Project H.O.P.E., Inc.
Homeless Outreach Program Enrichment

Integration of Behavioral Health & Primary Care

October 15, 2015

**PHILADELPHIA REGIONAL TRAINING OF
THE NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL**

Lynda M Bascelli, MD
Brian Colangelo, LCSW, CADC

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Project H.O.P.E. – Camden, NJ

Project H.O.P.E., Inc. serves the medical and social needs of the homeless population in Camden County, particularly Camden City. The City of Camden is the largest urban center in southern New Jersey, with a population of 78,675 residents, and is ranked as the most economically depressed city in New Jersey and one of the most economically depressed cities in the United States.

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Project H.O.P.E. – Camden, NJ

- Stand-alone FQHC 330E Healthcare for The Homeless
- Initially started over 15 years ago as a street medicine program
- Approximately 3000 patients per year (11,000 visits)
- Staff of over 28 people
- 340B formulary (with collaborating pharmacy)

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Patient Discussion

- 33yo Male
- Opioid Dep, PCP Dep, Cocaine Dep
- Bipolar D/0
- Multiple ED visits – frequent infections

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Patient Discussion

- 30yo Male
- Opioid Dep, Benzodiazepine Dep
- Major Depressive Disorder
- HTN
- Has little family support

Critical Health Disparities

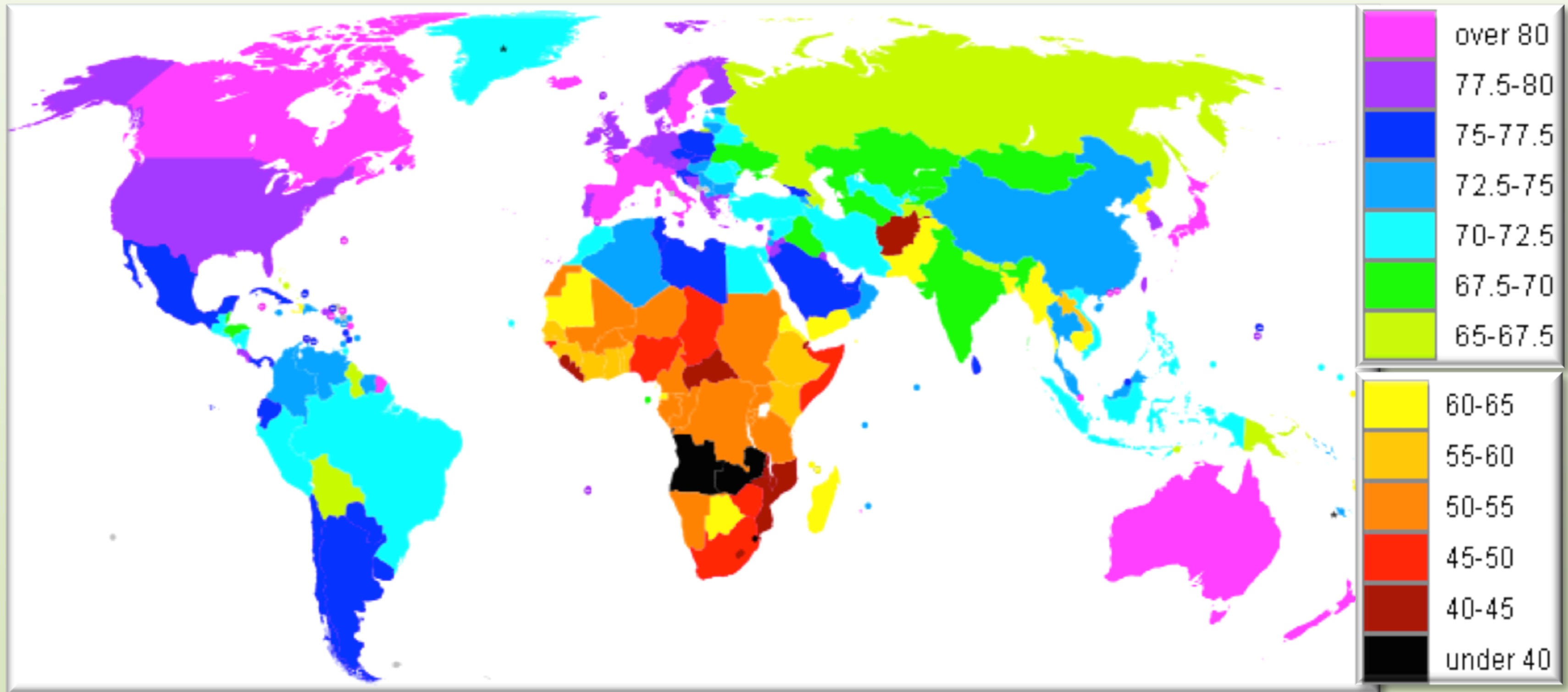
- 1928-1931: Malzberg found that patients in NY State's Psychiatric Hospitals die 15 years earlier than other NY state residents[1]
- Most of this excess mortality was due to "natural" rather than "unnatural" causes:
  - Heart Disease (33%)
  - Pneumonia (10.1%)
  - Tuberculosis (9.5%)
  - Peripheral Artery Disease (8.9%)

