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
Colorado Coalition for the Homeless Integrated Health Services Model

- Developed in 3 Phases:
  - West End Clinic
  - Stout Street Clinic
  - Stout Street Health Center
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 |
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)

PCP

Patient

BHP II

Consulting Psychiatrist

BHP I

Other Resources

Case Management
Patient Navigation
Substance Abuse
Specialty/Referrals
Vaccinations
Housing

Eye Clinic
Dental Clinic
Pharmacy
Groups
Nursing
Outreach

www.integration.samhsa.gov
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

<table>
<thead>
<tr>
<th>Targeted interventions</th>
<th>Confidentiality includes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited sessions</td>
<td>PCP</td>
</tr>
<tr>
<td>Faster pace</td>
<td>Shared medical record</td>
</tr>
<tr>
<td>15-30 minute sessions</td>
<td>Public health approach</td>
</tr>
<tr>
<td>Physician controls</td>
<td>Population-based vs</td>
</tr>
<tr>
<td>treatment</td>
<td>individual-based</td>
</tr>
<tr>
<td>Referral based on</td>
<td>Functional focus</td>
</tr>
<tr>
<td>presentation</td>
<td>Medical and behavioral</td>
</tr>
<tr>
<td></td>
<td>health</td>
</tr>
</tbody>
</table>
How can BHPs Assist With Medical Patients Who Are Experiencing Homelessness?

<table>
<thead>
<tr>
<th>Treatment compliance / medication adherence</th>
<th>Interventions Utilized:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambivalence/motivation enhancement</td>
<td>• Motivational Interviewing</td>
</tr>
<tr>
<td>Goal setting</td>
<td>• Cognitive Behavioral Therapy</td>
</tr>
<tr>
<td>Behavior change plans</td>
<td>• Acceptance and Commitment Therapy</td>
</tr>
<tr>
<td>Coping with medical diagnoses</td>
<td>• Solution-Focused Therapy</td>
</tr>
<tr>
<td>Coping with stress</td>
<td>• Dialectical Behavioral Therapy</td>
</tr>
<tr>
<td></td>
<td>• Group Therapy</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Date</th>
<th>Number of Patients seen</th>
<th>Number of patients BHP saw</th>
<th>Number of patients referred to IBH upstairs</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/11/14</td>
<td>29</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>3/13/14</td>
<td>32</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>3/14/14</td>
<td>24</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>3/18/14</td>
<td>41</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>3/20/14</td>
<td>22</td>
<td>7*</td>
<td>3</td>
</tr>
<tr>
<td>3/21/14</td>
<td>40</td>
<td>2^</td>
<td>0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>188</strong></td>
<td><strong>33</strong></td>
<td><strong>15</strong></td>
</tr>
<tr>
<td><strong>Percentage of total patients seen in pod</strong></td>
<td><strong>17.5%</strong></td>
<td></td>
<td><strong>8%</strong></td>
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</tbody>
</table>
# BHP Pilot – Blue Pod Summary

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

- PCP
- Patient
- BHP II
- Consulting Psychiatrist
- Other Resources:
  - Case Management
  - Patient Navigation
  - Substance Abuse
  - Specialty/Referrals
  - Vaccinations
  - Housing
  - Eye Clinic
  - Dental Clinic
  - Pharmacy
  - Groups
  - Nursing
  - Outreach
Integrated Health Care – First Floor Front Desk Sub-Process A1

1. FIRST FLOOR FRONT DESK
   - Eligible?
     - YES: Do Needs Assessment
       - OR: Front Desk Begins Registration
         - Check In to Suite Clinic Triage
     - NO: Other Services
       - NO: Health Suite Sub-Process B2
       - YES: Established Patient?
         - NO: HAVE: Check In Patient
           - Health Suite Sub-Process B2
         - NEED: Check In to Suite Clinic Triage
           - Health Suite Sub-Process B2
   - NO: Have Appt or Need Appt?
     - YES: Check In to Suite Clinic Triage
       - Health Suite Sub-Process B2
     - NO: Other Services
Integrated Health Care – Health Suite Sub-Process B2

- HEALTH SUITE B2
  - Suite Front Desk
    - What Brings You In?
      - TRIAGE
        - Already Checked In to Clinical Triage
        - Schedule Future Appointment
      - EITHER
        - Schedule Same-Day Appointment
        - Check Out Sub-Process C3
    - GROUP
      - APPT
    - MA Pre-Appt Routine
      - Nursing
      - Medical
      - Psych Rx
      - BHP
      - Case Mgmt

- Level II Group
Integrated Health Care – Check Out Sub-Process C3

- Vaccinations
- Eye Clinic
- Follow-Up Scheduled
- Lab Work
- Pharmacy
- Dental Clinic
- Case Manager
- Specialty Appts and Referrals
- Other Needs

