# A Strategic Approach to Representing the Needs of Homeless People with Serious Mental Illnesses in Managed Care Systems

## A Guide For State PATH Contacts

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# INTRODUCTION

The multiple and complex health and social service needs of homeless people who have serious mental illnesses are not easily addressed by traditional health care providers, including those in the public mental health system. As States rely increasingly on managed systems of care to finance and deliver care for public-sector clients, State Contacts for the Projects for Assistance in Transition from Homelessness (PATH) program can play an important role in representing the interests of this underserved group.

## *The Scope of the Problem*

Since the emergence of homelessness as a major public health problem in the 1980s, homeless people with serious mental illnesses have presented unique challenges to health care systems. These individuals have a broad range of psychosocial problems that are significantly complicated by the conditions of poverty and homelessness.

Many homeless people with mental illnesses also struggle with general medical illnesses, legal problems, histories of trauma, behavioral problems, skill deficits, and a lack of connection to meaningful supports (Fischer, 1990). Further, these individuals may not seek help or may have trouble gaining access to traditional service programs.

The Federal Task Force on Homelessness and Severe Mental Illness has recommended that an integrated system of care for homeless people who have serious mental illnesses should include health care, mental health services, substance abuse treatment, social services, income support, legal services, housing, and employment (Interagency Council on the Homeless, 1992). However, most communities lack the administrative structures and systems of accountability that are required to coordinate this vast array of services.

Consequently, the behavioral health care needs of people who are homeless and have mental illnesses have not been adequately addressed by most public mental health systems (Morse, 1999). Public systems are designed to provide a "safety net" for consumers who are most vulnerable, including those who are uninsured, and in many communities the public system is considered the provider of last resort. Yet, many critical services may not be reimbursable under current medical criteria.

Many homeless people who have serious mental illnesses receive behavioral health care services from providers that specialize in services to homeless people and that are outside of both the public and private mainstream system of care. These

include programs that receive PATH funds, which are administered by the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services (CMHS). Unfortunately, such programs, operating with inadequate resources and limited access to mainstream services, have become the predominant system for providing care to the poorest individuals in our communities (Winarski and Dubus, 1995).

## *The Challenges and Opportunities of Managed Care*

The introduction of managed care into public mental health systems has created an opportunity to better address the needs of populations that have not been well served, such as homeless people with serious mental illnesses. States that contract with managed care organizations have the opportunity to "improve access to care, enhance the quality of care, better manage the cost of care, and facilitate prevention initiatives" (Edmunds, et al., 1997).

However, managed care's mechanisms for controlling cost and managing service utilization represent a significant departure from traditional public sector management policies and procedures. Some providers have expressed concern about the disincentive for managed care to enroll the large numbers of low-income clients with severe and long-term disorders who require a broad range of psychosocial services and supports (Winarski, 1998). In addition, public sector clients are more likely to need services, such as outreach and engagement, psychosocial rehabilitation, and case management, that may not be reimbursable under the current criteria for defining "medical necessity."

A recent report by the National Academy for State Health Policy indicates that managed care is now the dominant delivery system in State Medicaid programs, and that States are increasingly enrolling individuals with complex needs into these plans (Kaye and Pernice, 1999). However, such individuals typically require various services and supports over an extended period of time that ideally should be provided within an integrated system of care. Achieving the optimal balance among factors that impact access, quality, and cost creates formidable challenges. Managed care systems hope to meets these challenges by implementing technologies that enhance efficiency and promote accountability. The tension introduced by managed care as a third party in the clinician/consumer relationship holds the potential for both positive and negative impacts on the quality of care (Feldman, 1992). Success will ultimately be shaped by the continued development of partnerships among all key stakeholders, including clinicians, consumers, providers, payers, government agencies, and managed care organizations (Winarski, et al, 1998).

