JPS Health Network

- Founded in 1877
- JPS is licensed for 537 beds that includes advanced medical, surgical and neonatal intensive care units.
- JPS includes the county’s first Level I trauma facility which is part of our recently completed five-story Patient Care Pavilion.
- JPS began our open heart surgery program in 2010
- Over 50 locations in Tarrant County with 19 SBC’s
- JPS has more than 4,700 employees
- Over 1,000 credentialed providers including 39 specialties and sub-specialties
- We have 183 residents
- JPS is home to the largest family medicine residency program on one campus in the United States
- JPS patients are primarily indigent, uninsured or underinsured.
- Psychiatric Emergency Center
- Crisis Stabilization Unit
- Adult Inpatient Unit
- Adult Step Down Unit
- Adolescent Inpatient Unit
- Outpatient Clinics
- School Based Behavioral
- Integrated Medical Unit
A team of physicians, nurses, social workers, and support personnel provide services 24 hours a day, seven days a week for both voluntary and involuntary patients in mental health crisis. This center provides triage, evaluation, and admission services. It also contains a walk-in medication clinic to assist those patients who are established patients but need additional medication or evaluation.

Services include:

- Psychiatric Triage
- Psychiatric Evaluation
- Short-term interventions including observation, stabilization, and monitoring
- Referral services
- Evaluation for Admission to JPS inpatient services
- Walk-in medication clinic to assist those who are established patients but need additional medication
Patients Triaged in PEC

2000: 6,133
2001: 7,692
2002: 8,493
2003: 8,551
2004: 10,712
2005: 12,881
2006: 13,143
2007: 12,872
2008: 13,806
2009: 14,650
2010: 16,231
2011: 16,244
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<td>Cleburne</td>
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<tr>
<td>Colleyville PD</td>
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<td>Covington</td>
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<td>Crowley PD</td>
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<tr>
<td>Everman PD</td>
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<td>Grand Prairie PD</td>
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<td>Grapevine PD</td>
<td>62</td>
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<td>Halton City PD</td>
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<td>Hurst PD</td>
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<tr>
<td>Johnson Co SD</td>
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<tr>
<td>Keller PD</td>
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<td>Lake Worth PD</td>
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<tr>
<td>Mansfield PD</td>
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<td>NRH PD</td>
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<tr>
<td>Other PD not listed</td>
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<td>Pantego PD</td>
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<td>Westworth Village PD</td>
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<tr>
<td>White Settlement PD</td>
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</tr>
</tbody>
</table>
Psychiatric Emergency Center

**Ethnicity**
- Caucasian: 13.8%
- African American: 65.1%
- Hispanic: 19.0%
- Asian: 0.9%
- Other: 1.3%

**Gender**
- Female: 52%
- Male: 48%

**Age**
- Adults: 92%
- Youth: 8%

**Gender Distribution**
- Male: 48%
- Female: 52%
PEC Presenting Problem
2000-08

- Depression: 24.4%
- Suicidal Ideation: 22.5%
- Medication Refill: 11.7%
- Psychosis: 9.3%
- Anxiety: 7.0%
- Medication Adjustment: 6.4%
- Suicide Attempt: 6.1%
- Aggression: 5.1%
- Drug or Alcohol: 5.1%
- Mania: 1.4%
- Disorientation: 1.2%

Psychiatric Emergency Center
The 12-bed CSU is a collaboration between MHMR of Tarrant County and JPS Health Network funded by a state grant aimed at increasing the crisis mental health services available in our area. The services offered in the CSU are short-term treatments aimed at reducing acute symptoms to avoid a deterioration in the patient’s condition that might ultimately require admission into a psychiatric hospital. This unit is a part of a continuum of crisis services that also includes a mobile crisis team, a crisis respite unit, and a crisis residential unit all operated by MHMR.

Services often include:

- Process Groups
- Coping Skills
- Strength and Resource Identification
- Mental Health Education
- Medication Supervision
- Relapse Prevention
- Goal Identification
- Solution-Focused Group Therapy
- Individual Therapy
- Family Education
- Family Therapy
- Community Resources
2011 CSU Admissions

Crisis Stabilization Unit
MCOT comes to the CSU daily to complete intakes on all patients admitted to the CSU that are not initially referred through the crisis services. This allows for MHMR to capture the utilization information and provides access to a broader array of services for the patient.