1. Malzberg B. *Journal of the American Statistical Assoc Mar 1932; 27 (177A):160-174*

Critical Health Disparities

- Today. . . . .
- Individuals with Serious Mental Illness are dying approximately 25 years earlier than the general population
  - **Average age of death is 53**
- An Oregon study found that those with co-occurring MH/SUD were at greatest risk
  - **Average age of death is 45.1 years**

The 53 year lifespan for people *with* Serious Mental Illness is comparable with Sub-Saharan Africa



NASMHPD 2006 Study: *Morbidity and Mortality in People with Serious Mental Illness*

Increased Mortality and Morbidity are Largely Due to Preventable Conditions

While suicide and injury account for about 30 – 40% of excess mortality, 60% of premature deaths are due to preventable medical conditions such as:

- Cardiovascular Disease
- Diabetes
- Respiratory Disease
- Infectious Disease

Causes of Excess Mortality in Persons with Serious Mental Illnesses

- Lifestyle Issues
  - Smoking
  - Poor diet
  - Reduced physical activity[1]
- Social and Environmental Issues
  - Excess rates of poverty and social disadvantage[2]
- Poor quality of medical care[3]
- Poor quality of medical effects of psychotropic meds[4]

1. de Leon J, Diaz FJ. Schizophr Res 2005;76: 135–157, Compton M et al Harv Rev Psychiatry. 2006 Jul-Aug;14(4):212-22
2. Wilton et al Soc Sci Med 2004 58: 25-39
3. Mitchell A. Br J Psychiatry. 2009 Jun;194(6):491-9
4. Newcomer J. Journal of Clinical Psychiatry. 2007;68 Suppl 4:8-13. Review

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Decision for Integration

- National trends
- Local Data
- Agency Data
  - 444 Patients of Project HOPE were identified with a substance abuse disorder and
  - 1143 patients were diagnosed with a mental health disorder
- Community referrals
- 2008 Funding – Robert Wood Johnson Foundation
- 2010 Funding – Nicholson Foundation

