Summer 8-10-2018

Grounding Frequent Flyers: Understanding High ER Utilization and Developing Primary Care Solutions

Jillian Millares

jillianmillares@gmail.com

Follow this and additional works at: https://repository.usfca.edu/capstone

Part of the Community Health Commons, and the Psychiatric and Mental Health Commons

Recommended Citation

Millares, Jillian, "Grounding Frequent Flyers: Understanding High ER Utilization and Developing Primary Care Solutions" (2018). *Master's Projects and Capstones*. 824.
https://repository.usfca.edu/capstone/824

This Project/Capstone is brought to you for free and open access by the Theses, Dissertations, Capstones and Projects at USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. It has been accepted for inclusion in Master's Projects and Capstones by an authorized administrator of USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. For more information, please contact repository@usfca.edu.

Grounding Frequent Flyers: Understanding High ER Utilization and Developing Primary Care

Solutions

Jillian Millares

University of San Francisco

Abstract

Background: Regular access to primary care can positively impact long-term, chronic conditions. However, medically underserved individuals, particularly individuals with Severe Mental Illnesses(SMI), typically underutilize primary care. Root causes include client level factors such as socioeconomic barriers, provider level issues such as lack of training or general knowledge of SMI issues, and system level factors such as a lack of coordinated services. Methods: The present study conducted a needs assessment to identify the most influential of these factors on clients at an Acute Residential Treatment Center in San Francisco, California. The needs assessment consisted of semi-structured client and staff interviews. Results: Both staff members and clients interviewed found that client level factors had the most significant impact on client primary care utilization as compared to provider and system level factors. More specifically, a need for housing was reported to be the greatest client level competing factor in prioritizing primary care utilization. Discussion: Recommendations included a group curriculum focusing on peer-led chronic disease management.

Keywords: primary care utilization, severe mental illness, housing first

Executive Summary

Background

Progress Foundation provides services to individuals in the San Francisco Bay Area who struggle with mental illness. Clients are housed in temporary housing facilities anywhere from 24 hours to one year depending on their needs. During this time, clients prepare to acclimate back into society through independent living. This is done through securing housing and long-term benefits such as disability, general assistance, and CalFresh/food stamps. These benefits often take time to secure, requiring interviews at housing establishments and multiple appointments at the General Assistance, MediCal, and Cal Fresh offices. Though this time also includes medical appointments, interviews with administration and staff revealed a lack of primary care utilization among clients.

Purpose/Objective

A needs assessment was conducted at Dore Residential (Dore Res), a two week residential program within Progress Foundation. The assessment was meant to better understand current care seeking behaviors among residents and identify barriers to accessing and/or utilizing primary care services in the SMI population.

Methodology

The needs assessment consisted of semi-structured staff and client interviews. A staff member of each discipline was interviewed. This included two administrative staff (clinical director and assistant director), one nurse practitioner, one full-time counselor, and one clerical staff member. Administrative staff were interviewed because they are further removed from day-to-day behaviors and see the bigger picture of client health and well-being based on the client

interactions with the organization. The nurse practitioner and counselors were selected for the opposite purpose; they are familiar with day-to-day behaviors of clients and are most closely working with clients on re-entering society independently. The clerical staff member is most familiar with objective client information such as number of previous and recent medical encounters, which was helpful in data analysis. This totaled 5 staff interviews. Clients were recruited via a verbal ask when study personnel was present at Dore Res. All clients were eligible. A total of 10 client interviews were conducted.

Key Findings and Conclusions

Both staff and client interviews revealed that client related barriers such as socioeconomic factors (e.g. food security, housing, regular source of income) were most influential in preventing clients from utilizing primary care. More specifically, finding permanent housing was the biggest competing priority with establishing and utilizing primary care.

All staff members interviewed also reported that a general lack of understanding of the importance of primary care was a large barrier in clients utilizing primary care. This idea was reinforced in client responses, as many of them saw their medical providers as a means to receive care for already presented symptoms and did not realize preventive services were also offered through most primary care providers.

Lessons Learned

The biggest lesson learned during this study was to initiate client contact earlier. It often took several weeks for clients to acclimate to the study personnel's presence, meaning they did not agree to an interview until a few visits after meeting the study personnel. Rapport building

earlier could have sped up the interview process and yielded a greater number of interviews, especially in a program where clients are only scheduled to stay for a maximum of two weeks.

Recommendations

Based on the clients' inability to utilize primary care at this stage of recovery, the study personnel created a curriculum to be given by a Dore Res counselor. The focus is on peer-led chronic disease management, so that clients gain skills and knowledge on lifestyle changes to manage their chronic diseases without having a regular source of primary care. Clients are required to attend three group sessions a day during their stay at Dore Res; the created curriculum is recommended to be taught once a day across a six day period, as there are six modules to choose from.

Literature Review

Introduction

Regular access to primary care is a significant aspect within the large umbrella of health care services. With access and utilization, individuals can benefit from preventive care, early diagnosis of treatment and disease, and a higher quality of life (SFHIP, 2016). Studies indicate that a consistent relationship between primary care provider and patient can significantly decrease risk of overlooked symptoms; this is most impactful in the case of long-term, chronic conditions, including high cholesterol and blood pressure (Gorman, 2010). A regular source of primary care has also been negatively associated with mortality, with 1 primary care physician per 10,000 reducing deaths 35 per 100,000 (Shi et. al, 2003). On a larger scale, primary care can decrease unnecessary emergency room visits, saving both time and money (SFHIP, 2016). In fact, primary care health centers alone have saved the United States an estimated $24 billion

dollars from reduced hospitalizations and emergency room visits (U.S. Census, 2016).

