Developing an Integrated Health Care Model for Homeless and Other Vulnerable Populations in Colorado

A Report from the Colorado Coalition for the Homeless

OCTOBER 2013

COLORADO COALITION FOR THE Homeless Creating Lasting Solutions

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A Report from the Colorado Coalition for the Homeless *October 2013*

Executive Summary

Integrated Care is central to the Healthcare for the Homeless approach and has been implemented in varying degrees at the Colorado Coalition for the Homeless (Coalition), and throughout the United States, since the 1980s. This report chronicles efforts to transform the Coalition's current health care delivery model into a more advanced integrated system to better respond to the spectrum of complex problems patients bring to service providers each day. In addition, this document will serve as an orientation and training resource for Coalition personnel. It will continually evolve over time as our work becomes refined and new goals and challenges emerge.

We characterize who is homeless and why, and describe the particular health care needs common to homeless adults and children. An overview is included of various best-practices related to integration models and our efforts to employ this knowledge. We outline the clinical core competencies and organizational goals that we believe must be achieved to be successful. Public policy recommendations to advance integrated health care for homeless and other vulnerable populations complete our discussion.

Commissioned by the Colorado State Innovation Model (SIM) Project, this report will augment the updated Colorado Health Care Innovation Plan 2013. The Coalition is pleased to be a member of the SIM Stakeholder Team; we are firmly committed to do our part in achieving the Colorado SIM Goal: ***By 2019, 80 percent of Coloradans will have a comprehensive primary care home that integrates physical and behavioral health.***

Housing is Vital to an Integrated Delivery System

In addition to physical and behavioral health services, the Coalition contends that ***housing stability*** is an essential ingredient in any population-based, integrated service delivery model. This view drives our organizational vision and shapes our programmatic decision-making.

Residential instability increases risk for serious mental and physical health problems, exacerbates existing illness, and complicates treatment. Lack of stable housing presents serious barriers to improving the health of people with acute or chronic illnesses. The daily preoccupation for securing food and shelter leaves little time for medical appointments. The pain and discomforts associated with illness and treatment side effects are compounded by a lack of privacy, risk of abuse, and theft of medications associated with living on the streets and in shelters. Our clients frequently explain that they have "no place to lie down during the day" to rest and heal.

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Access to housing and supportive services has been shown to increase adherence to treatment, decrease arrests and incarceration that disrupt treatment, and reduce costly visits to emergency rooms. For example, the Coalition's Housing First program documented a 72.95 percent reduction in emergency service costs, hospital stays and incarceration days, saving an average of $31,545 per participant over a 24 month period. Improvements in health status, mental health status, and housing stability were also identified. Similar results have been recorded by programs in New York, Maine, Massachusetts, Washington, and Illinois.

Nevertheless, lack of affordable housing for people with very low incomes, poor housing conditions and environments, long waiting lists for transitional or permanent housing, combined with policies that exclude active substance users, and/or individuals involved in the criminal justice system, all significantly limit access to supportive housing, and impact health status and recovery from homelessness in many communities.

Patient-Centered

The Coalition's approach to health care is centered on the patient, is driven by a multi-disciplinary team, and is trauma-informed. All personnel recognize that the patient must be an active participant in the development of a treatment or service plan. Health care providers see the patient as a unique individual, not as a diagnosis or disease. Case managers, patient navigators, consumer peer mentors, outreach workers, others providing enabling services, and licensed or registered staff, work together with the person seeking care in order to reduce or eliminate barriers to healing and recovery. The Coalition's health care service system includes preventive, episodic, and ongoing care for acute and chronic conditions.

Trauma-Informed Approaches

Unaddressed early childhood trauma is often an unidentified trigger for mental and physical disease, addiction, and disability in the United States. These traumatic experiences are precursors to and strong predictors of homelessness. Categorically referred to as "Adverse Childhood Experiences (ACE)," they are defined as physical, verbal, or sexual abuse; neglect; having a substance addicted, mentally ill, suicidal, or incarcerated parent; witnessing domestic violence; and, losing a parent all before the age of eighteen.

The Coalition's approach to integrated care seeks to develop and incorporate interventions that address the impact of multiple traumas on the clients we serve, throughout childhood and as adults. We also strive to help parents heal from their own traumatic histories in order to build the internal and external skills necessary to raise emotionally and physically healthy children—a vital goal in the pathway to future trauma prevention.

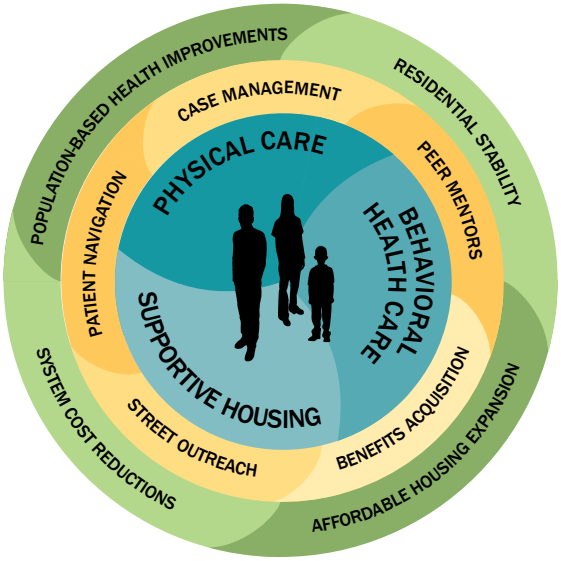
The Need for Integration

Traditionally, primary care, mental health care, and addictions treatment have been provided by different agencies scattered throughout the community. These multiple avenues could frustrate the efforts of anyone. People who are homeless—particularly those with trauma history, mental illnesses, and co-occurring substance use disorders—have substantially greater difficulty navigating these complex service systems. Building trust with a mix of unknown care providers, who may not treat them with dignity and respect, often inhibits persons from seeking care.

Furthermore, the impact of psychosocial factors on the body is even greater for people in poverty. Populations of low-income are less likely than the general public to accept a mental health definition of their problem. If they do accept a referral for mental health services, they encounter much greater difficulty negotiating travel and scheduling. This means that, while primary care physicians are the only providers treating between 50 to 70 percent of the diagnosable mental health problems in the U.S., that figure is higher for the underserved. Thus, it is especially important that care for vulnerable populations be supplied in a way that addresses the needs they present, in ways they can accept. Skilled screening, assessment, evaluation, and treatment of physical and mental health conditions, in one location, from one care plan, are crucial in settings serving homeless patients.

Executive Summary

The Coalition's Integrated Delivery Model: *From the Clinic into the Community*



The Coalition's integrated delivery model responds to the specialized needs of homeless adults and children. Our method blends the delivery of patient-centered physical care (medical, dental, vision, pharmacy, and chronic disease self-management) with behavioral health care (mental health care and substance treatment services) and supportive housing.

Street outreach personnel and patient navigators ensure that clients are able to access the care they need and can navigate effectively the systems in which it is provided. Case managers and benefits specialists provide the social supports and assist clients in securing the public benefits to which they may be entitled (Medicaid, SSI/SSDI, TANF, AND, etc.). Peer mentors build relationships with individuals to foster a sense of hope and trust by sharing lessons learned from their own recovery from homelessness. Each of these staff plays a vital role in addressing the social isolation and alienation that often leads to relapses and further aggravation of mental and physical conditions.

Combined, all personnel contribute to the goal of furthering positive health status and housing stability for the people served. As a result, individuals and families begin to thrive and enjoy an improved quality of life. In addition, positive social impacts in the community include population-based health improvements and residential stability; increased affordable housing supply; and, system cost reductions (i.e., emergency services, hospital stays, incarceration).

Three Key Goals for Integration

ACHIEVE PRACTICE TRANSFORMATION

Merged Practices in a Shared Space
One Treatment Plan
Patient-Centered
Management Supported
Aligned Business Model
Housing Acquisition

Goal 1

ENHANCE PROVIDER COMPETENCIES

Knowledge of Homelessness & Health Concerns
Knowledge of High Priority Clinical Issues
Managing Substance Abuse, Mental Health
Disorders and Cognitive Impairments
Providing Trauma-Informed Care
Managing Complex Multi-Morbidities
Developing Treatment Plans
Managing Medications
Conducting Outreach and Engaging Clients
Performing Motivational Interviewing
Supporting Client Self-Management
Communication and Negotiation Skills
Performing Self-Care
Mentoring Co-Workers

Goal 2

STRENGTHEN ORGANIZATION CAPACITY

High Quality Care
Quality Assurance
Continuous Quality Improvement
Peer Review
Risk Management
Workforce Development
Electronic Health Records

Goal 3

Executive Summary

The Coalition recommends that homeless service organizations who wish to implement a fully integrated service delivery approach should realize three goals: 1) achieve practice transformation; 2) enhance provider competencies; and, 3) strengthen organization capacity.

In order to achieve full practice transformation providers across disciplines should function in a shared space, as part of one team, working from one care plan. Methods of practice should be patient-centered, fully supported by management, and complimented by an aligned business model.

For many clinicians certain necessary competencies may not be an established part of their practice when they enter the homeless health care field; however, clinicians should understand what is expected of them and be willing to learn or build upon these fundamental skills.

Additionally, the ability to function effectively on a multi-disciplinary team, and to treat from one plan of care, enhanced through proficient use of an electronic health record is vital; as is enthusiastic adoption of an integrated delivery approach.

The delivery of high-quality, safe, effective, patient-centered, timely and equitable integrated care, through evidenced-based interventions, performance measures, and peer reviews is central to the operations of an effective and smooth running integrated system of care.

Stout Street Health Center and Renaissance Stout Street Lofts

The Coalition's integrated delivery model will be fully implemented in 2014 at the new Stout Street Health Center. The model is currently being pilot-tested and refined at the Coalition's West End Health Center.

The Stout Street Health Center is replacing the existing Stout Street Clinic, an aging structure that currently lacks adequate space to effectively meet the complex health care needs of an expanding homeless community. Located at 22nd and Stout Streets in Downtown Denver, this landmark property will combine a fully integrated health care center serving homeless and at-risk families and individuals with seventy-eight units of affordable, supportive housing at the Renaissance Stout Street Lofts. Construction will be completed in Spring 2014.

The Lofts, located on the top three floors of the property, will provide affordable rental apartments targeted to chronically homeless individuals, families, and youth. Onsite case management and support services will be provided.

The new 53,192 square-foot Health Center will accommodate physical and mental health care, substance treatment services, dental and vision care, pharmacy services, and a range of support services, including Medicaid enrollment and housing acquisition, to respond to the spectrum of problems homeless patients experience. Specialized services for homeless children and families will also be incorporated.

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The Health Center will feature larger interior waiting areas to eliminate the physical and emotional discomfort of standing in long lines on the street and a sheltered exterior courtyard for patients to utilize prior to opening hours. A new off-street access bay for ambulances and emergency vehicles will be more discreet and will prevent traffic obstructions that are common at the current site.

The project has created more than 75 construction jobs and will create 70 full-time permanent health care jobs, and provides job continuity for more than 100 current clinic positions. It is generating more than $70 million in direct and indirect economic activity in Denver. The entire development has been designed in accordance with Green Communities guidelines established by Enterprise Communities, utilizing green building materials in its structure and interior and exterior finishes.

Acknowledgements

The Coalition is grateful to more than 500 employees, volunteers, and consumer advisors who are dedicated to improving the lives of at least 15,000 men, women, and children each year, many of whom contributed key insights, experiences, and information for this report.

The lead writing and production team at the Coalition included *Nikki Allen, Dr. Joan Barker, Louise O. Boris, Dr. Elizabeth Cookson, Annetta Crecelius, Lisa Dannen, Mary Lea Forington, Bette Iacino, John Kelly, Mandy May, Dr. David Otto, John Parvensky, Dr. Jennifer Perlman, Meg Snead, and Gary Sanford, Executive Director of the Metro Denver Homeless Initiative.*

We are buoyed by thousands of homeless service providers and consumer advocates who share in our mission and have been united with us, since 1985, through the *National Health Care for the Homeless Council*. The work of our colleagues on the Council's Clinicians' Network, the National Consumer Advisory Board, the Respite Care Providers' Network, and the Policy Committee inform both this report and the ways in which we work. For more information about the Council, visit www.nhchc.org.

Local contributions were generated from homeless service providers and other stakeholders coalesced through the Metro Denver Homeless Initiative, and representing the seven regions comprising the Metro Denver area: *Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson Counties*.

The Coalition operates more than 40 programs at 18 locations that offer a range of services beyond the health care arena. To learn about the entire scope of our work, please visit www.coloradocoalition.org.

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About the Coalition

01

The Colorado Coalition for the Homeless (Coalition) is a 501(c)(3) non-profit organization that provides housing and integrated health care to individuals and families who are homeless in Colorado. The Coalition operates a Federally Qualified Health Center designated as a Healthcare for the Homeless Program.[1]

The mission of the Coalition is to work collaboratively toward the prevention of homelessness and the creation of lasting solutions for homeless and at-risk families, children, and individuals throughout Colorado. The Coalition advocates for and provides a continuum of housing and a variety of services to improve the health, well-being, and stability of those it serves.

Coalition health care programs at the Stout Street Clinic were first established in 1985 as one of the original twenty national Healthcare for the Homeless programs funded through a demonstration grant from the Robert Wood Johnson Foundation and the Pew Charitable Trust. These experiences influenced the formation of the federal Health Care for the Homeless Program within the Bureau of Primary Health Care[2] authorized by the Stewart B. McKinney Homeless Assistance Act in 1987.

The original model of care was heavily focused on physical care in order to divert homeless individuals from more expensive emergency room services. Collaborative relations were formed with Denver Health, Mental Health Center of Denver, and other mainstream health care and housing agencies. Over time, as the number of homeless persons increased, and their complex needs were unable to be met through referrals to these systems, the Coalition began developing capacity and resources to provide mental health, substance treatment services, and housing as part of its system of care.

Today, the Coalition practices a multi-disciplinary approach to delivering care that combines aggressive street outreach with integrated systems of primary care, mental health care, substance treatment services, dental care, vision care, case management, patient advocacy, and linkages to essential services such as housing, benefits, and other critical supports.

Health services are located in high need locales and are governed with involvement from the homeless community. Services are provided without regard to the patient's ability to pay.

The Coalition continually seeks ways to create new approaches to deliver comprehensive, integrated care; to unite community providers through collaboration; and, to decrease the fragmentation of services and the social and political barriers that prevent lasting solutions to homelessness.

Philosophy of Service

We believe all people have the right to adequate housing and health care. We work to remove the barriers that restrict access to these rights. Society benefits when adequate housing and health care are available to everyone.

We create lasting solutions to homelessness by:

- *Honoring the inherent dignity of those we serve, affirming their capabilities, and fostering their hope that a better life is possible;*
- *Building strong, caring communities through the integration of housing, health care, and supportive services;*
- *Advocating for social equity and challenging the status quo on behalf of the individuals and families we serve;*
- *Achieving excellence through continuous quality assurance, innovation, and professional development; and,*
- *Using resources judiciously and effectively.*

01

The People We Serve

Recognition of the instability of an individual's or family's living arrangements is critical to identifying those who are homeless. Individuals or families without permanent housing who may live on the streets, stay in a shelter or mission, abandoned building or vehicle, or in any other unstable or non-permanent situation are homeless. An individual or family is also considered to be homeless when "doubled up," the experience in which individuals are unable to maintain housing and are forced to stay with a series of friends and/or extended family members. Homeless individuals who are released from a prison or a hospital are considered homeless if they do not have a stable housing situation to which they can return.

Consumer Involvement

A Consumer Advisory Board (CAB), made up of participants from Coalition programs, meets twice monthly and provides input regarding program planning, access to services, quality of care, and the development of integrated clinical services. The CAB is self-governed with elected officers; a staff liaison is assigned to provide assistance.

Feedback is gathered from Coalition clients on an annual basis through anonymous Customer Satisfaction Surveys and focus groups. Information obtained is used to inform planning and program development decisions.

The Coalition also employs peer mentors to provide case management, peer counseling, and outreach, drawing on their unique experiences of recovery from mental illnesses, substance disorders, and homelessness. Sharing information regarding these experiences, as appropriate, is a powerful treatment tool.

Community Collaboration

The Coalition recognizes that the commitment of an entire community is vital to eradicating the causes and consequences of homelessness. We value our health care collaboration with other programs that serve homeless populations including, but not limited to, Denver Health Medical Center, National Jewish Health Center, the Denver Veteran's Administration Medical Center, Exempla St. Joseph Hospital, the Mental Health Center of Denver, Urban Peak, Denver Urban Ministries, St. Francis Center, Samaritan House, and the City and County of Denver. The Coalition also plays an active role within the Colorado Community Health Network.

Funding

Funding sources include public and private grants and foundation awards targeted to homeless service providers, as well as programs not aimed at the homeless population, such as Medicaid and the Colorado Indigent Care Program. Some services are dependent on inconsistent sources of funding. Specialty care services are limited and in high demand, resulting in significant access barriers for homeless individuals.

The Coalition's Health Center Service System

The Coalition's approach to clinical care is centered on the patient, is driven by a multi-disciplinary team, and is trauma-informed. All staff recognizes that the patient must be an active participant in the development of a care plan. Health care providers see the patient as a unique individual, not as a diagnosis or disease. Case managers, patient navigators, outreach workers, others providing enabling services, and licensed or registered staff, work together with the person seeking care in order to reduce or eliminate barriers. The Coalition's health care service system includes preventive, episodic, and ongoing care for acute and chronic conditions.

