The Colorado Coalition for the Homeless (CCH) opened its first clinic in 1985 to address the health needs of the homeless in Denver, operating out of a repurposed office building in downtown Denver. Since that time CCH has expanded to five locations offering medical, dental, vision, and behavioral health and substance abuse services. In the 2015 UDS report, CCH reported providing services to 13,197 patients. Of these patients 10,500 patients received some form of medical care, over 3,000 were seen in the dental clinic, 3,800 received behavioral health services and more than 1,100 received vision care services.

While CCH today boasts a beautiful state of the art clinic in downtown Denver that is the principal provider of health services to the city’s homeless population, the movement toward integrated care required time, teamwork, painstaking planning and cooperation. When the journey to integrated care began, the dental and medical programs were in different locations, each had their own health records (electronic vs. paper), the billing processes varied from discipline to discipline, reimbursement for dental services was very difficult, and there was no dental representation in medical and behavioral meetings.

Today, however, there is a shared enrollment process for all dental, behavioral, medical and vision clients. There is a shared electronic health record. There is a single revenue cycle management team sharing all billing and reimbursement responsibilities, and the Integrated Health Management Team meets regularly, sharing quality and productivity goals with one another. So what made the difference?

When CCH began its deliberate journey to Integrated Health Care, it adopted as a guide the model of “Six Levels of Collaboration/Integration” from SAMHSA/HRSA Center for Integrated health Solutions. [Click HERE for model.] Level Six describes an organization in “full collaboration in a transformed/merged integrated practice.” This kind of organization practices in the same space within the same facility, where they have resolved most or all system issues, communicate consistently at the system, team and individual levels, driven by a shared concept of team care, with formal and informal meetings to support an integrated model of care. That is the model. Implementing it is the challenge.

With changes in reimbursement rules in Colorado that went into effect in 2012, sufficient increased revenue was expected to allow plans for the expansion and refurbishment of the original location. Staff at CCH decided to use the opportunity provided by the construction of the new clinic to create a facility based on a model of inter-professional integration and clinic redesign. As clinic plans progressed, CCH leadership also took advantage of low-income housing tax credits to find investment partners to finance three floors of low income housing in the same complex. The result is the new Stout Street Health Center which is a model for integration of care from all departments, medical, dental, behavioral health, social services, vision care, pharmacy, other professional support services, and housing.
The first step in the redesign of the delivery of care was to gain clarity from all involved about the “why” of the redesign project. Administration, clinical providers from all disciplines, investors, and donors all agreed that this particular population would benefit from closer communication among the care team members. Because of the large numbers of behavioral and substance abuse issues in the CCH patient population it was agreed upon that each care team needed to have both medical and behavioral health providers on the team. This was to ensure that psychosocial needs were addressed by a provider with specialized training, in close consultation with the primary care provider. The medical provider was typically a primary care physician or Physician’s Assistant. Psychosocial care is coordinated by a “behavioral health provider” typically with training in counseling and social work. Early on in the decision making process, the various department directors of the clinic agreed that a dental hygienist should be included on the teams. The homeless population has a much higher rate of urgent oral needs, edentulism and decay than the general population. Lack of healthy teeth creates not only medical concerns but also social stigma for those living on the street as well as those transitioning from a homeless condition to functioning in society.

From the dental department’s perspective, integration was desirable due to the obstacles created by separate locations of the medical and dental departments. In addition, each department had separate patient care records; medical and behavioral used the Electronic Health Record while the dental and vision departments continued to use paper records. Efficient revenue cycle management was impaired due to different processes being used by medical, behavioral, vision and dental departments. Finally, departments had their own leadership meetings and there was no dental representation when medical and behavioral representatives met for planning and operational reviews.

For these reasons, all parties involved joined in a long and ongoing process of collaboration to redesign how care is delivered in this organization. A key first step was the hiring of a change consultant to work with the integrated health management team, which included representatives from all disciplines. Under the guidance of the outside consultant, CCH leaders were able to create flow charts of existing processes and potential future processes forecasted to be used in the new building. The consultant helped revise internal communication strategies, change staff performance expectations and set realistic, attainable goals. She led in team building exercises including demonstrating staff roles. Many were not sure what the responsibilities were for others on the team. She helped document a workflow that would encourage integration between the dental department and all others. Floorplans were developed of how the newly constructed clinic could be built to accommodate the increased levels of communication between disciplines, including shared work areas that brought providers together from different teams to deliver care to patients “empaneled” on the provider teams. Diagrams were created and studied that showed how integration would look from the point of view of the patients.
Other innovative changes were implemented as well. The dental department added an "integrated suite hygienist" that practices with the new provider teams and has a hygiene assistant to act as a support to the hygienist, providing oral health instruction, aiding in documentation and administration. These staff members work in Integrated Suites 1 & 2 shown in blue in the floor plan below. There is a single dental operatory in Integrated Suite 2 and eight more on the first floor directly below Integrated Suite 4 (right). The dental department has a behavioral health provider for assistance with crises and behavioral problems in the dental clinic. All planning processes included the Integrated Support Team (eligibility and scheduling) who have been trained to think in terms of treatment plans for all possible patient needs, not just triage for the current day.

One of the key benefits of the process used is that remaining providers are enthusiastically engaged with the process of integration and workflow redesign because they helped with the processes and are personally invested in the system results. Another benefit is the shared enrollment process for all behavioral, dental, medical and vision patients. We now have a shared electronic health record (NextGen) and have purchased and implemented a fully integrated electronic dental record (QSI). In January 2017 CCH hired an EDR analyst who has been crucial in troubleshooting/perfecting the EDR for the clinic’s use as well as training our staff. CCH now has a single revenue cycle management team and a fully integrated electronic health/dental record to share all billing and reimbursement responsibilities. We continue to have an Integrated Health Management Team that meets regularly, sharing quality and productivity goals among disciplines.

For the patients this has meant shorter waiting lines, greater convenience, all services under one roof, all staff trained in “trauma-informed care” and cultural diversity, and all services now integrated with clean, safe, modern housing and case management. Patient surveys have shown an increase in satisfaction across all health center departments. One patient said that he has truly found “one stop shopping” at The Stout Street Health Center. And perhaps most wonderfully, we have a beautiful new building that is built for integrating all health services under one roof.

Conclusion: It is impossible to overstate the importance of continued communication, both scheduled and informal. Workflow processes must be continually examined and improved, sometimes with an outside consultant. Relationships between leaders must remain supportive and functional as a lack of communication between leaders will be detrimental to the process in the long run. People must have permission to “fail” in the short term as processes are perfected. The most critical and dynamic lesson learned is that all of this effort will be worth it in the long term with improved patient outcomes, improved patient satisfaction, engaged staff and supportive executive leadership.

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