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Medical Home-HIV Evaluation & Resource Team

HRSA-SPNS Initiative, Building a Medical Home for Multiply-Diagnosed Homeless HIV+ Populations: The Role of Patient Navigators

May 29, 2014

BOSTON UNIVERSITY

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

MULTNOMAH COUNTY Health Department

PASADENA

AIDS ARMS

Presenting Partners

- James Apt, Boston Health Care for the Homeless Program, Boston, MA
- Meghan Dalton, AIDS Arms, Inc., Dallas, TX
- Angélica Palmeros, Pasadena Public Health Department, Pasadena, CA
- Jodi Davich, Multnomah County Health Department, Portland, OR

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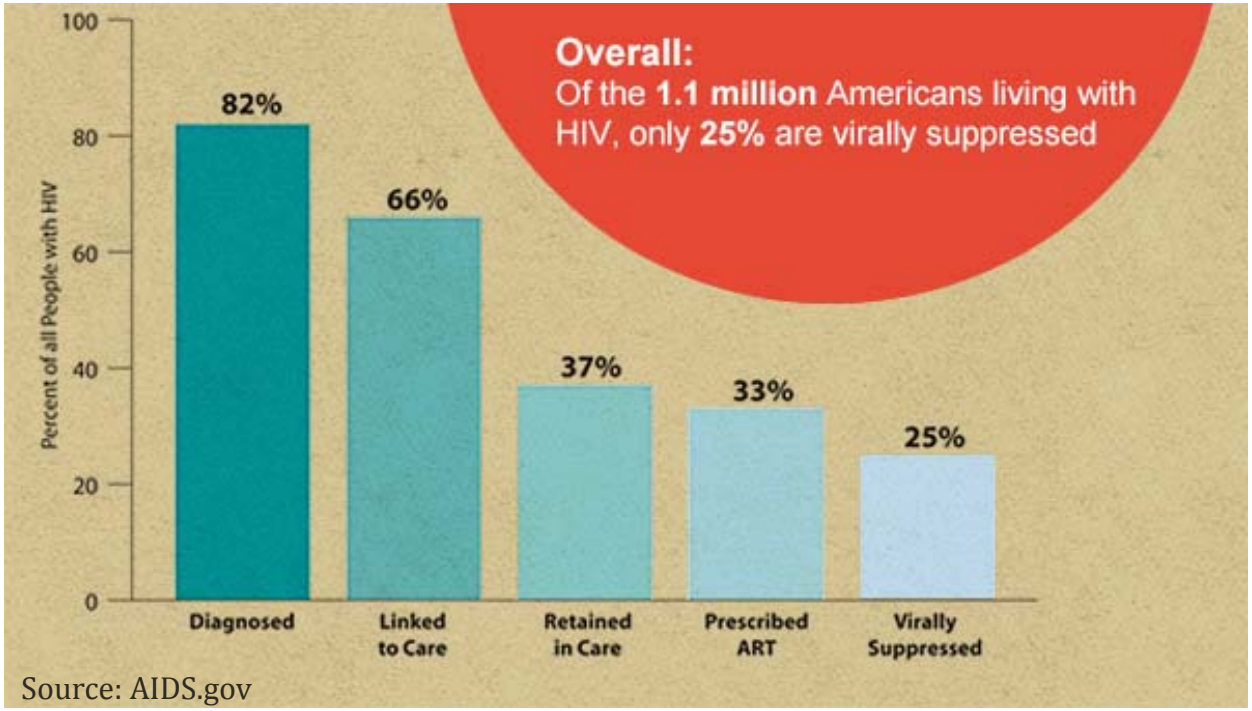
Background & Significance

HIV Continuum of Care



Source: AIDS.gov

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Background & Significance

- National AIDS Strategy
  - Reducing the number of people who become infected with HIV
  - Increasing access to care and optimizing health outcomes for people living with HIV, and
  - Reducing HIV-related health disparities

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Background & Significance

Homelessness and HIV:

- HIV is 3-9 times more prevalent among homeless individuals than those in stable housing (Kidder et al., 2006)
- Limited or inadequate health care utilization reported among unstably housed persons living with HIV (Aidala et al., 2007).
- Less likely to have ever been prescribed or actively taking HIV antiretrovirals (Kidder et al., 2006).
- More likely to use emergency rooms for HIV care or be hospitalized due to HIV related complications (Arno et al., 1996).

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Background & Significance

Behavioral Health, Homelessness and HIV:

- 26.2% of homeless population suffer from severe mental illness problem (HUD, 2010).
- 34.7% of homeless population have substance abuse problem (HUD, 2010).
- Injection drug use accounts for 9% of HIV/AIDS diagnoses (CDC, 2012).