Access

Clients access Coalition services through outreach, case management services, and self-referral. In order to create optimal availability and accessibility, program offerings are frequently reviewed and revised so that hours of service are convenient for individuals and families coping with the uncertainties of homelessness. Services are provided in locations that are convenient to public transportation systems. Often, care is taken directly to those individuals who are the most vulnerable and least likely to seek assistance. Language and cultural barriers are minimized through the use of culturally competent elements. Transportation assistance is often available for follow-up appointments. Direct outreach to people in need promotes awareness of available services in the community. Most importantly, all persons are treated with dignity, respect, and compassion.

Clinical Staff

Health care services are provided in multiple clinic sites (including two based in shelters), a mobile Health Outreach Program, at Coalition housing developments, and in public places and homeless camps. Most services are delivered by employees, including primary care providers (physicians, physician assistants, and advanced practice nurses), mental health and substance treatment providers (psychiatrists, licensed clinical social workers, clinical case managers, addiction counselors, licensed professional counselors, and licensed marriage and family therapists), dentists, nurses, medical assistants, and pharmacists. Volunteer staff includes ophthalmologists, medical specialists, psychologists, and medical, nursing and pharmacy students (supervised by attending physicians) from the University of Colorado School of Medicine. Health Center locations include:

Stout Street Clinic

- 2100 Broadway, Denver, CO 80205

Satellite Locations

- West End Health Center
  5050 West Colfax Avenue, Denver, CO 80204
- La Casa Quigg Newton Family Health Center
  4545 Navajo Street, Denver, CO 80211
- Stout Street Clinic at Samaritan House
  2301 Lawrence Street, Denver, CO 80205
- Stout Street Clinic at St. Francis Center
  2323 Curtis Street, Denver, CO 80205

Urban Peak

- 730 21st Street, Denver, CO 80205

Health Outreach Program Sites—Mobile Medical Services

- Father Woody's Haven of Hope
  1101 West 7th Avenue, Denver, CO 80204
- The Gathering Place
  1535 High Street, Denver, CO 80218
- Joshua Station
  2330 West Mulberry Place, Denver, CO 80204
- The Crossing
  6090 East Smith Road, Denver, CO 80216
- Crossroads
  1901 29th Street, Denver, CO 80216
- Christ's Body Ministries
  850 Lincoln Street, Denver, CO 80203

Respite Care Sites

- Samaritan House
  2301 Lawrence Street, Denver, CO 80205
- The Crossing
  6090 East Smith Road, Denver, CO 80216
- Beacon Place
  3636 West Colfax Avenue, Denver, CO 80204

To learn more about the Coalition's other programs, visit www.coloradocoalition.org.

Outreach

Outreach is an ongoing approach to engage homeless persons with the objective of developing a relationship of trust. Outreach is performed where homeless individuals and families are found, such as shelters, the streets, parks, camps, libraries, bus stations, and public buildings. Outreach services address immediate survival needs; provide health education; distribute basic necessities and supplies that contribute to health promotion (e.g., blankets, hygiene items, gloves, socks, and other clothing items); and, ultimately offer housing alternatives and support services necessary to end homelessness and instill hope for an improved quality of life. Additionally, the Coalition's Health Outreach Program provides mobile medical services throughout the Denver metropolitan area.

Physical Health Services

Physical health services include preventive, episodic, and ongoing care for acute and chronic conditions. Principles of harm reduction and disease management are utilized. The realization of living in poverty without stable housing is a critical consideration in treatment planning. Pharmacy services are available without charge. The pharmacy department makes extensive use of Patient Assistance Programs offered by many pharmaceutical companies and provides financial screening services in order to facilitate enrollment. Limited specialty care is provided by volunteer physicians as well as through referrals to other community clinics and hospital-based services.

Prevention

Prevention services include immunizations services, screening for breast, colon, and cervical cancer, sexually transmitted diseases and infections, elevated blood lead levels, glaucoma screening, and dental services. When a patient is diagnosed with a complex condition, such as cancer or HIV, that requires specialty care, the patient is referred to the appropriate service provider and provided assistance in accessing these services.

Mental Health Care

Diagnostic and prescriptive services are a priority given the high incidence of severe and persistent mental illnesses. Recent efforts have added vibrant group and individual therapy programs throughout the Coalition. The scarcity of services available to uninsured individuals throughout Colorado presents an ongoing challenge. Walk-in hours are offered daily to accommodate those whose lives are unpredictable and who have a difficult time coming to appointments.

Substance Treatment Services

The goal of substance abuse treatment is to provide assistance in abstaining from or decreasing the negative consequences of the use of substances. Group and individual treatment is offered in clinic and residential settings. Use of peer mentors is an integral component of culturally competent care. Sober housing is offered to those at later stages of recovery. Specialized case management services help individuals follow-through with treatment and engagement in non-homeless services. The Coalition works closely with community agencies providing medical and non-medical detoxification. Pharmacological treatments

that promote abstinence and specialized treatment for those with mental health and substance use disorders are also offered. The Coalition has recently developed a supportive residential community that combines housing with counseling, education, and vocational services, with an emphasis on serving homeless veterans.

Dental Services

Corrective and emergency dental services are provided in addition to standard preventive care such as assessment, cleaning, patient education, and pediatric dental screening. Dental services are not limited to extractions and frequently include restorations and prosthetics.

Respite Care

The Coalition's medical respite program offers hospitals an alternative to discharging patients to the streets while ensuring that the medical and psychiatric care received in a hospital or clinic setting is not compromised due to unstable living situations. Combined with housing placement services and effective case management, medical respite care allows individuals with complex medical and psychosocial needs to recover from an acute medical condition in a stable environment while reducing future hospital utilization.

Case Management

Case management services assist patients in coordinating physical health, mental health, and chemical dependency treatment in order to address the problems and needs associated with the condition of homelessness. This may include helping individuals obtain safe, affordable, and permanent housing; assuring access to treatment services; providing crisis assistance; identifying educational and employment options; and, assisting patients in developing a social support network.

Typical activities include accompanying the patient to appointments, consulting with other care-givers, providing guidance and advice, teaching living skills, and advocating on behalf of the patient. Case management activities are carried out within a context of ongoing assessment, care planning, and monitoring. Because problems and needs vary from one individual to another, the scope, intensity, and process of providing services varies. The case management relationship may be short-term or long-term in duration, primary or ancillary in role, intensive or more advisory in approach.

Support Services

Support services may include housing assistance; employment and job training assistance; nutritional counseling; patient navigation (targeted assistance to coordinate care among internal and external providers); and, specialized public benefit acquisition services,[3] translation services, and transportation. Transportation assistance for multiple purposes is provided in a number of ways, such as bus passes, taxi vouchers, or directly by Coalition employees.

02 Who is Homeless?

An estimated 842,000 adults and children are homeless in a given week in America, with that number swelling to as many as 3.5 million over the course of a year.[4] *In Colorado, 16,768 people*[5] *are estimated to experience homelessness on any given night; 38 percent of whom are members of a family.*[6] *Throughout the 2011–2012 school year, 23,680 homeless children were identified in K–12 in Colorado Public Schools.*[7]

Families

Families are the fastest growing segment of the homeless population in the United States. In 2012, there was a decrease nationally in all homeless subpopulations with the exception of persons in families.[8] Over the course of a year, approximately 1.6 million (one in 45) children are homeless across the country. On any given day, more than 200,000 children have no safe place to call home. The typical homeless family is comprised of a single mother with two young children. Half of the parents who become homeless are under the age of 30 and the majority of their children are less than five years-old. Not surprisingly, nearly all of these women are living with extremely low-incomes, typically below 50 percent of the Federal Poverty Level. For a family of three in 2012, this represents an annual income of less than $9,545 and a monthly income below $795.[9]

Of the estimated 11,167 homeless men and women in the Metropolitan Denver area, 62 percent are living in households with children. Of those households with children, nearly 20 percent are considered chronically homeless.[10] A chronically homeless family is a household with at least one adult member who has a disabling condition and who has either been continuously homeless for a year or more or has had a least four episodes of homelessness in the past three years. To be considered chronically homeless, persons must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency shelter or safe haven during that time. "Disabling condition" is defined as "a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions."[11]

A 2001 study of chronically homeless families found that those who experienced multiple homeless episodes were far more likely to have extensive histories of public assistance receipt (on average, 53 months versus 21 months) compared to families with one homeless episode. They were also significantly more likely to have been diagnosed with major depression or a substance abuse disorder in their lifetime, and to have been a victim of violence at the hands of a stranger.[12]

Women

The United States has the largest number of homeless women among industrialized nations and the highest number on record since the Great Depression.[13] Nationally, 25 percent of the estimated three million people experiencing homelessness are women.[14] Women constitute one out of four chronically homeless adults.[15] Of the estimated 11,167 people experiencing homelessness in the Metropolitan Denver area, 43.4 percent are women.[16]

Chronic Homelessness among Individuals

Nationally, 510,000 people, or nearly 15 percent of the homeless population, are experiencing chronic homelessness. The numbers of people experiencing homelessness have been slightly declining over the last few years; and in 2012, there was a 6.8 percent decrease among individuals identified as chronically homeless.[17] However, during the same period of time, Colorado experienced a 25 percent increase in chronic homelessness.[18] In the Metropolitan Denver area, 12.7 percent of the homeless population is estimated to be chronically homeless. According to the Metropolitan Denver Homeless Initiative's most recent Point-in-Time count, the proportion of chronically homeless respondents increased over the past three years and more people are reporting experiencing homelessness for a longer period of time in 2013, than in prior years.[19]

Veterans

Veterans are overrepresented among the homeless population. Nationally, approximately 16 percent of homeless populations are veterans,[20] compared to 10 percent in the U.S. general (housed) population.[21] Thirteen thousand of these veterans are female, but the number is quickly rising. The number of homeless female veterans has doubled in the past ten years. Female veterans are up to four times as likely as their male counterparts to be younger, self-identify as a racial minority, have lower incomes, experience unemployment, and are more likely to become homeless.[22] In the Metropolitan Denver area, 11.5 percent of the population experiencing homelessness has served in the military.[23]

Race & Ethnicity

Racial and ethnic minorities in America, particularly African Americans, are overrepresented among homeless populations; 40 percent are African Americans (*compared to 11 percent of the general population*); 11 percent are Hispanic (*compared to nine percent of the general population*); eight percent are Native American (*compared to one percent of the general population*); 41 percent are non-Hispanic whites (*compared to 76 percent of the general population*).[24] In the seven county Metro Denver region, approximately 47 percent of homeless individuals are non-Hispanic whites; 19 percent are African American; 22 percent are Hispanic; and, four percent are Native American.[25]

03 What are the Causes of Homelessness?

Individuals and families can become homeless for a myriad of reasons; the most common are lack of affordable housing, poverty, unemployment, mental illness, and domestic violence. Unaddressed early childhood traumatic experiences, most notably at the hands of caregivers, are also contributors to and strong predictors of homelessness.

Causes of Homelessness

- Lack of Affordable Housing
- Poverty
- Unemployment
- Mental Illness
- Domestic Violence

Lack of Affordable Housing

In every state in America, there is a shortage of affordable rental housing. This shortage grows every year and is the primary contributing factor to homelessness across the nation. Nearly seven out of 10 households in the United States with annual incomes of less than $15,000 (roughly equivalent to year-round employment at minimum wage) pay more than half their income for housing.[26] Today, this applies to 77 percent of Colorado's extremely low-income population and almost a quarter of households statewide.[27]

Over the last decade, the number of severely burdened households (those paying more than 30 percent of their pre-tax income for rent) increased by 6.7 million, or 49 percent. Since the beginning of the recession in 2007, the increase has risen by 2.6 million.[28] Thirty-three percent of households in Colorado are renters and yet, there is a shortage of more than 128,000 affordable rental homes.[29] When units *are* available, they may be inhabitable if they are dilapidated or far from public transit or too small for family needs.[30]

The lower the income threshold, the greater the shortage of affordable and available units; for every 100 households earning less than 30 percent of the Area Median Income, only 23 affordable units are available in Colorado. These low-income families spend about two-thirds as much on food, half as much on clothing, one-fifth as much on health care, and half as much on retirement funds as similar families living in housing they can afford.[31] In all regions of the state, when housing costs escalate, families and individuals face difficult decisions and are at a much greater risk of becoming homeless.

Poverty

People who are homeless are the poorest of the poor. While almost half (44 percent) of people who are homeless work at least part-time, their monthly income averages only $367, compared to the median monthly income for U.S. households of $2,840.[32] More than 46 million Americans now live in poverty, the highest rate since 1993.[33] Of the estimated five million residents in Colorado, 625,000 people are currently living below the Federal Poverty Level,[34] at least 50,000 of whom are living on less than $90 each month.[35]

Approximately 224,000 children or 18 percent of the state's children are living in poverty. The 2013 Federal Poverty Level is $23,550 for a family of four, $19,530 for a family of three, $15,510 for a family of two, and $11,490 for individuals.[36]

Unemployment and Underemployment

The jobs that homeless people most frequently secure are low paying—laborer positions, jobs in the services sector, and clerical or office positions. These jobs, frequently secured on a day-to-day basis, do not pay a living wage or provide vital health benefits. Individuals and families frequently cannot keep up with the increasing cost of living, making them extremely vulnerable to homelessness.

Unemployment among homeless populations is widespread, and the problem is especially great during economic downturns. Nationally, it is estimated that nearly 56 percent of people experiencing homelessness are unemployed. Once homeless, barriers, such as limited transportation, managing health conditions or disabilities, lack of hygiene facilities, and lack of marketable skills or work experience, make obtaining and retaining a job even more challenging.[37]

Mental Illness

Mental illness is a significant cause of homelessness. When individuals living with serious mental illness cannot get appropriate treatment or services, they often end up living on the street. As a result, mental illness is disproportionately represented in the chronically homeless population. More than 60 percent of people who are categorized as chronically homeless have experienced mental health problems in their lifetime.[38] While six percent of the general population suffers from a serious mental illness, approximately 39 percent of the homeless population has a mental disorder. An estimated 50 percent of homeless adults with serious mental disorders also suffer from substance abuse.[39]

Nearly 15 percent of the 11,167 individuals experiencing homelessness in the Metropolitan Denver area reported "mental illness, emotional problems" as the cause of their homelessness in 2013. More than 20 percent of this population, the largest group of respondents, reported that they or another adult in their household has a serious mental illness.[40]

Domestic Violence

Violence is a leading, immediate cause of homelessness among women, with predictive roots that may lead back to traumatic experiences in childhood. Most homeless women have experienced domestic or sexual violence at some point in their lives. Nationally, between 22 percent and 57 percent of homeless women report that domestic or sexual violence was the immediate cause of their homelessness, depending on geographic region.[41] More than 11 percent of homeless adults with children, in the Metropolitan Denver area, cite domestic violence as the reason for their homelessness.[42] More than 36 percent of homeless women said their partner threatened to kill them. Nearly one-third of homeless women are in need of medical treatment because of physical violence.[43]

04 Health Care Needs in Homeless Adults and Children

Providers, across all disciplines, who seek to deliver an integrated model of care, must first acquire a full understanding of the distinctive mix of factors that impact the health status of men, women, and children experiencing homelessness.[44]

Unstable Housing

Residential instability increases risk for serious health problems, exacerbates existing illness, complicates treatment, and often exposes persons to further traumatization. Lack of stable housing presents serious barriers to improving the health of people with acute or chronic illnesses. Meeting immediate needs for food, shelter, and safety leaves little time for medical appointments. Discomforts associated with illness and treatment side effects are compounded by lack of privacy, risk of abuse, theft of medications, and no safe place to rest and recover.

Access to housing and supportive services has been shown to increase adherence to treatment, decrease arrests and incarceration that disrupt treatment, and reduce costly visits to emergency rooms and detox centers.[45] Nevertheless, lack of affordable housing for people with very low-incomes, long waiting lists for transitional or permanent housing, and policies that exclude active substance users, persons with physical disabilities, and/or those involved in the criminal justice system, limit access to supportive housing in many communities.

Limited Access to Nutritious Food and Water

When coping with homelessness, you generally have to eat whatever is available. Meals are irregular, with limited or no dietary choices, especially for nutritious foods that promote health and wellness. Most meals provided in shelters or soup kitchens are high in fat, starch, salt and sugar, which increases the risk for complications associated with diabetes and cardiovascular disease, common health problems in homeless individuals. People living in shelters or on the streets who lack easy access to potable water are at increased risk for dehydration, especially in warmer climates.

Higher Risk for Abuse

Physical and sexual abuse has been identified as both a cause and a consequence of homelessness. Living on the streets, in shelters, or doubled up with other families increases stress and risk for abuse. As many as 90 percent of surveyed homeless women have experienced severe physical and/or sexual abuse during

their lifetime. Homeless children are physically abused at twice the rate of other children and are three times as likely to be sexually abused.[46] Homeless parents without access to childcare may have no other option than to leave their children with strangers.

Mental Health Disorders

Two-thirds of adults experiencing homelessness report a substance use and/or mental health disorder and about one in four meets criteria for a serious mental illness,[47] compared to one in 17 adults in the general (housed) U.S. population.[48] These unfortunate statistics could likely be mitigated by routine access to appropriate health care. Approximately 30 percent of persons experiencing homelessness have substance dependence/abuse disorders,[49] compared to nine percent of the general population.[50] The incidence of these disorders is considerably higher among people who have been homeless on a long-term basis. Substance use disorders, in particular, increase risk of exposure to infectious diseases and can cause or exacerbate diseases of the cardiovascular system and liver. Associated behavioral disorders and cognitive impairments often interfere with treatment adherence. Clinical practice adaptation and integration of medical regimens with the patient's regular activities can improve treatment effectiveness.