## *The Role of State PATH Contacts*

The PATH program's Second Generation report has identified the need to link people who are homeless to the mainstream behavioral health care system as critical to future success. Though managed care represents significant change in how services are delivered to clients in the public mental health system, the fundamental goal for the

systems and programs serving homeless people with mental illnesses remains unchanged - to ensure that the unique needs of these individuals are addressed. State PATH contacts are uniquely positioned to both understand and represent the needs of homeless people with mental illnesses within State-funded public mental health systems.

This report provides basic background information about managed care in public mental health systems and describes steps for developing a strategy to represent the needs of homeless people with serious mental illnesses in these systems. For a more in-depth discussion of issues specific to homelessness, mental health, and managed care, the authors recommend the monograph recently published by CMHS, *Reaching Out to Homeless People with Serious Mental Illnesses Under Managed Care* (Morse, 1999).

# SECTION I

# Delivering and Financing Mental Health Services

Each State is unique in the way it finances and delivers mental health services to homeless people. Some States include a full range of services for homeless people in their managed behavioral health care plans, while others continue to provide these services in more traditional ways. Also, States vary in the way in which they combine available resources to finance a managed system of care. Knowledge of what services are provided and how they are funded will be critical for State PATH Contacts protecting the needs of homeless people who have serious mental illnesses.

## *Delivering Services Under Managed Care*

Managed care is essentially a set of principles and technologies that focus on setting limits on spending while also ensuring access to quality care. In practice, there are many challenges that existed long before the advent of managed care to achieving the optimal balance among access, quality, and cost factors in health care. The level of success in achieving this balance varies greatly among States, communities, and specific managed care organizations (MCOs).

The primary objective of managed care is to reduce cost by improving efficiency and by carefully monitoring treatment processes and outcomes. Specific cost saving strategies include using less expensive providers, providing care in less expensive settings (e.g., outpatient rather than inpatient), emphasizing short-term treatment methods, creating frameworks for capitated rates, and managing the utilization of services. Quality management strategies include developing the capacity to compile, track, and analyze information specific to the process and outcomes of program and treatment activities.

### Carve-In and Carve-Out Strategies

The terms “carve in” and “carve out” generally refer to services that are either included (carved in) or excluded (carved out) of a managed care program. For example, some States contract with one MCO to provide both primary care and behavioral health care to members; this is often described as an integrated or carve-in

system. Other States carve out behavioral health care to an MCO that specializes in providing mental health and substance abuse services.

Likewise, with respect to services for homeless people who have serious mental illnesses, some States may carve in, or include, these services within their behavioral health care plan. An MCO may offer these services or contract with traditional safety net programs to provide them. Other States may carve out, or exclude, from a managed behavioral health care plan those services that are particularly relevant to this population (e.g., outreach, residential treatment). Still other States may use a mixed strategy, including some services that might benefit homeless people in a managed behavioral health care plan but leaving others out. When services for homeless people are carved out of a managed behavioral health care plan, traditional safety net programs continue to serve these clients.

## *Financing Managed Mental Health Services*

The major governmental sources of funding for mental health services include Medicaid, Medicare, the State Mental Health Authority (SMHA) general fund budget, federal grants, and the local mental health authority budget. States vary in the extent to which they are willing or able to combine sources of funding in a managed behavioral health care contract. The following is a brief description of factors that States consider in managing the major funding sources.

### Medicaid

This is a federal/State health care partnership for low-income individuals and families, including children, elderly, and disabled individuals. Eligibility is based primarily on income and assets. Medicaid is administered by the States following federal regulations, and the cost is shared between the federal and State governments. This program is most often the target of State-initiated managed care efforts.

### Medicare

This is a public health insurance program in which eligibility is based on age or disability if the individual has a work history. Private contractors administer Medicare, and the costs are borne entirely by the federal government. Enrollees may choose voluntarily to enroll in a managed care program. Some enrollees are also co-enrolled in Medicaid, which pays costs of health care if the individual's Medicare benefits are exhausted. If an individual is co-enrolled in both Medicaid and Medicare, they may not be enrolled in a state Medicaid managed care program without a special waiver from the federal Health Care Financing Administration.

