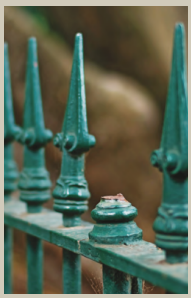
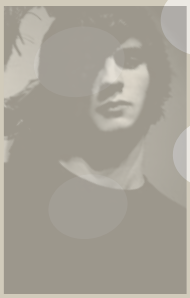
SPOTLIGHT ON PATH PRACTICES AND PROGRAMS

Program Focus:

Integrating Mental Health and Primary Health Care



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DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

PATH

Projects for Assistance in Transition from Homelessness

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Disclaimer

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INTRODUCTION

PATH programs focus on identifying people experiencing homelessness and serious mental health issues and assisting them in accessing services, resources, and housing. Addressing medical issues is one of the critical needs of the individuals they serve. Many face high rates of illness and injury, have difficulty accessing medical care, and must navigate the complications of co-occurring mental illness and substance abuse as it interacts with their health and their health care.

As O'Connell (2004) states in *The Health Care of Homeless Persons:*

> Homelessness magnifies poor health, causes an array of medical illnesses and injuries, exposes those… in crowded shelters to communicable diseases…, places individuals at risk for trauma and exposure to the elements, complicates the management of chronic illnesses such as diabetes and asthma, makes health care harder to access, leads to premature mortality, and presents vexing obstacles that exasperate health care providers… and systems. (p. xxix)

PATH providers recognize the need for medical assessment and care and they often struggle to find available health care services. Service integration is one way to gain entry to medical treatment for PATH clients.

Service integration is described as providers working collaboratively in a system of care across disciplines to address the multiple needs of individuals. Service integration is accomplished through various approaches. Integrating services can occur when a nurse from a primary health care clinic co-locates in a PATH program that provides assessment and services with direct links to medical care. Service integration is also represented by the work of an interdisciplinary team of medical, mental health, social, and addiction service providers who provide coordinated care to a person who is experiencing homelessness.

Routine information exchange is a fundamental element of integrated programs that also develop comprehensive treatment plans addressing all of the consumer's stated needs (Blount, 2003; Gordon et al., 2007; Hornik & Winarski, 2000). Consumers report that with their consent, they prefer that their medical and mental health providers communicate (Mauksch et al., 2000). They are often more comfortable when information sharing takes place within one program, rather than across separate programs (Alfano, 2004).

Some evidence suggests that integrated programs are cost effective (Druss, Rohrbaugh, Levinson, & Rosenheck, 2001; Mauksch et al., 2000; Parks, Pollack, Bartels, & Mauer, 2005), possibly because they have been found to provide more preventive care than programs that are not integrated. In their study of people experiencing serious mental illness, Druss et al. (2001) reported that when compared to the usual care group, individuals receiving integrated services were significantly less likely to visit the emergency room. This cohort was also significantly more likely to keep primary care appointments during the first year after the referral for services.

Service integration can be an effective model when it mobilizes an orchestrated response to the multiple health and socioeconomic needs of people experiencing homelessness. This "Spotlight" issue describes how one PATH program in Wisconsin links behavioral health and medical services for individuals they serve.

PATH PROGRAM IN MILWAUKEE

The PATH program in Milwaukee is operated by Health Care for the Homeless in the city. The HCH in Milwaukee (HCHM) employs four PATH outreach workers and subcontracts two additional PATH positions to the Milwaukee Chapter of the American Red Cross. The two PATH staff members at the Red Cross, one RN, and one outreach worker, provide services to people who are experiencing homelessness and serious mental illness in the city's shelters and meal programs. The four PATH outreach workers employed by HCHM engage individuals on the streets, under the bridges and in the parks of greater Milwaukee. Once a week, the PATH team conducts a 3:30 a.m. visit of the outside sleeping areas to reach out to the people there. The PATH outreach workers from HCHM and the Red Cross overlap shelter sites occasionally and meet to discuss mutual clients. All PATH workers have access to the integrated services available through the HCHM-supported clinics.