Physical and Cognitive Impairments

Physical and cognitive impairments are among factors that can precipitate and prolong homelessness. Exposure to the elements or to communicable diseases in shelters, victimization, nutritional deficiencies, co-morbidities, and limited access to health care increase the likelihood that relatively minor impairments will become much more serious. As many as 80 percent of homeless persons tested have marked deficits in cognitive functioning, likely the result of early relational trauma and ongoing victimization.[51] Cognitive impairments seen in homeless patients are often associated with traumatic brain injury, mental illness, chronic substance abuse, infection, strokes, tumors, poisoning, or developmental disabilities. Cognitively impaired persons with co-occurring substance use problems are frequently unable to access or benefit from traditional addiction treatment programs.

Developmental Discrepancies

Homeless children, adolescents, and young adults frequently exhibit developmental levels that do not match their chronological age. Many homeless children have speech delays. Insufficient opportunities to practice gross and fine motor skills, and regular emotional connectivity, in constrained shelter environments may also retard normal development. Although survival skills are more sharply honed in homeless adolescents and youth than in their housed counterparts, chronic substance use and stress associated with homelessness can delay normal development and cause severe neurological damage. Developmental regression or neuropsychological dysfunction is commonly observed in homeless individuals regardless of age, gender, diagnosis, or medical/psychiatric history; however, developmental discrepancies are especially pronounced in chronically homeless adults with cognitive impairments.[52]

Children

Children experiencing homelessness are sick four times more often than other children and go hungry at twice the rate of their housed counterparts. They have four times as many respiratory infections, twice as many chronic ear infections, and are four times more likely to have asthma. Additionally, children experiencing homelessness are four times more likely to show delayed development and twice as likely to have learning disabilities as non-homeless children.[53] Poor child health also strains family resources and has the potential to push poor families deeper into poverty.

04

Higher Risk for Communicable Disease

One out of every five homeless individuals tracked through the national Health Care for the Homeless Program has an infectious or other communicable disease. Respiratory infections, hepatitis, HIV and other sexually transmitted infections, skin diseases, and infestations are disproportionately represented in homeless populations. The potential for rapid spread in crowded shelters or other congregate settings poses health risks for the general public as well, making communicable disease in itinerant populations of particular concern.[54]

Women

Compared to housed women, health disparities among homeless women include higher rates of mortality, poor health status, mental illness, substance abuse, victimization, and poor birth outcomes.[55] Specific conditions that disproportionately affect homeless women include: skin disorders, lacerations, fractures, respiratory ailments, and chronic conditions, such as hypertension, diabetes, asthma, anemia, and ulcers. As a result, over one-third of homeless women have a chronic physical health condition.

Homeless women are also less likely than their housed counterparts to have a regular source of care, health insurance, access to cancer screenings, adequate prenatal care, appropriate ambulatory care, and specialty care for specific disorders.[56] This is partially because homeless women, in particular, face obstacles gaining entry to the health care system due to a lack of transportation, knowledge about where to go, and long waits for appointments.[57]

In conjunction with poor physical health conditions, homeless women suffer disproportionately from mental health and substance use disorders. About 50 percent of homeless women experience a major depressive episode after becoming homeless,[58] have three times the rate of Post-Traumatic Stress Disorder (36 percent) and twice the rate of drug and alcohol dependencies (41 percent) as housed women. For homeless and marginally housed women, remaining life expectancy at age 25 is 52 years—seven years lower than the general population, and five years lower than the poorest income group.[59]

Veterans

Compared to military veterans living in stable housing, homeless veterans are more likely to be disabled. They are more likely to be diagnosed with post-traumatic stress disorders, traumatic brain injuries, and co-occurring psychiatric diagnoses, including substance-related disorders. Homeless veterans also frequently report chronic medical conditions and higher rates of hepatitis/cirrhosis compared to homeless persons without veteran status.[60]

Serious and Complex Medical Conditions

People without stable housing are at increased risk for acute and chronic diseases with multiple co-morbidities.[61] Because they may not seek or be able to obtain care until their illness is advanced, they often present with more acute, often life-threatening conditions (e.g., heart attack, stroke, organ damage secondary to uncontrolled cardiovascular disease, and/or diabetes). Chronic health conditions, such as hyperglycemia, asthma, and hypertension are exacerbated by stress and exposures associated with homelessness, as well as by delayed or interrupted treatment. Psychosocial and structural factors that impede homeless peoples' access to treatment and self-care increase their risk for medical complications.

Inaccessible Health Care

As a consequence of homelessness, health care is frequently interrupted and uncoordinated. Mobility barriers, lack of health insurance, fragmented health services, and a mainstream health care system that often is not prepared to deal with the complex psychosocial problems presented by homeless patients partially explain their discontinuity of care. Transience makes comprehensive medical care, referrals and follow-up difficult to achieve effectively. Aggressive outreach and case management, together with efforts to provide integrated primary care, mental health care, substance treatment services, social services, and housing can promote continuity of care and better health outcomes.

Lack of Health Insurance and Resources

Approximately 70 percent of homeless patients have no health insurance, primarily because they do not qualify for public insurance and cannot afford private insurance.[62] Those who are eligible frequently have trouble completing the complex enrollment process and obtaining covered services. Lack of required documentation to verify eligibility is the most frequently cited obstacle to Medicaid enrollment among homeless people.[63] Proof of identity, residence, and income are difficult to provide without a home, a driver's license, or continuous employment. Even when they are able to obtain required documentation, homeless people may not have a safe place for storage and personal papers are often lost or stolen. In Colorado, these circumstances are being mitigated to some extent by the early adoption of the Medicaid Adults without Dependent Children (AwDC) program and the advent of the federal Affordable Care Act.[64]

Barriers to Disability Assistance

For many chronically homeless people, Supplemental Security Income (SSI) is the only door to Medicaid, supportive housing, and income. But, obtaining SSI is extremely difficult for this population, particularly for persons with severe mental illness. Homeless disability claimants have higher denial rates than other claimants. Insufficient documentation of functional impairments by medical providers partially explains this discrepancy. Persons with asymptomatic HIV infection and those with disabling addictions without evidence of underlying mental illness are excluded by federal law from eligibility for SSI. This restricts their access to housing, health care, and opportunity for recovery. In Colorado, the statewide SOAR[65] projects, as well as the BART program run by the Colorado Coalition for the Homeless, have shown significant success in SSI acquisition, compared to the national norms.[66] For example, on average, 13 percent of homeless persons are awarded disability benefits, compared to 65 percent in SOAR programs and 75 percent in the BART program at the Coalition.

Cultural and Linguistic Barriers

Minority racial and ethnic groups (particularly Black/African Americans, Native Americans, and Hispanic/Latinos) are overrepresented among people experiencing homelessness in the United States. Serious health discrepancies between cultural and ethnic minorities and the general population are starkly apparent in the higher prevalence of asthma, HIV, diabetes, cardiovascular disease, and depression among the unstably housed. Fifteen percent of homeless clients are identified as best served by languages other than English.[67] Insensitivity to cultural heritage, native language, patient beliefs and values, and to the special needs of people experiencing homelessness often present serious obstacles to health care.

Limited Education and Literacy

Homeless adults, especially those in families, are more likely to have dropped out of high school and less likely to have completed education beyond high school, compared to all adults in America. In Colorado, homeless students had a dropout rate of 7.2 percent during the 2009-2010 school year, compared to a 3.1 percent statewide dropout total for all students attending Colorado's public schools.[68] Mobility, chronic illness, stress, and anxiety associated with homelessness cause sleep loss and fatigue that can interfere with learning, often resulting in missed school days and educational setbacks for homeless children. A number of people experiencing homelessness do not read English well or are unable to read at all. Erroneously assuming that a patient can read directions or an appointment card can lead to serious complications and loss to medical follow-up.

04

Lack of Transportation

Limited or no access to transportation makes health care inaccessible for many people experiencing homelessness and is a primary obstacle to employment, particularly in rural areas. Severe geographic barriers in Colorado, such as mountainous terrain or vast distances from available services, exacerbate this problem. Even if a health center is only several miles away from those needing medical services, lack of transportation can be a serious barrier to care in urban as well as rural areas, particularly during periods of severe winter weather. Physical disabilities present additional barriers to limited public transportation services.

Lack of Social Supports

People who are homeless often lack the social supports on which most people depend during hard times. Many have traveled far from their place of origin seeking jobs, services, or respite from abuse. Alienation of family and friends often precipitates homelessness for those with chemical dependencies and/or untreated mental illness. Stigmatization of homeless people—particularly those with disabilities, chronic substance use disorders, HIV, or nontraditional sexual orientations—further isolates them and limits their access to appropriate health care. Having burned their bridges with the community, some retreat to camps or makeshift shelters, far from developed areas. Housing with supportive services is often prerequisite to their reestablishing or developing connections with family or community.

Unemployment

Employment is a significant social determinant of health. Poor health, unemployment, and homelessness are interconnected conditions that can exacerbate and reinforce each other. A physical or mental health condition that results in loss of employment can, in turn, lead to homelessness if an individual exhausts savings. Lack of housing increases an individual's exposure to disease and can worsen pre-existing medical conditions. Poor health only makes it more difficult to secure and maintain employment to pay for housing.[69]

Chronic Stress

Many homeless people live in a constant state of stress that can have negative effects on their health. Adaptations made while homeless can be maladaptive in other situations (e.g., distrust that protects street dwellers may prevent them from seeking needed health care; sleeping on the ground may desensitize them to signs and symptoms of disease). Homeless patients have even more difficulty than others focusing on medical providers' instructions or remembering them, due to preoccupation with meeting basic survival needs. Stress and anxiety may distract homeless parents from giving their children the attention they require for normal development.

Trauma and Homelessness

Trauma—physical, sexual, and emotional—is both a cause and consequence of homelessness. Trauma is defined as an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.[70]

Traumatic experiences may lead to Post-Traumatic Stress Disorder, an anxiety disorder that can occur after an individual has experienced a traumatic event.[71] The psychological effects of physical violence and/or sexual abuse persist long after the traumatic event occurs and impact every aspect of a person's life. One's responses to danger, ability to form and sustain relationships, self-concept, decision-making, physical and mental health, and ability to maintain housing and employment are all affected by past and present traumatic experiences.[72]

Once homeless, regardless of age or gender, individuals are particularly vulnerable to injury, accident, and assault; homelessness is itself a traumatic experience. For many experiencing homelessness, past traumatic experiences, such as physical and sexual abuse are compounded by the loss of home, community, stability, safety, friends, and routines.[73]

For those who have pre-existing mental health disorders or a history of traumatization, homelessness might serve as a breaking point. Frequently, individuals flee abuse at home and re-encounter it at shelters or in the streets. Those suffering from mental illness or chemical addictions are even more vulnerable to attack and are less likely to seek help afterwards.

Adverse Childhood Experiences

Unaddressed early childhood trauma is often an unidentified trigger for mental and physical disease, addiction, and disability in the United States. These traumatic experiences are precursors to and strong predictors of homelessness. Categorically referred to as "Adverse Childhood Experiences (ACE),"[74] they are defined as physical, verbal, or sexual abuse; neglect; having a substance addicted, mentally ill, suicidal, or incarcerated parent; witnessing domestic violence; and, losing a parent all before the age of eighteen. Chronic relational trauma is at the core of ACE, resulting in short- and long-term consequences on neurodevelopment, and thus emotional, cognitive, and behavioral development of children. Most of the ACE categories are experiences that occur at the hands of the caregiver or to the caregiver. This is particularly traumatizing to a child who relies on the primary caregiver for emotional and physical survival. ACE have a profound impact on a child's developing brain. Research demonstrates that changes to important brain structures and pathways significantly impact the ability to learn, concentrate, remember, control impulses, have empathy, and regulate emotion.[75] Because of this, ACE contributes to poor school performance, school dropout rates, substance addiction, unstable relationships, poor work performance, and homelessness. The number and levels of ACE are much higher among people who have experienced homelessness. Essentially people who become homeless have experienced highly toxic levels of ACE, whereas the general housed population has been impacted by fewer cases of ACE and have greater access to quality treatment.

Criminalization of Homelessness

People experiencing homelessness are frequently arrested for loitering, sleeping, urinating, or drinking in public places—activities that are permissible in the privacy of a home. This results in a criminal record for non-criminal behavior, which often prevents them from getting jobs, housing, and needed services. In many communities, when homeless people are arrested, even for a public nuisance offense, such as loitering or public urination, any medications they have with them may be confiscated and not returned. This punitive approach to homelessness detracts attention from the health care needs of homeless individuals.

05 Achieving Integrated Clinical Care for Homeless Populations

Integrated clinical care is central to the Healthcare for the Homeless approach and has been implemented in varying degrees at the Coalition, and by homeless service providers throughout the United States, since the 1980s.

Existing core components in the Healthcare for the Homeless[76] approach include compassionate and persistent outreach to persons experiencing homelessness with an emphasis on building trusting and respectful relationships. An understanding of the wide-ranging and complex needs of the individuals seeking care fosters a "whole person" strategy that addresses medical, behavioral and social service conditions in one plan of care. The delivery of comprehensive services by multi-disciplinary teams who can locate supportive housing, employment, and public benefits[77] compliments the philosophy.

However, care is usually episodic and individuals often seek treatment from more than one provider. Access to specialty care is often not possible or probable. Complex co-morbidities challenge adherence to treatment plans. And, the very nature of homelessness impacts the individual's capacity to cope with multiple health concerns.

The Triple Aim

Integration of care is also a critical component of federal health care reform. Improving the American health care system is thought to require a simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

Collectively, these goals are called the "Triple Aim." Preconditions for achieving these goals include the enrollment of an identified population (i.e., persons experiencing homelessness), a commitment to universal care for that population, and the existence of an organization, or an "integrator" (i.e., the Coalition), that accepts responsibility for accomplishing all three aims.

The integrator's role includes at least five components: partnership with individuals and families; redesign of primary care models; population health management; prudent financial management; and, macro system integration within the community.[78]

The Triple Aim

- **Quality**
- **Outcomes**
- **Cost**

The Need for Integrated Care

Traditionally, primary care, mental health care, and addictions treatment have been provided by different agencies scattered throughout the community. These multiple avenues could frustrate the efforts of anyone. People who are homeless—particularly those with trauma history, mental illnesses, and co-occurring substance use disorders—have substantially greater difficulty navigating complex service systems. Building trust with multiple unknown care providers who may not treat them with dignity and respect often inhibits persons from seeking care.

Furthermore, the impact of psychosocial factors on the body is even greater for people in poverty. Populations of low-incomes are less likely than the general public to accept a mental health definition of their problem. If they do accept a referral for mental health services, they encounter much greater difficulty negotiating travel and solving scheduling problems. This means that, while primary care physicians are the only providers treating 50 to 70 percent of the diagnosable mental health problems in the U.S., that figure is higher for the underserved. Thus, it is especially important that care for vulnerable populations be supplied in a way that addresses the needs they present, in ways they can accept.[79] Skilled screening, assessment, evaluation, and treatment of physical and mental health conditions, in one location, from one care plan are crucial in settings serving homeless patients.

Regardless of the population served, limited access to mental health specialists, stigma associated with mental illness, and negative health outcomes related to undiagnosed or untreated behavioral disorders make it incumbent on all primary care providers to address their patients' mental health needs.[80] For example,

- *Nearly 70 percent of all health care visits have primarily a psychosocial basis,[81] and about 25 percent of all primary care recipients have a diagnosable mental disorder, most commonly anxiety and depression.[82]*
- *Two-thirds of homeless service users report an alcohol, drug, or mental health problem.[83] These behavioral health disorders account for 69 percent of hospitalizations among homeless adults, compared with 10 percent of non-homeless adults.[84]*
- *One-third of all patients with chronic illnesses, homeless or housed, have co-occurring depression. Major depression in patients with chronic medical illnesses amplifies physical symptoms, increases functional impairment, and interferes with self-care and adherence to medical treatment.[85]*
- *Half of all care for common mental disorders is delivered in general medical settings.[86] Many patients, particularly ethnic minorities, perceive primary care as less stigmatizing than the specialized mental health care.[87]*
- *Half of mental disorders go undiagnosed in primary care. Primary care physicians vary in their ability to recognize, diagnose, and treat mental disorders.[88]*

"If your goal is taking care of the whole patient, it's not useful to separate physical and behavioral health care".

Dr. Elizabeth Cookson, Psychiatric Director

05

Integrated Clinical Care Models

The integration of physical and behavioral care can be accomplished in varying degrees. The literature characterizes three central concepts: ***Independent Coordination, Collaboration, and Full Integration.***[89] The value of the patient's participation and perspective is captured in each.[90]

The ideal model is supported by an organization that maintains full integration as the standard of care.

Independent Coordination: Minimal Clinical Integration

Coordinating care between independently functioning agencies that are treating the same individual takes a level of effort that often frustrates clinicians and hampers efforts to integrate services. For example, homeless service providers may 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, personnel develop a current understanding of community resources and refer patients accordingly. These arrangements do not always result in the sharing of treatment goals or objectives, and communication between organizations may be minimal.

Collaborative Services: Moving Toward Integration

In a collaborative model, an agreement such as a Memorandum of Understanding (MOU) establishes a formal relationship between the primary care provider and the behavioral health care or case management provider. In some cases, the client receives services in two separate settings, but the MOU allows for the exchange of information for the purposes of better coordination of treatment goals. Sometimes partnership arrangements result in co-location of services, which allows the patient to access both primary care and behavioral health within one physical setting. Co-location of services creates ease of access for clients and fosters communication between medical and mental health providers. And, primary care clinicians may realize a greater sense of security in addressing behavioral health disorders. Primary care homeless service providers in New York, Worcester, Hyannis, Nashua, Chicago, Raleigh, Irvine, Colorado Springs, and Nashville who have implemented the collaborative approach[91] suggest the following guidelines for success:

- *Focus on building strong relationships with mental health providers and know each other's limits.*
- *Get complete buy-in from the administration of each participating agency; agree on goals and objectives.*
- *Conduct a needs assessment to determine service gaps and how to fill them.*
- *Locate funding; this could be a grant, third-party reimbursement, or public funds.*
- *Find the right providers; people and personalities matter.*
- *Hold regular meetings with your team, your agencies, and your community. Ongoing communication is absolutely imperative.*
- *Cross-train staff. Use mental health and medical providers to train program staff and have new workers shadow their experienced colleagues.*
- *Take a client-centered approach; this reduces the friction that might result when providers each feel they need to see a client first.*
- *Do not give up on your patients or your partners; collaboration takes time. Keep the big picture in mind.*
- *Remember that collaboration is not always about money; you can enhance services by sharing data and reallocating existing staff.*
- *Use data; effective analysis can parlay the team's success into new funding.*

Full Integration: Achieving Clinical Practice Change

A full integration model refers to the care that results from one practice 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.[92]

Full integration is represented by one practice team that tailors its functions to the needs of each patient and situation. It draws from a suitable range of behavioral health and primary care expertise and functional roles. It relies on shared operations, workflows and practice norms, in which formal or on-the-job training is provided. The practice team is united by a shared mission and a common patient panel in order to achieve a desired set of health outcomes, for which all providers take responsibility.

