Using the BHI model in the Health Care for the Homeless Clinic utilizing a Team Approach

Lincoln Community Health Center
Health Care for the Homeless Clinic
412 Liberty Street
Durham NC, 27701

2015 National Health Care for the Homeless Conference
May 8, 2015
Washington DC

"Breaking the Links between Healthcare and Homelessness" NHCHC

Objectives

Participants will:

* Be able to identify the benefits and improved outcomes of utilizing a Behavioral Health Integration (BHI) model.
* Be able to describe the BHI continuum and consider which BHI model would be most adaptable to their practice.
* Learn the key components of integrated care from a systems perspective and will leave the workshop with strategies to begin implementation in their own practice.
* Be able to identify how to apply BHI principles to their own roles on the service delivery team (PCP, nurse, social worker, etc.).

What is Integrated Care?

"The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."

The Academy, Integrating Behavioral Health and Primary Care

What is Integrated Care ?

* The systematic coordination of general and behavioral healthcare.
* Using an Integrated Model reduces disparities such as the opportunity to eliminate the early mortality gap, reach persons who cannot or would not otherwise access the behavioral health services, and allow for early intervention or prevents worsening of conditions.

Patient Centered Medical Home

* Primary care provider and patient have ongoing relationship
* PCP responsible for meeting all of patient's healthcare needs or appropriately arranging care
* Whole person orientation
* Care is coordinated or integrated across systems
* Improved access
* Emphasis on quality and safety

Why Provide Integrated Care?

* 2/3 of homeless service users report an alcohol, drug, or mental health problem
* 20-25% of the homeless population in the US suffers from some form of severe mental illness (in contrast to ~6% in the general population)
* People with schizophrenia die from chronic medical problems at 2-3x the rate of the general population
* 1/3 of all patients with chronic illnesses, homeless or housed, have co-occurring depression
* 1/2 of veterans living in shelters are disabled
* 93% of females in homeless have history of trauma

CNVideo.mp4

Activity

Integrated Care Exercise

Framework for Integration

* Center for Integrated Health Solutions has established a 6 levels of Integration
* Based on the concept that integration is a continuum
* There are 3 main categories with 2 levels in each
  * Coordinated Care
    * Minimal Collaboration
    * Basic Collaboration at a Distance
  * Co-Located Care
    * Basic Collaboration on Site
    * Close Collaboration with Some System Integration
  * Integrated Care
    * Close Collaboration Approaching an Integrated Practice
    * Full Collaboration in a Transformed/Merged Practice

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

Key Clinical Delivery Differences

Coordinated Services

* Screenings based on separate practice models
* Separate treatment plans
* Patient Experience
  * Health needs treated separately
  * Patients may be referred, but barriers exist

Key Clinical Delivery Differences

Co-Located (Basic Collaboration Onsite or Close Collaboration Onsite with Some System Integration)

* May agree on specific screening
* Some collaborative treatment planning
* Knowledge of each other's Evidence-based Practices or shared Evidence-based Practiced
* Patient Experience:
  * Health needs treated separately at the same location
  * May be some warm hand-offs
  * Referrals are more successful

Key Clinical Delivery Differences

Integrated care (Close Collaboration or Full Collaboration)

* Screenings are standard protocol
* Treatment planning is collaborative
* Evidence-based Practices are shared across systems
* Patient Experience
  * Health needs are treated by a *TEAM*
  * Care is seamless

Key Practice/Organization Differences

Coordinated Services

* No coordination of collaborative efforts to some practice information sharing
* Little to some provider buy-in to integration

Co-Located

* Organization leaders with some investment in collaborative care
* More provider buy-in but not consistent across providers

Integrated care

* Leadership supportive of systems change
* Providers engaged in integrated model
* Blended funding

Strengths/Weaknesses

Coordinated

* Strengths: well understood model, may provide some shared information that is helpful
* Weaknesses: important health issues may not be addressed, barriers to referrals, sharing of information not occur or impact care