Unfortunately, almost a quarter of Americans report that they do not access primary care

services. (Community Commons, 2012). This population is a subsection of the medically

underserved category, defined as "those who face economic, cultural, or linguistic barriers to

obtaining health care" (HRSA, 2004). Among this population lies the sub-population of

individuals suffering from a severe mental illness, an additional challenge that creates many

barriers to primary care utilization.

Severe Mental Illness Comorbidities

An individual is characterized to have a severe mental illness (SMI) when they have a

"mental, behavioral, or emotional disorder resulting in serious functional impairment, which

substantially interferes with or limits one or more major life activities (NIMH, 2016)." An

overwhelming 10.4 million U.S. adults suffer from SMI (NIMH, 2016). As a consequence of

SMI and related physical challenges, this population has a life expectancy 25 years less than the

general population (Viron, Zioto, Schweitzer, & Levine, 2014). Many of these physical health

issues are considered chronic conditions; in fact, about 70% of SMI individuals have at least one

chronic illness (Viron et. al, 2014).

Obesity. Some of these physical illnesses can be attributed to obesity, which is

experienced significantly in this population. Obesity is often associated with lifestyle factors

such an exercise and diet. SMI individuals often do not understand the importance of lifestyle

changes to their health, and coupled with socioeconomic challenges such as reduced social

networks, poverty, and low educational attainment, they often resort to consuming processed

foods and remaining sedentary (De Hert et. al, 2011). Because of the high rates of obesity, there

is also an increased risk for Type 2 Diabetes Mellitus (Hert et. al, 2011). Further, these same factors affect this population's risk of developing hypertension and more serious cardiovascular conditions (Hert et. al, 2011).

Low Health Literacy. In addition, SMI individuals can experience obesity due to medical factors such as side effects from medications prescribed for SMI. Low health literacy rates and a lower ability to communicate physical needs prevent them from sharing these side effects with their providers (De Hert et. al, 2011). Low comprehension can also lead to lower compliance for individuals who receive health guidance and advice from their providers (De Hert et. al, 2011).

Infectious disease. Individuals with SMI are also at increased risk of contracting infectious diseases such as HIV and Hepatitis (Hert et. al, 2011). SMI is often associated with risky health behaviors such as sexual risk and substance abuse, and unprotected sex and the sharing of needles are significant transmitting factors of the aforementioned diseases (Hert et. al, 2011). Though these root causes are the same across the general population, they are much greater due to the increased poverty and homelessness in SMI populations (Rosenberg et. al, 2001).

In general, SMI individuals engage in more unsafe sexual behaviors such as multiple sexual partners, infrequent condom use, and same-sex sexual activity (Rosenberg et. al, 2001). This increases rates of Sexually Transmitted Diseases. Further, previous research found that the prevalence of HIV in a sample of SMI populations was 8 times greater than the general population (Rosenberg et. al, 2001). All of these conditions are considered chronic conditions that can be prevented with a regular source of primary care.

Prevalence of Primary Care Utilization Among SMI Populations

Studies have shown that individuals suffering from SMI are less likely to report having regular primary care compared to individuals with no mental illness (Garcia et. al, 2017). Instead, they utilize "high-cost" services such as the emergency room, resulting in over $4 million dollars spent over five years (Fuller, Sinclair, & Snook, 2017). They are also often arrested and placed into the prison system, only receiving medical treatment as symptoms persist, not as a regular source of care or for preventive purposes (Fuller et. al, 2017).

Due to difficulty in sampling and retrieving self-reported data in SMI populations, there are few studies that examine the exact discrepancy in primary care utilization between SMI and non-SMI populations. However, in a study looking at Medicaid recipients in California suffering from SMI, researchers found that 66% versus 80% of individuals had at least one general medical visit over the span of a year (SMI with Medicaid versus general Medicaid population) (Garcia et. al, 2017). Another study conducted in the Veteran Affairs healthcare system found that patients with schizophrenia, drug use disorder, or bipolar disorder were less likely to have a primary care visit within a one year period compared to their non-SMI counterparts (Chwastiak, Rosenheck, & Kazis, 2008). Lower utilization suggests that SMI populations are not receiving the care they need to prevent or manage chronic diseases.

Root Causes

Previous research has analyzed potential root causes for the gap in primary care utilization among SMI populations (Ross et. al, 2015). Barriers and facilitators were identified and can be split into three categories: client, provider, and system level issues.

Client Level Factors

Homelessness. Client level factors were mostly associated with socioeconomic barriers, especially those revolving around housing concerns. Individuals who are worried about securing housing (fixed address) and a regular source of food, are unable to make primary care a priority. Lack of housing can also contribute to access issues such as geographic distance and lack of transportation (Ross et. al, 2015). Gelberg, Gallagher, Andersen, & Koegel (1997) found that over 50% of homeless individuals reported to not have a usual source of care and 30% who needed medical care chose to forgo medical services. Further, they connected the lack of preventive and primary care seeking behaviors to a subsistence difficulty, or an inability to maintain oneself at a minimum level because of their homelessness (Gelberg et. al, 1997).

