MIDD Briefing Paper

BP 73 Mobile Medical Program

Existing MIDD Program/Strategy Review ☐ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept ☒ (Attach New Concept Form)
Type of category: New Concept
73 Mobile Medical Program

SUMMARY: The Mobile Medical Program (MMP) provides people experiencing homelessness with outreach-based, integrated mental health, substance use disorder, medical, and dental services. The MMP specializes in reaching individuals living unsheltered and/or experiencing crisis who have not had their healthcare needs met by mainstream health care providers with office-based care coordination programs, which lack the ability to locate and engage these individuals in settings they frequent.

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The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

The Mobile Medical Program (MMP) provides people experiencing homelessness with outreach-based, integrated mental health, substance use disorder, medical, and dental services. The MMP specializes in reaching individuals living unsheltered and/or experiencing crisis who have not had their healthcare needs met by mainstream health care providers with office-based care coordination programs, which lack the ability to locate and engage these individuals in settings they frequent.

The vast majority of program participants have unmet treatment needs for mental health conditions, substance use disorders, or both. The MMP clinical team utilizes a 38-foot mobile clinic parked at

community meal programs and other locations where individuals experiencing homelessness congregate as the hub for walk-in treatment services, relationship-building, and case management. The MMP practices a flexible, person-centered approach to build trust and address clinical and social problems individuals may be experiencing, using an incremental approach. The MMP has psychiatric social workers and staff with substance use disorder expertise who provide engagement, assessment, counseling, case management, and linkages to ongoing services offered by behavioral health agencies (both for mental health and substance use disorders). The MMP physician, in coordination with these behavioral health clinicians and with consultation assistance from an offsite psychiatrist, provides short-term treatment for psychiatric conditions and medical support for addressing substance use treatment needs. The program has secured funding for a second mobile clinic and will braid together funding to support operations. MIDD II would provide a portion of the operating funds for the second mobile clinic team by helping with the costs of two behavioral health providers, a physician, an outreach worker, and psychiatrist consultation time.

Public Health-Seattle and King County's Mobile Medical Program will expand capacity and geographic reach by purchasing a second mobile clinic in order to serve people experiencing homelessness within the City of Seattle. The new mobile clinic team, like the current team operating in South King County, will have a primary focus on people living unsheltered as well as people with unmet behavioral health needs, both for substance use and mental health. To reach these populations, Public Health will coordinate closely with City of Seattle Human Services Department (HSD) staff to work on addressing the housing and health needs of the unsheltered population as part of the City of Seattle Mayor and King County Executive's Homeless State of Emergency[1] response. The intention is to actively partner with encampment operators, food banks, and meal programs, such as Operation Sack Lunch and the Community Lunch Capitol Hill near Cal Anderson Park. Operating in coordination with community meals with significant attendance by the targeted priority population provides a platform for outreach and ease of access to an array of medical and behavioral health services offered on a walk-up basis. The clinical team includes a physician, Registered Nurse, licensed behavioral health clinician, and an outreach specialist who is qualified to assist individuals in enrolling in Medicaid/Apple Health and other benefits/entitlements.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☒ **Crisis Diversion** ☒ **Prevention and Early Intervention**

   ☒ **Recovery and Re-entry** ☒ **System Improvements**

   Please describe the basis for the determination(s).

The Mobile Medical team will meet all four of the MIDD II framework strategy areas. Many individuals access MMP services in the throes of a behavioral health crisis (e.g., individuals who have ceased taking psychiatric medications prescribed in the past by other community providers). The program's clinical staff works as a team to assess and address individuals' most pressing needs and intervene in a way focused on ameliorating the crisis (e.g. expediting access to a psychiatrist, a reconnection with an existing prescriber, or a bridge prescription). Many other individuals with untreated chronic behavioral health and physical health conditions access program services with an extremely high risk for crisis. In these cases, the program's clinicians also work in a closely coordinated manner to assess and address the individuals' most pressing needs and intervene in a way that prevents a crisis, from a harm reduction approach.

