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Community Unite: M3's integrated approach to behavioral health, medical services, and substance use within a housing first model

September 2022

Today's Objectives:

Understand the need for integrating primary care, behavioral health, and social support for individuals experiencing homelessness.

Explore the approach to developing and implementing an integrated model, in the context of a mobile health care delivery platform.

Discuss the organizational and operational challenges to achieving a high level of integrated care, and the unique challenges and opportunities as it relates to mobile health care delivery for individuals experiencing homelessness.

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Tony Nunez, MSSW, QMHP
Supervisor M3

Vaughn Hancock, LPC
Program Manager, M3

Tony Nunez, MSSW (he/him/his)

Job: QMHP Supervisor, M3
Housing and Homeless Services
Start Date: August 5, 2019

Ask Me About: El Paso, TX, cryptozoology, and community mental health.

Fun Fact: I enjoy finding new running trails around Austin, TX.

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Vaughn Hancock, LPC (she/her/hers)

Job: Program Manager, M3
Housing and Homeless Services
Start Date: March 27, 2022

Ask Me About: DBT, housing equity, swimming holes, cocker spaniels, and the best fries in Austin.

Fun Fact: I am an avid reader. I usually read a book a week, if I start a book, I feel the need to finish it.

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M3: Mobile Medical and Mental Health Care Team

A collaboration between Integral Care, CommUnity Care and University of Texas at Austin Dell Medical School.

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The University of Texas at Austin
Dell Medical School

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Mobile • Medical • Mental Health

M3

CommUnityCare™
HEALTH CENTERS

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

SAMHSA
Substance Abuse and Mental Health Services Administration

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M3

Dr. Justin Benzer, Organizational Psychologist and Professor in the Department of Psychiatry at Dell Medical School, and the Lead Evaluator of the M3 Team
Maria Correa, Performance Improvement Specialist

Dr. Timothy Mercer, Medical/Clinical Director
Ashley Sharma, RN
Ugo Ruffus, PMHNP

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M3, Contd

Tony Nunez: QMHP Supervisor

Cecilia Bates, Rehabilitation Specialist

Thomas Chatman, Rehabilitation Specialist

John Ridenour, Peer Support Specialist

Jesse Berkowitz, Housing Stability Specialist

Aloki Shah, Masters of Counseling Intern

Richard Johnson, Community Health Worker

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M3 is a community-based team that provides intensive, time unlimited, multi-disciplinary care to individuals experiencing chronic homelessness with tri-morbid conditions (chronic medical and mental illness with substance use disorders)

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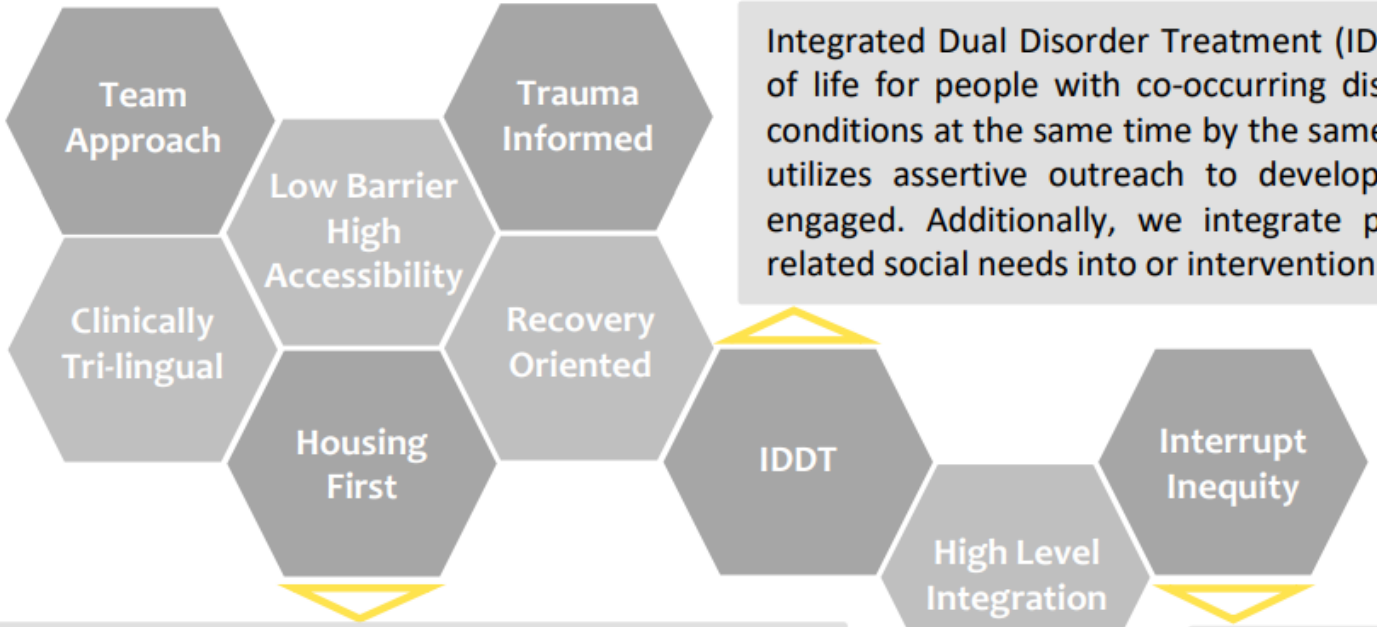
M3 is IDDT

