SAMHSA-HRSA
Center for
Integrated Health Solutions

Coordinating Primary Care and Behavioral Health Services Among People Who Are Homeless

September 22, 2011

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration

HRSA

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Webinar Agenda

- Barbara DiPietro, National Health Care for the Homeless
- Marianne Savarese, Health Care for the Homeless- Manchester, NH
- Bill Rider, Mental Health Center of Greater Manchester, NH
- Geoff Smith, Clinical Supervisor, Department of Behavioral Health, CA
- Kevin Hamilton, Deputy of Programs, Clinica Sierra Vista, CA
- John Loring and Tim Florence Washtenaw County CSTS – HPORT, MI

Health Care for the Homeless

- HCH grantees are FQHCs
- Authorized in the Public Health Service Act (§330) as part of the health center program (one of three “special populations”)
- Accept patients without regard to insurance status or ability to pay; sliding fee scale to $0
- Focus services on those without housing

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Health Centers: Required Services

- Primary care & Preventive health services
- Lab services
- Emergency medical services
- Prescription drug assistance
- Referrals
- Case management
- Enabling services
- * Substance abuse services (HCH grantees)

Health Centers: Additional Services

- Mental health and substance abuse services
- Recuperative care
- Environmental health

Health Care for the Homeless: Grantees

- 219 HCH grantees (19% of all FQHCs)
- Nearly 2,900 locations
- 46% are combined with CHC funding
- Others are freestanding, health departments, or combined with migrant/public housing FQHCs
- Fixed site, mobile units, outreach teams
- Size ranges from small to very large

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Health Care for the Homeless: Patients

- 805,000 patients in 2010; 4 million visits
- 91% have income below 100% FPL
- 65% uninsured, 26% Medicaid/CHIP, 4% Medicare
- Shelters, streets, “doubling up,” and/or transitional housing
- High rates of co-occurring acute and chronic diseases
- Homelessness creates new health conditions; exacerbates existing ones

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Definition of Homelessness

- Those living in shelters, transitional housing, streets, missions, single-room occupancy, abandoned building, vehicle, or other unstable/non-permanent situations. (PHSA)
- Also includes those “doubled up,” those previously homeless released from prison/hospital; “instability” is critical to definition. (HRSA)

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

ACA Investments in Health Centers

- $11 billion over five years to double number of health center patients
- Help meet growing demand for services, esp. after Medicaid expansion in 2014
- Allows for additional locations and expanded services

Current Challenges

- Reduction in annual appropriations in FY2011
- Reduced impact of ACA investments aimed at expansion
- Federal, state and local cuts in safety net services
- Poor economy + high housing costs = increased risks for homelessness/unstable housing
- Need for broad range of intense, coordinated services that are culturally competent

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

National HCH Council

- Membership organization funded largely through a HRSA Cooperative Agreement
- Provide training and technical assistance to HCH grantees
- Mission to improve the health of homeless populations by sharing best practices and working to end homelessness
- Also conducts research and policy analysis

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

SAMHSA-HRSA Center for Integrated Health Solutions

Collaboration & Integration of Care

The Mental Health Center of Greater Manchester (MHCGM)

and

City of Manchester Health Care for the Homeless (HCH) Program

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

CITY OF MANCHESTER INCORPORATED JUNE 1846

CATHOLIC Medical CENTER

The Mental Health Center OF GREATER MANCHESTER

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

A Life in the Community for Everyone SAMHSA Substance Abuse and Mental Health Services Administration

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Manchester NH

- Population = 109,263
- Manchester is the largest city in NH and the largest city in New England, north of Boston
- 16 % of Manchester residents live below < 100% poverty
- 32% of Manchester residents live below < 200% poverty
- Approximately 2,000 people are experiencing homelessness in the city
- Designated Refugee Resettlement area
- New Horizons is the largest homeless shelter in the state
- HCH Manchester shelter-based clinic is located on site at New Horizons Shelter

City of Manchester – Health Care for the Homeless (HCH 330h) Program

- **Grantee** – Manchester Health Department
- **Contractor** – Catholic Medical Center

Awarded 1987 – as 1 of 109 original HCH programs
Funded by the Stewart B. McKinney Homeless Assistance Act of 1986