Severe Mental Illness Manifestations. Another client level aspect was related to poor experiences and symptoms of mental health issues. SMI can be an enormous barrier in completing daily activities; a busy, loud waiting room could be triggering to a patient with SMI, and could potentially evoke a psychotic episode (Ross et. al, 2015). Additionally, negative side effects from antipsychotics such as lethargy and depression could prevent these individuals from keeping their standing appointments (Ross et. al, 2015). Other consequences stemming from SMI can prevent clients from seeking out physical care, including social isolation and a general unawareness of physical problems due to cognitive discrepancies (De Hert et. al, 2011).

Provider Level Factors

Provider level issues were also identified. Related to provider training, it was found that there was a general lack of knowledge about specific issues of mental health and substance use, perhaps suggesting that primary care providers are not fully prepared to serve SMI populations, especially those with substance use issues (Ross et. al, 2015). This lack of knowledge and

experience has led to provider discomfort and negative perceptions of these individuals, with providers regarding this population as disruptive (De Hart et. al, 2011). In turn, these providers are unwilling to have conversations about mental health and feel that physical health issues are the only conversations in scope with a medical visit (Ross et. al, 2015). Further, providers have been reported to regard physical complaints by SMI individuals as psychosomatic, taking these issues lightly (De Hart et. al, 2011). Patients who were surveyed, especially those who were experiencing homelessness and/or criminalization) categorized this behavior into stigma and discrimination (Ross et. al, 2015). Patients felt categorized due to their SMI. This increases patient suspicion and interacts poorly with the cognitive and social discrepancies the SMI population already struggles with, further discouraging them from seeking out primary care.

Providers who do regularly treat SMI individuals also report time and resource constraints, especially with such complex patient cases (De Hart et. al, 2011). More time with complex patient cases leads to an overall light patient load, as appointment time is significantly longer with SMI patients.

System Level Factors

Issues also exist on a systemic level. There is a general lack of clarity amongst primary care physicians and other healthcare providers in integrated care on who is responsible for patients' physical health, and lack of coordination results in assumptions that another provider is filling the physical health needs (Lawrence & Kisely, 2010). This divide between physical and mental health persists in both resource allocation and geographic location. Patients are not aware of this gap and become frustrated when they are asked to seek out multiple providers for various visits, leading to decreased follow up visits and more SMI patients lost to care (Lawrence &

Kisely, 2010). Though there has been a recent push for primary care and mental health integration, there is still a lack of coordinated services for individuals with SMI (Goodrich, Kilbourne, Nord, & Bauer, 2013). These models require a pilot stage that are often long-term, draining time and resources that are scarce to begin with. This creates barriers for such initiatives and has led to a difficulty in widespread programming due to a lack of structure, lack of financial resources, and lack of leadership. (Goodrich et. al, 2013).

The full scale of this issue is difficult to represent, as there is still a general lack of data and research conducted on primary care utilization in SMI populations on a national level. Even in national epidemiological studies, individuals with SMI are not accurately represented (Janssen, McGinty, Azrin, Juliano-Bult, & Daumit, 2015). This lack of data suggests that there is a need to build the evidence base to address this issue on national and local levels.

Perceptions of Care

In order to address the overutilization of "high-cost" emergency services, it could be useful to analyze this population's "value proposition," or how they view primary care settings and if they believe receiving treatment in these settings would provide specific benefits over what they receive in the emergency room (Enard & Ganelin, 2017). When asking the question, "Is there a particular place that you usually go if you are sick and need advice about your health?," research has been able to analyze opinions on usual source of care (USOC), whether it is non-ED, ED, or no USOC (Enard & Ganelin, 2017). Previous studies have shown that their decisions to utilize the emergency room actually represent logical, value based choices. Based on their experiences, they believe that the emergency room works in their benefit. Some of the

factors contributing to their decision include urgency, uncertainty, paying for care, convenience and quality of care (Enard & Ganelin, 2017).

Interestingly, many of these same individuals believed in the importance of a "medical home," or a regular source of primary care. In fact, 62% of those with no USOC agreed that "every person should have a medical home" (Enard & Ganelin, 2017). This brings up a question in the discrepancy between their beliefs and actions. Part of this discrepancy comes from a lack of knowledge about other options besides the ED. All groups, regardless of their USOC status, agreed that they trusted their ED the most. However, 51.4% of those individuals said that they would utilize a non-ED source of care if they knew it would be as affordable, reliable, and available (Enard & Ganelin, 2017). This demonstrates that financial aspects and perceived quality/convenience of ED are strong motivating factors in where patients choose to receive care (Enard & Ganelin, 2017). Further, individuals mentioned that the ED, as opposed to their primary care counterparts, provided them with a "one stop shop" that provides all the services they need, indicating the importance of care coordination and resource management in a patient's care plan (Enard & Ganelin, 2017).

