Integrated Primary Care in MISSION

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Available online at www.missionmodel.org

The views expressed in the following document do not necessarily reflect the official policies of the Massachusetts Department of Public Health, the University of Massachusetts Medical School, or Substance Abuse and Mental Health Services Administration (SAMHSA) nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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The MISSION materials mentioned within the document in addition to all versions of the MISSION treatment manual and their corresponding workbooks are available for download on the MISSION website at www.missionmodel.org. You may also contact the MISSION team through the website or Dr. David Smelson directly (see contact information below) regarding any questions about the MISSION Model and/or the materials.

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This document was developed and written by Ayorkor Gaba, Psy.D., University of Massachusetts Medical School; Siu Ping Chin Feman, M.D., University of Massachusetts Medical School; Diana Aycinena, RN, Boston Health Care for the Homeless Program; and Monica Bharel, M.D., MPH, Commissioner of the Massachusetts Department of Public Health. We are grateful for the valuable feedback we received from expert reviewers during the development of this document. Reviewers include: Alice Colegrove, DrPH, Bureau of Substance Addiction Services, Department of Public Health; Cheryl Kennedy-Perez, MS, Bureau of Substance Addiction Services, Department of Public Health; Captain Christopher Bersani, Psy.D., ABPP, Health Resources and Service Administration, U.S. Department of Health and Human Services; Marie Hobart, M.D., Community Healthlink; Sonya Gabrielian, M.D., MPH, Department of Veterans Affairs Greater Los Angeles, and the University of California at Los Angeles David Geffen School of Medicine - Department of Psychiatry and Biobehavioral Sciences; and David Smelson, Psy.D., University of Massachusetts Medical School. We would also like to thank the University of Massachusetts research assistant, Kathryn Bruzios, M.S., for her assistance in the production of this document.

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Integrated Primary Care

Introduction

Integrated primary care is vital to addressing the healthcare needs of individuals experiencing homelessness with co-occurring mental health and substance use problems.[1] *This module was developed as a practical guide for MISSION (*Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking*) teams and administrators on how integrated care is incorporated into the MISSION model. It also provides information on the roles and responsibilities of the MISSION primary care coordinator (PCC), who serves as the bridge between the MISSION team and the healthcare system.*

Module recommendations are based on current research in the field and lessons learned from a pilot project aimed at integrating primary care coordination into MISSION. The MISSION: Housed (MH) project delivered MISSION wraparound services and assisted clients experiencing chronic homelessness in accessing housing, who had co-occurring substance use and mental health disorders in the Boston metro area. As the project progressed, the pressing need for primary care coordination became more apparent, therefore the program developers applied for supplemental funding to enhance service delivery by adding a full-time registered nurse, to serve as a primary care coordinator. The primary care coordinator focused on supporting integration of the work of the MISSION clinical team and clients' healthcare providers by strengthening the linkage between medical care, behavioral health service staff, and clients. This role has been further adapted to the MISSION model, described in this guide as the primary care coordinator (see Appendix A for additional information about this pilot).

The Problem

Individuals experiencing homelessness have a higher prevalence of medical illness, behavioral health disorders, and substance use disorders than the general population.[2] While homeless, barriers to care, such as access, cost, low health literacy, and lack of coordination of care become more difficult for clients to surmount, which results in increased rates of hospitalization, use of acute care, and overall healthcare costs.[3] Integrated care has been demonstrated to improve access to care and improve outcomes, while decreasing costs.[4]

Homelessness Adds Complexity

Individuals with a co-occurring mental health and substance use disorder (COD) have higher rates of chronic medical conditions.[5] They often experience complex health problems due to a variety of factors (i.e., effects of behavioral health medications on medical problems, limited access to medical care, difficult living conditions which impact consistent care of both behavioral and physical health issues, etc.). In some cases, the medical conditions are due to the negative consequences of drug and alcohol use, such as sharing hypodermic needles or poor nutrition. Medical conditions that are strongly associated with substance use include tuberculosis, hepatitis, diabetes, and HIV/AIDS (SAMHSA, 2005; TIP #42).[6] In addition, older adults with a COD may have higher rates of chronic physical health conditions (e.g., heart disease, diabetes, etc.) than other older adults overall (Bartels et al.).[7]

Co-occurring substance use, behavioral health, and medical disorders are a particularly significant issue within the population experiencing homelessness. Among people experiencing homelessness, more than 80% report having a medical condition.[8] Health Care for the Homeless (HCH) treatment models have documented the high prevalence and complexity of caring for homeless people with CODs, with comorbid medical illnesses.[5,9-11] Adults experiencing homelessness are hospitalized at a higher rate than the general population for medical issues.[12,13] Inpatient lengths of stay for medical issues have also been consistently found to be longer than the general population.[12] Clients experiencing homelessness with CODs have also been found to be the heaviest utilizers of emergency department services.[14-16] These increased rates of hospitalization and increased lengths of stays have a significant impact on medical expenditures and costs.[12,17]

What is Integrated Care?

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines integrated care as "the systematic coordination of general and mental health." Integrated behavioral health and primary care services have been proposed as the most viable, efficient, and cost effective way to deliver healthcare. Both the Institute of Medicine (2006) and President's New Freedom Commission on Mental Health (2003) have identified achieving greater clinical and health system integration between service providers and systems as a key strategy for improving the quality of care for people with behavioral health and substance use disorders (SUDs).[18,19] Specifically integrated services have been found to be particularly effective in improving a multitude of outcomes, including medical, psychological, and housing outcomes for individuals experiencing homelessness.[20]

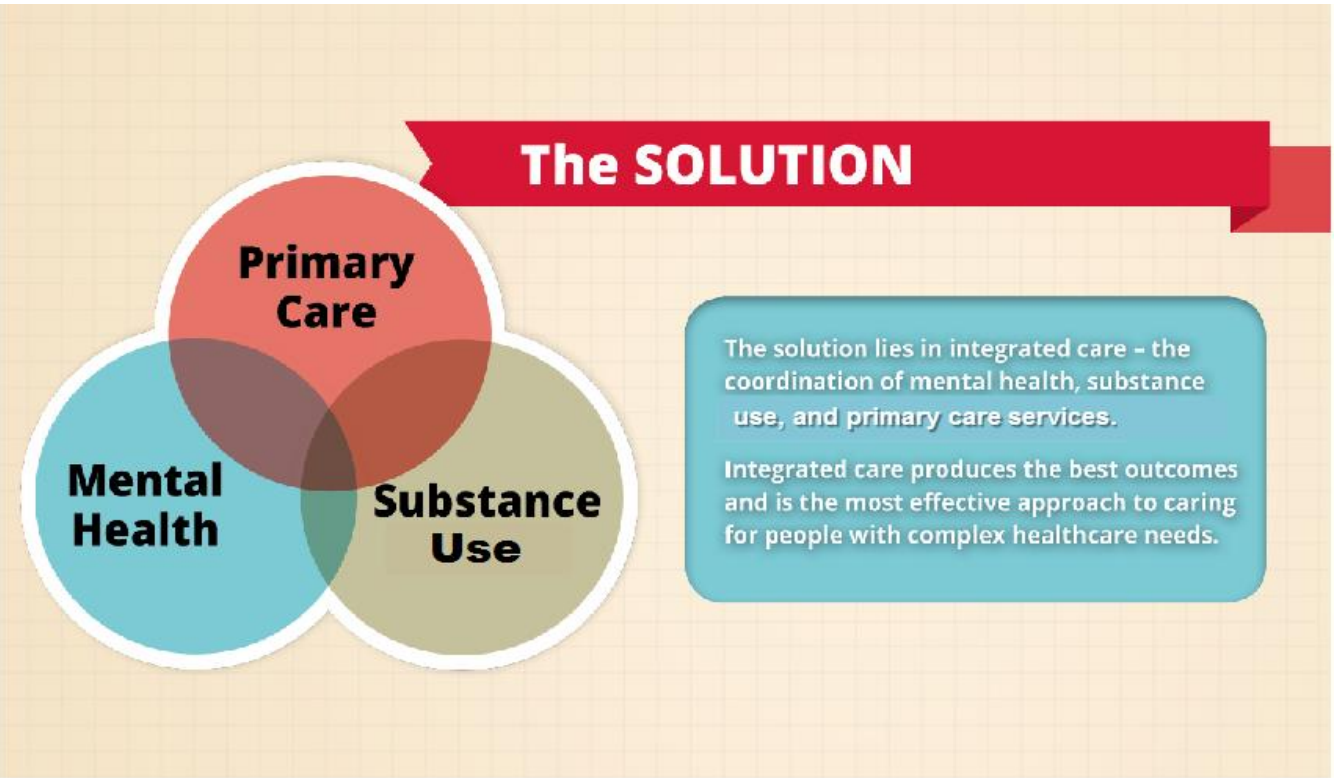

Figure 1. Adapted from "Integrated care solution."[21]

There is a growing and robust literature examining models of primary care integration. The following section reflects a brief synopsis of key points regarding primary care integration. Growing research in this area suggests that integration has generally occurred in two distinct ways: (1) behavioral care being introduced into primary care settings (BC:PC); or (2) primary care being introduced into behavioral care settings (PC:BC; see Appendix C for specific models of integrated care).

As systems move towards increased utilization of integrated models of care, the degree to which care is integrated in practice varies greatly. The SAMHSA level of integration framework (see Table 1), is a helpful guide that proposes six levels of collaboration/integration to help understand the possible range of integration. It includes three main categories — coordinated, co-located, and integrated care. It is designed to help organizations implementing integrated care to evaluate their degree of integration across several levels and to determine what next steps they may want to take to enhance their integration initiatives.

Table 1. Core Descriptions of the Six Levels of Collaboration/Integration [22]

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

Research has shown that integration of care improves quality of care for and outcomes of substance use and behavioral health disorders.[23,24] While there are many fewer studies of behavioral health-based integrated care (i.e., primary care integrated into a specialty behavioral health setting), reviews suggest that this approach is also promising.[25,26] For example, clients receiving services in behavioral health-based integrated care programs have shown an increase in primary care visits, improved attainment of performance measures related to metabolic and cardiovascular risk, and reduced emergency department use.[23,27-30] Integration of substance use treatment and primary care has not been as extensive or prevalent as integration of behavioral health with primary care. Further research is needed to more effectively support and understand substance use integration.[26,31] Even less is known about models of integration of primary care into SUD/COD treatment, and housing supports for individuals experiencing homelessness.[32,33] Therefore, given the paucity of research and the needs of this population, we set out to integrate our co-occurring mental health and substance use disorder (COD) model called MISSION, with primary care which is discussed in more detail in the next section.

Integrating the MISSION Model with Primary Care

The MISSION Model

MISSION is a time limited, yet flexible, evidence-based wraparound behavioral health service intervention for individuals who have experienced homelessness, hospitalization, and whose ability to return to independent community living is further complicated by co-occurring mental health and substance use disorders (CODs). The key service components of MISSION include: Critical Time Intervention (CTI), Case Management, Dual Recovery Therapy (DRT), Peer Support, Trauma-Informed Care, and Vocational and Educational Support. Because our work is with individuals who are experiencing homelessness, we have also integrated a Housing First philosophy to be used based on the setting. All MISSION clients have a COD and the model was developed specifically to treat the unique needs of individuals with a COD. More in-depth information on the MISSION model as well as treatment manuals and participant workbooks can be found at www.missionmodel.org.

Delivery of MISSION Services

The MISSION team works together to implement MISSION services, including Critical Time Intervention (CTI), Case Management, Dual Recovery Therapy (DRT), Peer Support, linkages in the community, assistance with employment/educational needs, and referrals for the treatment of trauma-related symptoms as needed.

Team Members

The MISSION clinical team consists of a primary care coordinator (PCC), peer support specialist (PSS), and case manager (CM). The heart of the intervention is the support provided by CM/PSS treatment teams, who work together to help clients make the critical transition from homelessness to community living and are supervised by the MISSION clinical supervisor (CS). The PCC works with the CM/PSS team to integrate primary care services into the client's treatment. For an in depth review of key responsibilities of the PSS, CM, and CS, please refer to the MISSION Treatment Manual at www.missionmodel.org.