## State Mental Health Authority (SMHA) General Fund Budget

These are funds annually appropriated by the State legislature that are administered by the SMHA. These funds are often "categorical," that is they are appropriated for a specific purpose (e.g., State inpatient care, outreach programs to people who are homeless and have mental illnesses). Generally, these funds are for services that are not reimbursable under the Medicaid program.

## Federal Grants

These are funds that are allocated according to a federal grant program (e.g., the Mental Health Block Grant Program, PATH). Funds are distributed through CMHS and administered by the States. States must account for spending and meet reporting requirements according to rules established by CMHS. This may make it difficult to include these funds in a managed care contract, or as in the case of the PATH program, the statutory requirement that local providers must be either political subdivisions of the State, or non-profit private entities, prevents States from funding managed care companies.

## Local Mental Health Authority Budget

These are funds appropriated annually by a county or city legislative body that are administered by a local mental health authority. These funds are also often categorical. Not all States have local mental health authorities that receive local tax dollars.

## Funding Managed Care

Federal grants and local mental health authority budgets are rarely included in a State managed behavioral health care contract. SMHA and Medicaid funds may be combined in a myriad of ways to finance managed behavioral health care, including services for people who are homeless. For example, some States may include all Medicaid funds and some SMHA funds in a managed care contract, but exclude those State funds that pay for services exclusively for homeless people. Other States may include only Medicaid funds in their managed care contract, or they may combine

Medicaid and all SMHA funds. The financing will determine which services are carved in or carved out of a State's managed behavioral health care plan.

## *Addressing the Needs of Homeless People*

Whether services for homeless people will be carved in or carved out of a State's managed behavioral health care plan, and how these services will be funded, are critical points in negotiations between the State and its MCO. In addition, such knowledge is important for State PATH contacts who need to know how best to advocate for the needs of their clients. Developing a strategy for representing the needs of homeless people with mental illnesses in managed care systems is discussed in detail in the next section.

# SECTION II

# Developing A Strategy

The strategies that State PATH Contacts select to represent the needs of people who are homeless and have serious mental illnesses will depend, in part, on their own role within the State government. However, there are common elements to developing an effective strategy that should be considered.

In particular, State PATH Contacts face two primary tasks in ensuring that the needs of people who are homeless and mentally ill will be appropriately addressed under managed care.
They must

- identify the characteristics of the current system for serving this population, and
- identify the process for developing and implementing mental health managed care.

This information can then be used by State PATH Contacts to influence the managed care planning process within States, specifically in relationship to carve-in and carve-out plans.

## *Assessing Current Services*

In preparing for managed care, it is important first to describe the current system, including gaps in services. A set of categories and methods for doing so is briefly outlined below. Each of these areas may already be familiar to State PATH Contacts. They are organized to provide an easy translation into the language of managed care.

### Define the Population in Need

The first step is to define the population in need. Each State will likely already have a definition of mental illness (e.g., an individual with a DSM-IV diagnosis) and a definition of homelessness. This designates the population that the PATH program and other related programs are designed to serve.

Once a definition is established, the next step is to estimate the numbers of people in this population. Many States have already developed estimates of the number of people who are homeless. The estimate of the proportion of this population that also has serious mental illnesses is usually based on either a State study or the literature. These estimates range from 10 to 33 percent. Another, and possibly more accurate procedure, is to obtain, or develop, an estimate of the number of persons who have serious mental illnesses. The next step is to obtain, or develop, an estimate of the number of such persons who are also homeless.

## Specify Range of Special Services

Services for people who are homeless and have serious mental illnesses include both those that are available to any individual in the public mental health system (e.g., inpatient and outpatient care, rehabilitation, and support) and those that are uniquely designed to meet the special needs of homeless people. The latter type of services may include the following:

- Outreach/engagement
- Emergency/transitional shelters
- Communications services (e.g., mailing address, voice mail)
- Basic supports (e.g., lockers, showers, clothing, etc.)
- Day programs/drop-in centers
- Mobile treatment teams
- Obtaining entitlements
- Peer interventions
- Community organization (e.g., with neighborhood coalitions, law enforcement, local businesses)

The State PATH contact should ensure that these and other needed services are covered
at a level sufficient to meet the needs of the population. It may also be strategically important to prioritize these needed services.