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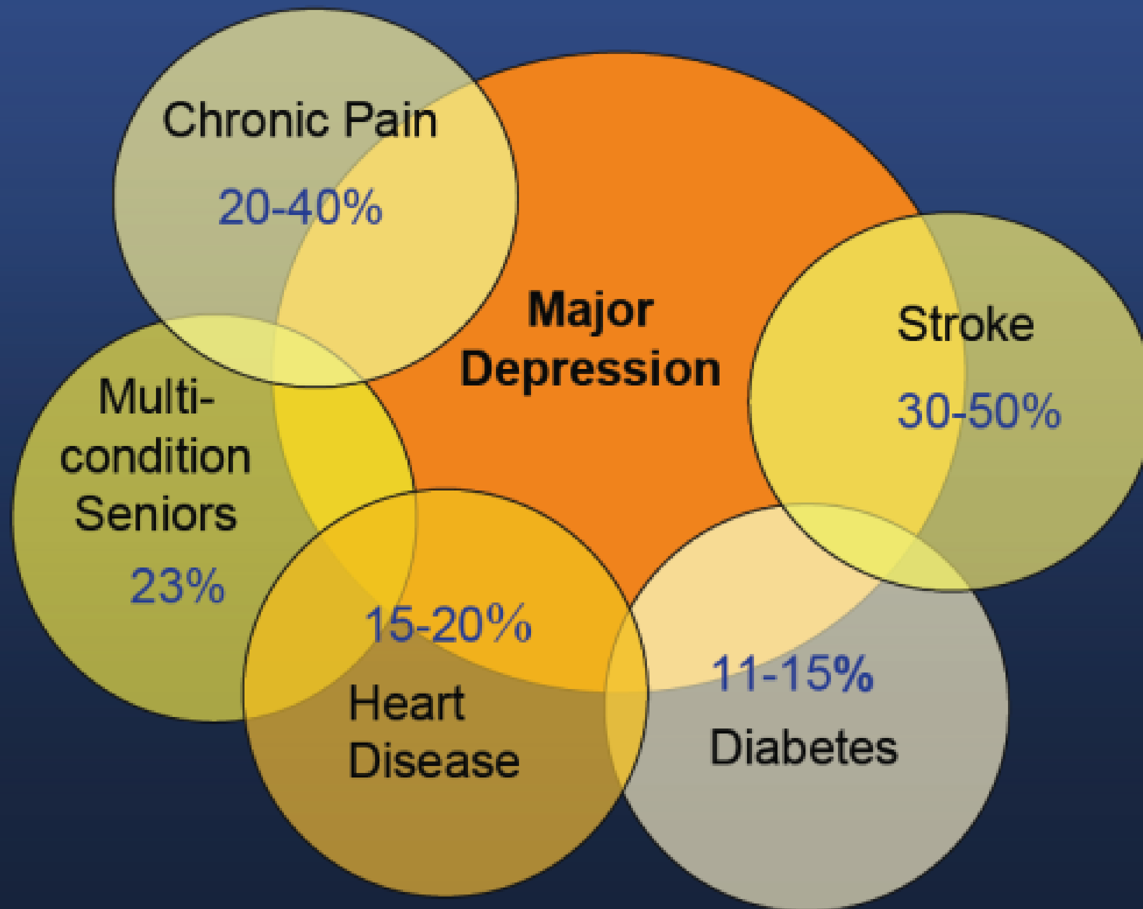
Decisions for Integration

- Prevalence of psychiatric disorders in low-income primary care patients:
  - At least one psych dx: 51%
  - Mood disorder: 33%
  - Anxiety disorder: 36%
  - Alcohol abuse: 17%

- Primary Care providers prescribe more anti-depressant and anti-anxiety medications than Mental Health providers!

Comorbidity



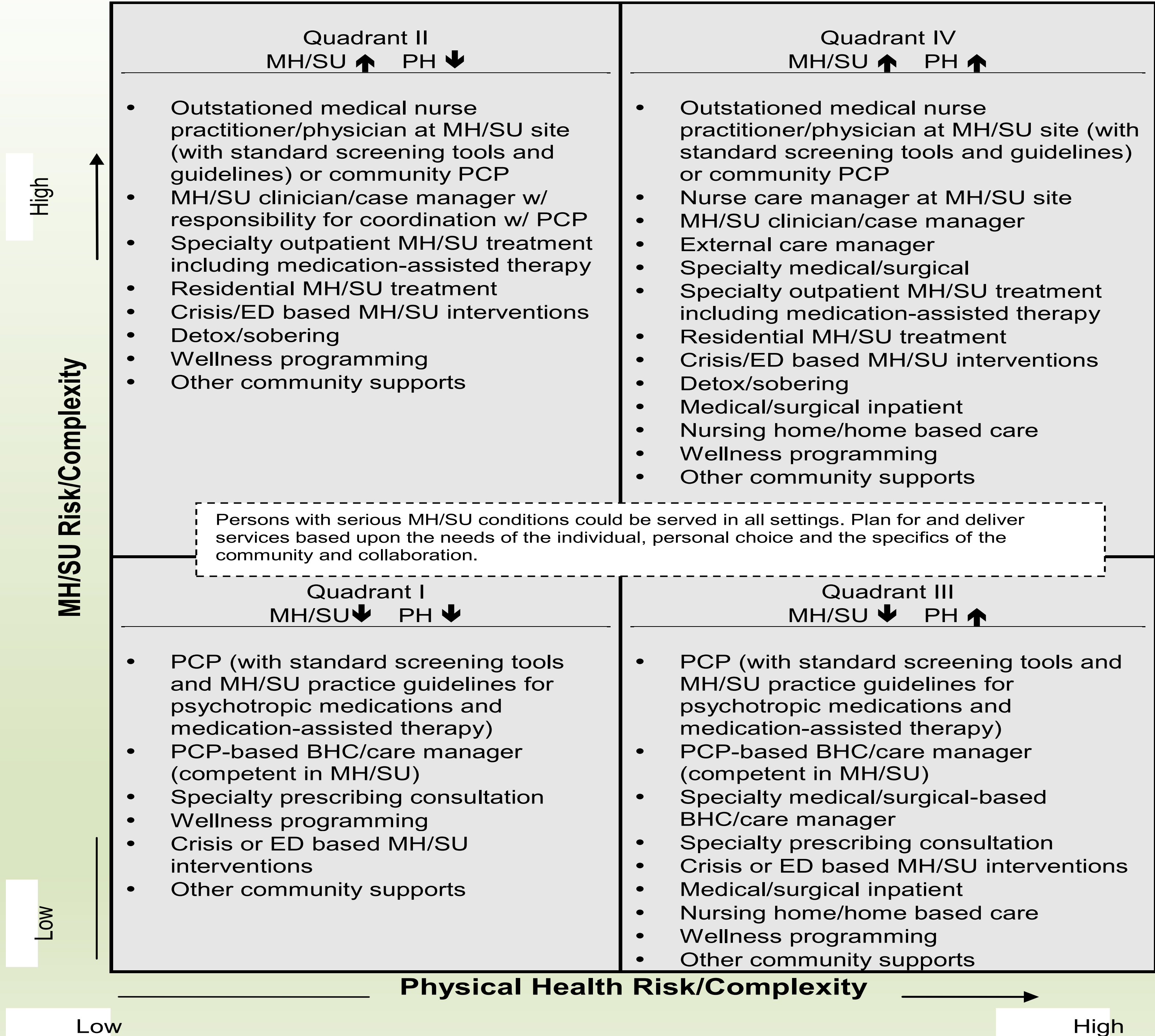
Five Levels of Behavioral Health-Primary Care Collaboration