HCHM provides mental health, substance use, and medical services for individuals and families who are experiencing homelessness. HCHM contracts with four primary health care clinics for medical services. HCHM has a dually certified behavioral health care clinic that provides mental health services and operates an outpatient substance abuse program. In recent years, they expanded services to include primary health care. A nurse triages clients daily and a physician provides care two days a week. The PATH coordinator, Jennifer Alfredson, MSW states that the addition of primary health care facilitates "quick access to medical services for PATH clients." In addition, the co-location of services promotes communication among the providers. Jennifer declares "We are in the same building so it is easy to go over and talk with the nurse or another provider."

Jennifer notes that the HCHM Primary Health Care Director is helpful to PATH clients who need assistance in navigating the service delivery system. The director acts as a "health broker," coordinating access for people who are experiencing homelessness into the primary health care clinics and the hospitals associated with them.

Jennifer relates that the HCHM Primary Health Care Director was particularly helpful when a PATH client got hit by a car walking across the street. The woman was taken to the hospital where she was assessed and treated. She was discharged to a shelter two days later. When the PATH outreach workers found her, she was having difficulty walking. Jennifer contacted the director requesting his assistance. Within hours, the director negotiated with the hospital to readmit the woman for further treatment. Three days later, she had a walker and was able to ambulate independently.

The PATH program in Milwaukee serves approximately 850 individuals experiencing serious mental illness annually. The PATH outreach workers provide short-term case management and they accompany individuals to psychiatric and primary health care visits. This PATH program procedure fosters communication between the behavioral and primary health care staff and assists the outreach workers in coordinating the plan of care. Jennifer notes that the mental health and substance abuse service staff share a chart but the PATH program and the primary health care clinic each have separate record systems. "We are all still on paper," she remarked, and "we do not have one treatment plan."

The PATH program in Milwaukee maximizes access to resources in the community and provides a point of entry into multiple services. Reducing fragmentation by offering many services at one site, or "one-stop shopping," is an effective way to deliver integrated care (Alfano, 2004; Hornik & Winarski, 2000).

CHALLENGES TO SERVICE INTEGRATION

Various barriers can interfere with the provision of integrated care. The lack of resources is often cited as the main challenge. Other barriers include:

Cultural Differences between Disciplines

The cultural differences between primary care and behavioral health extend to training (Alfano, 2004), competing priorities (Cocozza et al., 2000; Gordon et al., 2007), and the medicalization of mental health in primary care (Coyne, Thompson, Klinkman, & Nease, 2002). In an integrated system, it is essential that both the mental health and primary care providers share the same treatment philosophy and understand each other's goals.

Time

In medicine, time is scarce. People who are experiencing homelessness, serious mental illness, acute medical issues, and chronic health problems have complex needs. It takes time to sort out the physical and behavioral issues, pharmacological interactions, and the social context in order to create a plan of care. The time allotted for appointments in a primary health care setting can be insufficient to cover all of the medical issues that need to be addressed, often leaving little room for the consideration of behavioral health (Kern et al., 2005; Surgeon General, 2000; Unutzer, Schoenbaum, Druss, & Katon, 2006).

Location

Physical fragmentation of the delivery system results in consumers needing to travel to several different locations for services (Gallagher et al., 1997; Hornik & Winarski, 2000). It also decreases the likelihood that the providers will communicate and coordinate care. In rural communities and other areas where public transportation is not available, the provision

of services in different locations is particularly challenging for consumers. This fragmentation creates a disincentive for people to seek services as well as a barrier to care.

Health Insurance and Medication

Lack of health insurance, particularly for prescriptions, is a barrier to service integration. Public funding streams may cover certain services—e.g., behavioral health, and not others. Grants and other funding sources can support some services; however, programs often have to cobble together fragmented funding streams to support integrated services (Alfano, 2004; Surgeon General, 2000; Weinreb, Nicholson, Williams, & Anthes, 2007).