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Building a Medical Home Initiative

Goal

To engage homeless/unstably housed persons living with HIV who have persistent mental illness and/or substance use disorders in HIV and behavioral health care and to assist in obtaining housing

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Intervention Model

- Building a medical home for HIV positive homeless population
  - Housing partnerships
  - Behavioral health partnerships
  - Systems integration
- Use of network navigators for systems integration and care coordination

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Study Design Overview

- Nine demonstration sites
- Methodology
  - Longitudinal study with data collection at baseline, and follow-up points at 3,6,12, and 18 months
- Data collection instruments
  - Client interviews
  - Medical chart review
  - Intervention encounter form

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Study Design Overview

- Evaluation measures
  - Outcome measures
    - Clinical: CD4 and viral load, HIV primary care visits, behavioral health visits, quality of care, housing and HIV case management visits
    - Client level: perceived stigma, health related quality of life, housing status, HIV treatment adherence, substance use, mental health, etc.
  - Process measures
    - Number and duration of encounters with intervention staff, activities with intervention staff, types of encounters
    - Building a medical home: patient quality of care measures (for homeless), self-management and end-of-life plan
      - Qualitative supplement: provider and staff in-depth interviews

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Building a Medical Home for Homeless Populations

James Apt, Housing Case Manager
Boston Health Care for the Homeless Program
HIV Team

Patient Centered Medical Home

- Different agencies offer certifications/recognition for PCMH
  - National Committee for Quality Assurance – Levels 1-3 Recognition
  - Joint Commission on Hospital Accreditation – Certification
  - May be payment incentives in some states for meeting the goals
- Some clinics will develop the program philosophically without recognition/certification

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What is a Patient Centered Medical Home?

- A model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

- It is a place where patients are treated with respect, dignity, and compassion, and enable strong and trusting relationships with providers and staff.

- The medical home is not a final destination instead, it is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs.

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Characteristics of Our Chronically Homeless Clients…

- History of mental illness, domestic violence and substance abuse
- Frequent visits to ER
- History of incarceration
- Limited housing and employment history
- Not adherent to HIV meds
- Comorbidities such as Hep C, diabetes, hypertension, and depression.

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Navigator's Role in a PCMH

- Offer a deeper level of support for patients.
- Build effective one-on-one relationships with patients to engage (or retain) the patients in care while maintaining a consistent, holistic approach.
- Can literally meet patients were they are at, via outreach and office-based meetings.
- Meet regularly with clinical team to coordinate efforts on behalf of patients.

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What does PCMH Mean for Homeless Persons?

- Medical needs and psychosocial needs are greater in the homeless population
- Navigator/case manager intervention can be critical to improved health outcomes
- Communication with the entire team necessary for comprehensive care.
- Sharing information with all providers, even those outside of the primary care setting is facilitated by navigator
- In a population that suffers so much loss, the trust and relationship built with a PCMH team can feel like “home”

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Implementing a Navigator Model

Meghan Dalton, LMSW
Director of Homeless Programs
AIDS Arms, Inc.

Health, Hope & Recovery Program Highlights

Client Centered

- Reduce barriers by meeting clients in the community, under bridges, in encampments, at local shelters, etc.
- Clients lead the work by setting their own goals

Collaboration with:

- Client
- Medical/Psychiatric Team
- Mental Health/Substance Abuse Providers
- Social Service and Homeless Providers
- Support System

Strengths Based

- Care Coordinators work with clients to identify and build on client's strengths

Harm Reduction

- Care Coordinators utilize the harm reduction model to address substance abuse and risky behaviors

Long Term Intensive Intervention

- 16-18 month intervention followed by a 7 month maintenance mode

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Barriers to Care for A Complex Population

- Trauma
- Transportation
- Focus is on Surviving (arranging shelter, timing of meals, etc.)
- Loss/Theft of Medications
- Managing Side Effects without Facilities
- Stigma (Internal and External)
- Active Substance Abuse
- Limited Support System

Barriers to Achieving Stability Addressed By:

- Trauma/Stigma (Internal and External)
  Trauma Informed Care

- Transportation
  Bus Passes and Public Transportation Education

- Focus is on surviving (arranging shelter, timing of meals, etc.)
  Emergency Housing
  Food Vouchers and Pre-packaged Food Supply
  Pre-Paid Cell Phones Provided: Appointment and medication reminders programmed into phone

- Loss/Theft of Medications and Documents
  - *Organizational Supplies (med boxes/backpacks)*
  - *Locks*
  - *Document Storage*

- Managing Side Effects without Facilities
  Assist with locating safe and stable shelter

- Active Substance Abuse
  - *Integrate substance use goals into the care plan utilizing a Harm Reduction model*

- Limited Support System
  Connect with Behavioral Health, Legacy, The HIVE, Resource Center of Dallas, The Well
  Monthly Psycho-educational Meetings

