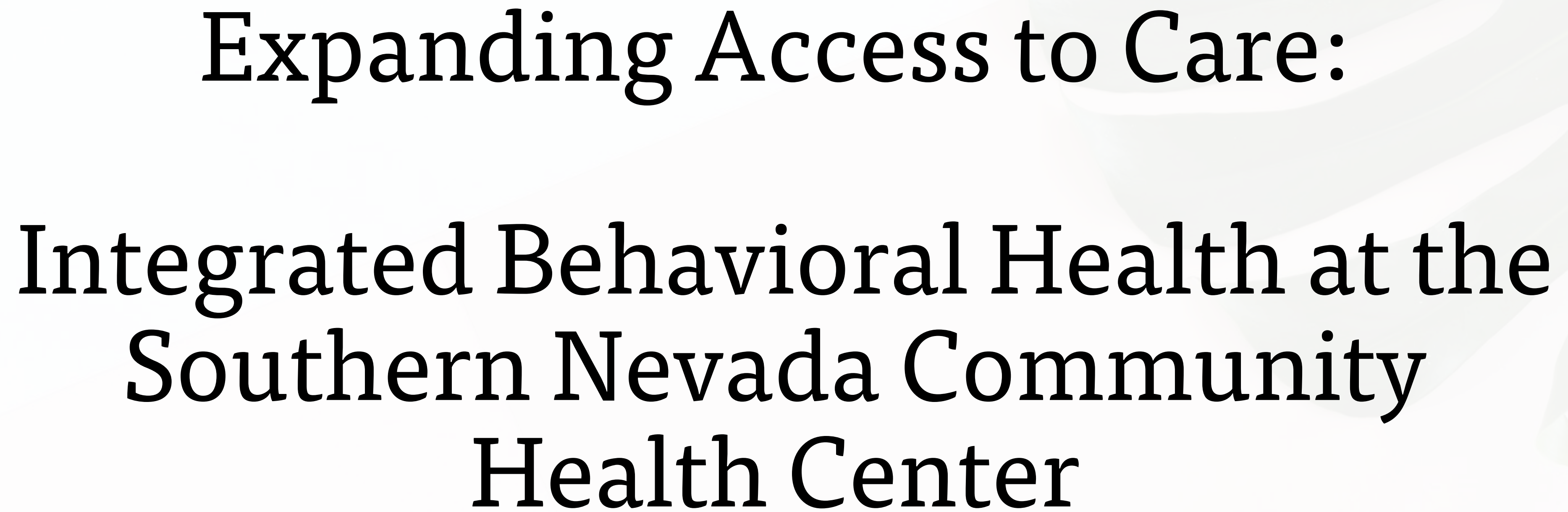
Expanding Access to Care:

Integrated Behavioral Health at the Southern Nevada Community Health Center



Behavioral Health Team

Tabitha Johnson, LMFT, LCADC
Behavioral Health Manager

Norma Ramirez-Rodriguez, LCSW
Licensed Mental Health Therapist

Kikam Yun
Psychiatric APRN

Taryn Smith, LMFT, LCADC
Licensed Mental Health Therapist

Elita Pallasigui
Psychiatric APRN

Behavioral Health Team

The Behavioral Health (BH) Manager, Tabitha Johnson, is dually licensed in both mental health and substance use and certified in EMDR therapy. She has previously led teams in both non-profit and for-profit settings, as well as in both inpatient and outpatient settings.

BH has two fully licensed mental health therapists who are both trained in EMDR therapy. One, Norma Ramirez-Rodriguez, is bilingual and the other, Taryn Smith, is also licensed in substance use counseling.

We have a full-time psychiatric nurse practitioner, Elita Pallasigui, who has hospital experience in working with veterans and other vulnerable populations.

We also have nurse practitioner, Kikam Yun, who holds dual licensure serving patients both as a medical nurse practitioner and a psychiatric nurse practitioner at Fremont.

SNCHC's BH Scope of Work

- BH currently treats moderate to mild patients who are established patients of SNCHC.
  - Moderate to mild patients are patients who do not need acute, inpatient care.
  - These patients may identify as having a high anxiety or depression screening score.
  - These patients may be dealing with a new medical diagnosis, such as diabetes or HIV.
  - These patients may be navigating substance misuse and are not at the level where they need a higher level of care.
- Patients deemed as acute or needing a higher level of care for both mental health or substance misuse are referred to a local community partners or agencies who treats that higher level of care.
  - For example, for a patient needing to detox from alcohol, BH provider and/or a Community Health Worker contacts local partners to determine if a bed is available.
  - Higher level of care for psychiatric needs, such as Intensive Outpatient Program (IOP), or Partial Hospitalization Program (PHP), BH coordinates care between the patient and local programs.

