

Key Elements of Integrated Care for Persons Experiencing Homelessness

*A Guide for
Health Care for the Homeless
Providers*

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National Health Care for the Homeless Council
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The National Health Care for the Homeless Council is a membership organization comprised of health care professionals and agencies that serve homeless people in communities across America. The Council works to improve the delivery of care to homeless people, and to reduce the necessity for dedicated health care for the homeless programs by addressing the root causes of homelessness.

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Dear Colleague,

The National Health Care for the Homeless Council is pleased to provide this document describing the *Key Elements of Integrated Health Care for Persons Experiencing Homelessness*.

The document is presented as *A Guide for HCH Providers*, but its reach is much broader, with implications for the entire health care system. Claire Goyer, the author, has succinctly conveyed the genius of the multi-faceted HCH “model” as it has developed over a quarter-century. She examines the *Key Elements* in light of the requirements of the Patient Centered Medical Home model that the Congress built into the 2010 national health care reform. As you will read, HCH shines as an exemplar of care integration.

Dr. Philip Brickner and his colleagues in the Program Office for the early HCH Demonstration Program wisely required *teams* of physicians, nurses and social workers to address the multiple interrelated health and social problems of people without homes. Since then, HCH leaders throughout the country have elaborated on the model and on the very concept of integration, introducing structures and approaches that are described in *Key Elements*. Meanwhile, the health care system and policy makers have come to recognize in the general population the same needs for well-managed, person-centered integrated care that are so glaring among the poorest of our neighbors. It is our fervent hope that the HCH experience expressed herein will inform and inspire the rest of the health care system.

In these pages, Claire acknowledges numerous important contributors to this document, but neglects the most significant one: Claire Goyer. Claire’s intellectual reach, expertise in HCH, and ability to sort through and summarize lots of information are evident in *Key Elements*. We are proud that her so-called retirement from Duffy Health Center includes work with the National HCH Council as a Technical Assistance provider to the HCH field and as the author of this timely document.

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Executive Director

INTRODUCTION

Integrated Care is central to the Healthcare for the Homeless approach and has been implemented in varying degrees in HCH sites since the 1980's. The major elements of the HCH model of care include compassionate and persistent outreach to persons experiencing homelessness; an emphasis on easy access to care through the use of walk-in models and same day appointments; an understanding of the comprehensive and complex needs of the individuals who are served; a "whole person" approach to care through the consideration of medical, behavioral and social service needs; the development of trusting and respectful relationships with the individuals who are served; and the delivery of comprehensive services and supports by multi-disciplinary teams.

The Patient Centered Health Home movement takes integrated care to another level, with the additional emphasis on continuity of care delivery, comprehensive quality assessment and outcome measurement and seamless coordination of care both within the team and with other health and service providers. The HCH model of care provides a solid foundation for programs to seek formal recognition as Patient-Centered Medical Homes although there are some interesting challenges which need to be addressed. Because of the transient nature of the population, care is often episodic in nature. Individuals may seek treatment from more than one health care provider, further complicating continuity of care. Complex co-morbidities challenge adherence to plans of care and the very nature of homelessness impacts the individual's capacity to address multiple health challenges. Despite these issues, HCH providers strive to provide evidence-based care which focuses on multiple health outcomes and recognize that coordination and integration of care are central to true person-centered care.

This document examines integrated care from the perspective of the key elements of the HCH model, with program examples drawn from interviews with a variety of HCH providers, representing urban and rural, small and large, newly funded or with long histories of service delivery, and varying organizational structures. Whenever possible, we have attempted to provide examples of common challenges as well as successful strategies, with an emphasis upon the creative, dedicated and outstanding work that is done in HCH programs to create health homes for the individuals who are served. It is our hope that the reader will gain a greater understanding of integration of care, the HCH model, and the alignment between that model and the Patient Centered Medical Home.

OVERVIEW OF KEY CONCEPTS

Defining Integrated Care

Also known as shared care, comprehensive care and seamless care, Integrated Care is a worldwide trend in health care reforms and other new organizational arrangements focusing on more coordinated and integrated forms of care provision. Integrated Care may be seen as a response to the fragmented delivery of health and social services, which is an acknowledged problem in many health systems. (Kodner, 2002)

Integrated primary care is a service that combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to their primary medical care providers. It allows patients to feel that, for almost any problem, they have come to the right place

Central Concepts of Integrated Care

The integrated care literature distinguishes between different ways and degrees of working together. Three central terms are *autonomy*, *coordination* and *integration*. While autonomy refers to the one end of the continuum with the least amount of cooperation, integration refers to the end with the most cooperation and coordination. (Grone, 2002)

Closely related to Integrated Care is also the concept of continuity of care, emphasizing the patient's perspective through the system of health and social services and hence providing valuable lessons for the integration of systems. Continuity of care is often subdivided in three components: 1) continuity of information (through shared records), 2) continuity across the secondary-primary care interface (discharge planning from specialist to generalist care), 3) provider continuity (seeing the same professional each time with value added if there is a therapeutic, trusting relationship).(Grone, 2002)

Rationale for Integrated Care

The primary care setting is often the first and most trusted place that people will go with health issues, and patients prefer to get their mental health needs taken care of by their primary care physician. Ninety (90) per cent of the ten most common complaints in primary care settings have no organic basis and 50 – 70% of all primary care visits are primarily for psychosocial concerns. Referral out to another site to address the psychosocial or behavioral elements is often a poor alternative. Research indicates that there is better adherence and outcomes, along with increased satisfaction, when care is integrated, resulting in long term benefits for all stakeholders.(Integrated Primary Care: Organizing the evidence, 2003)

Living in poverty is a health risk. The impact of psychosocial factors on the body is even greater for people in poverty. Low income and underserved populations are less likely than the general public to accept a mental health definition of their problem and if they do accept a referral for mental health services, they encounter much greater difficulty negotiating travel and scheduling problems. This means that, while primary care physicians are the only providers treating 50 to 70% of the diagnosable mental health problems treated in the US, that figure is higher for the underserved. It is especially important that care for low income and underserved patients be supplied in a way that addresses the needs they present in ways that they can accept. (Integrated Primary Care, Inc., 2011)

Integration of care is a critical component of federal health care reform. Improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. In the aggregate, these goals are called the "Triple Aim". Preconditions for achieving these goals include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an "integrator") that accepts responsibility for all three aims for that population. The integrator's role includes at least five

components: partnership with individuals and families, redesign of primary care, population health management, financial management and macro system integration. (Berwick, 2008)

Patient Centered Medical Homes

The patient-centered medical home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults in a healthcare setting that facilitates partnerships between individual patients, their personal clinicians, and, when appropriate, the patient's family.

PCMH practices have a whole person orientation, and patients have a continuous relationship with a personal clinician. Care is integrated and coordinated, and quality and safety are hallmarks. Enhanced access is made possible by system advances and new communication options.(A New Approach to Patient Care, 2011)

There are a variety of organizations providing recognition and accreditation services for designation as PCMHs. NCQA is one of the leaders in the field, and has identified six program standards which are considered essential to the patient-centered medical home, and are required for practices at all recognition levels. These elements include:

- Enhancing Access and Continuity
- Identifying and Managing Patient Populations
- Planning and Managing Care
- Providing Self-Care and Community Support
- Tracking and Coordinating Care
- Measuring and Improving Performance

The Health Care for the Homeless Model

The Health Care for the Homeless (HCH) model of care was developed through a 19-city demonstration program established in 1985 by the Robert Wood Johnson Foundation and the Pew Memorial Trust. In 1987, the Stewart B. McKinney Homeless Assistance Act replicated the foundations' program and now 207 local projects are funded in part by the federal Health Resources and Services Administration, Bureau of Primary Health Care. The federal HCH program is widely recognized as one of the most effective McKinney Act programs, and is an indispensable, front-line component of our country's struggle with homelessness.(The Basics of Homelessness)

Federally funded HCH programs must meet all requirements of Federally Qualified Health Centers (FQHCs). In addition, HCH projects must provide substance abuse services through assessment and direct intervention or referral systems.

In HCH programs, multidisciplinary teams work to remedy the variety of problems that affect their clients' health. Going beyond traditional medical care, these effective teams work with their clients to address issues of safe shelter and permanent housing, jobs and income, family relationships and mental health and substance use disorders. This comprehensive approach helps people get well, stabilize their lives, and move out of homelessness.

Alignment between PCMH and HCH Model

HCH programs are not uniform in structure or comprehensiveness, particularly as they reflect the local community needs in terms of model of service delivery. It is our belief however, that the core HCH model is in close alignment with the principles of the patient-centered medical home, especially in the areas of patient empowerment, care coordination and delivery of integrated, team-based care. This guide outlines

the key elements of the HCH model, and highlights specific practices reflective of a wide range of HCH programs, based upon comprehensive field interviews.

THE HCH MODEL: ENHANCING ACCESS AND CONTINUITY

A key component of the Patient Centered Medical Home (PCMH) is ensuring that patients have both access to and continuity of care. HCH programs utilize strategies which are responsive to the needs of the population through outreach, accessible and consistent hours and locations, creating safe and welcoming environments and coordinating access to specialty care.

Outreach

Outreach is defined as “...contact with any individual who would otherwise be ignored (or underserved)...in non-traditional settings for the purpose of improving their mental health, health, or social functioning or increasing their human service and resource utilization.” (Morse, 1987)

HCH program staff provide outreach at shelters, streets, motels, parks, campgrounds, under bridges, soup kitchens and other locations where individuals who are experiencing homelessness are likely to be found. Utilizing a team approach, outreach is provided in a friendly, non-threatening manner. Services are taken to the individual, rather than waiting for them to come to the services. Often there is repeated contact over time, in an effort to build a trusting relationship with those who are reluctant or suspicious to receive help. An immediate focus is a prompt response to a client’s basic survival needs, although overall needs are assessed, and a plan of service is developed which reflects each client’s unique needs. Using a flexible and patient approach, outreach teams work to engage clients in an effort to connect them to the appropriate services. (McMurray-Avila, 2001)

Examples from the Field:

Care for the Homeless, New York City, NY, provides outreach services where homeless persons congregate. Case managers and medical assistants work with staff at these sites, or at neighboring community resources, to attract people to care. Staff send letters, hang posters, conduct health fairs and voter registration drives and provide incentives such as socks for diabetics and a “pap smears for pocketbooks” program.

United Neighborhood Health Services, Nashville, TN, has an outreach team that engages people at day shelters, congregate meal sites and encampments, inquiring about health care needs, prescription refills, appointments and other medical issues.

Service Locations

HCH programs utilize a wide range of modalities to ensure access to care, including direct service delivery at shelters or other community locations such as permanent supported housing units. Although many HCH programs operate free standing fixed site clinics, many have established small clinics or service sites within other settings to further promote easy access to care and linkages to other services.

Examples from the Field:

In addition to a fixed site clinic and street outreach, Community Health Link, Worcester, MA has a medical clinic at the site of the St. John’s Church Soup Kitchen, as well as a clinic located at the newly established Assessment Center, an emergency overnight service providing short term sheltering with a focus on transition to more permanent housing arrangements.

United Neighborhood Health Services has a fixed site clinic, a shelter based clinic and also provides services at a day shelter for individuals with co-occurring health and addiction disorders, as well as at three separate large permanent supportive housing complexes, with a total of 380 units.

Heartland Health Outreach, Chicago, IL, operates a fixed site clinic, two dental clinics, has street outreach services and also visits at least 40 shelters a month utilizing a mobile medical team model.

Hours of Service

Hours of service vary, but the focus is on ensuring that services are available when most needed. Programs combine walk-in care with open access scheduling and appointments to meet the range of presenting needs.

Welcoming Environment

HCH programs strive to create a welcoming environment with minimal barriers to care. Many individuals seeking care at HCH settings have experienced indifference, hostility and trauma, resulting in a reduced ability to trust and build relationships with those who are in a position to provide supports. It is critical for HCH programs to demonstrate both respect and caring in the design and ambience of the facility, attitude and approach by staff, and the design of supports, both large and small, that send a strong message of client respect and empowerment.