The fully integrated team functions under a systematic clinical approach that targets those members of the population that may benefit most from services. Patients and their families are engaged in all phases of care and decision-making resulting in an explicit, unified, and shared treatment plan that is documented in an electronic health record. Systematic follow-up takes place and the plan is adjusted by the team and the patient if health improvement is not as expected.

Ideally, this entire model is supported by an organizational community that maintains full integration as the standard of care. It is further supported by office practice, leadership alignment, and a sustainable business model that links clinical management and operations.

Continuous quality improvement and measurements of effectiveness are prioritized to ensure the routine collection of practice-based data.

Barriers to Integrated Care

The need to integrate care among homeless and other vulnerable populations is vital. However, clinical, programmatic, and financial barriers can challenge even the most innovative and motivated teams.

Lack of time, training, experience, and resources makes fully integrated care difficult, but not impossible, to accomplish.[93]

Clinical

There are different and often conflicting paradigms in "physical" versus "behavioral" health care and treatment of mental illness versus substance use disorders.[94] Substantial differences in culture and language between clinical domains may be difficult to overcome.

Programmatic

Primary care practice pressures and time constraints often leave clinicians little time to attend to every need presented by each patient. Visits typically last 13 to 16 minutes with an average of six problems to address.[95] Lack of training for interdisciplinary care is also a significant barrier. Sharing information is problematic—records, treatment plans, and data systems are different in primary and behavioral health care settings. Concerns about client confidentiality and HIPAA[96] regulations also require high-level negotiation among collaborating clinicians, program managers, and across agencies.

Financial

Funding interdisciplinary care is a significant hurdle to effectively providing integrated services. There are few economic incentives for primary care and behavioral health care providers to collaborate. Funding for mental health services is more restrictive than for general health care. Even if patients qualify for Medicaid, billing procedures are often cumbersome. Finally, integrated care initially may be more costly than usual care, and cost offsets often do not accrue to the organization or agency that funds collaborative services.[97]

The Coalition's Integrated Delivery Model: *From the Clinic into the Community*

The Coalition's integrated delivery model responds to the specialized needs of homeless adults and children. Our method blends the delivery of patient-centered physical care (medical, dental, vision, pharmacy, and chronic disease self-management) with behavioral health care (mental health care and substance treatment services) and supportive housing.

Street outreach personnel and patient navigators ensure that clients are able to access the care they need and can navigate effectively the systems in which it's provided. Case managers and benefits specialists provide the social supports and assist clients in securing the public benefits to which they may be entitled (Medicaid, SSI/SSDI, TANF, AND, etc.). Peer mentors build relationships with individuals to foster a sense of hope and trust by sharing lessons learned from their own recovery from homelessness. Each of these staff plays a vital role in addressing the social isolation and alienation that often leads to relapses and further aggravation of mental and physical conditions.

Combined, all personnel contribute to the goal of furthering positive health status and housing stability for the people served. As a result, individuals and families begin to thrive and enjoy an improved quality of life. In addition, positive social impacts in the community include population-based health improvements and residential stability; increased affordable housing supply; and, system cost reductions (i.e., emergency services, hospital stays, incarceration).

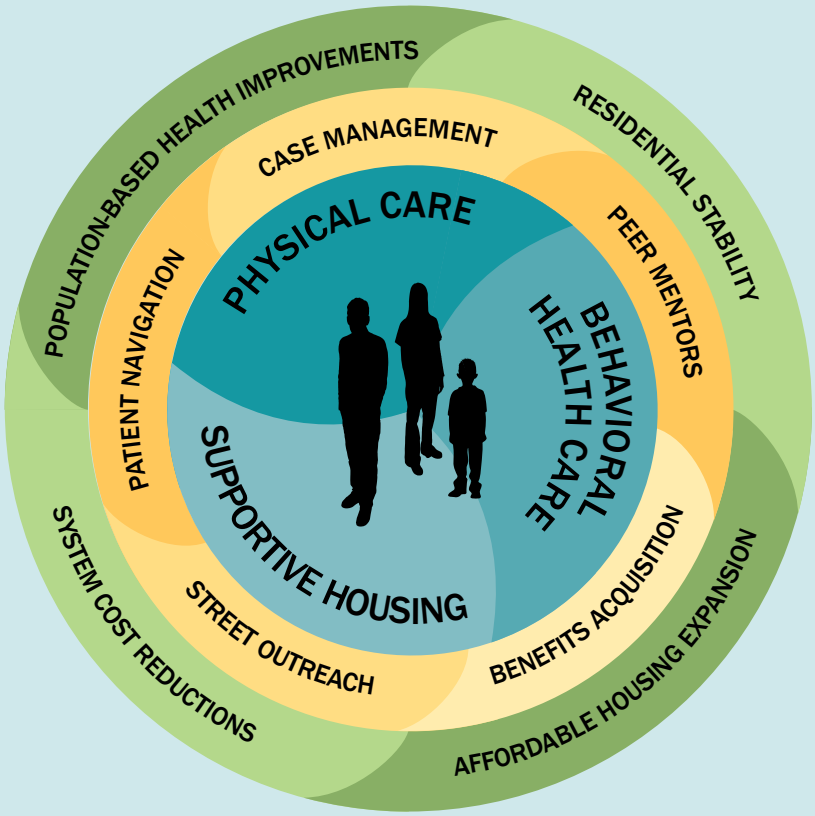
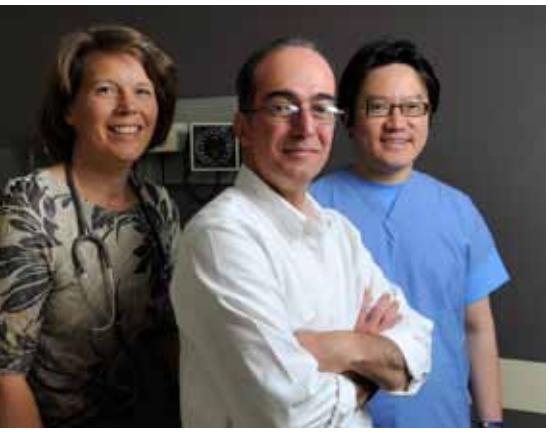


Figure 1: The Coalition's Integrated Delivery Model

The Coalition's integrated delivery model responds to the specialized needs of homeless adults and children—moving from the Clinic into the Community.

06 Three Key Goals for Integration



Health care providers serving homeless individuals, who wish to implement integrated service delivery, would benefit from the cultivation of competencies to realize three goals: 1) achieve practice transformation; 2) enhance provider competencies; and, 3) strengthen organization capacity.

GOAL 1: Achieve Practice Transformation

In order to achieve full practice transformation providers across disciplines should function in a shared space, as part of one team, working from one care plan. Methods of practice should be patient-centered, fully supported by management, and complimented by an aligned business model. Desired outcomes include:

Merged Practices in a Shared Space

Full collaboration will be achieved within a transformed and merged integrated practice that unites behavioral health care, primary care, and other providers, within the same facility, where they share all practice space. System issues will continually be resolved and the team will function as one integrated group. Effective and consistent communication will take place at the system, team, and individual levels. Collaboration will drive team care practices. Routine, formal, and informal meetings will support the integrated model of care. Individual roles and cultures will blend.

One Treatment Team

Medical and behavioral health screening for all patients will be a standard of practice with results available to all members of the practice team. Response protocols will be in place. Evidenced-based practices will be team selected, trained, and implemented across disciplines.

Patient-Centered

All patient health needs will be treated by a team, who functions effectively together. Patients will experience a seamless response to all health care needs as they present for care to a unified practice. They will feel that for most any health concern, they have "come to the right place."

Management Supported

Integration will be supported and advanced as a practice model by the organization's leaders. Service delivery changes will be expected. Resources will be provided for ongoing development and enhancement. Integrated care and all components will be fully embraced by all providers who are actively involved in practice change and refinement.

Aligned Business Model

An aligned business model will support all elements of successful practice change. Funding will be integrated based on multiple sources of revenue. Resources will be shared and allocated across the whole practice. And, billing will be maximized for integration and a single billing structure.

Housing Acquisition

Dedicated personnel will identify housing and related supports, for all patients. A service delivery system that provides stable housing for homeless patients will lead to better health outcomes and will prevent other health conditions from developing.

GOAL 2: Enhance Provider Competencies

For many clinicians certain necessary competencies may not be an established part of their practice when they enter the homeless health care field; however, clinicians should understand what is expected of them and be willing to learn or build upon these fundamental skills. Additionally, the ability to function effectively on a multi-disciplinary team, and to treat from one plan of care, enhanced through proficient use of an electronic health record (EHR) is vital; as is enthusiastic adoption of an integrated delivery model. Other desired provider competencies include:[98]

Knowledge of Homelessness and Health Concerns

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.

Knowledge of High Priority Clinical Issues

Clinicians who work in homeless health care settings should, ideally, have a varied background in their clinical discipline, including skills related to substance abuse treatment and mental health care. Clients who are homeless often have more complex diagnoses and difficulty managing illnesses. Clinicians will 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,

Figure 2: Three Key Goals for Integration

especially in these areas: *Asthma; Cardiovascular Diseases: Hypertension, Hyperlipidemia, and Heart Failure; Chlamydial or Gonococcal Infections; Chronic Pain; Diabetes Mellitus; HIV/AIDS; Otitis Media; Reproductive Health Care; and, Practice Adaptations for the Care of Homeless Patients.*[99]

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 complicate management of other illnesses and drastically hinder individuals from transitioning out of homelessness. Some clients may be attempting to deal with a mental illness by drinking excessively while other clients may have cognitive impairments after many years of substance use. Mental health providers and substance abuse specialists should be united 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.

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 heard and supported. Clinicians who employ a trauma-informed approach to care are better equipped to understand the actions of their clients and engage them in treatment planning.

Managing Complex Multi-Morbidities

A significant challenge in providing health care to a homeless population is the reality that many individuals have more than one significant chronic health condition. Treatment plans must reflect the specific combination of diagnoses and accommodate 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 create appropriate care plans.[100]

Developing Treatment Plans

Many homeless health care facilities do not have adequate finances, staffing, and services to meet the high level of need found in their patient population. Providing comprehensive and quality health care can be extremely difficult in any resource-poor clinical setting, but this is especially true in a homeless population with many complex access issues and management challenges. Given that preferred, and sometimes clinically recommended, services may not be directly available in all homeless health care settings, clinicians are required to learn what resources are provided by other entities to help their clients access needed treatments. A common example is the fact that many homeless health care sites do not have access to pharmaceutical treatments, though this is not the case at the Coalition. Clinicians at these sites may have to research local and national groups that provide free or discounted pharmaceuticals for their clients. This type of advocacy on the behalf of their client is a daily task for the dedicated homeless provider.

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. 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 require 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. Homeless clients often lose or have their medications stolen because they have nowhere to keep their belongings, while others sell medications to make money for other drugs or more important needs. Refrigeration requirements are obviously problematic. Ultimately, clinicians will have to develop medication plans that address the varying needs of each individual client.

Conducting Outreach and Engaging Clients

Individuals who are homeless are some of the most disenfranchised members of our society; they are often detached from the mainstream and distrustful of the medical community. For this reason, many homeless service agencies employ outreach workers that hit the streets with the goal of engaging homeless individuals on their own turf. 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.

Performing Motivational Interviewing

Motivational interviewing is a client-centered approach that clinicians can use to help clients understand their homeless predicament and develop goals for themselves to better their situation. 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.[101]

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 the need for health care services. Clinicians working with clients who lack so many resources will have to help those clients establish realistic 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.

Communication and Negotiation Skills

Effective communication skills are central to working within integrated care teams and settings. Clinicians should 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 a homeless patient's needs.

Performing Self-Care

Self-care for clinicians is essential to providing health care, especially when caring for homeless populations. Stress and burnout are common among clinicians who routinely treat clients with complex health conditions, treatment adherence barriers, and daily struggles merely to survive. Self-care is emphasized at the Coalition, for example, through strategies, such as active support for professional colleagues and team members, open discussion of stressful experiences, such as the death of a client, and organizational policies that promote staff well-being.

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 even before they enter the field.

Goal 3: Strengthen Organization Capacity

The delivery of safe, effective, patient-centered, timely, and equitable integrated care, through evidenced-based interventions, performance measures, and peer reviews is central to the operations of an effective and smooth running integrated system of care. Excellence in the use of electronic health records (EHR) and other data driven systems must also be a high-priority for all concerned. The Coalition's Quality Assurance Program (QAP) sets forth a coordinated approach to achieve these goals and may serve as a useful reference for organizations seeking to build a similar program. Elements include:

Delivering High Quality Care

Quality assurance activities include instituting programs to ensure the highest quality of care for all patients, identifying deficiencies, and implementing and monitoring corrective actions to improve performance. This method provides a systematic, organization-wide process for planning, measuring, assessing, and improving performance.

Oversight and Organizational Structure

The locus of responsibility for quality control at the Coalition is established through an interdisciplinary Quality Management Oversight Committee (QMOC) with four subcommittees: Peer Review; Risk Management; Quality Improvement; and, Workforce Development.

This leadership group develops the QAP, reviews subcommittee reports, and meets routinely. Results of quality improvement and assurance activities are reported to the Coalition's clinical and management staff, as well as to the President and the Board of Directors. The Coalition's Consumer Advisory Board participates in specific projects as appropriate. Composition of the Quality Management Oversight Committee includes the following staff: Chief Program Officer, Chief Administrative Officer, Vice President of Quality Assurance and Evaluation, Medical Director of Integrated Care, Director of Medical Services, Director of Psychiatric Services, Director of Integrated Health Services, Director of Human Resources, and others as designated.

The QMOC subcommittees are comprised of interdisciplinary clinical and management staff directed to provide a systematic, coordinated review of patient/participant satisfaction and access, quality of clinical care, quality of the work force and work environment, cost and productivity, health status outcomes, and risk assessments. It is recognized that some quality improvement and assurance activities may be relevant to more than one subcommittee.

The sources of data available to the QMOC include: Bureau of Primary Health Care Uniform Data Set (UDS); Health Resources and Services Administration (HRSA) outcome measures; Customer Satisfaction Surveys; Consumer Outcome Scales; Occurrences/Critical Incident Reports; Clinician Credentialing Review;

Peer Review Summary; Quality Improvement Activities and Reports; Data Quality Reports from the Homeless Management information System (HMIS) and the Coalition's Electronic Health Record; Patient Chart Audits; Meaningful Use Reports; Annual Performance Reports; Patient/Participant/Staff Complaints and Grievances; Yearly Quality Improvement Reports; External Benchmarks; Employee Turnover Reports; Employee Satisfaction Surveys; Practice Management System Reports; Emergency Management Reports; and, Clinic Safety Committee Reports.

Roles of the Directors of Medical and Psychiatric Services

The Medical and Psychiatric Directors are integral participants in the quality control process for the clinical services under their purview. They provide leadership for all clinicians and practitioners, whether employees or volunteers; identify areas for improvement in the provision of clinical services; review staff qualifications and competencies according to the Coalition's Credentialing and Privileging Policies and Procedures; oversee a formal peer review process based on systematic collection and evaluation of patient/participant records; consider peer review results during annual performance reviews; and, participate in the development, review, and approval of clinical standards of care. They also participate in the development and selection of health outcome measures for the annual Quality Improvement Work Plan.

Role of the Board of Directors

The Coalition Board reviews and approves the Quality Assurance Program; provides input relative to consumer satisfaction and access to integrated health services, quality of clinical care, quality of the work force and work environment, cost and productivity, and health status outcomes; and, approves major policies and procedures for the effective delivery of services. The Program Committee of the Board is responsible for receiving quality information/reports relative to patient/participant services and reports to the full Board of Directors.

Peer Review Subcommittee

Peer Review is defined as a periodic internal review that occurs among clinical providers to evaluate the appropriateness and quality of clinical services that are provided. The Peer Review Subcommittee assures regular performance of peer review activities and reports aggregate results from that data to QMOC. Clinician specific feedback is critical to the integrity and fulfillment of this process. Peer review results and quality improvement activities are presented annually to the Program Committee of the Board of Directors. Peer review results are used as a learning tool for clinicians as well as to inform the credentialing/privileging process.

Risk Management Subcommittee

The Risk Management Subcommittee monitors and assesses regulatory compliance, information, and risk management systems to proactively identify and plan for potential and actual risk. This is done through review of information/data from a variety of sources, which include Occurrence Reports, state and federal regulatory compliance standards, emergency management drills, chart audits, patient/participant billing reports, Safety Committee Reports, and other potential areas of liability. The Safety/Emergency Officer(s) review safety/emergency preparedness activities and reports and presents findings at each meeting.