In 2011, the CSU provided 2,209 days of service to served 784 people in crisis.
This 38-bed brief, acute program treats patients requiring comprehensive psychiatric evaluation and treatment to stabilize their psychiatric symptoms. Crisis intervention and individualized, structured treatment are provided to patients in need of an intensive and safe setting.

Services often include:

- Comprehensive and multidisciplinary biopsychosocial evaluation
- Case management and collaboration with the patient’s outpatient clinician, physicians, family and community agencies to facilitate an integrated approach and establish comprehensive transition plans
- Psychological and brief neuropsychological assessment
- Crisis intervention & stabilization of acute psych symptoms
- Psychopharmacological evaluation and mgmt
- Activity therapy interventions
This 16-bed unit provides treatment for adults able to engage in therapeutic activities. This level of treatment emphasizes assessment, brief treatment, clinical case management and the initiation of rehabilitation. Treatment integrates biological, psychosocial and life skills approaches in treating the individual holistically and helps patients achieve their goals.

Services often include:

• Group therapies focused on symptom management and coping skills, acute life stressors, psychiatric disorders, medication and recovery
• Case management and collaboration with the patient’s outpatient clinician, physicians, family and community agencies to facilitate an integrated approach and establish comprehensive transition plans
• Activity therapy interventions
• Comprehensive and multidisciplinary biopsychosocial evaluation
• Psychological and brief neuropsych assessment
• Psychopharmacologic evaluation and management
• Crisis-oriented family therapy and psychoeducation
• Crisis intervention and acute symptom stabilization
The Adolescent Inpatient Unit is a 16-bed acute care unit. This co-ed unit contains eight double patient rooms and two common areas, comfortable furnishings and indoor areas used for recreational therapy activities.

Services often include:

• ***Crisis-oriented intensive family therapy***
• Psychological and brief neuropsychological assessment
• Psychopharmacologic evaluation and management
• Individual and group therapy
• Comprehensive and multidisciplinary biopsychosocial evaluation
• Academic services provided in collaboration with Fort Worth ISD
• Case management and collaboration with each adolescent's school, outpatient clinicians, family and other community agencies to facilitate an integrated approach, to establish comprehensive transition plans and to promote the adolescent's optimal functioning.
Adolescent Inpatient ALOS

[Graph showing Adolescent Inpatient ALOS with data points and trend lines.]
JPS outpatient behavioral health services are integrated into strategically located JPS Health Centers. This integration allows for maximum coordination of care between patients’ physicians while maintaining ease of access.

**Outpatient Services:**
- Evaluation
- Medication Management
- Limited Psychotherapy
- Limited Psychological Testing

**Outpatient Clinics:**
- JPS Health Center – Central Arlington
- JPS Health Center – Northeast
- JPS Health Center – Stop Six
- JPS Health Center – Viola Pitts

New Patient Appointments – 817-702-1456
JPS has 19 school based clinics providing primary care services to school aged children and their siblings throughout Tarrant County. Two of those school based clinics have co-located behavioral health services on site. The services in these clinics are provided by a Family Psychiatric Nurse Practitioner and a Licensed Master Social Worker.

Services often include:

• Comprehensive and multidisciplinary biopsychosocial evaluation
• Psychopharmacologic evaluation and management
• Crisis-oriented intensive family therapy
• Individual and group therapy
• Case management and collaboration with each adolescent's school, outpatient clinicians, family and other community agencies to facilitate an integrated approach, to establish comprehensive transition plans and to promote the adolescent's optimal functioning.
1. * Lena Pope Charter School - Chapel Hill
2. * HEB ISD-35 schools
3. Arlington ISD-74 schools
4. Birdville ISD-33 schools
5. Crowley ISD-20 schools
6. Castleberry ISD-8 schools
7. Eagle Mountain-Saginaw ISD-22 schools
8. Everman ISD-8 schools
9. Fort Worth ISD-144 schools
10. Grapevine-Colleyville ISD-19 schools
11. Lake Worth ISD-6 schools
12. Mansfield ISD-40 schools
13. White Settlement ISD-10 schools