[1] http://murray.seattle.gov/murray-constantine-city-council-declare-emergency-announce-new-investments-to-respond-to-homelessness/#sthash.w9BzxhaK.dpbs

The following example helps to illustrate the coordination: the program recently worked with a man who was trying to recover from a stroke while living in his car. The MMP team believed that he might address some of his behavioral health and medical issues much more easily in permanent supportive housing, and they were able to work with partnering agencies to secure an apartment unit in such a building operated by Plymouth Housing Group. Other crisis prevention work includes providing Naloxone overdose prevention kits and training to individuals who use injection drugs. The MMP team also assists with recovery and re-entry services by offering a community resource to walk alongside someone who needs ongoing behavioral health and/or medical care. Clinicians work in a case management capacity, using evidence-based methods such as Motivational Interviewing and harm reduction, to engage and assist individuals navigate their goals of obtaining services at partnering agencies such as community health centers, community mental health centers, and substance use disorder treatment centers. MMP managers closely track the effectiveness of work to link individuals to these services. Finally, the MMP team represents a system improvement by integrating medical care and behavioral health care and using the program's mobility to reach people who are difficult for mainstream providers to engage and support.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

According to an article about the Columbia-Harlem Homeless Medical Partnership,
"*The relationship between poor health and homelessness is bidirectional: homelessness increases the risk of poor physical and mental health, and physical and mental illness can contribute to an individual or family becoming homeless*."[2]

Since the MMP began in 2008, program staff have discovered hundreds of people living outside across King County—in encampments, in their cars, or on the streets— who are effectively disconnected from behavioral health and primary care providers and not actively engaged with clinicians in managing their chronic health conditions. Many reports attest that individuals experiencing homelessness have more health problems per visit, more functional limitations, and a greater prevalence of chronic disease with later presentation[3] . The same is often true of the numerous King County residents who bounce between shelters, couch surfing, other temporary indoor living situations and living outside in their cars or tents. Individuals experiencing homelessness are not only more likely to have poor health, but due to their living situations they are also more exposed to communicable diseases (tuberculosis and influenza), suffer from untreated skin diseases that can lead to cellulitis, and are more prone to hypothermia and frostbite. Furthermore, individuals who are experiencing homelessness also

[2] P. Batra, J.S. Chertok, C.E. Fisher, M.W. Manseau, V.N. Manuelli, and J. Spears (2009). *The Columbia-Harlem Homeless Medical Partnership: A New Model for Learning in the Service of Those in Medical Need.* Journal of Urban Health: Bulletin of the New Your Academy of Medicine, Vol. 86, No. 5. Doi:10.1007/s11524-009-9386-z

[3] J. Hastings, D. Zulman, and S. Wali. (2007) *UCLA Mobile Clinic Project.* Journal of Health Care for the Poor and Underserved. pp. 744-748

experience very high rates of behavioral health disorders and injuries related to assaults and accidents[4]. The current MMP has been highly successful in addressing the needs of individuals in south and east King County, and plans to replicate this success within the City of Seattle.

According to research and data provided by the National Health Care for the Homeless Council, individuals experiencing homelessness have many reasons why they are not willing to access medical or behavioral health care[5]. Some of them are related to prioritization of needs, accessing food, clothing and shelter are a more immediate need. Other barriers are also: lack of trust in/feeling intimidated by the traditional health care system; a history of abuse, mental illness, and/or a substance use disorder; stigmatization; and language barriers. The MMP has set out to provide physical and behavioral health services in a nontraditional way when traditional means of utilizing services (e.g. clinic-based) does not meet the individuals' access needs. MMP has created an operating model around the need to address an array of barriers to engagement by making care available on a walk-up basis and in a manner that facilitates building rapport, trust, and relationship. The foundation of its success is creating a welcoming, respectful atmosphere and starting wherever the individual is at when they seek services.

The MMP's work with unsheltered and other individuals experiencing homelessness and families in south King County has shown that a significant portion of this population has unmet behavioral health treatment needs and faces significant obstacles in accessing both mental health and substance use services in a timely way. It has also shown that outreach-based clinicians can be extremely effective in engaging such individuals and establishing the necessary rapport to walk with them in navigating the health care system. These clinicians can advocate for individuals and use their knowledge of health care providers to work through or around potential barriers much more effectively than individuals can on their own or with assistance from non-clinical case managers.

2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.