Co-Located

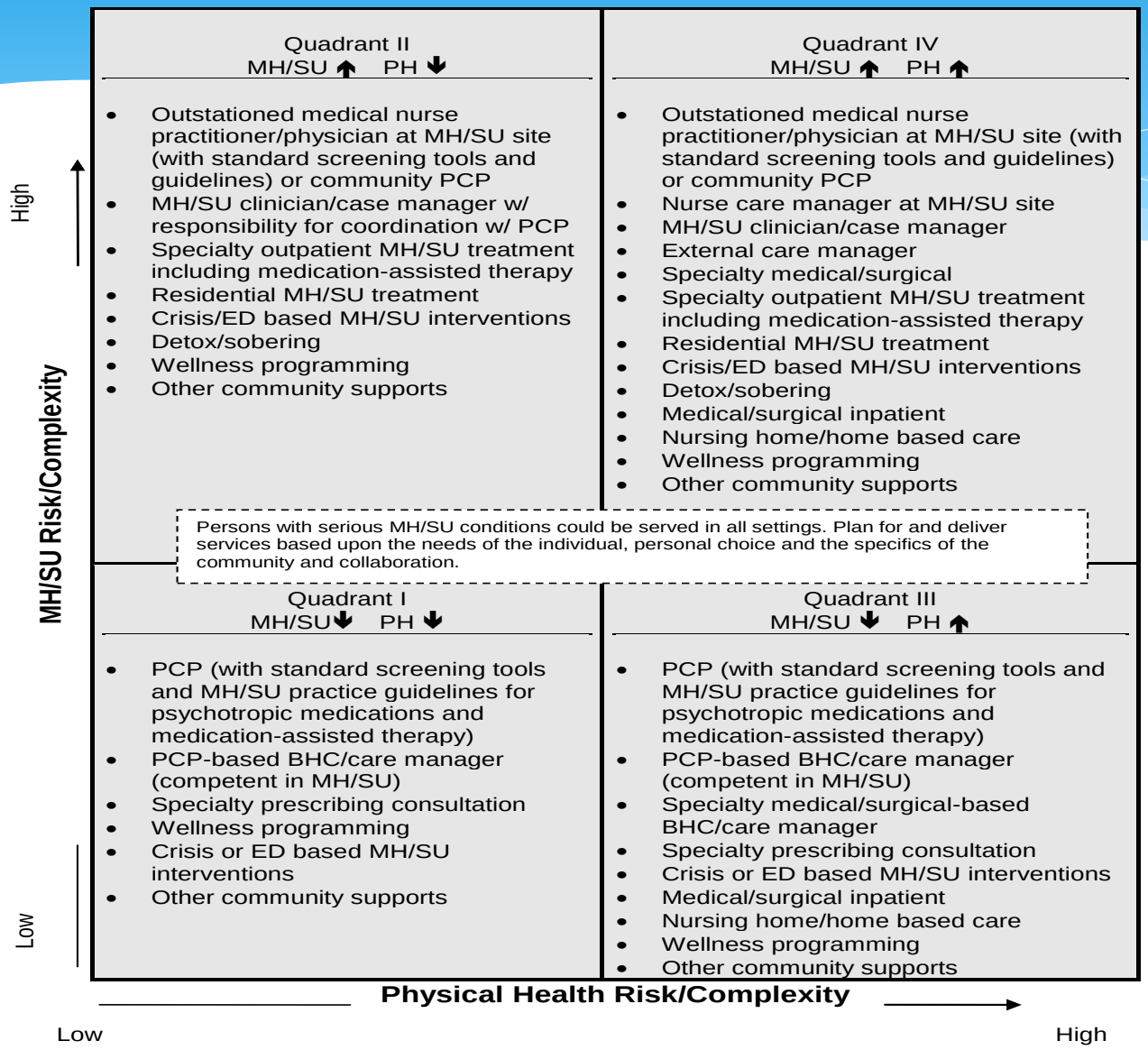
* Strengths: more shared information between providers, providers can learn more about what each other does, referrals more successful
* Weaknesses: systems issues may limit collaboration, effort required to facilitate relationships