Quality Improvement Subcommittee

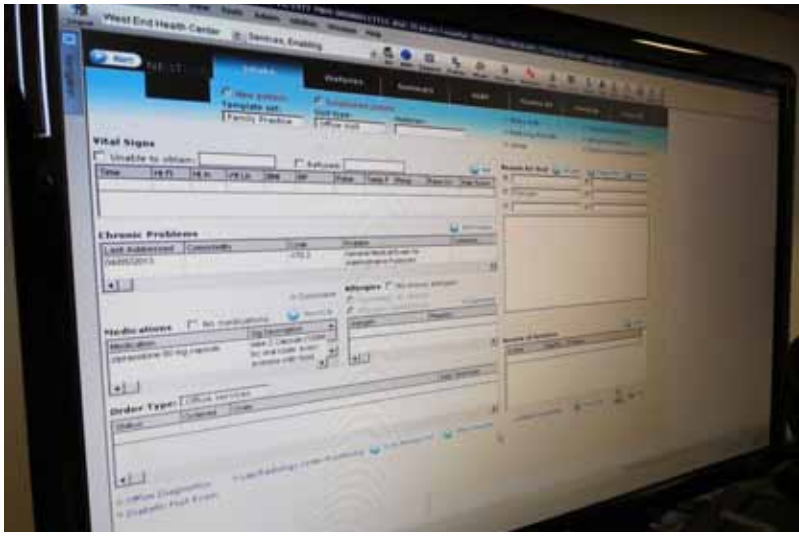
The Quality Improvement Subcommittee assesses the quality of integrated services, patient/participant satisfaction and outcomes, and clinical systems and processes. This is done through review of information/data from a variety of sources, including Incident Reports, EHR and HMIS Data Quality and Summary Reports, customer satisfaction survey reports, domain-specific outcome assessments, infection control practices and findings, and consumer feedback. The Quality Improvement Subcommittee is also responsible for evaluating and approving all proposals to conduct research within the Coalition, as well as education and training opportunities for staff.

Workforce Development Subcommittee

The Workforce Development Subcommittee assesses the quality of workforce management and development activities in order to meet recruitment and retention goals. They obtain and analyze data from a variety of sources including staff surveys, exit interviews, compensation data, and workforce statistics. Specific areas of focus include recruitment and selection, staff training and development, performance management, compensation, employee benefits, and diversity and inclusiveness.

Electronic Health Records

The Coalition's Electronic Health Record (EHR), implemented in 2011, contains all the components of the, previously paper, medical record in an electronic format. An electronic chart is maintained for every patient receiving medical care, mental health, and/or substance treatment services. It is recognized as a vital element of a fully integrated system of care. The ultimate goal is to create a comprehensive health record to enhance the quality of care provided through improved documentation and communication among providers, improve patient safety, and increase efficiency. Exchanging health information between providers has also been shown to reduce costs and duplication of services. A multidisciplinary team oversees the utilization of the EHR.



07 Integrated Pilot Program: West End Health Center

In June 2012, the Coalition completed construction of the Renaissance West End Flats and West End Heath Center, an integrated housing and health care development that is revitalizing the West Colfax corridor.

Integrated Location

Renaissance West End Flats offers 101 supportive housing apartments; 50 units are targeted to chronically homeless families and individuals; 51 units are allocated for low-wage households who are unable to afford market rate housing in the area. The property also includes the 5,500 square-foot West End Health Center (West End). The West End expansion significantly increases the Coalition's ability to meet the integrated health care needs of homeless and at-risk patients in West Denver and Lakewood, Colorado.

Program Development

At West End, the Coalition is pilot-testing its most advanced level of clinical service integration to date, one that features close provider collaboration in a shared space, approaching a fully integrated practice model. Lessons learned are informing the implementation of a transformed and expanded model of integrated care at the Coalition's upcoming Stout Street Health Center, now under development.

Prior to establishing the integrated care model for the West End Health Center, the Coalition identified probable linkages among program resources, activities, outputs, audiences, and short-term, intermediate, and long-term outcomes. A Logic Model (See Figure 3), articulating the desired clinical impacts to patients, staff, and the local community was created to inform program development.[102] Included are better health outcomes for patients through an integrated care model; a provider team committed to integration with the requisite homeless care competencies, who work "at the top of their credentials;" and, the efficient use of resources for both patients and the community.

Depression diagnosis and treatment, increases in health related quality-of-life factors, high patient satisfaction rates, cultural responsiveness, decreases in tobacco use, increases in service utilization, improved diabetes management, high staff satisfaction, high community satisfaction, cost effectiveness of services, and high regulatory compliance were among the key goals and themes addressed.

The resulting plan is guiding service delivery. It emphasizes care coordination and care management, regular/proactive monitoring and targeted treatment, the use of validated clinical rating scales, regular/systematic psychiatric caseload reviews, and consultation for patients who do not show clinical improvements.

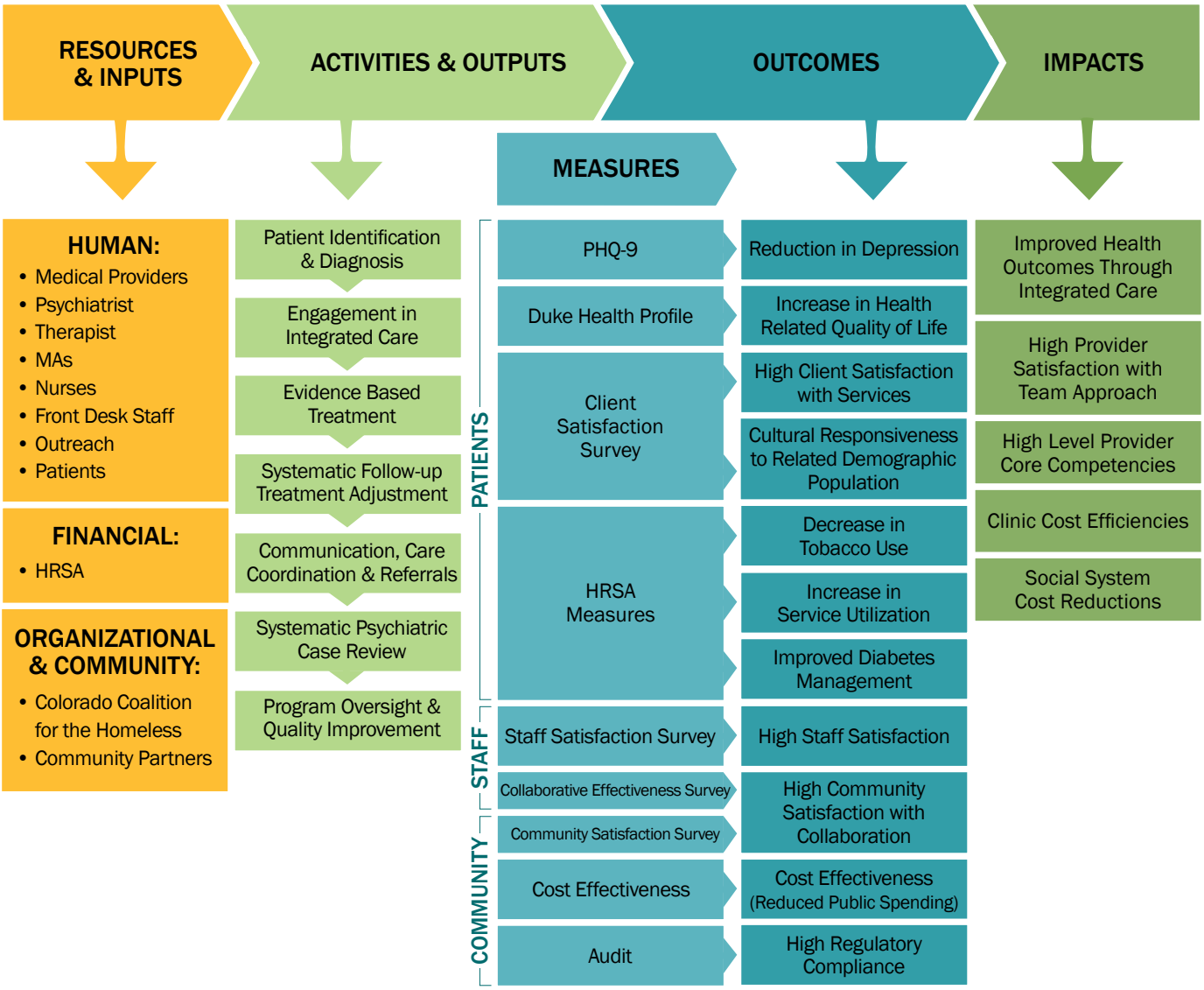


Figure 3: West End Health Center Integrated Care Logic Model

A series of surveys and screening tools measure and guide overall performance. For example, the providers target physical, mental, social, general, perceived health, self-esteem, anxiety, depression, pain, and disability measures through the PHQ-9 Depression Screen and the Duke Health Profile.[103] HRSA measures[104] intended to decrease tobacco use, increase service utilization, and improve diabetes management are also being captured.

The Coalition's Customer Satisfaction Survey and various focus groups will inform the effectiveness of services and systems on patients. Staff satisfaction and input is captured through surveys, focus groups, and routine staff meetings. Staff performance will be monitored according to established core competencies promoted among Healthcare for the Homeless practitioners and through peer reviews.

07

West End Clinical Outcomes

Ongoing evaluation of clinical outcomes is currently focused on tracking these eleven goals:

Diabetes: By 11/30/13, increasing from baseline to 46 the percent of diabetic patients with HbA1c levels which are less than or equal to nine percent. Baseline established 12/1/11 to 11/30/12.

Cardiovascular Disease: By 11/30/13, increasing from baseline to 42 the percent of patients, age 18 years and older, diagnosed with hypertension, whose most recent blood pressure was less than 140/90. Baseline established 12/1/11 to 11/30/12.

Cancer: By 11/30/13, increasing from baseline to 44 the percent of women aged 21–64 who receive one or more Pap tests during the measurement year or during the two years prior to the measurement year. Baseline established 12/1/11 to 11/30/12.

Prenatal Health: By 11/30/13, increasing from baseline to 43 the percent of pregnant women who initiate prenatal care in the first trimester. Baseline established 12/1/11 to 11/30/12.

Perinatal Health: By 11/30/13, decreasing from baseline to 30 the percent of infants whose birth weight is less than 2,500 grams. Baseline established 12/1/11 to 11/30/12.

Child Health: By 11/30/13, increasing from baseline to 51 the percent of children who turn two years-old during the year who have received all appropriate immunizations. Baseline established 12/1/11 to 11/30/12.

Behavioral Health: By 11/30/13, achieving a 20 percent reduction (from baseline) in severity of symptoms among patients diagnosed with Dysthymic Disorder or Major Depressive Disorder. Baseline established 12/1/11 to 11/30/12.

Oral Health: By 11/30/13, increasing from baseline to 75 the percent of new dental patients who receive oral health education, toothbrush, toothpaste, floss, and a new patient dental referral to the Coalition's main dental clinic. Baseline established 12/1/11 to 11/30/12.

Asthma: By 11/30/13, increasing from baseline to 60 the percent of patients diagnosed with persistent asthma that are prescribed corticosteroids (ICS). Baseline established 12/1/11 to 11/30/12.

Infectious Disease: By 11/30/13, increasing from baseline to 50 the percent of patients diagnosed with Hepatitis C who have completed Hepatitis A and Hepatitis B vaccine series or have proof of immunization. Baseline established 12/1/11 to 11/30/12.

Substance Treatment Services: By 11/30/13 among patients screened for substance use disorder, increasing 20 percent above baseline the number of patients receiving one or more individual or group treatment sessions. Baseline established 12/1/11 to 11/30/12.

Semi-annual reports identify patients diagnosed with Diabetes, Hypertension, Asthma, Hepatitis C, Dysthymic Disorder, or Major Depressive Disorder; patients who are pregnant, newly born, or who have recently turned two years-old; female patients between the ages of 21–64 years; new dental patients; and, patients screened for substance use disorder.

West End Clinical Integration Performance Indicators

Successful implementation of the West End integration model includes performance elements focusing on team work, clinical delivery, patient experience, organizational leadership, and the business model. These performance indicators are:

- *The extent to which the team actively seeks system solutions and develops work-arounds together*
- *The frequency of in-person communication*
- *The extent to which individuals collaborate, driven by a desire to become an active member of the care team*
- *The occurrence of regular team meetings to discuss overall patient care and specific patient issues and collaborative treatment planning for all shared patients*
- *The team's in-depth understanding of roles and culture*
- *A consistent set of agreed upon screenings across disciplines to guide treatment interventions*
- *Evidence-based practices that are shared across disciplines, with some joint monitoring of health conditions for some patients*
- *The methods through which shared patient needs are treated by a team*
- *The responsiveness of care to identified patient needs*
- *The extent to which organization leaders support integration*
- *The engagement of providers in the integrated model*
- *Blended funding streams and the sharing of expenses and billing functions*

"In an integrated care setting, communication breaks down at distances greater than 36 feet."

Dr. Marilyn Smith, Psychiatrist

West End Health Center Facility Design

The West End Health Center occupies 5,500 square-feet located at the street level. It includes an entry reception area with a space suitable for children; one congregate work station, known as a "suite" to accommodate as many as 16 providers adjacent to 12 mixed-use treatment rooms; a "mothers" room; a laboratory; a pharmacy; one "group" room to conduct patient education programs, group visits, staff meetings, etc.; a staff break room; one office; four rest rooms; a janitor's closet; an IT room; and, storage and biohazard rooms.

WEHC Floor Plan

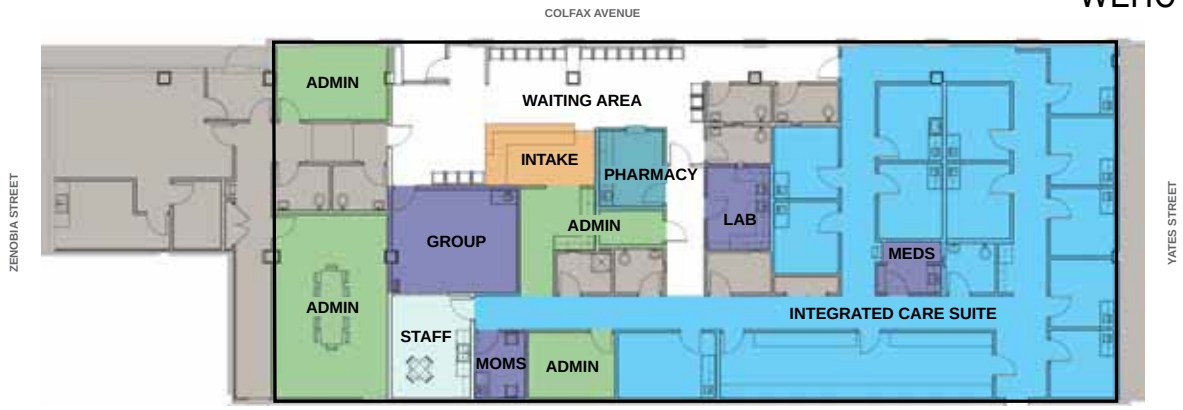


Figure 4: West End Health Center Floor Plan

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"Providers and support staff work as a team to deliver the best medical and mental health care possible. We consult regularly on patient care and coordinate follow-up. We are all developing higher levels of knowledge across our disciplines because we work as a team. It's a rewarding environment in which to work."

Diane Dennehy,
West End Medical Assistant

Clinic Procedures

The West End design ensures that patients can receive physical and behavioral health care services, in one place, from a cohesive team of providers who interconnect with each other about each person's care, in a shared work space. Patients who present with primary care needs are evaluated for behavioral health care needs and quickly connected with the appropriate provider.

Patients, especially women and children, are typically referred from neighborhood homeless service organizations and Coalition case managers. Walk-in appointments are always available. To date, the West End Health Center has served 730 individuals and provided over 3,500 health service visits.

Personnel

All health care providers at West End are located together in a multi-use suite, enabling continual interaction with each other, including real-time access to each team member's electronic schedule. This allows all of the providers to see where a patient is and who is treating them at any given time. As various primary care and behavioral health care needs are discovered, or when a patient makes a cross-discipline request, the operational system and the design of the space in which the team works enables timely consults with ease.

West End is staffed by a Primary Care Physician, one full-time Physician Assistant (PA), one full-time Integrated Health Services Therapist (IHST) who is a trained Licensed Clinical Social Worker (LCSW), one Registered Nurse (RN), two full-time Medical Assistants (MAs), one part-time Psychiatrist, and two Health Operations Associates (HOAs), also known as Front Desk Staff, who are trained MAs. A Pharmacist (PharmD) and a Pharmacy Assistant complete the staffing mix.

The Primary Care Physician

The West End Primary Care Physician serves as manager of clinical services, provides primary care services, and is available to the PA whenever needed.

Physician Assistant

The Physician Assistant (PA) serves as the initial point of entry to care and provides acute care, chronic disease management and preventive care to all patients. The PA conducts most aspects of the initial health assessment, including patient history[105] and the initial physical exam.[106] In addition, the PA can facilitate most diagnostic tests, including baseline labs, asthma screenings, STI (sexually transmitted infections) screening, mental health and substance abuse screening, cognitive and developmental assessments, interpersonal violence screenings, and health care maintenance plans. The PA is also sometimes responsible for creating the care management plan[107] for the patient, providing education[108] to the patient, assisting with medications,[109] and dealing with associated problems and complications.[110]

Integrated Health Services Therapist

The Licensed Clinical Social Worker, known as the Integrated Health Services Therapist (IHST), is a full-time position that focuses on behavioral health treatment. The current practitioner completed the Certificate Program in Primary Care and Behavioral Health offered by the Center for Integrated Primary Care at the University of Massachusetts Medical School. The goal of the program is to "prepare mental health professionals for success as primary care behavioral health clinicians."