Lack of Systems Integration

Fragmented funding streams reinforce separation of systems. The various federal, state, and local systems often lack a tradition of coordination, posing challenges for improving service integration. A systemic approach to coordination has not been conceptualized on a large enough scale to bring together federal, state, and local efforts. Until recently, there had been an absence of a message from federal funders that a coordinated, system approach was valued.

STRATEGIES FOR SERVICE INTEGRATION

Integrated mental health and medical care is challenging, but steps can be taken in this direction to improve the quality of overall care for consumers. Key elements to improving service integration include effective relationships between provider staff and provider organizations; ongoing communication between service staff, teams, and administration; co-location or imbedded service provision; cross training; tracking outcomes; and flexible funding (Alfano, 2004; Health Care for the Homeless Clinician's Network, 2006). When the delivery of client-centered care is the overall goal, the collaborative work will reflect that value and continue to move forward.

In May 2006, the Health Care for the Homeless Clinician's Network published an issue of *Healing Hands* entitled "Integrating primary and behavioral health care for homeless people." This publication reviewed the recommendations of providers who participated in collaborations to link health care for the homeless programs and community mental health agencies funded jointly by the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration. The lessons learned presented in the article for health care providers were used to provide the strategies below for PATH programs interested in improving integrated care in their communities.

- Build relationships with health care providers in your community;
- Get buy-in from the administration of the partner organizations for mutual goals, objectives, and an understanding of each agency's resources and limitations;
- Conduct a community needs-assessment to identify gaps in services and how they can be filled by the partners;
- Locate funding for services through grants, local financing, and increasing access to benefits, but remember that change can happen through changing practices and policies even without additional funds;
- Identify medical providers who will work well with mental health consumers and who are responsive and collaborative;
- Hold regular meetings of partners, consumers, and stakeholders;
- Provide initial and ongoing cross-training of the medical and mental health providers, and ensure training of new staff;
- Focus on the goal of client-centered care when navigating service coordination across disciplines and organizations;
- Track outcomes through effective data collection; and
- Stay focused and do not get discouraged when change takes time.

A report by the Bazelon Center for Mental Health Law examined models for improving integration of mental health and medical care. The report, *Get it together: Physical and mental health care for people with serious mental disorders,* recommends using policy to encourage collaboration (Koyanagi, 2004). Some of the suggested strategies from this report include:

- Build initiatives to improve communication and understanding between the two fields into contracts;
- Encourage consumers to agree to allow information-sharing;
- Share information about resources across disciplines and organizations;
- Ensure primary health providers have sufficient behavioral health support;
- Use performance measures and incentives in funding strategies; and
- Provide training material and education programs to cross-train and improve collaborative communication.

The PATH program in Milwaukee is representative of programs that have taken steps towards service integration. Although this program has the advantage of having funding to directly provide mental health and primary care through the umbrella of their Health Care for the Homeless contract, many of the components of their program can be implemented in PATH programs without significant changes in policy or funding.

Specific strategies for service integration include:

Staffing

Staff outreach teams with both mental health and medical care expertise. This can be accomplished by the PATH program hiring a nurse, providing joint outreach with a nurse from another agency, or training outreach workers to recognize medical issues and have medical expertise readily available to assist as needed.

Co-Location of Staff

Locate mental health outreach staff in clinics that provide primary care. Co-location of staff can be accomplished through working agreements among agencies. Mental health staff can provide the case management, service broker services, and follow-up planning for PATH consumers that many health clinics are not able to offer.

Discharge Planning

Collaborate between mental health and primary care clinics to provide for effective discharge arrangements from hospitalization.

