



SAMHSA-HRSA Center for Integrated Health Solutions

Integrated Primary/Behavioral Health Care For Those Experiencing Homelessness

June 23, 2014 , 2:00 PM ET

Colorado Coalition for the Homeless Presenters

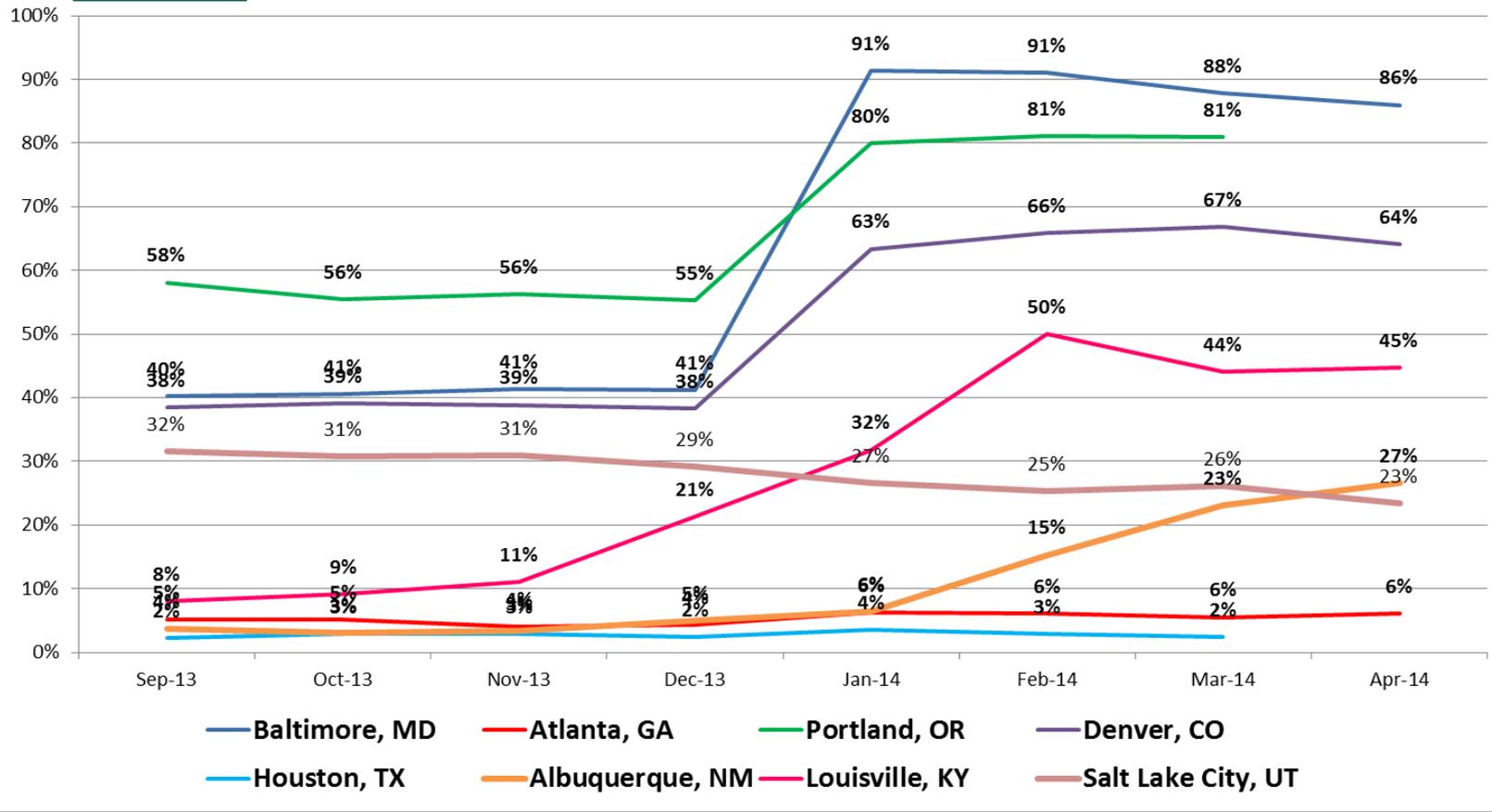
- Dr. David Otto, Medical Director of “Integrated Health Services at Colorado Coalition for the Homeless”
- Bette (BJ) Iacino, Vice President, Public Policy and Communications “Colorado Coalition for the Homeless”
- (APRN, will present case study, waiting for information)

Colorado Coalition for the Homeless (An HCH Provider)

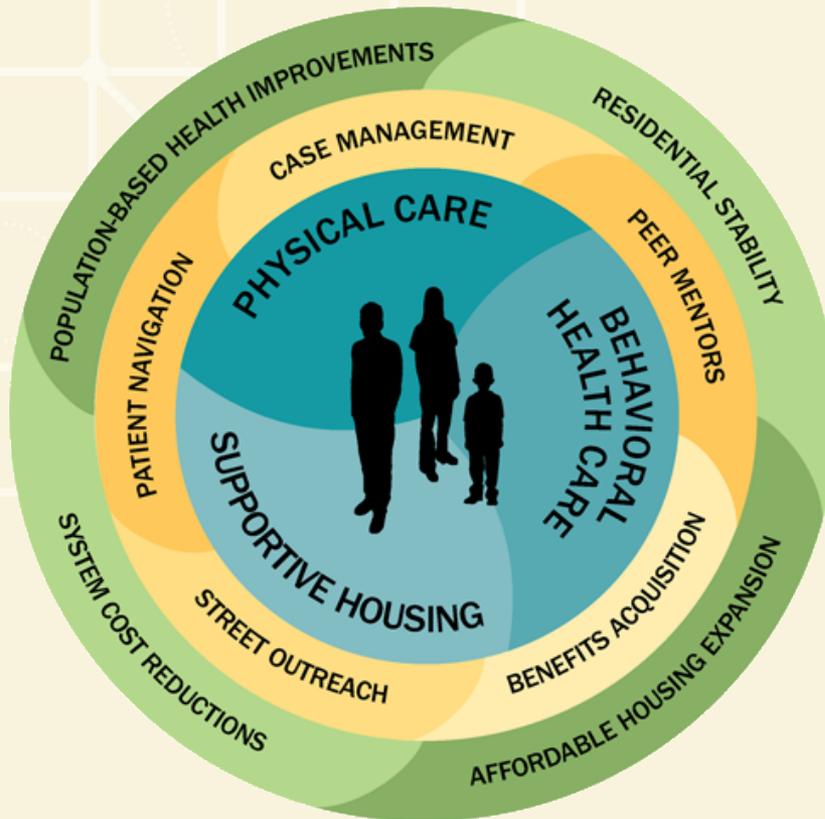
- 30 Years: FQHC & HCH Provider
- 54 Programs & 500+ Staff: Housing, Healthcare & Support Services (Outreach, Employment Services & Childcare)
- Healthcare @ 8 locations
- Housing @ 18 locations
- Serve 15,000 men, women and children



Health Care for the Homeless Projects
Percent of Visits with Clients Who Have Health Insurance:
January 2013 to April 2014



Colorado Coalition for the Homeless Integrated Health Services Model



- **Developed in 3 Phases:**
 - ✓ **West End Clinic**
 - ✓ **Stout Street Clinic**
 - ✓ **Stout Street Health Center**

ACHIEVE PRACTICE TRANSFORMATION

Merged Practices in a Shared Space
One Treatment Plan
Patient-Centered
Management Supported
Aligned Business Model
Housing Acquisition

Goal 1

ENHANCE PROVIDER COMPETENCIES

Knowledge of Homelessness & Health Concerns
Knowledge of High Priority Clinical Issues
Managing Substance Abuse, Mental Health
Disorders and Cognitive Impairments
Providing Trauma-Informed Care
Managing Complex Multi-Morbidities
Developing Treatment Plans
Managing Medications
Conducting Outreach and Engaging Clients
Performing Motivational Interviewing
Supporting Client Self-Management
Communication and Negotiation Skills
Performing Self-Care
Mentoring Co-Workers

Goal 2

STRENGTHEN ORGANIZATION CAPACITY

High Quality Care
Quality Assurance
Continuous Quality Improvement
Peer Review
Risk Management
Workforce Development
Electronic Health Records

Goal 3



- **Three Organization Goals**

- ✓ **Integrated Teams**
- ✓ **Provider Competencies**
- ✓ **Organization Capacity**