Building Partnerships

Strong Network

Food Pantry/Meals

Mental Health, Psychiatric Substance Abuse Services

Clothing

Dental

Religious/Spiritual Services

Women's Services

Hygiene

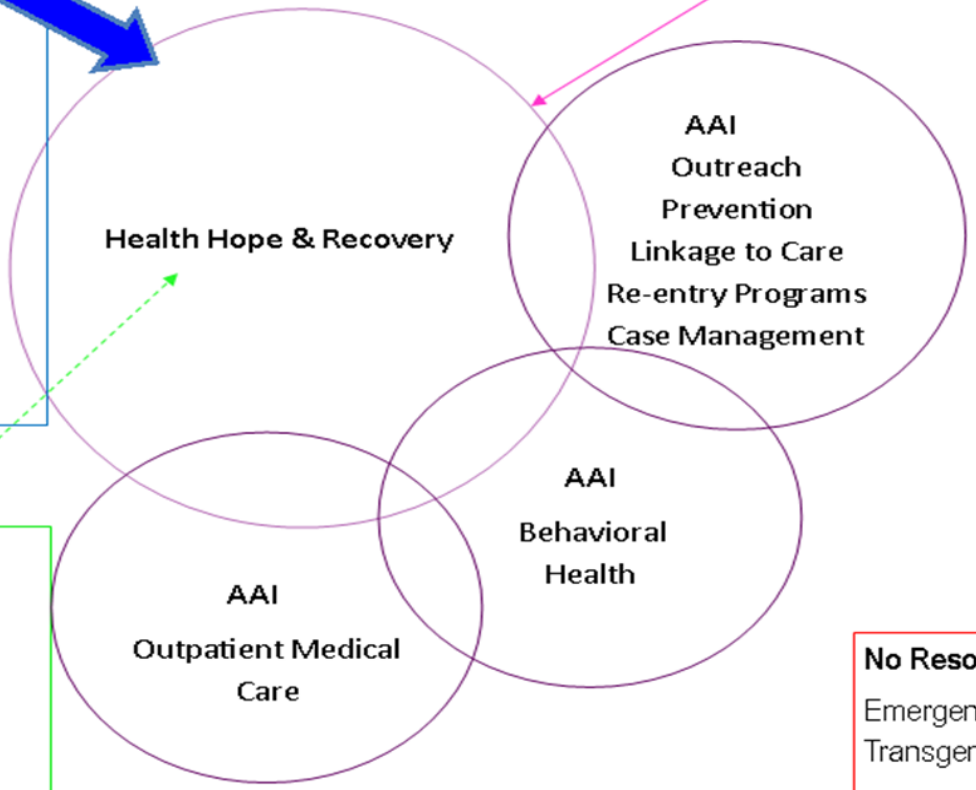
Veteran Services

Pet Services

AIDS ARMS

Health, Hope, & Recovery

Community Service Network



Moderate Network

Housing

Prescription Assistance

Vision

Emergency Shelter

Job Search/Training

Emergency Financial Assistance

ID and Document Replacement

Transportation

Legal (Civil)

SSI/SSDI Application Assistance

Medical Specialty Care

Weak areas/gaps

Legal (Criminal)

Social Activity Programs

Domestic Violence Services

Communication

No Resources Available

Emergency Shelter/Housing for Transgendered Individuals

AIDS Arms, Inc.

Day in the Life

5:00-6:00am– Rise and shine .
6:00– 6:30am– Leave before breakfast in order to avoid fights with other guests.
6:30- 7:00am Take medications / Walk to the Stewpot.
7:00-8:00am- Struggle with constant diarrhea while waiting in line for ID replacement services at the Stewpot as a result can't complete paperwork today.
8:00-10:30am– Threatened with loitering charges by police while sitting outside Stewpot
10:30-11:30am- Walk to AIN.
11:30-1:30am– Feeling weak but manage to make it to DAIRE center for lunch.
1:36-2:00pm Take Bus to Trinity
2:00-3:30pm Meet with medical provider. Medical provider sends me to Parkland via ambulance for severe dehydration.
4:00- 11:30pm– Feeling better after ER visit and but lost mat due to missing shelter check in.
10:00pm– Attempt to get some sleep in a folding chair at the shelter.

The Health, Hope & Recovery Program could have...

- Held client's place in line while he struggled with medication side effects so client could complete ID paperwork needed for housing and employment.
- Provided secure storage for client's documents/ medical records in order to prevent theft/ damage.
- Provided bus passes or arrange caravan services for all medical appointments.
- Called the shelter to secure a "crisis recovery mat" upon ER discharge.
- Provided coping strategies on how to handle conflict as well connection to mental health services.
- Advocated for client with shelter, medical and social service staff.

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Strategies to Identify & Outreach to Persons in Need of HIV Medical & Housing Services

Angélica Palmeros, MSW
Project Director, Operation Link
Pasadena Department of Public Health

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Outreach Concept

- To engage individuals and agencies to collaborate, identify, refer and link to project program;
- To provide services to persons “where they are at” ;
- To establish rapport with individuals within the environmental and community context;
- To assist potential clients in accessing services, needed; especially clients who have difficulty engaging into treatment and care on consistent basis;
- Opportunity to build and establish a relationship among clients who are distrustful of systems of care;

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Modalities of Outreach

- Street Mobile Unit Locations
- Foot Outreach
- Social Network
- Marketing
- Service Provider