Doherty, McDaniel, & Baird (1996)

Level 1	**Minimal Collaboration** (only referrals)
Level 2	**Collaboration at a distance** (some direct communication)
Level 3	**Basic on-site Collaboration**
Level 4	**Close Collaboration in a partly integrated system**
Level 5	**Close Collaboration in a fully integrated system**

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/ Partly Integrated	Fully Integrated/Merged
THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE					
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility
Governance	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
EBP	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants
Data	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source

Doherty, Baird, Reynolds, McDaniel Scale


Quadrant II
MH/SU ↑ PH ↓
Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP
MH/SU clinician/case manager w/ responsibility for coordination w/ PCP
Specialty outpatient MH/SU treatment including medication-assisted therapy
Residential MH/SU treatment
Crisis/ED based MH/SU interventions
Detox/sobering
Wellness programming
Other community supports
Quadrant IV
MH/SU ↑ PH ↑
Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP
Nurse care manager at MH/SU site
MH/SU clinician/case manager
External care manager
Specialty medical/surgical
Specialty outpatient MH/SU treatment including medication-assisted therapy
Residential MH/SU treatment
Crisis/ED based MH/SU interventions
Detox/sobering
Medical/surgical inpatient
Nursing home/home based care
Wellness programming
Other community supports
Persons with serious MH/SU conditions could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.
Quadrant I
MH/SU ↓ PH ↓
PCP (with standard screening tools and MH/SU practice guidelines for psychotropic medications and medication-assisted therapy)
PCP-based BHC/care manager (competent in MH/SU)
Specialty prescribing consultation
Wellness programming
Crisis or ED based MH/SU interventions
Other community supports
Quadrant III
MH/SU ↓ PH ↑
PCP (with standard screening tools and MH/SU practice guidelines for psychotropic medications and medication-assisted therapy)
PCP-based BHC/care manager (competent in MH/SU)
Specialty medical/surgical-based BHC/care manager
Specialty prescribing consultation
Crisis or ED based MH/SU interventions
Medical/surgical inpatient
Nursing home/home based care
Wellness programming
Other community supports
MH/SU Risk/Complexity
High
Low
Physical Health Risk/Complexity
Low
High

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Integration Project

- Treat mental health patients where they feel most comfortable
- Improved coordination of care
- Delay in obtaining outside treatment
- Less stigma
- Established patient relationship with Primary Care
- Majority of mental health treatment occurs in community health settings
- Unique patient issues – Who is the homeless patient?

