

Integrated Service Delivery and Health-Related
Quality of Life of Individuals in Permanent
Supportive Housing Who Were Formerly
Chronically Homeless

Integrated Primary & Behavioral Healthcare in PSH

SEARCH Homeless Services: Phoebe Wong, LCSW & Cathy Crouch, LCSW

Poll: Tell us who you are!

Go to www.menti.com. Enter code **5584 4971**.

Choose the description that best fits your role and click "Submit."

Poll Results: Tell us who you are!

Six Levels of Collaboration/Integration

From the SAMHSA-HRSA Center for Integrated Health Solutions

COORDINATED KEY ELEMENT: COMMUNICATION		CO LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
<ul style="list-style-type: none"> » Have separate systems » Communicate about cases only rarely and under compelling circumstances » Communicate, driven by provider need » May never meet in person » Have limited understanding of each other's roles 	<ul style="list-style-type: none"> » Have separate systems » Communicate periodically about shared patients » Communicate, driven by specific patient issues » May meet as part of larger community » Appreciate each other's roles as resources 	<ul style="list-style-type: none"> » Have separate systems » Communicate regularly about shared patients, by phone or e-mail » Collaborate, driven by need for each other's services and more reliable referral » Meet occasionally to discuss cases due to close proximity » Feel part of a larger yet non-formal team 	<ul style="list-style-type: none"> » Share some systems, like scheduling or medical records » Communicate in person as needed » Collaborate, driven by need for consultation and coordinated plans for difficult patients » Have regular face-to-face interactions about some patients » Have a basic understanding of roles 	<ul style="list-style-type: none"> » Actively seek system solutions together or develop work-a-rounds » Communicate frequently in person » Collaborate, driven by desire to be a member of the care team » Have regular team meetings to discuss overall patient care and specific patient issues » Have an in-depth understanding of roles and 	<ul style="list-style-type: none"> » Have resolved most or all system issues, functioning as one integrated system » Communicate consistently at the system, team and individual levels » Collaborate, driven by shared concept of team care » Have formal and informal meetings to support integrated model of care » Have roles and cultures that blur or blend

Poll: How integrated are you?

Go to www.menti.com. Enter code **2774 5056**.

Choose your response and click "Submit."

Poll Results: How integrated are you?

New Hope Housing Sites



1115 Medicaid Waiver

- High utilizers of emergency department who were living on the streets
- Randomized between 2 Federally Qualified Health Centers (FQHCs)
 - Healthcare for the Homeless – Houston partnered with SEARCH
 - Avenue 360 was already providing housing services into PSH

Context

Building Institutional
Knowledge & Skill

- Partnership with Baylor College of Medicine since SEARCH opened our doors in 1988
- Background in randomized clinical trials in medical school settings
- Comfortable using standardized assessments
- Clinical backgrounds
- Use of evidence-based practices beginning in 1996
- At the same time began relationships with academic researchers
- Full-time data analyst on staff since the late 90s
- Able to find \$\$ for these kind of projects
- Location, location, location

Program Design

Integrated Service Delivery

- Project Staff
 - SEARCH
 - Executive VP (clinician)
 - Case managers
 - Clinical case managers
 - Healthcare for the Homeless – Houston
 - CEO (clinician)
 - RNs
 - Community Health Workers
 - Behavioral Health clinicians (located at HHH clinic)
- University of Texas Houston School of Public Health
 - evaluator

Program Model

- Integration of Clinical Case Management with Primary Care and Behavioral Health
 - All staff officed onsite at the various housing locations
 - A nurse, community health worker and case manager assigned to each site
 - Total number of residents at any point in time was 100?
 - Weekly clinical staffing involving the entire team
 - Senior leadership was almost always present to
 - promote adherence to the clinical models and approaches
 - Ensure that neither PSH nor med/psych views were ignored
 - Periodic review of data
 - On-going reference to recent scores:
 - A1C
 - Depression scores using the PHQ-9
 - SF-36 decline

SF-36 (shorter version from the Medical Outcomes Study)

- Administered at enrollment (baseline) and every six months thereafter while housed
- Residents are provided a \$10 cash incentive for every completion
- During interview, staff 1) assess Stage of Change for a client-identified behavior and 2) use motivational interviewing or behavioral therapy or CBT

PHQ-9

- Same frequency, but without the intervention. Referral to Behavioral Health Specialist.