Physical Locations of Behavioral Health SBC’s

School Districts Served by BH SBC
1. * Lena Pope Charter School - Chapel Hill
2. * HEB ISD-35 schools
3. Arlington ISD-74 schools
4. Birdville ISD-33 schools
5. Crowley ISD-20 schools
6. Castleberry ISD-8 schools
7. Eagle Mountain-Saginaw ISD-22 schools
8. Everman ISD-8 schools
9. Fort Worth ISD-144 schools
10. Grapevine-Colleyville ISD-19 schools
11. Lake Worth ISD-6 schools
12. Mansfield ISD-40 schools
13. White Settlement ISD-10 schools
Top Ten Diagnoses

- ADD w/ Hyperactivity: 50.2%
- Depressive D/O NEC: 19.2%
- ADD w/o Hyperactivity: 10.6%
- Episodic Mood Disorder: 5.3%
- Major Depressive D/O single episode, severe: 4.0%
- Major Depressive D/O recurrent episode severe: 3.2%
- Bipolar D/O: 2.8%
- Undersocialized Conduct D/O aggressive type: 2.4%
- Major depressive affective disorder recurrent episode severe with psychotic behaviora: 1.2%
- Unspecified Psychosis: 1.1%

Behavioral Health SBC Visits
### 2010 Total Service Volumes

#### Inpatient Days

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<tr>
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<th>Inpatients</th>
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</thead>
<tbody>
<tr>
<td>2NW</td>
<td>15,261</td>
<td>3,147</td>
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<tr>
<td>CSU</td>
<td>2,232</td>
<td>716</td>
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<tr>
<td>AIU</td>
<td>4,501</td>
<td>726</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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<td><strong>4,589</strong></td>
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#### Outpatient Visits

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<td>NEC</td>
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<td><strong>Total</strong></td>
<td><strong>37,726</strong></td>
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## Outpatient Clinic Schedules

### Adult Psychiatric Clinics

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<tr>
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<th>Tuesday</th>
<th>Wednesday</th>
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<tr>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Northeast</td>
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<tr>
<td>Viola Pitts</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Central Arlington</td>
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<td></td>
<td>✓</td>
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### Adolescent Psychiatric Clinics

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<thead>
<tr>
<th>Location</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop Six</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Viola Pitts</td>
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### School Based Behavioral Health Clinics

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<th>Location</th>
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<th>Friday</th>
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</thead>
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<tr>
<td>Arlington SBC</td>
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<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEB SBC</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
Mental Health Court is held in TSP twice weekly. MHMR provides two staff members who serve as court liaisons between TSP, MHMR, the North Texas State Hospital, to ensure the transfer of patients and the commitment process occurs smoothly for all parties involved.
Our multidisciplinary staff is able to address the many facets of psychiatric illness using a range of services including pharmacotherapy, case management, group therapies, skill-building groups and crisis intervention.

Treatment team members include:

- Psychiatrists
- Psychologists
- Nurse Practitioners
- Registered Nurses
- Licensed Clinical Social Workers
- Certified Therapeutic Recreational Specialists
- Licensed Professional Counselors
- Licensed Chemical Dependency Counselors
- Chaplains
- Physician Assistants
Residency Program

Our general psychiatry residency is a four year program which is fully accredited by the Accreditation Council for Graduate Medical Education (ACGME) and also by the American Osteopathic Association (AOA) and includes 4 resident slots per year for a total of 16 residents supported by 16 faculty members.