Primary Care and Public Health New innovations have focused on utilizing the patient-centered medical home, where patient treatment is streamlined through the primary care provider. This, combined with public health efforts in housing, creates an integrated health home, where interdisciplinary partnerships are created between various healthcare professionals to communicate and collaborate on patient health care plans. In this case, Thomas Jefferson University (TJU) in Philadelphia partnered with Pathways to Housing to address both health and housing disparities. This 'Housing First' approach provides services for individuals with SMI,

12

Figure 1

many who are homeless and/or have a history of chronic substance use (Weinstein et. al, 2013). The workforce includes social workers, nurses, peer specialists, psychiatrists, and a drug/alcohol counselor, all from either Jefferson Family Medical Associates or St. Elizabeth's Clinic (see Figure 1).
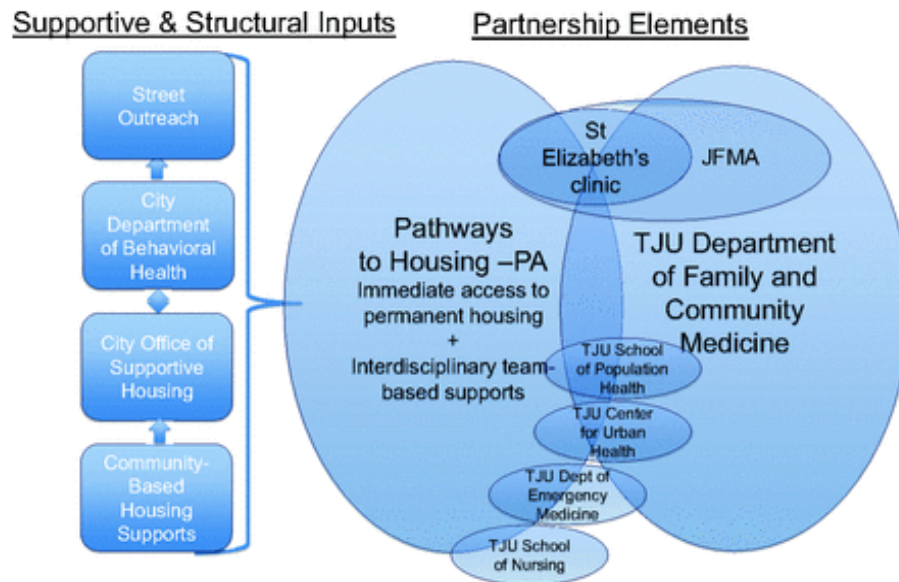

Figure 1: Diagram of TJU +
Pathways to Housing Collaboration

What is unique about this program is that it is 'on-site,' removing the locational barriers that this population faces in accessing regular care. In their preliminary assessment, they highlighted 8 "essential Public Health Services" that they hoped to address in their practice (Weinstein et. al, 2013). The third of these services is to 'inform, educate, and empower people about health issues." This service was addressed due to the results of focus groups conducted, revealing that without housing, access to health care may not have its intended effect on health, especially in a primary care capacity (Weinstein et. al, 2013). Furthermore, they found that

secured housing could shift this population's perspective to their health care priorities. Discussing chronic health concerns and issues with their residents led to increased awareness of these health issues, in turn increasing engagement with health services (Weinstein et. al, 2013).

An Organizational Profile: Progress Foundation

Progress Foundation is a private, non-profit organization that provides individuals disabled by mental illness with treatment. It acts as an alternative to institutionalization. The organization is affiliated with the county health departments of San Francisco, Napa and Sonoma, and many of their referrals come from these departments.

Founded in 1969 when the deinstitutionalization movement was at its height and thousands of mentally ill individuals were left without long-term psychiatric care options, the hope of the Progress Foundation was to move individuals from state psychiatric hospitals back into the community. It has spent nearly five decades developing community-based programs to support their clients and to prevent them from returning to institutions or correctional facilities. They have grown to offer 19 programs across the three aforementioned counties and serve over 3,000 individuals annually. These programs fall either under crisis residential and transitional residential categories. Crisis residential programs allow for clients to stay anywhere between 24 hours and 2 weeks while they prepare to transition into a fully independent lifestyle. During this time, staff helps to coordinate medical appointments, housing interviews, and any other counseling needed. Transitional residential clients can stay in programs for up to one year, which time they build support networks and practical skillsets.

Progress Foundation is able to accept all clients regardless of other challenges they may be facing, including alcohol/substance abuse, major health problems, and history of criminal

justice. They aim to provide culturally and socially competent care, offering programs to individuals across demographics. This includes programs for specific racial groups, elderly individuals, and even new mothers. This approach allows for camaraderie and community building.

The organization is funded through contracts with county health departments of San Francisco, Napa and Sonoma. These contracts are reviewed annually to ensure effective, responsible care that is satisfactory to clients. Funding has also previously been secured through the Department of Housing and Urban Development and private grants. Personal donations are also accepted.

The stated mission of the Progress Foundation is to "promote rehabilitation and encourage the highest possible level of self-sufficiency for individuals who are considered severely disabled due to mental illness". This is accomplished through their innovative approach of community-based programs integrated in the neighborhoods they already know and are comfortable with. This programming operates using the Principles of Social Rehabilitation, emphasizing the role of a home-like treatment environment. With that said, there are multiple treatment sites tailored to the community in which they serve, and all are found in neighborhoods rather than commercial areas. Crisis programs include La Posada, tailored to the Spanish speaking community, and Shrader House, specialized in treating clients with co-occurring mental health and substance abuse needs. A unique transitional program is offered at Ashbury, the first licensed treatment setting in the state that allows families (mother and child) to remain physically together while a mother receives rehabilitation services. In addition, continuum of care is highly

valued in all programs, so cooperative and independent living apartments are available to clients after graduation from their program.

For my fieldwork project, I worked in the Dore residential clinic, a voluntary alternative to Psychiatric Emergency Services at San Francisco General Hospital. This clinic allows clients to stay up to two weeks. The organization believes that focus groups and educational curricula are best conducted in this clinic due to the longer stay period and the higher levels of client mental stability at this stage.