Effectively engaging individuals experiencing homelessness with unmet behavioral health treatment needs and linking them to ongoing services requires incrementally building a relationship of trust. According to the Columbia-Harlem Homeless Medical Partnership, working with marginalized individuals often requires a degree of time, flexibility, and continuity;

"*The chaotic social situation of the homeless patient creates a need for community outreach and a period of courting between patient and doctor that can be quite extensive; just to establish a relationship*."[6]

Often the Mobile Medical team begins building that trust by meeting an urgent medical, dental, or other need such as providing wound care for an abscess related to injection drug use, taking care of a painful tooth, on-site Medicaid enrollment, or providing a Narcan (Naloxone) overdose reversal kit and training.

[4] W.C. Lin, M. Bharel, J. Zhang, E. O'Connell, and R.E. Clark. (2015) *Frequent Emergency Department Visits and Hospitalizations Among Homeless People with Medicaid: Implications for Medicaid Expansion*. American Journal of Public Health Vol. 105, No. 5, pp. 716-722. Doi: 10.2105/AJPH.2015.302693

[5] P. Post (2007). *Mobile Health Care for Homeless People: Using Vehicles to Extend Care.* National Health Care for the Homeless Council. https://www.nhchc.org/wp-content/uploads/2012.mobilehealth.pdf

[6] P. Batra, J.S. Chertok, C.E. Fisher, M.W. Manseau, V.N. Manuelli, and J. Spears (2009). *The Columbia-Harlem Homeless Medical Partnership: A New Model for Learning in the Service of Those in Medical Need.* Journal of Urban Health: Bulletin of the New Your Academy of Medicine, Vol. 86, No. 5. Doi:10.1007/s11524-009-9386-z

During the process of addressing the immediate need with which the individual presents, no matter what it is, the program conducts a standard screening to identify other needs, including those related to behavioral health.

As rapport begins to develop, the MMP clinic team member who initially works with the individual considers the screening results or other information and provides a warm hand-off to the team member(s) best equipped to meet other needs. Warm hand-offs ensure that a personal introduction is made and provides a chance to build on any initial trust that has been established. In working with individuals with chronic behavioral health issues, the team often requires multiple engagements in order to move beyond urgent or one-time needs. Sometimes the clinician's primary goal for a first individual visit is a second visit. The flexibility and patience of the program's team approach is critical to allowing clinicians to go deeper into establishing ongoing behavioral health treatment, counseling regarding harm reduction, or navigating the way to stable housing. Along the way, team members use case conferencing to coordinate their work with a given individual and learn from each other in tackling the complexity of their physical health, behavioral health and psychosocial needs.

MMP staff shall be trained as *Housing Assessors* under Coordinated Entry and Assessment (CEA)[7] – Housing Assessors are staff from designated community agencies. Housing Assessors may work out of Assessment Hubs, be designated as the Assessor for his/her agency, or may be part of a mobile outreach team. All Housing Assessors are required to complete a Homeless Management Information System (HMIS) intake and housing assessment with individuals in need of housing and pull, from HMIS, "housing matches" available to each individual. The Housing Assessor passes the referral information to the individual's Case Manager or a Housing Navigator. Housing Assessors' responsibilities include, but are not limited to the following:

- Operating as the initial contact for the *CEA*
- Conducting *Housing Assessment*
- Notifying clients of *Eligibility and Referral Decisions*
- Submitting referrals to the *Receiving Program* through HMIS
- Participating in case conferences as needed
- Responding to requests by the *System Manager,* as appropriate.

3. What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.

Electronic tracking of individual progress has helped prove the effectiveness of the MMP's unique approach. For example, in 2013 over 60 percent of South King County individuals using the program with an identified mental health need completed a psychiatric assessment conducted by a program social worker on-site at a mobile clinic/meal, and 49 percent of individuals with this need attended at

[7] U.S. Department of Housing and Urban Development Office of Community Planning and Development. "Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status." (2014).

least one appointment for mental health treatment with a community mental health center-based provider following the field-based assessment.

In a 2007 national review of mobile health care for individuals experiencing homelessness[8], mobile medical is described as part of a continuum of outreach services:

"The use of mobile clinics to reduce financial, geographic, and psychological barriers to health care for people who are homeless is distinctive yet complementary to other outreach methods, such as "street medicine" provided by walking teams."

The report notes that mobile programs can improve access to care by providing "*compassionate, culturally competent outreach; help with transportation to clinics and other incentives to promote engagement in a therapeutic relationship (food vouchers, hygiene kits and clothing); a consistent mobile service schedule, and assistance in applying for public benefits including health insurance*."