West End Health Center: Phase One

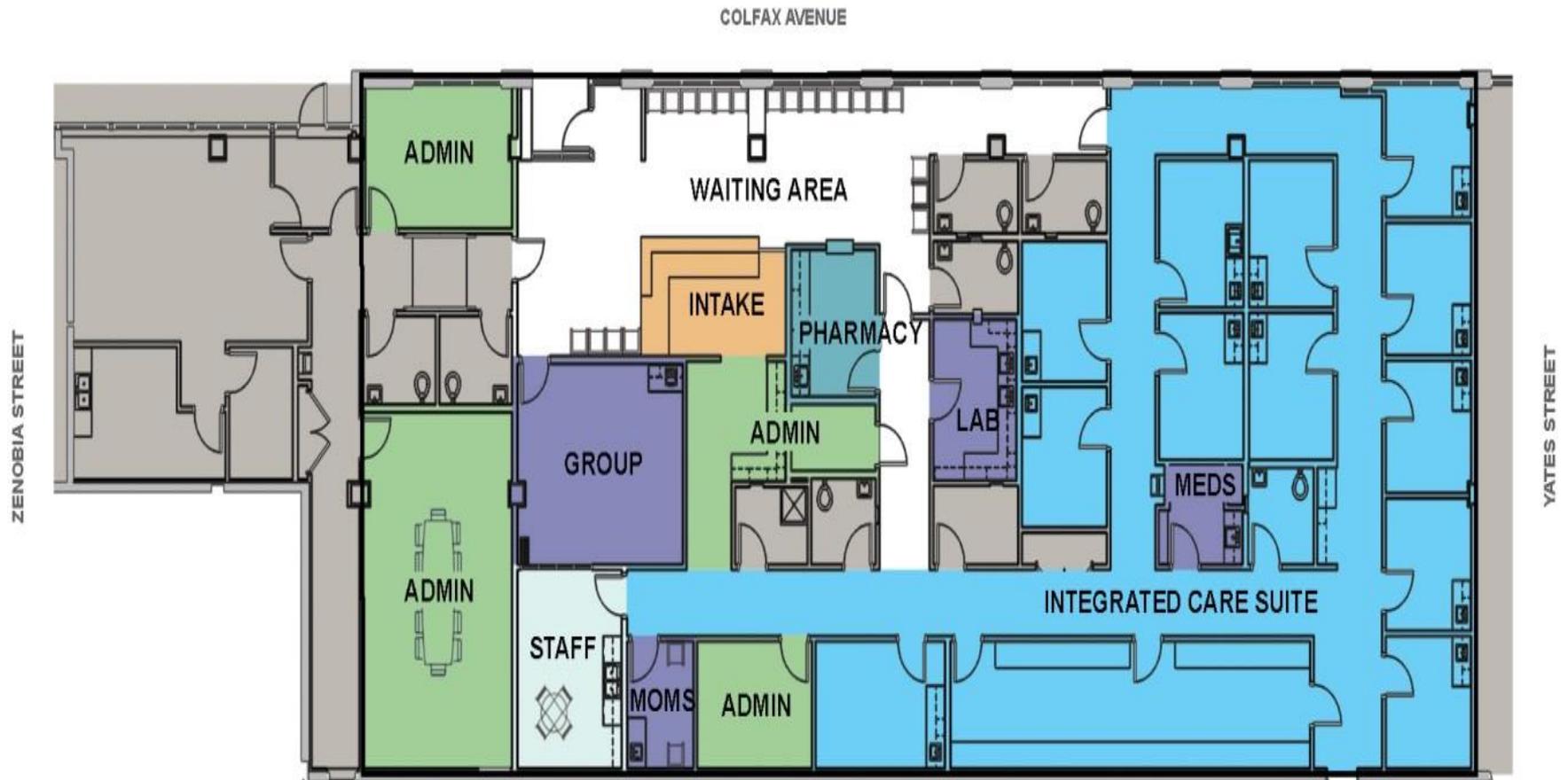


West End Clinic Full Integration

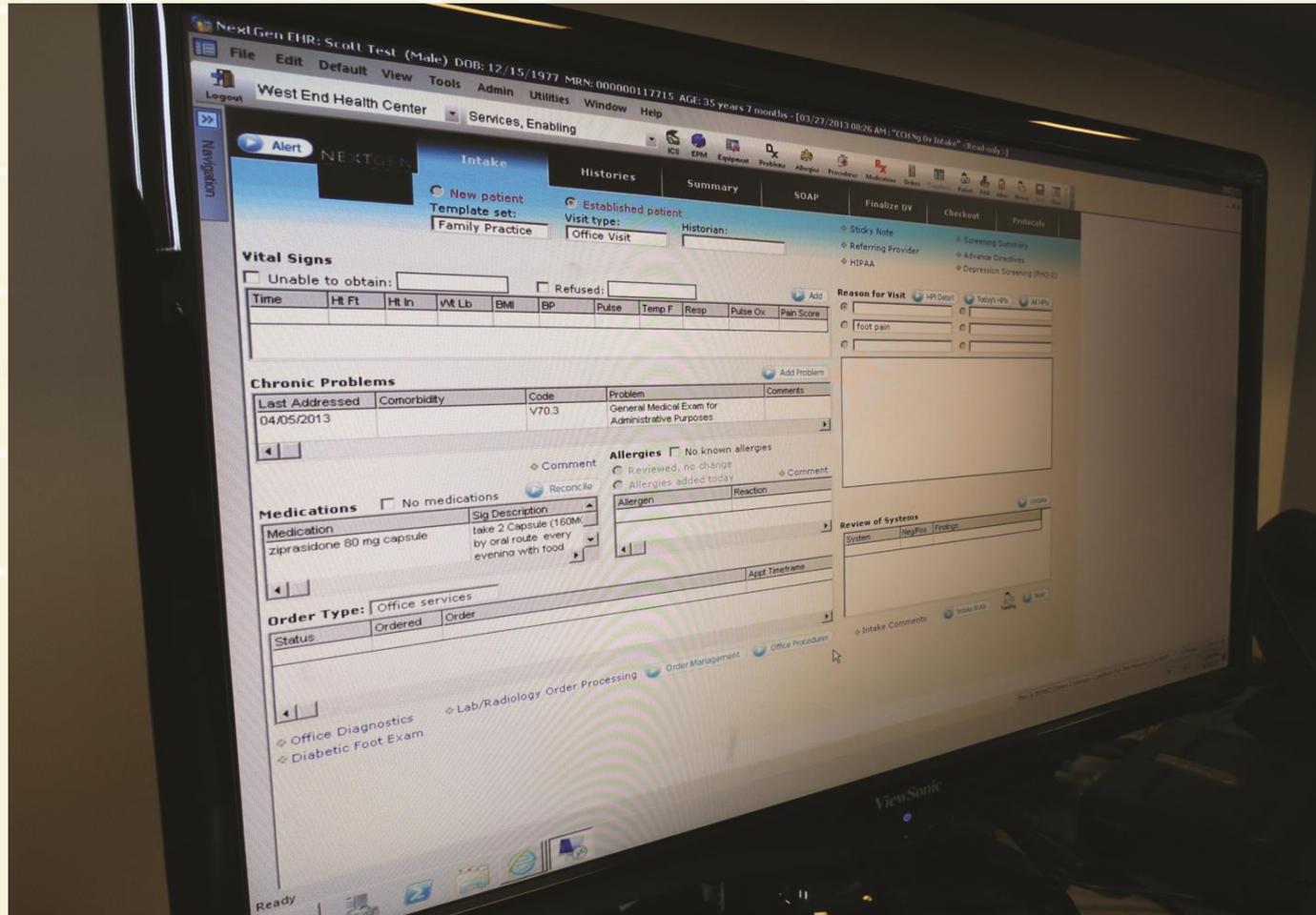


| Physical Care |
| Behavioral Health Care |
| Supportive Housing |

West End Health Center



EHR is Essential

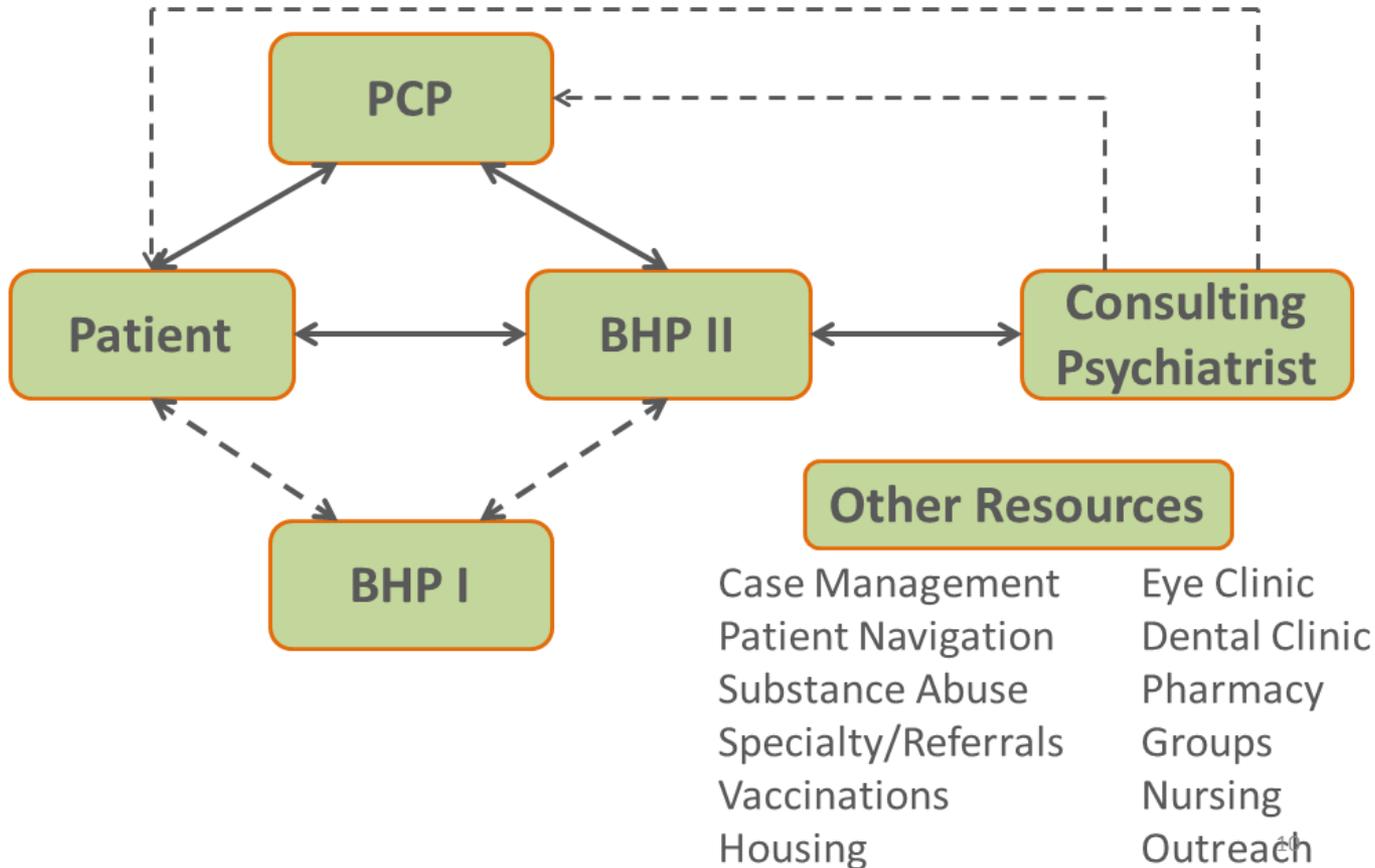


Behavioral Health Provider (BHP) is Central to the Model

Behavioral Health Provider (BHP)

- Member of the primary care team
- Main role - identify, consult, treat, triage and manage primary care patients with behavioral health and/or medical problems
- Goal is to improve their ability to function.

Behavioral Health Provider (BHP)



Who Are BHPs?

- **Multiple professions and license types**
 - Social Workers: LCSW, LSW
 - Counselors: LPC
 - Registered Psychotherapists: RP
 - Doctors of Behavioral Health: DBH
 - Psychologists: PhD, PsyD
 - Registered Nurses: RN
- **Additional specialist in CCH model**
 - Substance Abuse Counselors: LAC, CAC II, CAC III

Why is BHP Needed in Primary Care for Homeless?

- 50% of mental health care is currently provided in primary care
- 70% of community health patients have mental health and/or substance use disorders
- 70% of all primary care visits have some sort of psychosocial component
- 50-60% of non-adherence to psychoactive medications occur within the first 4 weeks
- One in four patients referred to specialty mental health do not make it to their first appointment

(Strosahl & Robinson, 2009)

Integrated Primary Behavioral Health Care for the Homeless

- **Targeted interventions**
- **Limited sessions**
- **Faster pace**
- **15-30 minute sessions**
- **Physician controls treatment**
- **Referral based on presentation**
- **Confidentiality includes PCP**
- **Shared medical record**
- **Public health approach**
- **Population-based vs individual-based**
- **Functional focus**
- **Medical and behavioral health**

How can BHPs Assist With Medical Patients Who Are Experiencing Homelessness?

- **Treatment compliance / medication adherence**
- **Ambivalence/motivation enhancement**
- **Goal setting**
- **Behavior change plans**
- **Coping with medical diagnoses**
- **Coping with stress**

Interventions Utilized:

- **Motivational Interviewing**
- **Cognitive Behavioral Therapy**
- **Acceptance and Commitment Therapy**
- **Solution-Focused Therapy**
- **Dialectical Behavioral Therapy**
- **Group Therapy**

Stout Street Health Center

| Physical Care |
| Behavioral Health Care |
| Supportive Housing |



| Patient Navigation | Case Management | Peer Mentors |
| Benefits Acquisition | Street Outreach |

Pilot Project: Stout Street Clinic



BHP Pilot – Green Pod Summary



Date	Number of Patients seen	Number of patients BHP saw	Number of patients referred to IBH upstairs
3/11/14	29	6	4
3/13/14	32	5	1
3/14/14	24	5	1
3/18/14	41	8	6
3/20/14	22	7*	3
3/21/14	40	2^	0
Totals	188	33	15
Percentage of total patients seen in pod		17.5%	8%

BHP Pilot – Blue Pod Summary

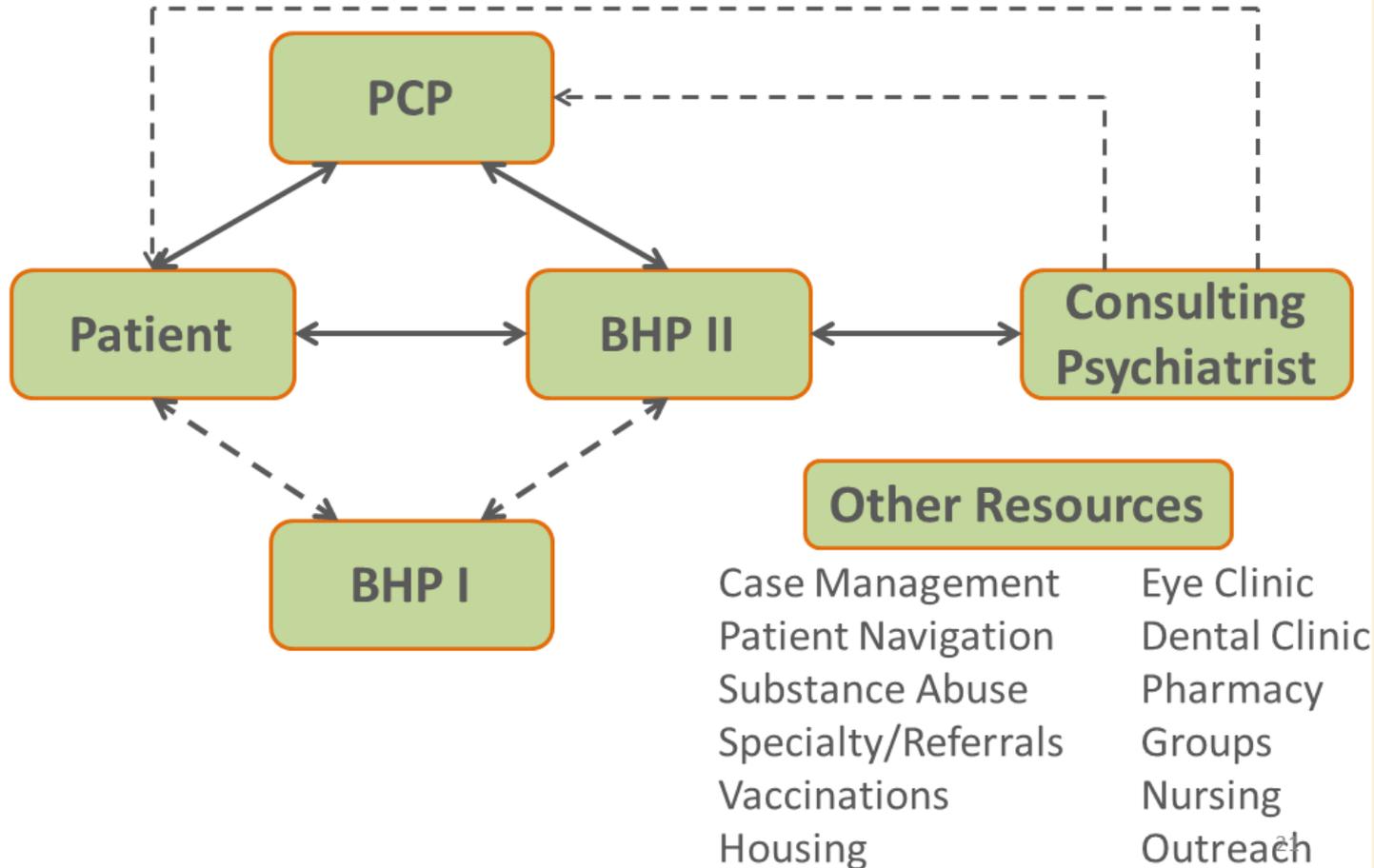


Date	Number of Patients seen	Number of patients BHP saw	Number of patients referred to IBH upstairs
3/25/14	5	1*	1
3/27/14	23	6^	2
3/28/14	41+	1#	1
4/3/14	22	7+	4
4/4/14	16	5=	1
Totals	107	20	9
Percentage of total patients seen in pod		19%	8%