## Define Outcomes

The articulation of outcomes that are expected as a result of providing behavioral health care services to homeless people is an area that is often neglected. Anticipated outcomes may be specific to a type of service or be general across all special services. Existing State contracts with providers of homeless services may already identify key outcomes for which these organizations are accountable. The following are examples:

- Placement in housing
- Access to mental health treatment services
- Access to case management services

Outcomes may also include more traditional treatment outcomes like improvements in functioning and reduced symptoms of mental illness or rehabilitation outcomes like obtaining employment. It is also becoming more common to assess satisfaction with services. The State PATH contact should determine in consultation with others what outcomes may reasonably be expected from these special services.

## Determine Financing

A fourth area of concern is the financing of services that are available to people who have mentally illness and are homeless. Though PATH funds are an important source of funding, there likely will be others, including federal Mental Health Block Grant funds, SMHA funds, and State Medicaid funds. For each type of service listed, the total available funding and the sources of those funds must be understood.

## Identify Service Providers

Creating an inventory of providers who offer services to people who are homeless and have serious mentally illnesses is extremely important. For each critical service area, the organizations that currently offer the services should be identified. It is also important to determine the number of people served by each provider, along with the prime sources of funding. In many States these services will be offered through community mental health centers that provide many other services within a defined geographic area. In other States, small not-for-profit agencies, sometimes affiliated with religious charities, are the providers of services, and this may be their sole business. Services for people who are homeless are sometimes also offered by either for-profit organizations or directly by State-operated programs.

# *Assessing the Managed Care Process*

## Determine Lines of Authority and Roles

Planning for managed care is often initiated through the governor's office, the State department of health and human services, or the State Medicaid agency. The role of SMHAs varies from State to State, but these agencies are rarely in a lead role.

To influence key decisions, stakeholders need to know where the SMHA fits in the planning process and who represents the agency in interagency meetings. The SMHA itself may have internal committees to develop ideas for inclusion in this process. State PATH Contacts should be knowledgeable about the organizational structure of their SMHA and let the agency's lead managed care person know of their interest in contributing to system planning.

Similarly, it is essential to understand the process through which the managed care plan is developed and implemented. As with most State procurement processes,

the central events are the development of a Request for Proposals (RFP), the evaluation of proposals and selection of a contractor, and the negotiation and signing of a contract. Some States also issue a draft RFP for public comments, prior to issuing the final RFP.

The contract language generally follows the requirements that are articulated in the RFP. *If a requirement is not included in the RFP, it is highly unlikely that it will be included in the contract.* Therefore, any requirements regarding services for people who are homeless and have serious mentally illnesses must be clearly explained in the RFP. The State PATH Contact can help ensure that there are appropriate requirements in the RFP to safeguard the needs of their clients.

## Plan to Participate in the Process

The process for establishing the plan for managed care will typically have both external (public) and internal (within government) mechanisms. When public meetings are held, it is important to be sure that advocates, including those individuals who themselves are homeless and have serious mental illnesses, are invited to participate. When documents (e.g., a draft RFP) are circulated for public comments, it is equally important to be sure that advocates receive them and have a reasonable opportunity to comment on them. The presence of compelling, vocal representation in the external process is often necessary to ensure that relevant requirements will be incorporated in the RFP during the internal decision process.

Decisions about what will be included in the RFP are part of the internal process. The State PATH contact should ensure that relevant requirements are "on the table" and are seriously considered. This is best accomplished by drafting relevant sections directly and circulating them to appropriate parties. For example, most RFPs will include some broad statement of vision, principals, and goals as a part of the opening language.