A1C

- Baseline. Clinic visits and 8-session diabetes awareness education by COH Health Department

Data Analysis

- Site analysis run by data analyst semi-annually looking at change over time from baseline
- Program managers and line staff can run their own reports to see which of their individual clients are getting better, staying the same, or getting worse by dimension

Clinical Assessments

SF-36

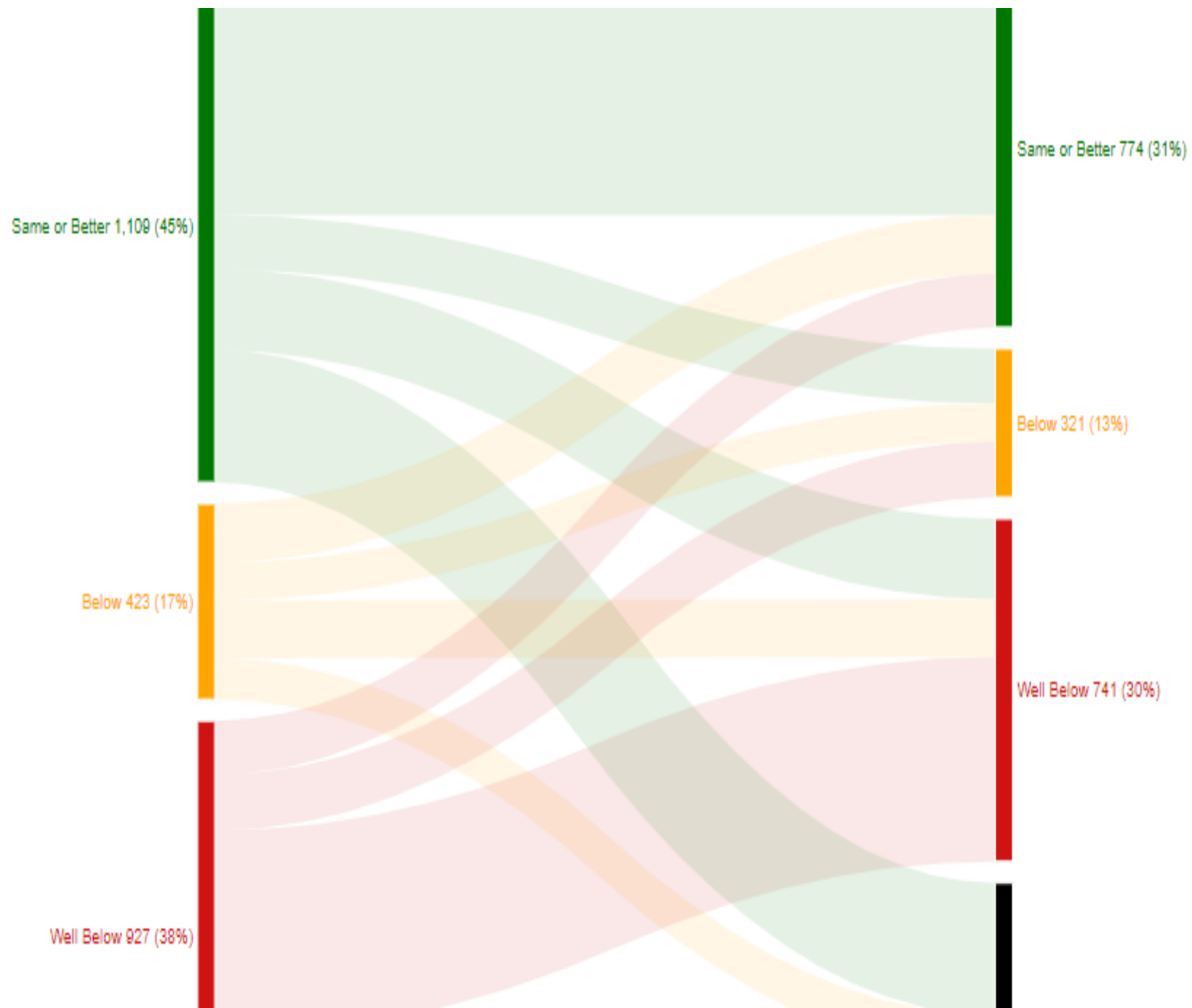
Health-Related Quality of Life

The following questions are about activities you might do during a typical day. In the past 1-week does your health limit you in these activities? If so, how much?