Examples from the Field:

At Community Health Link, there is a street level access point for the main clinic. Wait spaces are available in all departments. The organization offers snack foods and there is a shower available on a sign in basis.

At Duffy Health Center, there is a concerted effort to maintain a calm environment. The program recently moved to a new building, which is painted in warm colors and has a large and sunny waiting room. Original art work, including client pieces, is placed throughout the building. The design of the space ensures privacy and confidentiality.

At Harbor Care Clinic in Nashua, NH, the space is bright, cheerful and well-lighted. There are plants and seasonal decorations, lots of seating options, the ability to check in but go back outside to wait; and books and health information are available.

In all three settings, all staff have been trained in evidence based practices designed to promote non-judgmental and respectful interactions at all levels.

Mobile Units

Services are designed to address the specific needs of the local community. In some cases, this means the use of a mobile health unit to ensure that services are brought to individuals who are not utilizing other service locations and who are unable to travel to a fixed site location. Mobile units are operating in both urban and rural locations.

Examples from the Field:

The Illumination Foundation (IF) in Irvine, CA, is a free clinic that intends to apply for FQHC look-alike status, once their fixed site clinic is operational. IF has a mobile unit with two exam rooms and a pharmacy, with service delivery provided through a unique three-way collaboration. The mobile unit visits 29 separate locations, with consistent providers at each location. Staff include public health nurses, social workers, psychiatrist and students in medicine and nursing. Mobile medical services are provided in partnership with the County Public Health Department as well as Kaiser Permanente Family Residency Program. The County Health Department provides public health nurses as well as a part-time psychiatrist. Kaiser Permanente residents must provide a full year of service on the mobile unit. This can include participating in large scale health outreach fairs or service delivery at specific mobile unit service sites. IF leases the vehicle and driver and provides mental health specialists, both paid staff and interns.

Peak Vista CHC in Colorado Springs, CO has a small staff team which divides its time between service delivery at a local shelter-based clinic and the program's mobile medical unit, which has an exam room, intake and lab areas. The mobile unit provides consistent outreach twice weekly to four separate locations; and for many clients, the mobile services constitute their ongoing primary health care. Staff work to make linkages to specialty providers as well as to the FQHC main clinic.

Lack of public transportation, particularly in more rural communities, presents specific access challenges. Duffy Health Center has a centrally located fixed site clinic and uses a mobile medical unit to reach individuals who reside in communities on Cape Cod which are a distance from the main clinic site. Working in partnership with local community service providers, Duffy has established four separate mobile sites which are each visited weekly. Medical services are provided on the van through a consistent nurse practitioner, and linkages are made to the main clinic or to other health care providers in the community.

Specialty Care & Other Resources

HCH programs vary in terms of scope of specialty care provision, depending upon the size and complexity of the program. If the program does not offer the service in-house, memoranda of agreement are in place with other community providers, including podiatry, dermatology and vision services. A number of HCH programs are recipients of Ryan White funding and have developed expertise in the delivery of HIV/AIDS services. When dedicated funding is not available, HCH programs often partner with HIV service providers such as infectious disease specialists or HIV coordinators from other agencies. Larger programs, particularly those embedded within community health centers, may offer dental programs and pharmacy services on site. Several programs have been able to attract volunteer specialists, including chiropractors.

HCH program staff also work to reduce additional barriers to care through a wide range of additional support services, including applications for emergency financial assistance, health insurance enrollment, and Social Security programs.

Examples from the Field:

Harbor Care Clinic maintains some sample medications and has an active prescription assistance program. Although Harbor Care is a new program, it was immediately clear to staff that lack of access to medications was a major barrier. Through dedicated staff efforts, they have over \$80,000 worth of stock on site, acquired through pharmacy companies and a small amount of program funds.

Duffy is able to enroll all clients in health coverage through the state's Virtual Gateway program. This electronic benefits enrollment is completed during each client's initial intake meeting, resulting in over 95% of patients with health insurance coverage.

Horizon Health Center, Raleigh, NC, has a county funded HIV coordinator from another agency on site at their clinic two days per week.

Peak Vista CHC staff have set aside specific time during their work week to coordinate emergency assistance and SSDI applications. During this time staff work on documenting disability and coordinating with SOAR workers from another community agency for the follow up case management supports, including help with forms completion and assistance getting to appointments.

THE HCH MODEL: IDENTIFYING, PLANNING AND MANAGING PATIENT CARE

Identifying, planning and managing care are the major tenets of the PCMH. In order to develop a care plan, new clients must have comprehensive assessments followed by the development and implementation of relevant service plans. Patients need to be at the center of all of these activities. Individuals who are experiencing homelessness often approach the health care setting with high levels of anxiety and mistrust. In order to develop both person-centered and comprehensive plans of care, HCH programs need solid systems and practices that reduce anxiety, promote the development of trusting relationships between client and service provider, and allow for the identification of service needs and appropriate plans of care.

Point of Entry for New Clients

HCH programs strive to be welcoming, safe and nurturing environments. Access to care is simplified to the extent possible. “Handoffs” from outreach workers to clinic intake staff are “warm” and in-person, as are other referrals within multi-disciplinary staffs. Staff teams coordinate paperwork to ensure that the new client is not overwhelmed by intake requirements. The use of electronic health records is an extremely useful tool in streamlining point of entry into systems of care.

Examples from the Field:

Community Health Link (CHL) is the lead agency for the City of Worcester’s homeless triage system. As a result of leadership at the mayoral office, in concert with a state-wide focus on a paradigm shift from sheltering to assessment and rapid re-housing, CHL was awarded a contract to develop and manage a centralized assessment center, which includes emergency overnight service. Key to the principles of the new model is a comprehensive assessment completed by a case manager, which results in referrals for all identified service needs, including housing, primary care and behavioral health needs. Follow up intensive case management services assist each new client to access the resources identified in the service plan. The intent of this new model is to end the episode of homelessness within two weeks. Since inception of this project less than three years ago, the average length of homelessness for new clients has been thirty days. The emphasis on a clear point of entry as an efficient and cost-effective approach has allowed resources to be used in new and different ways. A major outcome of this new model has been the doubling of housing capacity, especially permanent supportive housing, despite the recent economic downturn funding challenges at the city and state level.

Duffy implemented a “no wrong door” approach as a result of strategic planning. Historically, the primary care department was the access point for all new clients, with behavioral health and case management services accessed via referral from primary care to those departments. With the new model, all new clients meet first with a *Connections* case manager, who is trained in conducting an initial assessment, and whose role is to educate about available services and to connect the new client with all requested services. As an additional component of this intake process, a modified PHQ-9 depression and substance abuse screening tool is scored by the case manager, with an immediate referral for behavioral health triage if the client’s score exceeds a severity scale. A “warm hand-off” is made by the case manager to all other internal services. In addition to connecting to Duffy services, the *Connections* case manager is knowledgeable about a wide range of community resources, and can facilitate client access to those services as well. This new model allows for the development of a person-centered, consumer-driven service plan, while encouraging use of a fully integrated continuum of services.

Departmental Assessments & Plans of Care

Once the individual has been established as a new HCH client, it is typical for each service department to conduct its own assessments related to its area of expertise. In many cases, requirements for these assessments are established by the payer source, especially in the arena of behavioral health services.

Medical services generally utilize a comprehensive review of systems, medical and family history, and presenting needs, and develop a plan of care accordingly. Behavioral health providers complete a biopsychosocial assessment with the client and collaboratively develop a treatment plan. Case managers generally complete an intake focused on presenting needs, including housing, entitlements and other social service areas and complete a service plan based on what the client prefers to prioritize.

Because HCH programs focus on the delivery of care through a team, sharing of information among departments is both typical and crucial to the coordination of care. A standardized and common tool shared among departments supports this coordination. In addition, many programs utilize a “huddle” model in which medical and behavioral health providers connect at the time of a patient visit to brainstorm on a shared course of action.

Examples from the Field:

At Horizon Health Center, the primary care physician and the behavioral health specialist develop discipline specific plans, with a heavy emphasis upon collaboration. Initial screening tools inform both providers of medical, mental health and substance abuse issues. For new patients, they often huddle to quickly share information and develop a plan for next steps as well as additional resources or assessments needed. For 30-40% of their existing clients they provide a joint encounter to further develop the plan. They also utilize the electronic health record to flag the need for collaboration prior to the client’s next visit.

At United Neighborhood Health Services, a common tool is used with all new patients. The tool covers behavioral health in considerable detail, with specialized instruments used for assessment and service planning as needed. All members of the patient care teams huddle at the beginning and end of the day to share information, and there is a strong emphasis on involving patients in the creation, implementation and monitoring of their care plans. As United moves toward a patient-centered health home model, they are further strengthening their patient care team model.

Evidence Based Practices

The use of evidence based practices which are particularly effective for individuals experiencing homelessness assists in the development of appropriate interventions as well as shared understanding and practices by members of the multi-disciplinary teams. The following evidence based practices are the most commonly implemented within HCH settings:

The Stages of Change Model

The Stages of Change Model was originally developed in the late 1970’s and early 1980’s by *James Prochaska* and *Carlo DiClemente* at the University of Rhode Island when they were studying how smokers were able to give up their habits or addiction. The Stages of Change model has been applied to a broad range of behaviors, including weight loss, injury prevention, and overcoming alcohol and drug problems. The rationale is that behavior change does not happen in one step; rather, people tend to progress through different stages on their way to successful change, at their own rate. In each of the stages of change, a person has to grapple with a different set of issues and tasks that relate to changing behavior. The stages of change include: Precontemplation (not yet acknowledging that there is a problem behavior that needs to be changed); Contemplation (acknowledging that there is a problem but not yet ready or sure of wanting to make a change); Preparation/Determination (getting ready to change); Action/Willpower (changing behavior); Maintenance (maintaining the behavior change) and Relapse (returning to older behaviors and abandoning the new changes). HCH programs utilize this practice both

from the perspective of understanding the point at which the individual is functioning as well as adopting techniques to support each person based on the specific presenting stage of change.

Example from the Field:

Dr. Jim Hartye, Medical Director of Horizon Health Center, states that “Stages of change theory infiltrates all that we do. Our conversations in both medical and behavioral health are grounded in the stages of change model.” Horizon is a program of Wake Health Services, a large FQHC, and Dr. Hartye has also provided in-services to all nurses in the FQHC regarding the stages of change theory. Horizon staff maintains a database which tracks each client’s specific addictions, including smoking and overeating, along with what stage of change the person is at for each particular addiction. This allows staff to provide the necessary response for each identified issue.

Motivational Interviewing (MI)

MI is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change. (Rollnick, 2009) The definition of MI has evolved and been refined since the initial description by William R. Miller in 1983, developed from his experience in the treatment of problem drinkers. Through clinical experience and empirical research, the fundamental principles and methodologies of MI have been applied and tested in various settings and research findings have demonstrated its efficacy. MI is now established as an evidence-based practice in the treatment of individuals with substance use disorders.

MI is a particular kind of conversation about change. It is a collaborative, person-centered approach, and seeks to call forth the person’s own motivation and commitment. The principles of MI include the expression of empathy, supporting self-efficacy, rolling with resistance, and developing discrepancy. The techniques utilized are open ended questions, affirmations, reflections and summaries.

HCH programs utilize MI as a core competency for all staff members to ensure that the client’s service plan is based on his/her readiness to change and immediate and long term goals.

Example from the Field:

At Duffy, all staff, including front office personnel, has received training in Motivational Interviewing. Practices are reinforced through supervision, department meetings, all staff meetings, and clinical case conferences. Duffy has a large Suboxone program and MI practices are implemented through all components of this service, including intake and assessment, care coordination and behavioral health treatment.