Service Area

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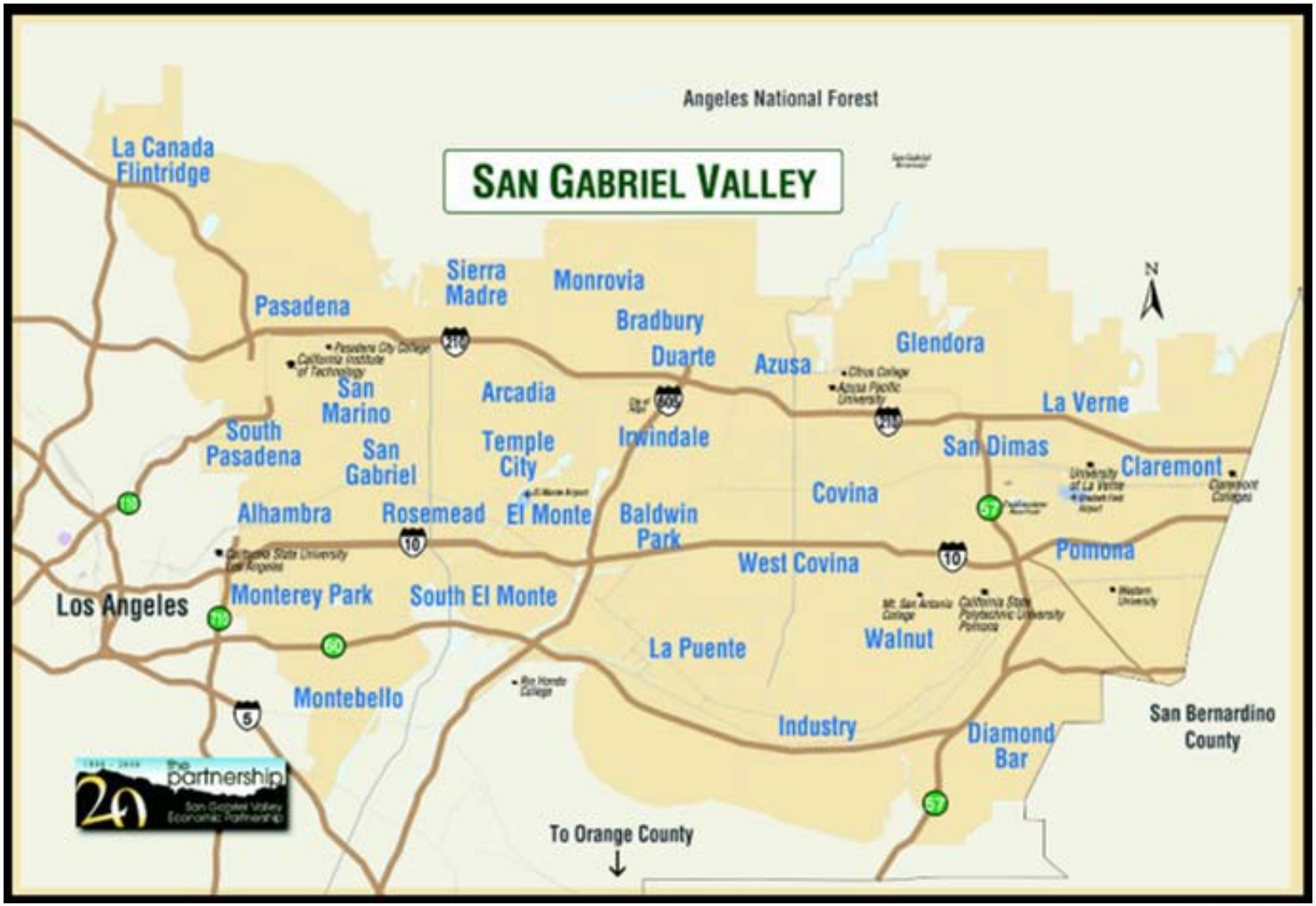
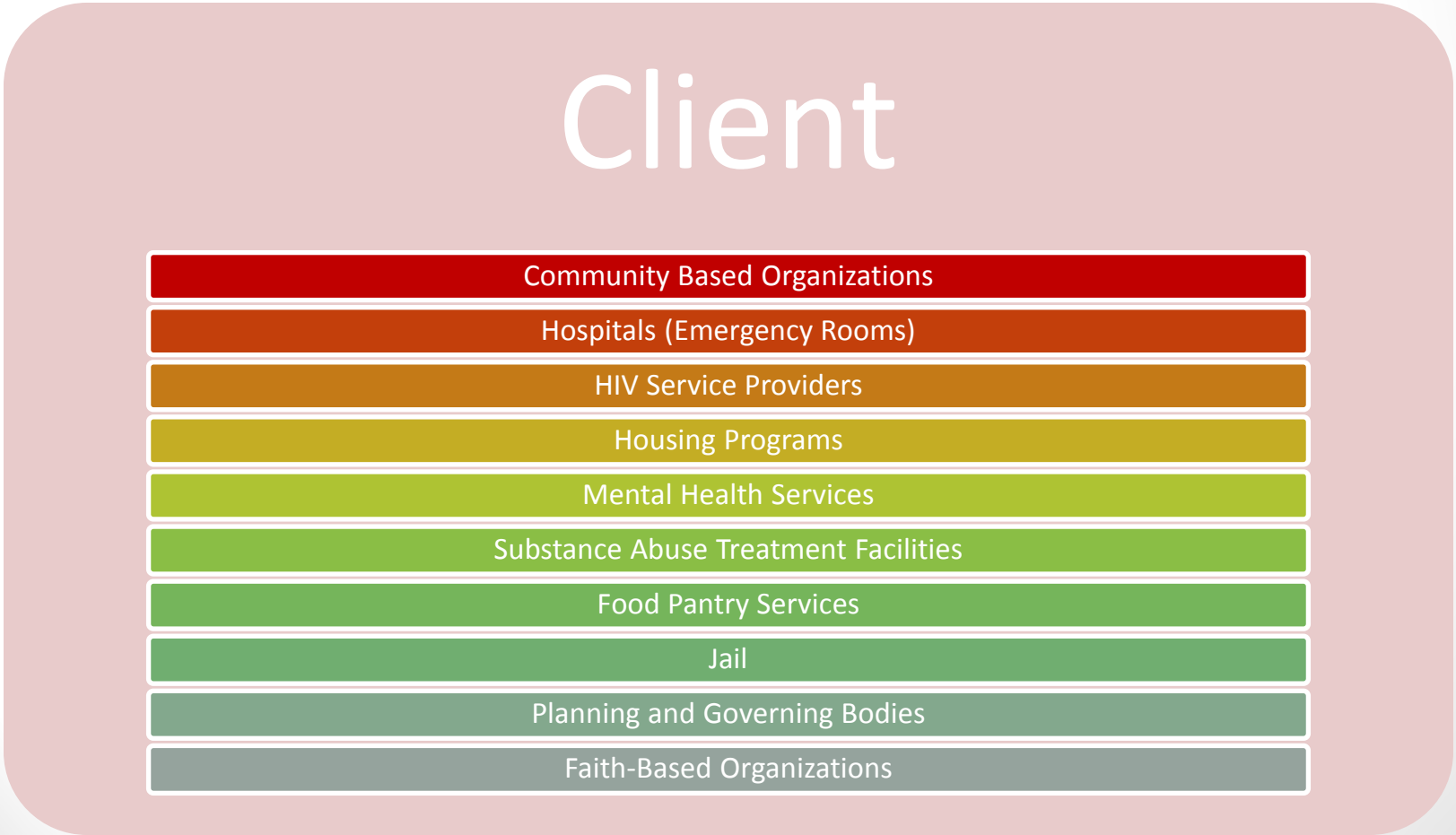