- 1 of 219 HCH programs – funded by HRSA nationwide
- 1 of 3 HCH programs in NH (Portsmouth – '02, Nashua – '09)

- **Membership:**
  - National HCH Council
  - VT/NH – Bi-State Primary Care Association
  - NH – Interagency Council on Homelessness

- **HCH Manchester**: Provides Primary Medical & Behavioral Health Care w/full access to Diagnostics and Specialty care for all persons who are homeless

- <u>3 Program Components</u>: Afford "no wrong door" access to care
  - Primary Care Clinics – daily, on site at 2 Shelter - based locations
  - Nursing Street Outreach – daily, in collaboration with MHCGM - PATH clinician
  - Health Education – twice weekly classes at various Shelter venues

HCH Manchester:
Staffing – Utilization – Patient Population

Clinical Team (6.83 FTE) comprised of: 2 MD's; 2 NP's; 1 Psych NP; 3 RN's; 1 MSW; 1 Addiction Counselor; 1 Health Educator; 1 Program Assistant

Patient Population – 2010 UDS:

- N = 1189 individual patients…..cared for through 6,857 encounters/visits
- 66% Male / 34% Female
- Age Range 16 – 75 yr; 75% age 20 – 49 yr; 3% > age 60 yr
- 83% Uninsured; 97% live below < 200% Poverty
- 62% report history/current Mental illness or Psychiatric problems
- 53% admit Substance Abuse; 51% report 1st Drink/Drug prior to age14 yr
- 48% Co-occurring mental illness/substance abuse
- 47% report history of head injury (r/o TBI & Cognitive Impairment)
- 36% report as victims of Domestic Violence
- 31% released from Prison/Jail within one year of intake/clinic enrollment

** Most suffer Tri-Morbid – Medical / Mental Health / Addiction disorders Co-occurring w/Poverty and Homelessness

The Mental Health Center of Greater Manchester

- Multiple partnerships to integrate care in the community
- Largest mental health services provider in the state
- Nationally & internationally recognized center of excellence for our innovative treatment approaches, research, consultation & training
- The Center employs a staff of more than 300
- The Center provides services to nearly 11,000 individuals each year including:
  - 800 Seniors
  - 2,000 children and adolescents
  - 4,000 persons with severe and persistent mental illness

PATH Program – Projects to Assist Transition from Homelessness

- Began in 1994
- Position designated to ACT Team, now part of Emergency Services team
- First things first - Understanding the homeless community (where they are, how they live, engagement strategies)
- Understanding what resources are available for homeless and homeless with Mental Illness
- Engaging directly with people experiencing homelessness
- Building relationships with providers including HCH-Manchester
- Education to other providers about mental illness in general, management strategies and what services MHCGM could offer

Successful Collaboration

- Effective Collaboration between MHCGM and HCH-Manchester
- Co-location of PATH and HCH program
- Joint outreach between PATH and HCH-RN
- Integration with HUD Continuum of Care
- Psychiatric APRN as part of HCH-Manchester

- **CHALLENGES**
- Continuous funding
- Finding PATH worker with availability, affability and ability
- Staff turnover at all agencies

HCH Manchester:
Integrating Behavioral Health Care, by necessity and design

Homelessness: Exacerbates Mental Illness; Confounds Recovery; Causes Psychological Distress; can be a Root cause of Trauma. All persons struggling w/homelessness need BH care

Universal Screening: All HCH patients are assessed for Mental illness & Substance abuse – Assessed briefly (SBIRT) at each visit and screened with formal tools annually

For 20 years (1988 – 2008) HCH Manchester addressed BH needs of patients through its Primary Care team …w/ referrals to MHCGM for ongoing care, assisted by PATH and Emergency Services

'08 – State Grant: added Psych NP (8hrs/wk) creating a dedicated HCH-BH team

- Psych NP acquired/hired via "purchased labor" contract with MHCGM
- Psych NP retains unique access/entry to MCHGM system for patient referrals
- Psych NP retains access to clinical supervision from MHCGM psychiatry
- Psych NP supported by HCH staff – MSW, RN & Substance Abuse Counselor – to form BH team
- HCH assess / screen all patients for triage & referral to BH team
- BH sessions are fully integrated; Run concurrent w/primary care , at shelter clinic
- BH provider is fully integrated / accepted as part of HCH Manchester clinical team
- Case management full staff meetings held weekly … includes BH team
- Care Plan is shared ; Primary Care and BH regimens are fully integrated for each patient
- HCH program assists patients with costs of Psychiatric medications and Transportation needs
- Uninsured patients have full access to HCH-BH care