Harm Reduction

Harm Reduction philosophy and practices originated in 1964 with a focus on reducing the use of nicotine and abuse of alcohol, and moved through several different phases addressing drug dependency. Harm Reduction is defined as a perspective and a set of practical strategies to reduce the negative consequences of drug use, incorporating a spectrum of strategies from safer use to abstinence.(McVinney, 2006) Using behavior change models and motivational enhancements, harm reduction strategies are used in HCH programs to address risky behaviors, alcohol and drug addiction, medication adherence and housing supports. The goal is to decrease the short and long term adverse

consequences of behaviors, even for those who continue to use drugs or alcohol or engage in potentially dangerous behaviors. Principles include a nonjudgmental approach, active involvement by the client, an emphasis on any level of positive change and a focus on providers of services working in a collaborative manner.

HCH programs implement Harm Reduction philosophy in concert with the Stages of Change theory. Client intake assessments allow for the identification of risky behaviors and as staff work with individual clients, they identify readiness for change and focus on effective strategies to assist that person to minimize risk.

Many HCH programs are actively involved in the Housing First model of housing supports for individuals with histories of chronic homelessness. This low threshold, barrier free model, represents a housing approach based on a harm reduction philosophy. Housing is seen as the first necessary response to homelessness, with minimal expectations in the area of sobriety or medication compliance. Expectations are related to maintenance of tenancy, and intensive supports are provided to enable each individual to remain successfully housed.

Trauma Informed Care

Most individuals seeking public behavioral health services and many other public services, such as homeless and domestic violence services, have histories of physical and sexual abuse and other types of trauma-inducing experiences. These experiences often lead to mental health and co-occurring disorders such as chronic health conditions, substance abuse, eating disorders, and HIV/AIDS, as well as contact with the criminal justice system.(Substance Abuse & Mental Health Services Administration, 2011)

Ninety-seven per cent of homeless women with serious mental illness have experienced severe physical and sexual abuse, with 87% experiencing this abuse as both a child and an adult. The prevalence of trauma is an epidemic among the population of persons seeking services in the public mental health system.(Trauma Informed Care: An Overview of Fundamental Concepts, 2004)

Services that are provided in the framework of trauma informed care are directed by a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual and an appreciation for the high prevalence of traumatic experiences in persons who receive services in HCH settings. A trauma-informed model frames the individual's symptoms as adaptations, rather than pathology, and staff are able to recognize adaptive behaviors such as aggressiveness, use of drugs and alcohol, self-destructiveness and refusal to take medications as potentially linked to a history of trauma.

The key principles of trauma informed care systems include integrating this philosophy of care across all clinical interventions, including the survivor's perspective, and recognizing that coercive interventions cause traumatization and re-traumatization and are to be avoided.(Trauma Informed Care: An Overview of Fundamental Concepts, 2004). Trauma informed systems, such as HCH programs, value the individual in all aspects of care; use neutral, objective and supportive language; develop individually flexible plans and approaches; and provide training and supervision in assessment and treatment of people with trauma histories.

HCH programs provide training to staff in understanding the role of trauma as related to homelessness as well as effective strategies to implement in working with individuals who have experienced trauma. The integrated model of care found in HCH programs allows for an ability to both recognize and address the trauma, addiction and mental health issues when they co-occur. In addition, many programs use a “trauma-informed lens” to analyze their policies, procedures and processes, including input and feedback from consumers of services to ensure that services are delivered in a trauma-informed manner.

THE HCH MODEL: TEAM

One of the key principles of the Patient-Centered Medical Home is the delivery of person-centered services through a consistent team of clinicians and providers. In addition to enhancing quality and improving patient satisfaction, it increases efficiency and staff satisfaction, as each member of the team can function at the highest level of professional expertise and licensure. HCH programs strive to focus on person-centered planning and the delivery of services through a coordinated and multi-disciplinary team.

Team Composition and Key Roles

As noted in the Introduction, one of the key elements of the HCH model is the delivery of care through an integrated team model. Integrated teams generally include both primary care and behavioral health providers. In some organizations, case managers, care coordinators or pharmacists are routinely included in service teams. In all cases, welcoming and respectful front desk staff is critical to client satisfaction and team functioning. (National Health Care for the Homeless Council, 2011)

Integrated care teams can consist of members of the same organization or reflect collaborative partnerships. Generally, teams are formed in response to multiple factors, such as the organization’s strategic planning and goals, history of partnerships with other community service providers, local resources, and organization mission.

Developing and implementing an integrated care model often leads to a more trans-disciplinary model of care, with medical providers more comfortable assessing and treating behavioral health issues, and behavioral health providers and case managers supporting chronic disease interventions.

Examples from the Field:

At Heartland Health Outreach (HHO), HCH staffing includes physicians, nurse practitioners, psychiatric nurse practitioners, RNs, medical assistants and a case manager. In addition, HHO has the ability to partner with staff from other agency programs, including addiction specialists, housing support staff and medical case managers. Typically, one program in the organization serves as a “clinical home” for each participant, even if the participant may be served by several programs. The clinical home is generally the program where the participant receives the most clinical services. As HHO moves toward a more integrated model of care, it is studying the National Council of Community Behavioral Health Providers’ Four Quadrant Model, which would lead to identification of the lead staff team based on the severity and complexity of behavioral health issues.

At Duffy Health Center, staffing includes physicians, nurse practitioners, psychiatric nurse practitioner, psychiatrist, RNs, medical assistants, clinical social workers and case managers. Duffy has a large Suboxone program managed by the medical director in collaboration with the Directors of Behavioral Health and Case Management Services, and several housing programs, including Housing First, managed by the case management department. Many of the primary care providers are very comfortable addressing behavioral health issues, particularly depression and addiction. Because of the complexity of the patient population, psychiatric services are critical to both diagnosis and medical management. Behavioral health staff reinforce medical issues, such as smoking or weight reduction, as part of their overall treatment planning. They also address the mental health component of chronic disease, e.g. depression related to inability to work due to health status. Case managers focus on ensuring that there are no barriers in the way of keeping appointments with primary care or specialists, and will arrange transportation accordingly. Duffy has a strong focus on housing outcomes, so case management staff ensures that the necessary supports are in place to ensure that clients retain housing, which enables them to address their physical and mental health issues. Providers may team for some client appointments, e.g. case managers and/or behavioral health

clinicians attending primary care appointments with the client or case managers and behavioral health clinicians meeting jointly with a client.

At Horizon Health Center (HHC), if a patient is diagnosed to be HIV positive or if a patient presents with an acute mental health, substance abuse issue or both, a service team is identified. HHC has a small staff team of 10, including physician, nurse practitioner, RN, medical assistants and a licensed mental health/substance abuse specialist. The medical director, Dr. Jim Hartye, provides assessment, initial prescribing and management of psychotropic medications. Dr. Hartye stated that he “had to learn due to the lack of available psychiatry in the community, especially psychiatrists who are comfortable with the homeless population.” With the addition of a mental health/substance abuse specialist, he feels “much more informed about behavioral health issues.” Staff have identified the lack of a dedicated case manager as a service gap for their program.

Community Health Link (CHL) has a staff team consisting of both medical and behavioral health providers, including psychiatry and Suboxone prescribers. Because the organization now operates the Assessment Center, which provides triage, assessment and service linkages for individuals experiencing homelessness, there is a range of available case management supports. CHL also has a Housing First program which is an intensive case management model. Clients are assigned to specific team members based on client profile matching and availability, as well as known historical relationships. The team member with the strongest working relationship with the client is the identified lead. Primary care providers prescribe more common medications such as anti-depressants, but all other behavioral health needs are managed by the behavioral health team. One primary care provider is Suboxone certified and the Suboxone service is coordinated through the behavioral health team. The organization recently piloted the inclusion of a behavioral health intern within the primary care team to address chronic disease issues, and will analyze the outcomes to evaluate further development of this role within the program. Case managers provide care coordination and assist with transportation. Other key functions of case managers include assessment of social service needs, linkages to community providers and housing, and provision of comprehensive case management to residents of permanent supportive housing environments. Care for the Homeless has a large staff team consisting of medical and behavioral health providers, case managers and patient advocates. The majority of the primary care providers are comfortable treating mental health issues, including serious mental illness. Debbian Fletcher-Blake, Assistant Executive Director, states that “having resources around, including psychiatry, really makes a difference. It’s how we work now. We had to have a lot of trainings and meetings, followed by a lot of hand holding and collaboration, but we developed the necessary skill sets. When you can provide everything that you can in one setting, you can make a real difference. You will lose clients if you have to fragment, even internally.” Behavioral health providers address patient stability both medically and psychologically, with a lot of co-management with primary care providers. Case managers also focus on understanding all of a client’s needs, including medical and behavioral, and provide care coordination and support as appropriate.

Communication and Coordination

Effective team functioning requires both communication and coordination. Communication, as defined by the Merriam-Webster dictionary, is “a process by which information is exchanged through a common system of symbols, signs or behaviors.” Well integrated teams rely on the right systems and processes by which to communicate, the shared value of communication, and the adequate amount of work time to maintain communication.

Merriam-Webster defines coordination as “the harmonious functioning of parts for effective results.” Synonyms include collaboration, cooperation and team work. Again, coordination must be a shared value embedded in the organization’s systems and structure.

HCH programs utilize a variety of strategies to enhance both communication and coordination, recognizing that the provision of a person-centered health care home is dependent upon efficient and useful team based service delivery.

Examples from the Field:

Staff at Heartland Health Outreach states that communication among team members can be a challenge, given the complexity of services, different work shifts and multiple sites across Chicago. Cell phones have enhanced the ability to both directly communicate and leave messages. In the agency's more intensive programs, there are scheduled integrated care meetings where several programs convene for treatment planning. The shared health record inherently improves communication by simple review or use of the notes section to send other team members notes on a particular patient. Email, shift change meetings, integrated intake meetings and clinical staff meetings also help team members to communicate.

At Duffy Health Center, staff also find the electronic health record to be an aid to communication. In addition to department level staff meetings, and a quarterly full staff meeting, directors of the three primary service departments, Medical, Behavioral Health and Case Management have formed the ALL Team, which meets every week for one hour. The primary purposes of the meetings are to promote integration of care through problem solving and development of policies and procedures, and to learn from and support each other. Dr. Lisa Zandonella-Huhta, Medical Director, states that "We work hard at understanding each other's perspective, and are sure to bring this shared understanding back to our respective departments. If we are integrated, then the staff does a better job of integrating."

At Community Health Link there are two weekly multi-disciplinary team meetings (one clinical and one administrative) and each department has department specific meetings at regular intervals. Brooke Doyle, Vice President of Homeless Services, states that "Team communication is continuously looked at for improvements. With growth, communication becomes more challenging."

At Peak Vista CHC, the small HCH team relies heavily on informal communication among staff members, but recently started a monthly staff meeting which includes staff members of partnering organizations who provide support to the HCH program.

THE HCH MODEL: THE ROLE OF THE CONSUMER

HCH programs have particular strength in the development of person-centered models of care and generally exceed the PCMH requirements for cultural competency and obtaining patient feedback. Consumer involvement is woven into all elements of HCH practice, including assessment of need, development and monitoring of service plans, and feedback regarding programs and services.

Governance

A FQHC requirement is that 51% of board membership must consist of consumers of services at the health center. HCH programs are allowed to apply for a Governance Waiver, but must demonstrate that they are actively seeking the input and guidance of consumers in the development and evaluation of programs and services. HCH programs have a strong value attached to consumer involvement, and many have board members who have experienced homelessness or are currently homeless.

Consumer Advisory Board

One form of input from clients is the development of a Consumer Advisory Board which is consumer run, but often supported by HCH program staff. Consumer Advisory Boards engage in a variety of activities, including advocacy, peer support, voter registration drives, coordination of National Homeless Persons Memorial Day, etc. Amy Grassetto from the NHCHC CAB states that one of the strengths of the HCH model of care is that “people have a say in their health care.” She further states that “HCH programs need to understand what a CAB purpose is, provide a space to meet and perhaps some food, offer transportation stipends, and value what consumers bring to the table.”