(Please circle one number on each line)

ACTIVITIES		Yes Limited A lot	Yes Limited A little	No, Not Limited At All
3a:	Vigorous activities, such as running, lifting heavy Objects, participating in strenuous sports	1	2	3
3b:	Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
3c:	Lifting or carrying groceries	1	2	3
3d:	Climbing several flights of stairs	1	2	3
3e:	Climbing one flight of stairs	1	2	3
3f:	Bending, kneeling, or stooping	1	2	3
3g:	Walking more than one kilometre	1	2	3
3h:	Walking half a kilometre	1	2	3
3i:	Walking 100 metres	1	2	3
3g ww:	Wheeling more than one kilometre	1	2	3
3h ww:	Wheeling half a kilometre	1	2	3
3i ww:	Wheeling 100 metres	1	2	3
3j:	Bathing or dressing yourself	1	2	3

^aModified from SF-36¹: Items 3 (a to j) are the original SF-36 questions, while 3g ww to 3i ww (shaded area) comprise the supplementary SF-36ww modification.



Physical Component Summary

	Same or Better	Below	Well Below
Same or Better	136 Members	38 Members	92 Members
Below	36 Members	14 Members	61 Members
Well Below	80	43	141

4 5 6 7 8 9 10 ... <div>▶ ◀</div> Page size: 20 1-20 of 641													
	Age	Gender	Survey Date	PCS	PF	RP	BP	GH	MCS	VT	SF	RE	MH
	31	F	05/19/2022	49.5	36.5	25.7	62	45.1	34.5	58.5	57.3	24.8	22.1
	69	M	05/18/2022	58.6	57.5	57.2	62	50.8	48.7	52.6	47.3	49.2	56.1
	59	M	02/11/2022	58.9	57.5	48.2	62	59.4	47.6	46.7	57.3	56.2	43
	64	M	04/13/2022	34	28.8	32.5	38.6	38	41.9	52.6	32.3	35.3	37.8
	59	M	03/22/2022	41.5	38.4	39.2	38.2	43.7	38.7	46.7	37.3	35.3	37.8
	63	M	05/26/2022	35.2	32.7	39.2	34.6	35.6	41.1	43.7	37.3	35.3	40.4
		F	02/09/2022	31.8	30.7	23.5	26.5	33.2	23.1	34.8	17.2	21.4	24.7
	71	M	05/23/2022	31.6	34.6	36.9	25.7	33.2	39.7	34.8	37.3	35.3	40.4
	30	M	05/04/2021	54.4	49.9	57.2	62	57.9	62.7	64.5	57.3	56.2	63.9
	64	M	02/18/2022	34	28.8	48.2	47.5	38	63.1	49.6	57.3	56.2	56.1
	52	M	08/02/2021	57.4	55.6	48.2	55.5	43.7	33.3	46.7	42.3	35.3	37.8
	67	M	05/18/2022	34.3	36.5	32.5	42.6	35.6	52.3	55.6	47.3	38.8	50.9
	33	M	03/18/2022	66.3	57.5	57.2	43.5	49.9	8.7	40.7	17.2	24.8	14.2
	45	M	01/25/2022	60.9	57.5	57.2	62	66.5	58.2	64.5	57.3	56.2	58.7
	56	M	09/27/2021	49.6	53.7	48.2	42.2	38	39.1	49.6	42.3	45.7	35.2
	59	M	06/02/2022	48.3	48	57.2	42.6	38	47.8	49.6	57.3	56.2	35.2
	43	M	01/17/2022	36	26.9	30.2	38.6	41.3	30.6	37.7	27.3	24.8	32.6
	52	F	10/19/2021	19.1	21.2	25.7	25.7	30.8	52.5	28.8	57.3	42.2	43
	61	M	10/07/2021	50.6	57.5	48.2	25.7	65.1	45.9	55.6	42.3	45.7	45.6
	51	M	01/13/2022	32.2	23.1	23.5	34.6	35.6	21.2	28.8	17.2	17.9	24.7
4 5 6 7 8 9 10 ... <div>▶ ◀</div> Page size: 20 1-20 of 641													

