

INTEGRATED CARE QUICK GUIDE:

Integrating Behavioral Health & Primary Care in the HCH Setting

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NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

Why this guide?

The purpose of this quick guide is to assist Health Care for the Homeless (HCH) grantees with their efforts to integrate behavioral health and primary care services. Individuals who are homeless often have multiple chronic health conditions and face numerous barriers to care. Integrating behavioral health and primary care is one way to help improve health care delivery and access for this population.

Who is this guide for?

While the practices and experiences highlighted in this document come from HCH grantees, this quick guide can be useful for any organization that serves individuals experiencing homelessness. It is also intended to be valuable for organizations at different levels of integration.

What does this guide include?

This quick guide reviews current literature on integrating behavioral health and primary care. It also includes promising practices for integrating services that are currently being utilized by three different HCH grantees.

What can you expect to gain from this guide?

- You will be able to explain the importance of integrating behavioral health and primary care services for unstably housed persons.
- You will be able to discuss examples of promising practices for initiating or deepening integration efforts for patients with co-occurring medical, mental health, and substance use issues.
- You will be able to describe facilitators and barriers to successfully integrating care.

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Introduction

Individuals who are homeless often have multiple chronic health conditions and face numerous barriers to care. Results from the Collaborative Initiative to Help End Chronic Homelessness study estimate the prevalence of dual diagnosis (mental illness and substance use disorders) to be 52% among individuals who are homeless (Foster, LeFauve, Kresky-Wolff & Rickards, 2010). The authors stated that participants had chronic illnesses as well—including cardiovascular disease, arthritis, hypertension, diabetes, respiratory diseases, HIV/AIDS, hepatitis C, sexually transmitted infections, and dental problems—but exact prevalence rates of these additional comorbidities were not provided. A study of veterans who were homeless found that the top five comorbidities from a predetermined list of diagnoses were (Goldstein, Luther, Jacoby, Haas, & Gordon, 2008):

- Drug abuse + alcohol abuse (78%)¹
- Tuberculosis + alcohol abuse (73%)
- Hepatitis + alcohol abuse (71%)
- Heart/cardiovascular + hypertension (70%)
- Tuberculosis + drug abuse (68%)

A different study of a free clinic for individuals experiencing homelessness found that those patients with schizophrenia and bipolar disorder were significantly more likely to have comorbidities, including asthma (23%), cancer (6%), seizures (16%), headaches (20%), kidney (10%) and heart diseases (23%) (Welsh, Patel, Fernando, Torres, Medrek, et al., 2012). In addition, mental illnesses have been found to be associated with higher mortality and poorer control of chronic illnesses. A mortality study by Piatt, Munetz & Ritter (2010) found that there was a difference of approximately 4 year of potential life lost between individuals who were diagnosed with serious and persistent mental illness and the general population. A mortality study conducted in Boston, MA, found that overdose was the number one cause for mortality among patients experiencing homelessness (Baggett, Hwang, O’Connell, Porneala, Stringfellow, et al., 2013). Overdose as a cause of death was immediately followed by cancer and heart disease, but psychoactive substance abuse was also one of the top causes of mortality. In order to address these high rates of multimorbidities and premature mortality, behavioral health and primary care issues must be addressed together to improve health care delivery, access, and outcomes for this population.

Elements of Integrated Care Models

According to the Institute of Medicine (2006), “Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care” (p. 212). This collaboration, they explain, can be achieved with shared treatment goals and clear clinical roles, effective communication between providers, and decision-making that is shared across providers. Too often, providers are operating and caring for patients in siloes without communicating with one another regarding treatment plans and outcomes. Integrating behavioral health and primary care services allows providers to communicate more effectively and share in decision-making about patient care.

The Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA) jointly funds the Center for Integrated Health Solutions (CIHS) to promote the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health

¹ Percentages represent the portion of individuals with the first diagnosis listed in addition to the second diagnosis. For example, 78% of those diagnosed with drug abuse also were diagnosed with alcohol abuse.

or primary care provider settings. A specific example supported by these Agencies offers some insight into the existing frameworks for viewing integrated care in *A Standard Framework for Levels of Integrated Healthcare* (Heath, Wise Romero, & Reynold, 2013). The authors propose a six-level framework (see Figure 1) that incorporates complementary pieces of the most common models maintaining that a standard framework will help guide discussions and research of integrated care models and related health outcomes.

Figure 1. Six Levels of Integrated Care	
Coordinated	
Level 1:	Minimal collaboration
Level 2:	Collaboration at a distance
Co-located	
Level 3:	Basic collaboration onsite
Level 4:	Close collaboration onsite with some system integration
Integrated	
Level 5:	Close collaboration approaching an integrated practice
Level 6:	Full collaboration in a transformed/merged integrated practice
(Heath et al., 2013)	

A detailed review of the literature on integrated care by the Agency for Healthcare Research and Quality (AHRQ) describes integrated care models that have been used in various health care settings and their related outcomes (Butler, Kane, McAlpine, Kathol, Fu, et. al, 2008). All of the settings included in the review where behavioral health was integrated into primary care incorporated a psychiatrist or psychologist while only a portion of the settings included mental health therapists. In many of the settings, care managers were present and acted as liaisons between providers and provided follow up with patients. A minority of studies reported shared medical records between behavioral health and primary care providers. Many had co-located care, frequent communication between providers (structured or not), systematic screening for mental health issues, and patient education. Reported barriers to providing integrated care included a lack of: reimbursement to primary care providers for providing mental health services, reimbursement for care coordination between providers, funding for care management staff, and time to conduct mental health/substance abuse screening. Integration levels were not necessarily associated with better outcomes, but integrated care models in general were. Improvements in behavioral health outcomes were seen in depression and anxiety, specifically.

Investigators from the aforementioned Collaborative Initiative to Help End Chronic Homelessness study described strategies that service providers used to address dual diagnoses (Foster, 2010):

- Stabilize patients by helping them acquire housing, taking care of basic needs, supporting “daily living activities”
- Take a thorough medical history before engaging in specific interventions
- Increase access to services – medical, mental health and substance abuse
- Utilize motivational approaches to encourage participation in care
- Incorporate trauma-informed care
- Provide opportunities for peer support and group treatment
- Implement integrated mental health and substance abuse services into treatment programs
- Utilize interdisciplinary teams and ensure regular treatment planning meetings, cross-training, multiple service locations, and partnerships with other community agencies

For these strategies to become evidence-based practices there needs to be strong data supporting the hypothesis that they improve health outcomes. The Santa Clara Valley Health and Hospital System found a reduction in emergency department and urgent care use as well as an increase in primary care use after opening a clinic designed specifically for vulnerable populations (Kwan, Ho, Preston & Le, 2008). These positive results were attributed to the health care delivery model used by this clinic, including outreach services, open access (walk-in appointments), specialty groups, and integrated treatment teams. The integrated care teams shared physical space, met with patients simultaneously, and had team meetings after every clinic to share information and ideas regarding their patients.

Morse (2006) compared the health outcomes of 3 programs on dually diagnosed individuals who were homeless—Integrated Assertive Community Treatment (IACT), Assertive Community Treatment Only (ACTO), and standard of care (the control group). The authors found that participants in the treatment groups were significantly more satisfied and experienced more days in stable housing than their counterparts in the control group. Unfortunately, there were no significant differences in mental health status and substance abuse between the treatment and control groups; however, there were significant improvements over time for all groups. The authors recommended that care teams be integrated and include full-time substance abuse counselors; program administrators should incorporate additional intervention strategies to improve care, such as “supportive housing arrangements, psychotropic medications, contingency management, and community reinforcement approach” for addressing substance abuse.