The MMP incorporates best practices related to outreach recommended by the National Health Care for the Homeless Council[9]. These practices acknowledge that individuals experiencing homelessness, especially those experiencing serious disability and/or long term homelessness, often have difficulty finding or accepting the services and care they need. This may be related to fear, lack of awareness, ambivalence, loss of hope, or any other number of personal reasons. Too often, services are difficult to access because of significant barriers presented by the system itself. Outreach workers attempt to mediate and overcome these psychological, informational and systemic barriers to care. They offer an entryway to services and safety, providing a bridge between the streets and a more stable life.

In addition to services discussed above. The following evidence-based practices (EBPs) will be embedded with best practice culturally competent services, varying by race and ethnicity of the individuals being served:

Trauma-Informed Care (Evidence-based practice)

The experience of living unsheltered and surviving without a place to live or receiving any medical or behavioral healthcare can be traumatic. For individuals who have a mental illness this experience is often layered on a history of trauma, both in adulthood and childhood. Research suggests up to 50 percent of individuals with a severe mental illness have a rate of three or more adverse childhood experiences (including abuse, neglect, and witnessing violence)[10]. These traumatic experiences can be dehumanizing, shocking or terrifying, and often include betrayal of a trusted person or institution and a perceived loss of safety. Trauma can include betrayal or a trusted person or institution and a perceived loss of safety. Trauma can induce powerlessness, fear, recurrent hopelessness, and a constant state of alertness. Trauma impacts one's spirituality and relationships with self, others, communities and environment, often resulting in recurring feelings of shame, guilt, rage, isolation, and disconnection. Trauma-informed services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization. This includes understanding an individual's need to be respected, informed, connected, and hopeful regarding their own recovery and

[8] Mobile Health Care for Homeless People: Using Vehicles to Extend Care, Patricia Post, May 2007. National Health Care for the Homeless Council.

[9] https://www.nhchc.org/

[10] Lu, Weili, Mueser, Kim T., Rosenberg, Stanley D., Jankowski, Mary Kay. *Correlates of Adverse Childhood Experiences Among Adults with Severe Mood Disorders.* Psychiatric Services. 2008 (59)"1018-1026

the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression and anxiety).

MMP services must be trauma-informed, recognizing the impact of these experiences on individuals they serve. Trauma-informed services offer choice whenever possible, respect the dignity of the person, and support individuals in re-authoring their personal narrative, moving from "criminal" to community citizen, as well as from "victimhood" to personhood.

Motivational Interviewing (Evidence-based practice)
Motivational interventions aim to respect and promote client choice. It is a directive, client centered approach for eliciting behavior change by helping clients to explore and resolve ambivalence. [11] The wraparound support system or MMP team works together to plan engagement strategies and utilize creativity in their attempts to meet people "where they are at" in readiness for change.

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Promising Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

MMPs are becoming more utilized across the United States. Cincinnati Public Health, Boston Health Care for the Homeless, Baltimore Health care for the Homeless and San Francisco Health Care for the Homeless have all created Mobile Medical Programs and have seen results similar to what King County has seen to date with its Mobile Medical Program. Mobile medical clinics have shown to increase healthcare accessibility and reduce health disparities for communities marginalized by geographic, social, and structural barriers through delivering essential services for preventative, primary care, and disease-specific care[12].

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

A Results-Based Accountability framework is necessary in order to identify the high/population level outcomes for all MIDD II work. At the system and program level, results should be aligned with broader Health and Human Services Transformation results in the Accountable Community of Health and Physical Behavioral Health Integration (*5732-1519 Recommended Performance Measures*) as well as the *Washington State Performance Measures Starter's Set* recommendations from December 17, 2014.

Program level outcomes for MMP should include:

- A significant increase in the number of individuals receiving services through the mobile medical program, particularly within the City of Seattle
- Measurable engagement in onsite treatment, case management and other services. For example, the number of total program individuals who meet with and engage with the

[11] Rollnick, S. & Miller, W.R. (1995). *What is motivational interviewing?* Behavioural and Cognitive Psychotherapy, 23, 325-334. Cited from http://www.motivationalinterview.net/clinical/whatismi.html
[12] B.A. Gibson, D. Ghosh, J.P. Morano, F. L. Altice (2014). *Accessibility and Utilization Patterns of a Mobile Medical Clinic among Vulnerable Populations*. Health & Place vol. 28 pp. 153-166.