PATIENT CHECK OUT → MA: Review plan with patient → Satisfied Patient
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.
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.
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)
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

- **DESC (n = 402)**
  - 10%: No Information
  - 41%: Not Homeless
  - 49%: Homeless

- **HMHAS (n = 381)**
  - 6%: No Information
  - 76%: Not Homeless
  - 18%: Homeless

- **Overall (n = 783)**
  - 8%: No Information
  - 58%: Not Homeless
  - 34%: Homeless
PBHCI: Race and Ethnicity by Housing Status as of 05/23/2014
N = 722

- **Homeless (n = 268)**
- **Not Homeless (n = 454)**

**Race and Ethnicity**

- **Alaska Native**: 1% 1%
- **American Indian**: 2% 2%
- **Asian**: 3% 3%
- **Black or African American**: 24% 26%
- **Multiracial**: 24% 17%
- **Native Hawaiian or Other Pacific Islander**: 1% 1%
- **White**: 40% 48%
- **Hispanic**: 11% 7%
PBHCI: Gender by Housing Status as of 5/23/2014, N = 722

- **Homeless** (N = 268)
  - Male: 73%
  - Female: 26%
- **Not Homeless** (N = 454)
  - Male: 64%
  - Female: 35%
  - Transgender/Other: 1% (total)

Total N = 722
PBHCI: Mental Health Diagnoses by Housing Status as of 05/23/2014, N = 722

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Homeless (N = 268)</th>
<th>Not Homeless (N = 454)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>21%</td>
<td>38%</td>
</tr>
<tr>
<td>Depression</td>
<td>19%</td>
<td>26%</td>
</tr>
<tr>
<td>Schizoaffective</td>
<td>19%</td>
<td>15%</td>
</tr>
<tr>
<td>Psychosis NOS</td>
<td>8%</td>
<td>21%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>15%</td>
<td>8%</td>
</tr>
</tbody>
</table>

PERCENT
PBHCI: % of Clients at-Risk for Selected Health Outcomes at Baseline by Housing Status as of 5/23/2014, N = 722

**Homeless (N = 268)**
- Hypertension: 38%
- Obesity: 53%
- Elevated HgbA1c: 19%
- Elevated LDL: 11%

**Not Homeless (N = 454)**
- Hypertension: 36%
- Obesity: 64%
- Elevated HgbA1c: 29%
- Elevated LDL: 21%
Common Integrated Health Care Issues and Concerns

- Acute
- Chronic
- Homelessness
Impact of Homelessness on Care
Impact of Homelessness on Care

Severity of Issues

Realities of Environment

Interaction of PC & BH

Health coverage, access & services

Trauma

Poverty
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

Flexibility

Partnership

Preparation
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 ≥ 130 mmHg and/or Diastolic BP ≥ 85 mmHg.

<table>
<thead>
<tr>
<th>Housing Status</th>
<th>% Improved</th>
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</thead>
<tbody>
<tr>
<td>Homeless (n = 42)</td>
<td>31%</td>
</tr>
<tr>
<td>Not Homeless (n = 101)</td>
<td>42%</td>
</tr>
<tr>
<td>Overall (n = 143)</td>
<td>38%</td>
</tr>
</tbody>
</table>
**Obese 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 $\geq 25 \text{ kg/m}^2$

<table>
<thead>
<tr>
<th>Housing Status</th>
<th>% Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless (n = 53)</td>
<td>13%</td>
</tr>
<tr>
<td>Not Homeless (n = 179)</td>
<td>7%</td>
</tr>
<tr>
<td>Overall (n = 232)</td>
<td>8%</td>
</tr>
</tbody>
</table>
Percent of Clients Using Illegal Substances

Positive at Baseline

Homeless Clients (n = 113)
- 48%

All Clients (n = 414)
- 32%

Positive at Second Interview

- 39%

33%
Percent of Clients with a Stable Place to Live

- **POSITIVE AT BASELINE**
  - **HOMELESS CLIENTS (n = 116)**: 51%
  - **ALL CLIENTS (n = 428)**: 61%

- **POSITIVE AT SECOND INTERVIEW**
  - **HOMELESS CLIENTS (n = 116)**: 0%
  - **ALL CLIENTS (n = 428)**: 76%
PERCENT OF CLIENTS FUNCTIONING IN EVERYDAY LIFE

Positive at Baseline

Homeless Clients (n = 118)
- 25%

All Clients (n = 429)
- 42%

Positive at Second Interview

47%
58%
PERCENT OF CLIENTS WITHOUT SERIOUS PSYCHOLOGICAL DISTRESS

- HOMELESS CLIENTS (N = 117)
  - Positive at Baseline: 57%
  - Positive at Second Interview: 74%

- ALL CLIENTS (N = 425)
  - Positive at Baseline: 74%
  - Positive at Second Interview: 80%
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