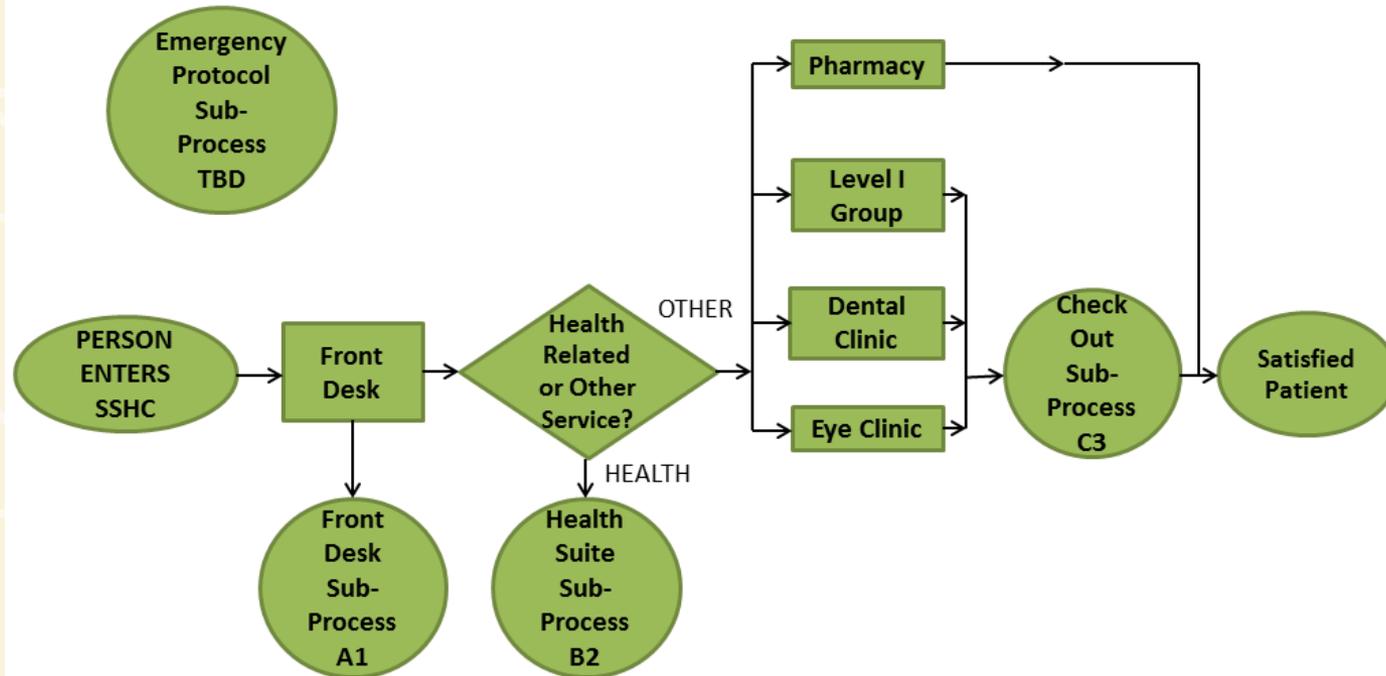
Reason for Referral

- Depression – 23
- Psychosis/Schizophrenia – 14
- Bipolar Mood Disorder – 8
- MH Hold Assessment – 6
- Anxiety – 6
- PTSD – 4
- ADD – 1
- Substance Abuse – 1
- Pain – 1
- Transgender Transition Readiness – 1
- School Problems – 1
- Diagnostic Clarification and Resourcing - 1

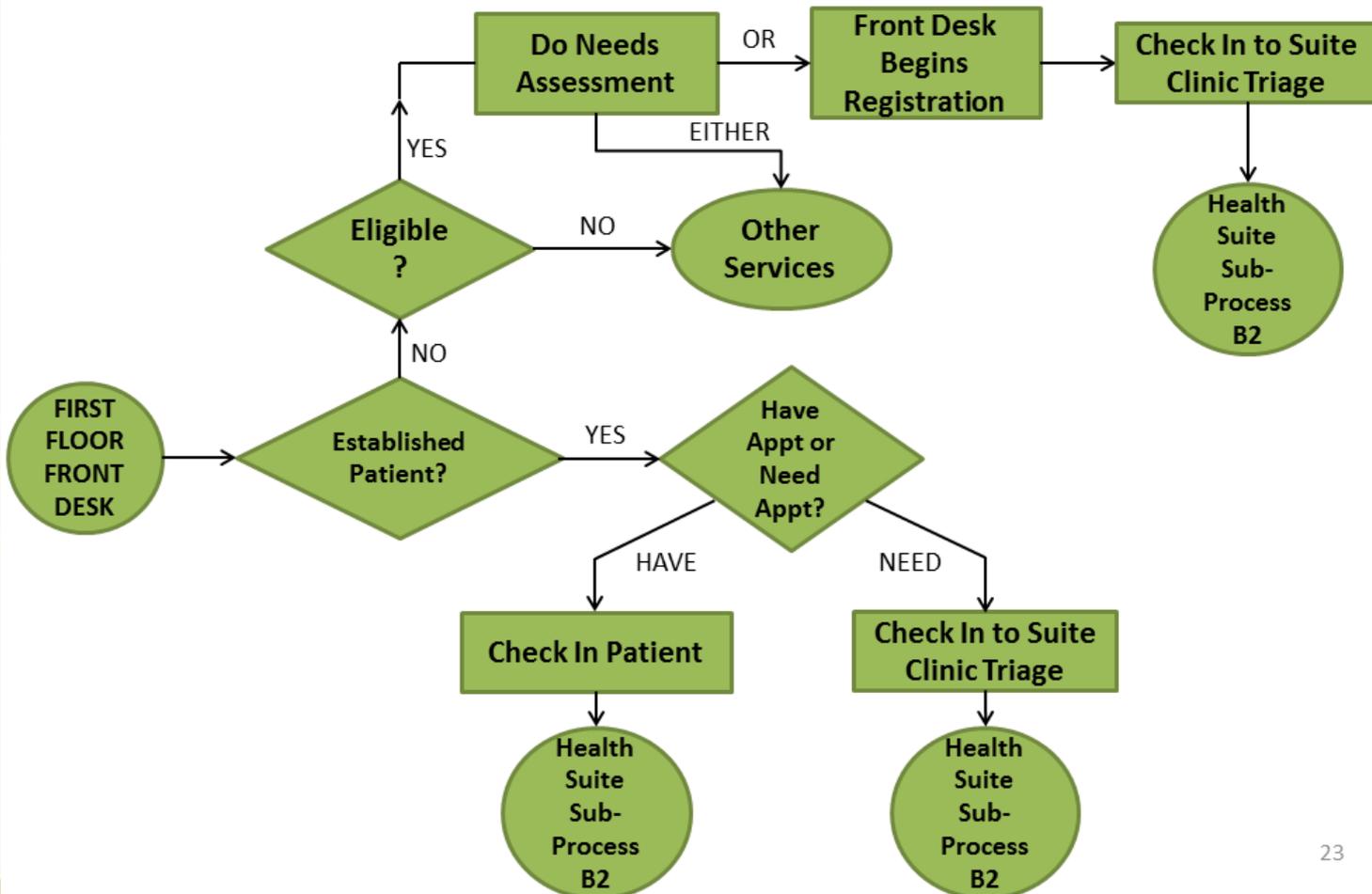
Behavioral Health Provider (BHP)



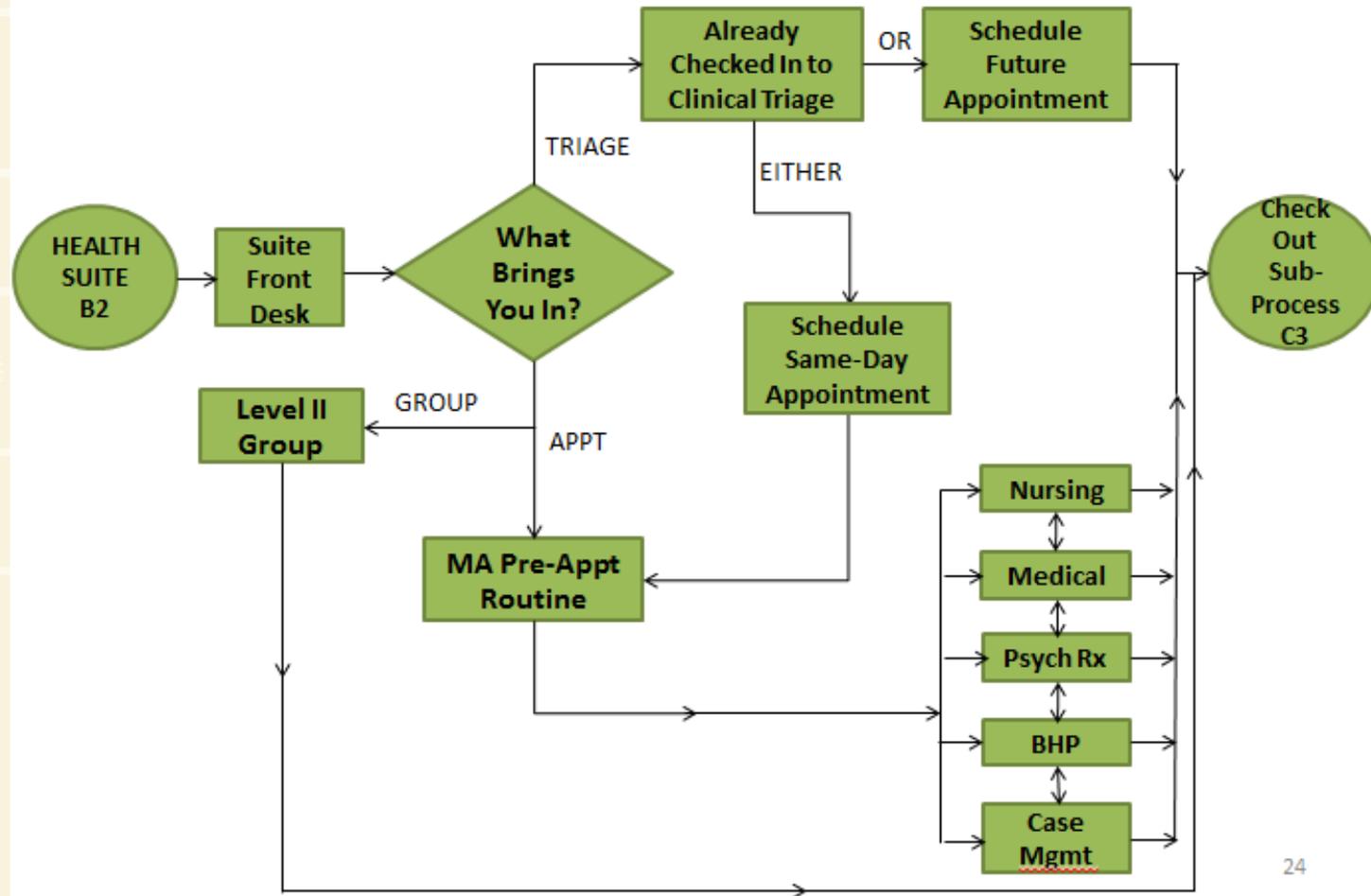
Integrated Health Care – Process Overview