program's chemical dependency professional to discuss their substance use, harm reduction options, and/or treatment options.
- Confirmed linkages to offsite treatment or social services
- Mobile Medical Program completes a needs screening form for every individual and collects outcome data related to the most common areas of need (ex. The program determines how many individual have a mental health treatment need, and for those individuals with this need, it collects data on how many had a documented clinical assessment provided by a program clinician and confirmed follow-up treatment provided offsite at a community clinic.)
- Reduction of preventable emergency room visits for individuals receiving services
- Right fit for care/service linkage demonstrated by culturally responsive services and the individual feeling their culture is centered in the outreach relationship.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☒ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☒ **Children 0-5**	☒ **Black/African-American**
☒ **Children 6-12**	☒ **Hispanic/Latino**
☒ **Teens 13-18**	☒ **Asian/Pacific Islander**
☒ **Transition age youth 18-25**	☒ **First Nations/American Indian/Native American**
☒ **Adults**	☒ **Immigrant/Refugee**
☒ **Older Adults**	☒ **Veteran/US Military**
☒ **Families**	☒ **Homeless**
☒ **Anyone**	☒ **GLBT**
☒ **Offenders/Ex-offenders/Justice-involved**	☒ **Women**

☒ **Other – Please Specify:**

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

MMP aims to serve difficult to engage individuals experiencing homelessness and who are disconnected from care. The best results come from going to meal sites, encampments, shelters and other locations where individuals experiencing homelessness are going in order to meet their basic needs. While the program finds that the typical individual served falls into the adult or older adult category, it strives to provide clinics at sites that encourage access for young people who are teen-age and transition age youth. MMP also coordinates with agencies providing outreach to individuals with U.S. Military service (veterans) experiencing homelessness in order to attract these veterans to program services and also provide effective linkages to services for veterans (e.g., Veterans Health Administration and veteran-specific housing, employment, and social services).

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: Seattle

The MMP has been highly successful in addressing the disconnection between health care services and people living unsheltered or otherwise experiencing homelessness south and east King County and plans to replicate this success within the City of Seattle. The City of Seattle's new initiatives to address the surge in people living unsheltered, including outreach to address behavioral health needs and support for organized encampments, provides many specific partnership opportunities to help the second MMP team to efficiently site services and maximize the number of people served who have the needs that the program is designed to address.

If additional funding is available, the team is also willing to provide services to north King County.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**
4.

In south King County the MMP has actively collaborated with numerous partners and in expanding into Seattle will replicate this level of extensive collaboration.

Some current program partners include:

- Community Health Centers, (e.g., Healthpoint);
- Community Mental Health Centers (e.g., Navos, Valley Cities and Sound Mental Health);
- Approximately 10 Faith-based meal programs;
- Various first responders and police departments (e.g., Renton and Burien);
- Housing and shelter providers (e.g. Catholic Community Services, Sound Mental Health and Valley Cities Counseling and Consultation);
- Substance use disorder treatment providers (e.g., Evergreen Treatment Services - REACH Program);
- Veteran-specific providers, (e.g. numerous DCHS contractors);
- WA State Department of Social and Health Services); and
- Medical Teams International (provides mobile dental care to Mobile Medical Program individuals).

Other partners to include:
City of Seattle; King County Jail; Harborview Medical Center; housing and social service providers and providers within Public Health's Health Care for the Homeless Network such as Neighborcare Health, Country Doctor Health Centers, The Edward Thomas House Medical Respite Program, Neighborcare Health, Pioneer Square Clinic, Seattle Indian Health Board, and the YWCA.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

Health Care Reform has created both opportunities and challenges for individuals experiencing homelessness with unmet physical and behavioral health care needs; the Mobile Medical Program has developed a highly effective model for assisting individuals overcome the challenges and take advantage of the opportunities. For example, the program has helped enroll over 500 individuals experiencing

homelessness in Medicaid since Medicaid expansion in 2014. The team has documented, however, that many of these individuals have faced difficulties in using their new benefits to obtain specialty care for both physical and behavioral health chronic conditions. To address these kinds of problems, the State has begun seeding county-level experimentation with different approaches to helping individuals who are high-risk and have chronic illnesses to better navigate the process of linking to and maintaining strong relationships with appropriate care providers. King County can take advantage of these State initiatives to prove out the effectiveness of intensive care coordination models for high-risk, chronically ill individuals experiencing homelessness. The MMP represents a prime example of an innovative local model that King County should test within the context of State-funded Medicaid 1115 Global Waiver.