	SEARCH/HHH - (1115)	N = 54	N = 49	N = 40	N = 34	N = 34	UNDA VISTA / 1185	N = 29	N = 32	N = 27	N = 21		Temenos I	N = 21	N = 21	N = 19	N = 13	N = 5	Temenos II	N = 49	N = 45	N = 41	N = 30	N = 24	Villas at Eastwood	N = 59	N = 48	N = 36	N = 2						
		18 months	24 months	30 months	36 months	42 months		18 months	24 months	30 months	36 months	42 months		6 months	12 months	18 months	24 months	30 months		6 months	12 months	18 months	24 months	30 months		6 months	12 months	18 months	24 months	30 months					MID
VT		2.8	3.2	3.2	4.4	0.8		-1.8	-2.2	-1.8	-5.1			-1.1	0.7	0.6	0.5	3.6		-0.8	-1.8	1.7	2.7	0.0		-2.0	-0.8	-2.6	-10.4					2	
PF		0.5	2.6	1.9	1.2	0.3		-0.8	-1.4	0.8	3.8			-2.5	-0.7	1.5	-0.4	-1.5		-1.1	-1.7	-1.0	-1.1	-1.4		-0.9	0.4	1.0	-7.7					3	
BP		2.3	2.4	3.1	5.7	2.0		2.6	-0.5	-0.9	0.0			-3.4	-0.9	5.3	0.1	11.8		0.9	2.4	2.0	5.1	2.0		-0.9	1.4	-0.6	-5.8					3	
GH		2.3	4.0	4.0	2.6	-0.8		-0.5	-1.4	1.1	1.6			2.2	4.2	4.5	1.9	3.0		0.9	0.4	1.6	2.3	3.0		-0.2	-1.2	-2.0	-1.9					2	
RP		3.7	4.7	5.3	4.9	2.4		-0.5	-0.1	0.0	0.1			1.1	4.5	5.4	1.4	7.2		-0.8	0.6	1.8	1.9	1.8		0.0	-0.2	0.3	-10.1					3	
RE		8.0	6.6	6.8	4.1	3.1		1.8	3.2	-1.4	-2.8			-1.8	0.8	2.4	1.6	5.6		0.4	-2.1	2.5	2.0	2.0		-1.6	3.5	2.0	-1.7					4	
SF		6.3	5.6	6.4	5.6	3.4		1.9	3.0	4.8	1.2			1.0	1.2	2.1	-1.5	4.0		0.6	0.8	3.4	3.0	2.9		-0.5	0.1	-1.4	10.0					3	
MH		5.3	5.1	6.3	4.5	3.8		-0.6	-1.1	1.3	-3.2			1.7	3.2	3.4	1.0	-3.1		0.1	-1.9	2.6	1.9	-0.4		-2.5	-2.7	-4.3	-1.3					3	
PCS	0.2	2.2	2.0	3.0	0.0	-0.1	-1.5	0.2	3.2		-1.3	1.2	4.1	0.3	6.1	-0.4	1.2	0.2	1.6	1.1	0.1	0.1	0.3	-8.9					3.5						
MCS	7.5	6.1	7.0	5.0	3.7	0.6	1.5	0.8	-4.6		0.8	2.1	1.8	0.8	1.1	0.5	-2.0	3.4	2.7	1.3	-2.2	-0.2	-2.3	2.5					3.5						