Because Progress Foundation has a plethora of services and facilities, their staff is quite comprehensive. In addition to mental health clinicians, they have a large support staff that takes care of all administrative tasks, such as coordinating Medicaid, referrals, and other aspects of client files. At the Dore Clinic alone, they have 3 social workers, 2 registered nurses, and 1 nurse practitioner at any given time. Their flexible staff often move from site to site when gaps need to be filled.

Progress Foundation's primary audience are individuals disabled by mental illness who are looking to improve and stabilize their mental health. Referrals are accepted, but individuals can check themselves in and out as they see fit. Progress Foundation believes that their clients should not be forced into treatment and that greater strides are made when they feel in control of their treatment and recovery.

Methods

Population & Sampling

Due to variable data on the topic of primary care utilization in SMI populations, a needs assessment was conducted to gain insight on the understanding of primary care and care seeking behaviors in Progress Foundation clients. More specifically, clients housed at the Dore Residential Acute Diversion Unit (Dore Res) were targeted as a convenience sample. This population was chosen due to the residents' greater stability, both in mental and physical state, as compared to clients in the urgent care units. Residents at Dore Res are housed for two weeks as a means to rehabilitate from substance use as well as to make arrangements to re-enter the world. Clients are generally available for interview purposes. In addition, a structure for a potential curriculum deliverable is already in place in the form of daily 'groups.' These groups are designed to increase independence amongst Dore Res clients, and clients are generally willing to engage.

Participation in the needs assessment will be voluntary and through an informal ask of Dore residents who are in communal spaces (e.g. the kitchen, dining room table, or living room area with couches). The researcher will be at Dore Res 3 times a week for 4 weeks. Clients who are at the house at that time will be made aware of the researcher's presence by a Dore Res counselor and will be told to approach the researcher should they be interested in an interview. This was manageable on a weekly basis, as there are consistently a maximum of 12 residents at any given time. All clients were eligible to participate, as the group curriculum was created for all clients at Dore Res to participate in during a daily group, regardless of current care behaviors.

5 staff members with different roles (nurse practitioner, clinic director, assistant director, full-time counselor, and relief counselor) were interviewed. Staff with different roles were chosen due to the varying interactions they have with clients, in turn bringing diverse

perspectives to the subject. This included two administrative staff (clinical director and assistant director), one nurse practitioner, one full-time counselor, and one clerical staff member. Administration was selected because they are familiar with the clients on a larger scale; they are a bit further removed from day-to-day behaviors and see the bigger picture of client health and well-being. The nurse practitioner and counselors were selected for the opposite purpose; they are familiar with day-to-day behaviors of clients and are most closely working with clients on re-entering society independently. The clerical staff member is most familiar with objective client information such as number of previous and recent medical encounters, which was helpful in data analysis. Staff was asked about current client health seeking behaviors and what they feel Dore Res staff has to assist with the most. They were also directly asked if there were barriers they believe clients experience in accessing and utilizing primary care.

Instrumentation

  Needs Assessment. The purpose of the needs assessment is to understand where Dore Res clients stand on primary care utilization, in terms of knowledge and behaviors. A semi-structured interview was utilized, part of which is being adapted from a Canada conducted study who interviewed SMI populations who were clients of a similar residential program (see Appendix A). The interview was created to determine client perspectives on barriers to access ad utilization of primary care, which is aligned with the purpose of the present study.

  In addition, a staff interview (see Appendix B) was created to understand staff needs when conducting a Dore Res 'group.' Clients participate in three daily mandatory group sessions, all of which are led by a Dore Res counselor. The interview guide was created by the researcher based on observations made during shadowing of daily 'groups' and expressed needs of the

counselors. The clinical director of Dore Res was also consulted on preferences of a potential 'group' curriculum. This interview guide was created to ensure a high ease of use for Dore Res counselors, as they will be conducting this curriculum with Dore Res clients after the researcher concludes the project. This was done by including a separate set of questions on what sort of resources or changes counselors would need to lead a successful group.

Data Collection. Client and staff interviews were 25-30 minutes in length and conducted by the researcher. 10 clients and 5 staff members were interviewed over the course of one month. Interviews were recorded via written notes. The clinical director was not comfortable with the use of audio devices due to potential emotional triggers, so the interviews were not audio recorded.

Data Analysis. Interview responses were reviewed and themes were identified regarding current barriers to primary care utilization or gaps in understanding of primary care. These themes will inform the content of the group curriculum.

Group Curriculum

The content and format of the curriculum was dependent on the client and staff interview responses. The goal was to identify the most frequently mentioned barriers to seeking or maintaining care. Once these barriers were identified, the curriculum was developed of educational content and local resources meant to address these barriers and inform clients with action items on how to address primary care related issues.

Results

Interviews were conducted at Dore Res with both staff and clients. Staff interviews were conducted to determine barriers to accessing and utilizing primary care services, and client

interviews were conducted to better understand current client health seeking behaviors and their impressions with their current care.

Staff Interviews

5 staff members from different disciplines were chosen based on how often they interface with clients, how much client data they see and/or analyze, etc. The most common themes can be seen below:

Client Engagement. All five staff members mentioned barriers that stemmed from a lack of client engagement with health care. Client engagement in this case can be defined as active participation in setting long-term health goals. Behaviors related to engagement include, but are not limited to, making and keeping medical appointments and being interested in medical case management. In a two-week short-stay setting, it is difficult to focus on making and keeping medical appointments, especially when there are competing priorities. Staff noted that for many of these clients, the most urgent needs related to their housing status after finishing the program. Much time is spent on interviews with clients and housing units for further rehabilitation, most frequently 90 day programs. For others, it is hard to acquiesce to their new environment, leading to minimal participation and an inability to interact with the resources and materials provided to them. This difficulty often stems from the mental state that results from the immediate drug detoxification.