BH Services Offered

- 1:1 Mental Health Therapy (Typically 40 min. long) Includes intake, active treatment, and discharge upon treatment goals being met
- 1:1 Substance Use Counseling (Typically 40 min. long) Includes intake, active treatment, and discharge upon treatment goals being met
- Psychiatric Evaluations
- Medication Management
- Community and Partner Referrals
- Group Therapy

Group Therapy

- The Behavioral Health Team provides group therapy in English and Spanish for Ryan White patients at the Decatur location.
- The therapy group name is “Evolve”.
- The group is co-led by a Community Health Worker (CHW) who has lived experience with HIV, a licensed therapist from the BH Team, and a Health Educator who provides educational information.
- Examples of topics covered includes disclosure, healthy boundaries, managing depression/anxiety, etc.
- Group members have provided positive feedback that they have found a sense of community with others who understand their situation.

Standardized Screening Assessments

- Patient Health Questionnaire-2 (PHQ-2) to measure depression symptoms
- Patient Health Questionnaire-9 (PHQ-9) to measure depression symptoms
- Generalized Anxiety Disorder-7 (GAD-7) to measure anxiety symptoms
- Alcohol Use Disorders Identification Test – Consumption (AUDIT C) to measure when positive for alcohol use
- Drug Abuse Screening Test (DAST-10) to measure when positive for substance use

Patient-Centered Medical Home (PCMH)

- It is the goal of Southern Nevada Community Health Center to receive the Patient-Centered Medical Home (PCMH) designation.
- PCMH is a model of primary care that uses a team-based approach to coordinate patient care. The goal is to provide high-quality, cost-effective care that is culturally appropriate, accessible, and maximizes patient engagement.
- PCMH designation will create pathways for collaboration across all clinics, to include behavioral health.
- BH is actively working with the Medical Director, Quality Management Coordinator, etc. on various components for PCMH designation, such as integrative care and Chronic Care Management (CCM).