Strengthened by this specialized training, the IHST serves as an integration team leader and coach. She conducts therapeutic behavioral interventions for medical and mental health concerns, psychosocial assessments when needed, group skill-building classes, psycho-education, and crisis management.

At their initial visit, patients are screened for behavioral health concerns, including depression, interpersonal violence, and substance abuse (See Figure 5). The PA reviews the screening and will further evaluate any concerns and document prior psychiatric treatment history or other diagnoses not captured by the initial screening form. When the PA believes that IHST intervention is warranted, a "warm handoff" is conducted immediately to introduce the patient to the IHST.

The IHST briefly assesses the reason for referral and determines next steps, such as providing a therapeutic intervention immediately, scheduling an appointment for a more complete psychosocial assessment, and making appropriate referrals; sometimes all three occur at the same visit. The IHST often books follow-up appointments in advance for ongoing therapy encounters.

The number of sessions patients receive from the IHST is dependent on the diagnosis, acuity, and patient response to treatment. A high degree of flexibility is offered through the integrated care model. The IHST may also refer the patient outside of West End to other appropriate resources, if necessary (i.e., domestic violence services, detox facilities, etc.).

"The staff at West End is proactive in helping you with services you may not have known you needed. Services such as prescriptions and appointments are delivered in a very timely way, with great care."

Jane, West End Patient

"With a high mental health need in our population, it is extremely helpful to have same day access to meet a mental health clinician and get scheduled for follow-up without delays, waitlists, or shut doors. When a behavioral health problem is identified, the Primary Care Provider introduces the patient to the Integrated Health Services Therapist immediately."

John Radloff, Physician Assistant

"Every new patient to our clinic goes through extensive screening for behavioral health issues. Because we ask primary care patients about mental health and substance use, patients tell us and we can treat them more holistically. Patients who would not otherwise have sought mental health services have been engaged in mental health care as a result."

Dr. Joan Barker, Medical Director

Psychiatrist

A part-time Psychiatrist provides treatment for patients with severe and persistent mental illness or patients who are not improving through West End's standard depression treatment protocol. The Psychiatrist primarily conducts patient consultations and provides medication management. Currently, the Psychiatrist has limited in-person availability, but is available for phone consults with the PA and IHST every day. The medical provider, IHST, and Psychiatrist meet formally, once per month, to review the entire caseload of patients who are being treated for mental health diagnoses. Ongoing, regular contact between providers occurs through the Electronic Health Records (EHR) system, verbally, and by phone as needed, to provide quality care to all patients.

The Psychiatrist currently sees patients approximately 26 hours per month; additional funding is being sought to increase these service hours. Typically, the PA and IHST manage patients with depression/anxiety symptoms. If the patient presents with bipolar mood disorder or thought disorders, the IHST conducts a psychosocial assessment and the patient is pre-booked to see the Psychiatrist for medication management. The IHST also completes psychosocial assessments for patients with an unclear diagnostic presentation and refers to the Psychiatrist as needed for further evaluation or treatment of a more complex mental health concern.

The Psychiatrist will manage the patient's medication until a level of stability is maintained, at which time, she transfers patient care back to the PA, with the understanding that ongoing consultation will continue and the patient could return to see the Psychiatrist in the future, if needed.

Registered Nurse and Medical Assistant

There is one full-time Medical Assistant (MA) and one full-time Registered Nurse (RN) on the integrated team. The MA is also the coordinator of daily operations, who is responsible for all staff schedules and administrative functions. All staff at West End, including the MA and the RN, are responsible for entering patient information into the EHR after every patient encounter. The RN and the MA take turns conducting initial intake assessments with clients. They also treat wounds, conduct routine tuberculosis skin tests (PPDs),[111] and conduct triage with patients.

Front Desk/Health Operations Associates

Two full-time MAs serve as front desk staff and are called Health Operations Associates (HOAs). They greet the patients as they enter the facility, conduct initial patient intake, provide the screening forms for the patients, collect basic information and patient history, and direct the patients on their next steps.

Pharmacist

A Pharmacy doctoral student from the University of Colorado manages the West End pharmacy; 16 students each complete a six-week rotation, followed by a two-week break at which time a Pharmacist from the Stout Street Clinic is deployed. They assist with reconciling medications, medication education, dispensing, and consult with providers and patients. Medications are filled at the Stout Street Clinic pharmacy and are available for patient pick-up at West End the following day.

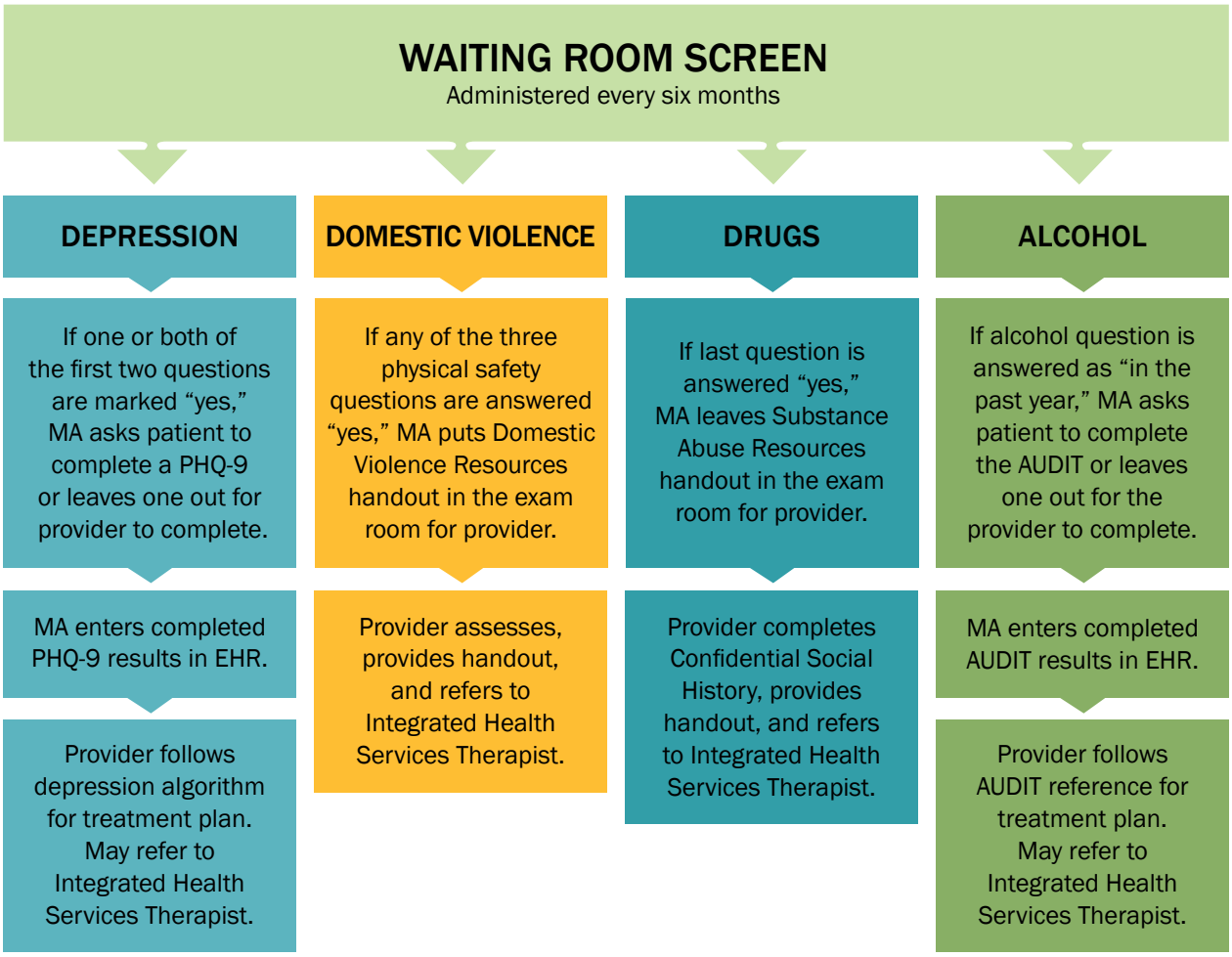
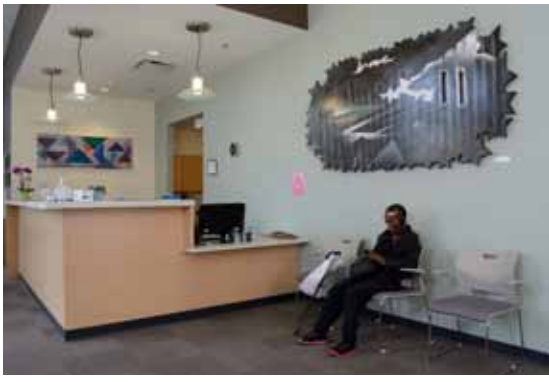


Figure 5: West End Health Center Waiting Room Screen

Screening Protocols



After a new patient is greeted in the lobby at West End, waiting room screens[112] for depression, domestic violence, drug and substance abuse are self-administered.

Additional screening tools include the Adult Intake History and a Half-Sheet Questionnaire that is administered at each visit. The Adult Intake History is a comprehensive health history completed on paper by the provider and entered into the EHR after the visit. The questionnaire is a brief screen used to assist the team in meeting clients' needs, even if they cannot be met onsite. Those not available to be seen at West End include patients with Denver Health Medicaid, patients who are eligible for Veterans Administration services, and patients who have a primary care provider elsewhere. In each of these scenarios, patients are encouraged to maintain their continuity of care with the providers with whom they have existing relationships.

Patient Case Studies

A forty-one year old female presented with a history of Grave's disease, complaining of a 12 pound weight loss over the course of a week after stopping her thyroid medication. The patient's PHQ-9 score was 19, indicating severe depression, and she complained of anxiety. The MD who initially saw the patient referred her to the IHST for help managing mood swings and stress. As the IHST began treating the identified issues, it became evident that the patient had struggled with a thought disorder since she was in high school. The patient was able to be seen by the Psychiatrist the same day and was started on an anti-psychotic medication. The patient was unwilling to see her Endocrinologist again due to paranoia, but was able to resume treatment for thyroid issues through primary care after initiating treatment for psychosis.

A fifty-two year old male presented with uncontrolled diabetes, obesity, chronic pain, and depression. His PHQ-9 screen was 23, indicating severe depression. The patient began receiving medical care from the PA immediately and was introduced to the IHST at the initial visit to engage him in services around depression. The patient was clearly skeptical, but willing to explore the idea because he was scared by a recent increase in suicidal thoughts. The patient has been able to gain better control of his diabetes, and he has since engaged in treatment for depression with the IHST. Understanding the connection between depression and pain and normalizing his experience made a huge difference for this patient's outlook. While he continues to struggle with the pain and depression, he appears more hopeful and is willing to begin making lifestyle changes that will benefit all of his health issues.

A forty-nine year old female presented with history of long-standing treatment for bipolar mood disorder in the community. The patient was immediately directed to the first available appointment with the Psychiatrist after completing the psychosocial assessment with the IHST. During her first psychiatric evaluation, multiple issues of adverse reactions from psychotropic medication use were identified. The Psychiatrist initiated a change in medications and involved the PA the same day to monitor renal function and refer the patient to nephrology for further medical evaluation.

A twenty-seven year old female presented with significant medical and mental health concerns. She was accompanied by her 18 month-old daughter. A "warm handoff" occurred to introduce the patient to the IHST. After the initial visit the IHST and PA discussed some concerns about the interaction observed between the patient and her daughter. There was no obvious abuse or neglect but the child did not seem to interact normally with her mother. It was agreed to continue to observe these patterns at future visits. The patient later brought the child in for care, as well, and the PA continued to have some concerns. Through the course of the mother's treatment with the IHST, Psychiatrist, and PA, the team began to feel strongly that the child may be on the autism spectrum. The Psychiatrist addressed this concern with the patient at a visit and at the next visit with the PA; a referral was made to the child developmental health department at Children's Hospital so that the child could have a complete evaluation.

A sixty year old female presented for primary care for hypertension and depression. The patient self-identified with chronic alcoholism and was working very hard to stay sober. In consultation with the Psychiatrist, the PA treated the initial concerns and also offered the patient a pharmaceutical option for helping prevent alcohol craving. The patient was introduced to the IHST and encouraged to follow-up, but she did not do so feeling that she was on top of her alcoholism at that point. The patient had a period of sobriety, obtaining employment and housing but eventually relapsed, had a suicide attempt, and became homeless again. At that point, the patient was willing to engage with the IHST. She slowly began to open up about her history and was willing to discuss referral to inpatient treatment for alcoholism. The patient continues to remain sober and is currently in a six month community substance abuse program. She checks in by phone on a regular basis and continues to receive her medication refills through the clinic while she is in treatment.

A forty-seven year old male presented for primary care and screened positive for depression and alcohol abuse at his initial visit. The patient was introduced to the IHST immediately and the IHST provided a psycho-educational/ therapeutic intervention that same day. He agreed to return for a full assessment because his symptoms were suggestive of bipolar mood disorder rather than unipolar depression. Meanwhile, he started receiving wound care from the certified wound specialists at Stout Street Clinic. He also agreed to attend a screening for substance treatment groups at Stout Street Clinic. When the patient returned for his intake, he had followed up and was planning to attend two substance treatment groups per week. The patient reported a history of failed attempts at sobriety and a refusal to continue mental health treatment in the past. The patient was scheduled to see the Psychiatrist for further evaluation and treatment of probable bipolar mood disorder and agreed to see IHST every other week for therapy addressing anger management and depression. The patient's wounds have begun to heal, his depressive symptoms are slowly improving, and his anger outbursts have decreased. He has maintained sobriety during this course of treatment and has a growing confidence about his ability to maintain his multiple lifestyle changes.

Patient Satisfaction

A Consumer Satisfaction Survey was completed in November 2012 at West End. Thirty-six patients participated. Offered in English and Spanish, the paper survey was completed by the patient and captured information on gender, age, length of contact with West End, ethnicity, and race. Results indicated an overall satisfaction score of 4.78; results greater than 3.5 indicated "satisfaction."

The highest satisfaction ratings, at 100 percent, were in response to the following statements: ***"The staff treated me with respect and dignity," and "The staff had the knowledge and ability to help me."***

The majority of patients indicated ***feeling emotionally safe*** (97.2 percent) and ***physically safe*** (97.2 percent) at West End; three-quarters of respondents (75 percent) indicated that they were asked about traumatic experiences in their lives.

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When asked what they most liked about services, the majority of respondents indicated that the helpfulness of staff was most appreciated. One patient responded, ***"Staff [are] proactive on helping you with services you may not have known you needed."***

Survey respondents were also asked what they liked least about the services they have received at West End; 82 percent indicated there was nothing they disliked or that the question was not applicable to them. More than three quarters (83 percent) indicated there was nothing they would change or the question was not applicable to them.

Finally, when asked if there was anything else they would like staff to know, the predominant theme was one of appreciation for personnel and the quality of care provided. Sixty-one percent of respondents offered thanks and compliments for their experience in the Health Center.[113] One respondent stated, ***"Thank you for all you have done for me already. I look forward to our future relationship."***

In August 2013, a focus group was conducted with patients to collect qualitative feedback regarding accessing care and satisfaction with the integrated approach to treatment. Although only two patients attended the first group, they provided valuable insights.

Each person described positive experiences with the care they received at West End, such as convenience, minimal wait time, and quality services from attentive, caring staff. One participant stated, ***"It's convenient, since I don't live far from here and the quality has been outstanding here, where other places I couldn't go or get in. There was either too big a waiting list or I didn't qualify for it."***

They also portrayed the services provided at West End as being comprehensive due to the blending of behavioral health and primary care, and the ability to access all services in one place. ***"They're very thorough here, more than regular doctors that I've seen in clinics. Here they really take the time to check everything and see you and help you and give you the right medications and they spend time with you and they care about your health more than other places I've been to."***

Several components differed from their previous experiences in other settings. Both participants agreed that it is beneficial for all of their health care needs to be met in one location. And, in comparison to procedures at other clinics, the ability to make appointments and to be seen promptly was highlighted. One participant stated, ***"I was so surprised 'cause I was getting seen immediately. I was going other places and they wouldn't even answer the phone sometimes."***

Focus group participants made observations regarding the interactions between West End personnel. They appreciated the team-based communication that enabled each provider to become aware of their treatment needs. ***"That's the best thing. You don't have to repeat yourself and tell different doctors at different places what you're taking."***

When asked if they noticed a difference in overall health since receiving services at West End, both participants replied, ***"100 percent!"*** They were grateful that the West End team was knowledgeable about homelessness and the difference it has made in their lives. ***"Another thing about this place is that they specialize in homeless people so they know the situation; they know about mental health issues too, they understand the situation…Before coming here, I thought I was going nowhere, I seriously did. And then I finally saw a doctor here and the rainbow came out and the storm clouds left."***

Provider Satisfaction

In July and August 2013, individual interviews and a staff focus group were conducted with providers (including clinic providers and housing clinical case managers) to elicit their impressions of implementing the new model of care at West End. Overall, high satisfaction was reported in the methods used to develop the integrated care model. All primary care and behavioral health providers participated at some point in the planning phase. The proximity of the providers working in the same location created further opportunities to refine operations in real time.

Personnel identified examples of positive elements they believe have led to better health care for patients, such as the holistic approach to care. By addressing patients' primary and behavioral health care needs when patients first present for services, the whole person is cared for through a patient-centered framework.

Staff expressed appreciation for the ability to consult with one another and to leverage that shared knowledge. The communication used within the model allows for more effective connections between primary care and behavioral health and creates a system that is easily accessible for patients. One provider stated, ***"It's great to work side by side with colleagues that are very competent and have a lot of expertise in areas that I don't. The fact that we sit next to each other and talk about the patients on a regular basis makes it really easy and it really is a team care approach more than any other model I've had before."***

Providers and staff discussed how the integrated model more readily connects patients with necessary behavioral health services resulting from the proximity of primary care, behavioral health, and housing in a shared space. ***"The access to mental health care is instantaneous."*** Housing case managers are better able to advocate for their clients because of their ability to easily network with clinic providers.