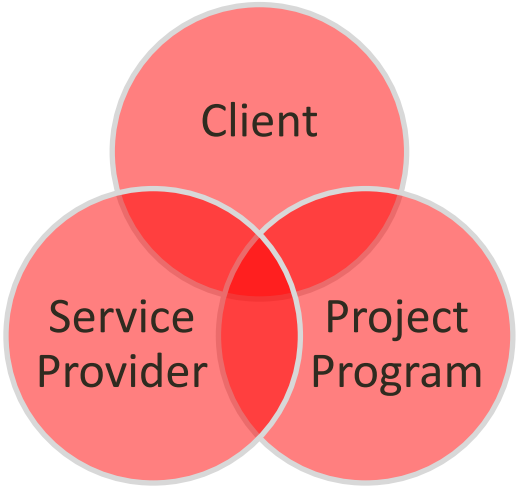
Service Provider Outreach

- Identification of service providers that serve the targeted population (points-of-entry)



Developed Relationships

- Conducted agency site-visits to develop and establish a liaison between the agency and the community.
- Face-to-Face, allowed an opportunity to develop trust, foster networking and collaboration between existing services and organizations.



Creation of the Network of Providers

The outreach process allowed the development of establishing formal relationships among the network of providers, expected goals:

- Incorporate the role of the Peer Care Navigation among the network providers;
- Increase awareness and decrease stigma;
- Improve the identification of client's in need of intensive services;
- Improve linkages to care and preventative supportive services;
- Increase client adherence to HIV/AIDS, Mental Health, and Substance Abuse Treatment;
- Improve the client's housing situation;
- Improve the client's medical and behavioral health outcomes;
- Institutionalize the Mobile Unit's presence in the community;
- Enhance relationships among and coordination between network providers;
- Enhance and improve the network by increasing the number of providers and breadth of services;
- Increase access points for clients.

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Service Partnerships

- Incorporate HIV and STD Prevention Services
- Support our community partnerships
- Establish trust among network providers
- Increase ability to track clients and re-engage back into care and treatment.

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Social Network

- Identified internet sites, such as grindr, blendr, twitter, and facebook;
- Most clients are self-referred;
- Client has the ability to contact project assistant.

Foot Outreach

- This approach provided the ability to engage a “potential” client into services. Locations included public areas, such as the parks, libraries, college campuses, freeway (underpass, overpass), community centers and business areas.
- Staff engage individuals, and move down a street, walking through the park, which allows them to discretely screen and engage potential clients. Small incentives are provided.

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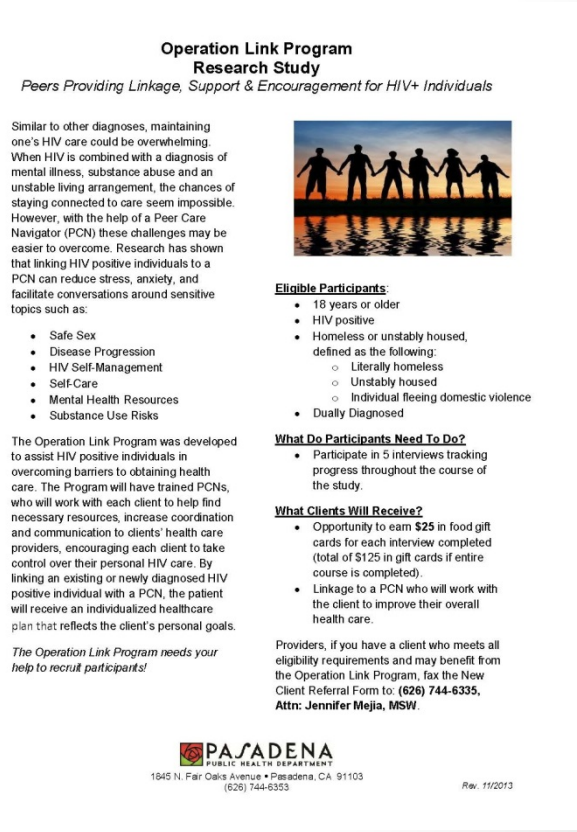
Marketing Outreach

- Traditional approaches via the use of e-mails, flyers, pamphlets, program website link, etc.