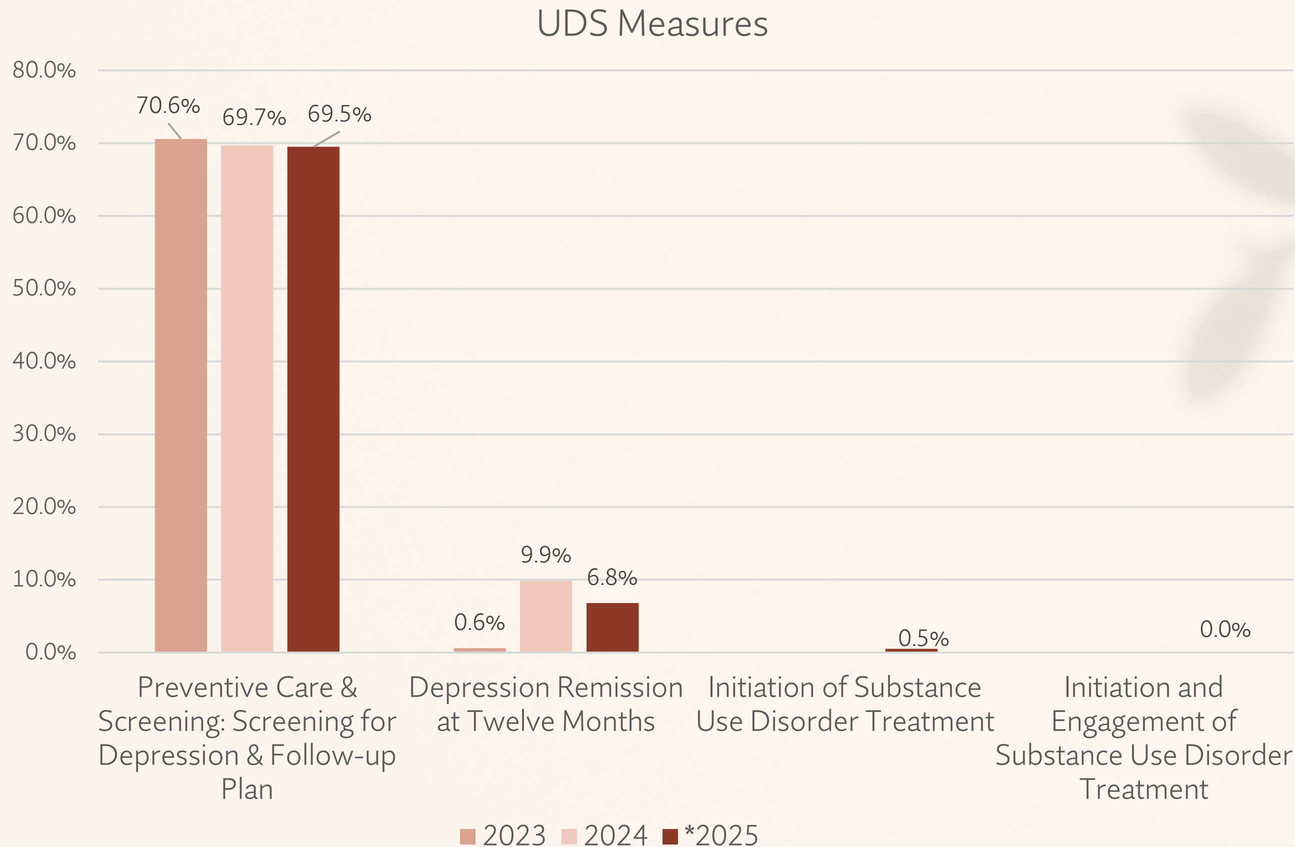
Integrated Care Model

- Improved communication and warm hand offs across all departments to assist patients with behavioral health needs to be seen in a timely manner.
- Enhanced coordination with the Ryan White program for newly diagnosed HIV patients to receive behavioral health assessments (ideally on the same day as meeting with their medical provider).
- Daily huddles and pre-visit planning between BH staff and medical staff to ensure that scheduled patients who have a behavioral health need are seen during that day.
- BH staff members at Decatur rotate and are present on the medical clinic floor daily.
- BH staff member at Fremont is actively involved in daily integrated care between scheduled patients.

HRSA Behavioral Health Clinical Performance Measures (CQMs)

- Annual screening for depression for patients 12 years and older and a documented follow-up plan for patients diagnosed with depression.
- Depression remission at twelve (12) months.
- Initiation and engagement of Substance Use Disorder (SUD) treatment for patients diagnosed with SUD.
- The BH Manager is working closely with BH providers and the Quality Management Coordinator to capture this data in the electronic health record.

CQMs – Behavioral Health



Measures	2025*
Depression Screening and Follow-Up Plan	**69.5%** (8,728/12,550)
Depression Remission at Twelve Months	**6.8%** (13/191)
Initiation of Substance Use Disorder Treatment	**0.5%** (1/213)
Initiation and Engagement of Substance Use Disorder Treatment	**0.0%** (0/213)

*Preliminary Data for 2025

HRSA Behavioral Health CQMs by Year

Measures	2023	2024	2025*	Target
Depression Screening and Follow-Up Plan (if positive, a follow-up plan is documented in EHR)	38.1%	69.7% (+31.6%)	69.5% (-0.2%)	63.0%
Depression Remission at Twelve Months (% of patients who reached remission 12 mos. After an event)	0.6%	9.9% (+9.3%)	6.8% (-3.1%)	15%
Initiation of Substance Use Disorder Treatment (initiating treatment within 14 days of new episode, to include therapy and/or medication)	n/a	n/a	0.5%	TBD
Initiation and Engagement of Substance Use Disorder Treatment (follow up within 34 days of initiation, to include ongoing treatment & 2 additional interventions or med. treatment events, or one long-acting medication event)	n/a	n/a	0.0%	TBD

*Preliminary Data for 2025

BH Provider Visits by Type and Year

The BH Team continues to increase access to care for the most vulnerable in our community:

- CY23: 1,444 **MH** visits/526 patients
- CY23: 303 **SUD** visits/178 patients

- CY24: 1,447 **MH** visits/546 patients
- CY24: 657 **SUD** visits/343 patients

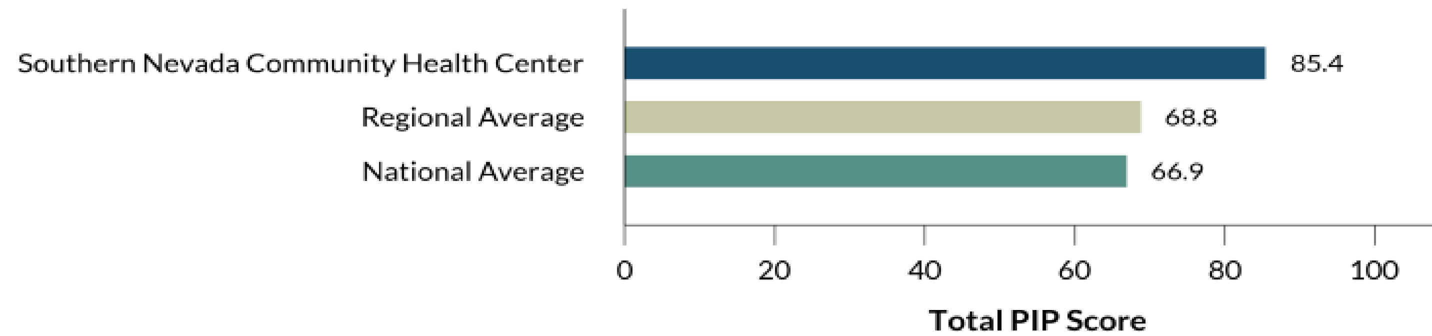
- CY25: 2,880 **MH** visits/830 patients
- CY25: 647 **SUD** visits/365 patients

