

# HEALING HANDS



Vol. 3, No. 5 ■ August 1999

## Integrated, Interdisciplinary Models of Care

30-yr-old male: compound fx L tibia secondary to assault (concrete block dropped on leg while asleep); history of severe depression & IV drug addiction; lab tests reveal co-occurring HIV, HBV, HCV & TB infections.

60-yr-old female: gangrenous foot ulcers secondary to diabetes mellitus; hypertension; history of schizophrenia (lapsed medication); widowed, unemployed, currently residing in emergency shelter.

55-yr-old male: Vietnam veteran presenting with severe bronchitis, frostbitten toes, cirrhosis secondary to chronic alcoholism; recently evicted from "dry" transitional living facility for relapse.

25-yr-old female: abrasions, contusions secondary to assault; possible PTSD; currently residing in domestic violence shelter with two children: a 5-yr-old with disruptive behavior (probable ADD), an asthmatic 3-yr-old.

*These abbreviated sketches illustrate multiple and complex health conditions that are characteristic of many homeless people in the United States. Experienced health care for the homeless providers can read between the lines of the clinical summaries to discern individuals who, in addition to being physically and emotionally ill, are poor, isolated and living in crisis. One glance is enough even for non-clinicians to begin to understand the challenge such clients present for caregivers and for systems of care. This issue of Healing Hands focuses on integrated, interdisciplinary models of care that have been developed to meet this challenge, and examines HCH projects which exemplify them.*

Integrated, interdisciplinary care is essential to address the multiple and complex health problems that are endemic to a significant portion of the homeless population. Navigating fragmented systems of care is often impossible for homeless people, particularly those who are ill. Federally funded Health Care for the Homeless projects were created to provide the coordinated, biopsychosocial services these individuals require. Nevertheless, the need for comprehensive and coordinated health services is not unique to individuals experiencing homelessness. All people could benefit from the holistic, client-centered approach to health care which HCH projects have been working to achieve since their inception.

**INTEGRATED CARE** occurs when one clinician or a team of clinicians coordinates health services across multiple disciplines and delivery systems. Service integration can improve the efficiency of health care delivery systems and produces better clinical results, particularly for individuals with co-occurring mental and substance use disorders.<sup>1</sup> Research has shown that of those treated simultaneously for both disorders, 50% achieved stable abstinence over three or four years, compared to 15% of persons without such integrated treatment.<sup>2</sup>

Integrated services for homeless people are thought to be most effective when they are broad-based, comprehensive, continuous and individualized, simultaneously addressing clients' medical and psychosocial needs. For example, mental health and substance abuse treatment should be integrated with the provision of supportive housing.<sup>1</sup>

Recently published outcomes of the Access to Community Care and Effective Services and Supports (ACCESS) program — a five-year, 18-site demonstration program sponsored by the Center for Mental Health Services — suggest that service system integration is also related to better housing outcomes for homeless people with mental illness. Integration of services for housing assistance, mental and general health care, substance abuse treatment, income support and vocational rehabilitation resulted in an increased percentage of mentally ill homeless clients with independent housing.<sup>3</sup>

HCH projects achieve integrated care by various means, including co-location of services, coordinated intake and referral, shared staffing, cross-training and interdisciplinary teams.<sup>1</sup> Here we focus on the team approach to service integration.

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**INTERDISCIPLINARY TEAMS** actively coordinate care across disciplines. In that respect they differ from multidisciplinary groups in which practitioners have an awareness and tolerance of other disciplines, but do not share care planning and coordination.<sup>4</sup>

Teams have a number of advantages over individual case managers:<sup>5</sup>

- Teams make better use of available resources, overcome fragmentation of services, and promote individualized care.
- Teams arrive at more complete patient profiles faster, combining assessments from various clinical perspectives.
- Teams are client-centered; clients have more options because they are less dependent on any one practitioner.
- Teams engender feedback and mutual support that preserves staff energy.
- Teams promote continuity of care; team membership is contiguous, leadership is flexible, and roles are often reciprocal.

Nevertheless, the team approach does have some drawbacks:<sup>5</sup>

- The value of collaboration is offset by the time and energy required to collaborate.
- Team members may feel less satisfaction because responsibilities and rewards are shared.

- Issues of territoriality, role misconceptions, duplication of effort, and competition among team members are potential sources of conflict.
- Clients may become confused when disagreements about treatment occur between team members.

A number of HCH projects across the country have successfully used teamwork to facilitate case management. In the article that follows, we report the experience of three projects with interdisciplinary teams.

