

Dan Russell, CEO, Genesee County Community Mental Health, connected with Barbara DiPietro, Director of Policy, National Health Care for the Homeless Council, on November 11, 2011, to discuss health care reform, integration of primary and behavioral health care and being a new member of the Council.

Barbara DiPietro: Let's plunge right in. As the lead for a large mental health services provider in Michigan, what's your view of homelessness and how it impacts your clients' health?

Dan Russell: In Flint like a lot of urban settings, we are experiencing an unprecedented and dramatic increase in homelessness. Many of our consumers that receive care for the first time are homeless. Those who are disenfranchised and always live on the edge can become homeless. We're seeing a huge increase in the numbers of homeless. Obviously, that creates lots and lots of problems. Not having a stable home environment, or some place that people can call home both physically and psychologically, becomes the most important thing and all the other concerns and needs and services take second place to getting people stable homes. Other services don't really match up to the importance of not knowing where you're going to sleep at the end of the day. I think it has a dramatic impact on our consumers' mental health and obviously their physical. Not having a stable home environment that makes getting good, nutritious meals, staying warm, and getting the appropriate amount of sleep much more difficult. All those things that are usually listed as prerequisites for having good health are much more difficult. You're literally trying to come up with this stuff on a daily basis. It becomes your main concern and all of the other concerns fall by the wayside until that can be taken care of.

BD: I'd like to follow that up with a question about broader health care services. With so many people talking about integrated care, meaning both primary care and behavioral health services, how do you envision combining these to two fields? And what benefits do you see for clients in that approach?

DR: I think the least amount of time we spend having clients run around for services the better. Trying to combine everything into one stop obviously makes life easier for them. Most people who are homeless don't have great transportation and just getting from one appointment to the next or one screening to the next to be determined to be eligible for services can take enormous amounts of time, not to mention energy and resources. It's just an additional barrier we throw into the mix to make it more difficult. If we can provide the basic services in one place, mental healthcare and primary healthcare, it at least makes having to run around, less of an obstacle and hopefully people can get what they need in one spot and not have to worry about: How to do I get there? Who's going to pay for that? What are their hours? What happens if they're not there?

BD: Currently what you do is behavioral health focused. What kind of primary care issues do you see in a behavioral health care setting?

DR: We see pretty much what other behavioral health providers have seen for a long time. The Park study that came out in 2005 confirmed what I think most all of us knew. Individuals with severe mental illness die 25 to 30 years earlier than the general population. Not due to what most people would consider mental health issues or suicide, those kinds of things. It's the result of cardiovascular events just like the rest of us. It's just because of all the other problems and challenges they deal with it hits them earlier. When that study came out in 2005, we ran our own data and our graph pretty much mirrored the graph presented in the study. Our individuals who receive services here are dying at an average, I believe, of about 53 years of age. The chances our consumers have of living past the age of 60 are minute. We can replicate that study in Genesee County and I doubt that we're much different than other places.

BD: You had mentioned the idea of integrated care providing a one stop place, trying to minimize the running around and transportation that clients, particularly homeless clients have to arrange. How do you see that meshing with the concept of patient-centered medical home, health home, Meaningful Use, and electronic health records? Do you see these new models coming into play helping with that vision you describe?

DR: I think so. Whatever reform becomes, whatever's left of it, whatever form it takes, I think all those buzz words now being used basically move toward the same goal which is trying to get services to the people who need them as easily and efficiently as possible. We've had our local FQHC in our building since 2001, before integration was the big thing. We didn't even call it integration at the time. We called it "Our consumers need primary care." That's been a great collaboration. We try to build that as much as possible and we want to extend that into the homeless community – put that primary care right at the site where most homeless individuals will go for the other services. They won't have to get a referral to go see the doctor. The doctor and the dentist are going to be right at the one stop and they are going to be right in the large public housing complex. We're going to try to make that as simple as possible. I think everything that's coming with health reform is going to get to that same point, to put services where people need them.

BD: Your organization received a planning grant from HRSA recently to become an FQHC. How do you plan on using that grant? And what benefit do you think that will bring to your community?

DR: We did. We got the HRSA planning grant. Our plan is to work with the community as part of the planning process. We've already done a great deal of that. Again, our vision would be to put healthcare clinics at the sites where homeless or those at risk of being homeless often reside. We have a small one-stop center for homelessness in the county. We're trying to expand that. Then we would look at putting a small clinic at a large public housing complex in the county, where people are right on the verge of, just that one crisis away from, being homeless. Our being

right there, having those services available right there means people don't have to worry about transportation. They don't have to worry about how they're going to get to the doctor. The doctor is going to be right there.

BD: Excellent. You had mentioned health reform a moment ago. What changes do you see the health reform law bringing to the services you provide either now or when you become an FQHC? And do you think that all these changes are going to be helpful with access and quality of care?