Team Meetings

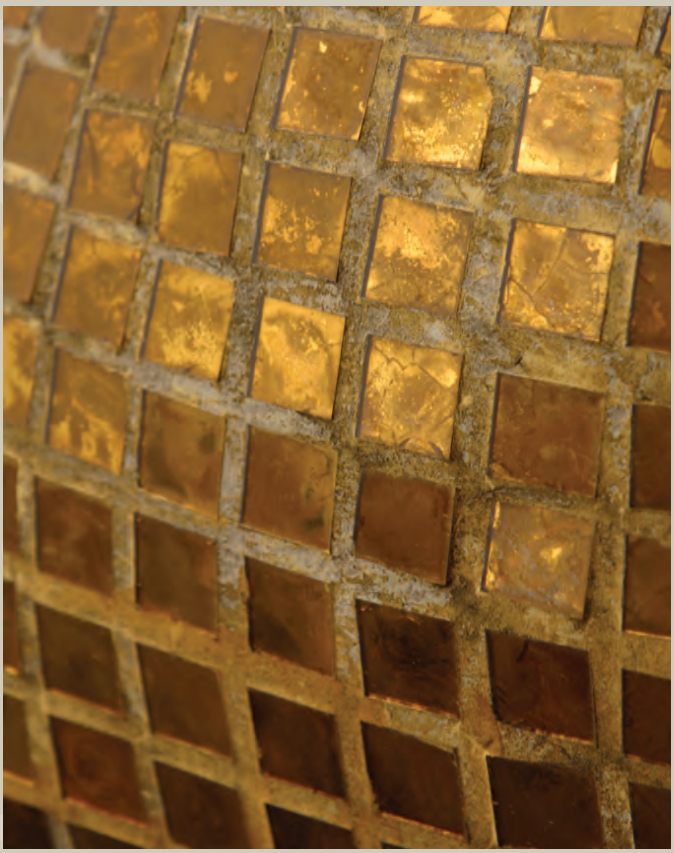
Interdisciplinary treatment team meetings can occur across organizations with the consumer's consent and involvement.

No Wrong Door

Provide a "no wrong door" approach for access to mental health and medical services that is respectful to the service desires of the consumer and can readily link and engage other services as needed and requested.

CONCLUSION

Integrating services requires partnerships, commitment, planning, and resources. For PATH programs that do not offer multiple services on site, a strong relationship with a primary health care clinic can be the beginning in creating an integrated service system. Service integration is a viable model for PATH programs who are responding to the multiple health and social needs of people who are experiencing homelessness and serious mental illness.



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WHAT IS PATH?

Projects for Assistance in Transition from Homelessness

The PATH Program—or Projects for Assistance in Transition from Homelessness—was authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. PATH funds community-based outreach, mental health and substance abuse services, case management, and limited housing services for people experiencing serious mental illnesses—including those with co-occurring substance use disorders—who are experiencing homelessness or are at risk of becoming homeless.

PATH funds stimulate state & local contributions

PATH funds are worth more than their face value because they are matched with state and local resources. For every $3 in federal funds, state or local agencies must put forward $1 in cash or in-kind services. At a minimum, a $52 million Federal allocation would result in a $17 million match. In some states PATH funds and the state and local match are the only resources specifically for serving people experiencing homelessness and mental illnesses.

PATH

Projects for Assistance in Transition from Homelessness

PATH providers deliver innovative services

PATH providers work with service delivery systems and embrace practices that work. These include:

- Partnering with housing first and permanent supportive housing programs
- Providing flexible consumer-directed and recovery-oriented services to meet consumers where they are in their recovery
- Employing consumers or providing consumer-run programs
- Partnering with health care providers, including Health Care for the Homeless to integrate mental health and medical services
- Assertively improving access to employment
- Improving access to benefits, especially through SSI/SSDI Outreach, Advocacy, and Recovery (SOAR)
- Using technology such as PDAs, electronic records, and HMIS

PATH providers are strong community partners

PATH providers and State Contacts are involved in local and regional planning efforts to end homelessness, including Continuum of Care, 10-Year Plans to End Homelessness, and other planning efforts. PATH providers and State Contacts work to ensure that services are coordinated and available to people experiencing homelessness.

For more information about PATH, please visit http://pathprogram.samhsa.gov

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