Indeed, according to an article about access and utilization patterns of mobile medical programs[13], *"As patients are enrolled in care and expected to receive care in nearby federally qualified community healthcare centers, subsets of patients with socially or medically stigmatizing conditions may not utilize them*."

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

The engagement process for individuals who are unsheltered with added behavioral health concerns, who are distrustful of the healthcare system requires a support network that can walk with them through the process. Traditional medical models do not allow for the time to do this slow engagement; restrictions around funding, need to meet outcomes and desire to move individuals quickly through the transitional programs make it difficult to really engage someone. Behavioral Health agencies have six to eight week wait times for psychiatric prescriber appointments and starting behavioral health medications with this timeline is difficult. The lack of access to behavioral health and medical providers, as well as lack of access to withdrawal management (detoxification) beds make it difficult for individuals to access services. Furthermore, there is a definite difference in behavioral health clinical outreach, where therapeutic treatment is being provided along with engagement, versus general outreach, where the emphasis is on providing referrals.

These barriers can be overcome by having an integrated team that is consistently providing outreach, medical services and behavioral health services to the areas that individuals are frequenting. The MMP can meet this need by working with existing mental health services and providing a clinical outreach worker who can also provide onsite services with the Mobile Medical Program. This staff could also go with the individual to traditional medical appointments. The Mobile Medical Program can also negotiate working with existing community-based behavioral health programs to have special set aside provider appointments or referral times in order to expedite the transition from the Mobile medical program.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

Without the robust behavioral health clinical capacity that MIDD funding can provide, the MMP physician working on the second mobile medical unit in Seattle will continually identify individuals with

[13] B.A. Gibson, D. Ghosh, J.P. Morano, F. L. Altice (2014). *Accessibility and Utilization Patterns of a Mobile Medical Clinic among Vulnerable Populations*. Health & Place vol. 28 pp. 153-166.

acute needs for behavioral health treatment but no immediate resource with which to address these needs. When the program was in early implementation in south King County and did not have a budget for mental health and substance use clinicians to provide assessment and treatment as part of the mobile clinical team's regular activities, this problem was pervasive.

The City of Seattle is helping with the current startup of a second mobile medical unit. The funding stream for most mobile medical units are braided and although there is money for the start of this second unit, the need for more funding is needed in order to have the unit meet the needs of the individuals they serve. Finally, good coordinated care is a must. A lot of the individuals may be connected and engaged with other services providers and so mobile medical clinicians will need to be diligent in working with other providers to coordinate care and avoid duplication of effort.

4. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

Currently there is one Mobile Medical Program operating out of south and east King County. This program has been operating since 2008 and has shown significant positive results for individuals experiencing homelessness. The City of Seattle has been willing to help fund the expansion of the program into Seattle, but this funding is insufficient to allow for the needed level of behavioral health clinical capacity that has been established over the past seven years of serving south King County. MIDD II could help continue the program and start the expansion of moving this program to north King County as well.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

- Health and Human Services Transformation - Accountable Community of Health, Familiar Faces and Physical and Behavioral Health Integration strategies
- King County Equity and Social Justice Initiative
- King County Veterans and Human Services Levy
- 2015 Declaration of State of Emergency for Homelessness –King County and City of Seattle

The MMP fits with the overarching goals of all listed initiatives by offering accessible, outreach based integrated care in areas of King County and the City of Seattle, targeting individuals not being served in our current service system and who are experiencing extreme poverty, homelessness and disenfranchisement from community-based/clinic-based medical and behavioral healthcare.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

MMPs are rooted in the principles of recovery and resiliency. The programs are developed to engage people where they are normally accessing other services and to provide ongoing services, assisting individuals with developing the skills and tools to manage their own health. The MMP goals are to help individuals meet their own needs, self-determine asking for help and develop skills to access that help in a more meaningful manner. The program helps individuals access preventative primary care, learn about and access healthcare benefits, and obtain/sustain access to behavioral health services.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

The Mobile Medical Program provides health and human services that are high quality, affordable and culturally appropriate and support the optimal well-being of all people. The program's target population of individuals experiencing chronic homelessness is overwhelmingly living in extreme poverty or very low-income. In 2011, 97 percent of Mobile Medical Program individuals were below 30 percent of the median income level for King County. Numerous research studies have indicated that homeless and low income populations have much more limited access to primary medical care, mental health services, and dental care than the general population. It is also important to note that communities of color are overrepresented in the population of King County experiencing homelessness, and MMP serves a racially diverse client population. The program focuses its resources on expanding access to all needed health services for this vulnerable special population.