Evidence-Based Model



Integrated Dual Disorder Treatment (IDDT) improves the quality of life for people with co-occurring disorders by addressing all conditions at the same time by the same team of providers. IDDT utilizes assertive outreach to develop trust and keep clients engaged. Additionally, we integrate primary care and health related social needs into or intervention model.

Quickly move people experiencing homelessness into permanent housing without pre-condition and continue to provide services once housed to ensure stability. Shelter is a basic human right and housing stability is key for long-term recovery.

Acknowledge how power, prejudice, privilege and systemic oppression have impacted housing solutions and healthcare outcomes for people of color.

Target Population

Experiencing chronic homelessness

Have at least one chronic medical condition

Suffer from a serious mental illness, AND

Have a substance use disorder

African American prioritized

Current Enrollment: 41

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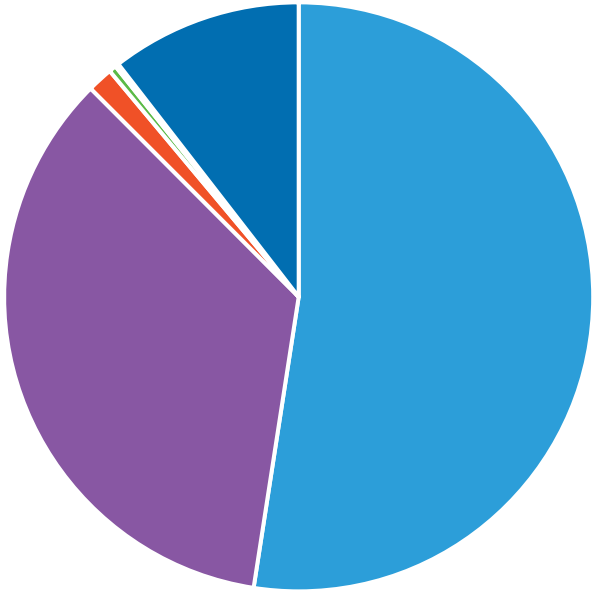
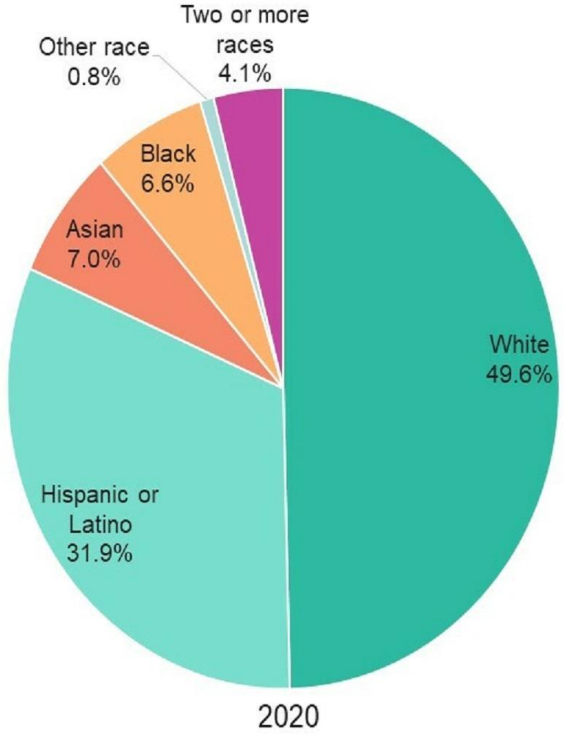
Travis Co. Racial breakdown of "Point in Time" Count 2020



