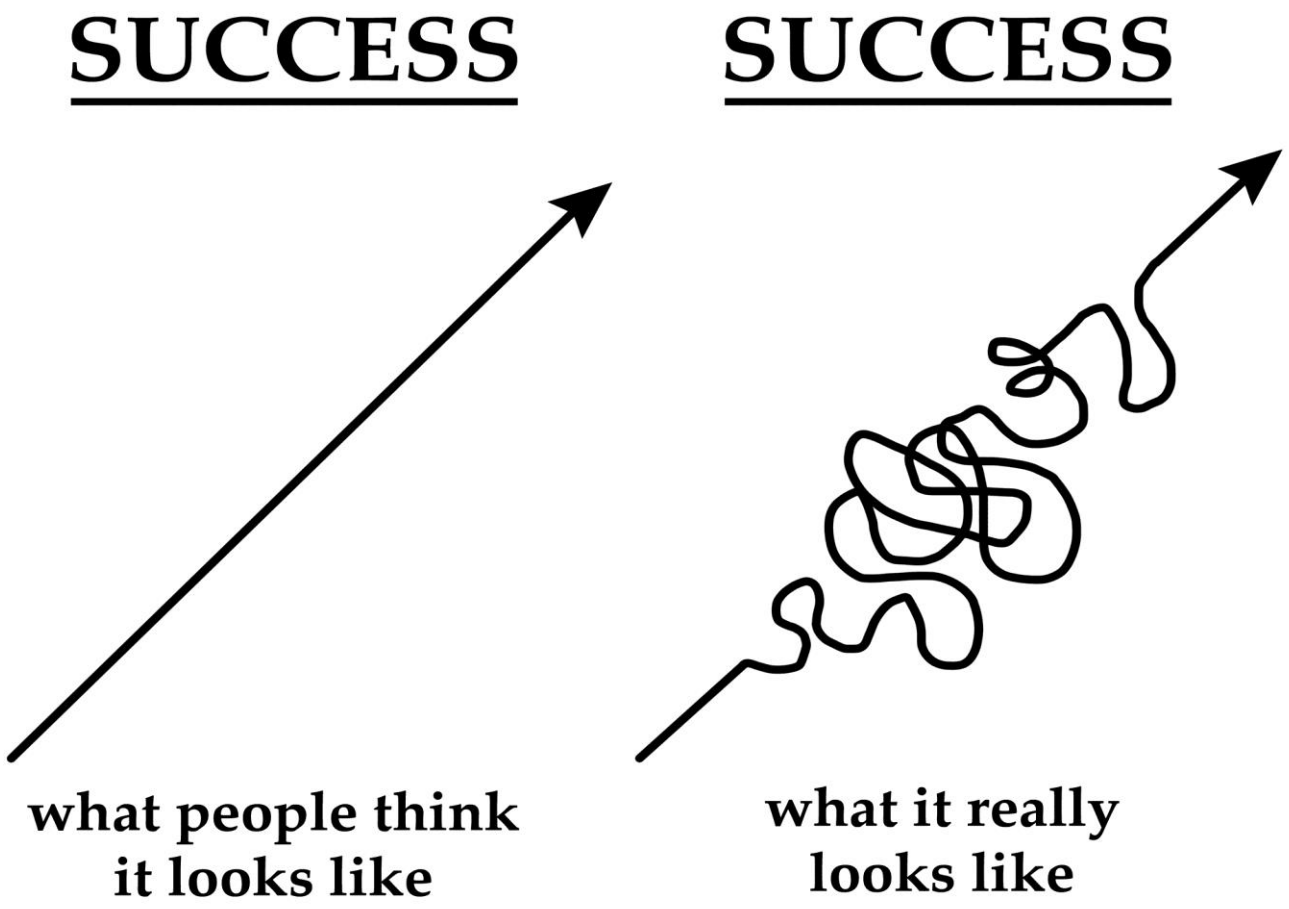




# Learning Collaborative

We currently have 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
- Lake Regional MHMR Center
- MHMR of Tarrant County
- Pecan Valley Centers
- Wise Regional Health System


SUCCESS
SUCCESS
what people think
it looks like
what it really
looks like

# Questions?