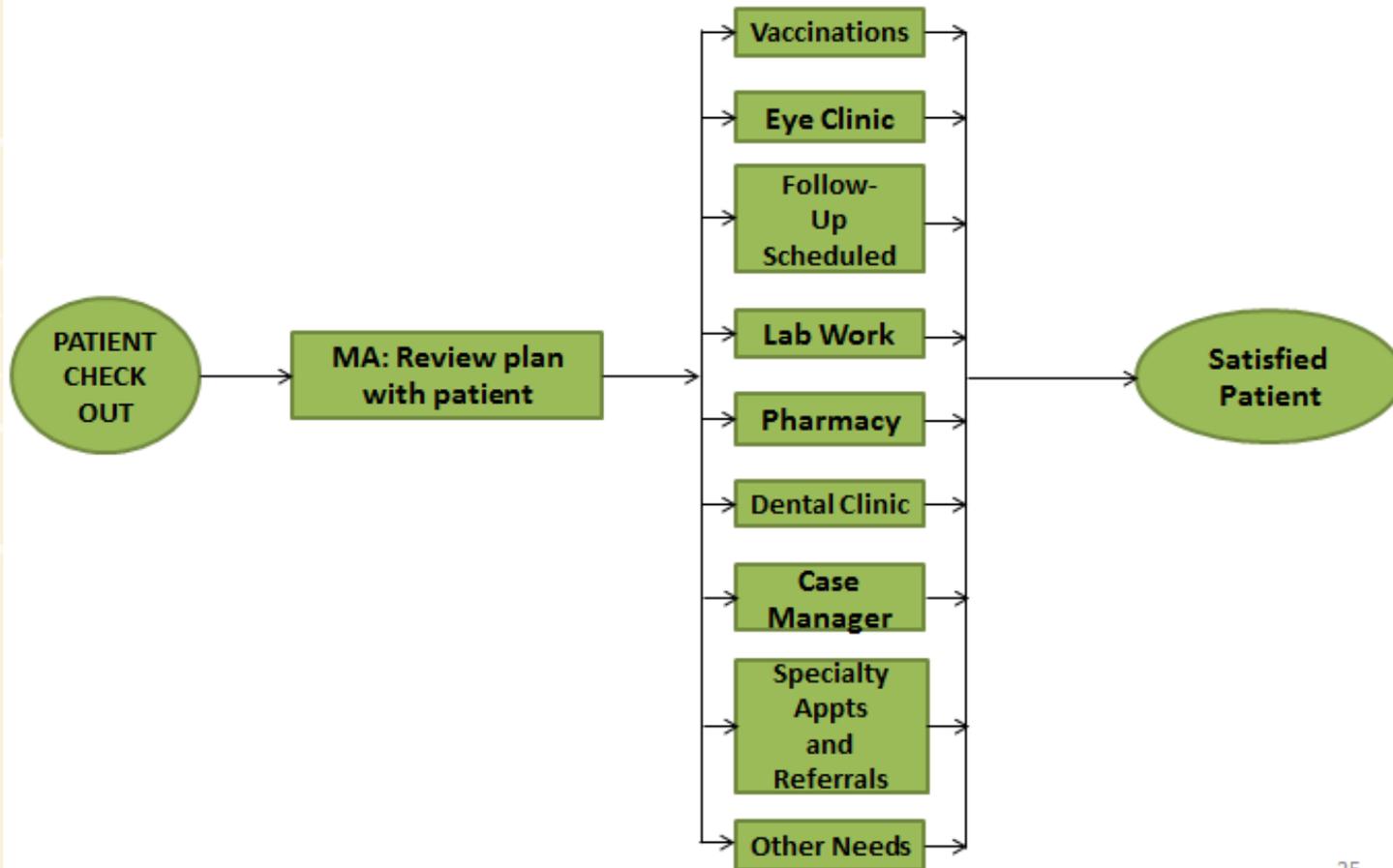
Integrated Health Care – First Floor Front Desk Sub-Process A1



Integrated Health Care – Health Suite Sub-Process B2



Integrated Health Care – Check Out Sub-Process C3



Audience Poll Question #1 and Chat Box Questions

Integrated Case Study



Case Study: Mr. A

- Mr. A is a middle aged man who presented to the Medical Team at our Stout Street Clinic for the first time, late on a Friday afternoon, this past winter.
- He was psychotic and suffering from severe frostbite to both his feet.

Mr. A

- Due to his mental illness, he was unable to care for his feet and was referred to respite.
- Nurses were unable to find a Medical Respite that would accept him, due to his untreated psychosis, loud outbursts, and irritability.
- He was referred to a local shelter, but instead continued to sleep outside on freezing cold nights.

Mr. A

- He was referred to our Mental Health Team by Medical after observed to be responding to internal stimuli.
- He was evaluated by MH and placed on a Mental Health Hold for grave disability.
- Unfortunately, the ER discharged him late on a cold night.
- He continued to sleep outside.

Mr. A

- He was started on Risperidone and his psychiatric symptoms appeared to improve.
- He was accepted to Medical Respite.
- For multiple weeks, he stayed in respite and returned for regular foot care.
- He was evaluated by a foot specialist and scheduled for amputation.

Mr. A

- He stopped taking Risperidone.
- He missed his pre-op appointment and stopped coming in for foot care.
- He returned to the clinic several weeks later, requesting pain management.
- He had been prescribed Tramadol, but took up to 7 tablets at once and ran out. He was prescribed Tylenol with codeine by a covering MD and quickly took the entire bottle.

Mr. A

- It was determined that his infection risk was too great for outpatient care; he was referred to a local ER anticipating he might be taken in for emergency surgery.
- He was not admitted.
- Approximately 1 week later, he was seen in MH and switched to Abilify, after reporting that the Risperidone was too sedating.
- He did not follow up in medical and was not seen again. A nurse heard that he was camping east of town under a bridge.

Outcomes

- The team met to discuss how we could engage this gentleman in both medical and mental health care, as well as move him toward housing and public benefits.
- Mr. A was discussed in the outreach meeting. That afternoon, an outreach worker found him and Mr. A informed him that he had an appointment the next day with surgery at a local hospital. Mr. A was then transported by outreach and he received wound care.

Outcomes

- Mr. A was placed in a motel with a 2-week voucher in hopes that he would be willing to come to the clinic daily for wound care and medication monitoring.
- The PCP ordered Tramadol to be delivered to our clinic.
- During those daily visits, Mr. A was provided with wound care, dispensed Tramadol for pain, (1 tab in clinic and 1 to take with him, 5 to take with him on Friday).
- He receives a daily dose of Abilify and is encouraged to consider a long-acting injectable.

Outcomes

- Outreach transports him 4 days/week and he is offered bus fare when needed.
- RN's have the greatest alliance with Mr. A and interact with him at every visit.
- Mental Health staff stop into medical visits and attempt to engage him.

Outcomes

- We hope he will become familiar with all potential providers on his team, in order to increase engagement.
- The BHP has contacted Medicaid to establish increased case management services and to see if he is eligible for a group home.
- The Patient Navigator is discussing him further with Respite, in hopes of placing him there until his wounds heal.
- He has been referred to the Benefits Acquisition Team.
- He has been referred to Supportive Housing.

SAMHSA-HRSA
Center for Integrated Health Solutions



Audience Poll Question #2 and Chat Box Questions

Grantee Perspective Presenters

DESC

Downtown Emergency Services Center

Seattle, WA

Christina Clayton, LICSW, CDP - Clinical Program Manager (DESC)

Lisa Johnson, ARNP (HMC)

Lew Middleton, Peer Specialist (DESC)



Outline

- Agency mission
- Program description
- Considerations
- Strategies
- Findings
- Lessons learned



Overview of DESC



- Emergency shelter
- Drop-in/Day Services
- Licensed mental health
- Licensed chemical dependency
- Supported Employment
- Crisis Diversion
- Permanent Supportive housing
- High level of integration across programs

Core Convictions

- Housing is a basic human right, not a reward for clinical success or compliance.
- Once the chaos of homelessness is eliminated from a person's life, clinical and social stabilization occur faster and are more enduring.



Homelessness is still a crisis...

King County

- More than 2 million residents (14th most populous in U.S.)



One Night Count in King County:

- January 24, 2014—800+ volunteers
- 3,123 living outside
- 2,906 in emergency shelters
- 3,265 in transitional housing

TOTAL = 9,294

- Estimate 20% meet chronic homelessness criteria (1,858)



Our Program

- **Primary care clinics co-located in two sites in downtown Seattle:**
 - Downtown Emergency Service Center (DESC),
 - Harborview Mental Health & Addiction Services (HMHAS)
- **Both sites serve high need urban population, high percent:**
 - Experiencing homelessness, including chronic homelessness
 - With co-occurring substance use issues
- **Target populations**
 - Year 1 focus: Individuals with diagnosis of psychotic disorder, taking atypical antipsychotic medication; no regular source of primary care
 - Current focus: Anyone served by either clinic who is not connected or poorly connected with primary care.



Our Team

- Advanced Registered Nurse Practitioner (ARNP)
- Nurse Care Coordinator (RN)
- Peer Specialist
- Behavioral Health Staff: Case Managers, Nurses, Psychiatric Providers, Peers, Employment, Substance Use staff, Drop-in staff, Shelter and Housing staff

Role of Primary Care Partner

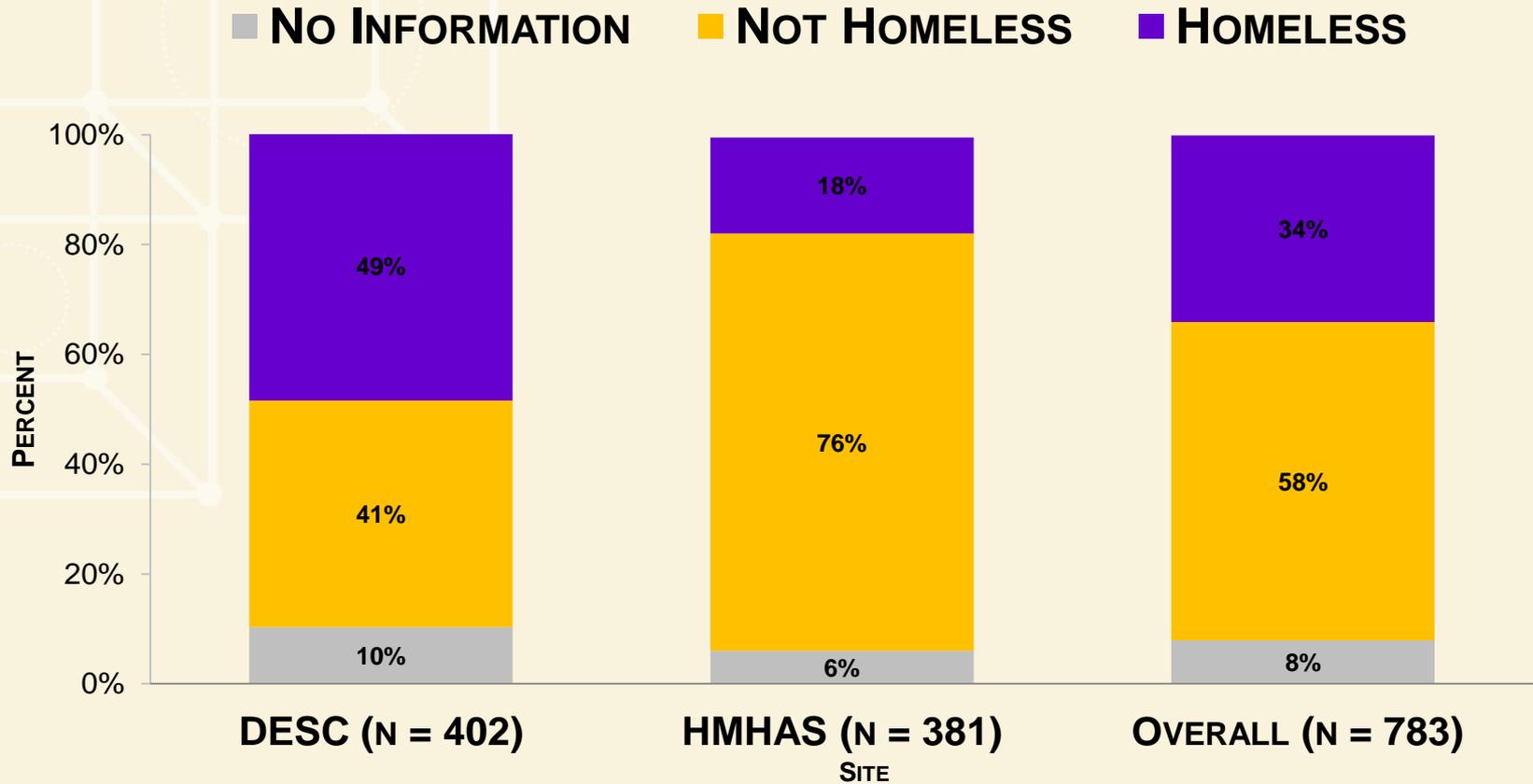
- Mission and Core Values
- History of Partnership
- Location & Logistics
- Services Provided
- Aligning Approach
- Collaboration with Teams