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Overview of Integration Project

- The purpose of integrated care at Project H.O.P.E. is to improve the assessment, diagnosis, and treatment of both behavioral health and medical disorders in one setting.
- Formalized screening process for mental health and behavioral health
- Improved clinical assessment
- Tracking of patient symptoms and outcomes
- Improved comprehensive clinical care of patients

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Overview of Integration Project

Principles:

- Focused behavioral intervention in primary care - When both mental health and substance use services are provided by the same person or team, the client has one treatment plan, one set of goals, and one relapse plan.
- Comprehensive screening and assessment of mental health and substance abuse disorders
- Embedded Behavioral Health Consultant on the Primary Care Team
- Behavioral medicine scope of practice
- Shared decision making - clients with co-occurring disorders decide what goals they want to pursue, how they want to proceed with treatment, and what their path to dual recovery will be
- Encourage patient responsibility for healthful living

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CALENDAR | CONTACT

About | Systems Support | Implementation Center | Change Agents | Events | Blog | News and Updates

COMPASS-PH™

The COMPASS-PH™ is a tool for primary health settings to organize themselves to develop core capability in meeting the needs of complex populations with co-occurring health and behavioral health needs. The tool does not require any particular level of experience or expertise in primary health/behavioral health integration-both "newbies" and "seasoned veterans" will benefit from the process. The most important purpose of the COMPASS-PH™ is to create a foundation for an improvement process through an empowered conversation that involves as many people working together to build the program and its services as possible.

The COMPASS-PH™ is a continuous quality improvement tool that can be used by any primary care setting as it is currently designed. It helps establish a baseline, define initial starting places or building blocks of previous success, allows organizations to demonstrate measurable progress, and, most importantly, promotes an empowered team approach to managing complex care.

Tools & Resources

- COMPASS-EZ™
- CODECAT-EZ™
- COMPASS-PH™
- Resources

Categories

- News and Updates

Recent Posts

- Small Victories Are Big Milestones on Road to Recovery
- Dr. Ken Minkoff on Value-Driven Systems Change
- Welcoming: An Essential Practice for Systems Recovery

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Integration Team

- Primary Care Provider
- Behavioralist
- Clinical Care Manager
- Case Manager
- Nurse
- Outreach Worker

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Staff Assessment

- Who is supportive?
- Who is resistant?
- Who needs training?
- Who wants training?
- Who is being under utilized?

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Organization Assessment

- Know your organization's strengths and weaknesses and use them
- Know your staff
- Review organizational policies – what is written vs what is spoken
- Psychopharmacology

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Screening Tools

- Pre-screen form
- PHQ-9
- GAD-7
- AUDIT
- DAST- 10

Wellness Screen

	Not at All	Several Days	More than Half the Days	Nearly Every Day
The past two weeks, how often have you been bothered by little interest or pleasure in doing things?				
The past two weeks, how often have you been bothered by feeling down, depressed, or hopeless?				
The past two weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?				
The past two weeks, how often have you been bothered by feeling nervous, anxious, or on edge?				
The past two weeks, how often have you been bothered by not being able to stop or control worrying?				
In the past 12 months, have you used drugs other than those used for medical reasons?				
How often do you have a drink containing alcohol?				
How often do you have six or more drinks on one occasion?				

How many standard drinks containing alcohol do you have on a typical day drinking? ____________

Have you used drugs other than those required for medical reasons? YES or NO

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Screening Process

- Patients complete at each visit
- Information entered into EMR
- Provider Review
- Decision on intrevention

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Screening Tools – PHQ-9

- The PHQ-9 is a powerful tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment.
- Assesses symptoms and functional impairment to make a tentative depression diagnosis, and derives a severity score to help select and monitor treatment
- The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV).

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Screening Tools – PHQ-9

1. Over the past two weeks, how often have you been bothered by any of the following problems (Make an "X" in the appropriate box)?

	Not at All	Several Days	More than Half the Days	Nearly Every Day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling/staying asleep, sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
h. Moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

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Screening Tools – GAD 7

- Robert L. Spitzer, MD (et. al) reports on their development of a new, quick and effective tool to measure anxiety in the May 22, 2006 edition of the Archives of Internal Medicine2. The name of this anxiety inventory is the GAD-7 (the Generalized Anxiety Disorder-7 questions).
- The researchers conclude that the “GAD-7 is a valid and efficient tool” to screen for anxiety and to assess “its severity in clinical practice and research.” What is more impressive is that you can do this by answering seven short questions.