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

The Mobile Medical Program will require at a minimum one Full Time Equivalent (FTE) Mental Health Professional and one substance use focused clinician who will join with the physician, nurse, and outreach staff to provide the full continuum of program services on an outreach basis at locations throughout Seattle.

2. **Estimated ANNUAL COST. $100,001-500,000 Provide unit or other specific costs if known.**

   See number 1.

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

The MMPs operations in south and east King County are funded by the Veterans Levy and Human Service Levy, a grant from the federal Health Resources and Services Administration, and the Cities of Auburn, Burien, Federal Way, Renton, and Tukwila. The City of Seattle has a one year initiative that is assisting the startup of the program's expansion into Seattle. The current funding from the City of Seattle is for 2016, but there is no assurance of continued funding after 2016, since the 2017 budget has not been discussed yet.

4. **TIME to implementation: Currently underway**

a. What are the factors in the time to implementation assessment?
Public Health has already received funding for one year to start up a new Mobile Medical team for Seattle proper. It anticipates that it will need to braid together funding streams in order to make the Seattle team sustainable, just as it has in South King County.

b. What are the steps needed for implementation?
Public Health has developed a staffing model for the Seattle team that reflects is experience providing mobile medical and behavioral health services in South King County. If MIDD funding is approved it will use this staffing plan to recruit and hire behavioral health clinicians for the Seattle team and then work to integrate these team members with the physician, nurse, outreach worker and other staff.

c. Does this need an RFP? no

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional) Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

MMP links to multiple other briefing papers that focus on outreach and engagement services, including: *BP 34, BP 39, BP 72, and EP 1b* which have been combined to be referred to as the Outreach and In-reach System of Care. This also can be connected with *BP 35 Homeless Outreach Coordination and BP 44 Familiar Faces Cultural Care Management Teams.* This program, as well as the other outreach programs, would benefit from a coordinated effort around services, communication and support from other local outreach programs.

#73 Working Title of Concept: Mobile Medical Program

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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

The Mobile Medical Program provides people living homeless with outreach-based, integrated mental health (MH), chemical dependency (CD), medical, and dental services. It specializes in reaching people living unsheltered as well as other people in crisis who are challenging for mainstream health care providers and office-based care coordination programs to locate and engage. The vast majority of program patients have unmet treatment needs for MH conditions, substance use disorders, or both. The clinical team utilizes a 38-foot mobile clinic parked at community meal programs and other locations where homeless individuals congregate as the hub for walk-in treatment services, relationship-

building, and case management. It employs a flexible, patient-centered approach to build trust and address clinical and social problems incrementally. Its psychiatric social workers and CD specialists provide engagement, assessment, counseling, case management, and linkages to ongoing services offered by MH and CD agencies. Its physician, in coordination with these behavioral health clinicians and with consultation assistance from an offsite psychiatrist, provides short-term treatment for psychiatric conditions and medical support for addressing CD needs. The program has secured funding for a second mobile clinic and will braid together funding streams to support its operation. MIDD would provide a portion of the operating funds for the second mobile clinic team by helping with the costs of two behavioral health providers, a physician, an outreach worker, and psychiatrist consultation time.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

Since the program began in 2008, it has determined that hundreds of people living outside across King County-- in encampments, in their cars, or on the streets -- are effectively disconnected from behavioral health and primary care providers and are not actively engaged with clinicians in managing their chronic health conditions. The same is often true of the numerous King County residents who bounce between shelters, couch surfing, other temporary indoor living situations and living outside in their cars or tents. Because people in such situations tend to live in crisis management or survival mode, they are challenged to jump through the hoops of mainstream care providers; in turn, they are challenging for mainstream providers to engage in long-term treatment and disease self-management programs. Often mainstream providers and managed care organization staff cannot even locate such individuals. The Mobile Medical Program has been highly successful in addressing this disconnection in South and East King County and plans to replicate this success within the City of Seattle. To accomplish this goal, it will collaborate with various agencies serving the homeless within Seattle, including encampment operators, behavioral health providers, and agencies specializing in street outreach to people with chronic mental health and substance use conditions. The City of Seattle's new initiatives to address the surge in people living unsheltered, including outreach to address behavioral health needs and support for organized encampments, provides some specific partnership opportunities to help the second Mobile Medical team efficiently site its services and maximize the number of people served who have the needs that the program is designed to address.

