

Project Summary: People with severe mental illness in St. Louis die decades before their peers, due primarily to poor access to healthcare. *Healthcare in Place* creates new access opportunities by locating a Family Care Health Center primary care satellite clinic at Places for People and by locating PfP case managers at FCHC.

Need Statement: The **issue** that concerns us is that St. Louisans are dying prematurely. A recent internal review at Places for People (PfP) revealed that over the past 26 months, 19 PfP patients died. The manner of death was deemed natural in 14 of these deaths, accidental in 3, and unknown in 2. Of those deaths that were natural (mostly cardiovascular disease in people with multiple other chronic medical conditions) or unknown, the average age at death was 56.5 which is 22 years earlier than the average life expectancy. This is consistent with the finding that Missourians with serious and persistent mental illness (SPMI) have a 27 year reduced life span as compared to the general population (National Association of State Mental Health Program Directors, 2012, p. 2 and 6). It is important to the St. Louis community to address the causes of this mortality gap because these statistics represent real people whose lives are cut short as well as real losses to the family, friends, and communities of these people.

The gap at Family Care Health Centers (FCHC) to be filled by this project is the unrealized potential to prevent mental illness from progressing to more severe stages. Because primary care is the default access to mental health care for many in our community, FCHC could be the access point where mental illness is diagnosed early and treated assertively before it becomes most severe. By locating Critical Time Intervention (CTI) case managers at FCHC for screening and treatment of the mentally ill patients who first present there, the *Healthcare in Place* program is an intervention that fills this gap.

This intervention also addresses the lack of integration between agencies in our community. It is especially important to SPMI patients in our community that our common resources coordinate in such a way that there is “no wrong door.” Patients also need to experience seamlessly integrated care in which all of their providers coordinate. Finally, at a systems level, it is crucial

that scarce resources be conserved by having all components work together efficiently and effectively. By having PfP and FCHC deepen their collaboration in a reciprocal way, *Healthcare in Place* strengthens the healthcare network for the benefit of the St. Louis community.

Community data that supports the above: Satellite: The gap at PfP was identified through interviews with PfP's Health Care Home (HCH) and clinical directors and through review of the recent deaths at PfP. Via its HCH, PfP employs 7 hours per week of primary care physician consultants, 2 nurse care managers, and an HCH director; PfP does not yet include on-site primary care. A systematic review of those patients enrolled in our HCH revealed that 47% have hypertension, 31% have diabetes, 80% have a Body Mass Index higher than 25, and 79% use tobacco. Despite having these serious conditions, 30% of HCH enrollees have not seen a PCP in the last 12 months. The most important evidence of need is that the review of deaths cited above revealed many examples of people who died prematurely of preventable conditions.

CTI: The gap in access at FCHC was identified through interviews with the primary care and behavioral health (BH) providers. There is constantly a long waiting list for the limited BH services that are available at FCHC. Two social workers at FCHC estimated that about 20% of the 250 patients they work with (about 50 patients) need more intensive mental health case management and psychiatric services than can be provided at FCHC.

Evidence-based practice at the satellite clinic: The evidence based practice proposed for the PfP part of the project is the co-located partnership model, described in "Behavioral Health Homes For People with Mental Health & Substance Use Conditions," a publication by Substance Abuse and Mental Health Services Administration's (SAMSHA.) In a co-located partnership model, the BH agency arranges for healthcare providers to provide primary care services onsite (May 2012, <http://www.integration.samhsa.gov>) In a randomized trial evaluating integrated medical care for patients with serious psychiatric illness, Druss et al. compared care-as-usual with on-site, integrated primary care. On-site integrated primary care was associated

with improved quality and outcomes of medical care. (Druss BG et al, Arch Gen Psychiatry. 2001 Sep;58(9):861-8.)

Evidence-based practice of CTI: CTI is listed on the SAMHSA National Registry of Evidence-Based Programs and Practices. A 1997 study demonstrated that CTI services result in a better housing outcome than normal interventions for men with severe mental illness (Susser et al. [1997]. American Journal of Public Health, 87[2], 256-262). In a 2009 study of 150 men and women following discharge from New York City state psychiatric hospitals, those receiving CTI were five times less likely to be homeless after 18 months than individuals who received more typical community support services (Herman, D., [2009] www.criticaltime.org).

Project Narrative: FCHC is requesting \$225,701 of start-up funding for this project to pay for: (1) one-time administrative staff hours for the change of scope application and preparation for both the satellite clinic and CTI components, (2) one-time building modification and equipment costs, and (3) limited-time salary/benefit support during the start-up period. (See project budget and budget narrative for more detail.)