Clinical Rotations

<table>
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<th>First-year</th>
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<th>Third-year</th>
<th>Fourth-year</th>
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<tr>
<td>Six months</td>
<td>Three months</td>
<td>Twelve months</td>
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<td>Two months</td>
<td>Five months</td>
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<tr>
<td>Two months</td>
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<tr>
<td>Hospital Inpatient Psychiatry</td>
<td>Psychiatric Emergency Center</td>
<td>Continuous Outpatient Psychiatry</td>
<td>Geriatric Psychiatry</td>
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<td>Neurology</td>
<td>Hospital Inpatient Psychiatry</td>
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<td>Substance Abuse Treatment</td>
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<td>Inpatient Internal Medicine</td>
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<td>Consultation Liaison</td>
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Clinical Rotations
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<tr>
<th>Service</th>
<th>National Performance</th>
<th>JPS Performance</th>
<th>JPS vs National Performance</th>
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<tr>
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<td>2009</td>
<td>2010</td>
<td>Percentage Point Change</td>
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<td>Admission Screening</td>
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<td>Continuing Care Plan</td>
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<td>Contining Care Plan Transmitted</td>
<td>74.10%</td>
<td>80.60%</td>
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<td>Physical Restraint (hours per 1,000 Patient hours)*</td>
<td>Lower is Better</td>
<td>0.11</td>
<td>8.60%</td>
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<tr>
<td>Seclusion Restraint (hours per 1,000 Patient hours)*</td>
<td>Lower is Better</td>
<td>0.07</td>
<td>16.70%</td>
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</table>
In recognizing the role trauma plays in our patients’ illnesses and recovery, we have initiated several projects at improving our recognition and sensitivity to trauma.

Strategies:

1. Trauma Informed Care Workgroup
2. Enhanced Trauma Assessment
3. Groups regarding the impact of trauma
4. Education for Psychiatric Tech’s by psychologist
5. Staff education by expert as a part of P3
On admission the interdisciplinary plan of care is started by the admitting nurse.

Establish an estimated length of stay and create a discharge plan.

All documentation includes patient signature, date and time of the initial plan of care.

After reviewing assessments with the patient, identify strengths and liabilities.

Nurse reviews and updates plan as needed at every shift and charts to the goals.

Patient and nurse set initial goals.

All disciplines document patient/family education and update plan of care as needed.

The interdisciplinary care team (consisting of the patient, nurse, physician, social worker, and adjunctive therapist) reviews and adjusts goals.
A Collaborative Multi-Tiered Approach to Psychiatric Emergencies

Lesley Smith RNC, BN JPS Health Network, 1500 South Main, Fort Worth, Texas

Problem
Patients with psychiatric emergencies present with a broad array of problems, levels of acuity, and seriousness of mental illness. Timely response and easy access for patients with different needs and levels of crisis requires a multi-tier emergency mental health approach.

Solution
Core services in operation prior to Crisis Redesign recommendations

- Mental Health Emergency Room: Tarrant County (MHMRTC), among its many services, provided a Crisis Call Center, a 24-hour, seven-day-a-week Crisis Hotline, and the Law Enforcement Liaison program, providing telephone resources for police officers.

Response to Recommendations
MHMRTC implemented a Mobile Crisis Outreach Team (MCOT), accessed through the I-Care Call Center. This team of mental health professionals provides face-to-face assessment, intervention, and follow-up services to adults, adolescents, and children in their place of residence, school, and other community-based locations 24 hours a day, 365 days a year. MHMRTC also expanded the I-Care Call Center by increasing staff and gaining American Association of Suicidology certification, expanding the ability to provide immediate crisis screening and assessment.

Additionally, MHMRTC implemented Crisis Residential and Respite Units, the target population of which is any individual experiencing a crisis who has been seen by MCOT and is in need of a short-term stay until either the crisis is over or alternative living arrangements have been made.