Implementing the integrated model has proven to require new transition skills. Staff identified a steep learning curve that involves understanding how to work across disciplines and how to develop collaborative routines between practitioners with different areas of expertise.

When asked about challenges experienced within the integrated approach, staff identified the complexities related to negotiating the demands of meeting patient needs and health care system expectations. Providers discussed the challenges of maintaining fidelity to the integrated model, while simultaneously meeting increased documentation, regulatory, and funder requirements.

Some providers reported competing demands between the expectations of the EHR and fidelity to the model of care. The EHR, while providing an integrated medical chart, is geared toward a medical practice. Workflow adaptations have been necessary. Additionally, providers and staff expressed the need for additional case management resources. The demand for specialty mental health care was also an identified gap in services. Providers discussed the difficulty balancing brief interventions with long-term therapy and the high needs associated with long-term mental health care.

Overall, personnel expressed positive feelings about working in an integrated care setting, in comparison to working in other systems of care. The constant dialogue between primary care and behavioral health providers, the teamwork approach and the coordination of care into one treatment plan have improved access to necessary services and improved patient care.

Providers and staff conveyed feeling fulfilled by their work. While the implementation of integrated care has been a learning experience, it has also been an opportunity for staff to be more innovative in meeting patient needs.

"I think overall, we've all been pretty satisfied and feel like we're giving better care on the whole."

Additional patient focus groups will be conducted and the qualitative data will be analyzed further to inform the implementation of an expanded integrated model at Stout Street Health Center.

Stakeholder Involvement

The Metro Denver Homeless Initiative (MDHI) convened ten stakeholder meetings from July 17 through August 30, 2013, to seek participants' observations on the factors they believe most affect the health status of homeless individuals in their communities.

Representatives from Douglas, Adams, Jefferson, Boulder, Denver, and Arapahoe Counties; the Cities of Aurora and Broomfield; the MDHI Regional Planning Committee, and the MDHI Coordinating Committee, all completed written surveys.

Overall, participants identified six factors as *critically impacting* health status among individuals and families experiencing homelessness in their communities (See Figure 6): unstable housing; mental health disorders; trauma and homelessness; unemployment; discontinuous/inaccessible health care; and, lack of health insurance/resources. Ongoing discussions among these groups will continue to shape integrated health care program planning at the Coalition and across the Metro Denver region.

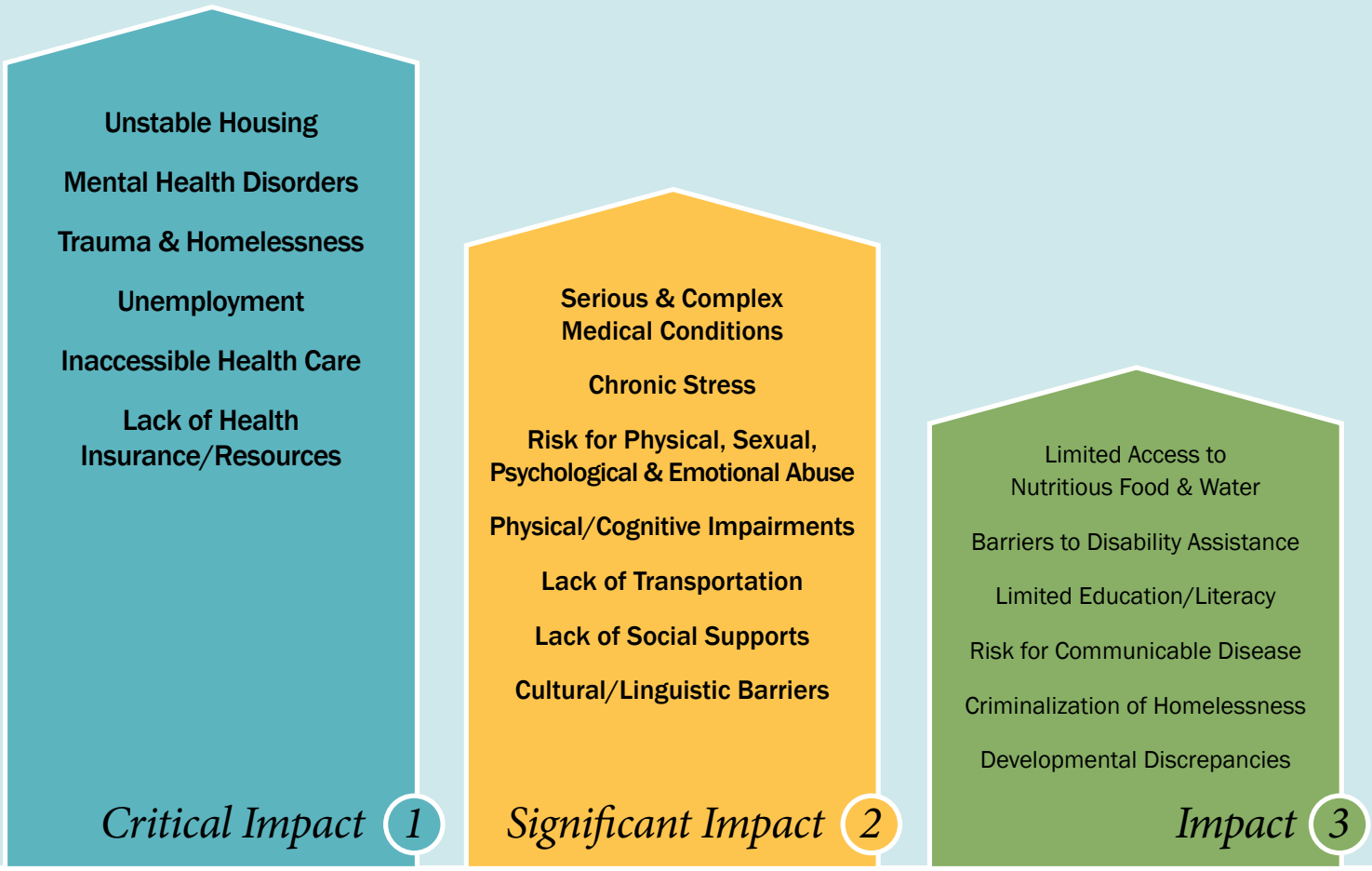

Figure 6: Stakeholder Input on Factors Impacting Health Status

Participating agencies included: *Adams 5D School; Adams County Housing Authority; Almost Home, Inc.; Arapahoe/ Douglas Works!; Arapahoe House; Auraria Higher Education Center; Aurora Chamber of Commerce; Aurora Housing Authority; Aurora Housing Corporation; Aurora Mental Health; Bayaud Enterprises; Calvary Church; Castle Rock Town Council; Castle Oaks Evangelical Covenant Church; City Center Community Center; City of Aurora; City of Thornton; Cold Weather Care; Colfax Community Network; Colorado Coalition for the Homeless; Crisis Connection; Denver Colorado AIDS Project; Denver Department of Human Services; Douglas County; Douglas County Libraries; Douglas County Housing Authority; Douglas County Housing Partnership; Douglas County Schools; Douglas/Elbert Task Force; Englewood Police Impact Team; Family Promise of Greater Denver; Growing Home; Homeless Action Awareness Task Force; Inter-Faith Community Services; Mental Health Partners; Metro Denver Homeless Initiative; Mile High Council/Comitis Crisis Center, Inc.; Mile High United Way; New Hope Presbyterian Church; Parker Taskforce/Food Bank; Public Defenders; Rotary Club of Douglas County; St. Francis Center; St. Vincent De Paul Society; School District 27J; Severe Weather Shelter Initiative; South Metro Health Alliance; The Empowerment Program; The Family Tree; The Women's Crisis and Family Outreach Center; Tri-County Health Department; Volunteers of America; and, Wellspring Church.*

08

Full Integration: The Stout Street Health Center and Renaissance Stout Street Lofts

The Coalition broke ground on the new Stout Street Health Center and Renaissance Stout Street Lofts in January 2013. Located at 22nd and Stout Streets in Downtown Denver, this landmark property is combining a fully integrated health care center serving homeless and at-risk families and individuals with seventy-eight units of affordable, supportive housing. Construction will be complete in Spring 2014.

Vision Statement

In July 2010, the Coalition's Leadership Team formed a vision statement to guide the ongoing development process of Stout Street.

"As we envision the new Stout Street Health Center and Renaissance Stout Street Lofts, we are united in our desire to shape a model of care crafted according to the highest standards of excellence and compassion. We seek to achieve a trauma-informed, fully integrated service delivery system, recognizing that people heal when they are cared for emotionally and physically. We will create a space that projects a sense of peace and calm; the floor-plans will honor patient privacy and confidentiality. The architectural design will not result in an institutional style or feel. Construction decisions and property maintenance standards will minimize negative environmental impacts to the greatest extent possible over time."

Renaissance Stout Street Lofts

The Renaissance Stout Street Lofts, located on the top three floors of the property, will provide affordable rental apartments targeted to a variety of incomes. The Lofts will blend supportive housing units for chronically homeless individuals, families, and youth with affordable housing units targeted to other low-income households. Amenities will include onsite laundry facilities, a community room with a common kitchen and outdoor courtyard, a computer room, elevator access, video surveillance systems, and electronic secured access. Onsite property managers and social workers will also be available to residents for various services, as needed.

The project has created more than 75 construction jobs and will create 70 full-time permanent health care jobs, and provides job continuity for more than 100 current clinic positions. It is generating more than $70 million in direct and indirect economic activity in Denver.

The entire development has been designed in accordance with Green Communities guidelines established by Enterprise Communities, utilizing green building materials in its structure and interior and exterior finishes. Site lighting, heating, and cooling will be energy efficient and designed to minimize light pollution. Materials are selected with an emphasis on recycled content and local availability. Water conserving plumbing fixtures, Energy Star® appliances, and energy efficient lighting will be featured.

Stout Street Health Center

The Stout Street Health Center (Stout Street), located on the first two floors of the property, is replacing the existing Stout Street Clinic, an aging structure that currently lacks adequate space to effectively meet the complex health care needs of an expanding homeless community. Physical and behavioral health service providers are currently located on two different levels of the facility. The Dental Clinic is located in a different building altogether, across a busy street. Communication and interaction among providers of all disciplines is routinely problematic and ineffectual for patient care.

The new 53,192 square-foot Health Center will fully integrate medical and mental health care, substance treatment services, dental and vision care, pharmacy, social services, housing acquisition, and Medicaid enrollment to more fully address the spectrum of problems homeless patients experience. Specialized services for homeless children and families will also be incorporated.

The property will feature larger interior waiting areas to eliminate the physical and emotional discomfort of standing in long lines on the street and a sheltered exterior courtyard for patients to utilize prior to opening hours. A new off-street access bay for ambulances and emergency vehicles will prevent traffic obstructions that are common at the current site.

08 SSHC Floor Plan: Ground Floor

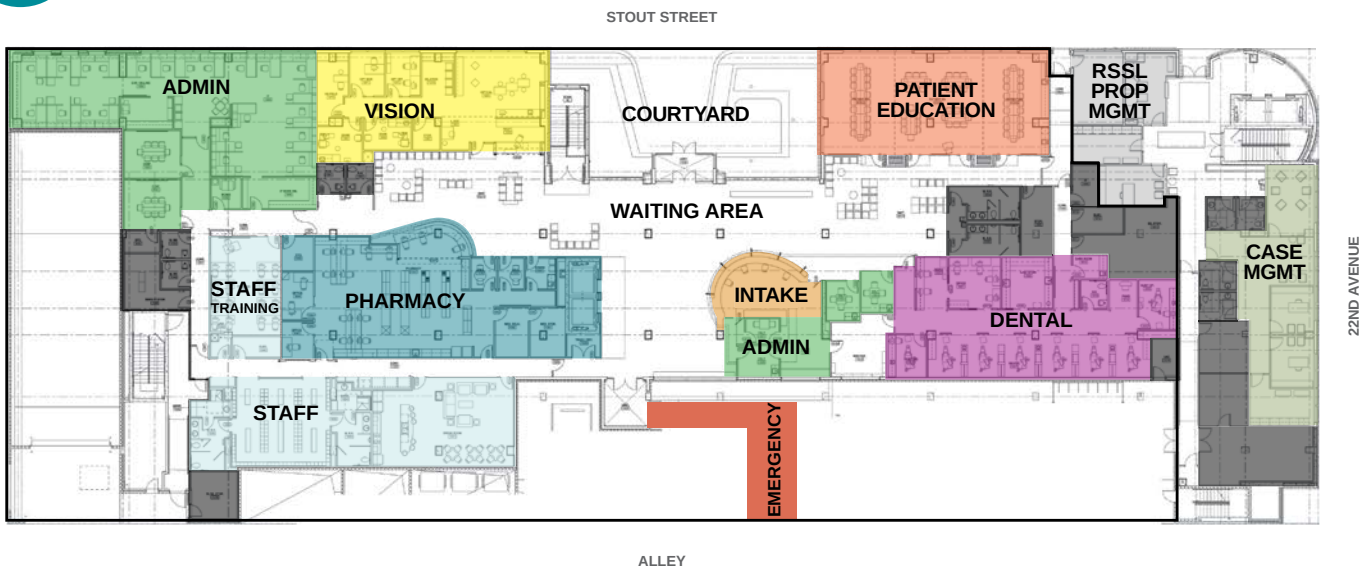

Figure 7: Stout Street Health Center Floor Plan: Ground Floor

Ground Floor

All patients will enter through the exterior courtyard on the ground floor and will be greeted in the main lobby at a centralized "intake" desk. Intake personnel will be the first point of contact for all patients and will be responsible for guiding patients in the appropriate directions, including to Medicaid and other public benefits enrollment specialists.

On the east side of the building, accessible from the main lobby, are the Patient Education suite, the Dental Clinic, and resident-restricted access to the Renaissance Stout Street Lofts. The Patient Education suite will be accessible from a separate entrance off the street, as well as an entrance from the main lobby. It will consist of two large and two medium-sized conference rooms that may also be available for use by local community members. The Dental Clinic contains a records room, a waiting area for patients, a laboratory, eight examination bays, two of which are fully enclosed or "quiet," ideal for children or persons needed a greater level of privacy, a shared office and work space, a storage area, and a restroom.

Adjacent to the Patient Education suite on the west side of the building will be the Eye Clinic, the Pharmacy, and office spaces for Information Technology (IT), Billing, and Electronic Health Records (EHR) personnel. The Eye Clinic contains a waiting area for patients, the optical/frame room, two examination rooms, a customized pediatric bay, a laser treatment room, two offices, a shared work space, and a storage space. The Pharmacy, located next to the Intake/Reception area, contains a large work area equipped for robotic medication dispensing, two consultation rooms, and two private offices. The IT, Billing, and EHR office spaces consist of two conference rooms, a staff training center, and work spaces for staff. Additional shared office space for all personnel, mechanical rooms, and maintenance bays are also located on the ground floor. Personnel will also have access to a locker room with showers, a break room, and a staff training area.

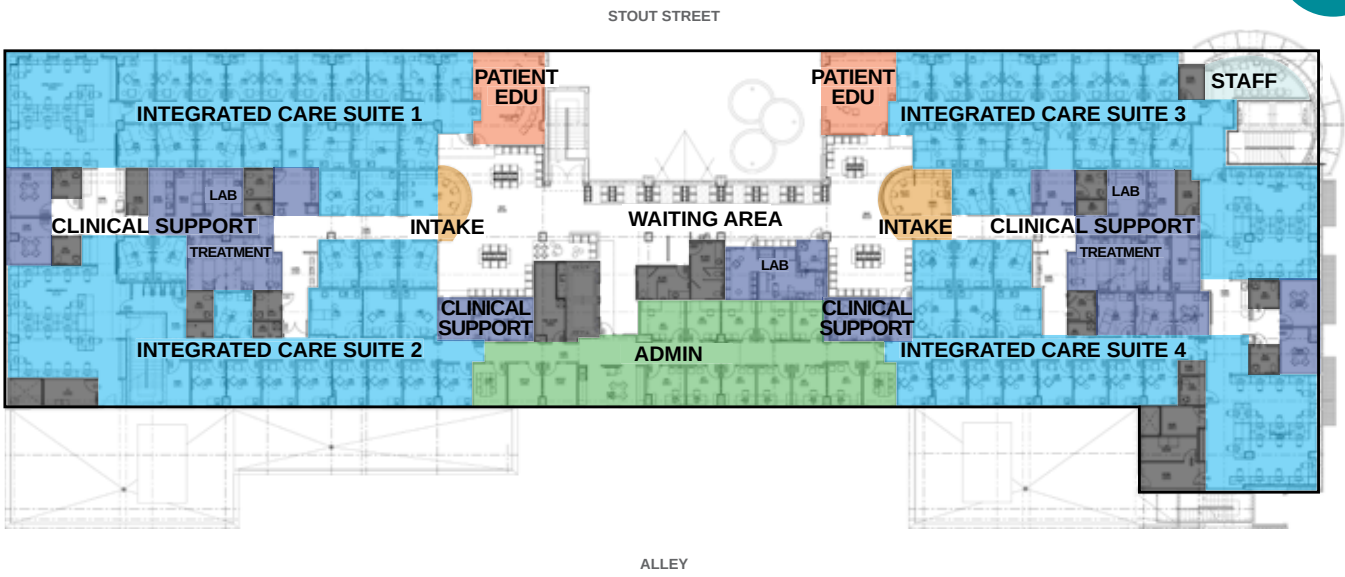

Figure 8: Stout Street Health Center Floor Plan: Second Floor

Second Floor

All patients will access the second floor of the Health Center by elevators or stairs from the main lobby. A large waiting area is located in the center of the second floor. Intake/Reception areas, conference rooms, and restrooms, located on the east and wide sides, serve four provider teams, placed in shared work areas (suites). Each patient will ultimately be assigned to one of these teams and will present directly to that suite at subsequent visits, following their initial visit. Each suite can accommodate up to 20 staff work stations, adjacent to eight examination and eight behavioral therapy or "talking" rooms. Two group visit rooms, two immunization rooms, two large treatment rooms for triage and wound care, one large and two small laboratories with adjoining sterilization spaces, four additional conference rooms, three specialty health rooms, six procedure rooms, 13 private offices, and a staff lounge complete the configuration of the second floor.