#### SOURCES:

- <sup>1</sup> Oakley, Deirdre. "Training Institute on Co-Occurring Disorders Sparks System Change," *Access: Information from the National Resource Center on Homelessness and Mental Illness*, 8(1): 3, March 1996.
- <sup>2</sup> *Am J Orthopsychiatry* 66(1): 4-76, January 1996 (special section on co-occurring disorders).
- <sup>3</sup> Rosenheck R, et al. "Service System Integration, Access to Services, and Housing Outcomes in a Program for Homeless Persons with Severe Mental Illness," *Am J Public Health*, 88(11): 1610-5, November 1998.
- <sup>4</sup> Ray MD. "Shared Borders: Achieving the Goals of Interdisciplinary Patient Care," *Am J Health Syst Pharm*, 55(13): 1369-74, July 1998.
- <sup>5</sup> Brickner PW et al. *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: W.W. Norton & Co., 1990: 71, 285-299. To order, call 1-800-233-4830. ■

## Making Interdisciplinary Teams Work

**Bruce W. Burking**, Homeless Health Care Coordinator for the Homeless Initiative Program (HIP) in Indianapolis, Indiana, reports that interdisciplinary teams are an integral part of his project's work. "The homeless people we see have so many different needs in so many areas, that it's not practical for only one clinical discipline to work effectively with them," he explains.

The project's 40-member staff includes two prenatal medical providers, two mental health providers, a consulting psychiatrist and part-time paralegals that deal with entitlement eligibility issues. They serve about 4,300 homeless men, women and children each year. HIP provides services to 25 different shelters and missions, staffing medical clinics at 12 sites. In addition, project staff conduct street outreach 14 hours a day, five days per week. At least one outreach worker is on call around the clock, seven days a week.

Clients in four targeted groups require intensive interdisciplinary collaboration: 1) prenatal clients, 2) those engaged in employment or pre-GED activities (the "Choices" program),

3) persons in transitional housing managed by HIP subcontractors, and 4) formerly homeless clients who have achieved permanent housing.

**TIME TO COLLABORATE** is an essential requirement for implementing teams successfully, notes Burking. "To do adequate case counseling or to achieve appropriate communication within and among teams is very challenging, because the vast majority of staff are mobile. Services are provided at missions and shelters all over the county, and staff have a hard time touching base with each other."

To address this problem, four hours every Wednesday morning are reserved for team meetings at which all staff must be present. Case conferencing occurs on two out of four Wednesdays each month. Interdisciplinary teams serving each of the four targeted groups meet bimonthly. One Wednesday is reserved for a general staff meeting, and the fourth is devoted to interdisciplinary collaboration with clinicians at other local agencies engaged in mental health counseling, including the VA homeless team.

**INFORMATION SHARING** is another challenge, says Burking. Services are provided in many different locations, and individual clients may access services at more than one site. Multiple providers see the same client. The need for all clinicians caring for a particular client to keep track of prescriptions and other clinical data makes information-sharing essential.

Currently all clinical records are on paper, filed in the central office to protect client confidentiality. Staff must call in from other sites to have files read to them. To solve this problem, the project is planning to purchase an automated case management system. Intake and treatment records will be stored in a computer database that is accessible to all team members from multiple sites. Burking expects to have the new system up and running by December.

**PROFESSIONAL DIFFERENCES** present a third challenge for interdisciplinary teams at all sites, including HIP. Pronounced differences in perspective — some due to education or training, some to professional habit — may

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engender intense disagreements among clinicians. Social workers and medical providers often hold strongly differing opinions about the right treatment plan for a client. Regular case conferencing helps to resolve these differences constructively, observes Burking. “Team meetings require the discussion to move beyond disagreements between two parties. Other team members can help referee, clarify issues and show where there is common ground.”

**H**arris County Hospital District in Houston, Texas, has always been committed to the concept of interdisciplinary teams. One of the original McKinney Act grantees, this hospital-based HCH project was established in 1988 to facilitate homeless individuals’ access to new and existing medical, mental health and substance abuse services. The project also provides clinical services and transportation for homeless clients at 12 local shelters.

**INTEGRATING SYSTEMS** Administrative Project Director **Marion Scott, MSN, RN**, emphasizes the importance of interagency collaboration. “In our shelter clinics, there are many problems we can’t solve by ourselves,” she says. “If we didn’t enhance homeless peoples’ access to all existing programs, many would not be successful in achieving even the simplest of goals.”

Services offered in the shelters include physical examinations and basic medical assessments, immunizations, patient education, case management and entitlement assistance. On-site mental health counseling is provided through a contractual agreement with the Harris County Mental Health and Mental Retardation Authority, one of the largest providers of mental health services in Houston and Harris County. On-site substance abuse counseling is provided through a contractual agreement with the Cenikor Foundation. Both subcontractors have remained as service providers to the HCH project since its inception.

Interdisciplinary teams other than those funded by the Harris County project help homeless clients access HCH services from shelters beyond the hospital district. HCHD is getting an outreach van soon to bring more services to clients in outlying areas.

The need for health services for homeless individuals is growing in the Houston area. “Three years ago, 65% of our clients in homeless shelters were uninsured; now 88% are uninsured,” reports Scott. “There are virtually no entitlement programs for single males, but this forgotten population ends up in emergency rooms, too.”

**EDUCATING PROVIDERS** To buy into interdisciplinary teams requires education, stresses Scott. Not many clinicians are experienced at providing health care to homeless people at all, much less in teams. “We send new staff members out to the shelters so they can see for themselves how HCH teams work. It is important to educate providers from the beginning, to help them realize that many of the care plans formulated in hospital and clinic settings are unrealistic for the homeless population. Care plans must be individualized and evaluated frequently to assist clients in meeting treatment goals.”