Project plan for satellite clinic: Upon funding of the project, FCHC will immediately apply for a change of scope from Health Resources and Services Administration (HRSA) for a new satellite clinic at PfP; since FCHC is partially funded by HRSA, we are required to have their approval to open a new site. Upon this approval, the physical plant adjustments for accommodating the satellite clinic will be done by PfP. During the probable 6 month waiting period for the change of scope, PfP will prepare to integrate the satellite clinic with all other operations at PfP: community support, psychosocial rehabilitation, wellness groups, on-site pharmacy, and Health Care Home. FCHC will meanwhile prepare by identifying the primary care physician and medical assistant who will staff the satellite clinic, and will prepare the necessary supplies and equipment for installation in the satellite clinic. FCHC and PfP will work together to create the protocols necessary for operating this clinic. Once the clinic is operational (expected 6 months

post grant approval), the gap in access identified above will be addressed as follows. Patients who have not had contact with a primary care provider in the last 12 months and/or whose medical needs are complex or complicated by their BH will be identified and tracked through TEAMcare. PfP's TEAMcare is based on the TEAMcare developed at the University of Washington (www.teamcarehealth.org.) In PfP's TEAMcare, PfP's Primary Care Physician Consultant meets with a psychiatric prescriber, nurse care manager, and Community Support Specialist (CSS) to review patients that have complex physical health and psychiatric co-morbidity. Action items and new treatment plan goals are generated for the benefit of the patient's overall health. TEAMcare will continue to be the main mechanism for communication between all members of this multi-disciplinary team because the FCHC primary care physician in the satellite clinic will attend TEAMcare when the review concerns his/her patients.

Initial appointments in the satellite clinic will be 40-60 minutes and follow up appointments will be 20-30 minutes, depending on complexity. The PCP will work with the Medical Assistant (MA) to obtain baseline health measures and document them in the electronic health record (her).

The case manager at PfP - the CSS – will help the patient get to the appointment and will attend these appointments as the patient allows. He or she will work with the patient and PCP to update the patient's case management treatment plan with the new healthcare goals, objectives, and action items. The PCP, CSS, and HCH Nurse Care Manager (NCM) will as a team employ motivational interviewing, wellness groups, the on-site pharmacy and any other HCH resource in order to make needed progress.

Project plan for CTI: The job description of the CTI CSS will be adjusted for work in a primary care setting. A CSS appropriate for this kind of integrated health care will be identified, trained, and integrated into the BH team already at FCHC. The FCHC staff as a whole (especially primary care providers) will be oriented to the purpose of CTI, how to refer to the CTI team, and how to maintain integrated teamwork throughout. After this preparation phase, there will be a

CTI CSS at FCHC for 16-18 hours per week. The FCHC patient will experience the following: their PCP (sometimes in consultation with the BH provider) will identify a need for services; the typical patient is one who is struggling to meet their basic needs due to a combination of mental health and psychosocial barriers. The patient will then have an in-depth psychosocial assessment with CTI staff including the Daily Living Activities (DLA) Functional Assessment (DLA-20), a functional assessment proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. Staff and patient will develop a culturally competent person-centered treatment plan approved by the patient, intake staff, and the doctor. CTI is a structured and time-limited treatment model consisting of three distinct phases, each about three months duration. In Phase I, the CSS assesses the individual's needs and resources and provides intensive support, including connecting the patient with the psychiatrist and identifying potential supports in the community. In Phase II, the goal is to move the person served toward utilizing these natural, community-based supports. Finally, in Phase III, the person is encouraged to manage his/her own needs and to pursue personal goals. Phase III marks the transition of the patient back to FCHC's resources.

Satellite clinic's impact: FCHC's mission statement emphasizes treating the medically underserved in the St. Louis area. The PfP patients served at the satellite clinic would otherwise be underserved because, prior to the satellite clinic, they were either not getting primary care services at all, or the primary care services were not effective because those services were not integrated well enough with PfP's BH care interventions. This new integrated access to primary care will provide treatment for previously untreated or undertreated chronic medical conditions, which will positively impact the health, functioning, and life span of PfP patients.

CTI's impact: PfP has learned over time that the best way to impact people in need is through outreach. To that end, PfP outreaches at homeless shelters, at hospitals, and in the courts. This project will add FCHC as another outreach location. CTI will impact the need described above

by identifying the mentally ill people at FCHC in order to provide timely case management and psychiatric services; all of this while maintaining their status as an FCHC patient.

Measuring success of the satellite clinic: For the patients of PfP, success of the satellite primary clinic will be measured by improvement in the enrolled population's biometric health measures like blood pressure, blood glucose, blood cholesterol, and weight. Much of the grant funded 2 year period will be occupied by start-up: approval for the clinic, establishing the clinic, ramp-up as patients are introduced to the clinic, and baseline measurements. We project that at 12 months, we will have 90% of the baseline biometrics measurements complete and that at 24 months, 105 of the 150 new patients show improvement in at least one of their biometrics.