Thus, a first step is to offer a brief sentence or two that fits with the approach in this section and that formally expresses the State's commitment to meeting the needs of all people who are homeless and have serious mental illnesses under the managed care plan. This establishes the legitimacy of more specific requirements elsewhere in the RFP. Other areas that should be addressed follow directly from the assessment of needs. Translating these into the language of managed care is discussed below.

The process of drafting a State's RFP is often a shared one. For many people involved in the process, like the State PATH Contact, this is not their only responsibility. One result is that individuals take responsibility for drafting sections in areas that they know best. Thus, the PATH Contact may be called on to draft all

provisions that are relevant to the population of people who are homeless and have serious mental illnesses. In some States, if the PATH Contact does not make himself/herself available to do this, it may not be done.

### Determine How Funds Will Be Allocated

The State PATH Contact's approach to planning for managed care will be determined, in part, by how funds that have been used to pay for services for people who are homeless and have serious mentally illnesses are to be allocated. Although States typically use a mixed strategy, for purposes of this discussion, we are describing two simplified scenarios. In the first, we make the assumption that all funds associated with services for this population are carved in (that is, included in) the managed care plan. In the second, we assume that all funds that pay for services that are particularly relevant to this population (e.g., outreach, residential treatment) are carved out (excluded from the plan) and that these services will continue to be funded in the same way they have been.

## *Influencing the Plan for Carve-in Services*

Once information and ideas about the current system are gathered, the primary task for the State PATH Contact is to translate this information into the language of managed care so that it can be incorporated into the RFP. Steps for doing so follow.

### Population Eligibility and Enrollment

For homeless people with serious mental illnesses to be effectively served in a managed care program, they must be both eligible to enroll and knowledgeable about the process. In order to ensure that people who are both homeless and mentally ill will be eligible to enroll, the definition of this population must be incorporated into the managed care plan.

Eligibility is only the first step, however. Advocates fear that if MCOs believe this population will be costly or difficult to serve, they may enroll homeless people in name only. To ensure that homeless people have a real opportunity to enroll, the contract (and therefore the RFP) should contain provisions that require the MCO to take appropriate actions to encourage enrollment. This could include making information available, hiring special counselors (often other consumers) to answer questions about

rights and responsibilities under the plan, and identifying and removing barriers to enrollment. Monitoring ongoing utilization of services is also important (Care for the Homeless, 1998).

Based on the experience of PATH providers, each State Contact should have knowledge about what is necessary to encourage people to enroll in the plan and to draft provisions for the RFP that will require those actions. If these activities will entail additional costs for the MCO, some added payment (e.g., higher premium, special enrollment payment) might be included in the contract as evidence that the State places a high priority on ensuring access for this population. These provisions should be incorporated into the section of the RFP that describes the plan enrollment process.

## Describe Covered Services

Covered services are those services that a managed care organization is required to offer enrollees under its contract with the State. *If a service is not listed in the plan, then the MCO typically will not provide it.* For example, if people who are homeless and mentally ill are enrolled and require outreach services to meaningfully participate, there is no obligation to provide outreach unless it is listed as a covered service, even if the funds to pay for outreach are incorporated into the plan. Indeed, if funding has been designated to pay for services for people who are homeless and have serious mental illnesses, State PATH Contacts will want to be certain that these services are listed as covered in the MCO's contract.

There are two approaches to deciding what should be included under covered services. The more conservative approach would include all services supported by funds that are incorporated in the managed care contract. A more expansive approach would add other services representing gaps that have been identified by State PATH Contacts.

The justification for adding other services is that these services are needed. Also, the MCO may be able to save money from an overall decrease in more expensive services (e.g., psychiatric inpatient care) to persons who have serious mental illnesses. They may then reallocate some of these savings to community-based services, more specifically for people who are homeless and have serious mentally illnesses. If there are significant gaps in services, the State PATH Contact should describe and justify services that need to be included.

