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HEALING HANDS

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Integrating Primary & Behavioral Health Care for Homeless People

Higher incidence, prevalence, and acuity of medical and behavioral problems among people who are homeless warrant the availability of comprehensive medical and behavioral health services. Limited access to mental health specialists, stigma associated with mental illness, and negative health outcomes related to undiagnosed or untreated behavioral disorders make it incumbent on primary care providers to address their patients' mental health needs. The following articles explore a variety of approaches used by Health Care for the Homeless providers to integrate primary and behavioral health care.

NEED FOR INTEGRATED CARE "Integrating behavioral health services into primary care is an idea whose time should have already come," writes Alexander Blount, Ed.D.[1] Here's why:

- **Nearly 70 percent of all health care visits have primarily a psychosocial basis,**[2] and about 25 percent of all primary care recipients have a diagnosable mental disorder, most commonly anxiety and depression.[3]
- **Two thirds of homeless service users report an alcohol, drug, or mental health problem.**[4] These behavioral health disorders account for 69 percent of hospitalizations among homeless adults, compared with 10 percent of non-homeless adults.[5]
- **One-third of all patients with chronic illnesses, homeless or housed, have co-occurring depression.** Major depression in patients with chronic medical illnesses amplifies physical symptoms, increases functional impairment, and interferes with self-care and adherence to medical treatment.[6]
- **Half of all care for common mental disorders is delivered in general medical settings.**[7] Many—patients particularly ethnic minorities—perceive primary care as less stigmatizing than the specialized mental health care.[6]
- **Half of mental disorders go undiagnosed in primary care.** Primary care physicians vary in their ability to recognize, diagnose, and treat mental disorders.[3]

These statistics only begin to tell the story. Traditionally, primary care, mental health care, and addictions treatment have been provided by different programs in various agencies scattered throughout the community. People who are homeless—particularly those with mental illnesses and co-occurring substance use disorders—have difficulty navigating these multiple service systems. To address this need, HCH grantees are required to provide addiction services and referrals to specialists, as medically indicated, and to other health services, including behavioral health care.

Lack of time, training, experience, and resources makes fully integrated primary and behavioral health care difficulty to accomplish in primary care settings. Referrals can also be problematic for indigent patients. "If someone who is living on the streets is hearing voices *and* has hypertension *and* a substance abuse problem, it's going to be impossible for him to get care," says **James O'Connell, MD**, President of Boston Health Care for the Homeless Program.

Skilled screening, assessment, evaluation, and treatment of behavioral health disorders are crucial in the HCH setting, notes **Matias Vega, MD**, Medical Director of Albuquerque HCH. "Inadequate treatment of serious mental illness and/or chemical dependency often precipitates and perpetuates individual and family homelessness." To address the complexity and acuity of behavioral health problems experienced by displaced people, many HCH projects have already added or expanded the behavioral health services they provide, as illustrated by the programs profiled in this issue.

BARRIERS TO INTEGRATED CARE The need to integrate care for physical and behavioral health disorders is indisputable, but clinical, programmatic, and financial barriers can stymie even the most innovative and dedicated teams.

Clinical Barriers There are different and often conflicting paradigms in "physical" versus "behavioral" health care and treatment of mental illness versus substance use disorders.[1] Substantial differences in culture and language between clinical domains may create a chasm that is difficult to cross.

Programmatic Barriers The pressures of a busy primary care practice leave clinicians little time to attend to each patient's needs. Visits typically last 13 to 16 minutes and patients have an average of six problems to address with their provider.[3] Lack of training for interdisciplinary care is also a significant barrier. "Most primary care doctors have limited training in psychiatry and a great deal of angst about treating people with serious mental illnesses," notes **Earl Lynch, MD**, Medical Director of the Santa Barbara County Public Health Department. Moreover, sharing information can be problematic in an interdisciplinary setting. Records, treatment plans, and data systems are different in primary and behavioral health care settings, and concerns about client confidentiality and HIPAA regulations may require high-level negotiation among collaborating agencies.