3. How would your concept address the need?
Please be specific.

Effectively engaging homeless people with unmet behavioral health treatment needs and linking them to ongoing services requires incrementally building a relationship of trust. Often the Mobile Medical team begins building that trust by meeting an urgent medical, dental, or other need such as providing wound care for an abscess related to injection drug use, taking care of a painful toothache, on-site Medicaid enrollment, or providing a Narcan (Naloxone) overdose reversal kit and training. During the process of addressing the immediate need with which the individual presents, no matter what it is, the program conducts a standard screening to identify other needs, including those related to behavioral health. As rapport begins to develop, the clinic team member who initially works with the individual considers the screening results or other information provided in providing a warm hand-off to the team member(s) best equipped to meet other needs. Warm hand-offs ensure that a personal introduction is made and provide a chance to build on whatever level of initial trust that has been established. In working with individuals with chronic behavioral health issues, the team often requires multiple touches in order move beyond urgent or one-time needs. Sometimes the clinician's primary goal for a first individual visit is a second visit. The flexibility and patience of the program's team approach is critical to

allowing clinicians to go deeper into establishing ongoing behavioral health treatment, counseling regarding harm reduction, or navigating the way to housing. Along the way, team members use case conferences to coordinate their work with a given individual and learn from each other in tackling the complexity of his or her health and psycho-social needs.

4. Who would benefit? Please describe potential program participants.

The program would expand its geographic range in providing wide-ranging benefits to homeless people with mental health and substance use conditions. These benefits include direct clinical services, linkages to other community providers, and linkages to housing and social services. Service sites could include encampments sanctioned by the City of Seattle. They could also include soup kitchens and other sites at which vulnerable homeless people congregate, reflecting the sites that have worked well in South and East King County. Ultimately, program managers will collaborate with numerous community partners in determining service sites and clinic schedules.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

Successful implementation would result in (a) measurable engagement in onsite treatment, case management, and other services and (b) confirmed linkages to offsite treatment or social services. The Mobile Medical Program clinic team completes a needs screening form for every individual and then collects outcome data related to the several of most common areas of need. For example, the program determines how many individuals have a mental health treatment need, and for those individuals with this need, it collects data on how many had (1) a documented clinical assessment provided by a program clinician and (2) confirmed follow-up treatment provided offsite at a community clinic.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☐X **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☐X **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☐X **Recovery and Re-entry:** Empower people to become healthy and safely reintegrate into community after crisis.
☐X **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

The Mobile Medical Program has over the last seven years developed a comprehensive approach to engaging and wrapping around a segment of the homeless population that experiences an extremely high level of risk for poor health outcomes, frequent criminal justice system involvement, and social disenfranchisement. Because the process of exiting homelessness is so complicated for this population by chronic substance use and/or serious mental illness, program individuals have often been caught in a Catch-22 prior to program intake. They have been the most in need of help and yet the least able to self-advocate and marshall the resources required to navigate complex health and social service safety net systems. The Mobile Medical Program's clinicians and outreach workers short-circuit this Catch-22 by reaching individuals where they are, building trusting relationships, and using a team-based model to address the complex puzzle of moving the individual forward to care and housing.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

In determining services sites and schedules program managers will partner with the City of Seattle, King County Jail, Harborview Medical Center, housing and social services agencies, and providers within Public Health's Health Care for the Homeless Network such as Country Doctor Health Centers, the Edward Thomas House Medical Respite Program, Neighborcare Health, Pioneer Square Clinic, the REACH Program, Seattle Indian Health Board, and the YWCA. In order to achieve the desired outcomes the program will partner with agencies providing mental health care, substance use treatment, outreach services, and housing. Success will also depend on partnerships with encampment organizers or other organizations providing services such as meals that attract unsheltered and other vulnerable homeless people to sites that will function as the hosts for the program's mobile clinics.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: **$ 500,000 per year, serving 750 people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.