Operation Link Program
Research Study
Peers Providing Linkage, Support & Encouragement for HIV+ Individuals

Similar to other diagnoses, maintaining one's HIV care could be overwhelming. When HIV is combined with a diagnosis of mental illness, substance abuse and an unstable living arrangement, the chances of staying connected to care seem impossible. However, with the help of a Peer Care Navigator (PCN) these challenges may be easier to overcome. Research has shown that linking HIV positive individuals to a PCN can reduce stress, anxiety, and facilitate conversations around sensitive topics such as:

- Safe Sex
- Disease Progression
- HIV Self-Management
- Self-Care
- Mental Health Resources
- Substance Use Risks

The Operation Link Program was developed to assist HIV positive individuals in overcoming barriers to obtaining health care. The Program will have trained PCNs, who will work with each client to help find necessary resources, increase coordination and communication to clients' health care providers, encouraging each client to take control over their personal HIV care. By linking an existing or newly diagnosed HIV positive individual with a PCN, the patient will receive an individualized healthcare plan that reflects the client's personal goals.

The Operation Link Program needs your help to recruit participants!

Eligible Participants:

- 18 years or older
- HIV positive
- Homeless or unstably housed, defined as the following:
  - Literally homeless
  - Unstably housed
  - Individual fleeing domestic violence
- Dually Diagnosed

What Do Participants Need To Do?

- Participate in 5 interviews tracking progress throughout the course of the study.

What Clients Will Receive?

- Opportunity to earn **$25** in food gift cards for each interview completed (total of $125 in gift cards if entire course is completed).
- Linkage to a PCN who will work with the client to improve their overall health care.

Providers, if you have a client who meets all eligibility requirements and may benefit from the Operation Link Program, fax the New Client Referral Form to: **(626) 744-6335, Attn: Jennifer Mejia, MSW**.

PASADENA PUBLIC HEALTH DEPARTMENT
1845 N. Fair Oaks Avenue • Pasadena, CA 91103
(626) 744-6353

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Street Mobile Services

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This community-based approach consists of five intervention strategies:

- Develop and adhere to a routine monthly schedule in locations where potential clients and clients are likely to be found. The MCU is a multi-disciplinary team composed of the Peer Care Navigator, HIV Risk-Reduction Counselor, Substance Abuse Counselor and a Medical Care Coordinator (i.e., social worker);
- Engage and enroll clients in the program and conduct a customized needs assessment to assess their individual needs;
- Strategize a proposed plan for the potential client that identifies specific service providers in the target area that can meet the client's needs;
- Provide ongoing, consistent, and compassionate care navigation, transportation, and personal support to clients.
- Collect data during each client contact to support continuous quality improvement and the aggregate reporting of outcomes at the client- and project- levels.

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Project Approach/Partner Agencies

Care Navigation
Peer Support
Medical Case Management

- Screened for Eligibility and Needs
- Coordinates Services Across Providers
- ID/Eliminate Barriers to Service
- Strengthen/ Expand Network

Community Services/Collaborators

Alliance for Housing and Healing	IMPACT Drug & Alcohol Treatment	Pasadena Housing & Homeless Network	Pasadena Police Department & HOPE Team
San Gabriel Valley Housing & Homeless Coordinating Council	Union Station Homeless Services	AIDS Service Center	Pasadena Housing Department

City of Pasadena Public Health Department

Dental Clinic	Food Pantry	Medical Care Coordination	Recovery/ Substance Abuse Clinic
Transportation	Mental Health	Benefits Specialty	HIV Counseling and Treatment

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Drop-In Locations

DO YOU KNOW YOUR STATUS?
DO YOU KNOW YOUR PARTNER'S STATUS?

HAVE YOU PARTICIPATED IN ANY OF THESE ACTIVITIES:

PRISON TATTOOS

UNPROTECTED SEX

SHARING NEEDLES OR

PIPES FOR DRUG USE

GET TESTED KNOW YOUR STATUS

GET A FREE HIV TEST

Weekday Drop-in Schedule, Find Us!

To find us at weekend events, follow us on Facebook.

Mon	Tue	Wed	Thu	Fri
1st Monday of the Month Location: Corner of Walnut Ave & Garfield Ave Time: 4:30pm-8:00pm				
			3rd Thursday of the Month Location: 500 N. Villa Ave, Pasadena, CA 91104 Time: 12:30pm-2:30pm	
4th Monday of the Month Location: 9900 Baldwin Pl, El Monte, CA 91731 Time: 10:00am-2:00pm			4th Thursday of the Month Location: Corner of Hammond St & Morton Ave Time: 5:00pm-9:00pm	4th Friday of the Month Location: Corner of Orange Grove Ave & Marengo Ave Time: 5:00pm-9:00pm

OPERATION STREET TEAM

If you have any questions, please call Sandra at 626-744-6098

Andrew Escajeda
Comprehensive Care Services

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Protect. Promote. Live Well.