Examples from the Field:

At United Neighborhood Health Services there is an active CAB of twelve members who attend bi-weekly lunch meetings, which are facilitated by members, who also set the agenda. Projects include the violence survey conducted under the National Health Care for the Homeless Council’s auspices in 2011; fact finding initiatives related to issues such as shelter testing for TB; and the development and writing of newspaper articles for purposes of publication, education and advocacy.

Horizon Health Center has a five member CAB which meets once a month. The group has focused on a variety of issues, including reducing paperwork requirements at the HCH program and voter registration drives.

Care for the Homeless has two consumer boards; one for the HCH program and one for the HIV program. These groups help with the organization’s quality improvement process and provide input as to how best to improve agency services. In addition, the groups participate in advocacy efforts at the state and local level.

At Heartland Health Outreach, there is an active CAB which has met monthly for the past four years. The seven member group nominates one representative to attend the National HCH Conference annually. In addition, the organization has a Community Advisory Council (CAC) for the mental health program which meets monthly. This group is facilitated by a prosumer staff person. A prosumer is an individual who has received services for a psychiatric or substance use disorder. The facilitator forwards meeting minutes to program and senior management teams. The Council discusses issues around service delivery and programming, and is also a forum for participants to learn more about specific issues, such as funding.

Focus Groups

Many HCH programs utilize consumer focus groups to both obtain feedback about existing services and to elicit input into the development of new programs and services.

Examples from the Field:

Care for the Homeless actively conducts focus groups on a random selection basis to obtain the direct input of clients in order to improve and strengthen service delivery. Focus group meeting notes are taken and reviewed and changes implemented as needed. Once a year a staff team will select 50% of the service sites to visit and will organize a focus group when they arrive at the site. The organization has received valuable feedback related to satisfaction with staff and the current services, along with suggestions for program development.

Heartland Health Outreach conducts Consumer focus Groups annually to inform executive leadership's strategic planning vision for the year. Questions are compiled from each agency department to form one survey. The survey is completed by members of the CAB for each program.

Duffy Health Center focus groups have been conducted for purposes of feedback regarding programs and services and for suggestions regarding new program development. For example, a focus group was convened as part of the preparation for a HRSA New Access Point grant application for a mobile unit; another for feedback on new agency logo and outreach materials, and another for graphics for the new mobile unit.

Satisfaction Surveys

Most HCH programs utilize satisfaction surveys to obtain feedback from consumers. Survey results and trends are reported to staff and board of directors and reviewed by the Quality Improvement program to address any areas of concern and modify or change organization processes and practices accordingly.

Examples from the Field:

Care for the Homeless consumer satisfaction surveys are conducted on a quarterly basis. Results are compiled and reviewed and changes made as necessary. Examples of how feedback has been used include modifying the check-in process by staggering lunch hours so the clinics can remain open, modifying the grievance procedure, extending the clinic hours later in the day, and ensuring that all materials are available in Spanish.

At Heartland Health Outreach surveys are conducted bi-annually and results are reported back to the all-staff meeting as well as to the board of directors. Feedback spurred considerable facility renovations, modified the appointment schedule and changed the phone tree system.

Consumer as Employee

Many HCH programs employ staff members who may not have experienced homelessness, but who are in recovery. In addition, some HCH programs have developed employment or stipending opportunities for consumers, generally as Peer Support Specialists.

Examples from the Field:

At Care for the Homeless a peer advocacy program was initiated several years ago. Members of the CAB are supported by the agency to attend advocacy training which results in a stipended internship at the program. The goal of the project is to develop skills that will translate to other employment opportunities. Peer Advocates receive ongoing training and work on a stipend basis for a three or four month period as outreach or intake interns. Current and former interns are also very active in the organization's policy department and conduct voter registration drives, outreach projects, and advocacy at the state level.

Heartland Health Outreach has prosumer positions which are filled by individuals who have a history of struggling with homelessness, serious mental illness or substance use. Prosumers fill some case manager

positions which normally require a bachelor's degree, as their life experiences are considered the equivalent of a degree. The organization hires those individuals who meet the skills criteria for the position and who are ready, willing and able to integrate their own experience in the work.

At Community Health Link volunteer opportunities are available for interested clients, such as coordinating shower access. CHL recently hired a consumer into a paid position as a triage case manager. He had been volunteering at the assessment center and demonstrated a strong skill set which made him the best candidate when the position became available. Although the job description does not require life experiences related to homelessness, he is encouraged to use his personal experience to the extent he is comfortable. He did agree to transfer his care to another health provider to avoid any potential conflict of interest.

THE HCH MODEL: COMMUNITY PARTNERSHIPS

Community partnerships are critical to the success of a HCH program as well as to advocacy efforts to address and end homelessness. Debbian Fletcher-Blake from Care for the Homeless states, “I truly believe it takes a village in health care. The stronger your community partnerships the better your program is able to function. Developing these relationships is critical. As a patient centered home, advocacy within the community is also crucial to address the wide range of needs of our clients and ensure that resources are available.”

Hospitals

HCH programs have strong collaborative working relationships with local hospitals. In some cases, hospitals are project sponsors or underwriters of specific program offerings, such as Medical Respite Care. Some HCH physicians admit and follow patients, and some HCH programs utilize hospitalists for after-hours care and coordinate transitions accordingly. A common and shared goal with hospitals is to reduce the use of emergency department visits for issues that are best addressed in the primary care setting.

Examples from the Field:

United Neighborhood Health Services has a formal emergency room diversion program with two local hospitals as well as formal discharge coordination with the local city/county hospital and the area state psychiatric hospital.

The Illumination Foundation (IF) has active partnerships with Kaiser Permanente and the Hospital Association of Southern California. Kaiser Permanente provides medical professionals for the mobile health service via a memorandum of agreement. The Hospital Association contracts with the National Health Foundation, which in turn partners with IF to deliver respite care services. All respite care clients are referred directly to IF by the Foundation.

Cape Cod Hospital has provided physician recruitment services to Duffy Health Center. The CEO of Duffy, along with the CEOs of the three other Cape Cod community health centers, meets with the hospital CEO on a quarterly basis to address emergency department utilization projects and recruitment needs.

Other Inpatient Settings

It is not atypical for clients of HCH programs to have inpatient stays at either mental health or substance abuse treatment settings. Often it is the staff team at the HCH program who facilitates such admissions based on presenting behaviors, and advocates for often-scarce available beds. Staff also works closely with in-patient settings to ensure smooth discharge transitions.

Specialty Care

Patients/clients of HCH programs often present with multiple health challenges, including chronic diseases or medical conditions requiring specialty care services. Their usual lack of health insurance makes referrals to specialty care a particular challenge. HCH programs have developed a range of responses to these challenges, including providing some specialty services in-house, hosting specialty clinics, membership in networks focused on recruiting volunteer specialty care providers for the uninsured, and cultivating relationships with specialty care providers in their local communities.

Once specialty care appointments are in place, it is often a challenge to ensure that the client keeps the appointment due to the transient and crisis-driven nature of homelessness, in addition to transportation barriers. HCH programs lend support to clients through the provision of transportation vouchers; case

managers or care coordinators follow-up, including accompanying clients to visits, and frequent reminders by staff members involved with each client.

Correctional Facilities

Persons experiencing homelessness are frequently arrested and processed through the criminal justice system, disrupting treatment plans, living arrangements, and insurance coverage. Jail and prison interventions are essential to continuity of care and provide the foundation for individuals to comply with conditions of release and to make the most of corrections' investments in their treatment. (DiPietro, 2011) A number of HCH programs have developed collaborative relationships with local jails, prisons, probation and parole departments to ensure both in-reach for the purposes of establishing relationships with prisoners prior to release and outreach to prevent recidivism.

Examples from the Field:

Staff from Heartland Health Outreach visits clients while they are incarcerated at Cook County Jail and collaborate with the social work staff at the jail's hospital to ensure continuity of care and coordinated discharge planning.

Community Health Link (CHL) provides in-reach to the Worcester House of Correction for offenders who will be homeless at the time of release. The House of Corrections obtained access privileges for members of the primary care team in an effort to provide continuity of care for individuals who were already known to CHL and to introduce services to those inmates who are not yet connected to care. Staff at CHL gets notified by the House of Corrections any time they have an inmate who will be homeless at the time of release. If the inmate has medical issues the medical team is notified by the discharge planning specialist from the facility and an appointment is made for one of the nurses to go to the jail to obtain medical information, a list of medications and a plan for refills upon discharge.

Housing Providers

There is a deep rooted belief in the HCH movement that "housing is health care." To that end, many HCH projects work collaboratively with local housing providers or provide housing services themselves. HCH providers are often critical to the success of clients residing in permanent supportive housing settings, including Housing First models.

Examples from the Field:

Duffy Health Center has a Housing First program which serves individuals with histories of chronic homelessness and mental health issues. Housing is provided by the HCH program through multiple sources, including project based vouchers from the local housing authority, shelter plus care vouchers through the area HUD SuperNofa grant, housing subsidies administered by the regional housing development agency and close collaboration with a network of private landlords. In addition, Duffy has been awarded several homeless prevention and rapid re-housing grants and has a housing case manager on staff.

At Community Health Link supportive housing services has dramatically increased over the past three years, and now includes a Housing First program, two transitional housing programs, and supportive housing units funded by HUD and a local health foundation. The organization now has over 225 people enrolled in supportive housing and recently received additional funding from the City of Worcester to do housing stabilization and shallow subsidy housing placements.

Care for the Homeless assists clients with housing applications, provides transitional housing and operates a transitional housing program for 200 women who are medically frail and mentally ill. In addition, CFH

partners with another agency in the provision of both congregate and scattered site permanent supportive housing.

Heartland Health Outreach's parent organization, Heartland Health Alliance, operates over 225 units of HUD funded housing, most of which are scattered sites. Partnering with the City of Chicago, a project has been initiated to engage long term outside dwelling individuals in an effort to link them to housing. In addition, the organization has nine units of housing available for persons who have been diagnosed with TB and who are experiencing homelessness.

Shelters

An axiom of HCH is to "start where the clients is," often meaning in an emergency or domestic violence or runaway youth shelter. HCH programs have strong relationships with local shelter services, including outreach to shelter residents, shelter-based clinics, and health education for shelter staff. There is a long history of collaboration around referrals and service planning. Respite programs are often housed in shelters. In some cases, the HCH project is shelter-based only; in others there is a combination of shelter-based and fixed-site clinics.

Examples from the Field:

In Los Angeles County, there are thousands of families who are housed in hotels through family shelter funds. The Illumination Foundation provides health services to a number of these motel sites through its mobile health unit. The mobile unit also visits two cold weather shelters for adults.

Heartland Health Outreach has a mobile health team which visits up to 40 shelter sites per month. In some cases there is dedicated clinic space available but most sites do not have dedicated space, consequently, the goal is to engage individuals in care and connect them to the more comprehensive services offered at the fixed site clinic.

Care for the Homeless has clinics co-located in 18 shelters in addition to operating its own 200 bed shelter for women who are medically frail and mentally ill.

Peak Vista operates 24 hours per week in a shelter based clinic which has three exam rooms, two dental chairs and a group room for counseling or client meetings.

Veterans Services

Approximately 40% of homeless men are veterans, although veterans comprise only 34% of the general adult male population. On a single night in January 2009, 75,609 veterans were homeless nationwide; 57 percent were staying in an emergency shelter or transitional housing program; and the remaining 43 percent were living on the street, in an abandoned building, or another place not meant for human habitation. (HUD and VA, 2009). An estimated 136,334 veterans spent at least one night in an emergency shelter or transitional housing program between October 1, 2008 and September 30, 2009. This accounts for 1 of every 168 veterans in the United States. (HUD and VA, 2009) The U.S. Department of Veterans Affairs says the nation's homeless veterans are mostly males (96%) and the vast majority is single. Most come from poor, disadvantaged communities, 45% suffer from mental illness, and half have substance abuse problems. Female homeless veterans are more likely than male homeless veterans to be married and to suffer serious psychiatric illness, but less likely to be employed and to suffer from addiction disorders. Comparisons of homeless female veterans and other homeless women have found no differences in rates of mental illness or addictions.(National Coalition for the Homeless, 2011)

Providing HCH integrated care to veterans requires a sound knowledge and practice of trauma-informed care (see Evidence Based Practices). In addition to the direct provision of care, many HCH programs work collaboratively with local veterans' providers to coordinate care, including housing referrals. HCH staff must also be well informed regarding VA benefits and eligibility standards to ensure that appropriate referrals are made.