Stout Street Integration Vision

Successful implementation of the Stout Street Health Center integrated delivery model will build on lessons learned from the West End Health Center, with the expectation of serving an expanded population base of approximately 18,000 men, women, and children each year. The focus on team work, clinical delivery, patient experience, organizational leadership, and the business model will continue to be refined.

The expected advantages will include shaping an environment in which multiple teams are treating "the whole person." All or almost all system barriers will be resolved allowing providers to practice in a high-functioning atmosphere. All patient needs will be addressed as they occur. The ultimate shared knowledge base of providers will increase and will allow each professional to respond more broadly and adequately to any issue.

Change Management

Once the plan was put in place to build the new Stout Street Health Center and to employ a fully integrated model of care, the Coalition's leaders began to tackle the challenges of realizing wholesale change. The work of the West End pilot team is expanding the organization's understanding of and capacity to blend primary and behavioral health care services. However, a complete, Coalition-wide practice transformation will require an all-embracing acceptance of "a new way of doing things" among personnel across all departments. Throughout this process, emotional and situational impacts have occurred. It is not unusual for the adoption of an entirely new clinical identity or role to become necessary for some providers.[114]

The first phase of change management began with the visioning process in 2010, from which the Renaissance Stout Street Lofts and Stout Street Health Center has since been designed, financed, and is now under construction. A sense of urgency drove a completion deadline of March 2014, to coincide with Colorado's plans to carry out the requirements of the federal Affordable Care Act.

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A clinical integration leadership team was appointed to shape and implement the pilot program at the Coalition's West End Health Center.

The second phase, currently underway, is engaging staff to become involved and "buy-in" to the process. Multiple avenues of communication will, over time, allow personnel to learn about and place their own mark on the Coalition's integrated care model. Meanwhile, short term contributions to decision-making such as finalizing interior design plans, selecting office furniture and medical equipment, crafting the plan to relocate from the current Stout Street Clinic into the new Stout Street Health Center, and redefining job roles and responsibilities, is expected to fuel successful implementation and long-term sustainability.

Personnel

The Stout Street Health Center is managed by the Director of Integrated Health Services, the Medical Director of Integrated Care, and the Directors of Medical and Psychiatric Services, under the leadership of the Coalition's Chief Program Officer and President.

The Coalition's health services system consists of seven departments, comprised of more than 150 full- and part-time staff and volunteers, who currently provide care in a collaborative model at the main Clinic, at five satellite locations, at three respite care sites, and through one mobile Health Outreach Program that serves at least six locations in the Metro Denver area each week (see page 9). Practitioners provide primary care, mental health care, substance treatment, nursing, dental, ophthalmology, pharmacy, patient navigation, and case management services. Additional team members provide technical support in Electronic Health Records administration and training, regulatory compliance, quality assurance and database administration, billing, and accounting.

The provider configuration currently being tested at West End (see page 40), with the inclusion of a Case Manager and a Patient Navigator attached to each suite, is currently expected to be replicated in four teams at Stout Street. Personnel not assigned to a team will float on and off as needed to cover staff absences, or will be assigned to other locations or programs within the Coalition's health care

system. All Health Center personnel will be trained to participate on an integrated team. Dental, eye, and respite care linkages will also be put in place. Outreach and Medicaid enrollment specialists will be assigned to teams and will rotate through all Coalition program and property locations.

Clinical Outcomes

Clinical outcome goals are currently being established for the Stout Street Health Center service year 2014, but will be directed to high-priority health conditions, which were identified by the Institute of Medicine[115] as needing national action for health care quality improvement. Targeted areas include prenatal care; cancer screening; immunizations; and, chronic disease management, particularly for asthma, high blood pressure, cardiovascular disease and diabetes; weight assessment and nutritional counseling; tobacco use screening and counseling; depression; and, substance use screening and management.

Social Impact

The Coalition plans to measure the social impact of its integrated care model in four, population-based areas: 1) health improvement; 2) residential stability; 3) system cost reductions; and, 4) supportive housing expansion (See Figure 9).

Health improvement goals include the number of patients receiving integrated health care, including medical and mental health care screenings, and the level of improvement in health status, with emphasis on depression reduction and management. Residential stability refers to the length of time individuals, families, and chronically homeless individuals remain housed at intervals up to two years. Cost reductions in the use of detox facilities, emergency rooms, hospitalization, and emergency shelter are desired as is an increase in the number of supportive housing units developed by the Coalition.

SOCIAL IMPACT MEASURES	TIMELINE	MEASUREMENT METHODOLOGY	BASE LINE	TARGET
Health Improvement Measures				
Patients receiving health care	12/31/2015	UDS Report to HRSA	9,374	12,000
Percent decrease in depression	12/31/2015	Patients with diagnosis of depression screened with PHQ-9 on four or more occasions	0%	30%
Percent improvement health status	12/31/2015	The Duke Health Profile assessment of health related functioning and quality on four or more occasions	0%	30%
Percent patients screened for both medical and mental health care	12/31/2014	Electronic Health Record Annual Report	0%	50%
Residential Stability Improvement Outcomes				
SHP residents stably housed at RWEF, RSSL and RNCS Families	at 6 months	APR Report to HUD	70%	90%
	at 1 year	APR Report to HUD	65%	80%
	at 2 years	APR Report to HUD	50%	75%
Chronically homeless individuals	at 6 months	APR Report to HUD	75%	90%
	at 1 year	APR Report to HUD	70%	90%
	at 2 years	APR Report to HUD	68%	85%
System Cost Reductions				
Percent of SHP residents with reduction of emergency service utilization from 2 years prior to entry for:		Pre and Post analysis: Random selection of residents and patients for 24 months prior to entry vs. 24 months after entry		
• Reduction in detox use	24 mos after entry		50%	75%
• Reduction in emergency room use	24 mos after entry		50%	75%
• Reduction in hospitalization	24 mos after entry		50%	75%
• Reduction in emergency shelter use	24 mos after entry		75%	90%
Percent of health care patients with unnecessary emergency room or hospital admissions:				
• Reduction in emergency room use		Compared to typical Medicaid patient	0%	30%
• Reduction in hospital re-admission		Compared to typical Medicaid patient	0%	30%
Supportive Housing Expansion				
Increase in number of supportive housing units	over 3 years	Number of units developed	0	178

UDS Uniform Data Systems Report
HRSA Health Resources and Services Administration
U.S. Department of Health and Human Services
SHP Supportive Housing Program
RWEF Renaissance West End Flats
RSSL Renaissance Stout Street Lofts
RNCS Renaissance North Colorado Station
APR Annual Performance Report
HUD U.S. Department of Housing and Urban Development

Figure 9: Stout Street Health Center Integrated Delivery Model: Social Impact Measures

09 Conclusion

The year 2014 marks a period of historic transformation for the delivery of health and long-term care in America for homeless and other vulnerable populations. The Affordable Care Act (ACA) provides new opportunities to improve health care access, quality, and outcomes while reducing costs. The ACA also incentivizes states and health care providers to adopt the practice of integrating primary care and behavioral health care services. Opportunities continue to exist to further integration goals for individuals experiencing homelessness, through targeted outreach and Medicaid enrollment efforts combined with increased access to mental health care, substance treatment services, medical respite care, specialty care, and permanent supportive housing.

Medicaid and the Affordable Care Act

The Colorado Health Institute estimates that 240,000 residents will gain Medicaid coverage by 2022: 140,000 newly eligible uninsured Coloradans, 27,000 uninsured Coloradans who are already eligible, but will enroll, and 73,000 who will switch from commercial insurance.[116] The following strategies are recommended to ensure the ACA works well for people without homes:[117]

- *Ensure that Colorado's focus on the Affordable Care Act (ACA) is an equitable blend of emphasis between the Medicaid expansion population and those eligible for products within the Insurance Exchange.*
- *The state of Colorado should ensure assertive outreach and Medicaid enrollment efforts are targeted to people experiencing or at-risk of homelessness and that resources are available to a full range of service providers to participate in those activities.*
- *The single, streamlined health insurance application process should combine enrollment in a Medicaid plan in the same step as eligibility determination. Colorado should maximize options for greater efficiency (such as incorporating applications for multiple programs), prevent ongoing enrollment barriers (such as mailing address requirements), and include service providers as authorized representatives to the fullest extent possible.*
- *Colorado should ensure that all health plans include an adequate network of primary care, mental health care, specialty care, and substance treatment providers who are willing and able to meet the complex health care needs of those experiencing homelessness.*

- *In order to eliminate a major barrier to care, improve outcomes and save administrative costs, Colorado should eliminate Medicaid cost-sharing (fees for prescription drugs, outpatient services, emergency department visits, hospital stays, etc.) for enrollees below 133 percent of the Federal Poverty Level.*
- *Colorado should establish adequate provider reimbursement levels to promote Medicaid participation, ensure a sufficient supply of trained primary care and mental health care providers who are willing and able to serve high-needs, very low-income populations, and integrate primary care and mental health services systems.*
- *Because the essential health benefits required by the ACA do not include key services (such as adult vision, dental, and case management), Colorado should exercise options to provide more comprehensive Medicaid benefit packages in order to meet the intensive needs of vulnerable populations.*
- *Health insurance carriers must not be allowed to engage in practices that effectively discriminate among populations based on socioeconomic status, housing status, health status, or the presence of certain diagnoses. In addition, they must be prohibited from introducing administrative barriers to plan participation or access to services that have no medical rationale, and must be held accountable for the same high standards of care for all enrollees.*
- *U.S. Department of Health and Human Services programs must remain available as the safety net for the millions of people who will remain uninsured under the ACA, and to help fill gaps in Medicaid service packages. The policies and guidelines of these programs should be reassessed within the context of a changing health care environment. These programs include Community Health Centers, Substance Abuse and Mental Health Services Agency Block Grants, Ryan White HIV/AIDS Programs, and Projects for Assistance in Transition from Homelessness.*
- *States and local jurisdictions should pursue options to combine health care resources with housing resources such as permanent supportive housing, medical respite care, and other arrangements that ensure residential stability.*
- *Though the ACA may significantly improve access to care for many people living with low incomes, additional reforms are necessary to ensure universal coverage of all populations, housed and homeless.*

Mental Health Care and Substance Treatment Services

Adequate mental health care and substance treatment options for people experiencing homelessness are seriously lacking in Colorado. Individuals with mental health disorders represent almost 11 percent of the individuals enrolled in Medicaid and represent almost 30 percent of all Medicaid expenditures. It is anticipated that 14 percent of the individuals who are uninsured and have incomes below 133 percent of the Federal Poverty Level may have a substance use disorder.[118] Three in 10 Coloradans are in need of mental health or substance use disorder care; nearly one in 12 have a severe need.[119]

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Public policies and legislation dedicated to integrating, improving, and expanding access to mental health care and substance treatment services for homeless and vulnerable populations are vital. Examples include the inclusion of a full substance abuse benefit in Medicaid; payment reforms that focus on the provision of appropriate care, regardless of diagnosis; and, criminal justice reforms to reduce recidivism and ensure continuity of behavioral health care.

Medical Respite Care

Homeless adults are hospitalized more frequently than those in the general population and often require longer inpatient stays; however, their lack of a stable home environment diminishes the long-term effectiveness of their hospital care. Living on the streets after hospital discharge creates competing priorities for homeless patients. Challenges, such as obtaining healthy food, accessing transportation, and finding a safe and clean place to rest, can compromise adherence to medications, other physician instructions, and follow-up appointments, thus increasing the probability of future hospitalizations.[120]

Medical respite care is an essential component within the continuum of care needed to serve individuals experiencing homelessness or those at-risk of homelessness. Medical respite care provides short-term residential care that allows homeless individuals to rest while receiving medical care for acute illness or injury. Medical respite programs offer hospitals an alternative to discharging patients to the streets while ensuring that the medical care received in a hospital or clinic setting is not compromised due to unstable living situations. Combined with housing placement services and effective case management, medical respite care allows individuals with complex medical and psychosocial needs to recover from an acute medical condition in a stable environment while reducing reoccurring hospital utilizations.[121]

Medical respite care results in cost avoidance for hospitals, health care systems, and taxpayers. Research demonstrates that after three months and 12 months post-discharge, homeless patients who were discharged to a medical respite program had fewer hospitalizations and reduced hospital readmissions than homeless patients who were discharged to their own care. These outcomes are attributed in part to the time that medical respite care providers spend with patients, establishing a relationship between the patient and a primary care provider.[122]

Specialty Care

The ACA does not explicitly address the rise in specialty care needs that will result from coverage expansion, or provide solutions for the expected supply and demand problem. Many Medicaid enrollees already encounter barriers to specialty care in such areas as oncology, cardiology, orthopedics, and neurology, among others. Compared to privately insured individuals, if care *is* available, the problem often becomes obtaining timely appointments with medical and surgical specialists[123] because of difficulty finding providers willing to accept Medicaid patients.[124] This reluctance is typically due to low Medicaid payment rates. Administrative burdens, patients' non-medical needs, such as those relating to homelessness, and low patient adherence to treatment plans also contribute to the concerns of specialists.

Lack of timely specialty care can result in adverse medical outcomes, emergency room visits and hospitalizations, and potentially higher health care costs.[125] [126] However, several innovative approaches to expanding Medicaid patients' access to specialty care are showing early promise, according to a qualitative study by the Center for Studying Health System Change for the Commonwealth Fund.[127]

While these models have developed under existing state Medicaid policies, updates to Medicaid payment policies that support new types of interactions with patients will be necessary for replication and expansion. Such changes might include paying providers to consult with other clinicians or to treat patients remotely. The scope of Federally Qualified Health Centers (FQHCs) could be expanded to provide more specialty services. Funding could be allocated to training primary care clinicians in certain types of specialty care. And, managed care contracts could be modified to change the way non-clinical activities, like coordinating patient care, are paid and accounted for.

Permanent Supportive Housing

Permanent Supportive Housing is a proven strategy for people whose health care needs are not urgent, but who require treatment and support to manage chronic conditions. Supportive housing programs that combine permanent housing with supportive services have been shown to successfully stabilize people who were previously homeless or are at-risk of homelessness due to mental illness, substance use, or physical health impairments.

Increasingly, health organizations such as hospitals, community health centers and mental health clinics, substance use treatment providers, and local public health agencies are providing services for permanent supportive housing residents. These services generally include intensive care coordination, behavioral health treatment, primary care, transportation, and patient navigation services to help tenants make their appointments and follow their treatment plans. For chronically homeless individuals with complex post-acute care needs, medical respite care prior to placement in housing will often optimize recovery and minimize risk of relapse to street life.[128]

Behavioral health clinics are also appropriate service providers for residents of supportive housing. Often mental health and substance use agencies realize that their treatment services have better outcomes if stable housing is a factor in recovery. It is difficult to quit using drugs, reduce alcohol use, or take medication while living on the streets or in a shelter. Some clinics operate housing programs while others partner with community-based housing providers—both models provide Medicaid reimbursable services.[129]

Hospitals can also be great resources to address the health needs of people experiencing homelessness. Hospital-based frequent use initiatives that offer care management to people with multiple needs can realize better results if they are connected to permanent housing providers in the community. Once housed, with continued care management, clients are more likely reduce hospital inpatient stays, keep appointments, improve eating habits, safely take and store medications, reduce emergency room use, and seek care before conditions reach a crisis state.[130]

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106. Physical examinations can include a comprehensive exam, a serial/focused exam, questions about special populations, and a dental assessment.

107. Care Management Plans can include a plan of care, basic needs, patient goals and priorities, patient action plans, patient safety plans, patient emergency plans, and patient adherence plans.

108. Education/Self-Management may include patient/parent instruction, prevention/risk reduction, behavioral changes, nutrition counseling, peer support, and education of the clinical staff.

Endnotes

109. Providers assist with medications by handling simple regimens, dispensing of medications, taking care of storage/access of medications, understanding and relaying information about Patient Assistance Programs and Aids to Adherence, understanding and educating the patient on the potential for misuse and side effects, analgesia/symptomatic treatment, immunizations, antibiotics, dietary supplements, managed care formularies, and lab monitoring.

110. These can include trauma, no place to heal, fragmented care, masked symptoms/misdiagnosis, developmental discrepancies, functional impairments, dual diagnoses, and loss of child custody.

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There are three questions relating to patients who experience physical violence on the screen. Staff wants to be aware of a patient's safety concerns with regard to a possible domestic violence situation or other unsafe relationship issue. A "yes" answer on any of the three questions prompts a further discussion by the provider, a possible domestic violence handout, and a possible referral to the Integrated Health Services Therapist.
Finally, the Waiting Room Screen includes a question about drug use. A "yes" on this question prompts a further discussion with the provider, a possible substance treatment resources handout, and a possible referral to the Integrated Health Services Therapist.
In any case where the provider feels as though additional follow-up is needed by the Psychiatrist, the provider will follow-up in person on the same day (when available), by phone on the same day, or at a biweekly team meeting. Those patients with depression and/or substance use disorders as indicated on the Screen are inputted into EHR by the Therapist who attempts to keep the patient engaged in care and who monitors appropriate follow-up.

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