		N = 24	N = 21	N = 24	N = 23	N = 20		N = 54	N = 48	N = 34	N = 25	N = 26		N = 12	N = 11	N = 8				N = 24	N = 15	N = 5				N = 85	N = 76	N = 63	N = 44	N = 41	
	Scattered Site I	18 months	24 months	30 months	36 months	42 months	Scattered Site II	12 months	18 months	24 months	30 months	36 months	Scattered Site III	6 months	12 months	18 months	24 months	30 months	Scattered Site IV	6 months	12 months	18 months	24 months	30 months	Harrisburg	6 months	12 months	18 months	24 months	30 months	MID
VT		-1.7	-1.0	0.4	1.6	2.5		-1.3	-2.2	-1.4	-0.1	-2.1		0.5	6.2	1.1				-0.5	-6.9	8.9				-0.7	-1.4	-0.8	-2.3	0.5	2
PF		-1.0	0.9	1.4	-0.6	-1.0		-2.1	-0.6	-2.6	-3.0	-2.9		-5.3	2.4	1.7				-2.2	-7.9	0.4				0.5	0.6	-1.2	-2.8	-1.3	3
BP		-0.9	3.8	3.2	2.2	3.2		-0.9	1.4	-0.9	-0.1	3.0		4.1	5.0	-2.9				-1.8	-7.2	-4.7				0.7	-1.7	-1.7	-3.1	-1.9	3
GH		-1.5	-1.2	-1.7	-1.8	1.2		-1.3	-2.5	-1.4	0.8	-1.5		-3.4	-1.4	0.8				0.0	-2.4	4.3				-1.3	-0.1	-3.2	-1.9	0.1	2
RP		-1.6	1.2	-0.4	-2.6	2.2		-2.2	2.1	-1.5	-0.5	-0.5		2.8	4.3	2.8				-0.1	-7.2	2.7				1.2	0.1	-1.9	-2.9	-0.9	3
RE		-1.9	-3.3	-4.9	-3.0	-0.2		-1.2	0.6	-4.4	-3.2	-2.8		-2.3	1.9	0.4				-1.9	-3.0	-3.5				0.4	-2.2	-3.3	-2.2	-1.4	4
SF		-0.8	0.0	5.0	2.8	4.5		0.5	-0.2	-2.5	0.8	1.7		2.5	5.5	7.5				-1.5	-3.7	1.0				0.4	-0.5	-1.9	-3.5	-1.7	3
MH		-0.2	-1.7	0.0	1.0	1.4		-0.7	2.0	0.2	0.0	0.5		5.0	0.4	1.6				-1.5	-4.6	1.0				-0.2	-0.5	2.2	0.4	0.4	3

Case Managers (CMs)

Priorities / Perspectives / Lenses:

- Emphasis on behavior change, informed consent, and boundary setting
- Creating and maintaining connections within the Integrated Care Team and with external partners
- Work with client to identify and pursue goals, including housing retention, income, and well-being

How They Help the Client:

- Motivational Interviewing:** assist clients with behavior change towards identified goals, with a focus on building client motivation and recognizing their strengths.
- Client Independence:** assist clients with building up their independent living skills by teaching, modeling, practicing, and providing feedback.
- Chaos Reduction & Applying for Benefits and Assistance:** help clients connect to resources outside the Care Team, including benefits like SNAP, Government phones, and housing, as well as resources like food pantries and the Trans Workforce Commission.

How They Help the Team:

- Documentation & Compliance:** maintain paper files, including initial RHCs and establishment of informed consent for program participation. Conducts semi-annual health and ADEL assessments and delivers the POC process.
- Build and Maintain Partnerships:** help to connect and coordinate between Integrated Care staff and external partners like New Hope Housing, Tennessee CDC, and the Houston Housing Authority (HHA).
- Behavior Change:** able to assist clients with following up on concerns identified by other disciplines on the Care Team, including management of chronic conditions, medical adherence, and Substance Use.

Notes on Working with Them:

- Client-Centered Case Management services are voluntary.** They rely on client motivation to drive behavior change and are unable to force changes even when doing so may seem to be in the client's best interest in the view of the Care Team. The only exceptions to this are safety-related, when the client poses a danger to self or others.
- Task Handoff:** Case Managers often coordinate with others on the Care Team to follow up on areas of shared concern. They are particularly effective at addressing ongoing behavioral health or motivational barriers, such as appointment adherence or management of chronic health conditions. They can also support other members of the Care Team with providing informed consent to clients.
- External Connections:** due to the voluntary nature of the services, Case Managers often have strong external connections to community resources.