Financial Barriers Funding interdisciplinary care is a significant hurdle to providing integrated services. There are few, if any, economic incentives for primary care and behavioral health care providers to collaborate.[3,8] Funding for mental health services is more restrictive than for general health care. Many community mental health agencies will only serve individuals who have insurance. "Only 4 percent of our patients are insured," says **Bart Irwin, Ph.D., MSW**, Assistant Director of Family Health Centers, an HCH grantee in Louisville, KY. "For the 96 percent who are uninsured, it is almost impossible to get mental health care."

Even if patients qualify for Medicaid, reimbursement for mental health services provided in primary care settings can be problematic. For example, Irwin says, he is not able to bill Medicaid for the mental health services his HCH project provides because the state has an exclusive contract with a mental health agency in the area. There are also limitations to reimbursement for non-physician providers, such as social workers or master's level psychologists, but most HCH projects do not have the resources to hire their own psychiatrist. Finally, integrated care initially may be more costly than usual care, and cost offsets often do not accrue to the organization or agency that funds collaborative services.[8]

APPROACHES TO INTEGRATED CARE As Blount notes, "The terms 'collaborative care' and 'integrated care' are growing in usage but not in specificity or agreed meaning."[1] He proposes a continuum of collaborative care, from coordinated to co-located to fully integrated care.

- **Coordinating care** between separate agencies that are treating the same individual takes a level of effort that often frustrates clinicians and hampers efforts to integrate services.
- **Co-location** of primary care and behavioral health services in the same site fosters communication between medical and mental health providers and may give primary care clinicians a greater sense of security in addressing behavioral health disorders.
- **Integrated care** presupposes "one treatment plan with behavioral and medical elements."[1] Co-location is not sufficient to ensure integrated care.

Primary Mental Health Care Development of a single treatment plan is only a small component of the primary mental health care model developed and taught by clinical psychologist **Kirk Strosahl, Ph.D.**[9] A principal with the Mountainview Consulting Group of Zillah, WA, Strosahl has provided technical assistance and training on integrated care to more than 100 community health centers around the country.

"The current behavioral health system is labor intensive, and few people get services that are needed by many," Strosahl says. He believes that is unacceptable. In the primary mental health care model Strosahl recommends, the mental health provider or "behaviorist" functions as a member of the primary care team, providing consultations to medical providers and brief, targeted interventions. The behaviorist is located near an exam room area, where patients can be seen for 15–30 minutes to focus on specific behavior changes, such as diet modification, medication compliance, or tobacco cessation.

"You can see very ill people in 20-minute visits because you're not treating all pathology," Strosahl says. "You're picking specific targets for self-management." Most often, the primary care provider will work directly with the patient to implement the behavioral change plan. "The behaviorist's job is to help primary care providers intervene effectively, because 90 percent of general medical care is behavior change," says Strosahl. Individuals who need a more intensive level of care are referred to a mental health specialist.

Strosahl believes it is important for the primary care provider to employ the behaviorist, rather than contract with a mental health center. Others are concerned that this may limit access to the specialty mental health sector for patients who need it. The Boston HCH Program contracted with a local mental health agency for a psychiatrist and a social worker to join its street outreach team. "The Department of Mental Health has the lion's share of mental health resources. If we're not part of that system, we're always going to be on the outside," warns Dr. O'Connell.

ADVANTAGES OF INTEGRATED CARE "The advantages of a fully integrated approach are obvious," according to Strosahl.[9] Studies of collaborative care models for treating depression as part of primary care indicate that these models improve clinical outcomes, functioning, and quality of life and are cost-effective.[6] Researchers have also found that integrated care appears to reduce access disparities for individuals from ethnic minority groups. Indeed, despite the barriers and regardless of the specific approach, HCH projects that provide some level of integrated care are sold on its benefits.

The Primary Mental Health Care Model In Practice

At Safe Harbor Clinic, Community Health Center HCH project in Burlington, VT, **Kathy Browne, LICSW**, is part of the medical team. When a doctor or nurse requests a mental health consult and receives permission from the patient to do so, they introduce Browne, who has her initial visit with the patient right in the exam room. This type of "warm hand off" is a hallmark of the primary mental health care model.