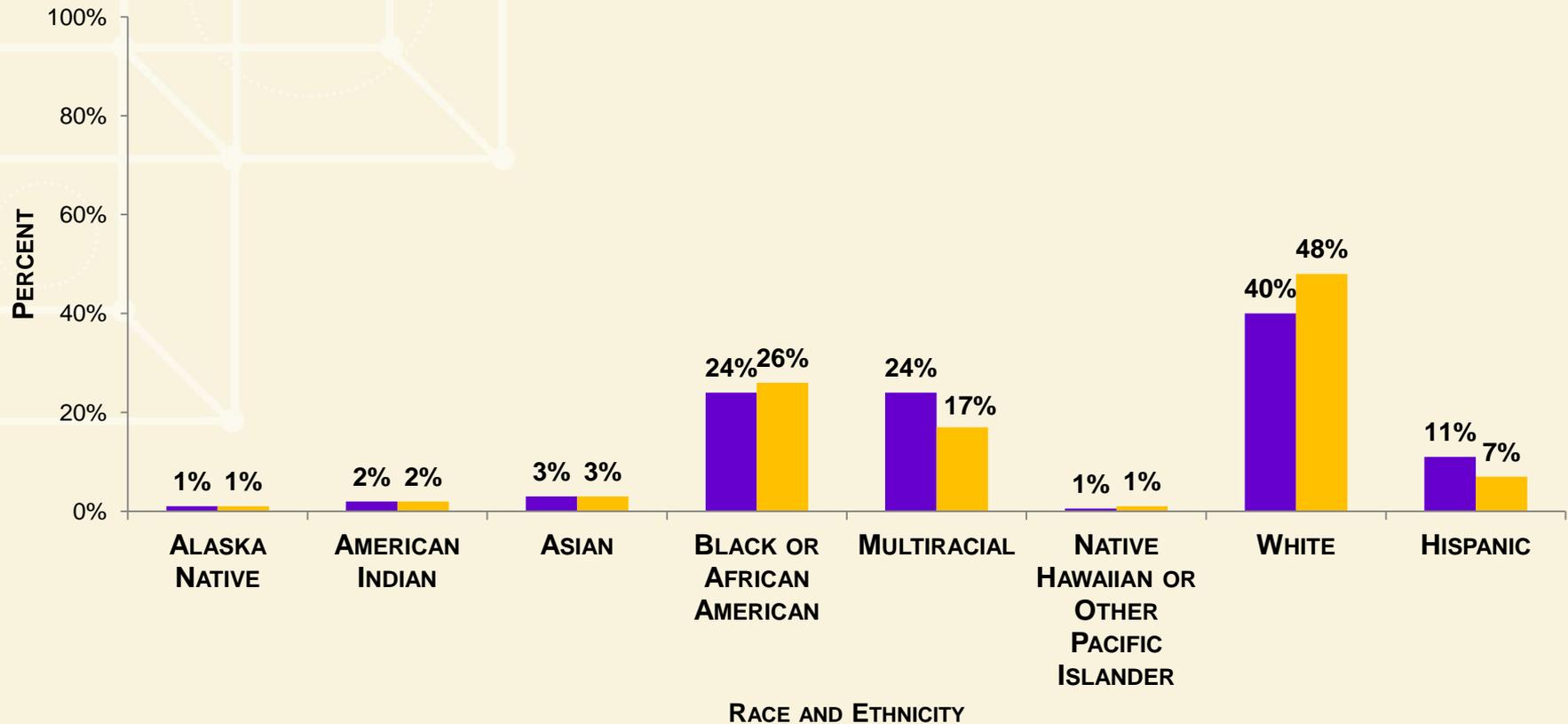
People We Serve

PBHCI: HOUSING STATUS AT BASELINE BY SITE AS OF 05/23/2014, N =783



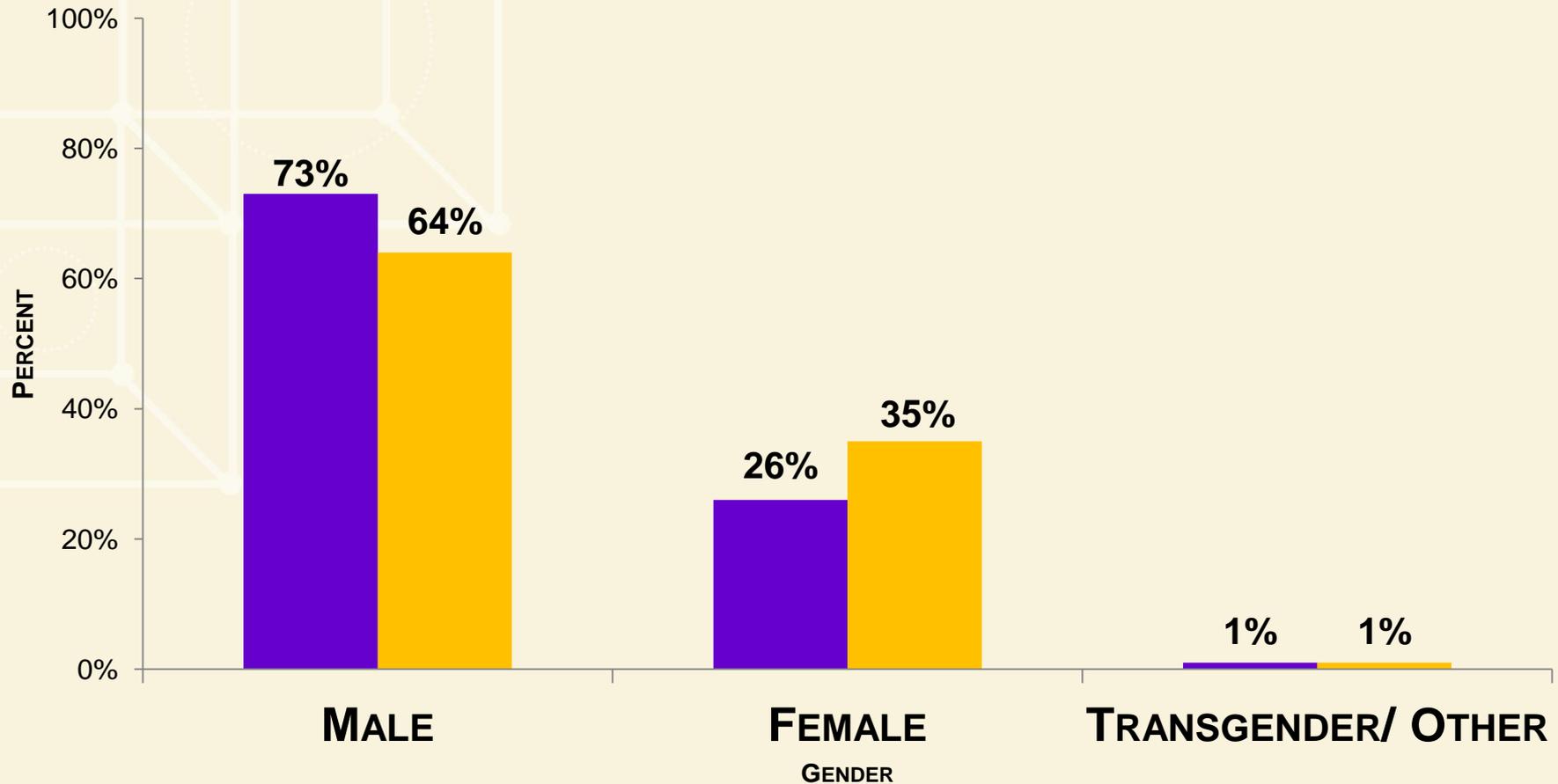
PBHCI: RACE AND ETHNICITY BY HOUSING STATUS AS OF 05/23/2014
N = 722

■ HOMELESS (N = 268) ■ NOT HOMELESS (N = 454)

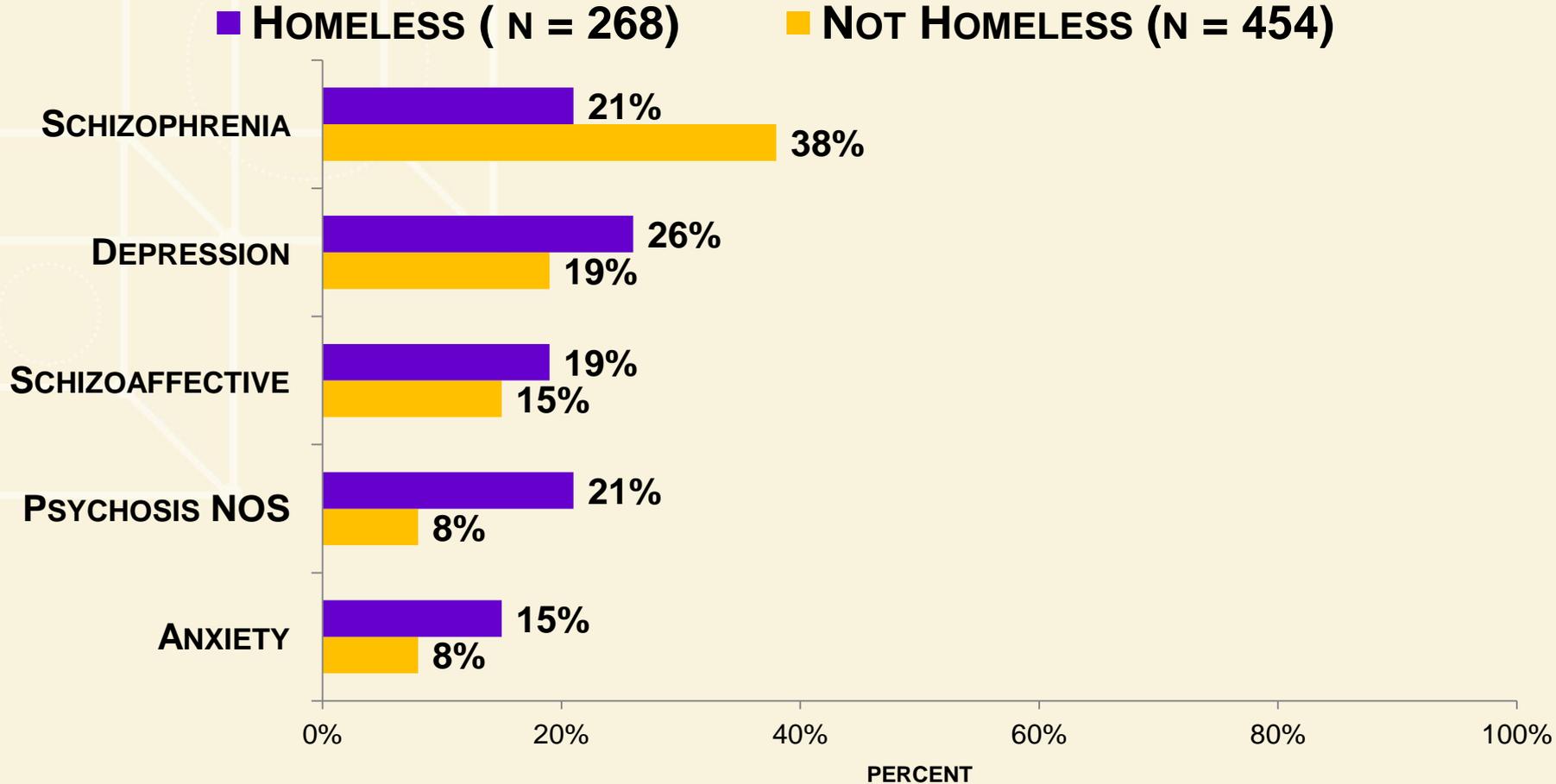


PBHCI: GENDER BY HOUSING STATUS AS OF 5/23/2014, N = 722

■ HOMELESS (N = 268) ■ NOT HOMELESS (N = 454)