White
Black
Native American
Asian
Pacific Islander
Two or more races

Austin Metro Demographic by Race 2020



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M3 GOALS

Improve Mental Health

Improve Health Outcomes

Decrease Substance use via Harm Reduction

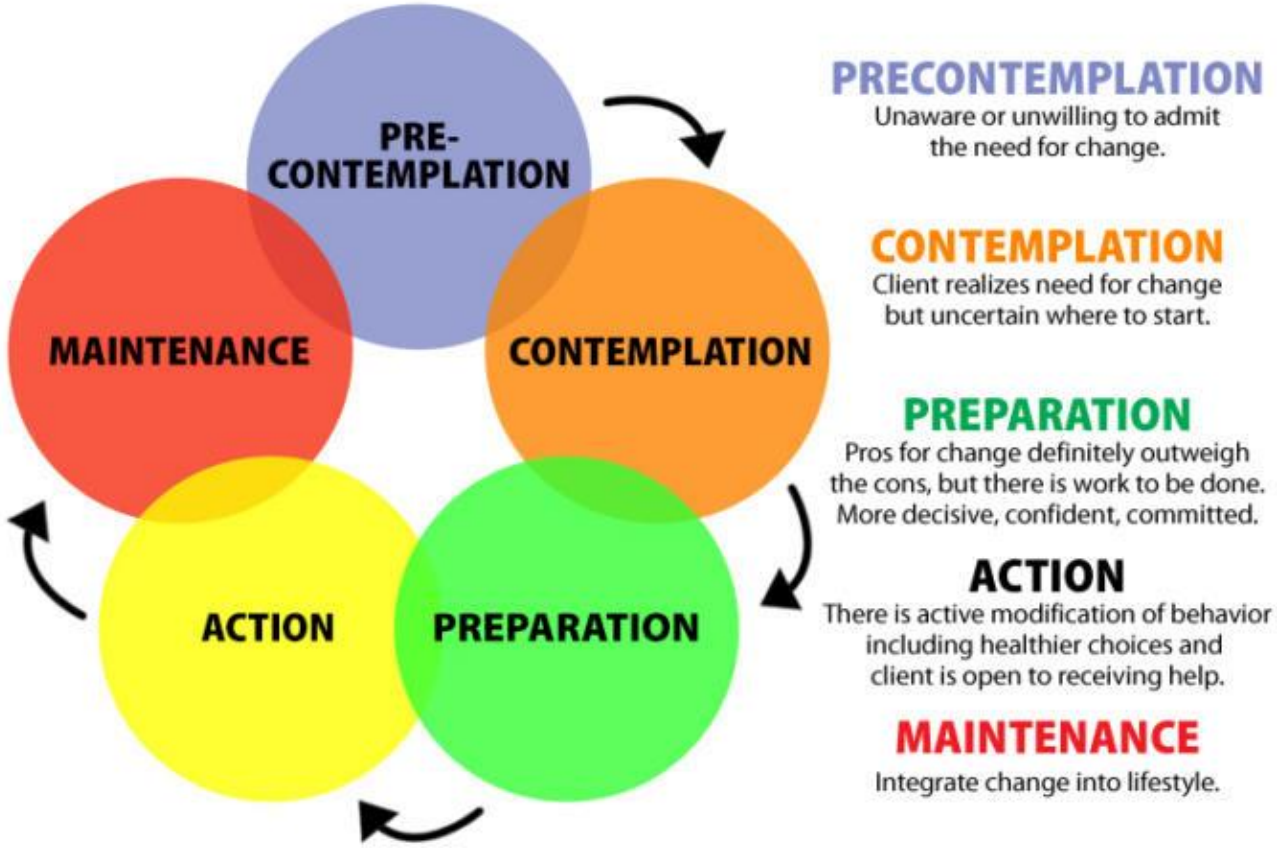
Decrease Emergency Department/EMS Presentation