"The initial visit is typically brief, about 20 to 30 minutes," Browne says. "This is not therapy, but a brief intervention dealing with such issues as coping and relaxation." Browne believes that traditional therapy has its place, but "you will miss a portion of the population if you require it. Many of my patients would not be willing or able to meet with me weekly for hour-long sessions."

Michael Sirois, MD, Medical Director of the Community Health Center, has practiced in clinics where services were co-located but not integrated, and he sees a significant difference. "People were not being referred to behavioral health even when providers were co-located," Dr. Sirois says. When mental health providers conduct traditional therapy in the primary care setting, there is little opportunity for the primary care clinician to seek their advice about patients or contribute to a combined treatment plan.

Dr. Sirois is candid about the challenges of this model. "If you can't bill or you don't have grant support, you can't do this," he says. In Vermont, Medicaid and some private insurers will pay for brief behavioral health interventions of 20 minutes or longer for patients who have a primary mental health diagnosis.

For Browne, the primary mental health care model "is an exciting way to practice. There is no formula, which makes it a challenge, but there is so much potential for you to help clients," she says. *Contact:* Kathy Browne, (802) 860-4310, kbrowne@chcb.org

"Patients like coming to a health center rather than a mental health center because it decreases stigma," Irwin says. They are more likely to see a mental health provider who is introduced to them by their primary care clinician. Primary care providers appreciate the opportunity to have real-time feedback on mental health problems, notes Dr. Lynch. The Santa Barbara County Public Health Department participates in the HRSA Depression Collaborative, which includes mental health providers on the primary care team.

Finally, the willingness of primary care and mental health providers to "step out of their boxes to coordinate care for homeless people encourages other providers to do the same," says **Mary Specio, MSW, LISAC**, Director of Community Health for COPE Behavioral Services in Tucson, AZ. Specio's agency partnered with El Rio Health Center in a grant program to fund collaborative care sponsored by HRSA and the Substance Abuse and Mental Health Services Administration (SAMHSA) (see next article).

Linking HCH with Mental Health Services

Federal agencies that fund primary care services (HRSA) and behavioral health services (SAMHSA) are "natural partners because the head is not disconnected from the body," HRSA Administrator Elizabeth M. Duke, Ph.D., told an interagency listening session in 2003.[8] In the fall of 2002, the two agencies—together with the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services—jointly funded the *Collaboration to Link Health Care for the Homeless Programs and Community Mental Health Agencies*. The collaboration was designed to build capacity for mental health screening and assessment in HCH programs and to promote outreach and engagement in community mental health agencies.

The 3-year grant program funded 12 projects around the country for a total of $3.1 million. Grantees included seven HCH-led sites in Albuquerque, Boston, Chicago, El Paso, Louisville, Pittsburgh, and Tacoma; and five sites led by community mental health agencies in Aurora and Denver, CO; Hazard, KY; Las Vegas, and Tucson. The National Center on Family Homelessness, in partnership with the Vanderbilt University Center for Evaluation and Program Improvement, are completing a cross-site evaluation of the project.

RANGE OF APPROACHES Among grantees, the most common service integration strategies were *co-location* (offering services in the same place but not necessarily at the same time), *joint staffing* (with clinicians available in the same place, at the same time), *cross referral*, and *clinical case management*, according to **Dawn Jahn Moses**, Director of Public Education and Policy for the National Center on Family Homelessness and Project Director of the cross-site evaluation.

Of these approaches, Moses says project directors found co-location and joint staffing to be most effective, improving access to services, faciliting communication between providers, and increasing cross-learning. Preliminary results of the evaluation indicate more stable housing for clients, decreased inpatient service use, some increased outpatient service use, increases in the number of people reporting an income or receiving entitlements, and clients reporting increased satisfaction with life.[10] Brief profiles of six SAMHSA/HRSA grantees, along with some key lessons learned, follow.