DR: I'd like to think that whatever changes are coming are going to be helpful and the people guiding it are going to make the right decisions. I think it is going to impact the community mental health world in a pretty significant way, not just in Michigan. I don't know how. I try to read as much as probably everybody else does and all the theories, the models, although somewhat similar all have different outcomes. I'm not quite sure what that means for us. In Michigan, we are also the Medicaid manager. We not only provide services but we manage the Medicaid dollars for the entire population of our catchment area. I think it's possible that somebody else might be managing those dollars and we'll still be a provider. I think part of health care reform is trying to simplify what the government does as far as writing fewer checks to everybody to take care of the same people. I think they'll be a big consolidation as far as who handles the money. I think we could be a provider of services as opposed the dual role we have now.

BD: You're also a new organizational member with the National HCH Council. As a non-HCH at the moment, what drew you to our organization and what are you hoping to gain from it?

DR: When we went through our application process – we applied for the 330 FQHC funding before we applied for the grant we received. We applied for both of them. We did not receive the 330 funding. None of the 26 Michigan applications were funded. We were contacted by the Council because our demographics in Genesee County and Flint came up and we received an email for participants in a panel about more healthcare access for the homeless. We responded and became aware of the Council and have just found it to be a tremendous resource which we wish we had known about while we were going through the application process. The Council has been very helpful. We've had some good conversations. I think the resources that they have and the knowledge they have is very crucial and extremely valuable with everything that's going on in Washington and with the federal regulations. As a continuing member, I would hope we get the same great service and information we have and to be able to work more with the Council as we head into what is, hopefully, an era of additional funding for services for the homeless.

BD: One of the things we've been pushing in our advocacy agenda is the value of health centers as an employer base for different communities. So much of the current political discussion focuses on jobs and the economy. As providers of not only healthcare and services to vulnerable populations but also as an employer, can

you tell us about some of your wellness initiatives and some of the things that you've been doing as a way of galvanizing the people who work with you?

DR: We have a number of wellness initiatives in the county and we're doing it at our agency because not only do our consumers face health challenges there but there are certainly staff health challenges as well. Michigan has an extremely high rate of cardiovascular disease and all the other diagnoses that go with it and not just in the severely mentally ill population. We have an extremely high rate of obesity in the state as well. We have a number of initiatives. We just got through with an initiative that was started by our local health association here, the Greater Flint Health Coalition. They have started a challenge for businesses both large and small to get their workforces involved in how they move and what they eat. The first challenge was to get as many staff as you could doing some kind of physically activity 30 minutes a day. We actually won that; we won the award for the large business division. We're trying to get staff more involved. We had a recent initiative where we redid all of our stairwells. The CDC has an evidence-based practice that has shown that if you make your stairwells attractive and can get just a small percentage of staff who were not using them before to take the stairs, you can make back the investment in doing them in as little as a year. We had very dingy stairwells; we're in an old building. We had them painted and we have murals on them. We have music piped in and motivational billboards and health-related information on the different levels and we have greatly increased the use of the stairs as opposed to the elevator. For our consumers we have a personal training program. When the Park study came out and everyone was scrambling to try to increase the health of their consumers we picked a program that had just started in New Hampshire. We have a personal training program for consumers which is exactly what it sounds like. We have certified personal trainers, not therapists, not social workers, but personal trainers. They take our consumers to the gym. They take them to the grocery store. They teach them how to shop. They take them to the garden. They show them what to pick and how to prepare food. We're starting to train them on a healthy lifestyle. It's a long process but we are starting to see some pretty significant, impressive results in weight loss and drops in blood pressure and cholesterol. That's pretty exciting.

BD: That is exciting. That sounds really cool. What advice would you give to other providers who are looking to expand their services in the way that you are and how they would thrive in a changing environment like the one we're in?

DR: My personal opinion is that you pretty much have to be friends with everybody and look for collaborations that a couple years ago you might never have thought of. I think the landscape is going to change. I don't know that everyone who is now in control is going to be in control when health care reform is fully implemented. Look at what you're good at and concentrate on that. Look for partners and look for services you can really do well. Partner with those other organizations that do other things well.

BD: I like that, “being friends with everyone.” I think that’s a good way of going about it these days.

DR: Yes, I’m trying to go to lunch with everybody and talk about what’s going to happen in the new world. We all might be working for one entity and we all really need to let all egos and control issues and turf issues fall by the wayside because they are just going to kill us in a couple years.

BD: Agreed. Anything else you’d like to share with our readers about what you’re doing, what you’re going through or your thoughts about the policy and health care world around you?

DR: I think with not knowing what health care reform is going to bring, as long as we remember why we’re here and get back to our basic mission which is to provide the best services we can to the people who need them, it will be hard to go wrong. I don’t think that people will all get what they want in the new health care world but I do think that it’s all about better services for the people we serve. I think as long as we remember that we’ll all be okay. Maybe not as okay as we are now, and the world won’t look like it looks now, but I think we’ll all be okay.

BD: Thanks so much for talking with me today.

DR: It’s been a pleasure, Barbara.

BD: I really look forward to seeing you again soon, maybe at our national conference in May.

DR: I’ve got it on my calendar and hope to be there.