Collaborative Results
Through the efforts of JPS Health Network and MHMRTC, Tarrant County residents have benefited from an extensive mental health crisis system that provided multi-tiered care for patients with psychiatric emergencies. In response to the needs identified by the Texas Crisis Services Redesign Committee, JPS Health Network and MHMRTC worked together to extend their comprehensive mental health crisis system. Psychiatric emergencies cover a broad range of individual crisis and this system provides opportunities for each patient to receive the appropriate level of care for his or her psychiatric emergency. The immediate and growing utilization of these services show that they fulfill an important community need.
Problem
Psychiatric emergencies are a significant and frustrating burden on Emergency Departments (ED) and law enforcement agencies, creating a potential for non-optimal treatment for the mentally ill in crisis.
- ED capacity continues to be outpaced by demand. ED visits increase while the number of hospital EDs decreases. These factors lead to ED overcrowding nationwide.
- Mentally ill patients are resource intensive and have longer stays than medical patients.
- Psychiatric emergencies can involve patient aggression and violence that EDs are not designed to manage.
- ED staff are often not trained for psychiatric emergencies and feel mentally ill patients to be challenging and frustrating.
- Adolescent mentally ill patients are especially challenging.
- Evaluation, treatment, and disposition may be less than optimal.
- Law enforcement officers experience long delays when escorting the mentally ill for admission, interfering with other public safety duties.
- The legal aspects of admitting voluntary and involuntary mentally ill patients are complex, requiring specific knowledge and procedures.
- Inefficiency in treating the mentally ill can lead to un-needed incarceration, affecting both the justice system and the mentally ill.

Solution
Establish a dedicated 24 hour, seven day a week facility for psychiatric emergencies.

Benefit for emergency departments:
- Diverts a substantial patient population requiring time and expertise not normally available in already overcrowded EDs.
- Reduces patient to patient and patient to staff violence.

Benefit for law enforcement agencies:
- Creates a dedicated 24/7 site for law enforcement officers to bring individuals in psychiatric crisis.
- The establishment of a system allowing rapid return of law enforcement officers to other duties.
- Reduces repeat crisis for the mentally ill, reducing repeat involvement with law enforcement.

Benefit for the mentally ill patient:
- Staff with specific training and expertise.
- Rapid crisis stabilization
- Thorough assessment and evaluation
- Extended observation services
- Involvement of family in assessment and discharge planning
- Direct link from triage to treatment improves outcomes
- Access to inpatient and community resources
- Medication management and adjustment
- Secure, therapeutic environment
- Age specific treatment planning

Total ED and PEC Visits 2007
- Total PEC visits equal 23% of all emergency visits

Conclusion
- The number of patient visits to the PEC at JPS Health Network shows the potential a dedicated facility for patients in psychiatric crisis has to reduce the patient load on an ED.
- Without the PEC, the ED at JPS would be subject to a 23% increase in patient visits.
- Removing this patient group from the ED allows it to concentrate on medical emergencies.
- A dedicated PEC has the potential for improved assessment, treatment, and outcomes for the mentally ill.
- The PEC has improved law enforcement productivity and diverted the mentally ill from inappropriate incarceration.
- Establishing a PEC with extended observation is an important component of the recommendations of the Texas Mental Health and Substance Abuse Crisis Services Redesign of 2006

For more information and references, contact: Lsmith02@jpshealth.org

JPS Health Network • 1500 South Main Street • Fort Worth, TX
Lesley Smith, RNC

The PEC at JPS Health Network
Implementation:
- Established in 1996
- Provides triage, assessment, observation, and crisis intervention for voluntary and involuntary patients 24/7
- Specific training and expertise allows rapid crisis stabilization, thorough assessment and evaluation using family input and support.
- Discharge planning is enhanced by direct access to inpatient services and mental health resources

ED Patient Visits in 2007: 65,020
PEC Patient Visits in 2007: 15,239
Voluntary: 11,474
Escorted by Law Enforcement: 3,765
10 Minute Police Turn Around

Effectiveness:
- The PEC at JPS Health Network experienced 15,239 visits in FY 2007, compared to 65,000 visits to the ED.
- Law enforcement agents experience a 10-minute turnaround with the PEC.

Emergency Department
Allowed to concentrate on medical emergencies
Specific Training and Expertise
Triage
Direct Access to:
Emergency Department
Short Stay Observation
Inpatient Services
Community Mental Health Resources

Poster Presentation
Comparison of Breathalyzer and Blood Alcohol Levels in Emergency Department Patients
Debbie Schmidt RN, MSN - Lesley Smith RNC - Charles Walker Ph.D., RN - Texas Christian University – JPS Health Network

Statement of Problem
Alcohol (ETOH) use among patients treated in Emergency Departments (ED) affects an estimated 10-20 million Americans and 15-20% of primary and hospitalized patients (Schumacher, Pruitt, Phillips, 2000). Blood alcohol level (BAL) can provide a reading of the presence and amount of alcohol in a person's system when the patient denies or minimizes the amount consumed. Knowing the patient’s alcohol level could alter the treatment or discharge plan.