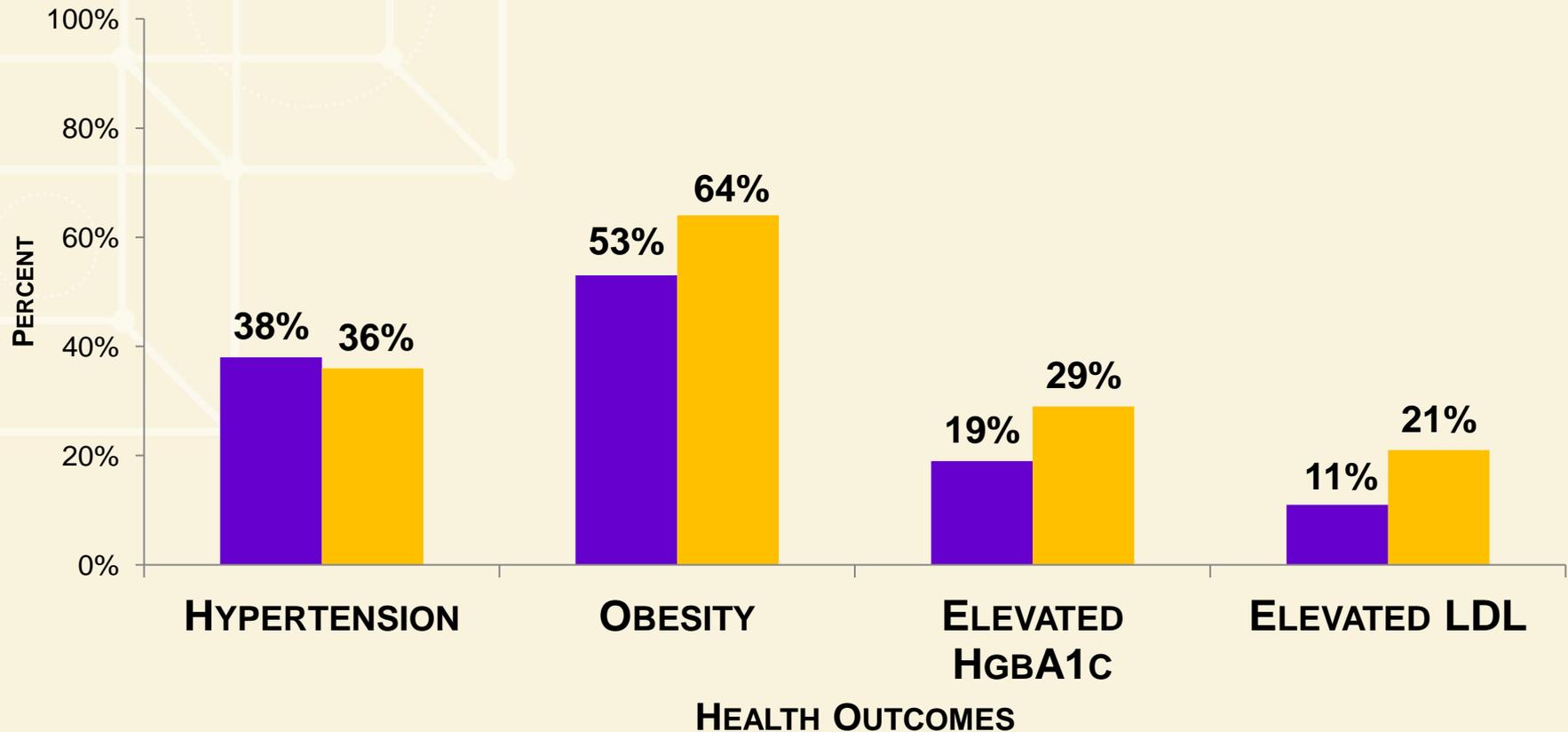


**PBHCI: MENTAL HEALTH DIAGNOSES BY HOUSING STATUS AS OF 05/23/2014,
N = 722**

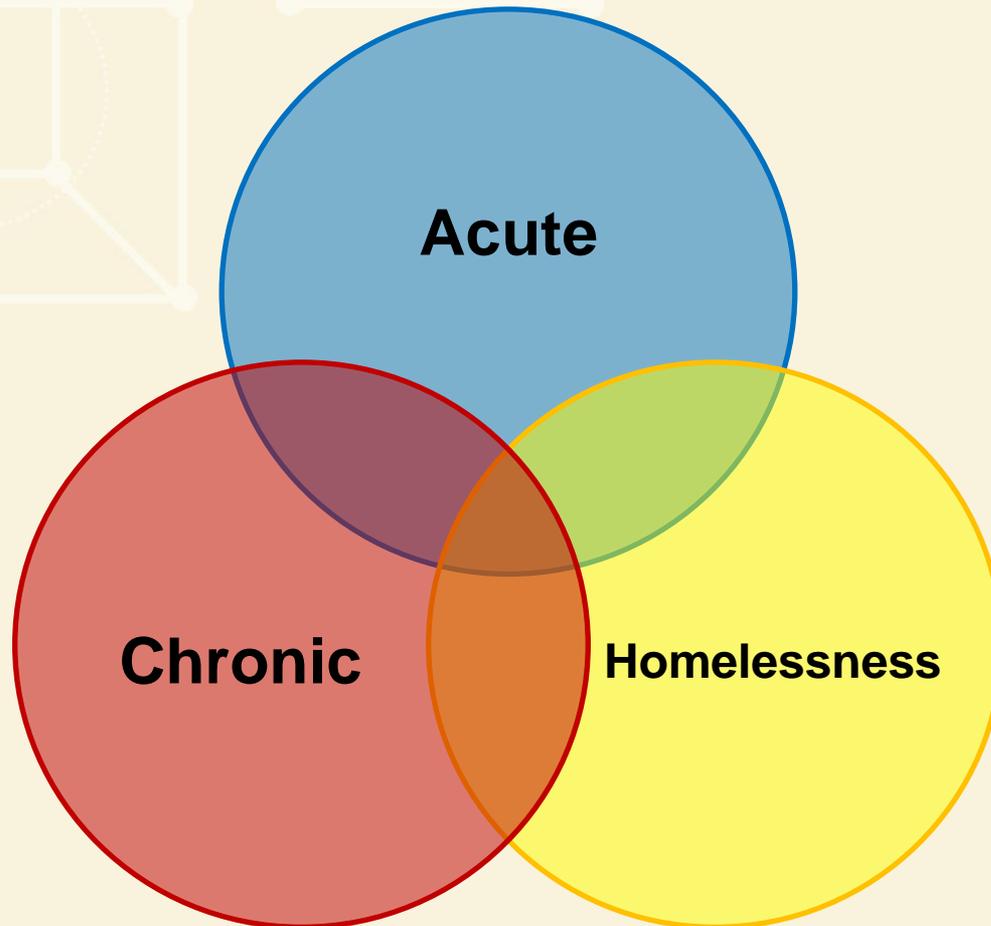


**PBHCI: % OF CLIENTS AT-RISK FOR SELECTED HEALTH OUTCOMES AT
BASELINE BY HOUSING STATUS AS OF 5/23/2014, N = 722**

■ HOMELESS (N = 268) ■ NOT HOMELESS (N = 454)



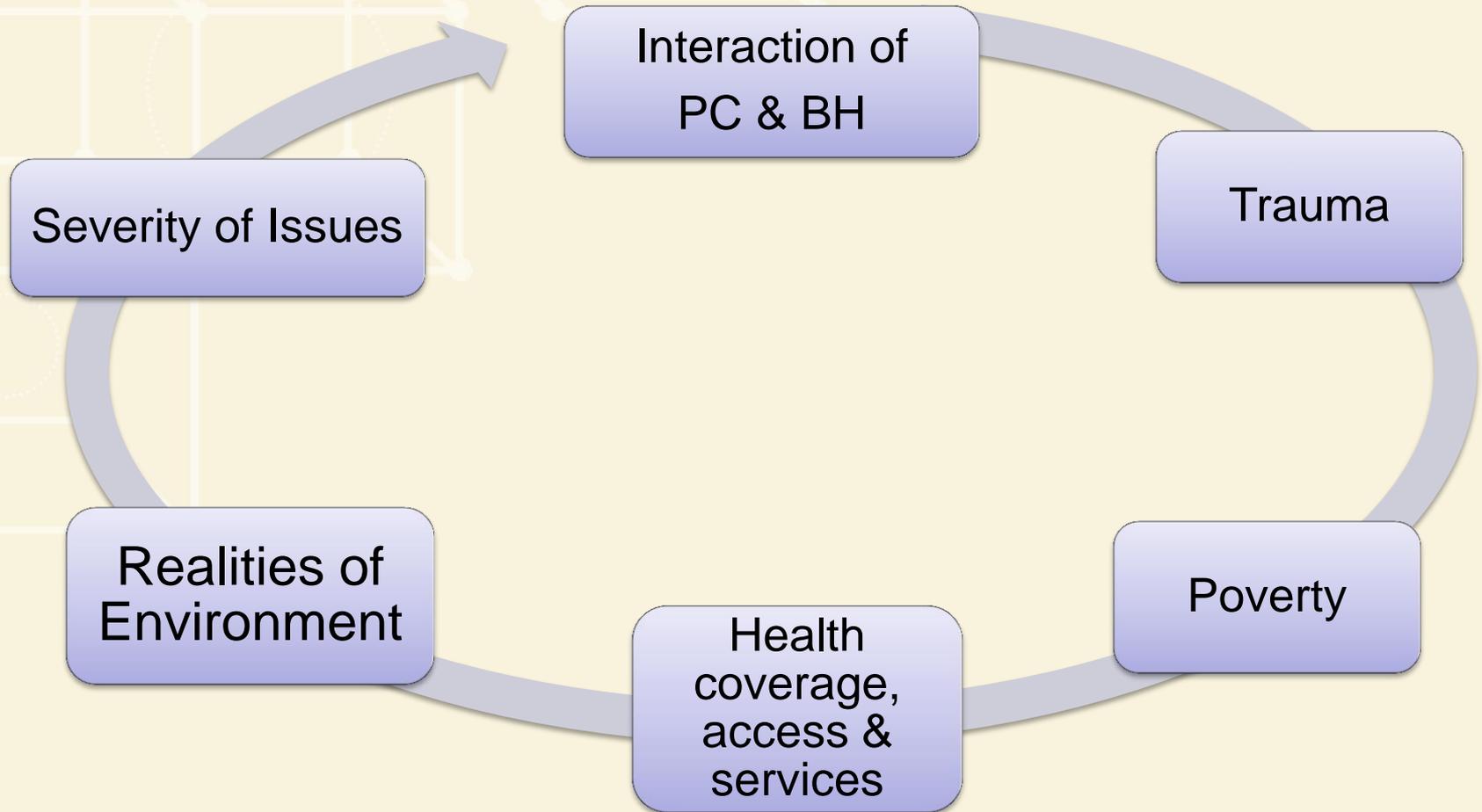
Common Integrated Health Care Issues and Concerns



Impact of Homelessness on Care



Impact of Homelessness on Care



Challenges for: people served, staff, system

- Fear & Stigma
- Understanding Motivation
- Health and Cultural Literacy
- Feeling Anxious & Overwhelmed
- Health Care Reform



A Journey Towards Recovery



Engage



Basic Needs
Dignity and Respect
Outreach
Peer Services

Educate



Access to Resources
Familiarity with Staff
Relevant Approaches

Empower



Wellness Activities

Consumer Advisory Board

Whole Health Approach

Harm Reduction & Motivational Interviewing

Advocacy

Strategies to Meet Grant Requirements

- Introduction & Engagement
- Patient Enrollment
- Collecting Data & Follow Up Measures
- Referral to Specialty Care and Completion

