

# Medical Home/Integrated Health Care Pilot Programs - Riverside County

Maria I. Marquez, MFT

Mental Health Services Administrator

Contact Info:

951.358.4526

[MIMARQUEZ@RCMHD.ORG](mailto:MIMARQUEZ@RCMHD.ORG)

# Riverside County Integrated Health Lead Agencies

- Department of Mental Health
- Community Health Agency (CHA)/Public Health
- Steering Committee Included:
  - MH Director, Assist Directors, Medical Director, Research, Program Administrator, PH Director, Program Chief, Fiscal, Medical Director
- Planning started Spring 2010
  - Blaine Services Started: January 2011
  - Rubidoux Services Started: Sept. 2011

# Implementation efforts: Phase I –

## **Blaine Street Integrated Health Program**

- Establish integrated health at Blaine Adult Services Program
- Added Nurse Practitioner, LVN, CMA
- Key Implementation Components (non-linear):
  - Facility, Staff, Equip/Supplies, Training & Workflow/Processes

# Facility modifications

- Med room (samples, P.A.P., vaccines & basic)
- Exam room (sink, wash station, exam table, equip storage, wall unit, privacy curtain, seating)
- Vital room (phlebotomy chair, scales, centrifuge, refrigerator, centrifuge, equip storage, scales, height measure, eye chart, seating)

# Logistics

- Identification and acquisition of medical equipment and supplies.
- Costs
- Technical Support within Medical Model approach/structure

# MH Workforce Development

- Staff Workshop – Change Management
  - Refer to agenda handout
  - Overview
  - Issue Identification
  - Problem Solving/Solution
  - NP started 1 mo prior to 1<sup>st</sup> appt.
- MD coordination Meetings
- Culture, Differences, Transformation

# Protocol development and implementation:

- Who to refer
- Linkage process
- Referral Forms
- Business Office
- Research Data Elements, Collection, etc.

# New vendors/processes

- Biohazard disposal
- Janitorial Upgrades
- Lab services
- Equipment calibration
- “Gases”
- CLIA waiver

# Sustainability?

- To FQHC or not?
  - FQHC = Medicare reimburse rules
- Service & Cost Tracking

# Client outreach and engagement

- Institutional/Learned barriers – changing staff approach/awareness/comfort/skills
- Consumer barriers – education, communication, direct connect or “warm transfer/linkage”

# Interagency Coordination

- IT compatibility
- Different organizational structure/behaviors
- Navigating internal and external landmines (familiar vs. unknown)

# Rubidoux Family Care Center

- Operated by Public Health
- Added MH staff
  - MD (20 hr)
  - Clinical Therapist (MFT) – 1 FTE
  - Peer Support Specialist – 1 FTE
- “Medical Home” for RCMHD clients with 2 or more physical health conditions
- Add MH services to Rubidoux patients that need but have not accessed MH services

# Rubidoux Family Care Center

- Health Education and Prevention a focus
- Serve/link all ages (child, TAY, Adult & Older Adult)
- Provide Substance Abuse/COD services and/or linkage
- Not intended to “case find” new service populations