HCH Manchester:
BH Utilization – Budget - Billing

2010 – HCH-BH cared for **196** individual patients through **522** visits

HCH-BH Team (1.70 FTE) comprised of: Psychiatric NP (0.20 FTE); MSW (0.50 FTE); Outreach Nurse (0.50 FTE); Sub Counselor (0.50 FTE)

HCH Manchester Expenditures: UDS table 8A

MH services = 10% / Sub Abuse = 3% / Street Outreach = 5%
Medical services = 54% / Dental = 11% / Pharmaceuticals = 2%

Primary Diagnoses of Patients: UDS table 6

(does not account for BH diagnoses which are underlying/secondary)

Depression/Mood Disorder = 5% / PTSD and/or Anxiety = 3%
Other Mental Health = 8% / Substance Abuse = 5%

Billing: Behavioral Health CPT Codes (90801 – 90809; 90862 – 90889)

BH Provider completes Super Bill after each clinic visit / encounter …
specifying CPT code and ICD 9 diagnosis … as would a medical provider

Medicaid Fee for Service:

Codes define /signify value based on "face to face" time, length of session
90801 = "Diagnostic Interview" highest rate with average reimbursement @ $88.00
Other codes rates range from $24 - $49

FQHC: flat rate pre-determined by annual Medicare Cost report … assigned to each FQHC

Medicare – "Psychiatric Reduction" should be expected as an adjustment to every claim

HCH- Manchester:
BH Records – EMR Security

- **Federal HIPAA, SAMHSA and State specific** privacy rules and disclosure laws re: BH records can be complicated; penalties for disclosure significant
- Seek legal counsel on case-by-case basis, when in doubt
- **Adopt a policy of Non Disclosure** unless consent is explicit, specific &written
- Maintain BH records in a **separate & distinct** part of EMR / chart
- **Psychotherapy notes** (conversation, counseling, analysis) command special HIPAA protection w/ separate, explicit written consent from patient for release
- HCH obtains written, explicit consent to verbally share/discuss care plans w/PATH & MHCGM staff … for safe collaboration as an extended team
- Psych NP documents in HCH EMR; levels of locked security allow Medical & Psych providers to read / share records
- All record requests are reviewed & approved by BH provider BEFORE sending
- Patients have Right to Request & Obtain own records w/ written consent
- HIPAA allows denial of release of Psychotherapy notes to patients when there is "substantial risk for adverse, detrimental consequences"
- Seek legal counsel on a case-by-case basis, when in doubt

HCH Manchester:
BH Utilization and QA Performance Measures

- % patients Screened annually w/formal tool
- Depression/PHQ-9 / Addiction/CAGE or UNCOPE
- % patients who Screen positive for Depression or Addiction
- who have documented follow up care/treatment
- # New patients enrolled into HCH program due to Street Outreach efforts / referrals
- # Patients enrolled successfully into Addiction Treatment programs (Residential or IOP)
- # Encounters / Visits for # Users / Patients by BH team member: Psych NP; MSW; Sub Abuse Counselor (UDS Table 5)
- Primary BH diagnoses presented (UDS Table 6)
- Tracking IVDU; Age of 1st Drink/Drug; Co-occurring MI/SA

Strategies
for successful partnership and integration

Shared Philosophy/Mission/Values:

- **Patients are Central**
- **Access to care must be unimpeded**
- **Creativity / Flexibility / Sense of Humor / Mutual Respect / Can do attitudes**
- **Mutual Respect and Trust between HCH & MHC … administrators and staff alike**