Taking Psychiatry to the Streets "The only model of care that makes sense is getting clinicians to work together in teams within

systems of care that offer a full array of services," Dr. James O'Connell says. At Boston HCH Program, that means taking medical and mental health care to the streets. Their grant funded a psychiatrist and licensed clinical social worker from the Massachusetts Mental Health Center to accompany the program's street outreach team, serving people with the most severe illnesses who most need coordination of care.

Their ultimate goal was to replicate the street team's success in getting patients to accept ongoing medical treatment by increasing their level of comfort with mental health services as well. "When you establish a relationship with people, they will follow you back to where you can provide more sophisticated care," he explains. Individuals engaged by the psychiatrist on the streets, often over a cup of coffee, receive follow-up services at the mental health center.

Major challenges included differences in working style and record keeping; they resolved the latter by maintaining separate records for medical and mental health care but placing a copy of the mental health note in the medical file. Sustainability is also an issue, now that the grant has ended.

"We're having a difficult time getting money to free up the psychiatrist," O'Connell acknowledges. Still he thinks the project was an unqualified success. "This is the type of care I used to dream about," he says. *Contact:* James O'Connell, (617) 414-7763, joconnell@bhchp.org

CASE STUDY

Gabriel is a cherubic Latino from El Paso. A skilled plumber for 35 years, he became unemployed after surgery to replace both knees. His 20-year marriage disintegrated. Without a family and home, he lived on the streets or in abandoned buildings for nearly 2 years, becoming more and more depressed and turning to alcohol to help numb physical and psychological pain. Finally, he went to the COPE–El Rio homeless services Integrated Health Care Center for treatment of his knees and his life changed.

Gabriel received primary care for his knees and medication to stabilize his behavioral health. When the nursing staff discovered that he could not read, they referred him to the behavioral health staff for additional support services. The behavioral health staff facilitated his entry into a substance abuse rehab center for his addiction to drugs and alcohol. After a year of recovery services, Gabriel earned a GED and began taking classes at the local community college where he maintains a B average. "This program gave me a second chance at life," he says.

— Submitted by Mary Specio, COPE Behavioral Services, Tucson, AZ

One-Stop Shopping Centro San Vicente operates a homeless health care clinic in the Opportunity Center in El Paso, a shelter in which multiple medical and social services are located. Though the local mental health authority visited the shelter, there was little if any coordination with health services, notes **Olivia Narvaez, BSW, LBSW**. "This grant allowed us to break through workplace cultures and develop a common goal." The project team created the Homeless Clinic Mental Health Counseling Center to fill the gap in services and coordinate care received from multiple providers.

All clinicians and case workers from the agencies serving shelter guests meet biweekly to develop a single treatment plan for each client so that "all providers can reinforce each other's treatment recommendations," Narvaez says. Clients sign releases authorizing information sharing to facilitate joint treatment planning. In addition to regular meetings, all staff attend "cross-training circles" to discuss key clinical and management issues, such as HIPAA regulations.

Having multiple agencies under the same roof is convenient for both clients and providers, but emphasizes the different approaches to addressing a clients' needs, observes **Alec Kissack, LPC**, Director of the Counseling Center. Still, he notes, "the benefits of one-stop shopping far outweigh the challenges." Centro San Vicente will continue project services with a HUD services only grant. *Contact:* Alec Kissack, (915) 351-0233, akissack@csv.tachc.org

Multidisciplinary Outreach Teams Because Kentucky River Community Care (KRCC) has had a longstanding relationship with Hazard Perry County Community Ministries, the HCH grantee in Hazard, KY, the SAMHSA/HRSA grant was a logical extension of the work they've done together. With grant funding, the two agencies developed a modified Assertive Community Treatment team they call the Appalachian Homeless Assertive Services Partnership (AHASP), which includes a psychiatrist, nurse practitioner, therapist, social worker, and family health navigators, says **Sue Baker, BSW**, AHASP Facilitator. The family health navigators are paraprofessional staff employed by Community Ministries who have specialized training in mental health services, notes HCH Project Director **Ruth ("Rosie") Woolum, BS**.