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Screening Tools – GAD 7

GAD-7 Questionnaire

Over the past two weeks, how often have you been bothered by any of the following problems (Make an "X" in the appropriate box)?

	Not at All	Several Days	More than Half the Days	Nearly Every Day
a. Feeling nervous, anxious, or on edge	0	1	2	3
b. Not being able to stop or control worrying	0	1	2	3
c. Worrying too much about different things	0	1	2	3
d. Trouble relaxing	0	1	2	3
e. Being so restless that it is hard to sit still	0	1	2	3
f. Becoming easily annoyed or irritable	0	1	2	3
g. Feeling afraid as if something awful might happen	0	1	2	3

Screening Tools - AUDIT

- AUDIT, the Alcohol Use Disorders Identification Test, and describes how to use it to identify persons with hazardous and harmful patterns of alcohol consumption. The AUDIT was developed by the World Health Organization (WHO) as a simple method of screening for excessive drinking and to assist in brief assessment. It can help in identifying excessive drinking as the cause of the presenting illness. It also provides a framework for intervention to help hazardous and harmful drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking.

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Screening Tools - AUDIT

Alcohol Use Disorders Identification Test:

<table>
<tr>
<td>1. How often do you have a drink containing alcohol?

(0) Never (Skip to Q's 9 and 10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week</td>
<td>6. How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily</td>
</tr>
<tr>
<td>2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more</td>
<td>7. How often during the past year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily</td>
</tr>
<tr>
<td>3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily
Skip to questions 9 and 10 if total for questions 2 and 3 = 0.</td>
<td>8. How often during the past year have you been unable to remember what happened the night before because of your drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily</td>
</tr>
<tr>
<td>4. How often during the past year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly</td>
<td>9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year</td>
</tr>
</table>

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Screening Tools – DASTу-10

•The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has "exhibited valid psychometric properties" and has been found to be "a sensitive screening instrument for the abuse of drugs other than alcohol.

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Screening Tools – DAST-10

Drug Abuse Screening Test – DAST-10

These questions refer to the past 12 months.			
1.	Have you used drugs other than those used for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop using drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No

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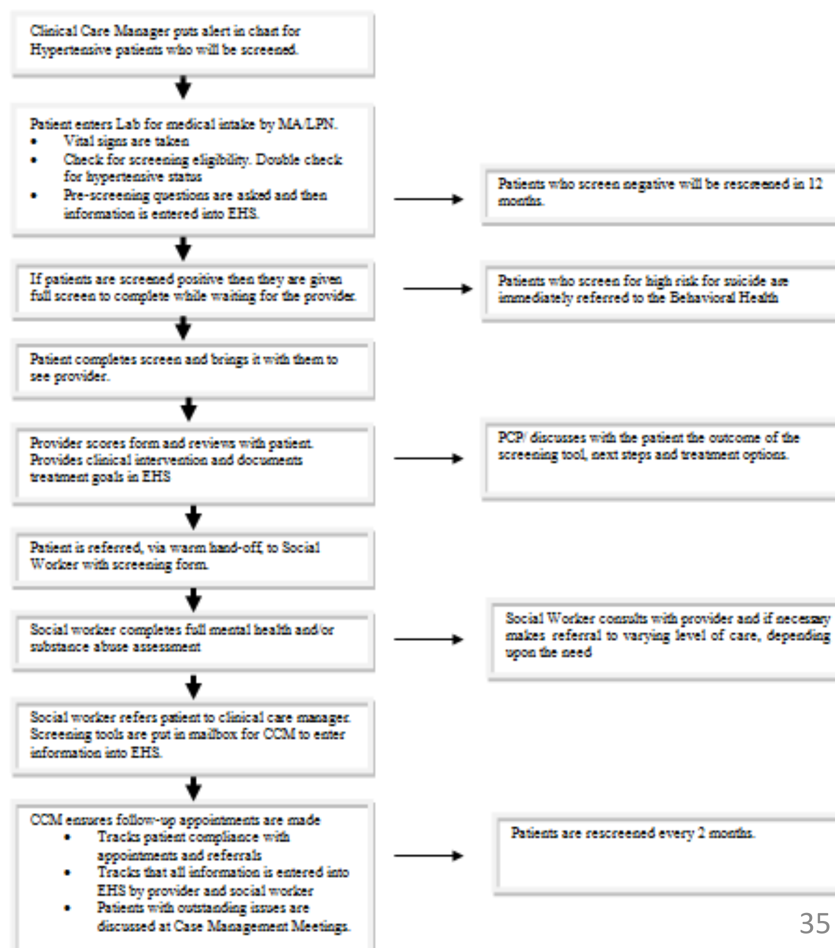
Patient Flow



