



# The Primary Health NETWORK

*Embracing Excellence in Healthcare*

**Bi-Directional Integration**

A photograph of a female doctor in a white lab coat and stethoscope, smiling as she examines the arm of an elderly male patient. The background is softly blurred, showing greenery. The text 'Our Mission' is overlaid on the top half of the image.

# Our Mission

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The Primary Health Network, a Federally Qualified Health Center, provides quality primary care services and access to specialty care commensurate with the needs of the people in the communities we serve. Services are offered regardless of age, race, creed, sex, national origin or ability to pay.

# Primary Care Medical Home (PCMH) at PHN

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- Behavioral Health (BH) stand alone location and PCMH location
- PCMH location with Collaborative Care Model
- PCMH location with BH integration
- Pandemic Response – BH Rapid Referrals from PCMH locations



# Implementation

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Time and education is KEY to success

- Entire team – 1<sup>st</sup> meeting 1 hour
- DO NOT HURRY process
- Consideration of teaching method
- Workflow discussion – ask questions
- Discuss how this can help the team
- Provide success stories, show impact
- Expectations for sustainability

# Generating referrals

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- Identify at huddle – participants - reports
- Direct referrals
- Non-Clinical and Clinical screenings
- Providers and team awareness
- Self referrals – through marketing
- Screenings throughout visits - providers
- Meet and greet – subtle introduction
- Warm hand offs – immediate needs

# Barriers and Challenges working with SPMI and PCMH

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- Trusting relationships - warm hand off – Community Health Workers (CHW) and Collaborative Care Specialists (CCS)
- Time to educate – return/encourage
- Transportation – PHNCF/ CHW
- Upfront sharing information – details
- Motivation for change – awareness
- Multi-disciplinary meeting(s)
- Celebrating success



# Bi-directional approach BH stand alone to PCMH

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SPMI Population connected to PCMH

- Check-in screenings – SDOH
- Clinical Staff screenings
  - Review SDOH positives – opportunities
  - Screenings completed – opportunities
- Provider visit
  - Encourage, educate, prevention
  - Referrals placed

# Bi-directional approach BH stand alone to PCMH

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- Care Coordinator(s)
  - Schedule and connect patient(s) to service
  - Reminders – phone and letter
- Tracking
  - Track to completion
  - Intervene when missed appointment
- CHW
  - Identify barriers, identify solutions
  - Work for success
  - Communicate and close loop



# Wrap-Up

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Questions?

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