Increase access to Primary Medical Care

Increase placement and maintenance in sustainable housing via Housing First Approach

Stage of Change Model

Matching interventions with current stage of change



Modality in the Community

- Weekly or twice weekly visits in the community.
- Provide/Arrange transportation to and from medical appointments
- Provide supportive case management around housing, employment, social support programs
- Community Nursing
- Telehealth coordination
- Obtain and store vital documents

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The Integrated Model

- Daily Roll Call for continuity of care and rotating team member approach
- Weekly Staffing with all clinical and non-clinical M3 team members
- IDDT fidelity compliance, exploring for stage-based appropriateness and outside the box thinking
- Team email address and chat for increased communication

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M3 in Numbers

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M3 GOALS

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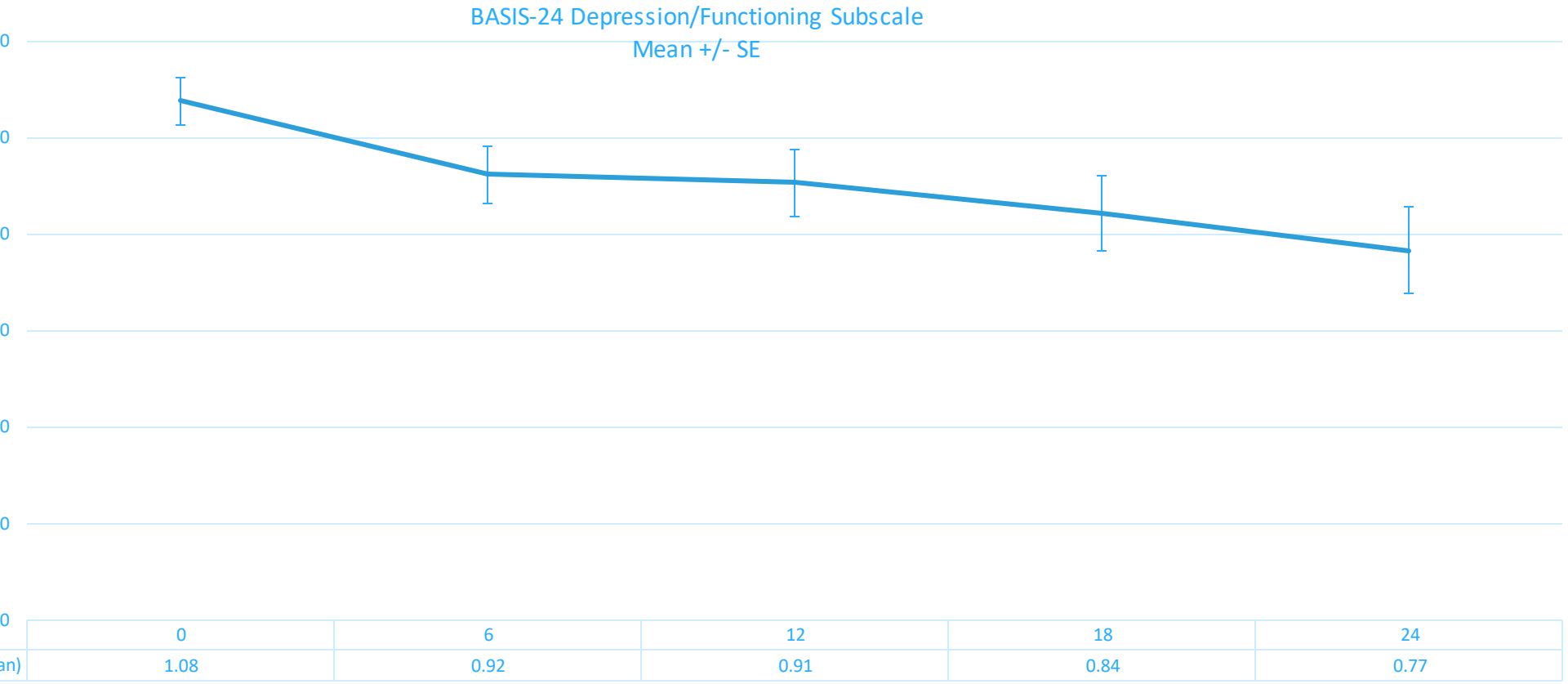
Depression