- **Structure/Design:**
- State funds seed project …w/HRSA – Change in Scope (CIS) to add Mental Health services
- Contract with MHCGM to "purchase labor" of Psych NP
- Memo of Agreement (MOA) for collaboration and partnership between HCH & MHCGM
- Psych NP is EMPLOYEE O of MHCGM … ensures entrée` into MHCGM continuum of care for patient referrals … and insures access to clinical supervision
- Non-compete for patients (83% uninsured)…3rd party FQHC revenue folded back into HCH-BH
- Co-location of BH team & HCH primary care staff; same adequate space; concurrent sessions
- HCH-MSW, RN, Sub Abuse Counselor on BH team **also staff** Primary Care sessions …
- provides bridge of continuity from BH to PC sessions
- Shared EMR w/locked levels of security; explicit consents for expanded team care
- Coordinated schedules between Outreach partners and BH team members
- Case Management meetings, include BH team
- HCH Continuing Education open to MHCGM staff – MHCGM Continuing Education open to HCH
- Deliberate / planned opportunities for cross-training

Strategies (continued)

Honest Recognition of Barriers:

- Some HCH patients are reluctant to go to MHCGM due to stigma, fear or denial
- Some cannot go due to transportation barriers
- Some refuse to admit MI or SA problems… not ready to accept MHCGM level of care
- Primary Care providers have limits, knowledge gaps, learning needs related to BH
- BH providers have limits, knowledge gaps, learning needs related to Primary Care

- **Practice:**
- Persistent, Gentle Outreach and Accepting presence
- Few rules; Open Access; No appointments (at first); MSW, RN, Counselors do initial screens
- Start where patient is at…Motivational Interviewing / Pre-Contemplative Counseling
- and Harm Reduction…offer BH care on pace w/patients' readiness for action
- Assess/screen for medical needs of all BH patients…and for BH needs of all medical patients
- Pre-Outreach and Post-Outreach meetings for every tour…open communication
- Meet while walking or driving to outreach sites; save time and improve efficiency
- Community wide outreach meetings (wkly)…convene all outreach workers from local agencies; PATH and HCH Outreach RN assist outreach workers w/ clinical issues and questions
- PATH and HCH Outreach RN get to know local shop-keepers, businesses, social service agencies, police and parole officers … to receive referrals and address needs
- HCH and MHC staff conduct Psycho-ed classes together within HCH Health Ed Component

Benefits of BH Collaboration: Perspective of HCH Street Outreach Nurse

Team Approach w/PATH provides:

- Creates an ideal team w/broad clinical skills spanning medical and behavioral health and with full access to each agency's care continuum
- "No Wrong Door" access to medical and/or behavioral health care
- Referrals can be immediate & smooth; "warm hand off" consults in either direction
- Safety in numbers…added intuition…extra set of eyes
- Decreased stress w/team-mate around … to share thoughts and ideas
- Patients can choose between outreach offerings…medical or mental health care
- Medical care is the hook…more easily accepted by patients…then MH can be offered at a later visit, as trust builds
- Patients vividly see the two agencies (HCH & MHCGM) working together on their behalf…this helps engender trust for each agency

Benefits of BH Collaboration: Perspectives of Medical Providers (MD's & NP's)

- On the spot consults; confer during clinic sessions while patients are there
- Helps me to assist patients when they are in crisis during their medical visit
- Learn more about psychiatric medication management;
- in turn I can teach Psych NP about medical care
- Homeless patients are complicated enough, medically…having someone there to assist w/psychiatric needs is an enormous relief
- Homeless patients never seem to have simple mental illnesses…there always seems to be a schizoid component…which is beyond my scope
- Shared Case Management meetings / Care Plans are invaluable
- Shared EMR…w/access to Psych NP progress notes is invaluable
- This quality and level of care coordination get us ready for Patient Centered Medical Home (PCMH) & Meaningful Use expectations
- We share patients …. and Psych NP helps ME not to lose my mind!!!