## Establish Referral Arrangements

Referral arrangements are critical for people who are served by more than one program and should be spelled out in the RFP. Ideally, linkages between the MCO and experienced homeless health care providers (Care for the Homeless, 1998) should be mandated. Further, a criterion for selecting MCOs should be experience in providing appropriate services for homeless people and in making these services accessible.

For example, if a person who is homeless and has a serious mental illness is referred by an outreach worker to an outpatient program, that individual should be seen within a specified brief period of time. Homeless people should not be placed on a waiting list with the expectation that they will be able to make and keep a future appointment.

Even prior to the introduction of managed care, most mental health systems have barriers to serving people who are homeless and have serious mentally illnesses. These barriers will not disappear, and may be exacerbated, with the advent of managed care, unless there are specific provisions in the RFP that require that they be addressed. The State PATH Contact should use his/her knowledge to ensure that actions to remove known access barriers are incorporated in the RFP.

## Ensure Accountability

One of the interesting aspects of the move to managed care has been renewed attention to accountability. Various national organizations, the federal government, individual States, MCOs, and others have been developing designs for managed care "report cards" (CMHS, 1996). A report card is generally a collection of performance indicators that measure the extent to which the plan lives up to its promises.

As with everything else, *if the MCO is not required, as a part of its contract, to produce data for performance indicators, it cannot be expected to do so.* Thus, identifying key measures and incorporating them in the RFP is essential. Otherwise, there is no way of knowing whether the MCO is attending to the needs of people who are mentally ill and homeless.

The following are examples of performance indicators that may be appropriate for inclusion in a plan report card.

Access to Care

Enrollment: How many people in the population have actually enrolled in the plan? Is this number increasing over time? What proportion is this number of the total estimated number of people who are homeless and have serious mental illnesses? What is the rate of disenrollment from the plan for this population? How does this disenrollment rate compare to the rate for other plan enrollees?

Service utilization: What proportion of people who are homeless and have serious mental illnesses and are enrolled in the plan are actually using mental health services? Is this rate increasing over time? What proportion of this population drops out of services (e.g., fail to return after the first outpatient visit)? What proportion is using health services if available through the same plan?

Appropriateness of Care

Acute service utilization: What proportion of people who are homeless and have serious mental illnesses and are enrolled in the plan are using psychiatric inpatient and emergency services? Do they use these services at a higher rate than other plan enrollees? Is the rate increasing or decreasing?

Satisfaction: How do people who are homeless and have serious mental illnesses rate the services they are receiving? Do they feel they are receiving quality services and that providers are respectful of them and responsive to their needs? How do their satisfaction rates compare with the rates of other plan enrollees? Is satisfaction improving over time?

Outcomes of Care

Placement in housing: People who are homeless and have serious mental illnesses need, first and foremost, to find and keep a stable place to live. For people who are enrolled, for how many months do they continue to be homeless? Once they have housing, for how many months do they remain in housing?

Income and employment: What proportion of enrollees have a stable source of income (including Supplemental Security Income and Social Security Disability Insurance)? What proportion are employed or enrolled in a vocational or educational program that will lead to employment? Are those proportions changing over time?

Substance abuse: What proportion of enrollees abuse alcohol or use illegal drugs at the time of enrollment? Is that proportion decreasing over time?

Functioning and symptomatology: Do enrollees show evidence of improvements in functioning over time? Do they exhibit reduced signs and symptoms of mental illness?

The State PATH Contact should also look at those outcome measures they are currently using to monitor contracts and services and assess whether they should be incorporated into the RFP.

## Review Contract Incentives

The way in which managed care financing arrangements are structured can have an impact on the treatment of homeless people. For example, contractual incentives to ensure enrollment of people who are homeless and have serious mental illnesses may increase the attention these individuals receive. Monetary bonuses to MCO staff and physicians for good or exceptional performance may also improve the quality of care received. However, this depends on how performance is gauged. State PATH Contacts should monitor closely how contract incentives are structured, so that an incentive to reduce the cost of care, for example, does not become a disincentive to serve people with multiple and complex needs.