Correlation Table

<table>
<thead>
<tr>
<th></th>
<th>Breath</th>
<th>BAL</th>
<th>Difference</th>
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</thead>
<tbody>
<tr>
<td>BAL</td>
<td>-124</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>COPD</td>
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<td>-.165</td>
</tr>
<tr>
<td>LIVER</td>
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<td>.204</td>
<td></td>
</tr>
<tr>
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<td>.885</td>
<td>-.821</td>
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<td>.333</td>
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<tr>
<td>SINCE</td>
<td>.055</td>
<td>.373</td>
<td>.318</td>
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<td>AMOUNT</td>
<td>.620**</td>
<td>.068</td>
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<tr>
<td>WEIGHT</td>
<td>.396</td>
<td>-.040</td>
<td>-.230</td>
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</table>

Demographics
Sample size: 50
Gender: Male 77%
Ethnicity: Caucasian 67%, Hispanic 20%, African American 13%
Mean age: 36 years (SD = 9.86, range = 18-56)
Mean weight: 167 lbs (SD = 25.91)
Mean height: 68.5 inches (SD = 3.86)

Drinking Habits
Frequency of alcohol consumption:
- Daily 61%
- Weekly 23%
- Less than 26%
Amount of alcohol consumed in last 8 hours:
- 0-3 drinks 36%
- 4-6 drinks 52%
- 7 or more 12%

DIFFERENCE between BAL and Breathalyzer was not explained by:
- Time elapsed between measurements
- Medical conditions (e.g. lung or liver)
- How much ETOH was consumed
- How long since the last drink
- How often participants drank
- Past BAL measurements
- Demographic variables

Conclusions
Breathalyzer screening was an invalid measure of blood alcohol in this sample (N = 30).

Sample and Context
- Convenience sample was used in this study.
- The sample was composed of individuals 18 years of age and older.
- Individuals presented to a county hospital seeking services in either the ED or Psych Emergency Center (PEC).
- ED: Level II Trauma Center with average census of 5,000/months.
- PEC: Average census of 1,100/months.

Method and Procedure
- Brand of Breathalyzer - FIOO digital screener*
- Data collected over an 8-month timeframe
- Data collector training: Online, hands-on
- Data analysis program used: SPSS
- IRB approvals obtained
- *Series: ED INNOVATIONS, LLC, Engle, MN.

Limitations
- Difficulty quantifying self-reported ETOH consumption
- “a lot,” “some,” “several,” “2 drinks”
- “one beer”
- Inability to control variables affecting ETOH metabolism
- Gender
- Weight/height
- Food consumption, smoking
- Medical illnesses

Practical Obstacles
- Time lapse between Breathalyzer and BAL samples
- Access to participants in the ED setting
- Breathalyzer recalibration
- Data collector training
- Other factors:
- Breath samples require active cooperation.
- Potential traumatic injury to the head or torso may inhibit adequate breath sampling.

Ethical and Legal Issues
- Obtaining two informed consents: for ED treatment and study participation.
- Participants may not realize Breathalyzer is drawn as part of routine lab work.
- Participant unwillingness to consent to breathalyzer if law enforcement is present.
- HIPAA: Information cannot be shared with law enforcement without additional consent.

Purpose
The purpose of this study was to compare breathalyzer and blood alcohol levels in the ED setting. If breathalyzer results were found to correlate with BAL, then the breathalyzer could be used in the ED to obtain a quick, inexpensive, noninvasive alcohol level.

Research Questions
- Do breathalyzer readings correspond to BAL in ED patients?
- Is the breathalyzer a useful diagnostic tool in an acute care setting?
- Are there meaningful correlations among demographics and other variables when comparing BAL and breathalyzer results?

Acknowledgements
Funded by The Alma and Robert D. Moreton Research Award, Harris College of Nursing.