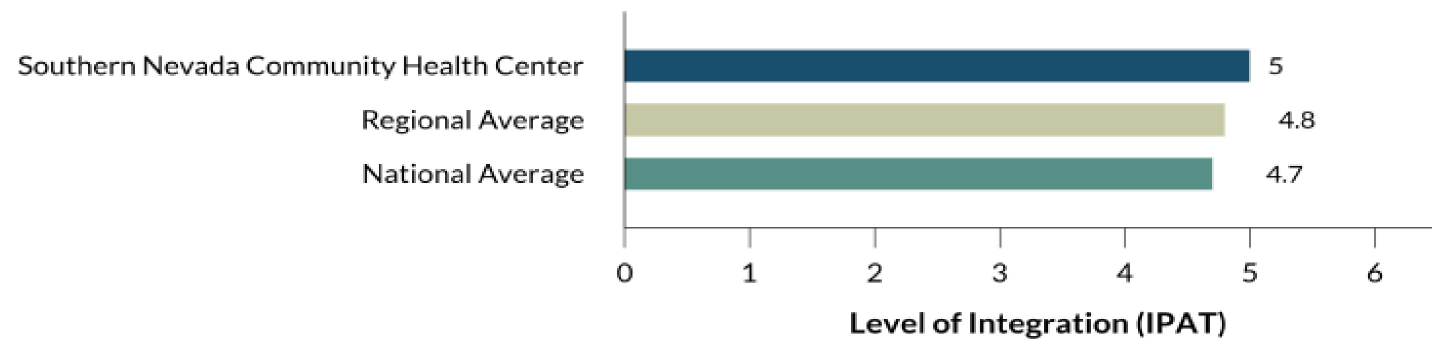
BeNCH Study

- In October 2025, University of Washington reached out asking SNCHC to take part in the Behavioral Health Integration Benchmarking Report.
- The study aims to highlight the value FQHCs provide to state Medicaid programs through integrated behavioral health services.
- The report includes site-specific results from both Decatur and Fremont health centers.
- Integration scores are based on two widely used tools: the Practice Integration Profile (PIP) and the Integrated Practice Assessment Tool (IPAT).
- *SNCHC's integration scores ranked higher than the national and regional averages.*

BeNCH Report

Organizational Integration Scores vs. Regional & National Benchmarks





Marketing Efforts

- The Behavioral Health team is collaborating with SNHD's Office of Communications on a marketing campaign to inform Clark County of SNCHC's integrated care
- Social media posts, commercials and videos aim to normalize prioritizing one's physical and mental health
- Launch date(s) expected through March and April 2026

Lessons Learned & Opportunities

- Recognizing the nuances between clinic sites when developing processes for Behavioral Health (e.g., integrated care at Fremont functions slightly different than at Decatur due to having one dedicated BH staff at Fremont).
- As the word continues to grow about Behavioral Health at SNCHC, being mindful of not stretching resources too thin with the current staffing.
- Continued communication improvement between SNCHC clinics as well as SNHD staff who may be impacted by any changes in the BH department (e.g., when group therapy started).
- Educating staff and employee opportunities to serve patients with chronic illness such as diabetes, hypertension or obesity who may need support managing their behaviors that contributed to their disease condition.

Patient Success Story

A patient recently came to the Fremont Clinic for a medical visit. Our BH team member, Taryn, did a “warm hand off” with her on the same day. It was found that the patient was under the influence during the time of her initial visit. The patient was able to complete an initial assessment the following day with Taryn. She then met with Fremont’s Psychiatric Nurse Practitioner the day after meeting with Taryn for her initial psychiatric assessment.

This patient is motivated to improve both her physical and mental health. The patient was navigating both mental health and substance use concerns and was willing to enter a detox program. The Fremont Team did a beautiful job in coordinating her care. The patient continues to see her providers and most recently has been working towards sobriety and is no longer attending sessions under the influence.

SNCHC continues to improve access to care through integrated care. To give context, most patients wait three weeks or more to for an initial appointment with a psychiatric provider in Clark County.

Well, done, team!

Thank you!

Tabitha Johnson, LMFT, LCADC

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