Lack of Understanding. All staff members also talked about a general lack of understanding within their clientele about the purpose and importance of primary care. Though many clients are insured many do not elect a primary care provider because of competing priorities that are perceived to be more important by the client, such as visiting the Social

Security office or Department of Motor Vehicles. Others are unaware that they were assigned one. Instead, they utilize the nurse practitioner at Dore Res when they have medical complaints because of locational convenience. Those who do have a regular primary care provider utilize them when they have a medical complaint or need medication refills.

Staff Solutions. The staff believe clients' time are Dore Res is a perfect time to learn about primary care, but the current practices of providing written resources have not been effective. One staff member stated that "a packet of resources doesn't encompass anything outside of the list itself," making the point that future initiatives should take a step further by explaining the reasoning behind these services and the positive health outcomes clients could experience if they were to utilize them. Some ideas mentioned were primary care outreach to Dore Res via a representative from a health care center and an informational session on the importance of primary care in a Dore Res group setting.

Client Interviews

7 Dore Res clients were interviewed to better understand their current healthcare encounters and perceptions of care (5 males and 2 females). Their age ranged from 45-69. Clients mostly commented on positive and negative aspects of their interactions with providers and barriers/facilitators of primary care utilization.

Client	Gender	Age	First Time or Returner to Dore Res
1	F	63	First Time
2	M	62	First Time
3	F	69	Returner
4	M	45	First Time

5	M	49	Returner (from 10+ years)
6	M	43	First Time
7	M	59	First Time

Medical Encounters. All interviewed clients reported to have at least one positive medical encounter in recent years. All clients referenced the demeanor of their provider as the source of their positive interaction.

Negative interactions were also frequently associated directly to provider behavior. For example, one client noted that they were accused by a provider of staying in the hospital for shelter, not for medical care. Others noted that they have avoided certain hospitals or providers due to negative interactions and poor relationships, and would consider going back if they exhibited more understanding for patients and are more willing to understand client motives. The most frequently mentioned factor within provider 'understanding' was patience, particularly when clients were exhibiting symptoms of their SMI and providers exhibited clear frustration. Further, clients mentioned wanting to be part of their medical decisions rather than being instructed to follow a plan created solely by their provider. For example, several clients mentioned encounters where providers would prescribe medication without thoroughly investigating medical histories, which led to severe allergic reactions when the prescribed medication interacted with an existing prescription.

Though full sentences were not written in interview transcriptions, certain words and short phrases were captured verbatim. All words that were recorded were associated with provider encounters can be seen in Appendix D.

Primary Care Utilization. When asked what sort of medical services were utilized, clients most often spoke of urgent care and emergency departments (ED) for physical health and psychiatrists for mental health. When asked the reason behind their consistent ED utilization, clients commented that they were most familiar with the ED and trusted their process based on positive past experiences; one client commented that he knew for sure they would be able to "get the job done." Several clients who reported having a primary care provider utilized them mostly for medication refills. Another attributed his ED utilization to being mugged, limiting him to only two clinics in San Francisco that already had his identification information. Both were at least an hour walking distance from Dore Res. Further, he was unable to obtain a new identification card because he could not afford to obtain a copy of his birth certificate.

None of the clients reported actively utilizing preventive services. The most popular responses for not utilizing these services were competing priorities and chronic pain preventing them from keeping appointments.

Discussion

Interpretation of Results

Based on interviews with Dore Res staff and clients, various themes emerged that were consistent with the literature on the SMI population.

Housing. Results of client and staff interviews supported previous research in the claim that housing is a significant barrier in client perceptions and attention to primary care. All clients who were interviewed were in transition to either 90 day or 1 year mental rehabilitation programs, but with no guarantee of a spot or housing after program completion. This is consistent with literature that says that access to primary care does not increase client health care

seeking behaviors if there is no change in their housing status (Weinstein et. al, 2013). This is only changed if a client is experiencing a life-threatening illness or symptoms. Further, securing housing can shift client attention to primary care and even initiate primary care seeking behaviors (Weinstein et. al, 2013).

Patient-Provider Interactions. Every client who mentioned negative medical encounters within primary care referenced interactions with their provider directly, revealing a provider related barrier to accessing primary care. These results were consistent with previous studies, where SMI populations reported to be highly impacted by provider attitudes during their medical visits. For example, one patient mentioned previous substance use and was accused of walking into the clinic seeking drugs, while another was told that providers didn't "deal with people" like her after sharing her dissociative identity disorder diagnosis (Ross et. al, 2015). These attitudes are deeply rooted in stigma in regards to mental health, as well as poverty, homelessness, and criminalization (Ross et. al, 2015). In contrast, positive medical encounters mentioned in interviews were attributed to empathic providers. In previous studies, clients who experienced such interactions were encouraged to cultivate long-term relationships with their providers and attend all appointments (Ross et. al, 2015).