	0	6	12	18	24
an)	1.08	0.92	0.91	0.84	0.77

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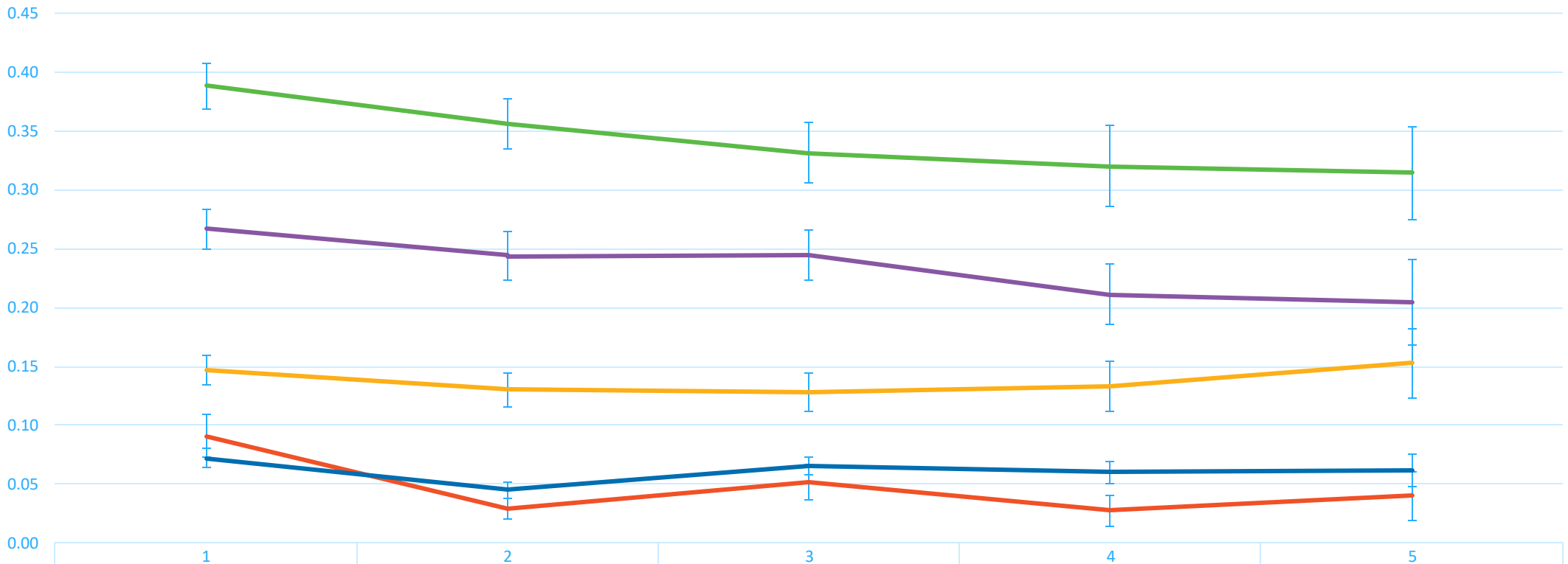
Mental Health Symptoms



	1	2	3	4	5
Relationship Scale (Mean)	0.27	0.24	0.24	0.21	0.21
Self Harm Scale (Mean)	0.09	0.03	0.05	0.03	0.04
Emotional Lability Scale (Mean)	0.39	0.36	0.33	0.32	0.31
Psychosis Scale (Mean)	0.15	0.13	0.13	0.13	0.15
Substance Abuse Scale (Mean)	0.07	0.04	0.07	0.06	0.06

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Key Take Aways from the Data

Depression Ratings:

- Depression/functioning mean scores were consistently higher than scores from other domains
- Depression/functioning scores show a downward trend, indicating that clients reported lower difficulty with or frequency of mental health symptoms after enrolling in the program
- Emotional lability and relationship scores also indicate a downward trend