Rosenheck (2003) supports the benefits of integrated care teams and community partnerships in delivering care to individuals who are homeless and dually diagnosed through the Access to Community Care and Effective Services and Supports (ACCESS) project. Perceptions of integrated care teams within the ACCESS project and other agencies outside of the ACCESS project proved important, as receipt of psychiatric services and the index of service integration were higher in accordance with positive perceptions. However, their results emphasize the impact of integration at the onset, as the effect of integrated ACCESS care teams on patient utilization of psychiatric services decreased over time, as was hypothesized. On the other hand, the effect of interagency cooperation on patient utilization of substance abuse services and psychiatric outcomes increased over time. Overall findings support the idea that program effectiveness, in both integrated teams and interagency approaches, is associated with communication, cooperation, and trust among providers.

Policy Developments Supporting Integrated Care

The Patient Protection and Affordable Care Act (ACA) has provided some opportunities for communities to provide integrated care, such as permitting states to create patient-centered health homes as part of their Medicaid programs and awarding grants through the Prevention and Public Health Fund to improve access to and integration of primary care services for individuals being treated for mental illnesses and substance abuse disorders.²

It is also predicted that ACA will increase support for integrated care by improving access, funding and infrastructure (Bevin & Parish, 2012). With the expansion of Medicaid slated for January 2014, approximately 5.5 million people with a mental health or substance abuse condition will be eligible for Medicaid although not all states have opted to expand. Insurers will also not be allowed to cap mental health and substance abuse treatment benefits at levels lower than those for medical services and these same

² The Substance Abuse and Mental Health Services Administration has guidance on these opportunities: <http://www.samhsa.gov/healthReform/healthHomes/index.aspx>.

services will be obligatory in state exchanges as essential benefits. In addition, \$50 million will be granted to increase the co-location of primary care services in behavioral health care programs, the patient-centered medical home model will be expanded, accountable care organizations will be supported, and reimbursement for Medicaid managed care and fee-for-service payments will increase to Medicare amounts. Finally, the ACA will support workforce development to train clinicians according to the integrated care, medical home, and team-based models of health care delivery.

Integrating Care in the HCH Setting

Although much literature focuses on integrated care, specifics regarding its application in the HCH setting are limited. To learn more about the ways that HCH grantees have been integrating behavioral health and primary care services, the National Health Care for the Homeless Council conducted phone interviews with three HCH grantees to inquire about their integrated care models. This section will provide a detailed summary of the promising practices employed by HCH grantees in their efforts to integrate behavioral health and primary care services, as well as barriers and facilitators of this process.

The 3 sites interviewed were:

- **The Daily Planet Health Care for the Homeless (Richmond, VA):** A stand-alone project that provides a range of health services to individuals who are homeless in the Greater Richmond Area of Virginia as well a Medical Respite program and a Safe Haven supportive housing program for individuals with mental illness.
- **Central City Concern (Portland, OR):** A large service organization that operates a stand-alone HCH project, which helps fulfill its mission to support individuals who are homeless by providing integrated health care services, peer support, direct housing, and employment assistance.
- **Cherry Street Health Services (Grand Rapids, MI):** A Health Center Program grantee that receives Health Care for the Homeless funding and provides health services to children and families with low incomes.

Promising Practices in Integration

All of the interview sites use an integrated care model in which behavioral health providers are integrated into the clinic workflow of the primary care practice. In addition, the integrated care practices implemented by the interview sites were similar to those found in the literature—creating partnerships, developing multidisciplinary teams with support staff, cross-training behavioral health and primary care staff, and integrating behavioral health screening into primary care.