Examples from the Field:

Duffy Health Center partners with the local Veterans Outreach Center to provide SAMHSA funded comprehensive case management to homeless veterans on Cape Cod, and recently submitted a partnership proposal for funding for veterans housing. Under this proposal, housing would be managed by the Veterans Outreach Center and Duffy would provide the supportive services, including comprehensive case management.

Social Security

The Social Security Administration's Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs are two of the most important mainstream resources available to people with low incomes. They provide crucial income support that can assist individuals who are homeless to regain housing and stability.

HCH staff members work directly with clients, or participate collaboratively with other service providers, to assist individuals to apply for Social Security entitlements. For many people who are homeless, who have mental health problems that impair cognition, or who are returning to the community from institutions (jails, prisons or hospitals) access to these programs can be extremely challenging. The application process for SSI/SSDI can be complicated, detailed and often difficult to navigate. Typically, only about 10-15% of individuals who are homeless found a way to access these benefits. This is compared to a 37 percent initial application approval rate for other applicants, as reported by the SSI/SSDI Outreach, Access and recovery (SOAR) program. Others apply and can wait for over two years before a final determination is made, significantly impacting their ability to stabilize their lives.

SOAR is a national initiative to provide training to case managers and other social service workers as they assist their clients in applying for disability benefits through the Social Security Administration. Persons receiving Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI) are also eligible for Medicaid and/or Medicare health insurance. Accessing these benefits is often a critical first step in recovery.

Many HCH programs have adopted or partner with agencies in implementing the SOAR model, recognizing that access to consistent income is integral to movement from homelessness to housed status, and that housed status is often an indicator of improved health outcomes.

Examples from the Field:

United Neighborhood Health Services (UNHS) has a van which takes people to and from the local Social Security office every day. The program also provides the Social Security Administration with medical records for approximately a dozen disability claimants a day. UNHS staff partner with local organizations which provide SOAR services.

Peak Vista (PV) has a memorandum of understanding with a local organization which offers SOAR services. PV staff has one afternoon per week set aside for documentation of disability for SSDI claims.

Other Safety Net Providers

HCH programs also work collaboratively with other community agencies such as food pantries, fuel assistance programs, local housing authorities, domestic violence shelters and local emergency fund sources. Widening the scope and breadth of community partnerships and collaborations strengthens the capacity of the HCH program to address the comprehensive needs of each client.

THE HCH MODEL: MEASURING AND IMPROVING PERFORMANCE

Measuring and Improving Performance is a critical component of the PCMH model, requiring, at a minimum, a continuous quality improvement program designed to enhance service planning and measure quality of care, patient health outcomes, integration of care and client and staff satisfaction. HCH programs utilize a wide range of strategies to ensure that outcomes are measured and data is collected and analyzed. Consumer feedback is a critical component of quality improvement. The use of electronic health records significantly enhances the HCH program's capacity to collect, report, analyze and respond to data.

Review of Service Plans & Outcome Measures

Each organization has developed its own procedures for the review of service plans, generally predicated upon the program's quality assurance and improvement protocols, funder requirements, and available resources and technology. HCH providers strive to adhere to developing plans which are individualized and comprehensive as well as in compliance with chronic disease interventions and protocols. In addition to HRSA clinical measures, many health centers track other health outcomes, including housing and behavioral health measures.

Examples from the Field:

The Peak Vista HCH project is a program of a large community health center, and service plans are reviewed as part of the organization's quality improvement process. An action team conducts chart reviews for all of the operating clinics and is required to review 10% of the charts for each program on an annual basis. The emphasis is on chronic disease interventions and protocols that are shared across the organization, such as foot exams and Ha1C levels for diabetics and hypertensive control. The HCH program has established some of its own protocols in an effort to address the complicating factors for their client population, and is often cited in quarterly reports as exceeding the organization's baseline standards for quality of care.

At Care for the Homeless (CFH), each manager of each department is responsible for reviewing charts of staff and reporting results to the Medical Director, Director of Health Services and Assistant Executive Director. Managers also do sample charting, e.g. 70 charts of diabetic patients, and review those for compliance with clinical guidelines. The Assistant Executive Director reviews all HIV patient charts. In addition, reports are generated from the electronic health record and data is available on both an individual provider and organization-wide basis, with follow up chart reviews done when trends are identified. In addition to HRSA clinical measures, CFH is participating in a depression study which tracks response to treatment; tracks smoking cessation and is involved in a Meaningful Use Initiative through the NY City Department of Health.

At Community Health Link, the organization recently piloted the inclusion of a behavioral health intern in the primary care team to address chronic disease issues, and will look at the outcomes to evaluate further development of this role.

At Duffy Health Center, in addition to HRSA measures, housing and employment outcomes are tracked and monitored for clients participating in both the Housing First and Suboxone treatment programs.

Electronic Health Record

The provision of comprehensive and integrated care is enhanced by the ability to access information from a centralized record for each individual. The meaningful use of electronic health records is a central concept for Patient Centered Medical Homes (PCMH).

A recent study conducted by the Geiger-Gibson Program at George Washington University surveying readiness for meaningful use and patient centered medical homes reported that 65% of the 144 HCH programs which responded already have an electronic health record in place, and another 34% intend to implement an electronic record within six months to one year.

Of the ten HCH programs interviewed for this Key Elements project, nine have electronic health systems in place, and the tenth is in the software testing phase.

Examples from the Field:

United Neighborhood Health Services (UNHS) has had an electronic health record since 2006. NextGen was selected because of its flexibility and the ability to customize for use in a CHC setting, compared to other products which were on the market at that time. All service departments in the organization utilize the same record. When a patient is registered at any UNHS site the record can be accessed by any other UNHS site or staff person that has access/rights to enter the patient's chart. Both the chief medical officer and CEO run a variety of reports, including clinical measures which the organization is tracking. Challenges cited include issues logging in to the main server from remote locations, particularly at peak log-in times such as first thing in the morning.

Harbor Care Clinic (HCC) has used GE Centricity since the program opened in 2009. All health centers in New Hampshire have used this product for ten years, and software has been customized to meet HRSA reporting requirements. Through membership in the NH Community Health Access Network (CHAN) the program receives a variety of support services specific to both the electronic health record and practice management programs. All HCC staff use the same record, and there are modules specific to medical, mental health and substance use treatment services. Currently documentation of enabling services in the EMR is limited. Access to information is dependent upon security access level which is based on job duties. Provider staff has full access to all notes. Diagnosis and prescriptions are available to all staff. HCC uses population based inquiries to obtain data for monitoring clinical and non-clinical established outcomes. One challenge which needed to be addressed was establishing documentation standards to address inconsistency among staff members.

At Heartland Health Outreach the Centricity software has been in place for five years. HHO is part of a user community, the Alliance of Chicago Community Health Services. The software was selected based on its relevance among all of the community health center partners in this user community. Supports provided by the Alliance include customization of forms and grant reporting requirements and common quality improvement/data management needs. Historically all service departments in the organization have used the same record except for the mental health team. Psychiatry services are currently being integrated into the software, but the remainder of the mental health team of case managers, social workers and psychologists will remain on a separate system dedicated to their specialized documentation needs until an interface can be identified. HHO uses monthly dashboards to review aggregate quality measures required by HRSA and the HIV AIDS Bureau. Reports reflect overall outcomes which ensure compliance with program health work plans and UDS reporting requirements. Reports are also generated to reflect productivity by health center and outreach sites as well as individual providers. Within the organization, each group of staff members' access to the record is restricted to areas of need. For example, the dentists do not see the psychiatry notes but do see the medication and problem list. Challenges cited by HHO were the significant amount of preparation time to implement the EHR and the inability to identify software that was usable by all departments in the organization, since most health records do not have mental health, case management or dental components.

Care for the Homeless has been using eClinical Works since 2008. This system was selected because it was recommended and subsidized by the New York State Department of Health. Primary care and behavioral health utilize the same record, but dental and health education services use separate systems. Clinical measures reports are used to track outcomes, including depression and smoking cessation, in addition to a number of indicators that are outside of the usual HRSA elements in order to be fully compliant with Meaningful Use criteria. The New York City Department of Public Health and the Primary Care Information Project have made significant changes to the basic software but there are still some issues that need to be addressed. The Regional IT Gateway in New York is developing a tool to ease the sharing process among organizations in an effort to ensure ability to track and manage referrals.

Community Health Link has three electronic record systems in place within its organization. The primary care department will implement AllScripts this spring and the behavioral health services have used Netsmart since March of this year. The AllScripts and Netsmart systems are electronically bridged to provide coordinated health record management. A separate electronic system is used for HUD funded programming and is required by HUD. All of the electronic records have reporting features for client and organizational outcomes, and CHL is tracking patient enrollment in primary care, behavioral health intake rates and treatment compliance rates, and clinical measures including Pap smear completion, mammogram follow through, comprehensive physical exam follow through, diabetes management and hypertension. The case management and health records are separate and case managers can request to view but do not have direct access. Similarly, the case management records are not directly accessible to the clinical staff, although they can view. A challenge for an integrated model is the external reporting requirements by funders such as HUD, which require separate data systems which are not compatible with the electronic health record systems, making it difficult to have a truly comprehensive client record in one location.

Duffy Health Center has had an electronic record since 2002 but recently upgraded to Intergy by SAGE, since the old record did not allow for adequate data tracking and performance measurement. The system has been customized for use by the behavioral health and case management departments in addition to primary care. One patient's record has a summary of all encounters from all organization service departments, with access on a need to know basis. Tracking and monitoring client and organization outcomes is still a work in progress with the new system. A lab interface is in the testing phase. Staff state that the electronic record has good capability but the challenges have been related to fully utilizing the report generation capacity. Challenges noted include the lack of a health record that has all the necessary components for an integrated care model in place upon purchase. Significant customization must occur, and this requires significant staff resources. Duffy has one IT staff person who provides hardware and technical support as well as serving as the HIT coordinator. Staff volunteers have been used to do forms production and training of peers. Additional resources are needed to ensure movement toward Meaningful Use.

THE HCH MODEL: PATIENT CENTERED HEALTH HOME RECOGNITION

Various entities provide formal recognition for organizations meeting the PCMH criteria. These recognition processes are designed to address the most critical systems and processes which impact the patient experience and which promote integrated care. Resources related to Patient Centered Medical Home recognition and Meaningful Use of electronic health records are included in Appendix A.

A number of PCMH demonstration projects have shown success in increasing the quality of care and in reducing cost of care on some measures. In the academic literature, a recent article also found reduced use of hospitalization and emergency room visits and overall savings; and another study showed significant improvement in patient and provider experiences and in the quality of clinical care. A study of the impact of the PCMH model on costs of care indicated a relationship between practices with established systems/processes and a decreased use of inpatient and emergency care by diabetic patients. (NCQA, 2011)

NCQA PCMH Recognition is the most common standard being studied or applied for by HCH programs in the Field Review. There are three levels of NCQA PCMH Recognition; each level reflects the degree to which a practice meets the requirements of the elements and factors that compose the standards. For each element's requirements, NCQA provides examples and requires specific documentation. There are six standards of care which align with the core components of primary care, and six must-pass elements which are considered essential to the patient centered medical home, and are required for practices at all recognition levels. Practices must achieve a score of 50% or higher on must-pass elements which include:

- Access During Office Hours
- Use Data for Population Management
- Care Management
- Support Self-Care Process
- Track Referrals and Follow-Up
- Implement Continuous Quality Improvement

In the Readiness for Meaningful Use and Patient Centered Medical Home survey conducted by the Geiger-Gibson Program at George Washington University in 2011, only 6% of the 144 HCH programs responding indicated that they had received NCQA Level 1 recognition for one or more sites in their organization, and only two programs have achieved Level 3 recognition. Another 14% are in the process of preparing an application to NCQA. Of the programs interviewed for this guide, only one program, Care for the Homeless, has achieved Level 1 recognition and is working on readiness to be certified at Level 3.