Team Structure

Each MISSION team consists of a CM, PSS, PCC, and clinical supervisor (CS). A full-time CM and full-time PSS typically work together covering a caseload of 15-20 clients. Each CS and PCC are responsible for working with approximately 22-30 clients at a time, which also means working with more than one CM and PSS. Given that the PCC role involves more care coordination, and less outreach and direct care, they are likely to be able to have a slightly larger caseload than a PSS or CM. This may vary, depending on the client needs and care environment (e.g., if clients are in a medical home, they may have less intense needs from the PCC).

Peer Support Specialist (PSS)

The PSS role is staffed by persons who themselves have experienced behavioral health issues and substance use disorder, homelessness, and who have achieved and maintained successful recovery

in these areas. MISSION PSSs share wellness and relapse prevention strategies, and provide practical supports to improve socialization and community life skills and help empower clients to self-determine their own recovery goals. MISSION PSSs facilitate weekly peer support group sessions. These sessions present opportunities for rapport-building, discussions of clients' upcoming transitions, and assessments of anticipated practical supports, while introducing and emphasizing self-care and socialization skills. PSSs meet with the client, often in the client's place of residence, ensuring that the client is utilizing the appropriate supports including community behavioral health and substance use treatment programs, 12-step meetings, and vocational/educational rehabilitation services. If the client is not using these supports, MISSION PSSs facilitate the process by accompanying clients to 12-step meetings or providing transportation to their appointments (e.g., a routine doctor's appointment). In addition, during regular "check-in" sessions with clients (i.e., weekly clinical team supervision), PSSs review and reinforce the work clients have completed on the Self-Guided Exercises contained in the MISSION Participant Workbook.

Case Manger (CM)

The MISSION CM is generally staffed by a clinical social worker (LICSW or LCSW) who ensures that supports are in place for the client to access treatment for substance use disorders and behavioral health issues, including appropriate referrals for the treatment of trauma-related symptoms; sustain safe and stable housing; and secure employment and education. The case managers provide direct services and linkages to their clients, assess their needs, monitor their progress, and help resolve barriers that arise in achieving their personal goals. Case managers are responsible for: conducting assertive outreach to engage clients; collaborating with other care providers and the client to develop a treatment plan; delivering Dual Recovery Therapy (DRT) sessions to help clients understand and manage their substance use and behavioral health problems; providing the client with rapid re-housing support; and helping the client secure and maintain employment, education, or trauma-specific treatment when needed.

Primary Care Coordinator (PCC)

The MISSION PCC ensures that supports are in place for the client to access treatment for medical, behavioral health, and substance use disorders; receive preventive healthcare and screening (i.e., colon cancer screening, dental care); collaborate with outside providers; identify unmet medical needs; provide client education; and establish a consistent relationship with a primary care provider (PCP) in the community. If the PCC is a medical professional, such as a nurse, they may also provide brief medical assessment and intervention as needed – pre-linkage to a health care provider. The PCC serves as a bridge between the client, MISSION team, and healthcare system. The PCC will work with medical providers, behavioral health providers, and MISSION supervisors to both integrate behavioral health and medical needs, and provide overall coordination of the client's care. The PCC will engage in assertive outreach as needed to ensure clients are connecting with medical care. Additionally, for specialized and/or complex medical care or care for CODs, the PCC may accompany the client to appointments.

Clinical Supervisor (CS)

Given the complex needs of the MISSION client population, the CS would meet weekly with the PCC, reviewing the client registry, identifying unmet medical needs, and assisting in coordination of care between systems and providers. As needed, the CS may participate in case conferences and consultation with the rest of the MISSION team, to close gaps in care and assist with complex cases. As with the PCC, the optimal supervisor would be experienced and have a wealth of knowledge of public health or community services. The role of this supervisor is to provide further support to coordinating care for the clients.[34]

Responsibilities of the MISSION Case Manager (CM), Peer Support Specialist (PSS), and Primary Care Coordination (PCC)

It is important for the PCC to understand that he/she is working jointly with the PSS/CM team and the CS, and to be aware of the specific responsibilities of these co-workers (see Table 2). Briefly, the CM and PSS closely work together to help MISSION clients make the critical transition into stable housing and, hopefully, recovery by providing direct care services, support, and linkages. It should be noted that within a Housing First framework, recovery is strongly encouraged but not mandatory for housing. The MISSION approach requires CMs and PSSs to work together in teams, with one PSS and one CM assigned to each client. CMs and PSSs are seen as equal members of the team, each of whom contributes their unique backgrounds and experiences to assist clients enrolled in the MISSION program.

Table 2. Responsibilities of the MISSION Case Manager (CM), Peer Support Specialist (PSS), and Primary Care Coordinator (PCC)

Primary Responsibility of CM, with Input from the PSS and PCC	***Primary Responsibility of the PSS, with Input from the CM and PCC***	***Primary Responsibility of the PCC, with Input from the CM and PSS***
Comprehensive assessment and treatment planning	Help clients advocate for themselves with providers and ensure effective two-way communications	Comprehensive assessment and treatment planning
Documentation related to behavioral health, substance use, and criminogenic risk/needs	Deliver structured peer-led psychoeducational sessions designed to promote recovery	Documentation related to medical conditions and medications
Provide rapid re-housing support as needed (i.e., pre-housing interview, coordination with landlords/ housing authorities, secure housing entitlements)	Recreational planning and modeling healthy living using free or low-cost community resources	Conduct pre- and post-housing medical assessment (see Appendix B1, B2, and B3)
Orientation/introduction, mid-program progress check, transition to community, and	Linkage to community-based behavioral health and substance use recovery programs (e.g., NA/AA, church	Facilitate linkage to health care system/medical services
		Provide brief direct care (pending connection of client to needed services)

discharge plans Management of clinical crises Delivery of DRT psycho-educational and booster sessions at each visit Identify, monitor, and provide referrals for trauma-related symptoms Provide vocational/educational supports as needed Facilitate linkage to other clinical services (i.e., substance use treatment, behavioral health services) Communicate with clinical service providers Review and work through benefits and entitlements issues (i.e., Social Security Income and Social Security Disability Insurance) Engage in assertive outreach	groups, etc.) Prepare the client for interviews with landlords, assist the client with housing applications, help the client move in, arrange for needed household items Accompany clients to routine clinical appointments Accompany clients to job interviews, recreational activities, and self-help group meetings Increase motivation toward recovery goals Assist clients with interpreting MISSION Participant Workbook exercises and readings, discuss material, and reinforce insights Engage in assertive outreach	Serve as a trainer/coach to provide education to CM/PSSs and/or a client about CODs and medical issues Engage in assertive outreach Communicate with medical service providers Consult with supervisor to maximize client engagement in medical care and client health Connect to medical services in emergencies Consider/address intersection of housing and medical care (i.e., specific housing is far from the client's PCMH) Collaborate with medical consultant Communicate with medical providers Work with CM to refer to MAT, and collaborate with MAT programs Accompany clients to non-routine clinical appointments (i.e., specialists, procedures, when clinical status has changed)

Primary Care Coordinator Role in MISSION

The following section will provide further detail regarding the role of the PCC. For a similar level of comprehensive description of other team member roles in MISSION, please see the MISSION manual at www.missionmodel.org.

Primary Care Coordinator Role

The primary care coordinator (PCC) is a new and unique role in MISSION requiring a unique set of skills. Briefly, the MISSION PCC heavily utilizes client outreach as an engagement tool to focus on relationship-building with the client and his/her care team; develop personalized treatment plans with the care team and the client; and integrate primary care, behavioral health, substance use, and housing needs. The PCC is proactive in coordinating dialogue and care across multiple organizations as they relate to the client's medical needs, including: supportive housing services, behavioral health, substance use, primary care providers, specialists, insurers, and home health care providers.

Collaboration

Case Manager (CM) and Primary Care Coordinator (PCC) Collaboration

The CM will communicate with the PSS and PCC regarding the client's behavioral health and substance use treatment needs and progress. As mentioned above, the CM will assist in referring the client to treatment for CODs. The PCC and CM will collaborate on treatment planning, with the PCC having direct input on planning regarding medical care and medical conditions. See Appendix F for an overview of communication tools for tracking medications, appointments, providers, and for clients on MAT (medication-assisted treatment).[35]

Case managers will work along with the primary care coordinators to integrate primary care considerations into treatment planning and activities as they relate to the client's presenting substance use and/or behavioral health concerns. With regard to connecting the client with medical care, the PCC will take the lead. However, the CM will still take into account the client's overall health, including medical problems, when working with the client. For example, in a DRT group session focused on Life Problem Areas Affected by the Individual's Co-occurring Disorder, the MISSION case manager and clients review problems the clients have experienced in a number of major life domains, including the health domain, and examine the degree to which these problems have affected their lives. This discussion facilitates the development of a personal recovery plan, which integrates physical health goals. CMs may monitor these goals and provide linkages to facilitate the attainment of these goals throughout as they relate to the client's COD, while the PCC will have a greater focus on these goals as they relate to the client's physical health.

Peer Support Specialist (PSS) and Primary Care Coordinator (PCC) Collaboration

The PSS will facilitate connecting the client's with routine medical, behavioral health, and substance use treatment appointments, including facilitating attending appointments, attending routine appointments along with clients, helping clients track appointments, emergency room visits, and

communicate with the CM and PCC about the client's medical needs. Routine visits include an annual physical, dental cleanings, an annual eye exam, and behavioral health follow-up visits. The PSS will work with the PCC to determine which visits are routine, and which are more specialized and should involve the PCC. The PSS will also work with the PCC to communicate client needs and the client's condition to providers at routine visits (See Appendix F for an overview of tools to facilitate communication with providers).

Supervision and Primary Care Coordinator (PCC)

The PCC will seek guidance from the clinical supervisor (CS) for MISSION matters, and reach out to providers directly if medical guidance is needed.

Goals

These efforts are focused on improving medical care; understanding the impact of medical problems and care on COD recovery and housing; and focusing on strengthening existing primary care relationships, rather than replacing them. Although there is some overlap with the PSS and CM activities/areas, the PCC focuses on all of these overlapping activities/areas (e.g., housing) with a specific focus on primary care and medical issues. The PCC is responsible for working with the client to develop a primary care coordination treatment plan, while the CM works with the client to create the basis of the MISSION treatment plan. Altogether, these plans are integrated to form the client's overall MISSION treatment plan.

Professional Background

The PCC is a professional who is trained and has experience in homeless health care, public health, interdisciplinary care teams, addictions certification, behavioral health, assertive outreach, motivational interviewing, and/or trauma-informed care. Professionals in this role include: nurses, health educators, case managers, social workers, and other individuals with appropriate training and skills. In the MISSION primary care integration pilot, a nurse was selected for the primary care coordinator role (see Appendix C for more information). All PCCs must have an understanding of the following key issues (see Figure 2).

Patient Population	**Physical Health** • Chronic and acute illnesses related to homelessness • Harm reduction techniques in disease management
	Mental Health • Impact on medical care and community re-integration • Cognitive impairment and traumatic brain injury (TBI) • Trauma-informed care and motivational interviewing
	Substance Use • Regional variation in substance use patterns • Medical consequences of intoxication, withdrawal, and chronic substance use • Treatment options, including Medication-assisted Treatment (MAT) and harm reduction
Local Context	**Different Shelters, Different Rules** • Access to health care varies • Logistics of medication storage, administration, and medical appointment adherence • Medical tools and equipment (e.g., Visiting Nurse Association, multi-dose medication vials, syringes, oxygen tanks, etc.)
	Housing and Barriers to Care • Transportation barriers - convenience versus long-term relationships with previous providers • Destabilizing impact of drugs or crime in housing neighborhoods • Isolation in housing may be dangerous for patients with chronic medical conditions

Figure 2. PCC needed areas of knowledge.

Additional Training

The PCC will receive the same background training on MISSION as the PSS and CM. All MISSION CMs and PSSs receive a general orientation on confidentiality, documentation, reporting, and crisis management policies and procedures. They are also trained in the theory and application of all service components in the MISSION program (i.e., CTI, DRT, Peer Support, Rapid Re-Housing, Vocational/ Educational Supports, and Trauma-Informed Care considerations), the respective roles of all staff in the delivery of these key components, and how the MISSION team functions as a whole to support clients. Depending on the PCC background, the PCC may also wish to pursue training in case management, such as the training in Integrated Case Management provided by the Case Management Society of America (cmsa.org).