How They Work with Others:

- Health Literacy:** CMs can talk to clients about both medical and mental health care, including encouraging clients to select a primary medical care home and supporting clients in advocating for themselves with their medical provider. Compared to nursing, behavioral health, and case coordination, Case Managers often perform more of a primary care role, helping to build client motivation before handing the client off to specialized medical staff or external providers.
- Substance Use:** CMs have expertise in behavior change, including substance use, and may work closely with Peer Recovery Specialists to address client use. This can either be a partnership, or a conversation about who will be taking the lead on working with the client to reduce substance use (based on client request and staff expertise), and these roles may evolve over time.
- Chronic Case Management:** CMs may provide clinical or case management services to clients with chronic conditions, such as medication management, appointment planning, and adherence to care plans.

Care Coordinators (CCs)

Priorities / Perspectives / Lenses:

- Navigating healthcare systems
- Client appointments and adherence
- Connections to benefits

Notes on Working with Them:

- Flexible Scope:** services can vary based on time and program. Care Coordinators work with various roles, including nurses, social workers, and other staff on the team for specific services and workflow may vary over time and from one workflow to another. As a result, CMs may need to complete certain tasks (e.g., SNAP applications, appointment reminders, etc.) typically completed by the CC during times when the CC is open. Thus, it can be important to talk about priorities and processes to find a structure and role boundaries that work for your specific team.
- Medical Priority:** Care Coordinators often work closely with, and follow orders from, medical providers, including both PHH Nurses and those staff at HHHH and elsewhere. They are also involved in client intake and other external systems, so the services available and delivery methods may vary from one client to another.

How They Help the Team:

- Medical Adherence:** track upcoming appointments, remind clients to promote adherence, and share information on adherence with the team to inform case planning and follow-up.
- HHH Administrative Work:** complete HHA assessments and client registration, identify documents to EPIC.
- Reduce Barriers to Access:** help to identify and reduce barriers to clients accessing services as indicated by care team recommendations and referrals (with PHH / Integrated Care and clinic medical providers).
- Good Hand on Community:** can speak to the "importance of the community" by virtue of working with all clients across conditions (in a variety of practical topics).

How They Work with Others:

- Scheduling Clinic Visits:** there can be some overlap with Behavioral Health Consultants and Nurses when it comes to scheduling clinic visits. Compared to other roles, Care Coordinators are better situated to schedule routine visits with existing providers, visits with clear presenting problems that don't require active navigation through the clinic, and visits at non-HHHH providers. Their knowledge of insurance is particularly valuable with non-HHHH providers where travel and billing could pose potential barriers to access.
- Support:** while CMs can give bus passes, and anyone on the team can accompany clients to an appointment to help navigate suburban transportation issues, CCs may have access to more specialized transportation options like HHHH Taxi Voucher, Medicaid Transport, and assisting the client with getting signed up for METRO LAR.
- Medical Prioritization:** Care Coordinators will often work closely with the Team's RNs to identify, prioritize, respond to, and track medical concerns with PHH clients. In programs with a large number of enrolled clients, the RN may assist with prioritizing client concerns to ensure a realistic scope of work for care coordination.
- Feedback on Client Independence:** beneficial in sharing out information on client's ability to schedule and/or keep appointments, manage their own travel, and their level of dependence on resources can be very helpful to others on the Team who are thinking about how to best reach out and support clients with goals (medical, behavioral, and substance use). The clients have access to transport? Do they need rides support to make a 12-step meeting or go to a food pantry?

Registered Nurses (RNs)

Priorities / Perspectives / Lenses:

- Client medical priorities and goals
- Coordination with Medical Providers
- Triage clients with the Care Team and external providers

How They Help the Team:

- Medical Language & Knowledge:** analyzing, clarifying, translating, and explaining information received from medical providers, including medications, labs, imaging, bloodwork, diagnosis, treatment plan, suggested lifestyle changes, follow-up, and other information from Primary Care Providers and Specialists.
- EPIC Expert:** manage the "Current Problems List" in EPIC, identify and translate important medical information for the rest of the Team.
- Facilitate Communication:** often serve as the go-between for questions and other communication between the Integrated Care Team and Primary Care Providers (particularly if within HHHH).