The team approach assures that clients get the best care through checks and balances among individuals in different disciplines and within the same discipline.

*Jonathan Dunning, MEd, CCS,  
Birmingham HCH*

**COMBATTING BURNOUT** is essential to preserve the energy and enthusiasm of interdisciplinary teams, whose resources are often stretched thin. HCHD established a Cheer Committee that remembers staff birthdays and other special occasions, and helps team members deal with job stress, which is intensified by unsuccessful outcomes.

**NAVIGATING FRAGMENTED SYSTEMS** The hospital district, the health department, the City of Houston — all harbor important information about homeless clients which each is reluctant to share, to protect patient confidentiality. Thus no comprehensive medical history is easily accessible to all HCH providers caring for the same individual. A homeless client may have five or six case managers across all systems (mental health, TANF and medical). Scott echoes Burking’s concern about access to information, pointing to the even greater difficulty encountered with agencies beyond the HCH service network.

**ASSESSING OUTCOMES** “If HCH service providers just refer clients out without follow-up, there is no coordination of care,” asserts Scott. Outcomes assessment is essential to successful case management, an important role of interdisciplinary teams.

**J**onathan Dunning, MEd, CCS, introduced interdisciplinary teams to Birmingham Health Care for the Homeless, Birmingham, Alabama, five years ago. He learned to staff cases this way in the Air Force. The team approach to case management has been particularly successful in the substance abuse treatment program which Dunning directed before becoming the project’s Executive Director last year.

The substance abuse treatment team is licensed to provide psychosocial assessments and diagnoses. Clients enroll in an intensive, 8–12 week program, four hours per day, followed by one week of aftercare including vocational counseling. Rigorous weekly drug-testing is a feature of the program. Though controversial, voluntary participation and positive outcomes support its use, contends Dunning. Clients have demonstrated a 75% success rate in maintaining abstinence, six months after completing the program.

**LETTING OUTCOMES CONVINC** The biggest challenge Dunning has encountered with interdisciplinary teams was getting clinicians to understand addictions treatment. Initially, medical staff members were skeptical about alternatives to drug therapy. Non-medical addiction counselors had a hard time accepting any treatment except psychotherapy.

To get staff to accept combined treatment modalities, Dunning held monthly staff training sessions at which prominent psychiatrists were invited to speak. Dramatically better short-term results from combined therapy finally convinced clinicians in difference disciplines to trust each other’s judgment. A \$1.8 million HUD grant based on these results further reinforced their commitment to collaboration.

Every Wednesday afternoon, all staff — mental health and medical providers, case managers and the housing counselor — meet to review substance abuse cases as an interdisciplinary

team. Formal team assessments occur at intake, every 30 days and at discharge. Clinical conferences also focus on other clients with multiple needs (e.g., WIC referral, transportation, childcare and health care) including the newly homeless.

**TEAMS AREN'T FOR EVERYONE** "Not every homeless person is unhealthy or needs social services," remarks **Sharon Brammer, CRNP**, who is part of the Birmingham HCH medical team. "Sometimes the worst thing you can do is to get too many clinicians involved." Even clients who need full case management may not be ready for it. It is important to respect the client's readiness for each therapeutic option. Some clients resist having to tell their story to multiple clinicians at different locations. On-site, integrated services ("one-stop-shopping") reduce both psychological and logistical barriers for clients and staff, notes Brammer. "To avoid jeopardizing our relationship with shelters where care is also offered, we try to avoid duplication of services already being received by clients elsewhere."

In general, Brammer's advice to projects unfamiliar with interdisciplinary teams is to start slowly. Make personal connections in referral agencies whose support is essential. Specify your interdisciplinary mission or goal, and discuss the best way to achieve it as a group. Juggling patient care with case management meetings isn't always easy. Nevertheless, the rewards of teamwork — for clients and staff alike — are well worth the effort! ■

## The Network Needs YOU!

At latest count the Network is 376 members strong, but there's always room for more! Benefits of membership include a free subscription to *Healing Hands* and opportunities to work with HCH colleagues all over the country to improve the lives of homeless people. For information about how to join, call 615/226-2292 or print out an application form from the HCH web site at <http://www.nhchc.org/networkform.html> and send it to: HCH Clinicians' Network, P.O. Box 60427, Nashville, TN 37206-0427; 615/226-1656 fax.

### Top Ten Reasons NOT To Join the Clinicians' Network

10. Seven cents a day to belong to a reputable organization is an outrage.
9. Never join any group with "work" in its name.
8. Avoid any organization that has people involved in it.
7. All the networking I ever needed I did in kindergarten.
6. Networking just breeds interdependence.
5. I thrive on burnout and professional isolation.
4. Ignorance is bliss; reinventing the wheel makes me feel heroic.
3. I'm waiting to join when I have more time...posthumously.
2. "It's my biggest regret that I never joined a network!"  
(from the little-known confessions of John Wayne)
1. It's a conspiracy! Today — networking.  
Tomorrow — Health care for all!

*inspired by Ken Kraybill, MSW, Seattle*

### Communications Committee

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**Healing Hands** is a publication of Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council.  
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