Pursue Integration through Community Partnerships

All of the grantees interviewed created community partnerships to develop and sustain their integration efforts. In 2010, the Daily Planet began integrating behavioral health into primary care after initiating a relationship with NIATx.³ The NIATx model was developed to help increase access to and retention in behavioral health settings by providing core aims and principles, best practices, and learning collaboratives to organizations that wished to improve their behavioral health care services. While the Daily Planet has a full behavioral department, it was the medical director of the primary care clinic who jumped at the prospect of utilizing this behavioral health care delivery model and the resources provided by NIATx. The primary care clinic was already providing medical care at a local detox center on a regular basis, calling it

³ NIATx (www.niatx.net) was formerly an acronym for the Network for the Improvement of Addiction Treatment and started as a collaboration between the Robert Wood Johnson Foundation's Pathways to Recovery project and SAMHSA's Strengthening Treatment Access and Retention project. It is now operated through the Center for Health Enhancement Systems Studies at the University of Wisconsin-Madison.

“reverse integration,” so they knew that integration was possible and beneficial for patients. After continued training with NIATx and receiving a Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant from SAMHSA, the primary care clinic was able to hire a part-time behavioral health consultant and psychiatrist.

Prior to integrating behavioral health services into primary care, Central City Concern had been providing primary care through its addiction treatment services. At some point, outpatient addiction treatment moved to a new site leaving the primary care clinic without behavioral health care. Joining a Patient-Centered Primary Care Collaborative sponsored by CareOregon in 2006 motivated the clinic to begin integrating care, a pursuit supported by staff who wanted to recapture the integrated care environment that they had previously experienced.⁴ The initial integration happened with a pilot team of a physician assistant, medical assistant, panel manager, and data specialist. The team-based model of care was integrated clinic-wide after it was tested and refined. CareOregon also provided grant funding to help with integration set up costs and has since supported the clinic through a pay for performance model.

For Cherry Street, fully integrating services was a natural progression that solidified in 2011 through the physical joining of three organizations that were serving vulnerable populations—Cherry Street Health Services (a Health Center Program grantee), Touchstone innovare (a contract agency through the Community Mental Health program serving those with severe and persistent mental illness), and the Proaction Behavioral Health Alliance (originally a residential substance abuse treatment facility that now also serves previously incarcerated populations). The three organizations had been providing coordinated care since 2009 as part of a pilot project they were conducting with a small group of patients. As the three organizations were planning to move into a newly constructed building, they decided to merge into one organization since they were serving the same populations and wanted to further improve care to their patients. Without the merger, they would have been providing co-located care but now they are able to provide truly integrated care.

“The patient can’t tell who’s who. All they know is they’re a team and there’s no prejudice against psychiatry. All those barriers are brought down.”

-Medical Director, Daily Planet

Operate in Multidisciplinary Teams

Integrated care requires the introduction of behavioral health staff into the primary care environment and sufficient support staff who can help manage care. When the Daily Planet began integrating behavioral health into primary care, the medical director was the only primary care provider. Since then they have hired a nurse practitioner. The other staff members include a behavioral health consultant, psychiatrist, and two case managers (who are all part-time) as well as medical assistants. Because of limited physical space, the providers sometimes share exam rooms or talk to patients in the hallways. If the primary care provider needs the behavioral health consultant or a case manager, they are able to invite them into the exam room to deliver their care in real time. Even if the behavioral consultant and case managers are busy with other patients, they step away for a few minutes to make a connection with the patient and make plans to meet again. If they have time to work with the patient for a while, the primary care provider can then see another patient simultaneously. This prevents patient from feeling stigmatized if they have to see a behavioral health provider. The Medical Director explained, “The patient can’t tell who’s who. All they know is they’re a team and there’s no prejudice against psychiatry. All those barriers are brought down.”

⁴ CareOregon is the largest Medicaid managed care plan in Oregon. The Patient-Centered Primary Care Collaborative (<http://www.pcpcc.net>) educates health care providers about the benefits of the Patient-Centered Medical Home model, advocates for policies that support the implementation of this model, and provides a space for providers and patients to share ideas and experiences.