Notes on Working with Them:

- Part of Larger Health System:** Nurses represent bottom-up (client-driven) concerns, symptoms, and presenting problems, and they also follow up on and reinforce top-down (provider-driven) medication management, appointment planning, and adherence to care plans.

How They Help the Client:

- Health Literacy:** provide information on topics like medication management, and flags for current medications, how to communicate with healthcare providers, information on chronic conditions and managing personal health risks. Assist clients with understanding and following instruction from their Primary Care Physician (PCP).
- Facilitating Appointments:** can schedule in clinic appointments and help facilitate the process. Assist client with navigating their visit and pass information along from Integrated Care Team to clinic staff (and vice versa). Advocate for the client with Providers who may not see how the client functions in daily life.
- Client-Centered Care:** help to support client decision-making process through Informed Consent and advocacy on behalf of client.

How They Work with Others:

- Clinic Visit:** Behavioral Health Consultants and Care Coordinators may have some overlap in scheduling and navigating clinic visits. In situations where determining which member of the Care Team should accompany the client to their appointment. If the client needs help navigating the visit, explaining present symptoms to a Provider, or with understanding the information provided, the Nurse or Behavioral Health Consultant may want to accompany the client to their appointment to assist with communicating effectively with the Provider. (Care Coordinators are great for clients who can manage more independently.)
- Behavior Change:** Care Managers are experts at engaging with clients around the topic of behavior change. If the client has a chronic health issue that could use some lifestyle adjustments, keep the Care Manager in.
- Monitor Substance Use:** if client's use is impacting their health, or if their medications have important drug interactions, be sure to loop in the rest of the team.

Peer Recovery Specialists (PRs)

Priorities / Perspectives / Lenses:

- Substance use and substance abuse
- Whole-life recovery, including client values and goal setting

How They Help the Team:

- Support:** because of their lived experience, Peers may develop a particularly strong support with clients that can be leveraged to connect them to other services within and outside of the Care Team. They are also well equipped to listen to and share out information on "the temperature of the community."
- Information:** since Substance Use frequently impacts every area of a client's life, Peers frequently possess valuable information about client situations, barriers, and risk factors that can inform the work of other Care Team Members.
- Recovery Expertise:** Peers are the primary source for information on Substance Use within the Care Team, including information on current and past treatment options as well as available treatment options and community resources.

How They Work with Others:

- Recovery and Case Management:** the shared focus on behavior change and some overlap in skill sets means that there may be some negotiation in serving shared clients. Both Case Managers and Peers are encouraged to be intentional in thinking about how to best serve the client, in terms of both intervention planning and service delivery. There is room to negotiate roles and shift balance over time based on client need and staff observations.
- Transportation:** Peers are encouraged to collaborate with Care Coordinators around client appointment adherence. Both roles are often in the position of helping clients to connect with office meetings or appointments and may have complementary insights and interventions designed to help reduce barriers to access.
- Owning Expertise:** Substance Use can have a wide impact on the lives of clients, placing Peers in a position to share relevant information, insights, and interventions with other members of the Care Team who are otherwise the lead in their particular area of specialty. Peers should own their expertise and experience and speak up when they have something to add to a conversation about housing, physical and mental health, etc.

How They Help the Client:

- Modeling:** Peers may self-disclose more than other Team members, which can be helpful for clients struggling with addiction and other challenges. Peers are experts in connecting clients with care as well as working with clients towards harm reduction as clients to community support groups as well as admission becomes ready.
- Non-judgmental Support:** Peers play a hands-on role in helping clients to navigate the system, which can be particularly helpful for clients who are struggling with addiction and other challenges. Peers may accompany clients to office Support Groups or to treatment to determine which treatment option will work best for them. Peers often accompany clients to the treatment facility at time of client admission into the program and will visit the client while in treatment. Peers coordinate with treatment staff on client Discharge Plan and to put supports in place prior to the client's return.
- Facilitate Onsite Support Group:** Peers facilitate onsite Peer Support Groups, often with a CM acting as the co-facilitator.