Limitations

Client interaction was difficult to initiate and maintain. Clients use this two week stay to stabilize, so moods fluctuate during their residence. This led to a longer rapport building period between the study personnel and clients, as well as unexpected setbacks if clients were experiencing a negative day or had already taken part in exhaustive interviews that same day. The takeaway from this experience was to initiate overall client contact early to allow for clients

to acclimate to the personnel's presence as well as to account for visits that potentially yield no interview content. Timing in such a project is key, especially in a program where clients are only scheduled to stay for a maximum of two weeks.

Future studies could benefit more from collecting similar data from clients in longer-term care, where Dore Res staff has commented that clients generally feel more stable and prepared to enter a long-term commitment such as a relationship with a primary care provider. It is recommended that clients in one year or longer programs be the subject of future interviews.

Due to potential emotional triggers and policies of the agency, the study personnel was unable to audio record interviews conducted at Dore Res. Thus, interview transcription does not include direct quotes.

Recommendations

Clients generally know how to access primary care and/or already have a designated primary care provider, but competing priorities prevent them from initiating these behaviors. Thus, while clients are in Dore Res program, it is unrealistic to expect them to build primary care seeking behaviors during this time, particularly with the evidence that these behaviors are not feasible without secured housing. Instead, study personnel recommends for Dore Res to utilize peer-led self-management groups. These groups will reinforce the importance of peer relations that Dores Res promotes and will allow clients to address chronic conditions, increase self-efficacy, and initiate lifestyle changes that are feasible for them.

The self-management group will be an adaptation of The Health and Recovery Peer (HARP) Program, which was successfully run in SMI populations. It was noted to be practical in its implementation and yielded in improvements in patient initiation of primary care seeking

behaviors and activation of lifestyle behavior changes (Druss et. al, 2010). Further, these changes were seen greatest in populations at a social and financial disadvantage, which is consistent with Dore Res clients (Druss et. al, 2010).

This group would be integrated into existing programming at Dore Res. Clients are required to attend three group sessions a day during their stay at Dore Res; the created curriculum is recommended to be taught during one of these groups (Appendix D). Clients would have the option of attending six different sessions. The first would be an introduction to self-management and goal setting that follows the SMART guidelines (specific, measurable, achievable, relevant, and timely). The following 5 fall into subsections of lifestyle changes, including eating healthy on a limited budget, exercise, medication management, pain management, and finding a regular doctor. Each group will be completed within one hour with opportunity for individual case management based on health concerns.

Future Implications for Practice

Previous studies coupled with this project have supported the importance of integrated health homes for SMI populations. Partnerships between healthcare institutions (e.g. hospitals, clinics) and social service housing organizations should be explored on a wider level, particularly in cities where homelessness is prevalent. This 'housing first' approach addresses the priorities of the SMI population by providing them with shelter and basic needs, allowing them to focus on their day-to-day responsibilities as well as their long-term health.

Further, training for primary care physicians and other providers to work in an integrated health setting could decrease provider burnout and frustration and eventually result in more positive patient interactions. A successful early intervention could include a cultural humility

and/or interprofessional experiences during professional (e.g. medical & nurse practitioner schools) so that students could gain the skills necessary to work with SMI populations from the beginning of their career track. This can be extended for existing providers into primary care medical home models, where multiple professionals from various disciplines work together. An integrated model would create a shared responsibility of patients amongst the staff and promote effective and efficient communication. Further, patients would benefit from coordinated care and be exposed to a wealth of resources.

References

Children's Health Fund (2016). Unfinished business: More than 20 million children in U.S. still

lack sufficient access to essential health care. Retrieved from   https://

www.childrenshealthfund.org/wp-content/uploads/2016/11/Unfinished-Business-

Final_.pdf

Chwastiak, L. A., Rosenheck, R. A., & Kazis, L. E. (2008). Utilization of primary care by

veterans with psychiatric illness in the National Department of Veterans Affairs health

care system. *Journal of General Internal Medicine, 23*(11), 1835-1840.   doi:10.1007/

s11606-008-0786-7

Community Commons (2012). Health indicators report, San Francisco, USA. Retrieved

from www.communitycommons.org

Enard, K. & Ganelin, D. (2017). Exploring the value proposition of primary care for safety-net

patients who utilize emergency departments to address unmet needs. *Journal Of Primary*

Care & Community Health, 8(4), 285-293. doi:10.1177/2150131917721652

Fuller, D., Sinclair, E., & Snook, J. (2017, April). *A crisis in search of data the revolving door of*

serious mental illness in superutilization (Rep.). Retrieved http://

www.treatmentadvocacycenter.org/storage/documents/smi-super-utilizers.pdf

Garcia, M. E., Schillinger, D., Vittinghoff, E., Creasman, J. M., Knapp, P., Newcomer, J. W., &

Mangurian, C. (2017). Nonpsychiatric outpatient care for adults with serious mental

illness in California: Who is being left behind? *Psychiatric Services,*

68(7), 689-695. doi: 10.1176/appi.ps.201600284

Gelberg, L., Gallagher, T. C., Andersen, R. M., & Koegel, P. (1997). Competing priorities as a

barrier to medical care among homeless adults in Los Angeles. *American Journal of*

Public Health, 87(2), 217-220. doi:10.2105/ajph.87.2.217

Goodrich, D., Kilbourne, A., Nord, K., & Bauer, M. (2013) Mental health colllaborative care and

its role in primary care settings. *Current Psychiatric Reports, 15*(8). Doi:10.1007/s11920-

013-0383-2

Gorman, C. (2010, October 1) *How primary care heals health disparities*. Retrieved from

https://www.scientificamerican.com/article/closing-the-health-gap/

Health Resources and Services Administration, U.S. Department of Health and Human Services.