Central City Concern has four primary care teams made up of physicians, physician assistants, naturopathic doctors, nurse practitioners, psychiatric nurse practitioners (part-time), medical assistants (MAs), and panel managers. The MAs work with the providers on patients who are visiting each day while the panel managers look at patients who have future visits or the patients who missed their appointment. As the Director of Health System Development stated:

“If you’re going to manage a whole panel of patients and really look at population health moving into a proactive model of care, you need staff who are focusing on everybody who didn’t come in and someone who is looking ahead at the schedule to see who’s coming in tomorrow. Some of it is looking at who’s not coming in but needs to – who are the diabetics that haven’t had their A1C in 3 months?”

“Warm Handoff”
Seamless transfer of care
in the moment between
primary care and
behavioral health care
providers

Central City Concern also has Master’s level behavioral health consultants, health assistants, occupational therapists, and acupuncturists. Similar to the culture at the Daily Planet, the providers at Central City Concern also expect and welcome interruptions, which they call “warm handoffs.” Some providers intentionally have blocks of time with no appointments scheduled so they are available for unexpected visits. Central City Concern also has shared office space where providers might overhear each other’s conversations and be able to give their opinion or recommendations for a particular patient.

At Cherry Street Health Services integrated clinic – called the Durham Clinic – there is an internist, physician assistant, registered nurse, psychiatrist, multiple MAs, two supports coordinators, and six health coaches. The supports coordinators function like case managers and the health coaches, who are licensed MSWs, help motivate and activate patients regarding their chronic health conditions. Every morning, all of the clinic staff comes together for a “team huddle” to talk about the patients with appointments that day and to coordinate care. This time allows the providers to share information about patients, such as why someone has been missing their appointments. The Director of Health Home Services provided the following example:

“If we have a patient who has been having trouble getting in appointments, the support coordinator might be able to let the internist know that they lost their housing. That’s why they’re having trouble making it in and the internist can say, ‘This is how it’s affecting their diabetes care.’ Whereas in a typical primary care clinic if you ‘no show’ twice, you’d probably get discharged, which is part of the struggle for our patients who are homeless and who have severe and persistent mental illness.”

Cross-Train Behavioral Health and Primary Care Staff

Staff members of all three sites have been cross-trained to help support the integrated care model. The behavioral staff learned about the most prevalent chronic medical conditions while the primary care staff were trained on how to assess for basic behavioral health conditions and provide basic behavioral health care delivery techniques such as motivational interviewing and dialectical behavioral therapy. Some sites also provided general trainings, such as improving communication skills, and allowed their staff many opportunities for continued training.

The Daily Planet closed their entire clinic for one day for staff to be educated on the integrated care model. Much of these trainings were around brief assessments based on the Screening, Brief Interventions, and

Referral to Treatment (SBIRT) model.⁵ Central City Concern also trained staff on team-based care, advanced access scheduling, and working at the top of licenses. Staff are able to work at the top of their licenses by the inclusion of a sufficient number of support staff. In addition, primary care providers are regularly trained on psychopharmacology, latest treatments for depression, and techniques for crisis intervention.

SBIRT

**Screening
Brief Intervention
Referral to Treatment**

At the Durham Clinic, the behavioral health consultants have been trained in major medical areas, such as diabetes, asthma, COPD, and chronic pain, while the primary care providers have been trained in cognitive therapy and dialectical therapy. The whole team of staff received motivational interviewing training by providers from Touchstone (the Community Mental Health partner) who were certified by the Motivational Interviewing Network of Trainers (MINT).⁶ Touchstone also had staff certified by the Beck Institute who trained the internist in cognitive behavioral therapy.⁷ Finally, some of the Cherry Street staff who were students of Marsha Linehan's dialectical behavioral therapy program trained the primary care providers in that type of therapy.⁸