Overview of the MISSION Primary Care Coordinator (PCC) Responsibilities

The PCC will work alongside the MISSION team. The traditional MISSION team consists of a case manager (CM) and a peer support specialist (PSS), who together are responsible for delivery of the MISSION service components to program clients. There is also a MISSION clinical supervisor (CS), who oversees and supports the work of the CM/PSS team. Table 3 provides an overview of the MISSION PCC's responsibilities per CTI phase.

Table 3. Overview of the MISSION Primary Care Coordinator's Responsibilities

CTI Phase 1: Transition to Community

The PCC will:

- Meet with the CM/PSS to receive preliminary information about the client
- Meet with new clients in a group to educate them about PCC role, resources and supports, including: medications, primary care, preventative care, dental care, behavioral health care, substance use treatment, specialty referrals, insurance and other benefits, coordinating care between providers and systems
- Meet with the client and his/her CM/PSS team to discuss MISSION services and provide a MISSION welcome/orientation
- Meet with the client individually to complete an initial pre-housing medical assessment (see Appendix B1 and B2 for a pre-housing assessment) and assess health literacy
- Meet with the CM/PSS to collaborate on the treatment plan (i.e., integrating medical and COD goals)
- If the PCC is a medical professional, he/she can provide "direct service" such as medication reconciliation, health and medication education, management, teaching and monitoring, physical exams, vital sign monitoring, or blood sugar checks, as needed until client is linked to primary care services
- Provide linkages, such as referrals to visiting nurses, home health services, wellness and preventive health programs, linkage to substance use treatment (including MAT options, etc.), behavioral health care, and dental care
- Obtain releases of information for communication between the MISSION team and healthcare providers
- Ensure the client is enrolled in appropriate insurance or other mechanisms for payment for healthcare
- Track client's progress in engagement and use of medical community resources and supports via informal check-in with the client, PSS/CM team, outside providers, and/or medical record (if possible)
- Attend clinical case conferences as well as weekly team meetings to facilitate collaboration
- Engage in assertive outreach activities as needed to facilitate engagement and collaboration

CTI Phase 2: Try Out

The PCC will:

- Continue to facilitate linkages that have already been established either by: 1.) Coaching the PSS/CM on "how to" accompany clients to medical appointments (e.g., questions to ask, how to talk with a PCP), for basic, routine, or preventative care (e.g., physical exam, dental cleaning, mammogram); 2.) Utilizing "Update" form or other means to communicate the client's needs from the MISSION team to providers (see Integrated Care in MISSION Toolkit); 3.) engaging clients regarding co-occurrence of medical and COD issues; 4.) accompanying the client to medical appointments; 5.) and/or by working with the client to attend sessions on their own (i.e., utilize motivational enhancement techniques to discuss and address barriers with the client, provide clients some tips on what to ask)
- Facilitate new service linkages for specialty medical, behavioral health, or substance use care (if needed)
- Identify and precipitate potential gaps in support systems, barriers in accessing services, or areas where the client needs more support (e.g., housing is far from PCP or PCMH)
- Track the client's progress in use of medical community resources and supports via informal check-ins with clients, PSS/CM team, and/or via medical record (if possible)
- Assist clients in maintaining logs of appointments, procedures, and medications, with the PSS/CM team
- Attend clinical case conferences as well as weekly team meetings to facilitate collaboration
- Engage in assertive outreach activities as needed to facilitate engagement and collaboration
- If client is housed in CTI Phase 2, complete post-housing assessment (see Appendix B3)

CTI Phase 3: Transfer of Care

The PCC will:

- Complete post-housing assessment, if it was not completed in previous stage (see Appendix B3)
- Provide consultation to the CM as they fine-tune connections with community-based medical resources and supports
- Provide consultation to the CM as they meet with community medical providers to review transfer of care and identify any gaps in service
- Develop collaborative discharge plan with CM/PSS and integrate medical goals, primary and specialty care recommendations, and plan
- Note: the length of time that the PCC provides services to the client varies

MISSION and Integrated Care

MISSION and integrated care share common foundations, and the addition of the PCC enhances integration of primary care and behavioral health care for clients. Table 4 illustrates how each principle of integrated care is implemented in the MISSION model.[36]

Table 4. Principles of Integrated Care

Principle	Definition	Demonstrated in the MISSION Model
Client-centered team care	Providers collaborate to form shared care plans	MISSION treatment plans are formed collaboratively
Population-based care	Sharing a defined group of clients Tracking clients in a registry	MISSION clients as defined population, tracked in a registry
Measurement-based treatment to target	Routine measurement of goals and clinical outcomes	Measurement of goals set by treatment plan
Evidence-based care	Clients offered treatments for which there is credible evidence to support their efficacy	MISSION is in the SAMHA National Registry of Evidence-based Programs and Practices (NREPP) [37]
Accountable care	Providers are accountable and reimbursed for quality care	MISSION has further literature on accountable care, funding and sustainability [38]

Tools to Support Integration

A variety of approaches are needed to facilitate integration between medical, behavioral health, and MISSION interventions. As part of population-based care, reviewing a client registry, and rounding on each client regularly (i.e., once a week as a clinical team) is essential, facilitated by CMs, including members from each part of the team. Additionally, using tools such as medication logs, appointment logs, and a provider update forms will strengthen the linkages between the client, MISSION team, and medical providers. These tools allow the PCC to work as an extension of the PCP, psychiatrist, therapist, specialist, or other provider, supporting the client in following recommendations and providing collateral information to providers. The PCC, CM, PSS, and CS will meet together regularly to review the registry and tools mentions above (see Appendix F) ensuring all clients are receiving the care they need and progressing appropriately. Weekly clinical review/staff meetings provide an opportunity for caseload review.

The PCC, along with MISSION team members, will work together to bring the client's medical needs to the forefront.

The Patient-Centered Medical Home (PCMH) as a Model of Integration

The Patient-Centered Medical Home (PCMH) model is one of the most well-known and researched models of integrated care (described in Appendix D). A significant number of MISSION clients may receive their health services from PCMHs and therefore it is important for MISSION staff to understand the structure and services of PCMHs. For example, in a PCMH, such as the Boston Health Care for the Homeless Program (BHCHP), physicians, physician assistants, nurse practitioners, nurses, case managers, and behavioral health professionals work in close collaboration to integrate care. BHCHP providers follow clients in a variety of settings - on the streets, in shelter-based clinics, in hospitals, and in housing - providing regular contact and uninterrupted care (see Figure 3). The PCC will be the primary liaison between PCMH and the MISSION team.

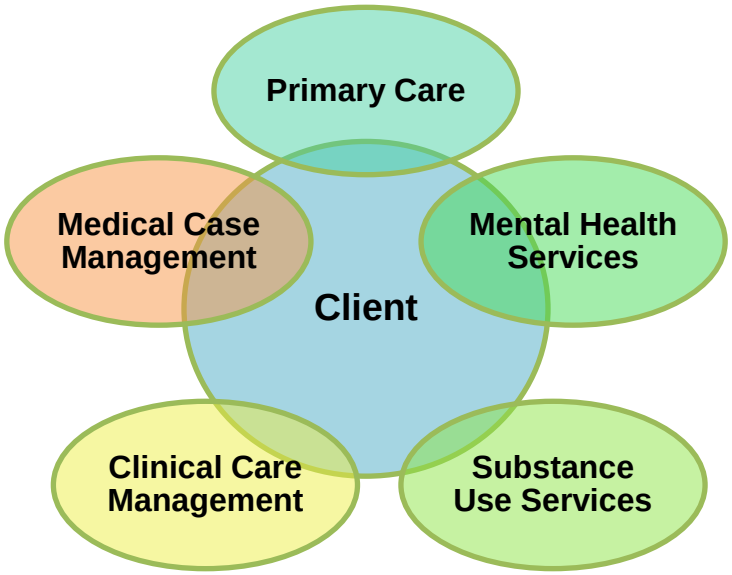

Figure 3. The Patient-Centered Medical Home (PCMH) model at Boston Health Care for the Homeless Program (BHCHP)

In addition, like most PCMHs, BHCHP provides integration and colocation of behavioral health, substance use treatment, and primary care to reduce overall costs and improve clients' outcomes through improved coordination of care.

As the movement towards integrated care systems grows, there is high likelihood that clients, particularly clients experiencing homelessness, may be participating in a PCMH. Currently, more than 15 percent of U.S. primary care practices, approaching 11,300 altogether, are recognized as PCMHs by the National Committee for Quality Assurance (NCQA). This number grows every day. In addition, the Departments of Defense and Health and Human Services is pushing to transform their primary care facilities into PCMHs. Dozens of states are developing PCMHs as part of their Medicaid programs, and the number of PCMHs continues to grow at a quick pace. Currently PCMHs serve 21 million patients and many individuals experiencing homelessness receive their care from PCMHs.[39]

It is important to note that although PCMHs streamline care, they may present some advantages and challenges for MISSION staff. First, there may be communication and coordination challenges to MISSION staff due to increased likelihood of fragmentation/duplication of services because PCMHs also integrate both substance use treatment and behavioral healthcare into clients' care. Second, a significant advantage is that clients are receiving all this care, including substance use and behavioral health treatment, in one location, but then this also leaves the question-"How are MISSION services different/distinct from what is already happening in a PCMH?"

Guide for MISSION Staff Collaboration with the Healthcare System

Introduction

Although the number of PCMHs is rapidly growing and many MISSION clients receive their health services from a PCMH, many MISSION clients continue to receive care from a multitude of direct providers. The remainder of this module will provide practical suggestions for how MISSION staff coordinate care for clients effectively, whether or not they are connected with a PCMH.

Working Effectively as a MISSION Treatment Team

The primary care coordinator works closely with the CM and PSS team to help MISSION clients make the successful transition and adjustment to independent community living. Research supports that care coordination can be a big part of this success.[9,10] To work effectively as a team, the four pillars below must align (see Figure 4).

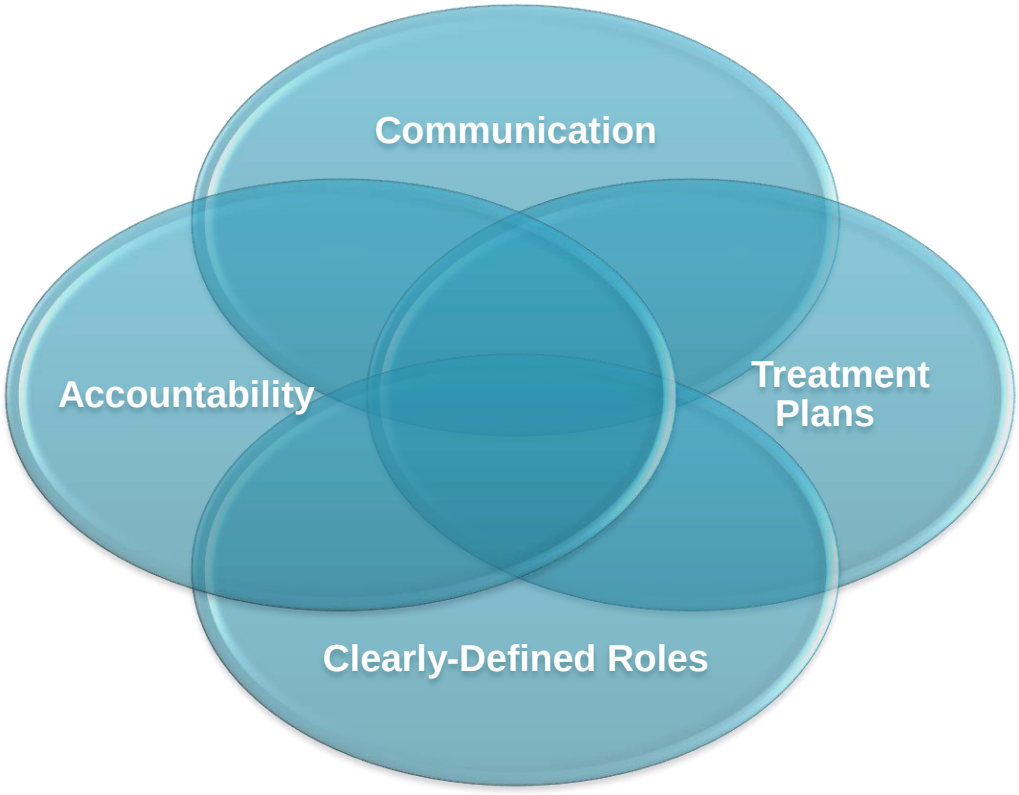

Figure 4. Four Pillars of Working Effectively as a Team.