Key considerations for a HCH program in determining whether to move forward with PCMH recognition include improving internal processes and systems in order to increase quality of care for patients and qualifying for enhanced reimbursement rates depending upon recognition level.

Vicky Tiglias, Program Care Information Project (PCIP) for the New York City Department of Health and Mental Hygiene, has been assisting health centers, including HCH programs, with the process of NCQA recognition. She stated that Level 1 recognition is possible even without an electronic health record, but Levels 2 and 3 require Meaningful Use of electronic software. NCQA has worked cooperatively with PCIP and although HCH programs don't quite fit the standard NCQA model, it is possible to demonstrate compliance with standards, even for mobile health vans. Challenges for HCH programs include patient transiency, which impacts continuity of care; lack of patient follow-up on referrals; and lack of provider patient panels in many programs.

Examples from the Field:

Care for the Homeless has Level 1 recognition for one of their five sites and is applying for Level 1 recognition for seven additional sites, as well as Level 3 recognition for the current Level 1 site. Staff stated that the critical component for recognition was the support that was received from the PCIP, which worked with CFH staff to collect all of the data that was required for the application process. Debbian Fletcher-Blake stated that “It takes a lot of time and resources to prepare and submit the application; and, most importantly to get your centers up to snuff. A lot of what they are asking is difficult for our patients, and you have to have the staffing level in place to meet the objectives.”

At United Neighborhood Health Services PCMH recognition is part of the organization’s formal strategic plan, and the HCH program is next in line to prepare for application for Level 1 recognition. Bill Friskics-Warren, Director of Homeless Services, states that “We hope to have NCQA recognition by the end of 2011 or early 2012. Our reason for this decision is the same reason why we seek to provide nonjudgmental, culturally competent healthcare – because it is the right and just thing to do. We adhere to Don Berwick’s Triple Aim of improving the patient experience of care, improving the health of the larger population and reducing per capita costs of care.”

Heartland Health Outreach staff is focusing on internal integration efforts in preparation for Accountable Care Organization structures and believe that this work will position them well for seeking recognition. They believe they are on target for Level 1 recognition at this time, but have not yet begun the application process.

Harbor Care Clinic plans to seek NCQA recognition and achieve Level III by the end of calendar year 2013. Kathi Fortin, Program Manager, states “Regardless of political majority, health costs must be decreased and health outcomes increased. As a critical access point for people experiencing homelessness, Harbor Care Clinic must be able to compete in the environment in which we operate. We must be able to prove our value in order to compete for funding and continue to meet the needs of the people who need us most – people experiencing homelessness.” Ms. Fortin was involved in a PCMH initiative when working in a previous capacity and participated in planning meetings which resulted in a pilot project through which four community health centers have obtained NCQA recognition. She stated that “A lot of the details that we focus on now are the foundation for PCMH and we keep the requirements in mind as we build our program. We need to do the fine tuning, but the PCMH philosophy of how we will do our work has been in place since day one.”

THE HCH MODEL: CHALLENGES TO INTEGRATION

Organization and Staff Willingness

An integrated model must be the identified model of care within the organization, with buy-in from leadership, board of directors and staff and with strategic initiatives designed to promote and enhance integration. Bill Friskics-Warren from United Neighborhood Health Services states that the greatest challenge for their organization is “changing our organizational culture from a transactional to a transformative model of care; that is changing minds, hearts and practices to reflect the values outlined in Berwick’s Triple Aim and in the PCMH mode. Strategies that are in use include focusing on a practice redesign based on the PCMH model, implementing a nursing supervisor model and focusing on the skills needed by staff to commit to and implement the model. Hiring new nursing supervisors was a critical step toward having the right people in place to model integration practices.

Duffy Health Center’s integrated model of care, including a “no wrong door” approach, is the result of strategic planning, and grant funding has been sought and used to promote integration practices. Louise Patrick, Director of Behavioral Health Services, states that “Willingness is key. If it is considered a value, people will make the time and prioritize efforts to improve delivery of integrated care. There has to be buy-in, trust and respect that go along with having a three legged stool (primary care, behavioral health and case management). It is easy to get trapped in your own silo.” The organization has a Leadership Team which meets weekly and focuses on strategic plan goals and objectives. In addition, an important strategy has been the development of the ALL Team, which consists of the Directors of Medicine, Behavioral Health and Case Management. This group also meets weekly with a focus on brainstorming and problem solving to enhance and increase integration. Dr. Zandonella-Huhta, Medical Director, states “When the three department heads are integrated, then the department staff can be integrated. We model integration. Staff knows that we meet, talk and come up with agreements, and this value filters down.”

The Right Complement of the Right Staff

Integration happens best when the team is composed of members of all three key disciplines – primary care, behavioral health, and case management. Most programs that were interviewed did have case management staff in place, but often the role was limited by funding source to housing supports only. The lack of reimbursement for case management to provide assessment and care coordination is a significant barrier to “rounding out the team.”

At Horizon Health Center, the team is well integrated between primary care and behavioral health, but leadership cites a strong need for a case manager. Catherine Thrash, LCSW, states “Every patient should see a case manager at the first visit. Sometimes patient needs fall through the cracks despite all of our best efforts.” In response to this challenge, HHC has partnered with another agency to have an on-site substance abuse counselor who is trained in screening and brief interventions, and staff continues to advocate for dedicated case management resources.

As important as having all of the right disciplines is having the right people filling those roles. A challenge for Care for the Homeless is finding the right staff. Debbian Fletcher-Blake states “It is so difficult to find people who want to work with persons experiencing homelessness. Not everyone is willing to work with the most indigent population and not everyone is trained to do it.” The organization is active in staff recruiting and focuses on staff skills in teamwork as well as commitment to the mission.

Staff Training and “Common Language”

A challenge to both communication and coordination is the lack of a “common language.” Clinicians and other staff members are often trained in specific approaches that do not share common approaches or

professional language, and there can be a lack of understanding about how other disciplines conduct their work with clients.

There are different and often conflicting paradigms in “physical” versus “behavioral” health care and treatment of mental illness versus substance use disorders. (Blount, 2003) Kathi Fortin from Harbor Care Clinic states that a challenge is “ownership of each piece toward the common goal without being territorial and ineffective.” Strategies used at HCC include multi-disciplinary staff meetings with a focus on connecting data collection, good business practices and good health for clients. Organization leadership makes a strong effort to create a supportive learning environment which stresses patience with colleagues as team members learn to “speak each other’s language” and emphasizing that everyone contributes to the overall goal. In addition, the program is building a foundation of evidence based practices in which all staff are trained.

Service Models

Collaborative care is provided on a continuum, ranging from partnerships with other agencies to full integration within one organization. Various structures for the delivery of integrated care present different challenges to both communication and coordination.

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; however, fully integrated care presupposes one treatment plan with behavioral and medical elements. Co-location is not sufficient to ensure integrated care.(National Health Care for the Homeless Council, 2006)

Example from the Field:

The Illumination Foundation program is a partnership-based model among three primary partners with varying organizational missions. This creates a complexity which requires strong attention to clarity and communication. Strategies that are used include regular meetings among partners with an agreed-upon willingness to revisit current practices and make changes in strategies while encouraging stability of volunteer staff and partners. For example, Paul Leon, CEO, stated that they are able to attract and retain physician volunteers by making it easy for them to participate and remain engaged. They streamlined the volunteer application and created a platform for immediate engagement with clients.

Continuity of Care

Providing continuity of care presents challenges when serving a transient population. Persons experiencing homelessness often find it difficult to focus on following up on their health care needs while they are stressed with the daily struggle of where to secure food and shelter. Some strategies that are used at Care for the Homeless include providing metro cards and transportation escorts and locating services where homeless persons congregate and adjusting hours of service accordingly. Many adult shelters are closed during the day, so outreach workers and mobile health teams connect with shelter residents during late afternoon and evening hours.

Systems Development

The right electronic health record can help to enhance team communication, data collection and outcomes measurement. In addition, continuity of care can be enhanced by e-prescribing and lab interfaces. Challenges in selecting and implementing electronic health records are discussed elsewhere in this document. Even with an electronic record in place, however, development of systems for care coordination

can continue to be complex and challenging. As Brooke Doyle, Community Health Link, states “With growth, the systems for care coordination are stressed. Electronic records will help with some but not all coordination needs. At CHL we continue to look at systems improvements during care coordination meetings.”

Resources and Funding

Lack of funding to hire a full complement of team members has been cited elsewhere. In many cases, lack of ability to offer all necessary services to all clients in need is constrained by lack of funding. For example, at Heartland Health Outreach, mental health services are limited to individuals with serious mental illness based on state reimbursement guidelines. Staff is focusing on both short term and long term goals to address this challenge. Using existing resources, the organization is examining ways to reduce barriers by co-locating primary care and mental health services and improve communication across those services. As the State of Illinois moves toward the development of Accountable Care Organizations and bundled rates, the Executive Director is very active in system design meetings at the state level, and is working to ensure that the needs of vulnerable people are prioritized. Ed Stellan, Senior Director, Heartland Center for Systems Change, states “As we look forward to health care reform we see a lot of opportunities for more integrated care and the potential for erosion of silos of funding. As those silos are collapsed into more pools we see a great chance for us to provide even more integrated care. For example, it would be much easier to configure integrated teams when funding silos have collapsed and all services are provided within a bundled or global rate structure.”

THE HCH MODEL: IMPLEMENTATION OF INTEGRATED CARE

Parallel Services: Minimal Integration

In some cases, HCH programs provide initial assessment of behavioral health or case management issues that would benefit from intervention, but have minimal in-house capacity to provide follow-up services. In these instances, programs have developed a good understanding of community resources and refer patients to these resources. These arrangements do not always result in sharing of treatment goals or objectives, and communication between the two organizations may be minimal. In some cases, releases of information are routinely obtained so the two service providers can consult about the specific client.

Partnerships: Moving Toward Integration

In a partnership model, the HCH program has a formal relationship with the behavioral health or case management provider through the use of a Memorandum of Understanding or Agreement. In some cases, the client receives services in the two separate settings, but the MOU allows for the exchange of information for the purposes of better coordination of treatment goals. Many partnership arrangements result in co-location of services, which allows the client to access both primary care and behavioral health within one physical setting. Co-location of services benefits ease of access for clients, but also can enhance the communication between members of the service team, even if the team represents staff from two separate organizations.

Examples from the Field:

Horizon Health Center is a small HCH program which has maximized resources through the development of partnerships. A county funded HIV Coordinator from another agency is on site at the HCH program two days per week. A local substance abuse treatment agency counselor who specializes in screening and brief interventions is on site twelve hours per week. Access to respite care for patients is available through a partnership with a local shelter-based respite project. Staff at HHC have almost daily contact with SOAR workers from another agency.

The Illumination Foundation has a broad range of community partners including Orange County, which provides vision care, psychiatry, primary care for children and teens, and individual and group counseling services. IF's respite program is funded by the local hospitals that pay a nightly fee. The mobile clinic is run in partnership with the local department of public health, which provides all the nursing services for the clinic, and Kaiser Permanente family residents provide primary care on the mobile health clinic. (IF is not a HCH grantee at this time but is opening a fixed site clinic and will begin application for FQHC look-alike status)

Full Integration within the HCH Program

Many HCH programs have case management staff that work in close collaboration with primary care providers and serve as the primary facilitators of community resource linkages. In some cases, case management staff within programs are also providing supportive services to individuals in housing, such as Housing First or PSH models. In response to the presenting needs of their clients, some HCH programs have also developed behavioral health services within their organizations. The scope of behavioral health services may include psychiatry, individual and group counseling for both mental health and substance use disorders, and behavioral health outreach. In addition, some programs have enhanced both their primary care and behavioral health services through the implementation of pharmacy services. Some HCH grantee organizations are now direct providers of housing.