Together, Baker and two family health navigators conduct outreach and perform medical and mental health screening. Team members transport clients to KRCC for mental health care and to Community Ministries' Little Flower Free Clinic for primary care, unless they already have a local medical provider in the community. AHASP staff also help clients meet basic needs, remind them about appointments, and "work with them until they tell us they don't need us anymore," Baker says.

Baker meets with the family health navigators each morning to discuss the clients they will see that day. KRCC and Community Ministries meet monthly, and both agencies also participate in bimonthly community stakeholders meetings. In addition, the two agencies cross-train each other's staff. This close collaboration benefits the clients they serve. "I know when patients leave my clinic they have access to the level of services they need," Woolum says.

AHASP services are continuing with funding from a HRSA Expanded Medical Capacity grant. *Contact:* Sue Baker, (606) 436-5761, ext. 7301, sue.baker@krccnet.com

Boundary Spanner When Family Health Centers of Louisville began partnering with Seven County Services, the local mental health agency, their goal was to establish walk-in mental health services at Phoenix Health Center, which offers walk-in medical

LESSONS LEARNED

Based on their participation in the SAMHSA/HRSA collaboration, HCH grantees and their community mental health agency partners suggest the following guidelines for success:

- **Build a good relationship** with your mental health providers. Without this, collaboration will be difficult.
- **Get complete buy-in** from the administration of both agencies. Agree on your goals and objectives. Know each agency's limits.
- **Conduct a needs assessment** to determine service gaps and how you can fill them.
- **Locate funding.** This could be a grant, third-party reimbursement, or State or county monies.
- **Find the right providers.** People and personalities matter.
- **Hold regular meetings** with your team, your agencies, and your community. Ongoing communication is absolutely imperative.
- **Cross-train your staff.** Use mental health and medical providers to train program staff and have new workers shadow their experienced colleagues.
- **Take a client-centered approach.** This reduces the friction that might result when providers feel they need to see a client first.
- **Don't give up** on your patients or your partners. Collaboration takes time. Keep the big picture in mind.
- **Use data to prove your success.** Good data can parlay success into new funding.
- **Remember that collaboration isn't always about money.** You can enhance services by sharing data and reallocating existing staff.

services for homeless people. "We soon became overwhelmed with mental health needs, so we went to an appointment system," notes Bart Irwin. They also designated a Masters-level social worker as a "boundary spanner" between the medical and mental health staff.

The boundary spanner, whose title was mental health coordinator, assessed patients and made appointments for them to see the psychiatric nurse practitioner or a psychiatrist who worked onsite 2½ days per week. When the Seven County Services' staff were unavailable, the mental health coordinator met with the primary care practitioners, "who were sometimes uncomfortable treating people with serious mental illnesses," observes Irwin. Because the boundary spanner was familiar with project participants' medical and mental health needs, "primary care providers felt confident enough to refill or alter medications," Irwin adds.

Though the Louisville project did not develop a multidisciplinary treatment team, "we achieved a certain level of integration by locating all providers off one major hallway," Irwin says. "We kept bumping into each other." Project staff maintained one treatment record at the HCH clinic, and each provider contributed to it.

Family Health Centers has applied for a SAMHSA Treatment for the Homeless grant to sustain project activities. *Contact:* Bart Irwin, (502) 772-8558, birwin@fhclouisville.org

Psychiatric Nurse Practitioner The need to increase access to mental health services while reducing their cost drove the collaboration between the Metropolitan Development Council (MDC) of Tacoma, an HCH grantee, and two local mental health agencies, according to MDC Vice President **Doug Swanberg, MSW**. "Prior to the grant, we had a psychiatrist one day a week, but we were turning away patients who needed mental health care," says **Sheri Adams, MSW, CSW**, HCH Director.