Four Pillars of Working Effectively as a Team

1. Communication

Communication within MISSION teams is critical. MISSION team members should consistently share information with one another about the contact they have with each MISSION client. This

communication helps MISSION team members support each other's work and track evolving issues that may require special intervention.

An Example of Communication in Action

A MISSION client is noted by the PSS to have low energy, ongoing alcohol use, and poor adherence to insulin for diabetes. The PSS communicates this to the MISSION team. The PSS and CM consider getting the client a visiting nurse to help with insulin administration and medication education. However, the PCC is aware that visiting nurses are not allowed in the shelter where the client is housed. The PCC is also aware that drinking alcohol can cause a dangerous low blood sugar and it will be very important to consider this in the client's COD treatment as well. The PCC then works with the CM/PSS team to coordinate a collaborative intervention integrating a PSS-led session on medication management, a booster DRT session focused on life problems areas, and a PCC outreach appointment integrating motivational interviewing techniques to address medication compliance.

Communication among team members is central to the functioning of the team and improving client care. Clients should be informed at the outset of their participation in the program that clinically relevant information is shared among team members in order to most effectively serve them. The framework in figure 5 is suggested to guide communication and collaboration amongst team members.

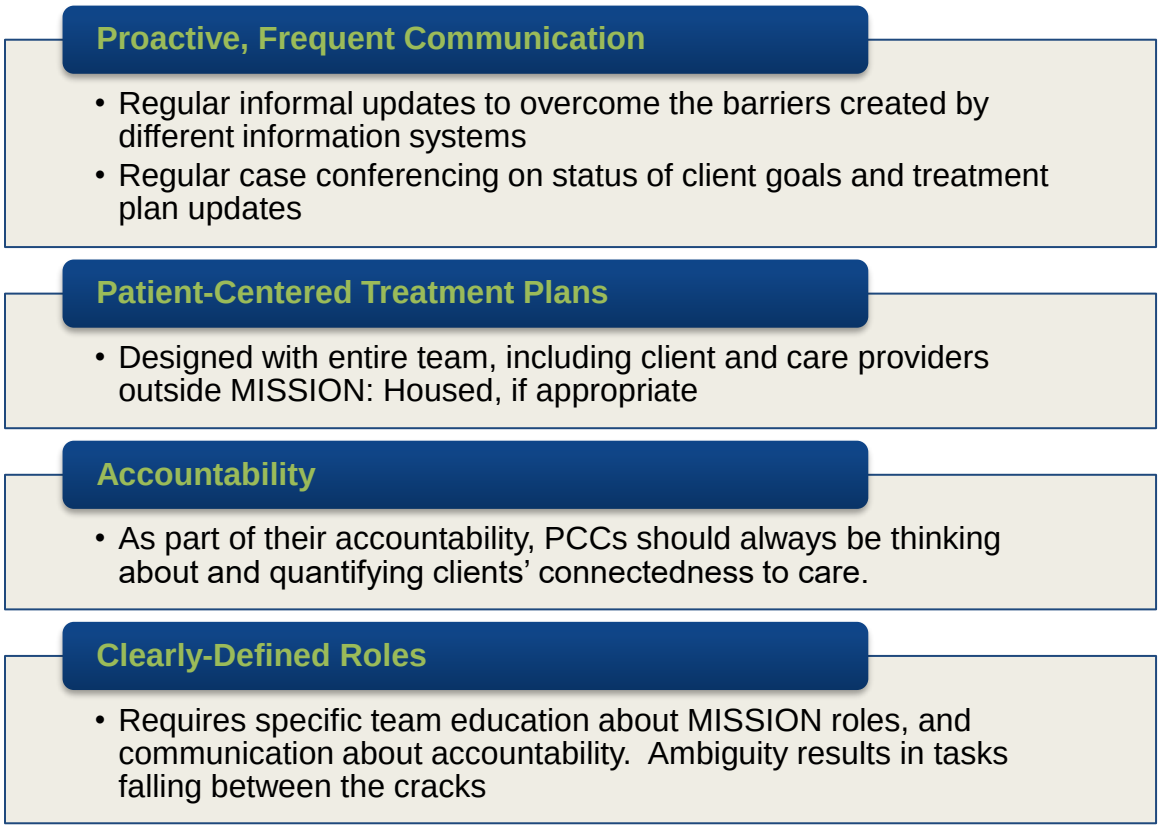

Figure 5. Structuring Communication and Collaboration amongst Team Members.

There are two key communication challenges that may arise for the PCC. The first pertains to medical information sharing between the PCC and CM/PSS team. The nature of MISSION relates to sensitive areas, such as trauma, substance use, and sexual transmitted infections. Clients will be educated about the need of the team to share essential information to best care for the client, as well as using the appropriate releases to document permission to share information. MISSION staff should use discretion in sharing information amongst each other and outside providers. This challenge is not unique to MISSION, as healthcare today frequently requires information sharing among multiple entities, with clients experiencing similar concerns. Additionally, the MISSION team will educate clients about scenarios which require mandated reporting, such as behaviors presenting substantial risk or harm to self or others.

Mutual access to clinical documentation and records is another potential communication challenge. For example, in the MISSION pilot, the PCC was sited within one agency, a PCMH, and the CM/PSS were sited at two different agencies; therefore they all did not have shared access to clinical progress notes and treatment plans to facilitate communication. This required concerted efforts to maintain frequent and consistent communication to collaborate and coordinate care.

Guidelines for Communication

Depending on the issues to be addressed and the preferences of each client, MISSION CMs, PSSs, and PCCs may meet with the client together or separately. By working together and communicating consistently, MISSION team members can effectively coordinate care and deliver services. The following are suggested guidelines for team communication with the client throughout his/her participation in MISSION:

- At least one meeting including the MISSION CM, PSS, PCC, and the client in CTI Phase 1 to clarify roles and discuss a collaborative treatment plan and again in CTI Phase 3 to discuss discharge planning. Throughout MISSION treatment the CM, PSS, PCC, and the client will meet as needed.
- When the CM, PCC, and PSS meet with the client separately, they review this together afterwards and discuss their observations, concerns, and treatment plan regarding the client during the weekly clinical supervision meeting as a team.
- Weekly clinical coordination/staff meetings, led by the MISSION clinical supervisor (CS), can provide another opportunity for the CM, PCC, and PSS to share their perspectives and benefit from clinical consultation.
- In terms of clinical supervision, it is suggested that at a minimum, the PCC should attend a once a month case conference with the CM, PSS, and CS. At the case conference the PCC, CM, PSS team should collaboratively present cases and discuss treatment planning and efforts to coordinate care. At maximum, the PCC should attend a monthly case conference and weekly staff meetings.
- In addition, if the PCC is a medical professional, such as an LPN, providing brief medical assessment/intervention, it is suggested that the PCC have access to some level of supervision by a supervisory medical professional, such as a RN, to discuss medical concerns and treatment planning.

2. Treatment Plans

With integration of care, comes the critical need to develop integrated service plans. SAMHSA notes that one of integrated care's core competencies—care planning and coordination—involves creating and implementing integrated treatment plans to ensure access to an array of services and easy information exchange among consumers, family members, and providers.[40] The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) has done extensive work in this area. Currently, there is no perfect model or template for integrated treatment plans. However SAMHSA has developed some key considerations for a blueprint for integrated care providers in creating and maintaining integrated treatment plans. To access this blueprint, go to the SAMHSA website (http://www.integration.samhsa.gov/about-us/esolutions-newsletter/esolutions_september_2015).

In CTI Phase 1, the PCC, CM, and PSS should collaboratively develop an individualized integrated treatment plan for each client. The PCC, CM, and PSS should meet with the client to review and sign the plan. A copy of the plan should be kept in the client's chart. The plan should be collaboratively updated every 3 months. The CS should use the treatment plan to guide client discussions in weekly staff meetings and monthly case conference meetings.

3. Accountability

Integrated care is provided by a team of professionals who must work together to deliver the necessary services. For the team to function effectively there must be clarity about who is responsible for what. All care providers need to understand what they are accountable for, develop, and then agree to follow protocols for how care will be delivered, and communicate regularly with other team members. The PCC is ultimately accountable for engaging and connecting clients with the healthcare system and coordinating their care with MISSION services. As part of their accountability, PCCs should always be thinking about and quantifying clients' connectedness to care.

Ways to Quantify Connection to Care

The primary care coordinator fidelity logs serve as a record of team activities related to each client. Data from these logs (e.g., appointment attendance, emergency room visits), can be used to evaluate how connected a client is to primary care, and whether that connection is reflected in a decrease in emergency room visits. Additionally, lack of appointments and/or missed appointments may be an indicator that a client is not adequately connected to care and may need assertive outreach.

4. Sustainability

As the accountable care organization (ACO) model becomes more widespread, access to case management will broaden. However, these supports will likely not meet the intense needs of the population MISSION serves. A possible solution would be to embed MISSION teams within ACOs. The shared principles of integrated care and MISSION will continue to apply in the care of this client population. In this dynamic time in healthcare, the MISSION team has a continued focus on sustainability, which is detailed further in these materials.[38]

Case Studies

The following case studies illustrate the role of the PCC in MISSION. The first two case studies are based on clients seen during the MISSION primary care pilot (see Appendix A for details on the pilot), the third case study is an example of how a case manager (non-RN) may serve the role of PCC. The case studies will highlight the 4 pillars of successful team collaboration and the medical focus of the PCC's work versus the focus of the CM's and PSS' work. Additionally, they will emphasize the differences in the roles of MISSION team members, depending on whether the client is part of a PCMH.

Case Study: #1 – RN as PCC, Client Without PCMH Services

Client Background: The client is a 59-year-old, male MISSION client who is currently experiencing homelessness, with a remote history of receiving medical services from a PCMH. At the time of enrollment with MISSION, the client was staying at a shelter, and receiving primary care and behavioral health care from a team within a medical group, not a PCMH. The client had several years of sobriety on Suboxone therapy prescribed by an external Office Based Opioid Treatment (OBOT) clinic, not affiliated with the client's primary care or behavioral health care providers. The client intermittently self-medicated his anxiety with Klonopin purchased on the street. At discharge, the client was successfully housed and demonstrated improved management of medical problems, and reduced mental health and substance use disorder symptoms.

Brief description of selected PCC interventions: On initial PCC medical intake, the client expressed concern regarding an abdominal hernia with several failed surgical repairs. The PCC contacted the client's PCP to discuss the client's referral to a specialty surgical team at an outside hospital. The severity of the client's hernia and risks associated with surgical repair limited the number of surgeons in the city capable of performing the procedure. The PCC worked with the MISSION CM to update MassHealth information to allow the surgical referral, and the MISSION team accompanied the client to the social security office. With the client's consent and in accordance with HIPAA regulations, the PCC provided updates weekly to the PCP at the medical group via email.

The PCC accompanied the client to several surgical appointments, attempting to help the client navigate his anxiety with medical professionals. On multiple occasions the client decided that he would not pursue further treatment because of his belief that he was treated poorly by staff at medical facilities who he believed were not trained to deliver care to individuals experiencing homelessness. The PCC attempted to mitigate tension between the client and surgical staff while accompanying him to these appointments. The PCC also utilized motivational interviewing techniques, such as decisional balance, to review both the pros and cons of pursuing further treatment as a way to support the client in making an informed decision.