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Responsibilities of Provider

- **CHECK** status and screening results BEFORE bringing patient to exam room
- **ASK** the patient if they were given any screening forms by the medical intake staff
- **SCORE** any forms that the patient has with them
- **TALK** to the patient about mental health issues and treatment plan/goals indicated by the forms or EHS information
- **REFER** patient to next staff member via warm handoff
- **GIVE** scored screening forms to patient for next staff person
- **UPDATE** treatment plan in EMR

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Responsibilities of the Social worker

- **MEET** with patients who screen positive to discuss treatment, goals, current circumstances, patient's questions
- **Provide** therapeutic support and counseling
- **Provide** referrals for care (partial care, IOP)
- **TRACK** treatment of mental health concerns with regular re-screens and patient adherence with appointments and referrals
- **REVIEW** progress of individual patients' treatment goals

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Challenges & Barriers

- Patient involvement
  - Language, time, refusal, attrition, follow-up
- Clinic patient load
- Team meetings
- Clinical Training

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Lessons Learned & Successes

- Positive staff participation & "buy-in"
- "Morning Huddle"
- Constant communication
- Staff recognition
- Warm handoffs
- Increased patient satisfaction
- Advocacy – Making system changes

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Patient Discussion

Case Studies

Patient Discussion

- The “Resistant Patient”
- 63 year old male living in an abando. Diagnosed with HTN, Seizure d/o & Cellulites. Also diagnosed with Schizoaffective d/o and using cocaine and alcohol to reduce mental health symptoms.
- Receives $700/month SSI
- 75 ED visits between Jan – June 2010
- “I’m not crazy”

Patient Discussion

- The "Siloed Patient"
- 44 year old woman living in the shelter. Insulin dependent diabetes & morbid obesity. History of cocaine dependence. Major Depressive Disorder & possible PTSD – History of trauma
- Community mental health weekly, substance abuse program weekly, primary medical care bimonthly.
- Full time job of "being sick."

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Patient Discussion

- The "Yearly Patient"
- 36 year old man couch-surfing from friend's house to friend's house. Needs medical clearance for a job.
- Recently out of jail for failure to pay child support. Last visit with his PCP was last year. Prescribed Zoloft – takes it intermittently. Has been referred to community mental health, but never goes. No insurance/Medicaid
- Daily marijuana use. Moderate depression
- Difficulty "adhering to" medications regimen, appointments and follow-up.
- His mother thinks he's just "lazy."

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Welcome to Cherokee Health Systems

Cherokee Health Systems' roots are planted firmly in East Tennessee. Since 1960, we have served the health care needs of our neighbors. Our philosophy is simple, we believe the best approach to wellness involves treating both the body and mind. That's why we offer an array of comprehensive primary care, behavioral health, and prevention programs and services. Whether you need medical, dental or behavioral health care, our compassionate, dedicated staff is here to help you.

With 43 clinical sites in 12 Tennessee counties, Cherokee's services are never far away. We offer convenient hours and have providers on call 24 hours a day for emergencies. We accept most insurance and TennCare plans and offer flexible payment schedules because we do not think money should ever stand in the way of your health care.

News & Events

07/18/11
What will become of the mental health saftey net?

By Dennis Freeman, Ph.D.

IMPACT Evidence-based depression care

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One in ten older adults visiting a physician suffers from depression

IMPACT Team Care doubles the effectiveness of depression treatment

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IMPACT key components

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Thank You

Success Stories from Across the Country

Read about how organizations across the US are having success with the IMPACT program. Click on the map to learn more.

Thanks for coming out!!!!

Brian Colangelo

colangelob@projecthopecamden.org

856-968-2320

Project HOPE

439 Clinton St.

Camden, NJ 08103