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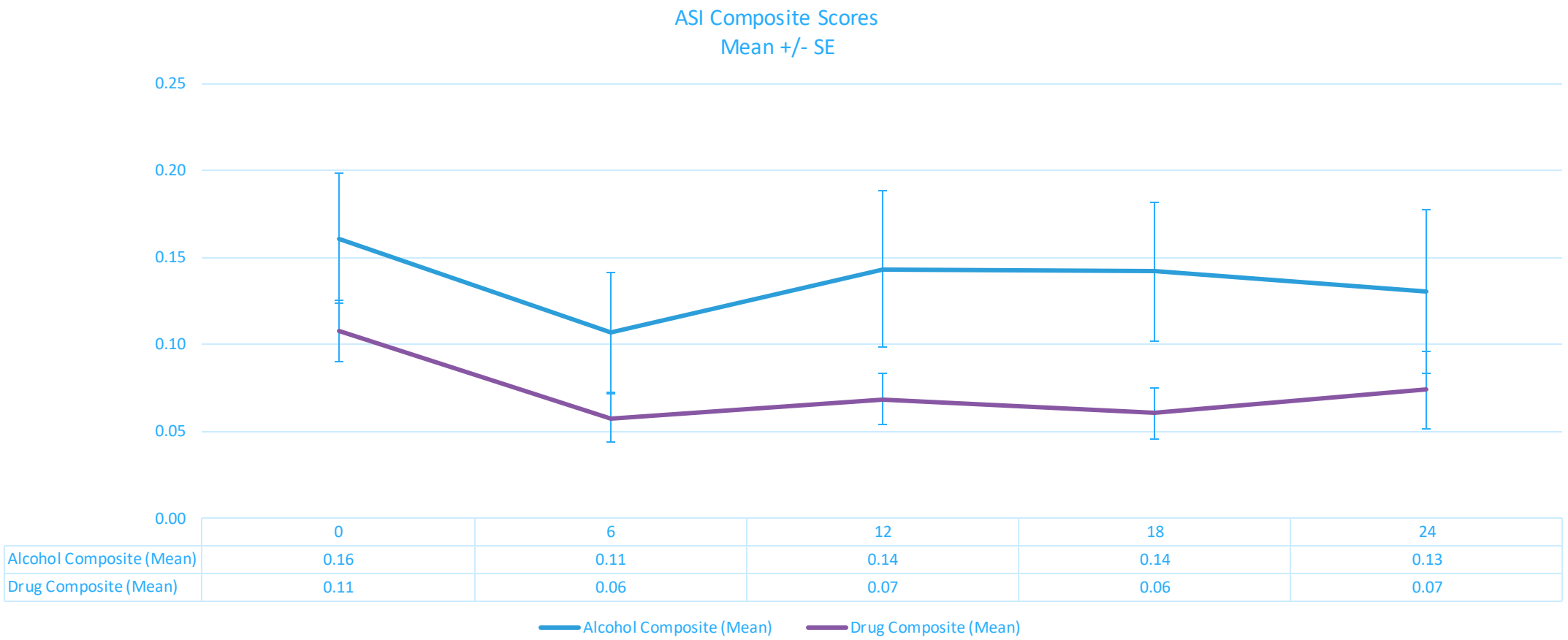
Substance Use



	0	6	12	18	24
Alcohol Composite (Mean)	0.16	0.11	0.14	0.14	0.13
Drug Composite (Mean)	0.11	0.06	0.07	0.06	0.07

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Key Take Aways from the Data

Substance Use Ratings:

- There was a sharp decrease in both drug and alcohol composite scores following the 6 months after enrollment.
- Scores remained relatively stable after 6 months.
- Possible increase in accurate reporting/rapport built with team.
- Decrease in high-risk use observed.

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Emergency Department Presentations

Outcome Measure	Timeframe	Source	N	Pre-Enrollment	Post-Enrollment	%Diff.
Total ED Visits with MH admitting dx	6-mo	ICC	40	25	9	64%
	12-mo	ICC	37	41	18	56%

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Medical Hospital Admissions

Outcome Measure	Timeframe	Source	N	Pre-Enrollment	Post-Enrollment	%Diff.
Total Inpatient Admissions	6-mo	ICC	20	16	21	-31%
	12-mo	ICC	21	24	33	-38%

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Key Take Aways from the Data

ED Presentations:

- Significantly decreased number of ED presentations following enrollment
- Connection to community-based nurse for medical need education and routing
- Increased connection to routine medical visits