Strengths/Weaknesses

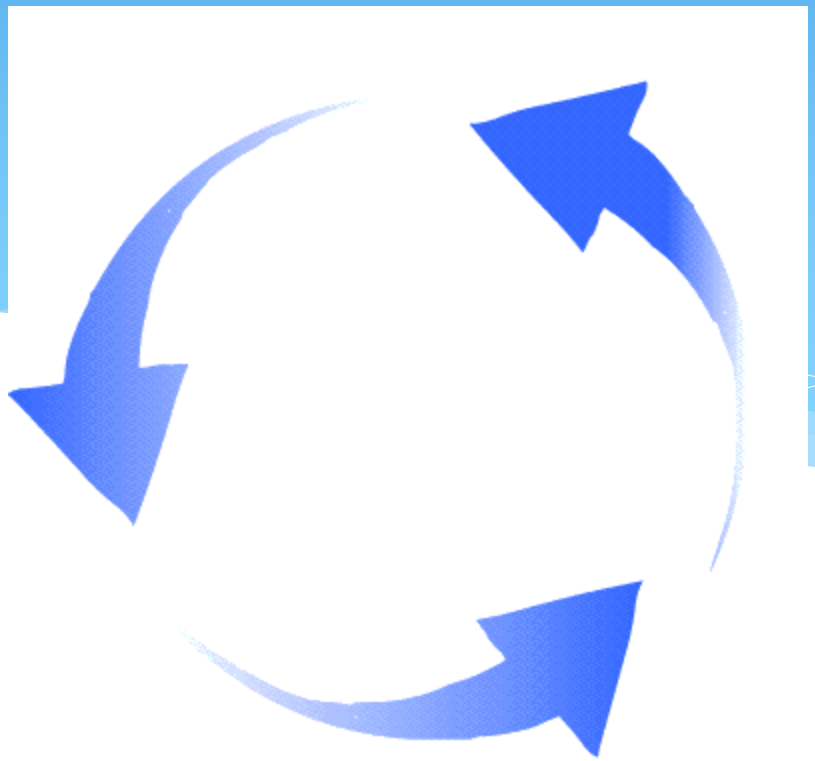
Integrated Care

* Strengths: high level of collaboration, more responsive patient care, ability to treat the whole person, barriers resolved, improved patient care, improved patient and provider satisfaction]
* Weaknesses: time restraints, sustainability issues, outcomes not established

The Four Quadrant Clinical Integration Model



Activity: Where do you fall on the continuum?