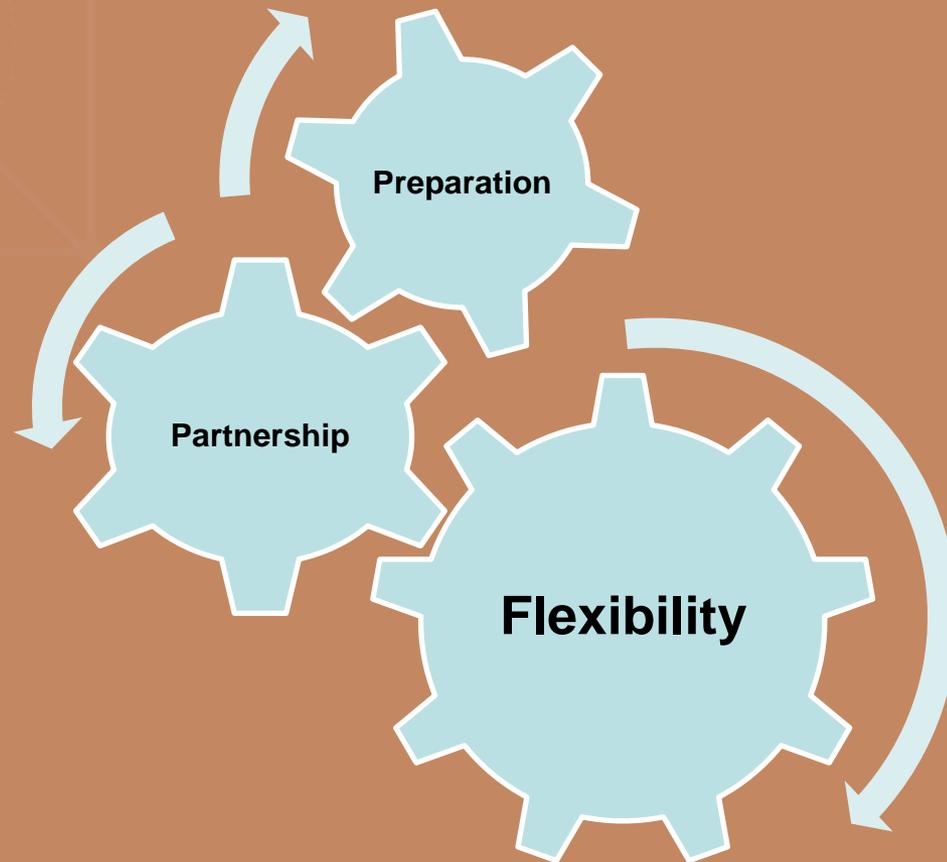


Team Building



- Review of data collection/analysis, goals of grant
- Discuss successes and challenges
- Share learning from webinars, other TA, workshops
- Collect information to help with reports
- Hold quarterly GPO conference calls with team
- Host visitors from other local grantee sites
- Dialogue and problem-solve from all levels
- Hear stories from those doing the direct work

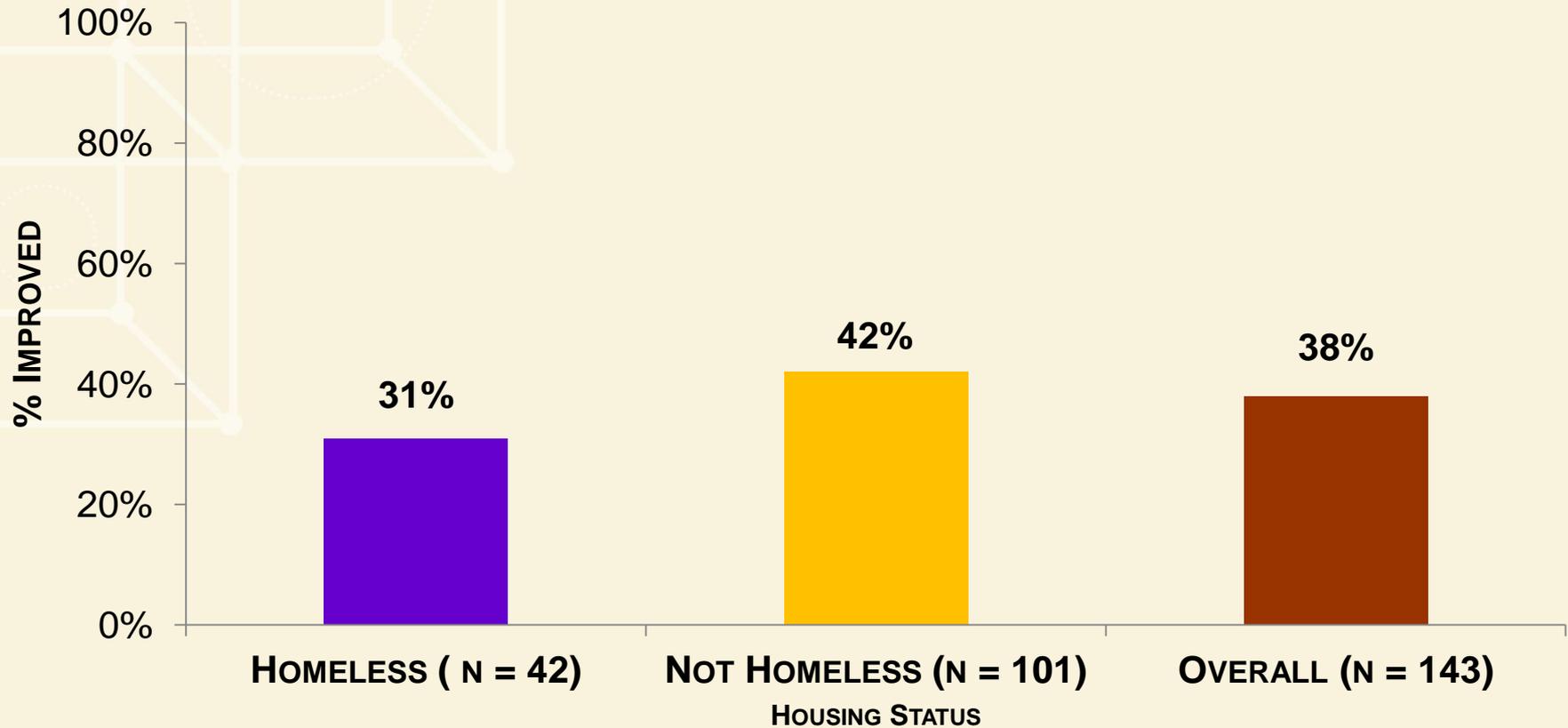
Ideas to Help Manage “No Show” Concerns



Evaluate

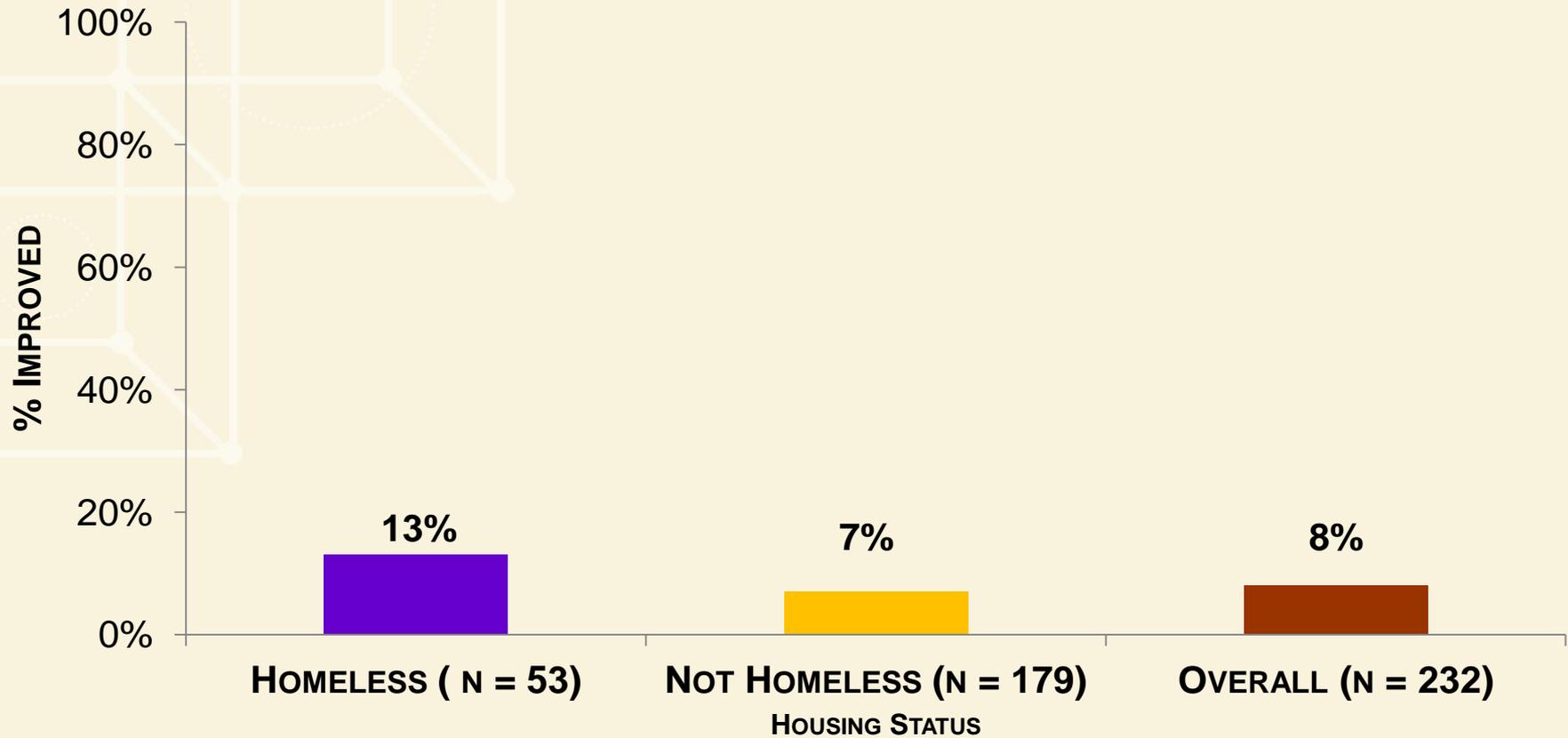
**CLIENTS WITH HYPERTENSION AT BASELINE AS OF 5/23/2014, N = 143 :
PERCENT IMPROVED AT MOST RECENT REASSESSMENT BY HOUSING STATUS**

PLEASE NOTE: HYPERTENSION REFERS TO SYSTOLIC BP \geq 130 MMHG AND/OR DIASTOLIC BP \geq 85MMHG



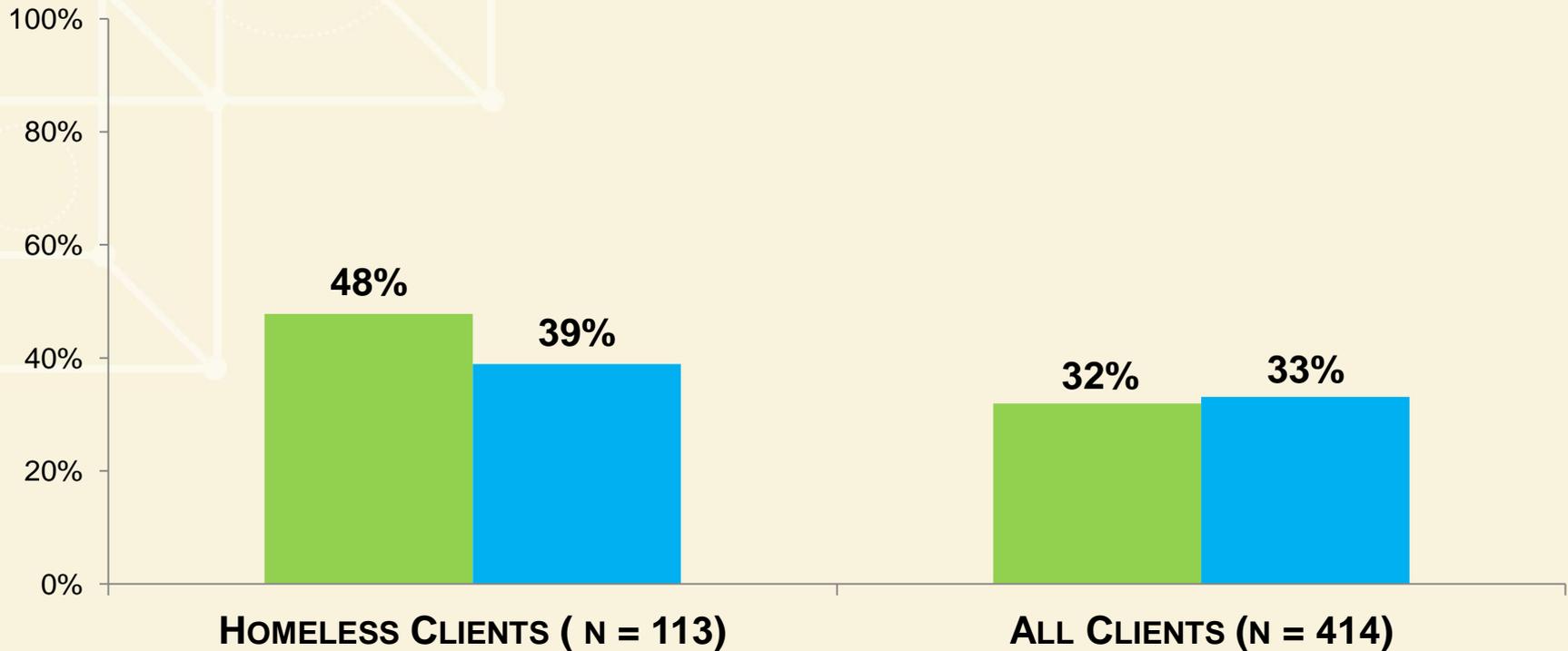
**OBESSE CLIENTS AT BASELINE AS OF 5/23/2014, N = 232 :
PERCENT IMPROVED AT MOST RECENT REASSESSMENT BY HOUSING STATUS**