## Maintain Provider Networks

Services under managed care plans are typically offered by programs that are formally a part of the network of providers with which the MCO has established contractual arrangements or which it operates directly. Enrollees are often restricted to using only those providers that are a part of the MCO's network. An MCO may be entirely free to decide which providers to include within its network and which to exclude. *Unless required by the contract, there is no obligation to include those existing providers who have been offering services to the population of people who are homeless and have serious mental illnesses.*

State PATH Contacts should evaluate the potential impact of the managed care contract on their existing providers. If they determine that the services offered by these providers are essential, they should take steps to ensure the involvement of these providers in the MCO network. The RFP may include provisions that require inclusion

of certain providers in the network, that ensure continuing referrals of clients to these providers, and that ensure the reimbursement rates offered these providers are not so low as to threaten the financial viability of their organizations.

While it may be argued that such actions will restrict the freedom of the MCO, they may be necessary to protect the integrity of essential programs at least for a short period of time. If these providers are lost, it may be quite difficult to rebuild, and people who are at high risk may fall through the cracks during the interim.

## *Influencing the Plan for Carve-out Services*

When services for people who are homeless and have mental illnesses are provided outside of the managed care contract (carved out), advocacy for critical services needs to take place outside of the RFP process. All States currently carve out services for this population funded by PATH, and programs receiving PATH funds are among the decreasing numberof providers who continue to serve these individuals.

PATH providers often describe high levels of success in engaging homeless people into services but have encountered the greatest difficulties when attempting to transition clients to providers in the mainstream system. Consequently, the primary objective for State PATH contacts in influencing a carve-out plan is to ensure that there is some provision for integrating homeless clients into mainstream services, including carve-in providers. The following discussion examines the purpose of carve-out plans and describes activities that are critical for representing the interests and needs of homeless people within these plans.

The decision to carve out behavioral health care services for people who are homeless and have mental illnesses is usually made out of practical necessity rather than the desire to create an ideal system for delivering services. The ideal system would provide comprehensive and integrated services and be equally responsive to all members of the community.

Many States have decided to carve out services for homeless people from behavioral health care contracts because of the difficulties involved in meeting their complex needs. Carving out services ensures that providers who have the expertise to serve homeless people with mental illnesses effectively will continue to have a place within the broad continuum of primary and behavioral health care programs.

However, the need for services integration remains urgent when individuals are served by multiple providers. States need to ensure that there is a formal policy and procedure for coordination that accounts for

- the heterogeneity of the population,

- the diverse and complex treatment needs of the population, and
- the need for participation from multiple providers within each community.

The special needs of people who are homeless and diagnosed with mental illnesses can best be met by structuring services to meet three primary objectives, as outlined below.

- Ensure continuity in the continuum of care.
- Ensure access to needed services.
- Ensure that multiple services/treatment plans are working toward a common goal.

The following section describes activities that are critical to achieving these objectives as part of a carve-out system of services.

## Ensure Continuity in the Continuum of Care

Service fragmentation has been identified as a principal factor related to negative outcomes among people who are homeless and have mental illnesses (Osher and Kofoed, 1989; Ridgely, et al., 1987). Demonstration programs have documented that the level of coordination among programs serving homeless people depends more often on the efforts of individual practitioners and programs than on a formal policy for organizing community care (Winarski and Dubus, 1995). Though this type of informal cooperation is important, a plan for carving out services should include formal policies and procedures for coordinating services. Key factors to consider in developing a plan include those noted below.

### The Need to Accommodate Multiple Pathways

People who are homeless and have mental illnesses may enter the system of care through a variety of entry points and require the services of a broad range of providers. Entry points may include outreach programs, emergency rooms, primary and mental health/substance abuse clinics, and primary/behavioral health care hospitals. All potential entry points should have a procedure for identifying homeless individuals and for screening these patients for mental health/substance abuse problems. This is sometimes referred to as a “no-wrong-door” approach.