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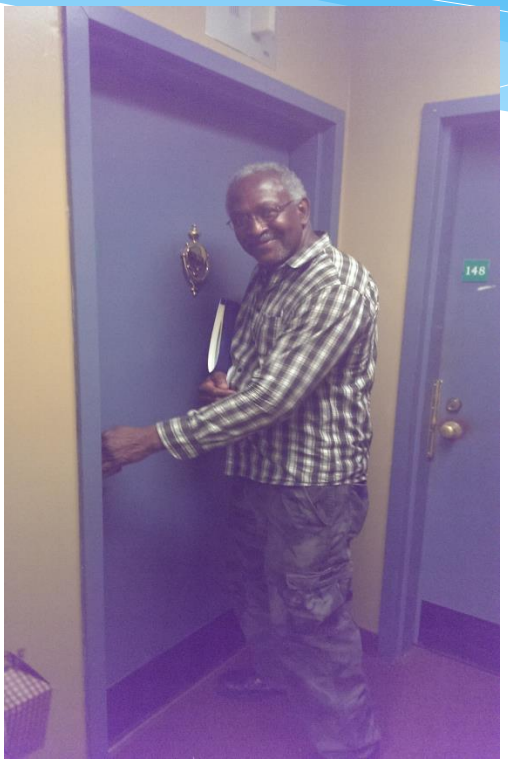
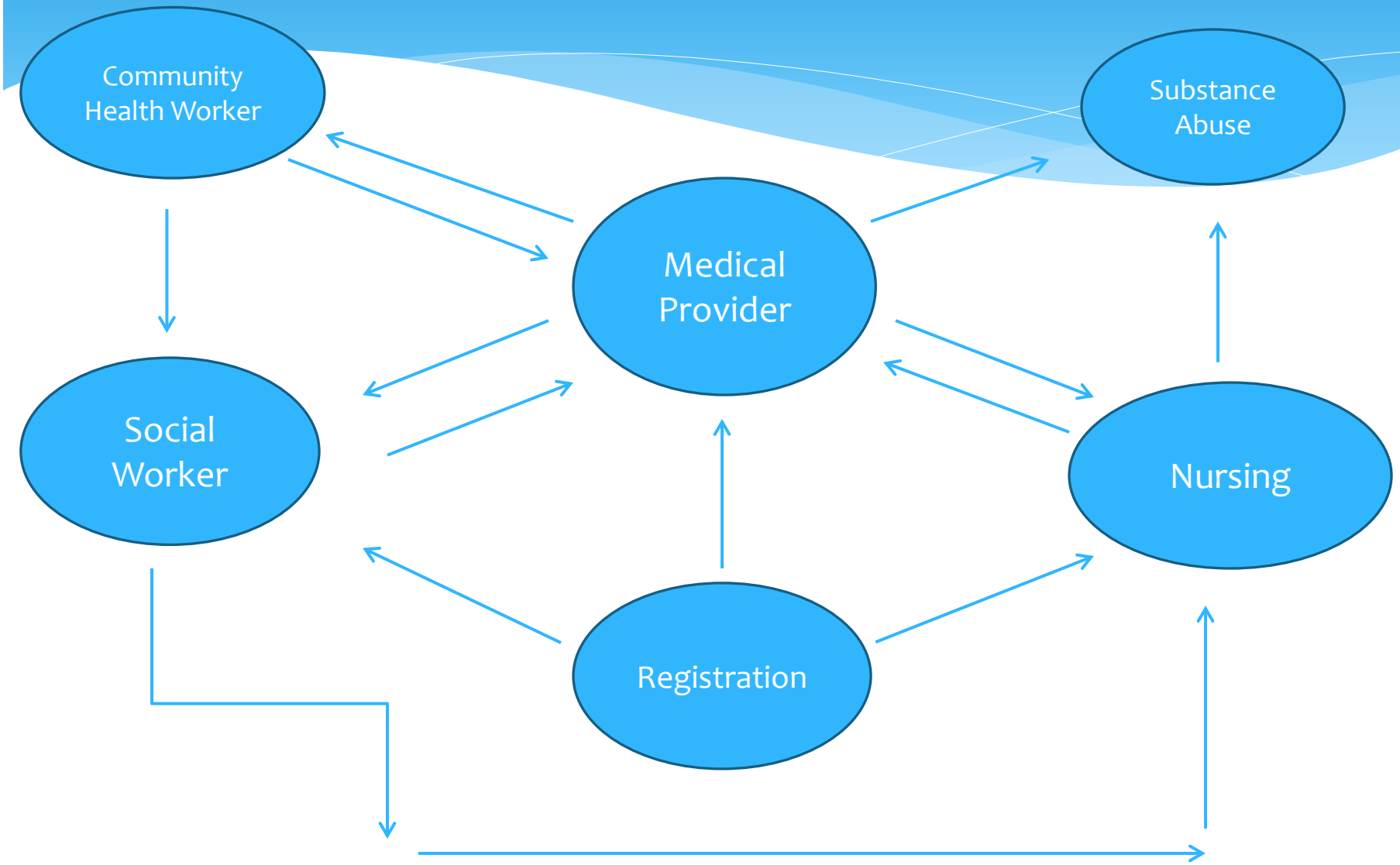
HCH Clinic
Patient Testimonial



How We Do It…


Community Health Worker
Substance Abuse
Medical Provider
Social Worker
Nursing
Registration

Medical Components of BHI

* PHQ-2/Substance Abuse Screening
* Medication Boxes
* Diabetes Education
* Motivational Interviewing Training/Techniques
* Trauma Informed Care
* Assessment of social/psychiatric determinants
* Ongoing communication and collaboration with behavioral health/substance abuse providers