Integrate Behavioral Health Screenings into Primary Care Visits

The services that are included as part of the integrated care models implemented by the interview sites include mental health and substance abuse assessments, counseling, health education, pharmacology, substance abuse therapy, and behavioral health treatment. At the Daily Planet, the MAs screen every patient for depression (PHQ-2) and smoking. In the future, they would like to begin screening patients for alcohol use using the Audit C assessment tool. If patients screen positive for depression, the behavioral consultant sees them and can provide therapy as well as further assessment using the PHQ-9. The primary care providers and the behavioral health consultants try to address all mild and moderate depression and the severe cases are referred to the psychiatrist. If patients screen positive for tobacco use, the clinic has a pharmacist who runs a smoking cessation program and can also prescribe Chantix. The Daily Planet also refers patients to the local detox center—the Healing Place. They have a strong relationship with this organization, which also refers patients to the Daily Planet for primary care services. For patients in their Diabetes IMPACT program, they provide stress management and yoga in addition to health education provided by pharmacy students from the Virginia Commonwealth University.⁹

Central City Concern also screens all patients for depression with the PHQ-2. If they screen positive, the primary care provider will assess further with the PHQ-9 and ask the mental health providers to assist. For patients with severe mental illness, providers refer to the organization's specialty mental health clinic which is located in a different building in close proximity. In addition, they provide substance abuse services, chronic pain management, cognitive behavioral therapy, PTSD groups, health education, case management, occupational therapy, acupuncture, yoga, exercise classes, and art therapy. Like the Daily Planet, Central City Concern also runs a Diabetes IMPACT program.

⁵ The SBIRT model was developed in response to recommendations by the Institute of Medicine to improve identification and treatment of behavioral health issues and substance abuse in community health care settings. (<http://www.integration.samhsa.gov/clinical-practice/sbirt>)

⁶ <http://www.motivationalinterviewing.org/>

⁷ <http://www.beckinstitute.org/>

⁸ <http://behavioraltech.org>

⁹ IMPACT is a national program from the American Pharmacy Association Foundation aimed toward improving diabetes care with multidisciplinary teams specifically including pharmacists. (http://www.aphafoundation.org/AM/Template.cfm?Section=Project_IMPACT_Diabetes)

At the Durham Clinic, primary care providers look for behavioral health issues, but it is typically the health coaches or supports coordinators who conduct the assessments (e.g. PHQ-9) and connect patients with other services. The health coaches can provide cognitive therapy, dialectical therapy, trauma therapy, substance abuse treatment (they are all Certified Advanced Alcohol and Drug Counselors). There is a psychiatrist available who can provide medication prescriptions if necessary and intensive outpatient services can be accessed at another Cherry Street clinic. The supports coordinators provide outreach, benefits assistance, and referrals to social services (housing, food).

Challenges to Integrating Care

Funding

Funding for services, staff, and training were challenges experienced by the HCH grantees interviewed. For the Daily Planet, HCH funding through their current grant does not pay for their integrated care model. Once the CABHI grant they received ends, they will have to identify additional funding to retain their behavioral health consultant and psychiatrist. Currently, they cannot bill for the behavioral health consultant's time, but they are looking for ways to do this. They have applied for a disruptive innovation grant from SAMHSA that would help fund the behavioral consultant to work with high risk patients who frequent the emergency room. The Medical Director is also passionate about providing employment assistance to patients who frequent the clinic. She described how her patients talk to her: "I'm broke and I need a job. You're telling me to take my blood pressure medicine and I need a job. And I don't have a house." The Medical Director would like to apply for a research grant to show the positive relationship between employment and health, so that she can get funding to provide assistance for employment opportunities.

The Durham Clinic also struggled with paying behavioral health staff through their primary care system. They would like to see Michigan participate in the Medicaid reimbursement plan to cover services by behavioral health providers. Doing so would have a huge impact on the number of patients they serve and the amount of services they can provide. This is an advocacy effort they are pursuing with their state Primary Care Association.