Medical Hospital Admissions

- Statistically significant increase in admissions.
- May signify a more appropriate use of ED visits with respect to full admittance to hospital.
- May signify connection to a medical team who can provide reliable information and advocate for marginalized population

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Unique Challenges

- M3 model reliant on face to face contact
- Target population lacking reliable communication devices/transportation
- Vital document systemic barriers
- Medically vulnerable
- Reliant on client report (symptoms, medication compliance, mobility)

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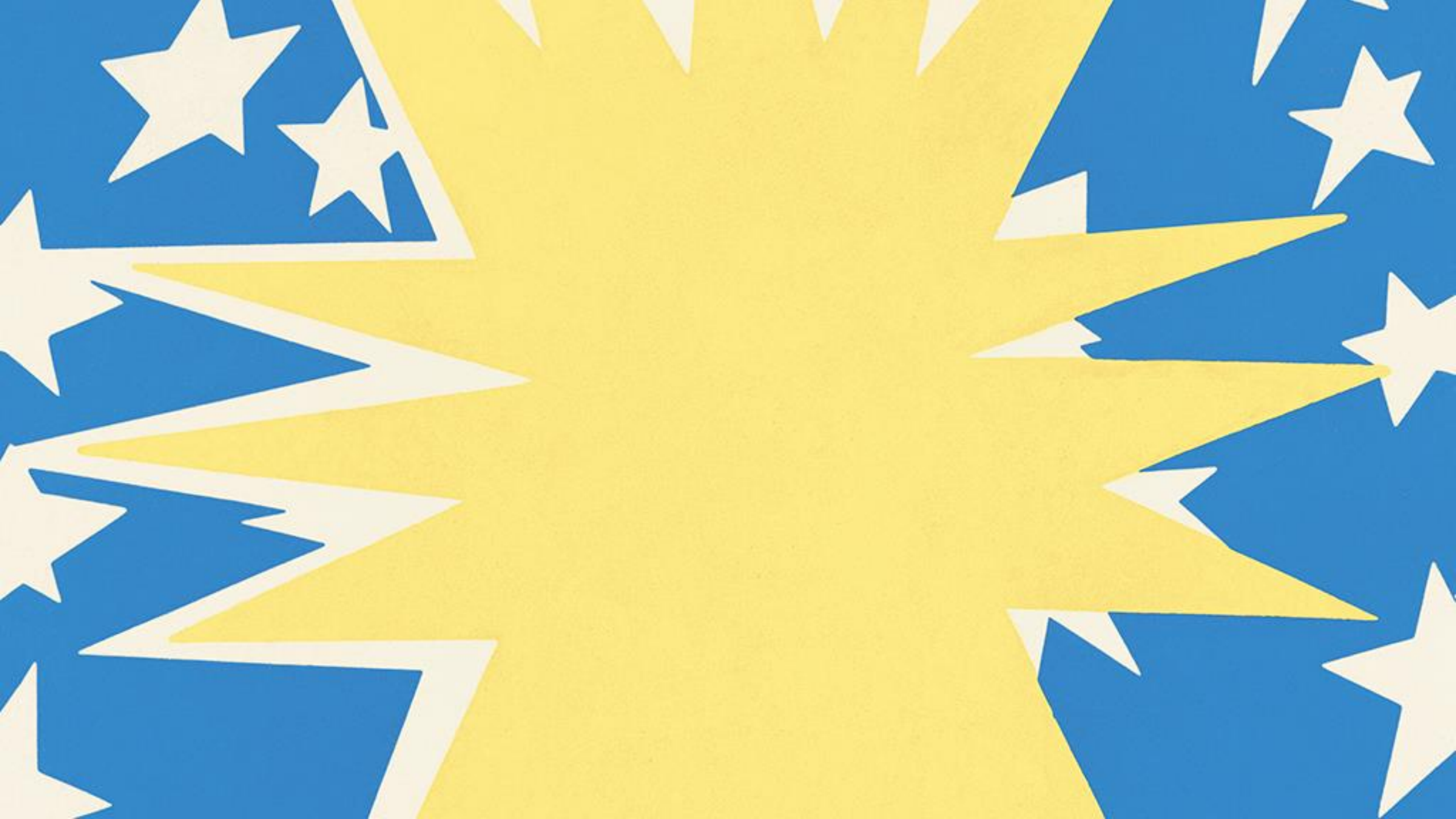

How the Pandemic Impacted the M3 Service Delivery Model

CDC guidelines restricting in person visits

Declining rapport due to reduced engagement with clients

Limited engagement with clients that did not have access to a reliable phone.