Nursing Care

-Medication Education

-Pill Box Refills and Monitoring

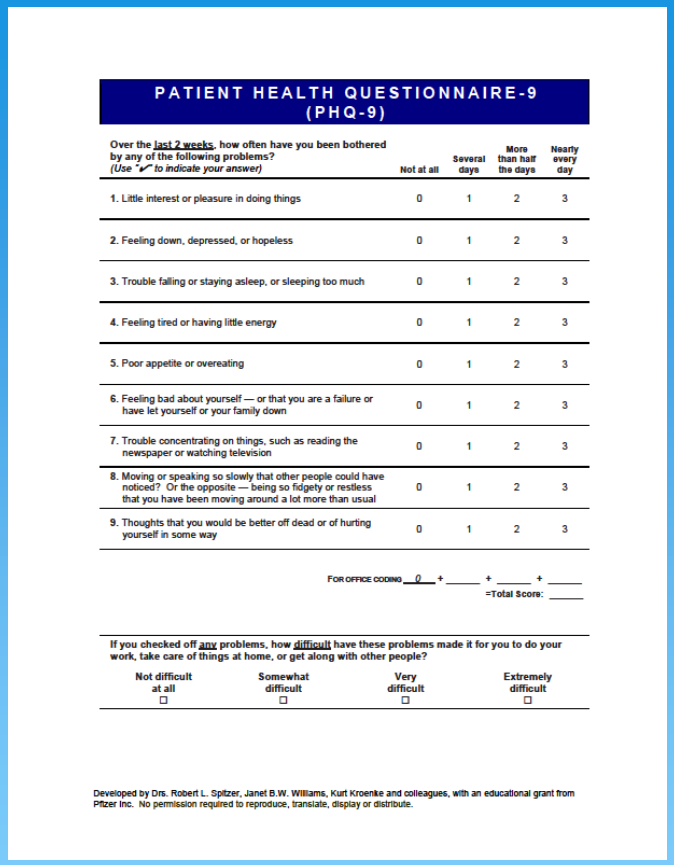
-Refill Support

-Creative ways of teaching medication compliance

-Recently added onsite lab services

Patient Health Questionnaire-2 (PHQ-2)

* First two questions of the PHQ-9 Depression screening.
* Maximum score is 6.
* A score of 4 or higher requires further exploration of depression symptomology and risk.



PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could 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
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

PHQ-9: Patient Health Questionnaire-9

Score of 1-4-Minimal Depression

5-9-Mild Depression

CAGE

* **C**ut back
* **A**nnoyed Family & Friends
* **G**uilt Associated with Use and Impact
* **E**ye-opener (consumption to start your day)

* Substance Abuse Screener used to determine significance of use.
* Yes responses= 1
* No Responses=0
* A score of 2 or higher indicates need for support.

Motivational Interviewing

"Motivational Interviewing is a clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health. The approach upholds four principles— expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy (client's belief s/he can successfully make a change)."

SAMSHA-HRSA Center for Integrated Health Solutions

Psychosocial/Substance Abuse

* Clinical Assessments for new patients
* Mental Health Interventions/Referrals
* Substance Abuse Counseling/Referrals
* Crisis Counseling
* Ongoing Case Management
* Disability
* Referrals
* Navigation/Outreach Services
* Advocacy Services
* Housing
* Emergency Room Diversion

Emergency Room Diversion Program

* 23% of ED visits are mental health related (difficult to accurately declare as coding in the ED doesn't always accurately reflect the actual causes and reasons of a visit)

* ED Diversion as point of entry

* CHW/ED Diversion role in BHI

Challenges to Full Integration

* Unified treatment plan
* Limited mental health capacity (in-house)
* Outcome measurements not formalized
* Specialized clinic within larger FQHC
* Time constraints
* Financial constraints
* Provider buy-in
* Service gaps in the community

Activity: What Will It Take to Move You Along Continuum?

2014 Clinic Data

* 1350 Medical Visits (460 unduplicated)
* 238 Nurse Only Visits
* 737 Social Work Visits
* 312 Community Health Worker Visits
* 99 Substance Abuse Specialist Visits
* 10 approved SOAR supported cases (3 cases pending)
* 14 Patients Housed (3 cases pending)
* 5 Medical Respite Referrals
* Provided Primary Care for 11 of 12 Medical Respite Cases

Collaborations

* Alliance Behavioral Healthcare
* Urban Ministries/Durham Rescue Mission
* Durham County Department of Public Health
* Project Access of Durham County- specialty care
* Legal Aid
* Vocational Rehabilitation Services
* Duke University Health System
* Department of Social Services
* Social Security Administration
* Housing for New Hope
* Durham Housing Authority
* Durham Community Land Trustees
* Durham County Police Department
* Judith Romanowski
* Open Table Ministries
* CAARE

Mission Statement

HCH Informal Mission Statement:

* To provide integrated care to homeless patients to promote improved medical, psychiatric, substance abuse, and social wellness.

Our Staff

* Administrative Assistant
* Nurse
* Clinic Manager
* Physician
* Social Worker/Case Manager
* MSW Intern
* Community Health Worker
* Clinical Addiction Specialist

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