Rev: 09/2013

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Mobile Unit Services

- HIV Testing
- Food Baggies and Hygiene Bags (Incentives)
- HIV and STD Education and Counseling
- Brief Benefit Assessment
- Social and Health Referrals
- Housing Referrals
- Substance Abuse Prevention Support

Existing Clients

- Case Management Services
- Emotional and Social Support
- Food Baggies

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Role of Navigator in Engaging & Retaining Persons in HIV Care

Jodi Davich
Project Manager, HIV Health Services Center
Multnomah County Health Department

Multnomah County HIV Clinic: A Little Context…

- Largest provider of primary care to Oregon's Medicaid, uninsured and low-income persons living with HIV/AIDS.
- Serve about1300 PLWH each year.
- 1 in 5 patients are homeless or unstably housed.
- Our navigator and housing partner is Cascade AIDS Project.

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Multnomah County HIV Clinic: Who We Serve…

- 84% of clients are male.
- 46% of clients are over 44 years old.
- 30% of clients are persons of color.
- 20% of our clients have been incarcerated at least once in the past two years—many are repeat offenders.
- Most clients have several co-morbid conditions.
- Our clients have high rates of substance abuse (29%) and mental illness (56%).

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Our Medical Home Priorities…

- Engage our clients in all aspects of their medical care
- Remove barriers to care
- Improve clinical outcomes
- Improve the patient experience of care
- Decrease or sustain the cost of care

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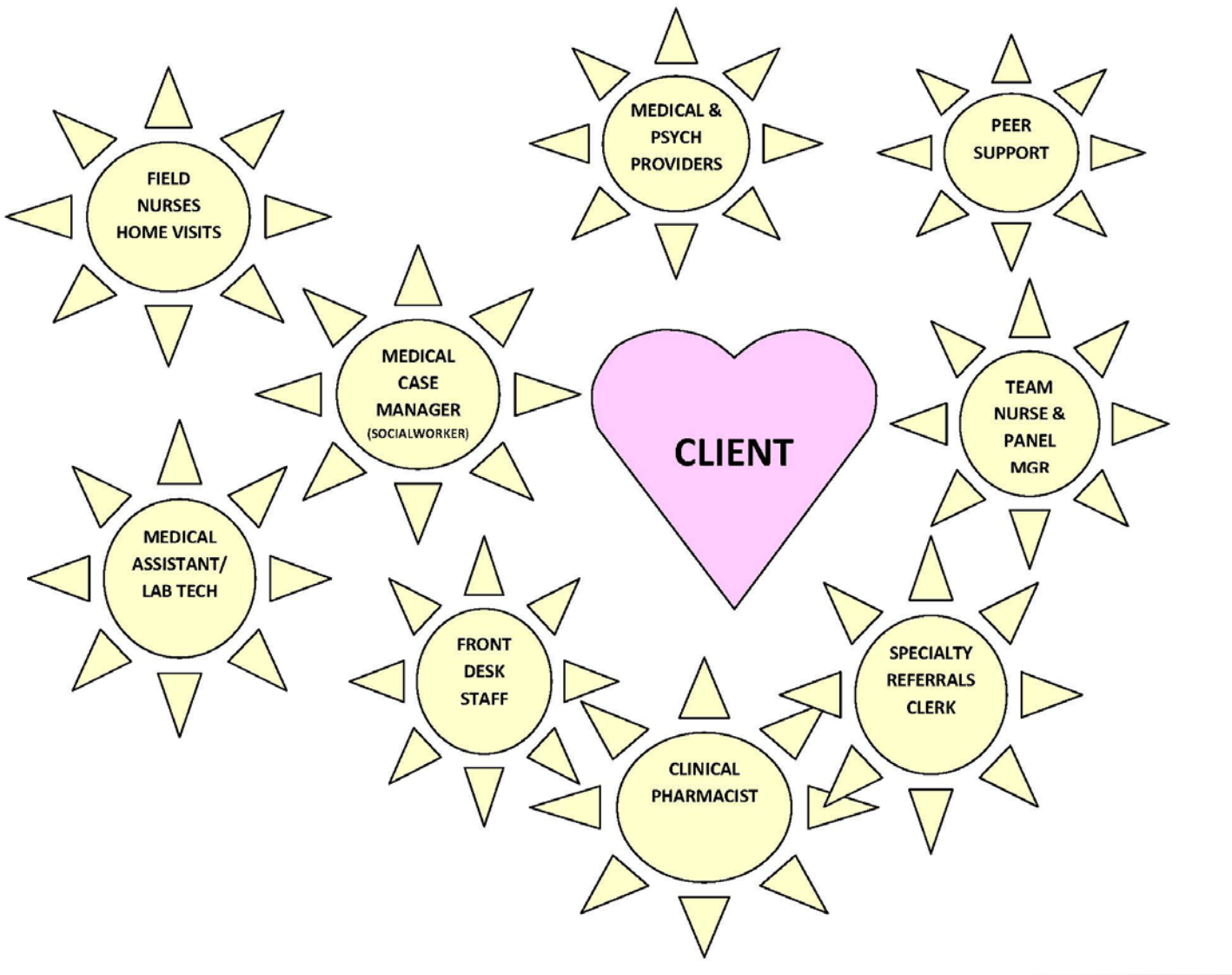
Medical Home Community

Our Original Medical Home Model….