Notes on Working with Them:

- Client Confidentiality:** Substance Use has a higher standard of confidentiality than other health information. The Peer may limit information shared in a public setting, and in the medical record (EPIC), to protect client confidentiality and maintain compliance with policy and regulation.
- Information Sharing:** since Substance Use can be embedded in every aspect of our clients' lives, Peers benefit from frequent, strong communication amongst members of the Care Team. This includes information on client access to public transportation, client appointment adherence, finances, rent payments, chronic health concerns, and concerns from Property Management about client behavior.

Behavioral Health Consultants (BHCs)

Priorities / Perspectives / Lenses:

- Mental health and serious mental illness, including assessment, diagnosis, triage, treatment, and medication
- Integrated Care and coordination with HHHH clinics

How They Help the Team:

- Mental Health Consultants:** contribute to Clinical Staffings, formal Plans of Care, and informal consultations with a focus on understanding and responding to unusual behaviors, serious mental illness, and mental health triage (including crisis and mental health warrants). They can be invaluable in the initial assessment of these behaviors, and they can serve as an extra set of eyes or as a second opinion, particularly on safety and health concerns.
- Facilitate Communication:** due to their familiarity with EPIC and close working relationship with HHHH clinical / medical staff, BHCs are often well positioned to interpret the information from HHHH and other medical systems, particularly around mental health and associated medications, as well as advocate back out to those providers and medical systems on behalf of the Care Team.

Notes on Working with Them:

- Limited Availability and Time Constraints:** BHCs will often need to spend a majority of their time at HHHH clinics, limiting their availability for onsite work. Staff are encouraged to be intentional in thinking about how to best serve clients' expectations or assist BHCs with coordinating onsite services (training notes to clients, helping to schedule appointments, etc.).
- Reduced Formal Footprint:** because of both limited availability and the fact that not every client may need their support, BHCs are not always fully integrated into workflows. This includes the Plan of Care process. BHCs do not have their own templates, but may be consulted as appropriate in the drafting of the RN/CC/CM progress and they contribute to the verbal Staffing and POC summary.
- Fewer Independent Goals:** because they do not generally carry their own caseload and have limited time onsite, BHCs can be more reactive than other roles to emerging needs and issues. Please reach out if you think they may be able to help you or your client. It is important to be proactive with your requests.
- Collaboration:** it will be important for a CM to collaborate with the BHC on mutual clients to ensure that the work is complementary rather than contradictory. This may be particularly relevant to licensed clinicians.

How They Help the Client:

- Help Facilitate Clinic Visits:** help to ensure clients get the right eyes on them when at the clinic, with a focus on behavioral health issues that might otherwise be missed during primary care visit. Assist client with navigating their visits and pass information from Integrated Care Team to clinic staff (and vice versa). Advocate for the client with providers who may not see how the client functions in day-to-day life.
- Group Services:** can provide high quality, clinically oriented group interventions at and across PHH sites. Have provided "Living Life Well," "Seeking Safety," and "ACT for Chronic Pain" groups.
- Individual Services:** can work directly with individual clients at PHH sites and in the clinic, using both brief and long-term interventions.
- Linkage & Referrals:** may be able to help link clients to appropriate referrals and appointments, including consulting psychiatry, trauma-specialized providers, and HHHH staff who can assist for SUD in clinic.

How They Work with Others:

- Differentiating Clinical Interventions:** there can be some overlap in individual and group interventions offered by BHCs and Case Managers. BHCs tend to have significantly less time onsite and will need to be more intentional in who they serve. Some clients value the potential firewall between therapeutic and case management services. There is room to call in BHCs as consults to supplement CM services, either in Staffings or direct client assessment without committing to ongoing future work.
- Scheduling Clinic Visits:** there can be some overlap with CCs and RNs when it comes to scheduling and navigating visits at the HHHH clinic. BHCs are the most likely of the three to already be at the clinic, and are thus well positioned to help clients navigate in-person visits. This can be particularly valuable when connecting clients with providers outside the Primary Care relationship—Behavioral Health Consultants, Psychiatry, and other issues where we want the clinic staff to follow-up with concerns we are seeing play out in the client's life at home.

Clarifying & Valuing Each Role