The SAMHSA/HRSA grant allowed MDC to add an extra day of psychiatric services, with a twist. Rather than having a psychiatrist see a limited number of patients for psychotherapy, the agency contracted for the services of a psychiatric nurse practitioner to see a greater number of patients per day for brief interventions, typically involving medication management.

"Our ultimate goal was to connect our patients to long-term case management in the mental health system, but this proved difficult due to financial constraints of our mental health partners," who could not provide free or subsidized care to uninsured individuals, Adams explains. MDC case managers arrange for any follow-up services that patients require.

A nurse and a mental health case manager conduct a joint assessment of each patient. Staff are still exploring ways to share records, Adams says. "We have joint clinical staff meetings, but we don't have integrated charts." Medical and mental health staff attend joint training sessions on such topics as motivational interviewing and the chronic care model.

MDC will continue project services with a HRSA Expanded Medical Capacity grant. *Contact:* Sheri Adams, (253) 597-4194, sheri@mdc-tacoma.org

Client-Centered Care The partnership between COPE Behavioral Services and El Rio Health Center was designed to be client-centered. "We shifted the paradigm to emphasize the client's immediate needs," and services are provided to address those needs first, says Mary Specio. "For example, we may need to reduce a patient's anxiety before he sees the medical provider." The grant paid for three COPE staff members to work in the HCH clinic. "They had walk-in hours and so did we," Specio says. Following the primary mental health care model (see lead story), COPE staff saw patients for brief, focused interventions. "We used motivational interviewing and stages of change to facilitate our client's entry into behavioral health care," she adds.

The HCH clinic is located adjacent to COPE's intensive case management services, where clients can be linked to ongoing care. Project staff developed a set of

innovative tools and techniques. To address conflicting data sharing regulations, they developed an abbreviated mental health case note that went into the medical record. To help engage clients, staff planned social activities at the clinic, such as a barbeque in the parking lot. They also developed a detailed locator form that helped them track clients, resulting in a 90 percent follow-up rate.

The Tucson team will continue services with a SAMHSA Treatment for the Homeless grant. *Contact*: Mary Specio, (520) 205-4724, maryspecio@copebhs.com

SOURCES & RESOURCES

1. Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems and Health,* 21, 121–134.

2. Fries, J., Koop, C., & Beadle, C. (1993). Reducing health care costs by reducing the need and demand for medical services. *The New England Journal of Medicine,* 329, 321–325.

3. U.S. Dept. of Health and Human Services. (2001). *Report of a Surgeon General's working meeting on the integration of mental health services and primary health care*. Rockville, MD: Author. *www.surgeongeneral.gov/library/mentalhealthservices/mentalhealthservices.PDF4*.

4. Burt, M.R., Aron, L.Y., Douglas, T., et al. (1999). *Homelessness: Programs and the people they serve*. Washington, DC: Interagency Council on the Homeless.

5. New York City Depts of Health and Mental Hygiene and Homeless Services. (2005). *The health of homeless adults in New York City*. *www.nyc.gov/html/doh/downloads/pdf/epi/epi-homeless-200512.pdf*

6. Unützer, J., Schoenbaum, M., Druss, B.G., & Katon, W.J. (2006). Transforming mental health care at the interface with general medicine: Report for the President's Commission. *Psychiatric Services,* 57(1), 37–47.

7. Reiger, D., Narrow, W., Rae, D., et al. (1993). The de facto US mental and addictive disorders service system: Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry,* 50, 85–94.

8. Substance Abuse and Mental Health Services Administration. (2003). SAMHSA/HRSA listening session. *Primary care and behavioral health: Exploring opportunities for better partnerships*. Unpublished draft.

9. See Strosahl, K. (2001). The integration of primary care and behavioral health: Type II change in the era of managed care. In N. Cummings, W. O'Donohoe, S. Hayes, & V. Follette (Eds.). *Integrated behavioral healthcare: Positioning mental health practice with medical/surgical practice*. New York: Academic Press.

10. To receive a copy of the final cross-site evaluation when it becomes available, send e-mail to *dawn.moses@familyhomelessness.org*.

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