Benefits of BH Collaboration: Perspectives of Diabetes Nurse Specialist and Health Educator

- Adds more ways to enter HCH care…"no wrong door"
- Patients w/Diabetes and Chronic conditions come to trust us, and then extend that trust to BH provider
- Patients more willing to discuss and address Depression, Addiction and other BH problems, that co-occur w/ Chronic Disease

- BH care helps with Cognitive Re-framing
- Patients more aware of depression/anxiety/anger/insomnia/grief/stress
- Awareness of their stressors gets patients ready (motivated) for change
- I link Physical Fitness, Smoking Cessation, Proper Nutrition…to relief of stress
- I can link Physical Fitness and Cognitive Fitness to Mental Health & Wellness

- Working closely with Psych NP, MSW & Addiction Counselor, we convey messages of Fitness & Wellness…helps to manage, control and prevent Diabetes, Cardiac disease, COPD, Cancer and other chronic conditions

Benefits of BH Collaboration: Perspectives of MSW and Substance Abuse Counselor

- Care coordination w/ PATH and BH provider … for most resistant street homeless
- Patients "feel safe" they trust the HCH team and extend that trust to Psych NP
- Working in tandem w/ Psych NP helps to expand our reach and skills set
- Receiving, addressing, triaging all BH referrals from the Primary Care team
- helps us to broadens our reach and knowledge of all who seek HCH care

- BH patients are assessed for entitlement & housing needs…assisted w/applications
- SSI/SSDI disability applicants have ready access to Psych NP for MH evaluation
- Access to Psych NP for prompt MH clearance for addiction treatment program entry
- Greatly improved access to care for those w/ Co-occurring disorders
- Access to psych meds … essential for successful treatment of co-occurring disorders
- BH collaboration provides a web of support for each patient; this web of support helps to promote and sustain recovery and prevent relapse.
- BH collaboration provides a web of support for Medical staff, as they learn to address BH needs and the complicated tri-morbidity of all HCH patients

Benefits of Collaboration: Perspective of Program Assistant/Front Desk Clerk

- BH participation and discussion at Case Management meetings help me to learn more about mental illness and how to better understand patients and their behaviors
- Psych NP assists me with all Medical Record requests by reviewing & approving all consents, records and restricted documents before they are sent out
- With the knowledge that I learned about Behavioral Health, I was able to help a suicidal patient (over the phone) to stay safe, as we secured and arranged immediate, emergency psychiatric care. After discharge, when that person came to our clinic for follow up care…he thanked me. Today he is in recovery, and no longer homeless.

Suggested Readings/ Authors / Contact Info:

Suggested readings/authors:

- AHQR National Agenda for Research Collaborative Care: July '11 pub #11-0067
- Maintenance and Disclosure of Mental Health Records in the Primary Care Clinic Setting; by Elizabeth C. Saviano, Esq., March 21, 2008
- CJ Peek, Ph.D., University of Minnesota Medical School
- Rodger Kessler, Ph.D., University of Vermont College of Medicine
- Benjamin F. Miller, Psy.D., University of Colorado School of Medicine
- Gene A. Kallenberg, MD, Dept. of Family and Preventive Medicine, University of California, San Diego
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SAMHSA-HRSA Center for Integrated Health Solutions

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Fresno, CA

Fresno County: Demographics

2010 Population: 930,450

Ethnic/Racial %

- Hispanic or Latino 50%
- White, non-Hispanic 33%
- Asian 10%
- Black/Af. Amer. 5%
- Other Responses 2%

2009 People below Poverty line- 21.5%

Primarily Agriculture: 5.3 Billion in 2007; #1 in nation.

MHSA (Mental Health Services Act)

1% tax on any income over $1 million/year passed by CA voters in 2004.

- Examples ($1,000,001 income = one cent tax; $2,000,000 income = $10,000 tax).
- MHSA has brought in hundreds of millions of dollars in new revenues statewide to go towards mental health services.

MHSA had been meant to supplement other mental health funding, but with the ongoing budget crisis much of the other resources have dwindled. MHSA funding now provides much of the basic mental health services in California.

MHSA (Mental Health Services Act) continued

A specific mandate of MHSA is to help with safe and adequate housing.

- Full Service Partnerships provide Assertive Community Treatment (ACT) model and have funds to help clients with housing.
- Specific housing projects for Severely Mentally Ill consumers are being provided (multi-unit, integrated housing complexes built or under construction).
  - New Projects.
  - Renovations.

Building Collaborations with Community Partners

Budget difficulties necessitate improved inter-agency collaboration.

Effective Collaboration needs:

- Support from Management of various agencies.
- Clear agreements about details of collaboration.
- Continued efforts to build positive relationships between agencies and meeting monthly with at least 12 organizations including Clinica Sierra Vista.
- Collaborative efforts have proven successful and continue to move in a positive direction.