In addition, the client was informed by the surgeons that surgery could only occur if he quit smoking and lost weight. The MISSION CM and PSS worked with the PCC to create a calendar for exercise and smoking cessation goals, and worked closely with the client to pursue these goals. As the client's discharge date from MISSION approached, the PCC provided the PCP at the medical group a

transition and discharge summary and plan to facilitate continued work on medical goals and treatment.

DRT sessions with the CM addressed anxiety symptoms and taught positive coping mechanisms to counter his self-medication. Additionally, the CM was in contact with the external OBOT clinic to give and receive updates on his Suboxone therapy and coordinate care. The PSS provided support by delivering the PSS session focused on medication, providing suggestions from his own personal recovery story to help the client manage his anxiety, and transporting and accompanying the client to appointments as needed. In efforts to coordinate care the CM, PSS, and PCC would have periodic formal and informal check-ins. Figure 6 illustrates the relationships between the MISSION CM/PSS team, the PCC, and the client's outside providers exemplified in this case study.

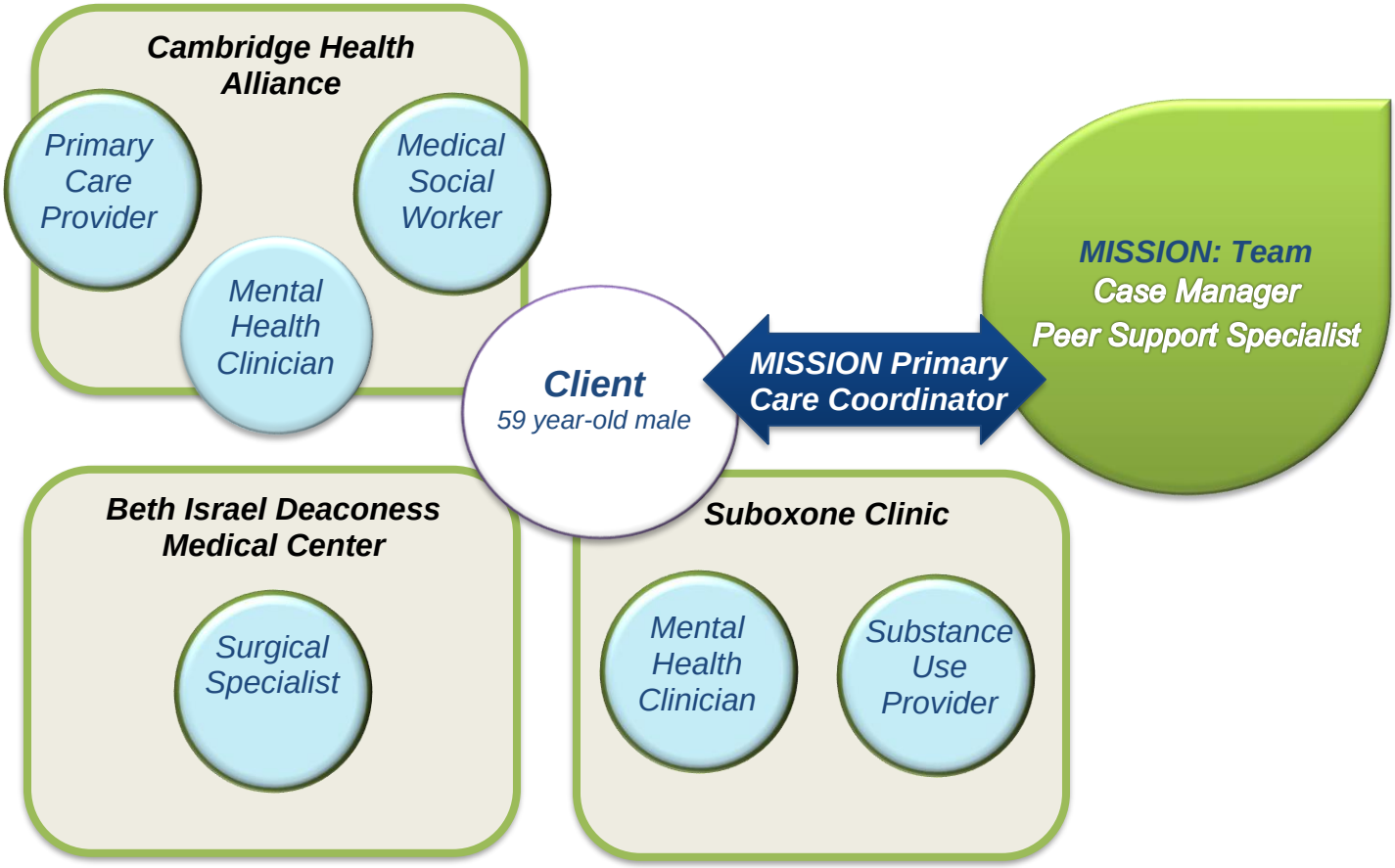

Figure 6. The Primary Care Coordinator in MISSION: Clients not receiving care from a PCMH

Case Study #2: RN as PCC, Client with PCMH Services

Client Background: The client is a 66-year-old, Veteran male MISSION client currently experiencing homelessness, who was diagnosed with alcohol use disorder, chronic lymphocytic leukemia, cardiac disease, diabetes, and is showing early onset symptoms of dementia. The client was known to the PCMH (where the RN was "sited") for almost twenty years. Although "known" he was very difficult to

engage in care due to dementia symptoms and suspicion of medical personnel. Many years ago, the client had developed a trusting relationship with a PCP at the PCMH, but when the PCP left the organization 5 years earlier, the client was lost to PCMH follow-up.

Brief description of selected PCC interventions: The MISSION CM, PSS, and PCC worked closely to develop a plan for engaging the client in care that may lead to a safe housing opportunity. Since the PSS already had a trusting relationship with the client from the shelter, the PCC started to accompany the PSS on shelter visits once a week until the PCC gained facial recognition and trust from the client. At that point, a new primary care provider and medical case manager from the PCMH started to accompany the PCC into the shelter to establish medical care with the client and start to build a relationship via assertive outreach. The PCC coordinated these efforts.

Because the client was a Veteran, the CM and PSS started to work with the VA to obtain indicated documents for housing. Over a 10-month time period, the PCC accompanied the client to follow-up appointments with hematology, podiatry, and psychiatry. The PCC also communicated weekly with clinic staff at the shelter to make sure the client was receiving medical care as needed. When acute medical issues arose, the client was admitted to the PCMH's medical respite unit. MISSION staff used this opportunity of sobriety, when the client was more lucid, to pursue further housing goals. VNA and other referrals were put in place by the PCC in anticipation of housing. Appropriate housing types were discussed in a case conference between the primary care team at the PCMH and the MISSION team.

Ten months into the client's enrollment in MISSION, he was hospitalized for a life-threatening infection. The PCMH acute care team began to pursue court-appointed guardianship for the client with the assistance of the MISSION CM and PSS team. By this time, the PCC no longer worked with MISSION, but continued to work at the PCMH allowing her to provide further collaboration towards safe client placement following hospitalization. Figure 7 illustrates the relationships between the MISSION CM/PSS team, the PCC, and the PCMH providers exemplified in this case study.

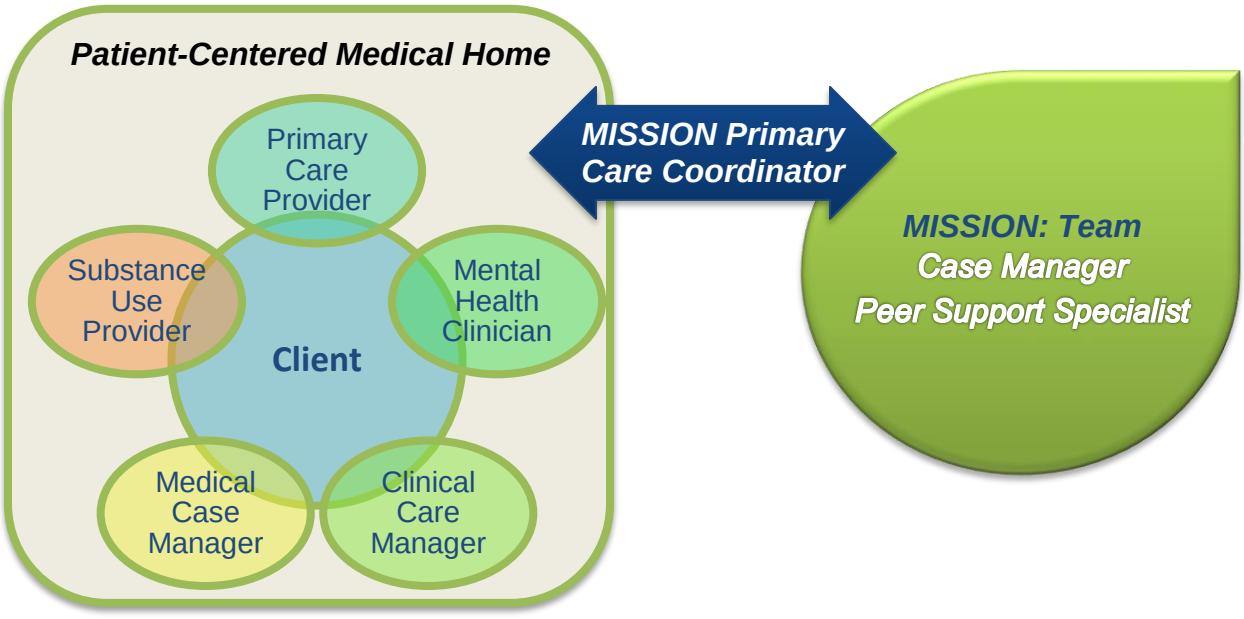

Figure 7. The Primary Care Coordinator in MISSION: Clients receiving care from a PCMH

Case Study #3: Non-RN as PCC, Client with PCMH Services

Client Background: The client is a 47-year-old, Vietnamese male refugee who is currently experiencing homelessness with a history of alcohol and opioid use disorders, depression, severe trauma, hepatitis C, cirrhosis complicated by variceal bleeding and hepatic encephalopathy, and osteoarthritis limiting ambulation. The client had also not engaged in regular medical care since his release from jail several years earlier.

Brief description of selected PCC interventions: The client had been living outside for nearly two years, and was not open to staying at the shelter due to untreated symptoms of trauma. Additionally, the client was primarily using emergency medical care, without treatment of his co-occurring disorders.

The PCC began by introducing the client to the medical team at the local PCMH. Through engagement at the PCMH, the PCC worked along with the PCP to connect the client with psychiatry, therapy, and later to mediation-assisted treatment for opioid use disorder with buprenorphine/naloxone. The PCC also engaged visiting nursing services on the client's behalf, to assist with medication administration, as the client's encephalopathy resulted in intermittent confusion, making medication adherence and attending appointments difficult. The PCC engaged the PSS to accompany the client to routine medical appointments, and support the client in attending other appointments, such as therapy, on his own.

The PCC and CM worked together to identify housing opportunities, which were further limited by the client having no income, a felony conviction, and not being a United States citizen. Through the client's affiliation with the PCMH, he was housed in a group setting with 24 hour staff for clients with co-occurring disorders, where his medical, behavioral health, and substance use significantly improved.