Measuring success of CTI: For the patients of FCHC, we expect that after a 2 month preparation phase, 2 patients per month will enroll in CTI. In addition to using the DLA-20 as an assessment tool, PfP uses the DLA-20 as a healthcare outcome. The FCHC patients enrolled in PfP's CTI will have DLA-20 assessments every 3 months (roughly after each phase of treatment.) The project will be deemed successful if, by the end of the 24 months, 35 of the 50 enrolled patients have an improvement in their DLA-20 over baseline at the end of their 9 months of CTI enrollment. The improved DLA will signify that these patients will have built a strong, community-based network of support and will be ready for PfP to end their involvement.

Measuring success of both: (1) By month 24, 90% of the CTI and satellite patients will have a comprehensive (behavioral and primary care) medication list, problem list, asset list, treatment plan accessed by all team members. (2) FCHC's collaboration with PfP will serve as a community model for successful partnership between Community Health Centers and Community Mental Health Centers. (3) A final mark of success would be that by the end of the 24 grant-funded months, both the FCHC satellite clinic at PfP and PfP's CTI at FCHC will be self-sustaining.

Partner Organization Name	Role, Key Skills & Resources
Family Care Health Centers	<p><u>Roles:</u> Apply for grant and change of scope, Manage subcontract with PfP, Primary care, Track outcomes</p> <p><u>Key Skills:</u> Leadership in integrated and comprehensive primary care, Experience with opening a new service site, Treating the medically underserved and patients from diverse cultures</p> <p><u>Resources:</u> Rich network of partner agencies, Electronic Health Record, Local and national reputation</p>
Places for People (see uploaded MOU)	<p><u>Roles:</u> Provide infrastructure for satellite clinic, Health Care Home, Identify and enroll FCHC patients into CTI, Track DLA-20, Assist these patients to recover</p> <p><u>Key Skills:</u> TEAMcare, Wellness services, Critical Time Intervention, Assessment for level of services, Person-centered culturally informed treatment planning</p> <p><u>Resources:</u> Local and national reputation, Leaders in the field of Mental Health Evidence Based Practices, Backup from ACT and CPRP teams</p>

Organizational Profile - Mission of the applicant and the population typically served:

FCHC’s mission is to provide affordable and accessible comprehensive primary care services to anyone, with emphasis on the medically underserved, and to train a primary care workforce in order to promote the general health of the service area. Relevant to this proposal, FCHC has been serving about 150 PfP patients at FCHC but would like to expand that number by creating a satellite clinic at PfP.

Experience and qualifications for conducting *Healthcare in Place*: Since 2009, FCHC providers and medical assistants have come to understand and provide for the special needs of complex PfP patients. In addition since 2009, PfP has been accepting FCHC patients into case management at PfP. Thus, the relationship between FCHC and PfP has been time tested; co-locating at each other’s agency is the next natural step in this growing collaboration. Many of the expected cultural tensions have already been worked out.

Also, FCHC has an excellent working relationship with FCHC's HRSA Project Officer, Catherine Beck, MSW. Since FCHC's HRSA grant has no negative conditions or restrictions placed on it, the likelihood is good that FCHC's change of scope application will be approved.

State or federal funding sources: FCHC receives direct Federal funding from the Bureau of Primary Health Care to support the costs of medical, dental and support services to uninsured patients. FCHC also receives direct State of Missouri funding to support outreach to women and minorities and to provide medical and dental services to uninsured patients.

Other funding sources and strategies used to maintain and increase organizational revenue: In addition to patient revenue, FCHC receives funding from Susan G. Komen and grant funding from St. Louis Mental Health Board. FCHC will participate in an Independent Practice Association (IPA) with other health centers in Missouri that will contract with Medicaid managed care plans. FCHC is exploring the formation of an IPA with other health centers for Medicare patients as well. FCHC stays abreast of any potential new grant opportunities.

In-kind services for the proposed project: Specialist services will not be available on-site at the satellite clinic, but FCHC will provide specialist services (e.g., Obstetrics/Gynecology, vision, dental) as needed at the Carondelet or Forest Park Southeast Site as an in-kind service. In addition, occupancy costs for CTI, medical and administrative supplies, and vital medications not covered by insurance will be donated in-kind by FCHC.

Project Impact: Both the FCHC satellite clinic at PfP and PfP's CTI at FCHC will continue long after the grant ends due to sustainability by revenue generated and due to the value that these components will have for the St. Louis community. The shared vision is that these components will expand well beyond the current start-up plans to encompass a full-service, full-time clinic. The shared vision involves lived and measurable improvements in life-span, quality of life, and functioning for the people served.