Building Collaborations with Community Partners continued

DBH has increased collaboration with several community partners:

- Community health providers
- Inpatient mental health facilities
- Law enforcement
- Homeless shelters
- Substance Abuse services
- NAMI and Mental Health America
- Faith Communities

Collaborative Efforts to Improve Mental Health Services to the Homeless

A Case Manager from our Substance Abuse program has been placed full-time at the local homeless shelter.

On-site case management at MHSA funded apartment complex.

Monthly meetings have been established with Fresno County Department of Behavioral Health (DBH), DBH contractors, and programs that provide services to the homeless. At least 12 programs and agencies regularly attend this meeting.

Collaborative Efforts to Improve Mental Health Services to the Homeless continued

- DBH has provided consultation from our psychiatrists for the Nurse Practitioner at the health clinic that works with the homeless population.
- Increased collaboration between psychiatric inpatient units and homeless shelters.
- Partnerships in housing mentally ill consumers with local HUD and DBH.

Collaborative Efforts with Community Health Care Providers

DBH Staff have been placed in a local Hospital Emergency Room to help coordinate treatment for mentally ill consumers.

Exploratory meetings between DBH and Clinica Sierra Vista to find ways to work together.

Increased collaboration between line staff at DBH and Clinica Sierra Vista.

Collaborations with individual Primary Care Physicians.

Extensive outreach from the DBH Peri-Natal program to OBGYNs in the community.

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Clinica Sierra Vista, Inc.
HCH Integrated Behavioral Health Model and Services

Kevin Hamilton

Deputy of Programs

Clinica Sierra Vista, CA

Axiom for the Homeless Patient at Clinica Sierra Vista

- All individuals are unique and their needs are unique.

Goals and Challenges of the HCH Program.

The following are **goals** and **challenges** of the HCH Behavioral Health program systems integration.

- Appropriate service delivery system.
- Coordinate a comprehensive referral system.
- Raise Awareness.
- Effective Service Integration.

CSV uses a Case Manager driven service model.

Case Managers coordinate supportive services to meet the basic needs of an individual/family by:

- Accompanying the client for appointments
- Consulting with care givers,
- Providing counseling and teaching living skills.
- Linking the patient/family to services
- Outreach to engage clients in services,
- Assessing individual needs (psychosocial assessment and service plan)
- Arranging requisite supports (such as housing, benefits programs, job training, monitoring medications and use of services, referral to county behavioral health.
- Advocating for client rights and entitlements.

HCH Case Management Model: Mixed (Hybrid) Model

Case Manager serves in both a therapeutic capacity and as a broker of services.

- Therapy Options.
- Service Delivery Options.
- Outreach and Engagement.

Challenges and Benefits to working in a split services community.

Challenges

Lack of local control.

Communication

Agency realignment

Service provider specificity

Changing eligibility criteria

Many doorways when needs exceed FQHC services capacity

Consumer disconnection

Advocacy: Advocates for client to gain needed services.

Benefits

Integrate Behavioral and Physical Health-no wrong door.

Care coordination

Complete case documentation at a single location.

Increase Access

Multiple partners-strength in numbers.

Outcome tracking.

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Healthcare for Persons with Serious Mental Illness: Clinical Perspectives

Timothy Florence, MD
John Loring, LMSW

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"Never, ever, think outside the box."

The Homeless Population

- 66% of homeless adults have a mental health condition and/or substance use disorder
- Lack of insight into the nature of behavioral health conditions is prevalent
- Majority have had prior contact with the mental health treatment system (“lost to follow-up”)
- Typically are long-term citizens of the communities in which are found homeless

Burt, 1999

Homeless in Washtenaw County

- Approximately 4,000 individuals annually
- 600-700 on any given night
- Survey respondents self-report
  - 42% mental health condition
  - 44% substance use disorder
  - 34% employed

Cumulative Social Disadvantage

Mortality is increased by:

- Lack of adequate housing
- Lower income
- Poor social cohesion
- Limited education
- Multi-morbidity

Housing, income, and social relatedness are treatments

Home Project Outreach Team (HPORT)