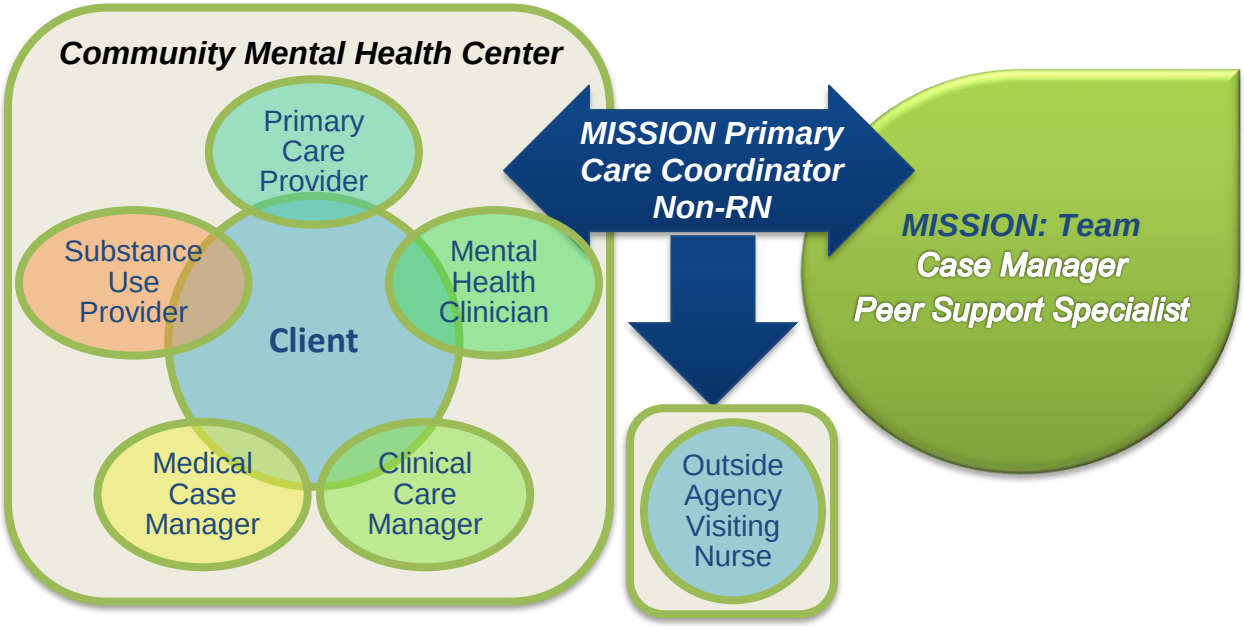

Figure 8. The Primary Care Coordinator in MISSION: Clients receiving care from a PCMH

Conclusions

Challenges

Role Confusion

The MISSION team is composed of individuals with skills, strengths and experience that often overlap. MISSION clients are often compelling, and team members may feel drawn toward assisting the client beyond their role. The MISSION team must continually work together with clients, providers, and each other to maintain their roles, with the support of their supervisors and available resources, such as this module and other MISSION materials.

Medication Adherence

Clients with multiple conditions, providers, pharmacies, and over-the-counter medications and supplements often have difficulty with medication adherence. Working with pharmacies and providers to obtain printed medication lists, using medication logs, pill planners, and visiting nurses (when appropriate) are all tools to improve adherence. Client education from PCCs, medical providers, and/or visiting nurses may increase adherence through the client's better understanding of the role of his/her medications.

Medication Interactions

Similar to the challenges of adherence, medication interactions are another challenge, particularly in the context of the fragmented healthcare system. The PCC will support the client and MISSION team in communicating with each provider the complete list of medications for each client. The PCC will work with the medical providers when needed to identify possible medication interactions and side effects.

Coordinating Between Providers and Systems

Trauma, shame, and other complex emotions may contribute to MISSION client's reluctance to allow for information sharing amongst medical providers and with MISSION team members, particularly regarding substance use or behavioral health treatment. Additionally, more restrictive privacy laws regarding care for substance use (e.g. 42, C.F.R. part 2) presents another challenge. Maximizing client autonomy and respect for client privacy is essential, while also educating clients that not allowing communication between providers may impede their care.

Conclusion

Integrated care is an important addition to the MISSION model. As national attention continues to focus on integration, it is important to develop innovative ways to integrate substance use, behavioral health, and primary care services in MISSION. The pilot served as an excellent opportunity to begin to test a model of behavioral health and primary care integration, specifically in a MISSION program for individuals experiencing homelessness with a COD. We hope to continue to build on this model. For additional integration resources, see Appendix E.

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Appendix A: *Primary Care Integration in MISSION Pilot Project*

MISSION Primary Care Coordination Pilot Project

Recognizing that primary care integration is a critical area of need in behavioral health services for individuals experiencing homelessness with CODs, funding from SAMHSA (SAMHSA # TI-025347 & 1H79SM062436) provided us the opportunity to pilot test the integration of the MISSION model with primary care. This project called MISSION: Housed (MH) is a project of the Massachusetts Department of Public Health Bureau of Substance Addictions Services (BSAS) in collaboration with the University of Massachusetts Medical School (UMMS), the Interagency Council on Housing and Homelessness (ICHH), the Interagency Council on Substance Abuse and Prevention (ICSAP), other state agencies, advocacy groups, and local housing and service providers, as well as Boston Health Care for the Homeless Program, the latter of which is an internationally known program and model for addressing the medical and behavioral health needs of the population experiencing homelessness. The MISSION: Housed project delivered MISSION wraparound services and assisted clients experiencing chronic homelessness with co-occurring substance use and mental health disorders (COD) with accessing housing from the cities of Boston, Cambridge and Somerville.

Like many programs that are addressing CODs and housing needs in a population experiencing homelessness, MISSION clients in this pilot project had a high level of need for primary care integration and coordination. During the development of the pilot project proposal, it was estimated that over two thirds of MISSION clients received their primary health care from providers at the Boston Health Care for the Homeless Program (BHCHP). BHCHP is a patient-centered medical home (PCMH), where physicians, physician assistants, nurse practitioners, nurses, case managers, and behavioral health professionals work in close collaboration to integrate care. BHCHP providers follow clients in a variety of settings - on the streets, in shelter-based clinics, in the hospitals, and in housing - providing regular contact and uninterrupted care.

Therefore the project added a 1.0 FTE registered nurse primary care coordinator to be sited at BHCHP to support integration of the work of the MISSION direct service staff and BHCHP's patient-centered medical home teams. The nurse provided direct care, care coordination, and supported integration between MISSION's direct service staff (i.e., case managers and peer support specialists) and primary care for the MISSION clients who received their primary health care at BHCHP. As the pilot project progressed, it became clear that there were also a significant number of clients who did not receive their care at BHCHP. Although, 83% of MISSION clients had received care from BHCHP at some point in their lives, only 35% of MISSION clients were receiving care (i.e., care ranged from ER services, OBOT, BH, shelter services, etc.) from BHCHP at the time of the pilot. Therefore, the nurse also provided direct care, care coordination, and supported integration between MISSION's direct services staff and primary care clients who were not being served by BHCHP.

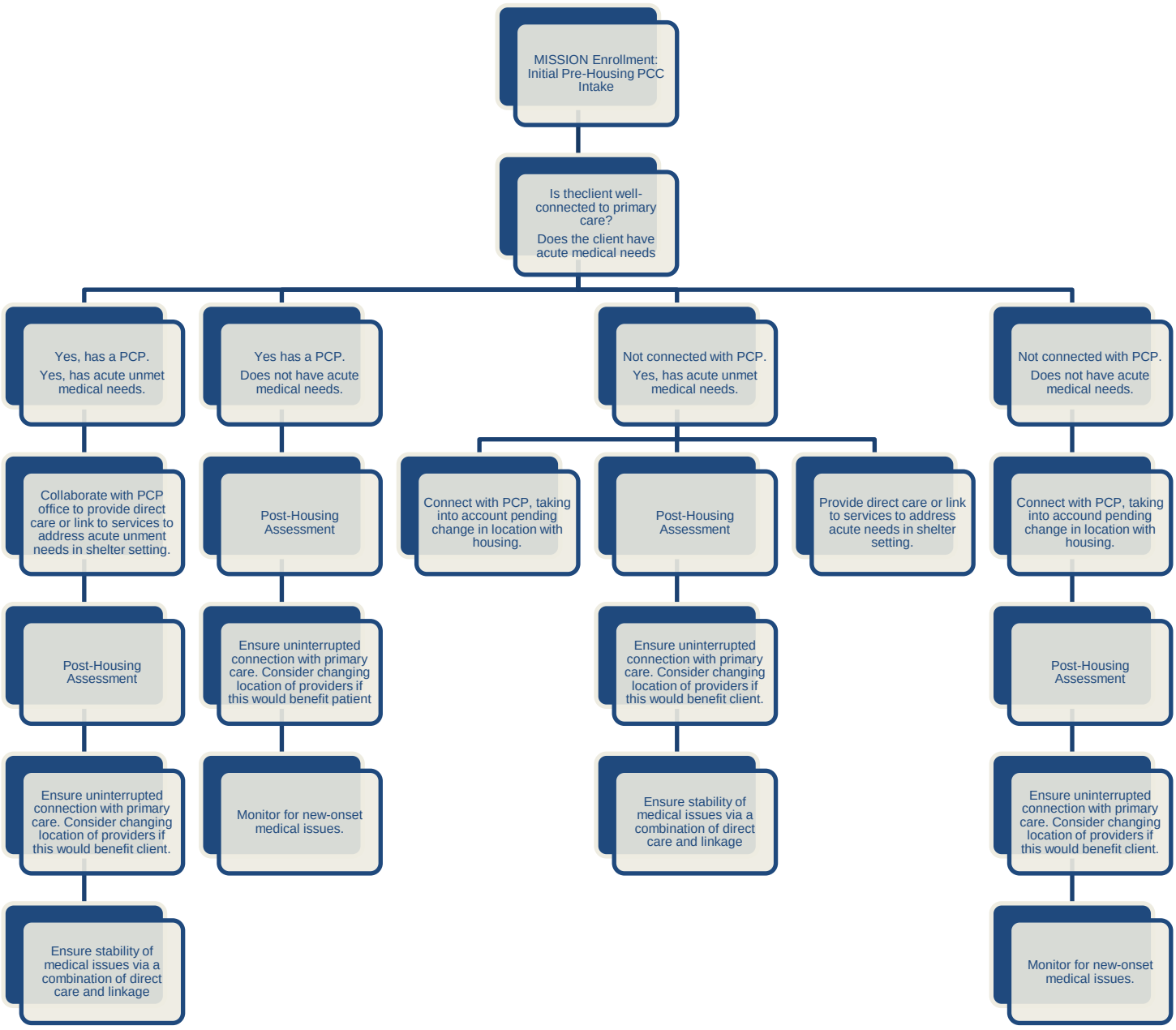
In the primary care integration pilot at MISSION: Housed a registered nurse was selected for the primary care coordinator role for several reasons. First, since the majority of MISSION clients received their primary health care from providers of the BHCHP, having a registered nurse primary care coordinator sited at BHCHP who was familiar with the system and had established relationships with the PCMH team, facilitated enhanced and accelerated implementation of the pilot. In addition, due to the complexity and acuity of the presenting comorbid substance use disorder, behavioral health, and medical conditions of clients, an RN was an invaluable addition to the MISSION team to facilitate quicker assessment and brief intervention because the nurse was able to provide these services on her own. From the pilot it is suggested that the medical services linkage role was well-suited for the RN scope of practice because the RN had established training and experience in working closely with primary care providers and was embedded in the homeless healthcare system. Last, due to the high prevalence of medical conditions and potential barriers to accessing care, the RN could also provide limited direct assessment and care of medical issues as needed. If a medical professional is selected for this role, he/she can provide direct medical care while the client is in a transition period between long-term care teams. However, the care coordination emphasis should be on linkage to services, which can successfully be done by a medical case manager, licensed social worker, or other trained health care professional.

MISSION clients, like many individuals experiencing homelessness with COD, experience a host of chronic and acute medical needs that impact COD's treatment and outcomes. Having a primary care coordinator to integrate the work of the MISSION direct service staff and primary care services was essential in addressing these needs. The RN primary care coordinator provided direct care, care coordination, and supported integration between MISSION's direct service staff and medical services for 60 clients.