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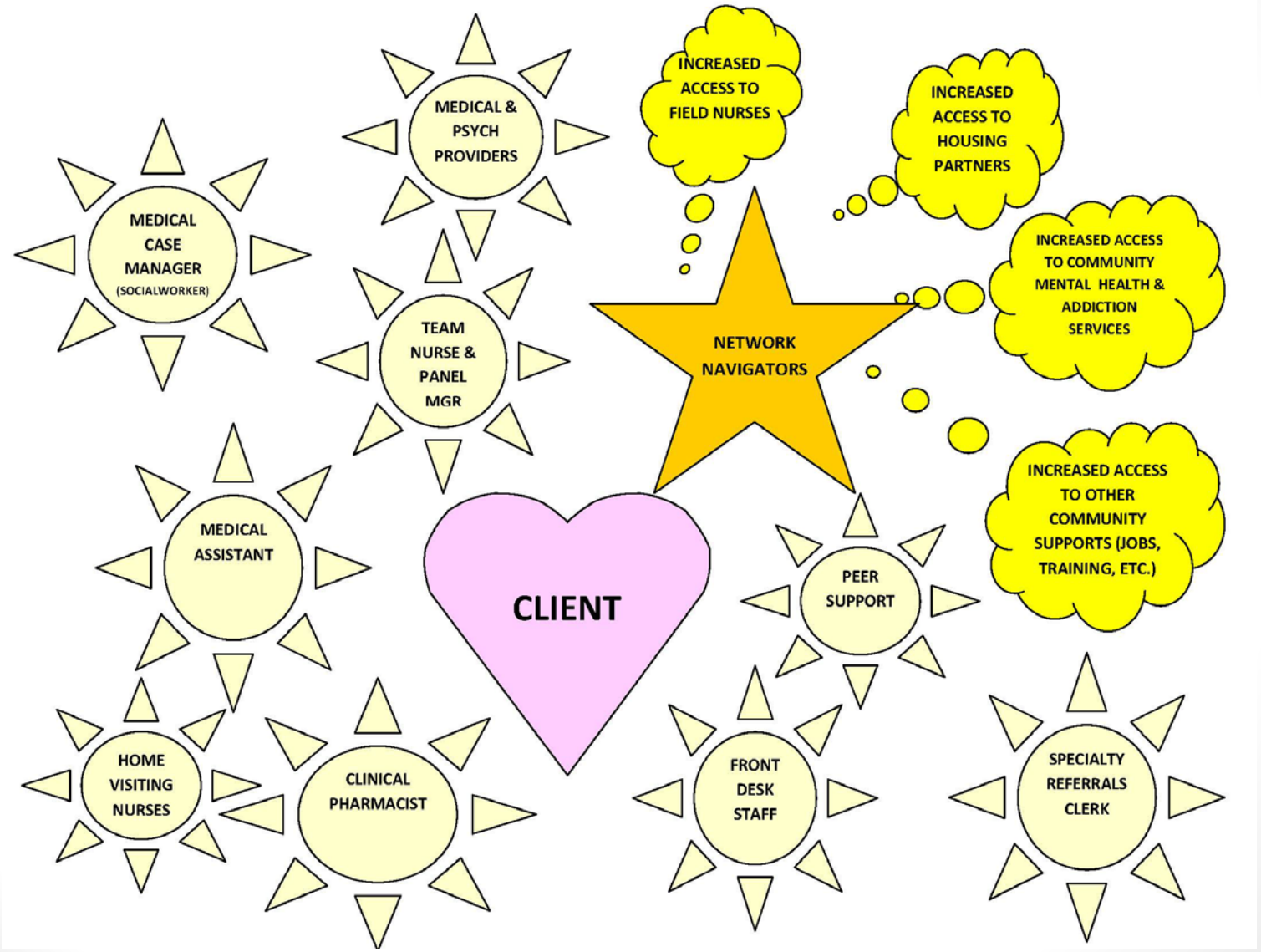
HOWEVER…..

- This model was not effective with our chronically homeless patients.
- Medical case managers and other staff had huge caseloads and limited ability to leave clinic in order to find and serve our homeless clients.
- Community Health Nurses were trained to make “home” visits not shelter and street visits.
- Clinical outcomes (Cd4 and VL) for homeless were worse than the average outcomes for all patients.

How Our Model Changed….



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Navigators Use the Stages of Change Strategies…

- Educate on risks versus benefits and positive outcomes related to change
- Identify barriers and misconceptions
- Address concerns Identify support systems
- Develop realistic goals and timeline for change
- Provide positive reinforcement
- Provide positive reinforcement
- Provide encouragement and support

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Role of Navigator in Engaging & Retaining Persons in HIV Care…

- Establish rapport with clients.
- Facilitate relationship building between the patient and their medical team.
- Advocate for the needs of clients.
- Guide the client to develop a series of brief interventions/action plans to address barriers to care and other issues.
- Serve as a liaison between client and medical team until client has established rapport with clinic staff and is firmly engaged in care.

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Role of Navigator in Engaging & Retaining Persons in HIV Care…

- Attend medical team huddles and semi-monthly case consult meetings with the provider team staff.
- Accompany clients to appointments to facilitate access to medical care, substance abuse treatment, mental health services, housing and other needed services.
- Work collaboratively with medical case managers, CAP housing case managers, and other service providers to develop individual client goal plans and provide intensive support to clients in carrying out their goal plan.

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QUESTIONS?