PLEASE NOTE: OBESITY REFERS TO A BMI ≥ 25 K/M²



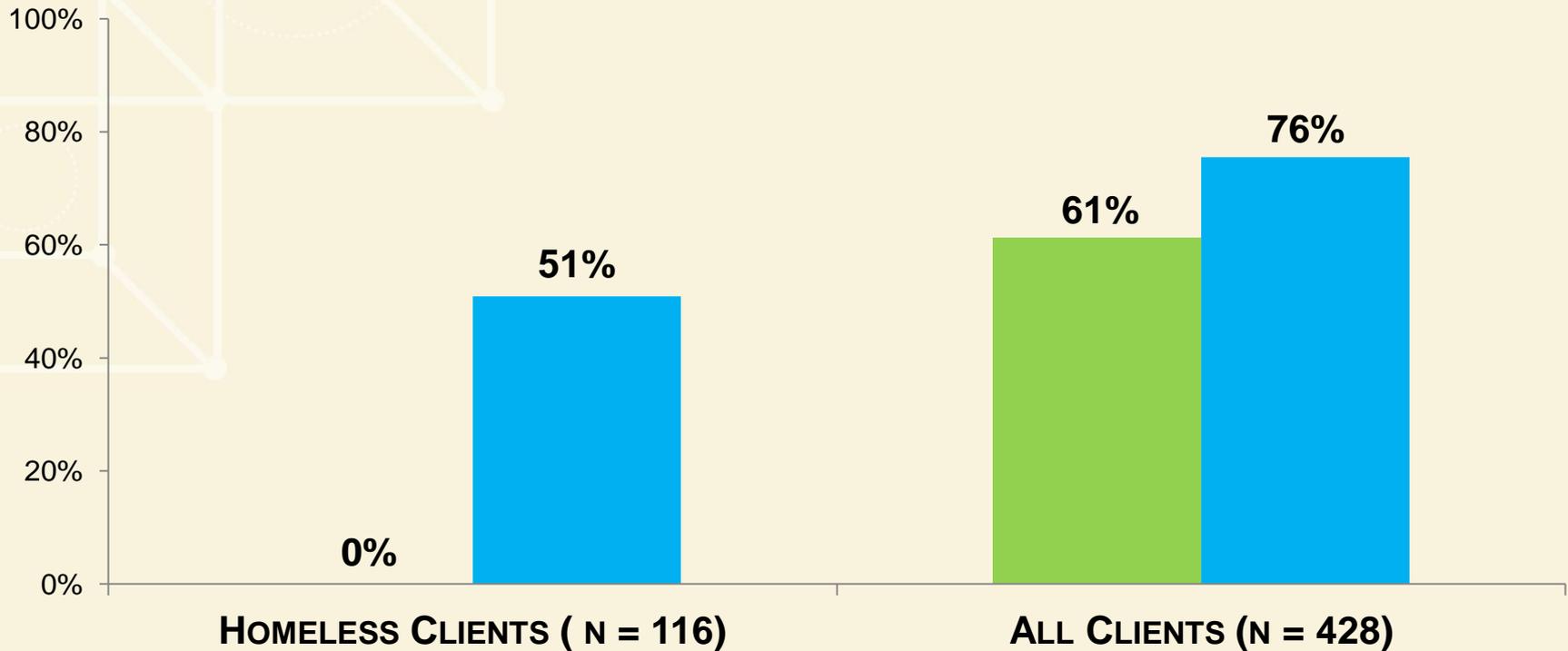
PERCENT OF CLIENTS USING ILLEGAL SUBSTANCES

■ POSITIVE AT BASELINE ■ POSITIVE AT SECOND INTERVIEW



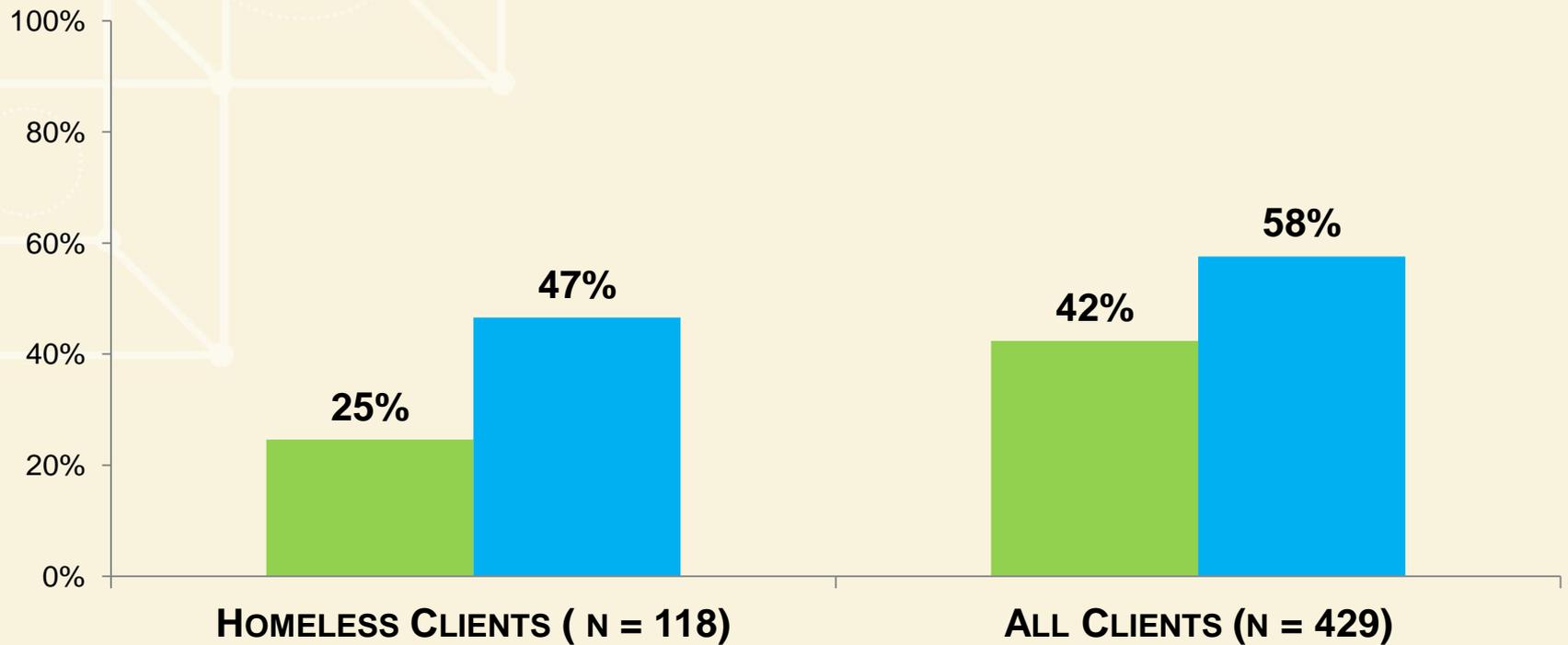
PERCENT OF CLIENTS WITH A STABLE PLACE TO LIVE

■ POSITIVE AT BASELINE ■ POSITIVE AT SECOND INTERVIEW



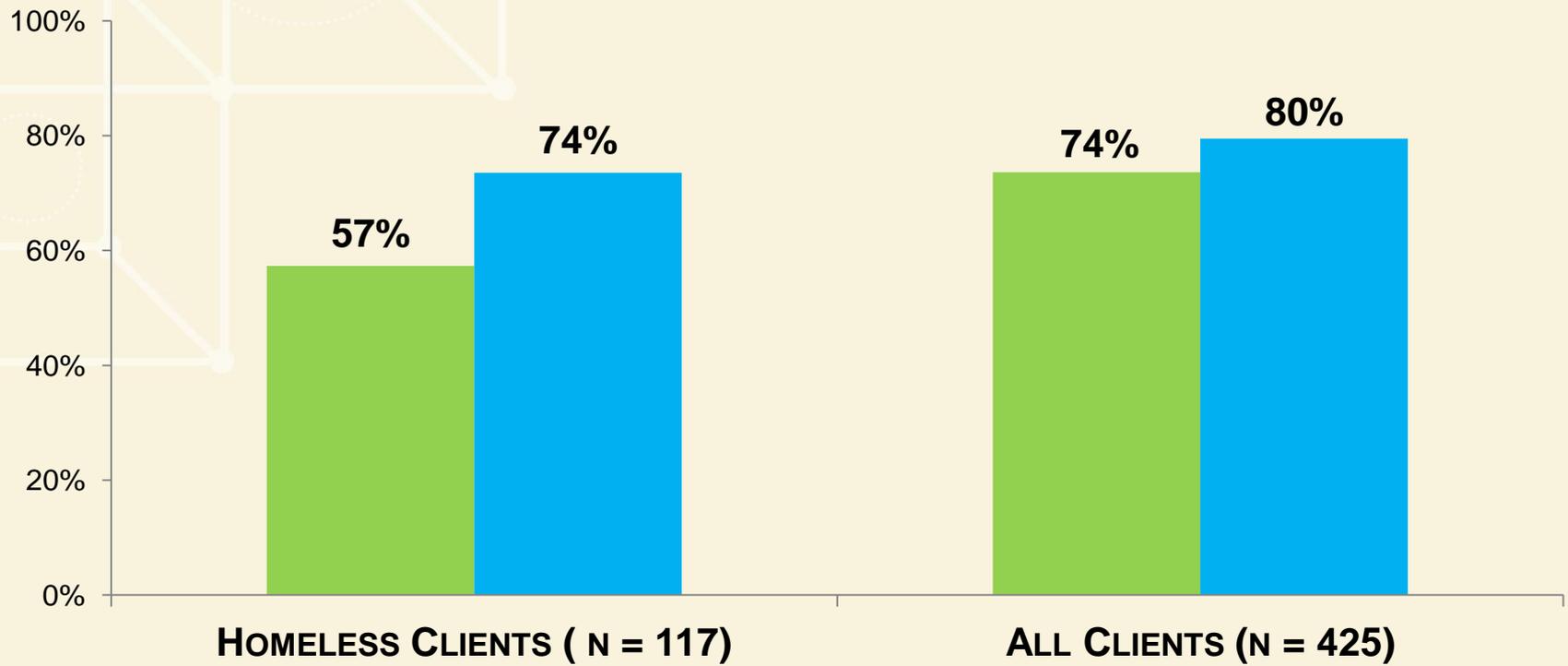
PERCENT OF CLIENTS FUNCTIONING IN EVERYDAY LIFE

■ POSITIVE AT BASELINE ■ POSITIVE AT SECOND INTERVIEW



PERCENT OF CLIENTS WITHOUT SERIOUS PSYCHOLOGICAL DISTRESS

■ POSITIVE AT BASELINE ■ POSITIVE AT SECOND INTERVIEW

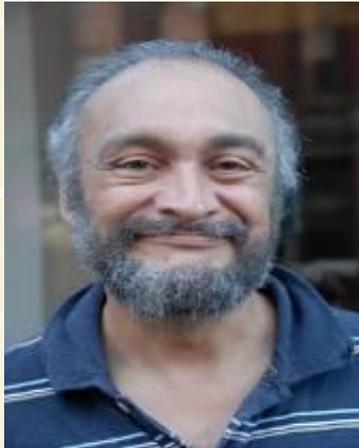


Lessons Learned

- Understand the Issues
- Approach Care Delivery with Respect
- See the big picture



Scenarios



Final Questions

**Website for Resources,
Presenter Photos/Bios,
Webinar Slides and Recording**

Special Thanks to Our Presenters!

Colorado Coalition for the Homeless (Denver, CO)

- **David Ott, MD/MBA** Medical Director of Integrated Health Services
- **Dr. Marilyn Smith,** Psychiatrist

Downtown Emergency Services Center, (Seattle, WA)

- **Christina N. Clayton, LICSW, CDP,** PBHCI Project Coordinator
- **Lisa Johnson ARNP,** PBHCI Primary Care Provider
- **Lew Middleton,** PBHCI Peer Specialist