(2004). Retrieved from http://bhpr.hrsa.gov/shortage/.

National Institute of Mental Health, Mental illness. (2016) Retrieved from https://

www.nimh.nih.gov/health/statistics/mental-illness.shtml

Hert, M. D., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D., Asai, I. & Leucht, S.

(2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of

medications and disparities in health care. *World Psychiatry, 10*(1), 52-77. doi:10.1002/j.

2051-5545.2011.tb00014.x

Hert, M. D., Cohen, D., Bobes, J., Cetkovich-Bakmas, M., Leucht, S., Ndetei, D. M., & Correll,

C. U. (2011). Physical illness in patients with severe mental disorders. II. Barriers to care,

monitoring and treatment guidelines, plus recommendations at the system and individual

level. *World Psychiatry,10*(2), 138-151. doi:10.1002/j.2051-5545.2011.tb00036.x

Janssen, E. M., McGinty, E. E., Azrin, S. T., Juliano-Bult, D., & Daumit, G. L. (2015). Review

of the evidence: Prevalence of medical conditions in the United States population with

serious mental illness. General Hospital Psychiatry, 37(3), 199– 222.   http://doi.org/ 10.1016/j.genhosppsych.2015.03.004

Lawrence, D., & Kisely, S. (2010). Review: Inequalities in healthcare provision for people with severe mental illness. *Journal of Psychopharmacology, 24*(4_suppl), 61-68.   doi: 10.1177/1359786810382058

Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness. (2001). *American Journal of Public Health, 91*(1), 31-37. doi:10.2105/ajph.91.1.31

Ross, L. E., Vigod, S., Wishart, J., Waese, M., Spence, J. D., Oliver, J. & Shields, R. (2015). Barriers and facilitators to primary care for people with mental health and/or substance use issues: A qualitative study. *BMC Family Practice, 16*(1). doi:10.1186/s12875-015-0353-3

San Francisco Health Improvement Partnership (2016). San Francisco community health assessment 2016. Retrieved from   https://www.sfdph.org/dph/files/hc/HCAgen/ HCAgen2016/April%205/CHAshort.pdf

Viron, M., Zioto, K., Schweitzer, J., & Levine, G. (2014). Behavioral health homes: An opportunity to address healthcare inequities in people with serious mental illness. Asian Journal of Psychiatry, 10, 10–16. http://doi.org/10.1016/j.ajp.2014.03.009

Weinstein, L. C., Lanoue, M. D., Plumb, J. D., King, H., Stein, B., & Tsemberis, S. (2013). A primary care-public health partnership addressing homelessness, serious mental illness, and health disparities. *The Journal of the American Board of Family Medicine, 26*(3), 279-287. doi:10.3122/jabfm.2013.03.120239

Appendix A

Staff Interview Protocol

Questions related to primary care at Dore Res
1. What services, if any, do you feel that clients could utilize more in regards to primary care?
2. How do staff members assist clients with accessing primary care, if at all?

Questions related to group dynamics:
1. What components make up a successful 'group' meeting?
2. What do you need as a staff member to lead a successful 'group'?
3. What materials would be useful to clients to provide during a 'group' meeting related to health education?

Appendix B
Client Interview Protocol

1. Who are the service providers in your life that help you take care of your mental and physical health? [figure out who or where they go for primary care] (YES, they have a regular primary care provider—i.e., someone they can make an appointment to see when needed)

2. How do you feel about the care that you receive?
 a) What do you like about the way (provider) delivers your health care?
 b) Is there anything you don't like about the way (provider) delivers your health care?
 c) (If they haven't already discussed) What about care for your mental health?
 d) (If they haven't already discussed)What about care for your physical health?
 e) (If they haven't already discussed) What about care for your substance use/ addictions?
 e) What about physicals or preventative screenings, such as cancer screenings (pap tests, mammograms, colorectal cancer screenings, prostate cancer screenings) or diabetes tests?
 f)Do you have any health needs that aren't being taken care of right now? Or any specific services you want but can't get? (NO regular primary care provider)

2. What would you say are the main reasons that you do not have a doctor or a nurse that you can go see when you need to?
 a) (If not already answered in #1) When you need health care, where do you usually go?
 b) Do you have any health needs that aren't being taken care of right now? Or any
  specific services you want but can't get? (Probe: for mental health care, physical health
  care, substance use or addictions care)

3. Can you tell me about a time when you needed to see a doctor or a nurse and it didn't work out? What got in the way?
4. Can you tell me about a time when you needed to see a nurse or a doctor and it did work out—you got the care that you needed? What made it work?
5. If you're having trouble getting health care, what strategies do you use to try to get the care that you need?
6. Is there anything you think could be done to help make sure that people with mental health and/ or addiction issues get the care they need from primary care providers (i.e. doctors and nurses)?

Appendix C

Chronic Disease Self Management Program

Sessions

1.   Overview of self-management

2.   Exercise/physical activity

3.   Pain + fatigue management

4.   Healthy eating on a limited budget

5.   Medication management

6.   Finding + working with a regular doctor

Action Plans:

1.   Identify problem of concern

2.   List ideas to solve

3.   Develop a plan with specific and short term goals

Appendix D

Word cloud of most frequently used words by clients when commenting on their best and worst

provider encounters