INTEGRATING PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES IN A COMMUNITY HEALTH CENTER

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Marana Health Center (MHC) is the OLDEST community health center in Arizona, incorporating in 1957.
LATE 1990S

- Money woes
  - Dental closes
  - Behavioral Health struggles
  - MTC and SMI Carondelet contract

- Commitment to treat the ‘whole person’ continues
GROWTH

- Federal Funding awarded in 1998
- Space woes
GROWTH

• Expansion to other rural communities

• New CEO in 2001
  • Clarence Vatne

• New Vision
  • Becoming a preferred provider
The Expansion Begins
In 1997, MHC Behavioral Health Services had: 1.25 FTEs
By 2007:

24 FTEs
• **Contracts**
  - CPSA (RBHA)
  - DES
  - CPS
  - Local prison
  - Federal prison
  - Superior Court (adult probation)
  - Southwest Intervention Services

• **Collaborations**
  - MUSD
  - City Court
  - Marana Court
  - Diversion

• **Licensed staff credentialed with private insurance companies**
MHC to a CSP was the result of three primary factors:

- Integrated health
- Streamline behavioral health services to persons in rural communities
- Meet DBHS RFP implementation requirement
CPSA DEVELOPMENT

- Network Development Team
  - Identified Development Team participants
  - Conducted assessment of current MHC infrastructure
  - Developed Implementation Time Line

- Three major areas of focus
  - Staffing
  - Notification of Members
  - Electronic Health Records
NOTIFICATION PROCESS

- Notification to Current MHC Members of New CSP
- 545 adult members; 46 children elected to enroll with MHC
- No interruption in care or access to services
- Change in physician services
New Facility Opens in 2011
More clients
More staff
More resources
More space
More cars and vans
INTEGRATION: THE VISION AND THE REALITY

- Serving SMI clients near primary care providers
- Assistance from CPSA
- Meeting with OBHL and ADHS staff
  - Architectural plans reviewed
  - Doors and walls and flower pots
INTEGRATIVE HEALTHCARE CENTER (IHCC)

- Approval from ADHS/DBHS
- IHCC opens in Internal Medicine hallway
- Behavioral Health Staff on site
  - IHCC Coordinator
  - Case Manager
  - Recovery Support Specialist
  - Therapist
  - PNP/Ph.D./RN
WHAT WORKS (AND WHAT DOESN’T)

• Relationship between Medical and BH Providers

• Be Open, Be Ready, Collaborate!
CHALLENGES

- Clinical versus Case Management Model
- Rural-ness
Commitment to Integration

• Obtain ROI from clients for data
• Percentage of client/patients in common?
• What do we want to measure?
  o A1C - Diabetes
  o BP – Hypertension
  o LCL - Hyperlipidemia
  o Hospitalizations (both medical and BH)
  o Depression/Anxiety
  o ‘Experience of Care’
• Different disciplines have different requirements for electronic records.

• Billing as opposed to ‘encountering.’
  • In many cases, this impedes integration
POSSIBLE SOLUTIONS

- Continuity of Care Documentation
  - Basic demographic information
  - Problem list
  - Medication list

- Staff with access to both systems
  - Case Manager
  - Medical Assistant
  - Integration Specialist/Behavioral Health Consultant
As Integrated Health expands into private insurances and single fund sources, administrators will have to be aware of possible billing limitations for same day services such as E&M codes.
As a result of integrative care, outcomes include:

Increased appointment attendance
Increased use of resources
“In the future we all have 15 minutes of fame and 15 minutes of healthcare”

Nicole Hollander

Let’s make it count!