Poster Presentation
Strategies for Successful Transition of an Acute Inpatient Psychiatric Facility to a Non-Smoking Environment

Allison Mason, BS, RN
JPS Health Network, Fort Worth, Texas

**Problem**

- Cigarette smoking is the most preventable cause of premature mortality for all Americans, including the mentally ill.
- Psychiatric patients are twice as likely to smoke as the general population and those patients with a diagnosis of schizophrenia are almost three times as likely to smoke.
- Psychiatric patients who are smokers evidence statistically greater agitation and irritability compared with non-smokers.
- Psychiatric nurses and other staff have been reluctant to implement smoking cessation on inpatient psychiatric units despite the high use of tobacco by psychiatric patients.
- This is due to fears of increased physical aggression, increased episodes of seclusion/restraints and disruption of the treatment milieu.

**Planning and Strategies**

- Through a multidisciplinary committee, an active education program was implemented to educate and prepare staff, patients and visitors for the change to a non-smoking environment.
- A survey of staff was conducted to gain input regarding the subject of smoking cessation.
- Staff were sceptical that it would be successful.

**Implementation**

Steps taken prior to implementation of the no smoking policy:

- Patients and families were notified by receiving educational handouts in the Psychiatric Emergency Center.
- Signs regarding the change were posted throughout the Department of Psychiatry.
- NAMI and other community mental health organizations were notified.
- Educational material was given to discharging patients regarding smoking cessation support groups.
- The unit schedule was adjusted eliminating scheduled smoke breaks and was replaced with outside activities and a smoking education group.

**Results**

Data Six Months Prior to and Post Initiation of a Non-Smoking Environment

**Conclusions**

- Successful initiation of a non-smoking environment in an acute inpatient psychiatric unit is possible with careful planning as well as multidisciplinary and administrative support.
- The use of nicotine replacement therapy by patients is shown to improve success.
- Increased vigilance is advised to monitor for smoking contraband.
- Clear communication to patients, families and visitors beginning at the point of entry is essential to managing expectations.

**Implications for Nursing Practice**

- Multidisciplinary collaboration and coordination including alternative activities, dietary options and clear and consistent protocols are essential.
- A didactic group led in collaboration by psychiatrists and RNs supporting smoking cessation was added to the unit programming.
- Patients are provided with education and information regarding smoking cessation support groups in the community upon discharge.

**Follow-Up**

- Three other local psychiatric facilities have implemented smoking cessation on their units after successful implementation at JPS.
- Implementation in the psychiatric environment has significantly reduced smoking among hospital staff and patients.

**References:**

Implementation of History of Violence Alert in the Psychiatric Emergency Center

Patient Presents to Psychiatric Emergency Center (PEC)

Triage Assessment
Asks the patient, family, law enforcement if the patient has exhibited any degree of physical violence to others or property
  - Injury to staff, patient, or others that requires medical treatment exceeding first aid.
  - Willful destruction of hospital property
  - Use of weapons to threaten staff or others

If the patient meets criteria for history of extreme violence:

- The nurse documents ‘risk of violence,’ creating a JPS JPS Health Network wide, online violence alert in both the critical factors screen and rounds report
- Patients positive for a history of violence have a red triangle sticker placed:
  - At the top of the PEC chart
  - On the workstation name board
  - Alert follows the patient to inpatient unit
  - Alert shows on each future episode of patient contact until removed by psychiatry

Evaluation of History of Violence Screening

In a Canadian study 71% of violent patients were successfully flagged
An Oregon study showed substantial reduction in violent attacks
In the PEC had a 29% reduction of staff injuries in the 23 months following implementation of the history of violence screening and alert protocol

Recommendations

Use a simplified process to ensure compliance
Expand the use of the tool to include some clinical factors such as substance abuse
Risk assessment should respond to clinical change in the patient
Continuing staff education is key to reducing patient violence
Respond to the patient perspective on contributing factors in the environment

Conclusion

The history of violence screening tool contributes to the reduction of patient violence against the staff in the PEC and in other organizations
A simple assessment can be more effective than a complex one
A history of violence tool alone will not eliminate violence
Any assessment and alert system must be part of a larger framework that addresses all aspects of patient violence prevention

For more information and references contact: lsmith02@jpshealth.org
Questions???