Hiring Staff Compatible with Integration

Central City Concern expressed that finding the right staff was a challenge. One main characteristic that they looked for in interviews was an openness to practicing in a way that is different than how the individuals were trained. It was mentioned by all of the interview sites that clinical practices varied depending on clinical background. For example, mental health providers may feel that they need at least an hour to work with a patient, cannot be interrupted while working with a client, or cannot share clinical notes because the information they have regarding their patients is too personal. However, to be the most effective in integrating services, the mental health providers may have to accept shorter visits to accommodate emergency situations and more patients. Also, if they want to improve care coordination, they will need to share relevant patient information so that other members of the clinical team can have a more complete picture of their patients.

Communication Challenges among Clinical Disciplines

The interviewees also reported that communication between staff was difficult at times. The behavioral health and primary care staff initially did not know how to talk to each other. The Director of Health Home Services from the Durham Clinic explains it this way, "We really spoke different languages. A PCP to a social worker is something different than it is to an internist. The first time we mentioned MI, or motivational interviewing, the internist thought we were talking about somebody having a heart attack

because that's what an MI is to them." Learning to communicate with providers from different clinical disciplines was something that the staff had to develop over time and with training.

Facilitators to Integrating Care

Improved Communication through Electronic Medical Records

All of the interview sites agreed that EMR systems helped with communication and coordination of care between providers. All staff work from the same patient profile, treatment plan, and medication list. At the Durham Clinic, they utilized the EMR during team huddles to look at the patients who were scheduled for that day. The Director of Health Home Services described it: "We can pull up the chart. We can see their current list of meds. We can see the last time they were in. We can see the last coaching note, or the last internist note. All of that is readily available and it makes a huge difference."

Central City Concern reported that the EMR makes it easier for everyone to have the same records and not have staff running around trying to bring records back and forth between providers. Also, the EMR helps them to match appointments so that patients can see the primary care and behavioral health in the same day. Some providers, like the behavioral staff, have had to adjust to sharing records. They have had to learn to include less detail about their patient visits if the information is too sensitive to share with all staff. On the other hand, primary care staff have had to learn how to read behavioral health notes.

Even though the Durham Clinic struggled with the EMR system in the beginning, they are fairly satisfied with its current incarnation. One unique aspect of their system is that all chronic conditions are associated with a stage of change (pre-contemplation, contemplation, determination, action, relapse, maintenance) and a status (uncontrolled, controlled, well-controlled). "Because somebody's diabetes could be controlled, but they could be in action and really trying to work on it. Or somebody's diabetes could be uncontrolled and they could be pre-contemplative and not even realize they have a problem," the Director of Health Home Services explained. The stages of change come from the behavioral health side and the status comes from the primary care side. It took some time for the providers to understand the meaning of these terms, but now they do and all providers have a better understanding of their patients' chronic health conditions.

Flexible and Collaborative Staff Attitudes

Although sites reported difficulty in finding the right people to work in an integrated care environment, they were extremely satisfied with the staff they had. Their staff members were flexible, worked well on teams, had good communication skills, and had a willingness to change and grow. The Durham Clinic expressly wanted staff who had high skill levels but were humble enough to admit when they did not know something but were willing to learn. In addition, they were able to find clinic staff who saw one another as equally important to the work of the team and did not feel the need to be in charge or the lead the group. The Durham Clinic was particularly explicit about the commitment of the leadership in allowing the integrated care model to blossom. The integration could not have happened without the ideas and efforts of the CEOs of the three agencies that merged into one.

The staff at Central City Concern had already been part of an integrated care environment and helped their organization make a smooth transition back to that model. After some training, staff were comfortable and receptive to the flexibility that was required to see patients on a whim and even be interrupted during a consultation.

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Resources

- AHRQ Integration Academy (<http://integrationacademy.ahrq.gov/evaluationtools>)
- SAMHSA-HRSA Center for Integrated Health Solutions (<http://www.integration.samhsa.gov>)

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