Impaired accuracy of telephonic healthcare assessments

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How the Pandemic Impacted the M3 Service Delivery Model

Clients experiencing homelessness having restricted access to formerly accessible community resources

Clients with chronic health conditions at higher risk of serious illness from COVID-19

Clients experiencing homelessness having limited options for quarantine/social distancing

Elective surgeries postponed

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How the Pandemic Impacted the M3 Service Delivery Model

Client reports of increased isolation, depression, SI, and anxiety.

Client reports of increases in substance use.

Client reports of increased difficulties in maintaining medications and telehealth appointments.

Vaccine hesitancy and PPE pushback

Thinking Outside the Box: How M3 Restructured Its Service Delivery Model

M3 provided agency purchased cellphones and distributed to all M3 clients.

Facilitated weekly check ins with healthcare and other social service providers via email/zoom to enhance continuum of care.

Acclimated clients to online/telephonic recovery, mental health, and housing resources

Advocated/triaged medical and housing services for clients amidst office closures

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Thinking Outside the Box: How M3 Restructured Its Service Delivery Model

PPE geared and socially distanced field visits offered to clients.

PPE drop offs to clients in the community.

Offered 3-way calls and telehealth visits with M3 psychiatric prescriber

Added additional phone check ins to build back rapport.

Coordinated admission into COVID-19 prevention shelters e.g. prolodges for clients experiencing homelessness

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Let's Talk About Racial Trauma: M3's Approach to Increasing Vaccination and Trust

"Pandemic trauma combined with the "routine" traumas of homelessness generate compounding traumas" (Jean, 2021).

Let’s Talk About Racial Trauma: M3’s Approach to Increasing Vaccination and Trust

Many BIPOC clients expressed hesitancy of getting the COVID-19 vaccine due to:

History of invalidation and harm by white providers

History of racialized medical trauma on BIPOC populations e.g. Tuskegee Syphilis Study

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Let’s Talk About Racial Trauma: M3’s Approach to Increasing Vaccination and Trust

M3 approached this response from a racial and health equity lens by:

Validating the generational trauma experienced by BIPOC populations

Having vaccinated providers and M3 team members provide a sense of safety and solidarity around receiving the COVID-19 vaccine.

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Let's Talk About Racial Trauma: M3's Approach to Increasing Vaccination and Trust cont.

Educating	Coordinating	Honoring
Providing education on the COVID-19 vaccine and proper PPE usage	Coordinating transportation for clients to receive COVID-19 vaccination.	Honoring the choice of the person to be or not be vaccinated.

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How Do We Heal? Pandemic Takeaways on How to Improve Relations between BIPOC Populations and the MH System

- Having BIPOC providers represented in the healthcare that clients are receiving
- Offering a menu of service delivery options
- Involving a person's natural supports in their mental health care

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How Do We Heal? Pandemic Takeaways on How to Improve Relations between BIPOC Populations and the MH System cont.

- Attending appointments with clients to increase safety and comfort in accessing mental healthcare
- Providing stage-based treatment
- Empowering and skills training with clients on how to self-advocate during healthcare appointments

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What's next for M3?

Quality Improvement Projects

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What's Next?

Groups!

Individual counseling

Returning to transportation

Decreasing barriers to medication access

Building a more flexible/reactive model

Partnering with Integral Care to provide weekly food pantry

Dedicated Housing and Homeless services respite beds for 90 day stays

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Questions?

Many Thanks!

Bibliography

National Health Care for the Homeless Council. (February 2021). Trauma, Mental Health, and Access to Services for People Experiencing Homelessness During the COVID-19 Pandemic. Healing Hands. (Author: Melissa Jean, Writer). Nashville, TN. Available at: www.nhchc.org.

Ending Community Homelessness Coalition

www.austinecho.org

Austin Chamber of Commerce 2020 Census data

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