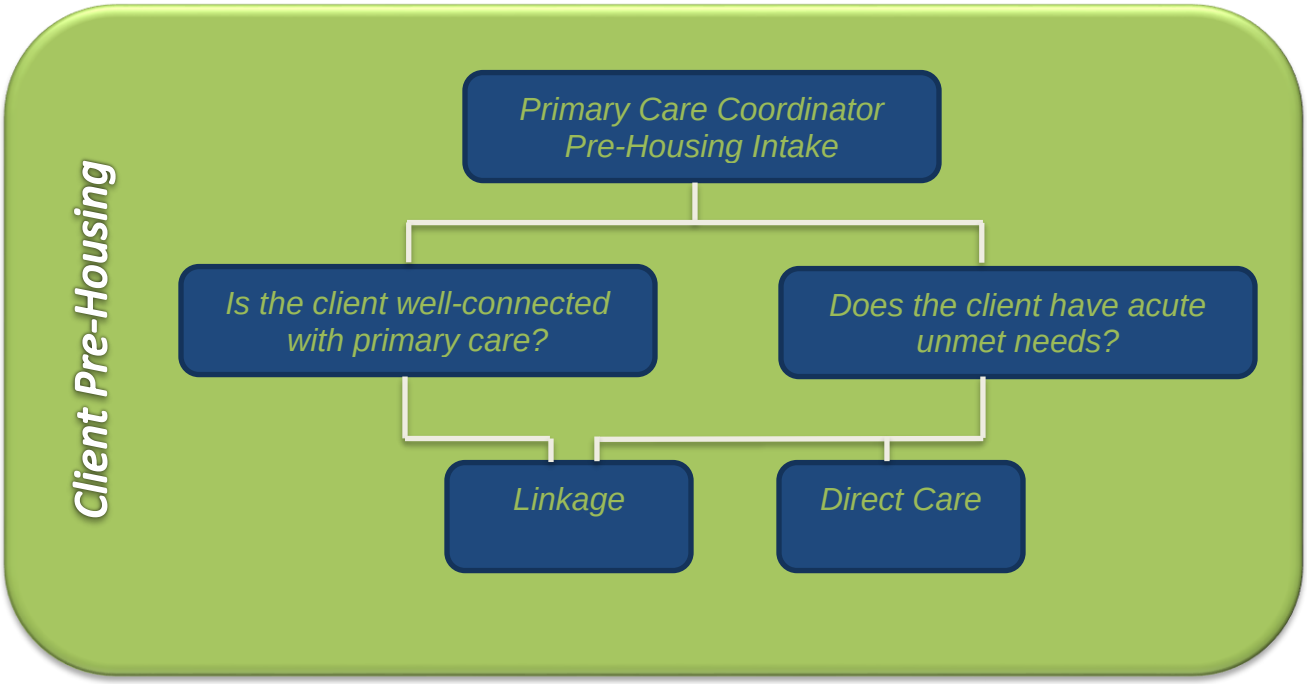
Based on the pre- and post-"housed" medical assessments conducted by the PCC, care coordination services ranged from medical case management, medication reconciliation, client medical education, assertive outreach, physical exams, vital sign monitoring or blood sugar checks (as needed until client was linked to primary care services), consultation with MISSION staff and primary care providers, provision of medical linkages (e.g., referrals to Visiting Nurse services, MAT options, etc.), to tracking of clients' progress in engagement and use of medical services and supports. All services were provided in a range of settings to effectively help clients, including shelters, MISSION: Housed office, medical settings (i.e., BHCHP and non-BHCHP medical provider sites), in client's homes (once housed), on the street, etc. Preliminary data analyses indicate that MISSION clients who received care coordination services experienced a significant reduction from baseline to discharge in the average number of days they had medical problems (in the past 30 days). More extensive data analyses to further examine the impact of care coordination services on client outcomes are planned and will be conducted in the coming months. Anecdotally, the PCC was successful in reducing fragmentation of care by coordinating these services; connecting clients with primary care, behavioral health, and substance use treatment; identifying barriers to care introduced by the transition into housing; and identifying specific medical diagnoses that may decompensate in the transition to housing.

Integrating care is vital to addressing all the healthcare needs of individuals experiencing homelessness with CODs. Current research has shown that integration and care coordination improve quality of care for and outcomes of CODs. While there are studies of behavioral health-based integrated care, integration of substance use treatment and primary care has not been as extensive or prevalent as integration of behavioral health with primary care. Therefore the work of the PCC was truly innovative and important to document. The PCC has worked closely with UMMS to document the process and lessons learned to inform adaptations to the MISSION model and the field.

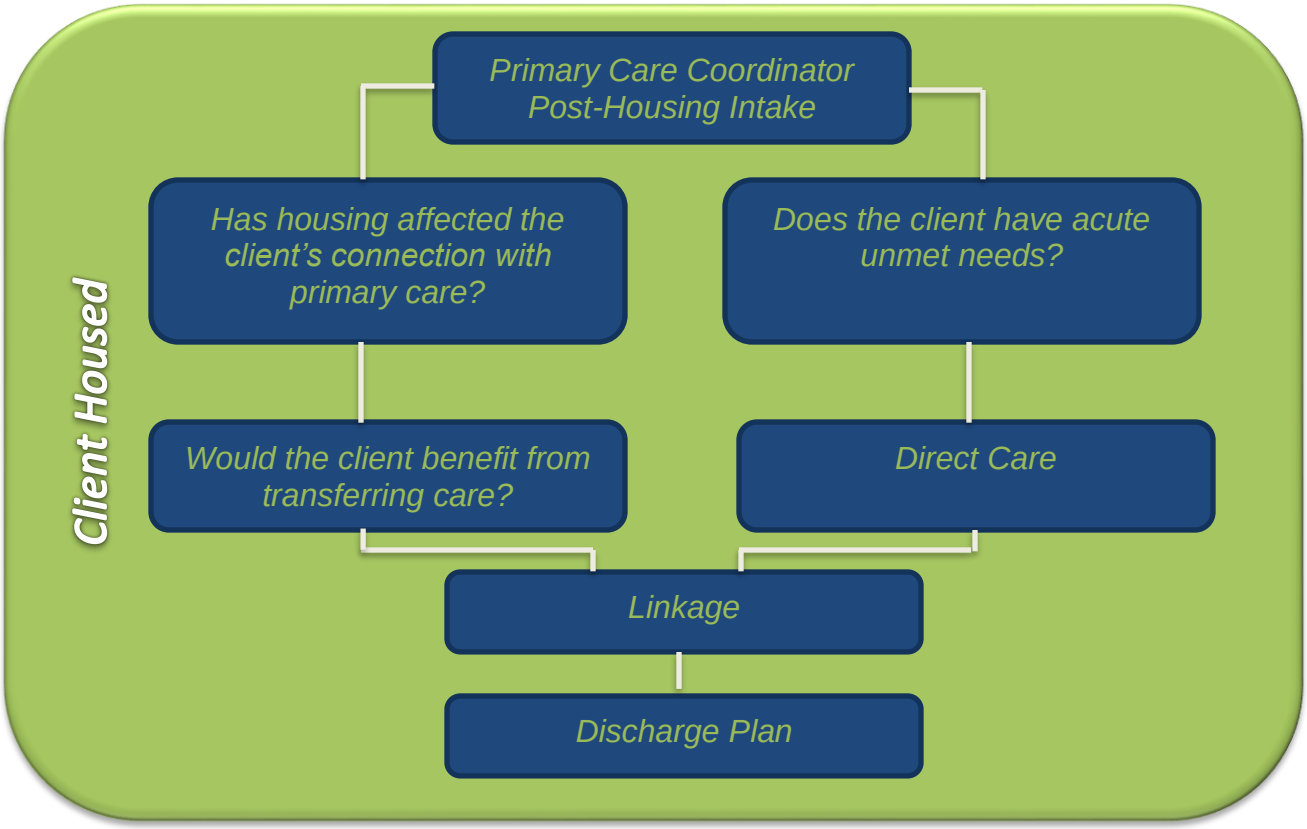
Appendix B1: Pre-Housing and Post-Housing Decision Tree



Appendix B2: A Closer Look at the Pre-Housing Decision Tree



Appendix B3: A Closer Look at the Post-Housing Decision Tree



Appendix C: Primary Care Coordinator Job Description

MISSION PRIMARY CARE COORDINATOR SAMPLE JOB DESCRIPTION

POSITION: Primary Care Coordinator (PCC)

SUMMARY OF POSITION:

MISSION uses a Housing First model to provide supportive housing consisting of comprehensive, intensive case management support to individuals who are chronically homeless with histories of substance use disorders and mental health disorders.

The MISSION primary care coordinator (PCC) works as part of an intensive case management and behavioral health team, serving individuals with co-occurring mental health and substance use disorders. MISSION uses a harm-reduction, trauma-informed approach to working with clients, including the utilization of the Stages of Change Theory, Critical Time Intervention (CTI), Motivational Interviewing techniques, and the MISSION model of clinical case management.

The PCC is the collaborating link between clients' primary care providers and their MISSION teams. The primary role is to coordinate primary care services for MISSION clients. The PCC will collaborate closely with primary care providers and synchronize the coordination of care between primary care providers and MISSION providers. The MISSION primary care coordinator will perform four core functions:

1) Meet with clients weekly to assess medical needs and provide linkages,
2) Conduct assertive outreach to help engage clients in their primary care,
3) Collaborate and coordinate with primary care services with the MISSION team and primary care providers, and
4) Deliver limited medical assessment and intervention services for clients who are not currently connected to primary care services.

QUALIFICATIONS:

The individual in this position must have a clear commitment to the population we serve, and be able to work as part of a team. The individual must have experience working with clients who have a history of homelessness and/or incarceration or are currently homeless and/or incarcerated; have co-occurring mental health and substance use disorders; and have significant medical needs. The individual must have experience providing psycho-educational programming to clients, preferably related to health; conducting assertive community outreach; and have two or more years working with the MISSION target population.

EDUCATION/TRAINING:

REQUIRED:

- Bachelor's degree or higher
- Strong verbal and written communication skills

- Excellent organizational skills
- Previous community health center or primary care experience
- Computer proficiency in Microsoft Office Products

PREFERRED:

- Degree or training in health education, medical case management, nursing, case management, public health, medical anthropology, drug and alcohol counseling, preventive nursing, prevention, or other related field
- Experience as a “visiting health provider”, such as a VNA, member of a health street team
- A valid driver’s license in good standing
- Experience with Critical Time Intervention and Trauma-Informed Care

KNOWLEDGE/EXPERIENCE:

REQUIRED:

- Two or more years working with the MISSON target population
- Prior experience conducting in-home or in-community interventions
- Experience assessing medical service needs
- Understanding of medical and health care needs in the context of recovery
- Thorough knowledge of the types and availability of medical services serving the MISSION target population, such as individuals experiencing both homelessness and co-occurring disorders
- Ability to establish, build, and maintain working relationships and links to primary care providers
- Ability to interact effectively and establish rapport with diverse groups of people of different ethnic, cultural, and/or socio-economic backgrounds
- Experience working as part of a team

PHYSICAL ABILITIES/SKILLS:

REQUIRED:

- Ability to access different building locations and program sites via vehicle, public transit, and by foot in varied weather conditions, including climbing several flights of stairs and lifting up to 50 pounds
- Ability to sit for long periods of time and use a computer, calculator, fax, copier, and other office equipment

MENTAL ABILITIES/SKILLS:

- Ability to juggle many competing demands, to prioritize work efficiently and effectively
- Ability to take initiative, plan, and work independently
- Interpersonal skills, patience, persistence, tolerance, ability to engage and develop rapport with a wide range of personalities
- Highly developed professional ethics, adherence to Professional Code of Ethics

- Ability to contribute to the overall integration and success of the program as a team player

ESSENTIAL FUNCTIONS INCLUDE BUT ARE NOT LIMITED TO:

- Meet weekly with the MISSION CM and PSS, both individually and as a group, to coordinate client care.
- Deliver training workshops to MISSION CMs and PSSs focused on the medical and primary care needs of the target population.
- Facilitate and/or participate in group client workshops focused on medical and primary care topics.
- Assume responsibility for the coordination of primary care between primary care providers and the MISSION team.
- Responsible for the coordination of outreach and engagement efforts to establish primary care referral systems and resources.
- Initiates and maintains ongoing communication regarding primary care needs (by phone and in-person) with clients and their caregivers.
- Provide strengths-based interventions with clients experiencing medical distress or other acute crises.
- Develop individually based crisis intervention plans with each client in order to reduce the number of hospitalizations.
- Intervene directly and/or cooperate with team efforts around medical stabilization for clients.
- Maintain accurate written records and documentation in accordance with program standards including, but not limited to client charts, incident reports, detailed case notes and referrals, and third party billing, when applicable.
- Communicates clearly and professionally with members of the primary care teams as well as MISSION team members (and housing supports as needed).
- Coordinates with the MISSION team and medical providers as necessary to provide continuity of care for clients.
- Demonstrate initiative in exploring existing and potential resources for clients through the development of positive working relationships with primary care providers in the community.
- Actively participate in treatment planning, referrals, and aftercare/ discharge planning with the MISSION CM/PSS.
- Attend regularly scheduled administrative, supervisory, and staff meetings, as well as in-house and external case conferences, and other meetings as needed.
- Participate in MISSION required and recommended trainings to enhance skills.