Examples from the Field:

Heartland Health Outreach is a FQHC within a larger human rights organization, Heartland Alliance. HHO has a fixed clinic site which houses primary care, dental and psychiatry services. Lab work is provided by another agency on site. Additional mental health and case management services are housed in the same building but in a different suite. Because of the State's funding requirements, most of the mental health and case management services are available for individuals with serious mental illness. HHO also has Ryan White funding which supports medical case managers who provide intensive case management for individuals diagnosed with HIV or AIDS. HHO has two outreach staff that are street and shelter based. Housing options for clients include 225 units of agency-run permanent supportive housing units as well as nine units specifically for people experiencing homelessness and diagnosed with TB.

Community Health Link is a program of a larger social service organization specializing in mental health and addiction treatment. CHL has a fixed clinic site as well as a medical clinic at a local soup kitchen and a clinic at the CHL Assessment Center, which provides case management triage and linkages and short-term 24 hour emergency shelter. A two person outreach team performs street outreach throughout the City of Worcester. The primary care team consists of seven providers who focus on delivery of care to single adults. One of the primary care providers is Suboxone certified. A MOA is in place with a local family care clinic for primary care for families. CHL's behavioral health team consists of psychiatrist, resident, prescribing nurse and four full time clinicians. The psychiatrist is Suboxone certified and one of the mental health clinicians is dedicated to Suboxone coordination. Case managers are employed at the Assessment Center as well as in housing support programs, including Housing First for persons with histories of chronic homelessness. The parent organization operates a Level 3 detox center in the same building that houses the medical clinic.

THE HCH MODEL: STAGES OF INTEGRATED CARE IMPLEMENTATION

Building a Foundation: Harbor Care Clinic

Harbor Care Clinic (HCC) is a HCH program of a large social service organization, Harbor Homes, Inc. Harbor Homes is one of the largest providers of permanent supportive housing for the chronically homeless and the largest employer of persons recovering from mental illness in the state of New Hampshire. Housing is provided for over 450 persons in the Greater Nashua area. Harbor Homes also operates a 30 bed emergency shelter, a 5 bedroom safe haven and 40 units of housing dedicated to homeless veterans and their families. The lack of available primary care services for individuals experiencing homelessness was identified as a result of the agency's strategic planning process and after submitting several grant applications, the agency was awarded a HCH grant in 2009 as part of the ARRA New Access Point funding opportunity.

HCC has a small fixed clinic on-site at the Harbor Homes administrative building. A team of eight staff (5.15 FTE) provides primary care to adults at the clinic and provides health related presentations at local shelters. An outreach worker goes to locations that potential clients are likely to congregate, such as a local tent city, under bridges, the public library and soup kitchen. The program is actively recruiting for a licensed mental health professional to provide screening and brief interventions as well as ongoing treatment. A substance abuse counselor from another organization is on site at the primary care clinic several days a week through a MOA. The program has already identified the need for a dedicated case manager to round out the team.

In terms of community resources, HCC staff access the housing services of the larger organization and also work with other community housing agencies which focus primarily on women and children. Discussion is underway with the local hospital for an ER diversion project. There are plans to reach out to the local county jail to determine if there can be improved coordination when persons are released back to the community, and staff will be attending a statewide summit on the needs of homeless veterans.

HCC has an electronic health record and all service departments utilize the same record. There is an ambitious quality improvement plan with a strong emphasis on data collection and analysis. The project director has experience in both FQHC programs as well as a solid understanding of PCMH principles, and has worked to incorporate PCMH recognition standards as the program is developed.

Communication among staff members is strong and a supportive environment for professional development is in place. The team is small, and day to day communication among all team members is possible. In addition, more formal team meetings are held regularly and an off-site retreat will be held this year. There is acknowledgement of the need for evidence based training of all staff, and the program has incorporated principles of Harm Reduction in their work to date. Efforts are underway to more formally implement EBPs and track client outcomes tied to the use of both Harm Reduction and Motivational Interviewing.

The program has not yet developed a formal CAB but has plans to do so as they are able to identify potential members. They are working on a consumer satisfaction survey which they will distribute in 2011. The board of directors for Harbor Homes has one member who has experienced homelessness.

HCC plans to seek NCQA recognition as a PCMH, with a goal to achieve Level III by the end of calendar year 2013. Program staff are working on baseline data collection and will conduct a readiness study during the summer of 2011.

Launching Integrated Care: Horizon Health Center

Horizon Health Center (HHC) is a program of Wake Health Services, a large multi-site FQHC in Raleigh, NC. The program has been funded for 12 years. HHC has a fixed clinic site within a family practice setting and also provides outreach to a local men’s shelter twice a month. HHC has a staff team of 10, including physician, nurse practitioner, registered nurses, medical assistants, mental health/substance abuse counselor, practice manger and receptionists. The program also has access to the parent organization’s data coordinator. In addition to the staff team, an HIV coordinator is on site at the clinic two days a week and the program recently implemented screening and brief interventions through on-site placement of a substance abuse counselor from a partner agency. Case management functions are performed by members of the primary care/mental health team, and there is need for a dedicated case manager.

HHC has strong community linkages which have been developed by the program’s two key staff members, the medical director, Dr. Jim Hartye and the mental health clinician, Catherine Thrash. Dr. Hartye has forged partnerships with a local organization which provides SOAR services, the county’s access center for individuals who are challenged by mental illness or addiction and the area’s respite program which is located at a shelter site.

The program has adopted the principles of Stages of Change, Harm Reduction and Motivational Interviewing. These evidence-based practices are primarily isolated to the HCH program, although Dr. Hartye has provided in-services to Wake Health Services’ nursing staff on Stages of Change. Initial assessments for each client include comprehensive medical as well as behavioral health needs. Staff members have strong competency in addiction treatment and have developed a database which tracks each patient’s specific addictions and where he is at in terms of change readiness for each issue. This assists staff in developing an appropriate and supportive approach.

This small staffing team utilizes a “huddle” approach for treatment planning in addition to more formal meetings. Dr. Hartye and Ms. Thrash often meet after one or the other has seen a patient to brainstorm on next steps or additional resources needed. They also see patients together as appropriate. Dr. Hartye is comfortable prescribing a wide range of psychotropic medications but also uses supports from the local Crisis Center when needed. There is a lack of available psychiatry in the area, particularly for individuals experiencing homelessness, so Dr. Hartye and Ms. Thrash have both made efforts to develop their professional knowledge of medication management. Program leadership cites the longevity of staff in the key roles as a critical component for the success of their integrated model of care.

One consumer is a member of the Wake Health board of directors and a CAB has been in place for approximately six months. Satisfaction surveys are in place and the data is reviewed by the administrative staff.

An electronic health record has been in place within Wake Health Services for some time and most recently adopted in the HHC setting. All service departments use the same record. HHC plans to seek recognition as a PCMH as part of the larger strategy of Wake Health Services. There is no timeline established for this process at this time.

Implementation and Midcourse Adjustments: Duffy Health Center

Duffy Health Center (DHC) is a stand-alone HCH program serving the homeless population on Cape Cod, MA. The program has been funded for nine years. There is a fixed site clinic in Hyannis and a mobile health clinic which travels to four other communities on a weekly basis as well as twice weekly to the only adult homeless shelter on the Cape. Street outreach is provided to persons who are homeless in the woods and in the downtown Hyannis area. Duffy has a staff of 53, including a medical team of physicians, nurse practitioners, registered nurses, medical assistants and contracted nutritionist; a behavioral health team with

a psychiatrist, psychiatric nurse practitioner and clinical social workers; and a case management team with staff providing initial intake, housing supports and both short-term and long term intensive case management. There are two part-time volunteer physicians and a group of local chiropractors who volunteer on a rotating basis to provide services on-site. Duffy has a Housing First program and also manages project based and scattered site housing vouchers in collaboration with the local housing authority. Duffy also has a large Suboxone treatment program with two prescribing physicians and two dedicated nurse care managers.

Duffy staff has strong community linkages including specialty care providers, the local Veterans Outreach Center, other homeless prevention and housing providers, the County's correctional facility and probation and parole departments, in-patient detox centers and other safety net providers. The CEO is an active participant in the Regional Network to End Homelessness as well as the local Cape & Islands CHC Network.

The program has adopted several evidence-based practices, including Stages of Change, Harm Reduction, Motivational Interviewing and Comprehensive Case Management. All agency staff is trained in EBPs and reinforcement of principles is conducted through individual and group supervision, case reviews and staff meetings. There is a strong addictions treatment competency throughout the organization. The Suboxone treatment program is an integrated model with all patients required to participate in individual or group counseling from the behavioral health department.

Development of the integrated model was a result of initial strategic planning efforts which identified the need for enhanced in-house behavioral health and case management services. Although great strides were made in strengthening the integration of care, another major change was made when the agency implemented a "no wrong door" approach as a result of the most recent strategic plan development. In this model all new clients are seen first by a *Connections* case manager. The *Connections* case manager's role is to provide a welcoming and supportive first encounter, assess presenting needs, outline the scope of available services and make appropriate linkages, both internally and in the community. All new clients are screened for depression and substance use disorders through a modified PHQ-9 tool, which is scored by the case manager. If the individual presents with a high score on this scale, an immediate connection is made for a behavioral health triage.

Integrated care is a strong value within the organization, and the directors of the medical, behavioral health and case management departments meet weekly to problem solve, brainstorm, learn from and support each other and focus on enhancing integrated care throughout the organization. The organization's Leadership Team, which consists of the CEO, CFO and directors of each service department as well as grant writing and development, meet weekly, with a primary focus on sharing of information and coordinating the implementation of strategic plan goals and objectives. Each department also has regularly scheduled staff meetings and there is a full staff meeting held on a quarterly basis. The electronic health record also allows for communication among staff members through tasking functions.

Duffy has had an electronic health record since 2002 and recently upgraded to new software which has greater capacity for data collection and analysis. All staff utilizes the same record and the systems have been customized for use by the behavioral health and case management departments.

One consumer is a member of the board of directors, and the organization conducts annual consumer satisfaction surveys as well as ad hoc focus groups. Several CABs have been formed which have disbanded as a result of changes in the lives of the members; a new CAB format is in development at this time.

PCMH recognition is a stated goal in the strategic plan and staff has begun some readiness assessment, but the organization has identified the need for additional resources in order to move forward with a complete assessment and application process.

Maturity and Growth: Care for the Homeless

Care for the Homeless (CFH) is a stand-alone HCH program in New York City which has been funded since 1985. CFH has 5 fixed clinic sites as well as 31 other sites located at shelters or other settings where homeless persons congregate or reside. The agency's street outreach program focuses on outreach to the mentally ill in four of New York City's five boroughs. The organization also operates a 200 bed transitional residence for women who are medically frail and mentally ill. This transitional housing program has an onsite medical and dental clinic. CFH employs 88 staff members, including physicians, nurse practitioners, podiatrist, psychiatrist, psychologist, psychotherapist, social workers, case managers, health educators and patient advocates.

Interdisciplinary teams visit the service sites from one to five days a week and offer comprehensive primary care services, including HIV testing and pre- and post-test counseling, TB screening, psychiatric screening and oral health screening. CFH delivers oral health services to homeless adults at two service sites, with a third site in development. The dental teams provide oral exams, cleanings, X-rays, fillings, extractions, dentures, sealants, night guards and referrals for any care that cannot be provided on site. Additionally, dental health education sessions are offered which address the main content areas recommended by the Centers for Disease Control and Prevention and the American Dental Association. The Social Service Team, consisting of behavioral health and case management staff, provides intensive and supportive case management services for homeless people dealing with HIV/AIDS, substance abuse and addiction as well as mental health issues. HIV workers engage clients to assess and support their adherence to medical appointments and treatments. Mental health workers provide assessments, psychiatric evaluations, therapy and assist in medication management. The substance abuse counselor provides individual and group counseling.