### The Need for a Referral Protocol

A mechanism for referring an individual to the appropriate provider should also be in place. Referral protocols should specify the path a client should take within the service delivery system and include a plan for support and follow-up. It is not sufficient for staff to make a phone call and set up an appointment. Clients may require assistance with transportation, an orientation to the service provider requirements, health information, and emotional support.

### The Need for Case Management Services

Case managers typically help link clients to needed services. Because of the social disaffiliation and complexity of needs among homeless people, case managers also must develop ongoing relationships that are responsive to changes in clients' needs over time. Consumer participation in the process of planning and linking is also critical.

### The Need to Streamline Community Linkages

One of the most critical elements in a plan for coordinating services is the capacity to exchange clinical information. Differences in policies and procedures among different programs can be a significant barrier to facilitating referrals and sharing information. Communication among providers is critical. The need to safeguard client confidentiality is also important.

## Ensure Access to Needed Services

Even a well-coordinated and comprehensive network of care cannot be effective unless individuals make use of the services, and unless each program truly responds to the strengths and problems of its clients. Some of the most common factors that create barriers to accessing services include rigid eligibility criteria, inflexible scheduling, long waiting lists, and negative attitudes toward homeless clients. States that are developing a strategy for carving out services for people who are homeless can enhance client access by implementing the interventions described below.

### Provide Outreach Services

The Federal Task Force on Homelessness and Severe Mental Illness recognized outreach as the first and most critical component of any program serving a homeless population (Interagency Council on the Homeless, 1992). The need to establish a human connection is especially urgent and often critical for survival. The key elements of outreach interventions include determining the target population, locating street dwellers, developing a helping relationship, conducting a thorough assessment, providing basic supports, and linking to needed services (Winarski, 1994).

### Develop Flexible Intake Procedures

Intake procedures need to recognize and respond to the special needs of people who are homeless. The challenge for programs is to maintain flexibility in program regulations without compromising the integrity of the program structure. People who are homeless may require special accommodation in keeping appointments and in complying with standard treatment regiments.

### Develop Centralized Information Systems

Aiken and others (1975) have identified centralized information systems as one of the key elements of a well-coordinated service delivery system. The system should ideally have centralized record keeping, up-to-date directories of service programs, practitioners with knowledge about available resources, and a process for continuous feedback about clients, resources, and programs. Policies and procedures should be in place to support the exchange of important clinical information, with informed client consent.

## Ensure That Multiple Services/Treatment Plans Are Working Toward a Common Goal

Because people who are homeless and have mental illnesses often require the participation of several agencies and may use several programs within each agency, there is a great risk for developing treatment plans with conflicting goals. Programs need to ensure that interventions serve a single purpose that is in the best interest of the client. This is best achieved as part of a centralized planning mechanism that includes a system of accountability.

However, most communities in most States lack such a system. Consequently, it is important for programs to coordinate case planning, to develop protocols for sharing clinical responsibilities and transferring case records, and to integrate case management functions as part of a program of long-term support.

## *Putting the Pieces Together*

State PATH Contacts are experienced and knowledgeable about the service needs of homeless people who have serious mental illnesses. By identifying these needs and assessing how they will be met in their State's managed behavioral health care plan, PATH Contacts play an invaluable role in enabling homeless people to receive appropriate, high-quality behavioral health care.

# CONCLUSION

As States make the transition from fee-for-service to managed care systems, it is critically important to ensure that vulnerable populations, such as homeless people with serious mental illnesses, are not lost in the shuffle. Though State PATH contacts have different job roles across the States, they all share an in-depth knowledge of the special needs of this population and the programs that provide critical services. This paper attempts to provide a strategic framework that will allow PATH contacts to apply this knowledge as their States develop managed care plans and contracts.

Organizational change is never accomplished without some growing pains, but the challenges associated with the transition to managed care also create opportunities. It is our hope that this paper will assist State PATH Contacts in responding effectively to opportunities for protecting the interests of some of the most vulnerable citizens in our communities.

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