Appendix D: Models of Integrated Care

These types of integration have been most researched via the integrated care models presented in table 5 below.

Table 5. Models of Primary Care Integration

Model	Description
The Chronic Care Model (CCM)	Incorporates 6 elements for improving the quality of chronic illness care: (1) providing chronic illness self-management support to patients and their families; (2) redesigning care delivery structures and operations; (3) linking patients and their care with community resources to support the management of their illness; (4) providing decision support to clinicians; (5) using computerized clinical information systems to support compliance with treatment protocols and monitor patients' health indicators; and (6) aligning the health care organization's (or provider's) structures, goals, and values to support chronic care.[41,42]
The Patient-Centered Medical Home (PCMH)	Incorporates 7 principles for providing comprehensive care that facilitates partnerships between individual patients and their personal physicians.[43,44] These principles are: (1) personal physician; (2) physician directed medical practice; (3) whole-person orientation; (4) coordinated and/or integrated care across the health system; (5) quality and safety; (6) enhanced access to care; and (7) appropriate payment structure. As of April 2013, 43 states have adopted a policy to advance medical homes and a large Medicare demonstration project was started.[9,45]
The Health Home	This model was established as an incentivized option for state Medicaid programs under section 2703 of the Affordable Care Act and builds on the PCMH model to provide accessible and accountable services for individuals with multiple chronic conditions. The Health Home includes key PCMH characteristics such as access to and coordination of services, including preventive care, and the adoption of recovery orientation, among others (Smith & Sederer, 2009; Alakeson, Frank, & Katz, 2010).[47,48] Health Homes can be specialized to meet the needs of a particular population, such as adults with behavioral health disorders.

Appendix E: Additional Resources

PCMH Resources

- Advancing Behavioral Health Integration within NCQA Recognized Patient-Centered Medical Homes
  http://www.integration.samhsa.gov/integrated-care-models/Behavioral_Health_Integration_and_the_Patient_Centered_Medical_Home_FINAL.pdf

- Substance Use Disorders and the Person-Centered Healthcare Home
  http://www.integration.samhsa.gov/integrated-care-models/National_Council_SU_Report.pdf

- The Patient-Centered Primary Care Collaborative (PCPCC) Primary Care Innovations and PCMH Map
  https://www.pcpcc.org/initiatives?utm_source=Patient+Centered+Primary+Care+Collaborative+List&utm_campaign=38ff29e392-Week_in_Review_June_26_2014&utm_medium=email&utm_term=0_56f71f22aa-38ff29e392-250371765

- The Patient-Centered Medical Home's Impact on Cost & Quality: An Annual Update of the Evidence
  https://www.integration.samhsa.gov/integrated-care-models/Patient Centered_Medical_Homes_Impact_on_Cost_and_Quality.pdf

Integration Resources

SAMHSA Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions (CIHS) is the first “national home” for information and resources dedicated to bidirectional integration of BH and PC. CIHS is a national training and technical assistance center that promotes the development of integrated primary and behavioral health services. It includes tools, resources, trainings that can assist PCCs in their work.

- http://www.integration.samhsa.gov/

- Health Care for the Homeless Models of Integrated Care for the Homeless Webinar
  https://www.nhchc.org/2011/04/health-care-homeless-models-integrated-care/

- Healthcare Integration In The Era Of The Affordable Care Act:
  http://www.integration.samhsa.gov/integrated-care-models/Healthcare_Integration_In_the_Era_of_ACA.pdf

Appendix F: Forms

These forms serve as examples, and are optional tools[1], meant to be customized by each site to maximize their benefits. Examples of each form are found in the "Integrated Care in MISSION Toolkit."

- **Medication Log**
  - **Completed by**: client, with primary care coordinator (PCC) assistance
  - **Description**: Tool to assist client in tracking current medications and medication changes.

- **Medical Appointment Log**
  - **Completed by**: PCC with client
  - **Description**: Tool to track scheduled, emergency, and other medical, behavioral health, and substance use treatment appointments, their indication, and whether these appointments were completed.

- **My Providers List**
  - **Completed by**: client, with PCC assistance
  - **Description**: Tool to maintain a list of the client's current providers, their field, and their contact information.

- **Client Safety Plan**
  - **Completed by**: MISSION team, with client
  - **Description**: Tool to identify triggers, warning signs, and coping skills for clients in difficult situations, as well as a quick reference to key supports and client's identifying information.

- **Coping Strategy Questionnaire**
  - **Completed by**: Case manager (CM), with client
  - **Description**: Tool to assist in recognizing coping skills and communicating them between the client and team members.

- **Treatment Narrative Log**
  - **Completed by**: PCC
  - **Description**: Tool for the client to bring to appointments, or for the MISSION team to send to providers (with appropriate releases of information) to enable MISSION team members to update providers on client's recent appointments, medication changes, and overall status.

- **Common Psychiatric Medications**
  - **Completed by**: N/A
  - **Description**: List of common psychiatric medications for quick reference. Medications are listed by primary indication, but may be used to treat other symptoms or conditions.

[1] Primary care coordinator fidelity logs are mandatory.

- **Common Medical Abbreviations**
  - **Completed by**: N/A
  - **Description**: List of commonly used medical abbreviations, for quick reference for MISSION team members.

- **Behavioral Health Referral Form**
  - **Completed by**: PCC
  - **Description**: Tool to collect key information needed in making a referral for behavioral health treatment.

- **Medication-assisted Treatment (MAT) Communication Form**
  - **Completed by**: PCC
  - **Description**: Tool for the client to bring to appointments, or for the MISSION team to send to providers (with appropriate releases of information) to enable MISSION team members to update providers on any concerns for clients in MAT.

- **PCC Fidelity Log**
  - **Completed by**: PCC
  - **Description**: Weekly log of key interactions, service delivery, and concerns regarding each client.

Appendix G: Acronyms

Acronym	Phrase
AA	Alcoholics anonymous
ACO	Accountable Care Organization
BC	Behavioral care
BHCHP	Boston Health Care for the Homeless Program
BSAS	Bureau of Substance Addictions Services
CCM	Chronic Care Model
CIHS	Center for Integrated Health Solutions
CM	Case manager
COD	Co-occurring Disorder
CS	Clinical supervisor
CTI	Critical Time Intervention
DRT	Dual Recovery Therapy
HCH	Health Care for the Homeless
HIPAA	Health Insurance Portability and Accountability Act
ICHH	Interagency Council on Housing and Homelessness
ICSAP	Interagency Council on Substance Abuse and Prevention
LICSW/LCSW	Licensed Independent Clinical Social Worker/ Licensed Clinical Social Worker
LPN	Licensed practical nurse
MAT	Medication-assisted treatment
MH	MISSION: Housed project
MISSION	Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking
NA	Narcotics anonymous
NCQA	National Committee for Quality Assurance
NREPP	National Registry of Evidence-based Practices and Programs
OBOT	Office-based Opioid Treatment
PC	Primary care
PCC	Primary Care Coordinator
PCMH	Patient-Centered Medical Home
PCP	Primary Care Provider
PSS	Peer Support Specialist
RN	Registered Nurse
SAMHSA	Substance Abuse and Mental Health Services Administration
SAMHSA-HRSA	SAMHSA-Health Resources and Services Administration
SUD	Substance Use Disorder
UMMS	University of Massachusetts Medical School
VA	Veterans Affairs
VNA	Visiting Nurse Association

Appendix H: Glossary

Affordable Care Act- Legislative two part Act that was put in place to expand coverage, hold insurance companies accountable, lower health care costs, guarantee more choice, and enhance the quality of care for all Americans. For more details on the Act please visit https://www.medicaid.gov/affordable-care-act or https://www.healthcare.gov/glossary/affordable-care-act/.

Assertive Outreach - A way of organizing and delivering care to provide intensive, highly coordinated, and flexible support and treatment for clients. It includes such activities as home visits, meeting with clients in their local communities, etc.

Community integration- Working with individuals to comfortably introduce, or reintroduce, them into the community, or communities, of their choice.

Co-occurring disorders (COD)- The existence of both a mental health and substance use disorder.

Fragmentation- In health care terminology, this refers to the uncoordinated care of an individual.

Harm Reduction Theory - An approach which uses practical strategies and ideas to reduce the negative consequences associated with risky behaviors. Some examples are needle exchanges, methadone or SUBOXONE programs, and condoms/dental dam availability. Organizations that institute this theory do not demand full abstinence, but rather meet people where they are at with the goal of reducing harm. You can find more information at http://harmreduction.org/about-us/principles-of-harm-reduction/.

Housing First - A human services approach that provides individuals experiencing homelessness with housing first and then addresses underlying issues. This is in contrast to other programs where individuals have to address issues and take other steps before getting housing. Housing First is guided by the premise that housing is a basic human right.

Health Insurance Portability and Accountability Act (HIPAA)- Legislative act that protects individuals' medical information. Information for individuals and professionals regarding HIPAA can be found at https://www.hhs.gov/hipaa/index.html.

Integrated care- The organization of healthcare that involves combining all of an individual's care in one setting, for example combining primary care and mental health care. https://www.nimh.nih.gov/health/topics/integrated-care/index.shtml

Lessons learned- Results from previous research that should be used in future research.

Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking (MISSION)- A wraparound service intervention designed to meet the needs of those experiencing homelessness and co-occurring disorders.

MISSION: Housed- Program designed to enhance the current efforts of the Massachusetts Interagency Council on Housing and Homeless in reaching their goal of ending homelessness in Massachusetts by directly delivering permanent housing and needed support services to individuals experiencing chronic homelessness with CODs in the Metro Boston area through the use of the MISSION wraparound service model.

Mandated reporter- Professionals who legally must report cases of suspected abuse and/or neglect of a child, elder, or individual with a disability; or if an individual reports wanting to harm themselves or others. What is reportable varies by state, for information on Massachusetts Disabled Persons Protection Commission's regulations around reporting, visit http://www.mass.gov/dppc/abuse-report/.

Motivational Interviewing (MI)- A goal-oriented, client-centered approach that utilizes the Stages of Change Theory to help clients explore their ambivalence by strategically using skills such as asking open-ended questions, active listening, and reflecting. There is more information at http://motivationalinterviewing.org/

Risk/Needs Assessment- A tool used to assess an individual's risk of recidivism and in turn determine what amount of treatment and level of intensity is needed for the individual. For example, an individual who is at "high risk" would need the most intensive services such as inpatient treatment.

Self-medication- The use of misuse of prescription drugs, or use of illegal drugs and/or alcohol to ease or relieve emotional or physical pain that an individual may be experiencing.

Social Security Disability Insurance (SSDI)- An insurance-based program for persons who have worked in the past and had Federal Insurance Contribution Act (FICA) contributions taken from their paychecks.

Stages of Change Theory- A model of behavior change which assesses an individual's readiness to act on new healthier behavior. There are five stages of change in this theory; Pre-contemplation, Contemplation, Preparation, Action, and Maintenance. When working within this model, MISSION team members are cognizant of which stage of change the client they are working with is in, and adjust their intervention strategies accordingly. A helpful website for more information is http://www.aafp.org

Substance Abuse and Mental Health Services Administration (SAMHSA)- The agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance use and mental health on America's communities.

Supplemental Security Income (SSI)- Needs-based program available to individuals who have less than $2,000 in resources, or less than $3,000 for a couple; are making less that the Substantial Gainful Activity limits set annually by Social Security Administration (SSA); and are disabled according to the SSA regulations.

Trauma-Informed Approach - A model that maintains that providers should presume going in to every relationship that there may have been some form of trauma (e.g., use, neglect, loss, etc.) in the person's life and then act accordingly when meeting with them. Some examples are letting the person choose where to sit, leaving the door open during meetings, not coming up behind someone, not hugging, and not touching without permission. You can find more information at http://www.samhsa.gov/nctic.