CFH has strong community linkages and contracts with four licensed health facilities to provide the health care and social services at the 36 service sites. The organization has placed a strong emphasis on developing community partnerships to ensure client access to entitlements, specialty care and housing opportunities. For example, the housing specialist at the women's transitional housing facility works closely with housing agencies to coordinate movement to permanent housing. One of the service sites has a large veteran population that seeks care from the CFH clinic. Members of the Social Service Team work closely with local Social Security offices to assist in client applications for SSI or SSDI.

CFH has adopted Comprehensive Case Management as an evidence-based practice and recently submitted an application for the entire agency to be trained in Motivational Interviewing and Trauma Informed Care. Over 50% of the staff has had some training in these areas, but the organization wishes to have a more comprehensive competency based approach for all staff members.

The organization embraces a team-based approach to care and staff communicates through team meetings, case conferencing, emails and telephone. The emphasis is on providing everything that a client needs in one environment, so team members are encouraged to call upon colleagues to enhance and add depth to service plans. Many primary care providers are comfortable treating mental health issues, including serious mental illness, primarily because of ready access to the agency's psychiatric services for training, advice and support.

CFH has two active consumer boards, an HIV/AIDS council and a Consumer Advisory Board. Both have consumers who are currently or formerly homeless and who have used the services of the agency within the year. The two boards assist with the organization's quality improvement process and focus on service improvement. In addition, members of the two consumer advisory boards work with the staff at the clinic sites as peer advocates and advocate with staff at the state and local government level. Consumer satisfaction surveys are conducted quarterly. Feedback from the surveys often results in improvements to processes or service delivery. Examples include changing the hours of service by staggering lunch hours to enable the clinics to remain open during lunch time, modifying the grievance procedure, extending clinic hours and ensuring that all necessary documents are provided in Spanish. Consumer Focus Groups are conducted as a component of continuous quality improvement. Once a year, clients are engaged in focus groups at a minimum of 11 service sites, offering feedback about quality of services, satisfaction with staff and recommended program improvements. Approximately 1 ½ years ago CFH initiated a consumer advocacy training and internship program. Consumers are provided with training in advocacy skills and once training is completed, offered a three month internship with a stipend. The goal is to develop skills which can enhance employability.

CFH has had an electronic health record since 2008. All primary care and behavioral health staff utilize the same record. Dental and health education staff use another record keeping system. Clinical measures are used to track outcomes. The organization has made a strong effort to work toward Meaningful Use of the electronic record.

CFH worked with the NYC Primary Care Information Project to obtain NCQA Level I recognition for one of the five standing sites and are in the process of applying for Level I for seven additional sites as well as Level III recognition for the current Level I site. The organization is committed to pursuing this certification, but cites the need for the necessary amount of staffing resources, particularly for Level III recognition.

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Key Elements of Integrated Care

Clinical Core Competencies

Individuals experiencing homelessness face many barriers in seeking health care services and managing their health. The clinicians who provide care to these individuals also face many barriers in ensuring access to quality care. The list of core competencies below attempts to articulate the knowledge and skills necessary to provide high quality care to individuals experiencing homelessness using an integrated care model.

Developing treatment plans require input from care teams composed of clinicians from various disciplines to provide the most complete picture possible of the factors impacting client health. It is important to note that these core competencies may not already be established when a clinician enters the homeless health care field; however, clinicians entering this field should understand what is expected of them and be willing to learn or build upon these competencies.

(1) Knowledge of Health Care for the Homeless 101

A solid understanding of the causes of homelessness and health concerns related to homelessness will help clinicians appreciate the difficulties of living without a home. While everyone's story of becoming homeless is unique, there are factors that can increase risk for homelessness and prolong homelessness.

Understanding these factors may prevent clinicians from misjudging their clients and allow for a better client-clinician relationship. A free online training called Health Care for the Homeless 101 is available at <http://www.nhchc.org/stafforientation.html>.

(2) Knowledge of High Priority Clinical Issues

Clinicians who work in homeless health care settings should have a good background in their clinical discipline, including substance abuse, mental health and cognitive health. Clients who are homeless often have more complex diagnoses and difficulty managing illnesses. Clinicians may need to hone their skills in those conditions which are highly associated with homelessness and adapt practices to be more effective in providing quality care to their clients who are homeless. The National Health Care for the Homeless Council provides many resources for the treatment of those experiencing homelessness. Specifically, nine adapted clinical guidelines on the following topics can be found at www.nhchc.org:

- Asthma
- Cardiovascular Diseases: Hypertension, Hyperlipidemia & Heart Failure
- Chlamydial or Gonococcal Infections
- Chronic Pain (coming soon)
- Diabetes Mellitus
- General Recommendations for the Care of Homeless Patients
- HIV/AIDS
- Otitis Media
- Reproductive Health Care

(3) Managing Substance Abuse, Mental Health Disorders and Cognitive Impairments

Substance abuse, mental health disorders and cognitive impairments are prevalent in the population of individuals experiencing homelessness and can provide many challenges for providers and clients. Each of these issues can have a significant impact on other health conditions as well as social relationships, job opportunities, housing stability and treatment adherence. Mental health providers and substance abuse specialists should be working with medical teams and case managers to ensure that treatment plans are developed in consideration of the various factors influencing a client's health status. The combination of both substance abuse and a mental health diagnosis, known as dual diagnosis, is also prevalent within this population and can complicate treatment even further. Some clients may be self-medicating a mental illness by drinking excessively while other clients may have cognitive impairments after many years of substance use. In summary, substance abuse, mental health disorders and cognitive impairments complicate management of other illnesses and hinder individuals from transitioning out of homelessness. Homeless health care clinicians should know how to assess for these disorders and develop treatment plans with an integrated care team to address them.

(4) Providing Trauma-Informed Care

Trauma-informed care is a non-judgmental technique for providing care to someone who has experienced and may still be experiencing trauma. This skill is important for homeless health care providers as homelessness is associated with previous childhood abuse and neglect, intimate partner violence, traumatic brain injury and a history of military service. Victims of trauma are sometimes left with a sense of betrayal and isolation; therefore, trauma-informed care attempts to provide a safe space for clients to feel supported. Clinicians who use a trauma-informed approach care may be better equipped to understand the actions of their clients and engage them in a treatment plan.

(5) Managing Complex Multi-Morbidities

A significant challenge in providing health care to individuals who are homeless is the reality that many have more than one primary diagnosis. Treatment plans must take into account the specific combination of diagnoses and how potential treatments for those diagnoses will interact with each other. Dual diagnosis of mental illness and substance abuse was previously mentioned as a complex combination of health conditions. Another example would be a client who is diagnosed with both type 2 diabetes and psychosis. Disease management is complicated by the effect of atypical antipsychotics on weight and metabolic factors. Adding a third diagnosis, which occurs frequently, would complicate treatment even further. Clinicians should become familiar with the multi-morbidities most common among those who are homeless and learn how to create appropriate care plans.

(6) Developing Treatment Plans

Many homeless health care facilities do not have adequate finances, staffing and services considering the high level of need found in their patient population. Care planning can be extremely difficult in these types of resource-poor treatment settings when working with clients who already have health care access and management challenges. Given that preferred and sometimes clinically recommended services may not be

directly available in all homeless health care settings, clinicians should learn what resources are provided by other entities to help their clients access needed treatments. For example, many homeless health care sites do not have access to pharmaceutical treatments. Clinicians at these sites may have to research local and national groups that provide free or discounted pharmaceuticals for their clients.

(7) Managing Medications

Proper medication management is difficult for clients experiencing homelessness for a number of reasons. For many clients, merely accessing recommended medications is a barrier because of a lack of money or insurance. Even once clients receive medications, those with health literacy limitations may require medication instructions with pictures or regular reminders to take their medications. Clients with substance abuse issues may need close monitoring if taking medications that have addictive properties; sometimes they will need non-pharmaceutical treatment options. Another common problem is how to assist clients in retaining their medications. Clients lose medications because they have nowhere to keep their belongings, have medications stolen when in vulnerable situations and sometimes sell medications to make money for other drugs or more important needs. This is not an exhaustive list of the challenges involved with medication management; as mentioned above, though, clinicians will have to develop medication plans that address the needs of each individual client.

(8) Conducting Outreach and Engaging Clients

Individuals who are homeless are some of the most disenfranchised members of our society, often detached from the mainstream and distrustful of the medical community. For this reason, many homeless service agencies employ outreach workers to go where potential clients are and engage them in care. Outreach workers build rapport with individuals, gain trust and try to meet immediate needs of clients. Even if clinicians do not practice street outreach medicine, they still have opportunities for engagement within their treatment settings, such as initiating client interactions without scheduled visits and letting clients know what services are available. In addition, it is important for clinicians to work closely with members of outreach teams to ensure seamless “warm handoffs” and care transitions.

(9) Performing Motivational Interviewing

Motivational interviewing is a client-centered approach that clinicians can use to help clients understand where they are and develop goals for themselves. Using a stages of change health behavior model, clinicians ask questions that help clients articulate their needs and capabilities for accomplishing self-identified goals. This technique sets a balanced tone to the client-provider relationship and allows for a dialogue regarding the treatment plan. Clinicians can provide education and recommend various treatment options, but the clients dictate the treatment plans depending on their readiness for action and self-identified priorities.

(10) Supporting Client Self-Management

For people experiencing homelessness, setting and meeting self-management goals can be complicated by many factors including lack of housing, income, nutritious meals, medications and needed health care services. Clinicians working with clients who lack so many resources will have to help those clients establish realistically attainable goals keeping in mind that non-adherence is not necessarily a sign of indifference.

Follow up of established goals should include a review of the barriers preventing clients from reaching their goals and a discussion on ways to overcome those barriers.

(11) Communication and Negotiation Skills

Effective communication skills are central to working within integrated care teams and settings. Clinicians need to be able to articulate concerns about clients, be open to the professional opinions of fellow clinicians and have the confidence to negotiate with clients and other clinicians throughout the treatment planning process. These communication and negotiation skills are also important when working with external agencies or providers who may not fully understand the extent of client needs.

(12) Advocating for Client Needs

Clinicians who provide health care to people experiencing homelessness may not recognize the important advocacy roles they play in the lives of their clients. Every time a clinician negotiates with other clinicians to provide services to their clients, they are advocating on behalf of their clients. Some clinicians go a step further and speak at community events to share their experiences working as homeless health care providers; this is also advocacy. Another type of advocacy involves educating policy makers about the health challenges faced by people who are homeless to ensure that needed services are available and accessible to health outcomes. Clinicians have the expertise to provide credibility to health policy efforts and should find ways to advocate for their clients at the local or national level.

(13) Performing Self-Care

Self-care for clinicians is essential to providing health care, especially when caring for underserved populations. Stress and burnout are very common for clinicians who constantly see clients with complex health conditions, treatment adherence barriers and daily struggles merely to survive. Self-care means taking action to eliminate stress and create more balance in one's life, such as practicing daily meditation or yoga. The purpose is to create time for enjoyable or calming activities to feel rejuvenated in work and remain effective as a clinician. It is also important for self-care to be stressed in the workplace through strategies such as active support for professional colleagues and team members, open discussion of stressful experiences such as death of a client, and organizational policies that promote staff well being.

(14) Mentoring Co-workers

Because of the stress and burnout of working in the homeless health care field, some service agencies experience high staff turnover. With the influx of new staff, clinicians may find themselves quickly becoming mentors. Being a positive mentor could help retain staff who might otherwise leave an organization because of lack of support. Additionally, mentoring health profession students could help attract new clinicians to the field and prepare clinicians before they even enter the field.