- A behavioral health program
- Serving homeless mentally ill adults of Washtenaw County, Michigan
- Gap filling service
- Kick off - January 2000

HPORT

Vision

- Support homeless individuals in our community to achieve the highest possible quality of life

Mission

- Engage and serve homeless individuals *"where they are"* through outreach

Values

- Service, Integrity, Compassion

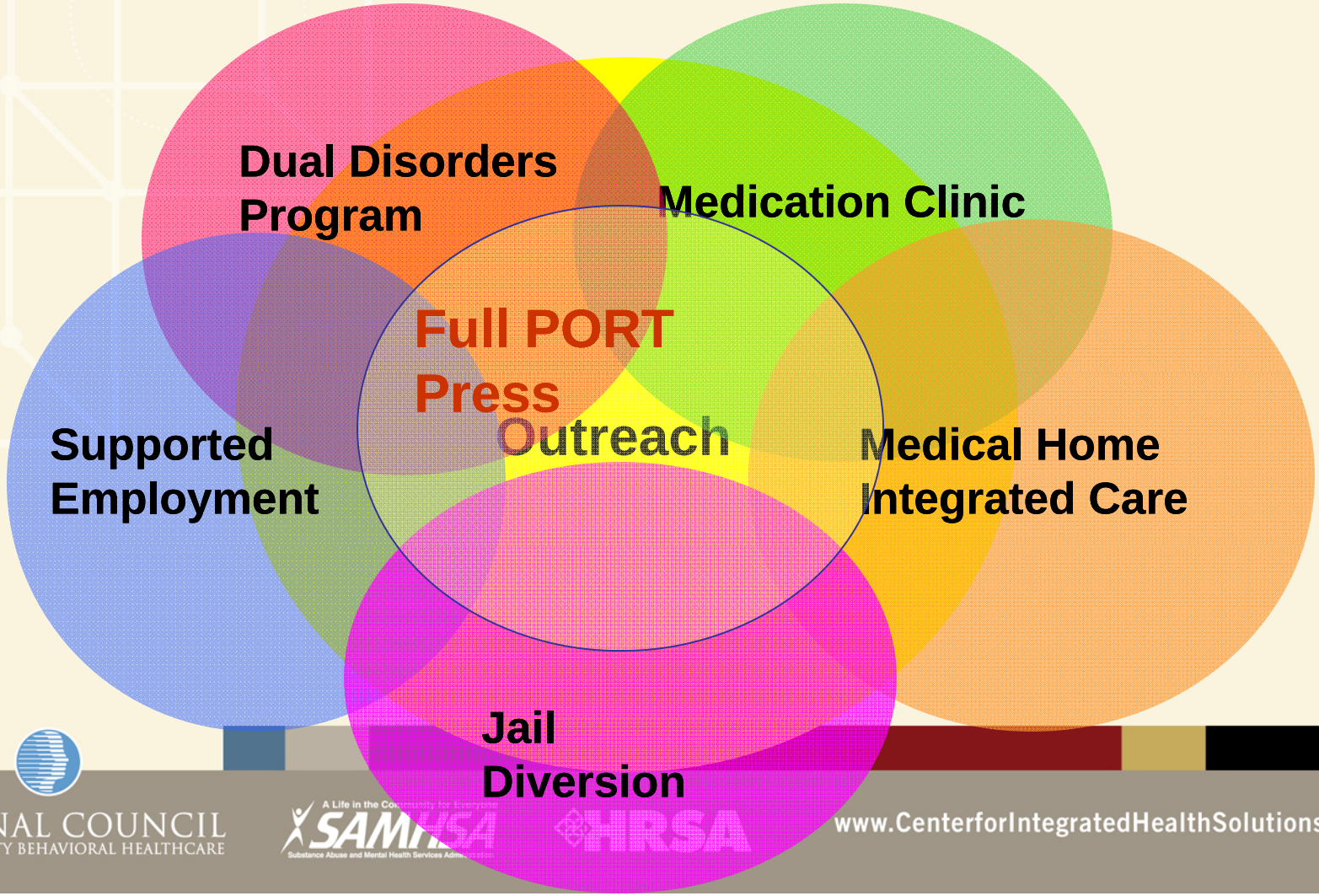
Clinical Mission

Engage untreated homeless mentally ill adults at shelters and in public spaces and ***advocate*** on their behalf

Treat using a best practice model

Transition into the public mental health system once housed and stable

PORT Model: CMHC Without Walls



Outreach and Engagement

" … a client-centered approach to working with people ***'where they are'*** rather than 'where they should be' as dictated by treatment providers."

G. Alan Marlatt, Ph.D., University of Washington, Addictive Behaviors Research Center

Outreach

Success depends upon it

Outreach is a profound manifestation of unconditional positive regard offered towards a stranger.

Outreach: Starting Where the Client Is:

Service must meet ***perceived needs***

- Clients don't care how much you know until they know how much you care
- Offer service, be concrete
- Be an active listener
- Use ***engagement tools***

Population avoids seeking services

- Don't come to the door, so ***bring the door*** to them
- Meet client where he/she is, both literally and figuratively

Remember Maslow - hierarchy of needs

- Food, clothing, shelter, safety, transportation needs often trump medical, substance abuse or psychiatric treatment

Engagement

Central to all work with homeless mentally ill persons

Engagement is a process of relational discovery between two or more people. It is characterized by mutual respect, shared responsibility, and commitment towards positive change.

Engagement As Empowerment

- Have been ***"done to"*** and ***"done for"***
- Need to "***do with***"
- Have appreciation of clients' ***strengths***
- Building of ***trust*** and ***relationships*** are key
- Work from stance of ***consensus***, not coercion
- Cultivate change ***together***
- Facilitate ***recovery]***

"The Four Legged Stool"

Safe, stable housing

- Housing First – *housing is treatment*
- Critical importance of the SOAR Model

Meaningful daytime activity

- Street Soccer – SSPORT

Sober peer support network

- Skill building, Process and Trauma Informed co-occurring groups

Positive alliance with a treatment provider

- Integrated Community Based Psychiatric Treatment

Mentally ill homeless
Or Homeless mentally ill?

Health problems as a cause and consequence of homelessness

- Vulnerability to homelessness
- Exacerbation of mental illness
- Delivery of service complicated by homelessness

Public Mental Health Consumers

Less likely to receive care for chronic physical health conditions

Increased morbidity and mortality due to general medical conditions

NASMHPD 2006

Causes of Morbidity and Mortality

Majority of premature deaths in persons with schizophrenia are due to medical conditions

- Cardiovascular disease
- Diabetes
- Respiratory diseases
- Infectious diseases

Suicide and injury account for 30-40% of excess mortality

NASMHPD 2006

Why Should We Be Concerned About Morbidity and Mortality?

Individuals with serious mental illness served by our public mental health systems on average ***die 25 years earlier*** than the general population.

PORT: Integrating Behavioral Health and Primary Care

At shelter based primary care clinic

- Onsite psychiatric services
- Behavioral health triage
- Team with clinic's care managers – outreach/in-reach
- Weekly case review meeting

In the field

- Care coordination with PCPs in other locations serving homeless mentally ill persons
- Health screening
- Medical monitoring

PORT Psychiatric Services

- Fully integrated into outreach team
- Assessment and treatment through clinics at local shelter and county building
- Targeted psychiatric outreach
- Consultation
- Teaching team with psychiatric residents and medical students

Psychiatric Services

- Be safe
- Be real
- Be flexible
- Start where the client is
- Be patient
- Embed diagnostic assessment in functional assessment
- Avoid power struggles

Gillig, McQuiston,

PORT Lessons Learned

Round pegs don't fit into square holes
- Six to nine month "dose" of PORT measurably meaningful

When in doubt, do what works
- Flexible model of service delivery critical

The system of care can change
- Leadership vision
- Community "buy in"

Teamwork breeds success
- Synergy, flexibility, adaptability

Cannot succeed without community partners
- Leverage system of care
- Fertile ground for teaching and training

The PORT Partnership

- Washtenaw Community Health Organization
- Community Support and Treatment Services
- Washtenaw County
- City of Ann Arbor
- Projects for Assistance in Transition from Homelessness
- State of Michigan Department of Community Health
- University of Michigan Health System
- University of Michigan School of Social Work
- The Ethel and James Flinn Family Foundation

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